

Indicator development programme

Consultation report

Indicator area: Mental health

Consultation period: 04 October 2022 to 18 October 2022

Date of Indicator Advisory Committee meeting: 07 November 2022

Executive summary.....	2
IND2022-127: Mental health: physical health checks	4
Appendix A: consultation comments.....	6

Executive summary

Overview

This paper presents a proposal for a mental health indicator potentially suitable for use in the Quality and Outcomes Framework (QOF):

- IND2022-127: Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.

The purpose of the annual checks is to identify and address risk factors linked to premature death: people with severe mental illness (SMI) are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population. Individual indicators on the provision of these health checks are already part of the NICE indicator menu and included in the QOF 2022/23. This indicator measures whether people receive all elements within a 12-month period. After committee consideration the indicator may progress to publication.

Development

The September 2021 Indicator Advisory Committee discussed a proposal from NHS England for a composite indicator on 6 physical health checks for people with schizophrenia, bipolar affective disorder and other psychoses. The committee rejected progression to the NICE menu because NHS Digital advised that a personalised care adjustment (PCA) against any of the 6 checks would remove the patient entirely from the denominator. There would therefore be no incentivised requirement to provide the remaining checks.

A similar indicator is been included in the [Network Contract Directed Enhanced Service for 2022/23](#) (HI-16). The construction does not remove patients from the denominator simply because of a PCA against any of the health checks. The only people removed from the denominator are those who have not had all 6 health checks but have PCAs for those not provided.

[Business rules](#) are published by NHS Digital.

Item 6: Mental health consultation report

Context

The 2022/23 QOF contains 6 indicators relating to single elements of this proposed indicator, for people with schizophrenia, bipolar affective disorder and other psychoses. 2021/22 national intervention rates show some variation across indicators:

- MH003 blood pressure: 70%
- MH006 BMI: 68%
- MH007 alcohol consumption: 63%
- MH011 lipid profile: 61%
- MH012 blood glucose: 60%
- SMOK002 smoking: 91%

[Network Contract Directed Enhanced Service data](#) for September 2022 for HI-16 show 26% of patients received all 6 checks in the preceding 12 months.

Potential benefits

Identifying and addressing these risk factors can support reductions in premature death of people with SMI.

Validity concerns

There are no specific guidance recommendations stating that smoking status should be reviewed annually for people with SMI, although [NICE's guideline on tobacco](#) (2021), recommends checking at every opportunity.

Stakeholders have flagged the potential to increase inequalities in deprived areas and that the indicator may improve PCA recoding rather than increase provision of health checks.

Committee decision

The committee is asked to decide whether the indicator should progress to the NICE menu as suitable for inclusion in the QOF.

IND2022-127: Mental health: physical health checks

Percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.

Rationale

The aim of the annual checks is to identify and address modifiable risk factors linked to premature death. People with severe mental illness (SMI) are at a greater risk of poor physical health and die on average 15 to 20 years earlier than the general population. Major causes of death in people with SMI include cardiovascular disease, respiratory disease, diabetes and hypertension ([PHE 2018](#)). It is expected that this indicator, incorporating all six elements of the physical health check, will increase the number of people with SMI who receive these checks annually.

Specification

Numerator: the number in the denominator who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness.

Denominator: the total number of registered patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses.

Definition: The six elements of physical health checks are:

- a record of blood pressure.
- a record of BMI.
- a record of alcohol consumption.
- a record of a lipid profile.
- a record of blood glucose or HbA1c.
- a record of smoking status.

Exclusions: Patients in remission

Item 6: Mental health consultation report

At the patient level, personalised care adjustments (PCAs) against each health check should be considered to account for situations where the patient declines, does not respond to invite or if the physical health check is not appropriate.

The denominator will include:

- Patients who have received all 6 physical health checks
- Patients who have not received all 6 checks, and for at least one of these checks there is no personalised care adjustment recorded.

Patients who have received less than 6 health checks but whose total number of health checks plus PCAs equals exactly 6 will be rejected from the denominator as a PCA.

Summary of consultation comments

Stakeholders welcome the inclusion of this indicator, commenting it will have a positive impact on health outcomes for people with severe mental illness.

Stakeholders noted that it can be difficult to engage people with severe mental illness and they felt that this indicator may disadvantage practices in more deprived areas.

Stakeholders had some concern that the people with severe mental illness who are at most need will still be missed as they will be excluded using PCAs.

Stakeholders felt that this has the potential to be a tick box exercise that is increasing the use of PCA coding, not the provision of interventions.

Committee decision

The committee is asked to decide whether the indicator should progress to the NICE menu as suitable for inclusion in the QOF.

Appendix A Consultation comments

Question 1: Do you think there are any barriers to implementing the care described by these indicators?

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH1	1	British Cardiovascular Society (endorsed by Royal College of Physicians)	No	Thank you for your comment.
SH2	1	British Medical Association	Regarding barriers, respondents noted that General Practice does not 'come to the patient', which is what is required to engage with and manage patients with SMI. One respondent flagged that these patients are often managed by mental health providers and General Practice, making it particularly challenging to organise their care.	Thank you for your comment. The committee noted the additional barriers that might need to be reflected through the use of achievement thresholds if included in QOF.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH3	1	Centre for Mental Health (on behalf of the Equally Well UK collaborative)	We do not believe there are any major barriers to implementing this measure that cannot be overcome. The proportion of people with 'SMI' receiving annual health checks is rising, but not everyone gets all six elements. Staffing resources are the biggest barrier to achieving this, but the revised indicator would create an extra incentive for investment in the workforce required to implement it at scale. In some areas of the country, including Sheffield, City and Hackney, and Cambridgeshire, outreach programmes and the employment of additional staff (such as healthcare assistants) to lead on this provision have ensured more people get access to this service.	Thank you for your comment. The committee noted the additional barriers that might need to be reflected through the use of achievement thresholds if included in QOF.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH7	1	Rethink Mental Illness	<p>One potential barrier to implementing the care described is the capacity of primary care providers. Capacity to deliver this kind of routine check-up has been cited as a barrier to delivery of Physical Health Checks and meeting of the target since it was set within the Five Year Forward View for Mental Health back in 2015. Since not all six parts of the Check need to be delivered by a medical professional, GPs should think creatively to utilise staff within their practices and/or work in partnership with other sectors to deliver all the various components of the Physical Health Check and ensure achievement of this indicator. We would also encourage systems to explore community-based VCSE and peer-led approaches to the delivery of Physical Health Checks to improve uptake of Physical Health Checks. Rethink Mental Illness and the Royal Voluntary Service have recently produced a proposal that would utilise RVS volunteers to support individuals living with severe mental illness to attend and make the most of their annual Health Check.</p>	<p>Thank you for your comment. The committee noted the additional barriers that might need to be reflected through the use of achievement thresholds if included in QOF.</p>

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH8	1	Royal College of Speech and Language Therapists	<p>The RCSLT is concerned that the indicator will not lead to improved outcomes for people with mental health needs.</p> <p>People with severe mental illness have a higher prevalence of speech, language and communication needs (Walsh et al 2007). As a result, people may struggle to understand what is happening during the physical health check, to take part and to explain any health concerns. Further consideration of communication needs and ensuring that a person can understand what is happening to them, needs to take place to improve conversations about better health.</p>	Thank you for your comment. This has been highlighted in the equality considerations for this indicator.

Question 2: Do you think there are potential unintended consequences to implementing/ using any of these indicators?

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH1	2	British Cardiovascular Society (endorsed by Royal College of Physicians)	No	Thank you for your comment.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH5	2	NHS England	<p>I agree that these physical checks are important to be done.</p> <p>But there will need to be flexibility when and how these checks are done.</p> <p>These checks should be allowed to be done more opportunistically and also not be template driven.</p> <p>The unintended consequence would be that if opportunistic capture of data is not done – this might lead on some occasions to some patients missing the tests happening as the appointments made for them could get missed or they could get missed in process of organizing a formal assessment for them.</p>	<p>Thank you for your comment. This indicator will not require all of the elements of the physical health check to be completed at once, they can be completed across several consultations.</p>
SH8	2	Royal College of Speech and Language Therapists	<p>Yes, this may show a need to dramatically increase training in speech, language and communication needs amongst those carrying out the physical health check.</p>	<p>Thank you for your comment.</p>

Question 3: Do you think there is potential for differential impact (in respect of age, disability, gender and gender reassignment, pregnancy and maternity, race, religion or belief, and sexual orientation)? If so, please state whether this is adverse or positive and for which group.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH1	3	British Cardiovascular Society (endorsed by Royal College of Physicians)	No	Thank you for your comment.
SH2	3	British Medical Association	<p>Regarding the potential for a differential impact, respondents noted that cholesterol disease and Diabetes are more prevalent in ethnic minorities, whereas alcohol related disease is more prevalent in deprived communities. Practices in deprived areas will therefore have a much harder battle to achieve this target (compounding existing inequalities)</p> <p>Other respondents noted that many patients with SMI have less structured lifestyles, making it very hard to engage with them.</p>	Thank you for your comment. The committee noted the additional barriers that might need to be reflected through the use of achievement thresholds if included in QOF.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH3	3	Centre for Mental Health (on behalf of the Equally Well UK collaborative)	We are concerned that the definition of 'severe mental illness' used in the QOF excludes people with equally severe mental health conditions who do not fall within the current description. This is particularly the case for people with a 'personality disorder' diagnosis, whose life expectancy is similar to that for someone with psychosis but who are typically excluded from the 'SMI' list.	Thank you for your comment. Adults with other mental health conditions, such as personality disorder, are not included in the indicator as these checks are not recommended annually by NICE guidance for this population.
SH3	3	Centre for Mental Health (on behalf of the Equally Well UK collaborative)	It is likely that achieving this indicator will expose needs that have previously been hidden. Rates of diabetes and heart disease are likely to be considerably higher than has been recognised among people with severe mental illness, and it will be important for health checks to prompt interventions to support people identified as having needs. It will, nonetheless, be essential to tackle a major health inequality and to ensure people's health care is improved markedly and better integrated.	Thank you for your comment.

Question 4: If you think any of these indicators may have an adverse impact in different groups in the community, can you suggest how the indicator might be delivered differently to different groups to reduce health inequalities?

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH1	4	British Cardiovascular Society (endorsed by Royal College of Physicians)	<p>The 6 elements of the physical health check in mental health do not include any measures of socioeconomic wellbeing, although these also are determinants of cardiovascular disease. The physical health checks may therefore have differing impacts or relevance on people from different socioeconomic backgrounds.</p> <p>Similarly, there is no recognition of air pollution impacts on these patients' CVD health, although this is also a strong determinant of events. Air pollution effects disproportionately affect people of non-white ethnicity and of lower socioeconomic level. Failure to incorporate this in measures of risk will disadvantage people with SMI from those groups therefore.</p> <p>BCS suggests inclusion of recording socioeconomic factors as well as correlation with prevalent air pollution levels around the person's place of residence.</p>	<p>Thank you for your comment. This indicator has been developed to ensure the 6 physical health checks are being completed for this population. There are currently individual indicators covering each specific check however data shows that only a small proportion of the population are receiving all of these checks.</p> <p>Your comments on air pollution have been noted but not included in this indicator as this does not form part of the 6 physical health checks.</p>

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH5	4	NHS England	<p>There is potential that this draft indicator will have a positive differential impact on people from certain ethnic groups.</p> <p>Research indicates that people living with SMI from certain ethnic groups are more likely to experience multimorbidity. For instance, a study (Fonseca de Freitas 2022) found that among people with psychosis (controlling for sociodemographic factors and duration of care), compared to White British people, there was higher odds of multimorbidity for people of Black African, Black Caribbean and Black British ethnicity.</p> <p>Given higher rates of multimorbidity, delivery of a full physical health check for those living with SMI, will mean more people from certain ethnic groups may have physical health conditions identified earlier and be supported to take positive steps to improve and manage their physical health.</p>	Thank you for your comment. This positive impact of the indicator on people living with severe mental illness from some ethnic groups has been noted.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH8	4	Royal College of Speech and Language Therapists	<p>People with communication needs are more likely to have mental health needs, such as people with a learning disability or autistic people. If the indicator doesn't consider communication needs, people's ability to understand and take part, then these groups will be less likely to benefit from the aspiration of this indicator and benefit from improved health.</p> <p>To ensure that everyone can benefit equally the RCSLT recommends: (1) that in the physical health check it is recorded if someone has a communication needs; and (2) every person with complex communication needs has an advocate for example a family member, friend or speech and language therapy present, who know their communication ability and can help them understand what is happening and take part.</p>	Thank you for your comment. As noted above, communication needs have been added to the equality considerations for this indicator.

General comments

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH2	N/A	British Medical Association	Our respondents consistently stated that SMI must be dealt with in a systemic and preventative manner, and that in this sense QOF-related care is the ambulance at the bottom of the cliff. SMI interventions are very resource intensive and do not produce a high return on investment (with respect to patient health), and this indicator will considerably increase the associated workload. Some respondents worried that this indicator will be another 'tick box' exercise, rather than the holistic approach that is required.	Thank you for your comment.
SH2	N/A	British Medical Association	Respondents expressed consistent concern about the high number of health check 'elements' in this proposed indicator, increasing workload where there is very little capacity left in the workforce for additional activity, and that the amount of work required is not likely to be reflected in the resource attached, unless this is tagged with a large amount of QOF points.	Thank you for your comment. The committee noted the additional barriers that might need to be reflected through the use of achievement thresholds if included in QOF.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH2	N/A	British Medical Association	<p>Respondents approved of the inclusion of PCAs but raised concerns about the degree to which these are practical. Requiring a PCA against each individual health check is onerous, and the 'all or nothing' approach to PCAs is manifestly unfair; practices would not receive QOF funding for a patient even if they, for example, record BP and smoking status, and receive PCAs for alcohol consumption, BMI, and blood glucose (but no lipid profile). They noted needle-phobia as a major sticking point. We suggest reducing the number of elements, or to adopt a more permissive approach to PCAs as they apply to each health check element.</p> <p>Some respondents asked for further assurance that a PCA would apply where practices have, despite their best efforts, been unable to engage the patient to carry out this activity.</p>	<p>Thank you for your comment. This indicator would not require any additional coding of PCAs – they are already part of the construction of the current indicators used in QOF that focus on individual physical health checks.</p>
SH2	N/A	British Medical Association	<p>Some respondents asked whether the inclusion of this indicator is in response to SMI health checks (currently in place) not working/being effective, and what the evidential basis for concluding that this proposed indicator will work where the SMI checks have not.</p>	<p>Thank you for your comment. It is hoped that this indicator will ensure that more people with SMI receive all 6 physical health checks, leading to improvements in their care and, therefore, health.</p>

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH3	N/A	Centre for Mental Health (on behalf of the Equally Well UK collaborative)	<p>We strongly support the proposed new indicator to ensure that anyone registered with their GP as having a 'severe mental illness' received all six elements of the annual health check. We believe this is an important foundation for physical health needs to be understood in the round and any interventions or support that are needed to be identified. The experience of our GP member of the Equally Well UK clinical group is that the reinstatement of the MH indicators has both raised awareness of, and promoted action, amongst the practice team to address the health inequality and in turn lessen the impact of the documented diagnostic overshadowing impeding action in the past.</p>	Thank you for your comment.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH4	N/A	Mind	<p>Mind is generally supportive of this indicator. We know that people living with severe mental health problems are at higher risk of experiencing poor physical health and on average have a lower life expectancy. Evidence shows that premature mortality of people living with severe mental health problems is predominantly caused by poor physical health. It is essential that people living with a long-term mental health condition have access to effective, timely support for their physical health, and physical health checks for people living with severe mental illness (SMI) are key part of this. This indicator will allow us to monitor how successfully GPs are delivering on the requirement to provide physical health checks to people living with SMI and to push for improvements where we see shortcomings.</p>	Thank you for your comment.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH4	N/A	Mind	<p>We have picked up on a discrepancy in the definition of those who are eligible for the physical health checks. In the NICE consultation the indicator is measuring the 'percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who, in the preceding 12 months, received all six elements of physical health checks for people with severe mental illness'. However, the NHS England technical guidance (2019) on physical health checks for people with severe mental illness describes the SMI register as including 'all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy'. The indicator as described in the NICE consultation doesn't include 'other patients on lithium therapy'. For consistency it is worth ensuring both definitions line up.</p>	<p>Thank you for your comment. The definition of those eligible for the physical health checks matches the definition used for the 6 single indicators currently in QOF to ensure they can be used together.</p>

SH4	N/A	Mind	<p>The consultation states ‘At the patient level, personalised care adjustments (PCAs) against each health check should be considered to account for situations where the patient declines, does not respond to invite or if the physical health check is not appropriate’. It goes on to state ‘Patients who have received less than 6 health checks but whose total number of health checks plus PCAs equals exactly 6 will be rejected from the denominator.’</p> <p>We are concerned about how PCAs will be applied and the implication this will have on the indicator.</p> <p>There are many reasons why a person living with SMI may not respond to an invitation for a physical health check or may decline it. Often this comes down to the lack of access to personalised support, flexibility or choice that would enable a person living with SMI to take up the invitation for a physical health check. It is important that the indicator can shine a light on people who are missing out on physical health checks because of a lack of support, and therefore these people must be included in the denominator. This will require greater clarity around the use of PCAs to ensure that those who are</p>	<p>Thank you for your comment. Working to improve engagement of people with severe mental illness has been included in the equality assessment for this indicator.</p>
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ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
			excluded from the denominator have genuinely been given all the support possible and that a robust clinical decision has been made when a check is not deemed appropriate.	

SH5	N/A	NHS England	<p>We would very strongly welcome the introduction of a NICE indicator on 'physical health monitoring for people with serious mental illness (SMI)'.</p> <p>People living with SMI die 15 to 20 years younger than the general population, largely due to preventable physical illnesses. The healthcare system has historically underserved people living with SMI and targeted work is needed to address these inequalities. A 2022 OHID study comparing data for the periods 2015 to 2017 and 2016 to 2018 found a significant increase in premature mortality in adults living with SMI in England. Further studies indicate a growing excess mortality rate among people living with SMI during the pandemic.</p> <p>Good clinical practice has highlighted the need for a single co-ordinated physical health review of the patient made up of six components - a record of blood pressure, BMI, alcohol consumption, a lipid profile, blood glucose / HbA1c, and smoking status. These components are currently incentivised through six individual QOF indicators.</p> <p>Most recent data (Q1 2022/23) shows that delivery of the individual</p>	Thank you for your comment.
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ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
			components of the health check ranged between 333k and 370k. This is considerably higher than delivery of a complete health check (i.e. all six components) at 227k. This indicates many people are receiving some but not all components of the check.	
SH5	N/A	NHS England	This draft indicator supports a 'Making Every Contact Count' approach and would provide better patient experience by reducing the need for multiple appointments, by encouraging systems to deliver a complete health check in one (or fewer) appointments.	Thank you for your comment.
SH5	N/A	NHS England	This draft indicator would support the NHS Long Term Plan (LTP) ambition to deliver 390,000 full physical health checks to people living with SMI by the end of 2023/24. Only the completion of a full check (all 6 elements) counts towards this target.	Thank you for your comment.
SH5	N/A	NHS England	I think the indicators are fine and from my perspective very important that smoking status is a focus for this cohort. I think the programme could go further, i.e. the "so what" or "what next"? This comment is beyond the scope of the consultation but once smoking status is identified the GP follows the QoF pathway for smoking (and this is where the so what needs to be more action focused).	Thank you for your comment.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH6	N/A	Primary Care Cardiovascular Society	<p>Recording the data needs to have an endpoint with no evidence that at the risk has been discussed with the person and any reason for not intervening is clearly documented. This should not be an exercise in collecting data but of improving lives. It would make more impact if the indicator included a requirement for a specific CVD risk assessment such as QRisk2/3 (if all six elements are undertaken many of the components are there just not the final calculation).</p> <p>If blood pressure is recorded, why are we not also suggesting rate and rhythm? Should this indicator also include and assessment of CKD - renal function and urine albumin creatinine ratio (uACR)</p>	<p>Thank you for your comment. This indicator has been developed to ensure the 6 physical health checks are being completed for this population. There are currently individual indicators covering each specific check however data shows that only a small proportion of the population are receiving all of these checks.</p> <p>The suggestions for additional indicators will be logged for future committee consideration.</p>

SH7	N/A	Rethink Mental Illness	<p>Rethink Mental Illness has been a long-standing supporter of NHS England's commitment within the NHS Long Term Plan to ensure that 390,000 people on the general practice Severe Mental Illness register receive an annual Physical Health Check. According to OHID Fingertips data, people living with a mental illness are almost four times more likely to die before the age of 75 than their counterparts that are not living with a mental illness. The Department of Health and Social Care found in 2018 that people in contact with mental health services in England have death rates that are five times higher for liver disease, over three times higher for cardiovascular disease and two times higher for cancer.</p> <p>We additionally support the intention to add an indicator that incentivises delivery of all six elements of the Physical Health Check. The six-part Check has been designed to pick up on early signs that someone may be at greater risk of life-limiting conditions. This means that action can be taken before these issues become more serious. If this indicator is successful, we would hope to see more people receiving all six elements of the</p>	Thank you for your comment.
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			<p>Physical Health Check. As indicators for individual elements of the Check remain, we believe this should not serve to decrease the number of individuals receiving elements of the Check as part of other appointments is has been happening to this point. However, improvements in outcomes for patients is subject to individuals receiving appropriate follow-up support. This support should be tailored to the needs of individual patients and be delivered in a way that is mental health-aware (for example – weight management support that takes into account the appetite-inducing side effects of some psychiatric medications). This follow-up intervention could be delivered by the NHS, or through a local authority or voluntary, community, and social enterprise (VCSE) sector provider. Primary care staff should be aware of what is support is available in their local area, for example via new and improved models of community mental health care as delivered through the rollout of the Community Mental Health Framework. Utilisation of dedicated non-clinical staff in primary care (for example, Mental Health UK’s Mental Health Navigation model) has been shown to improve access to and</p>	
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ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
			uptake of social interventions for patients in in primary care.	
SH10	N/A	Royal Arsenal Medical Centre	The patients are difficult to contact – do they have a carer? Do they engage with other services? Have they been contacted by a social prescriber?- Once they are engaging with Primary Care we can access these health checks, some mental health services are starting to pilot their own “primary care” health checks, and one would question what they do with the results, from experience passing the information onto Primary care can happen, if not would the expectation be that secondary care will be managing the results of health checks	Thank you for your comment. Working to improve engagement of people with severe mental illness has been included in the equality assessment for this indicator.
SH9	N/A	Thrombosis UK	Thrombosis UK is delighted that the six elements of the physical health monitoring for people with serious mental health illness include: <ul style="list-style-type: none"> - a record of blood pressure - a record of BMI - a record of alcohol consumption - a record of lipid profile - a record of blood glucose or HbA1c - a record of smoking status. And would like to thank and congratulate the committee.	Thank you for your comment.

ID	Proforma question no.	Stakeholder organisation	Comment	NICE response
SH9	N/A	Thrombosis UK	<p>Thrombosis UK is aware that hospitalised psychiatric patients are often not assessed for venous thromboembolism, even though they have been hospitalised and may have other factors which increase their risk of blood clots</p> <p>Ref: https://thrombosisuk.org/vte-in-psychiatric-patients.php</p> <p>We appreciate this may more appropriately need to be part of the VTE guideline, however given the risks and low levels of VTE risk assessment indicated in the freedom of information request, increasing focus on this important assessment of high-risk individuals would help protect and increase awareness of the risk of VTE in hospitalised psychiatric patients.</p>	<p>Thank you for your comment.</p> <p>The suggestion for an additional indicator will be logged for future committee consideration.</p>