NHS England

Physical health check and follow-up interventions for people with severe mental illness

Technical guidance

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Document Status

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Physical health check and follow-up interventions for people with severe mental illness

Technical guidance

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1 Technical definition

1.1 Overview

1.1.1 The indicator

In 2016, the *Five Year Forward View Mental Health* (MHFYFV) set out NHS England's approach to reducing the stark levels of premature mortality for people living with severe mental illness (SMI) who die 15-20 years earlier than the general population, largely due to preventable or treatable physical health problems.

In the MHFYFV, NHS England committed to leading work to ensure that by 2020/21, 280,000 people living with SMI have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year. This equates to a target of 60% of people on the General Practice SMI register receiving a full and comprehensive physical health check and the required follow up care. This ambition was reiterated in the *Next Steps on the NHS Five Year Forward View* and in key *NHS Long Term Plan* commitments to increase the number of people receiving physical health checks to an additional 110,000 people per year by 2023/24, bringing the total to 390,000 checks delivered each year.

This indicator specifies national reporting in 2019/20 on the delivery of:

- **Part 1 – the core physical health check (6 elements)**

Part 1 will form the core standard in 2019/20.

The indicator also specifies national reporting in 2019/20 on the following supporting measures:

- **Part 2 – individual subcomponents of the core physical health check (6 elements)**
    - a measurement of weight (BMI or BMI + waist circumference);
    - a blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate);
    - a blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement);
    - a blood glucose test (blood glucose or HbA1c measurement);
    - an assessment of alcohol consumption;
    - an assessment of smoking status.
- **Part 3 – additional elements of a comprehensive health assessment**
    - an assessment of nutritional status, diet and level of physical activity (nutrition/diet status + physical activity/exercise) status;
    - an assessment of use of illicit substance/non prescribed drugs (substance misuse status);
    - medicines reconciliation or review.

- **Part 4 – the relevant follow-up interventions where indicated by the physical health assessment**

- **Part 5 – access to national screening programmes (breast cancer, bowel cancer, cervical cancer)**

Data against Parts 3, 4 and 5 will not form part of the core standard (Part 1). NHS England commissioning guidance emphasises that all Parts (2-5) should be provided for people with SMI as part of a comprehensive assessment, in line with clinical evidence and consensus. CCGs are required to submit data on Parts 2-5 to aid understanding of service delivery and facilitate local benchmarking.

In addition to the elements outlined above, to address the elevated rates of sexual and oral health complications observed in people with SMI, a general physical health enquiry, including sexual health and oral health assessment should be provided as part of comprehensive physical health assessment in line with commissioning guidance, clinical evidence and consensus.[1,2] However, national reporting on the delivery of sexual health and oral health checks is not required for the purposes of this collection.

Physical health checks may be delivered in either primary or secondary care. The previous 2018/19 indicator asked CCGs to report quarterly on the delivery of physical health checks for people on the SMI register in primary care settings only. The updated 2019/20 indicator asks CCGs to report quarterly on the delivery of physical health checks for people on the SMI register in any setting. As per commissioning guidance, all physical health assessment results and agreed actions should be entered into the patient electronic record, in line with local information governance agreements, data protection and human rights legislation.

1.1.2 Rationale and case for change

People with SMI are at increased risk of poor physical health. The life-expectancy of the SMI cohort is reduced by an average of 15–20 years compared to the general population, mainly due to preventable physical illness. Two thirds of these deaths result from avoidable conditions, including heart disease and cancer. NHS England commissioning guidance document *Improving physical healthcare for people living with severe mental illness in primary care* outlines that compared to the general population, people with SMI are:

- three times more likely to attend A&E with an urgent physical health need;
- almost five times more likely to be admitted as an emergency case;
- three times more likely to smoke;
- three-and-a-half times more likely to lose all teeth;

[1] Kisely S, Quek LH, Pais J, *et al*. (2011). Advanced dental disease in people with severe mental illness: systematic review and meta-analysis. British Journal of Psychiatry, 199: 187–93.
[2] Hughes, E., Bassi, S., Gilbody, S., *et al*. (2016). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: a systematic review and meta-analysis. Lancet Psychiatry, 3(1), 40-48.

- double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream).[3]

Best practice evidence indicates that where primary care teams deliver care collaboratively with secondary care services, outcomes are improved. The lead responsibility for assessing and supporting physical health will transfer depending on where an individual is in their pathway of care, as set out in NICE guidelines CG 185 and CG 178, and NHS England commissioning guidance:

Primary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. patients with SMI who are not in contact with secondary mental health services, including both:
    a. those whose care has always been solely in primary care; and
    b. those who have been discharged from secondary care back to primary care; and
2. patients with SMI who have been in contact with secondary care mental health teams (with shared care arrangements in place) for more than 12 months and/or whose condition has stabilised.

Secondary care teams are responsible for carrying out annual physical health assessments and follow-up care for:

1. patients with SMI under care of mental health team for less than 12 months and/or whose condition has not yet stabilised;
2. mental health inpatients.[4]

1.2 Part 1 – The core standard

1.2.1 Part 1 – the core physical health check

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

As per QOF Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QOF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission.[5]

Numerator: Out of the denominator, the number of people who have received a comprehensive physical health assessment (i.e. all of the checks 1-6 listed in Part 2) in the 12 months to the end of the reporting period.

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[3] Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs

[4] NICE clinical guidance CG178

[5] QOF guidance outlines that clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:

- no record of anti-psychotic medication;
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

For the purpose of indicator Part 1, a person is counted as having had the core physical health check if they have received all of the 6 component parts listed in Part 2 at any point in the 12 months to the end of the reporting period.

It is recognised that people will have been on the GP SMI register for different durations and that some people may have had limited opportunity to be offered physical health checks in primary care, while some patients on the register may be under the care of secure mental health services. These are considered acceptable limitations of the data collection.

Calculations: Utilising the numerator and denominator definitions above, the percentage of people receiving health checks will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

1.3 Part 2 – Individual subcomponents of the core physical health check

1.3.1 Part 2 – individual subcomponents of the core physical health check

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

As per QOF Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QOF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission. This is the denominator for all 6 measures in this section and is the same as the denominator for Part 1.

Numerators:
Of the denominator, the number of people who have received each of the following elements of the physical health check(s) in the 12 months to the end of the reporting period:

1. a measurement of weight (BMI or BMI + waist circumference);
2. a blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate);
3. a blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement);
4. a blood glucose test (blood glucose or HbA1c measurement);
5. an assessment of alcohol consumption;
6. an assessment of smoking status.

Note that a person who has received all elements of the physical health check would be reported in all of the individual numerators.

Calculations: Utilising the numerator and denominator definitions above, the percentage of people receiving health checks will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

1.4 Codes for reporting against Parts 1 and 2

Information on the codes associated with each element of the physical health check to be reported in 2019/20 is set out in the tables below. Annex 1 summarises the code tables listed for all measures in this guidance.

Where alternative codes are routinely used to record the required elements of the health check, CCGs can undertake local mapping to match these to the codes provided in this guidance. Please refer to the NHS Digital SNOMED CT Browser and mapping lookup tools.

'Observable' codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant 'finding' code for reporting. READ V2 and CTv3 codes have been provided to support transition to SNOMED CT reporting.

People with SMI should always be supported to take up the physical health assessment. However, in some circumstances individuals may decline an element of the health check. Where this is the case, there should be documented evidence of refusal in clinical systems. To reflect this, 'declined' codes can be included in searches for reporting.[6]

1.4.1 A measurement of weight (BMI or BMI + waist circumference)

For this data item, CCGs should report on **EITHER** the number of people who have had a measurement of BMI **OR** the number of people who have had a measurement of BMI plus a measurement of waist circumference.

Box 1	READ V2 code	CTv3 code	SNOMED CT code
Measurement of body mass index	22K..	22K.. Xa7wG X76CO	60621009 Body mass index (observable) 301331008 Finding of body mass index (finding)
Measurement of waist circumference	22N0.	Xa041	276361009 Waist circumference (observable)

[6] To help ensure people are fully engaged in physical healthcare, services should provide reasonable adjustments to support engagement with the physical health assessment, such as longer appointment times, undertaking proactive follow up on the results of all assessments, providing proactive outreach, drawing on resources from peer support and voluntary sector organisations for those struggling to attend appointments or engaging with activities to improve overall health and wellbeing.

1.4.2 A blood pressure and pulse check

For this data item, CCGs should report on **EITHER** the number of people who have had both a diastolic **AND** a systolic blood pressure recording, **OR** both a diastolic **AND** a systolic blood pressure recording plus a recording of pulse rate.

Box 2	READ V2 code	CTv3 code	SNOMED CT code
Diastolic blood pressure reading	246A.	246A.	1091811000000102 Diastolic arterial pressure (observable) 163031004 On examination - Diastolic blood pressure reading (finding)
Systolic blood pressure reading	2469.	2469.	72313002 Systolic arterial pressure (observable) 163030003 On examination - Systolic blood pressure reading (finding)
Pulse rate	242.. 242Z.	242.. X773s XaIBo	78564009 Heart rate measured at systemic artery (observable entity) 8499008 Pulse, function (observable entity) 162986007 On examination - pulse rate (finding)

1.4.3 A blood lipid including cholesterol test

For this data item, CCGs should report on the number of people who have either had a cholesterol level recording **OR** have had a QRISK® measurement recorded.

Box 3	READ V2 code	CTv3 code	SNOMED CT code
Cholesterol measurement	Refer to cholesterol QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		

Box 3	READ V2 code	CTv3 code	SNOMED CT code
QRISK® measurement	22W.. 38DP. 8IEL. 8IEV. 9NSB.	XaYZR XaQVY XaYzy XaZdA XaZd8	810931000000108 QRISK2 calculated heart age (observable entity) 718087004 QRISK2 cardiovascular disease 10 year risk score (observable entity) 847201000000103 Unsuitable for QRISK2 cardiovascular disease risk assessment (finding)

1.4.4 A blood glucose test

For this data item, CCGs should report on the number of people who have had any of the following blood glucose measurement recordings **OR** HbA1c measurement.

Box 4	READ V2 code	CTv3 code	SNOMED CT code
Blood glucose measurement	44g.. 44TA. 44g1. 44TJ. 44U.. 44f.. 44f1. 44T2. 44TK.	XM0ly 44g1. X772z 44f.. 44f1. XE2mq	1010671000000102 Plasma glucose level (observable entity) 1003141000000105 Plasma fasting glucose level (observable entity) 997671000000106 Blood glucose level (observable entity) 1010611000000107 Serum glucose level (observable entity) 1003131000000101 Serum fasting glucose level (observable entity)

Box 4	READ V2 code	CTv3 code	SNOMED CT code
			997681000000108 Fasting blood glucose level (observable entity)
HbA1c measurement	42W.. 42WZ. 42W4. 42W5.	42WZ. XE24t XaERp XaPbt	269823000 Haemoglobin A1C - diabetic control interpretation (observable entity) 1019431000000105 Haemoglobin A1c level (Diabetes Control and Complications Trial aligned) (observable entity) 999791000000106 Haemoglobin A1c level - International Federation of Clinical Chemistry and Laboratory Medicine standardised (observable entity)

1.4.5 An assessment of alcohol consumption

For this data item, CCGs should report on the number of people who have had an alcohol consumption recording.

Box 5	Information on codes
Alcohol consumption assessment	Run alcohol consumption QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.

1.4.6 An assessment of smoking status

For this data item, CCGs should report on the number of people who have had a smoking assessment recording. Please run smoker/ex-smoker/current smoker/smoking habit/never smoked QOF clusters for reporting.

Box 6	Information on codes
Smoking status assessment	Run smoker/ex-smoker/current smoker/smoking habit/never smoked QOF clusters for reporting. Visit the NHS Digital website and click on 'Download the QOF V41 expanded cluster list for publication'.

1.5 Part 3 – Additional elements of a comprehensive physical health assessment (for monitoring)

CCGs are asked to report on the delivery of the following additional assessments:

- an assessment of nutritional status, diet and level of physical activity (nutrition/diet status + physical activity/exercise) status;
- an assessment of use of illicit substance/non prescribed drugs (substance misuse status);
- medicines reconciliation or review.

Data on these elements are captured to support local understanding of service delivery and benchmarking in 2019/20 and will not form part of the core standard measure (Part 1).

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

As per QOF Guidance, the SMI register includes all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. QOF Guidance documents contain detail on when clinicians should consider excluding patients from the SMI register because their illness is in remission. This is the denominator for all 3 measures in this section and is the same as the denominator in Part 1.

Numerators: Of the denominator, the number of people who have received each of the following assessments in the 12 months to the end of the reporting period:

- an assessment of nutritional status, diet and level of physical activity (nutrition/diet status + physical activity/exercise) status;
- an assessment of use of illicit substance/non prescribed drugs (substance misuse status);
- medicines reconciliation or review.

Calculations: Utilising the relevant numerator and denominator definitions, the percentage of people receiving each additional assessment will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

Information on the codes associated with these additional assessments is set out in the tables below. Annex 1 summarises the code tables listed for all measures in this guidance.

People with SMI should always be supported to take up the physical health assessment. However, in some circumstances individuals may decline an element of the health check. Where this is the case, there should be documented evidence of refusal in clinical systems. To reflect this, 'declined' codes can be included in searches for reporting.

1.6 Codes for reporting against Part 3

1.6.1 An assessment of nutritional status or diet and level of physical activity

For this data item, CCGs should report on the number of people who have had an assessment of nutritional status or diet **AND** an assessment of level of physical activity.

Clinicians and CCGs should consider the relevant guidelines when assessing an individual's nutritional status, in line with clinical evidence and consensus.

Box 7	READ V2 code	CTv3 code	SNOMED CT code
Nutritional status or diet	1F11. 1FA.. 1FB.. 1FC.. 1FE0. 1FE1. 1FE2. 1FH.. 3893.	XaCIx XaCIz XaCJ0 XaIUr XaIyg XaNJ6 XaNJ7 XaIUu	16208003 Diet - low in fat 310500000 Diet good 310502008 Diet poor 310503003 Diet average 401070008 Number of portions of fruit and vegetables daily 301961000000107 Intake of fruit and vegetables at least 5 portions daily 301991000000101 Intake of fruit and vegetables less than 5 portions daily 226234005 Healthy diet 391129005 Fruit and vegetable intake 391132008 Nutritional assessment completed

Box 7	READ V2 code	CTv3 code	SNOMED CT code
Level of physical activity	138..%	XE0os%	266930008 Exercise history 160628002 Exercise grading

1.6.2 An assessment of use of illicit substance/non-prescribed drugs

For this data item, CCGs should report on the number of people who have had an assessment of illicit substance or non-prescribed drug use.

Clinicians and CCGs should consider individuals who may be misusing prescribed medication and ensure substance misuse advice or referral to substance misuse services is provided as appropriate. Codes for reporting against follow-up interventions are outlined under the corresponding substance misuse intervention indicator (section 1.8.8, Box 17).

Box 8	READ V2 code	CTv3 code	SNOMED CT code
Illicit substance/non-prescribed drug use	13c..% 1V...%, E24..% E25..% Eu1..% *Excluding: E250.%, E251.%, Eu10.%, Eu17.%*	X00Rd% Ub0mp% *Excluding: X00Rl%, Xa17m%, E01..%, XE1YQ%, Xabi7, Xabi8, Xabi9, E251.%*	<<228366006 Finding relating to drug misuse behaviour <<191816009 Drug dependence <<363908000 Details of drug misuse behaviour <<228367002 Does not misuse drugs <<11061003 Psychoactive substance use disorder

1.6.3 Medicines reconciliation and review

For this data item, CCGs should report on the number of people who have had a medicines reconciliation or medicines review.

Box 9	READ V2 code	CTv3 code	SNOMED CT code
Medicines reconciliation or review	8B314 8B318 8B3S.%	XaK6e XaF8d 8B314%	<<182836005 Review of medication <<413143000

Box 9	READ V2 code	CTv3 code	SNOMED CT code
	8B3V. 8B3h. 8B3x. 8B3y. 8BM0.% 9H91.	XaJr3%	Mental health medication review <<314530002 Medication review done <<430193006 Medication reconciliation

1.7 Part 4 – Follow-up interventions (for monitoring)

From Quarter 1 2019/20 onwards, CCGs are asked to report on the delivery of the relevant follow-up interventions where these are indicated by the health check. Data on interventions are captured to support local understanding of service delivery and benchmarking in 2019/20 and will not form part of the core standard measure (Part 1).

Bespoke denominators and numerators appropriate for individual interventions are outlined below, along with the associated codes for reporting. Annex 1 summarises the code tables listed for all measures in this guidance.

Calculations: Utilising the relevant numerator and denominator definitions, the percentage of people receiving follow-up interventions will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

People with SMI should always be supported to take up the relevant interventions. However, in some circumstances individuals may decline an intervention. Where this is the case, there should be documented evidence of refusal in clinical systems. To reflect this, 'declined' codes can be included in searches for reporting.

Where social prescribing is available for a specific intervention, and where an individual has subsequently received a referral to social prescribing, the corresponding 'social prescribing' codes can be mapped to the relevant indicator and used for reporting purposes, as appropriate.

1.8 Codes for reporting against Part 4

1.8.1 Follow-up interventions – weight management

Denominator: The total number of people **with a BMI of 25 or over** on the General Practice SMI registers in the preceding 12 months (to the last day of the reporting period), excluding patients recorded as 'in remission'.

For the purposes of this indicator, a patient whose record meets the above qualifying values at any instance within the preceding 12 months to the last day of the reporting period is included in the denominator.

A BMI value of 25 or over is used for the purposes of this indicator, due to acceptable limitations in data recording and collection processes. However, members of black, Asian and minority ethnic (BAME) groups are at risk of developing chronic health conditions such as diabetes at a lower BMI compared to the white European population, as per NICE guideline PH46. The relevant interventions should be offered accordingly as appropriate and in line with clinical evidence and consensus.

Numerator: Out of the denominator, CCGs should report on the number of people who have received a weight management intervention (**EITHER** referral to weight management services, **OR** referral for exercise therapy, **OR** dietary or weight management advice, **OR** exercise advice) in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant weight management interventions is set out in the table below.

Box 10	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	8H76. 8HHH. 8HHH0	XaAdX XaJSu XaXZ9	306163007 Referral to dietetics service 103699006 Refer to dietician 408289007 Refer to weight management programme 771491000000104 Referral to local authority weight management programme
Referral for exercise therapy	8H7q. 8HHc. 8HkX. 8H7s. 8BAH. 8Hlu. 8HlF.	XaIPu XaREh 8HkX. 8H7s. 8BAH. 8Hlu. 8HlF.	390864007 Referral for exercise therapy 416974006 Referred for exercise programme 526151000000109 Referral to exercise on referral programme

Box 10	READ V2 code	CTv3 code	SNOMED CT code
			390893007 Referral to physical activity programme 310882002 Exercise on prescription 892281000000101 Referral to healthy lifestyle programme 492861000000101 Referral to health trainer
Dietary or weight management advice	6799. 67H7.	6799. XaQaU	11816003 Diet health education 443288003 Lifestyle advice regarding diet
Exercise advice	6798. 67H2. 8CA5.	6798. XaJIt 8CA5. XM18T	304507003 Health education – exercise 183073003 Patient advised about exercise

1.8.2 Follow-up interventions – blood pressure – Part A (lifestyle interventions)

Denominator: The total number of people **with a systolic blood pressure reading higher than 140 mm Hg OR a diastolic blood pressure reading higher than 90 mm Hg** on the General Practice SMI register in the preceding 12 months (to the last day of the reporting period), excluding patients recorded as 'in remission'.

For the purposes of this indicator, a patient whose record meets the above qualifying values at any instance within the preceding 12 months to the last day of the reporting period is included in the denominator.

Numerator: Out of the denominator, the number of people who have received a life-style intervention (**EITHER** referral to weight management services, **OR** referral for exercise therapy, **OR** dietary or weight management advice, **OR** exercise advice) in the preceding 12 months to the end of the reporting period.

Clinicians and CCGs should consider the link between alcohol consumption and hypertension, and ensure alcohol misuse advice or referral to alcohol cessation

services is provided for this patient cohort as appropriate, as per NICE guideline CG127. Associated codes for reporting are outlined under the corresponding alcohol misuse intervention indicator (section 1.8.6, Box 15).

It is recognised that individuals with a one-off reading of high blood pressure may not immediately require a specific follow-up intervention. While these individuals would therefore be captured in the denominator for this indicator, they may not be included in the corresponding numerator. This is an acceptable limitation of the data collection. Clinicians and CCGs should consider whether ambulatory blood pressure monitoring (ABPM) or home blood pressure monitoring (HBPM) has been delivered or may be appropriate to offer for an individual to confirm the need for further blood pressure intervention in line with NICE guideline NG10054.

Information on the codes associated with the relevant blood pressure lifestyle interventions is set out in the table below.

Box 11	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			
Dietary or weight management advice			
Exercise advice			

1.8.3 Follow-up interventions – blood pressure – Part B (pharmacological intervention)

Denominator: The total number of people **with a systolic blood pressure reading higher than 140 mm Hg OR a diastolic blood pressure reading higher than 90 mm Hg** on the General Practice SMI register in the preceding 12 months (to the last day of the reporting period), excluding patients recorded as ‘in remission’.

For the purposes of this indicator, a patient whose record meets the above qualifying values at any instance within the preceding 12 months to the last day of the reporting period is included in the denominator.

Numerator: Out of the denominator, the number of people who have received anti-hypertensive medication in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant blood pressure pharmacological intervention is set out in the table below.

Box 12	READ V2 code	CTv3 code	SNOMED CT code
Anti-hypertensive medication	Run the National Diabetes Audit and National Health Service Health Checks general practice extraction - antihypertensive medication simple reference set [Refset ID 999000941000001104] for reporting. Please visit the NHS Digital SNOMED CT Browser for individual refset members.		

1.8.4 Follow-up interventions – blood glucose – Part A (high-risk/prediabetic interventions)

Denominator: The total number of people **with a HbA1c reading of ≥ 42 mmol/mol and ≤ 47 mmol/mol (6.0 to 6.4% mol) OR a FPG value of ≥ 5.5 mmol/L and ≤ 6.9 mmol/L** on the General Practice SMI registers in the preceding 12 months (to the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of people who have received a referral to the NHS Diabetes Prevention Programme, **OR** who have received a life-style intervention (**EITHER** referral to weight management services, **OR** referral for exercise therapy, **OR** dietary or weight management advice, **OR** exercise advice) in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant blood glucose interventions is set out in the table below.

Box 13	READ V2 code	CTv3 code	SNOMED CT code
Referral to NHS Diabetes Prevention Programme	679m4	XaeDH	1025321000000109 Referral to NHS Diabetes Prevention Programme
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			
Dietary or weight management advice			
Exercise advice			

1.8.5 Follow-up interventions – blood glucose – Part B (diabetic interventions)

Denominator: The total number of people **with a HbA1c reading of ≥ 48 mmol/mol (≥ 6.5% mol), OR a FPG value of ≥ 7 mmol/L** on the General Practice SMI registers in the preceding 12 months (to the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of people who have received intensive structured lifestyle education, **OR** who have received oral diabetes medication or insulin in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant blood glucose interventions is set out in the table below.

Box 14	READ V2 code	CTv3 code	SNOMED CT code
Intensive structured lifestyle education programme	Run referred for diabetes structured education programme QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		
Oral diabetes medication or insulin	Run the Enhanced services general practice extraction – Diabetic drugs simple reference set [Refset ID 999000851000001109] Please visit the NHS Digital SNOMED CT Browser for individual Enhanced Services Diabetic drugs extraction refset members.		

1.8.6 Follow-up interventions – alcohol consumption

Denominator: The total number of people with a **record of alcohol misuse** on the General Practice SMI registers **in the preceding 12 months** to the last day of the reporting period, excluding patients recorded as 'in remission'.

For the purposes of this indicator, a patient identified as 'heavy drinker', 'very heavy drinker', 'alcohol intake above recommended sensible limits', 'problem drinker', 'alcoholic binges exceeding sensible amounts', **OR** a patient identified to misuse alcohol via the relevant assessment tools (including AUDIT, SADQ or LDQ), **OR** a patient consuming over 14 units of alcohol per week should be included in the denominator, in line with NICE guideline CG115. When assessing the severity of alcohol dependence, the criteria should be adjusted for women, older people, children and young people.

Numerator: Out of the denominator, the number of people who have received alcohol health education **OR** a referral to alcohol cessation service in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant alcohol interventions is set out in the table below.

Box 15	READ V2 code	CTv3 code	SNOMED CT code
Alcohol health education	6792. 67H0. 8CAM. 9k1A.	Yac8O 67H0. 8CAM. XaPPv	408947007 Health education – alcohol 281078001 Education about alcohol consumption 366371000000105 Brief intervention for excessive alcohol consumption completed
Referral to alcohol cessation service	8HkG.	XaORR	431260004 Referral to specialist alcohol treatment service

1.8.7 Follow-up interventions – smoking

Denominator: The total number of people **identified as smokers** on the General Practice SMI registers in the **preceding 12 months** to the last day of the reporting period, excluding patients recorded as 'in remission'.

For the purposes of this indicator, CCGs should align to QOF guidance when identifying patients as smokers for inclusion in the denominator.

Numerator: Out of the denominator, the number of people who have received smoking cessation advice, **OR** a referral to smoking cessation services, **OR** smoking cessation drug therapy or nicotine replacement therapy (NRT) in the preceding 12 months to the end of the reporting period.

Information on the codes associated with the relevant smoking interventions is set out in the table below.

Box 16	READ V2 code	CTv3 code	SNOMED CT code
Smoking cessation advice or referral to smoking cessation services	Run 'support and refer stop smoking service and advisor' QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		
Smoking cessation drug therapy or nicotine replacement therapy (NRT)	Run 'pharmacotherapy codes' QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		

1.8.8 Follow-up interventions – substance misuse intervention

Denominator: The total number of people identified **with a record of substance misuse** on the General Practice SMI registers in the **preceding 12 months** to the last day of the reporting period, excluding patients recorded as 'in remission'.

For the purposes of this indicator, CCGs should align to NICE guidelines CG120 and NG58 when identifying patients with a record of substance misuse for inclusion in the denominator, in line with clinical evidence and consensus.

Numerator: Out of the denominator, the number of people who are under the care of substance misuse services, **OR** have received substance misuse advice, **OR** a referral to substance misuse services in the preceding 12 months to the end of the reporting period.

Clinicians and CCGs should consider individuals who may be misusing prescribed medication and ensure substance misuse advice or referral to substance misuse services is provided for this patient cohort as appropriate.

Information on the codes associated with the relevant substance misuse interventions is set out in the table below.

Box 17	READ V2 code	CTv3 code	SNOMED CT code
Under the care of substance misuse services	9k5..%	Xaa66 XaPe7 XaQVn XaK9q XaPe8 XaKAI	176811000000105 Drug misuse enhanced services administration 176831000000102 Drug misuse enhanced service completed 372511000000103 Shared care drug misuse treatment 372541000000102 Drug misuse treatment in primary care 507041000000101 Pharmacy attended for drug misuse 372541000000102 Drug misuse treatment in primary care

Box 17	READ V2 code	CTv3 code	SNOMED CT code
			135828009 Under care of community drug team 744857009 Under care of drug misuse service 866391000000106 Seen by community drug team
Substance misuse advice	677W. 677T.	XaEBy XaNH9	313071005 Substance abuse counselling 299941000000103 Substance misuse structured counselling
Referral to substance misuse services	8HkF. 8Hh1.	XaLKJ XaNPH	201521000000104 Referral to substance misuse service 304301000000105 Self-referral to substance misuse service

1.8.9 Other follow-up interventions related to blood lipid measurements and an assessment of nutritional status, diet and level of physical activity

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of people who have received a life-style intervention (**EITHER** referral to weight management services, **OR** referral for exercise therapy, **OR** dietary or weight management advice, **OR** exercise advice) in the preceding 12 months to the end of the reporting period.

This data item collects information on the prevalence of patients in receipt of lifestyle interventions overall and thresholds for nutritional status, diet, physical activity or blood lipids have not been set.

Information on the codes associated with lifestyle interventions is set out in the table below.

Box 18	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			
Dietary or weight management advice			
Exercise advice			

1.8.10 Other follow-up interventions related to blood lipid (including cholesterol)

Denominator: The total number of people on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of people who have received statins in the preceding 12 months to the end of the reporting period.

This data item collects information on the prevalence of patients in receipt of statins overall and a corresponding threshold for blood lipid values has not been set. Clinicians and CCGs should ensure the relevant intervention is provided for appropriate patients, in line with clinical evidence and consensus.

Information on the codes associated with the relevant statins is set out in the table below.

Box 19	READ V2 code	CTv3 code	SNOMED CT code
Statins	Run the QOF general practice extraction – statins prescribable within general practice simple reference set [Refset ID 12464001000001103] for reporting. Please visit the NHS Digital SNOMED CT Browser for individual refset members.		

1.9 Part 5 – Access to national screening (for monitoring)

CCGs are asked to report on access to the relevant national screening programmes. Equitable access for individuals with SMI to all relevant screening programmes should be routinely monitored at a local level. This collection requires reporting only on cervical, bowel cancer and breast cancer screening.

Data on access to national screening is captured to support local understanding of service delivery and benchmarking from 2019/20 and are not part of the core standard measure (Part 1).

Bespoke denominators and numerators appropriate for individual interventions are outlined below, along with the associated codes for reporting. Annex 1 summarises the code tables listed for all measures in this guidance.

Calculations: Utilising the relevant numerator and denominator definitions, the percentage of people accessing the relevant national screening programmes will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

1.10 Codes for reporting against Part 5

1.10.1 Access to national screening – cervical cancer screening

Denominator: The total number of **women aged 25 to 64 with no history of hysterectomy** on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of women who have received cervical cancer screening in the preceding **60 months**.

Information on the codes associated with cervical cancer screening are set out in the table below.

Box 20	READ V2 code	CTv3 code	SNOMED CT code
Cervical cancer screening	Run cervical smear QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		

1.10.2 Access to national screening – breast cancer screening

Denominator: The total number of **women aged 50 to 70** on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of women who have received breast cancer screening in the preceding **36 months**.

Information on the codes associated with breast cancer screening are set out in the table below.

Box 21	READ V2 code	CTv3 code	SNOMED CT code
Breast cancer screening	Run breast cancer screening Learning Disabilities Observatory (LDO) cluster for reporting. Visit the Learning Disabilities Observatory (LDO) website and click on 'LDO_v1.1_Expanded_Cluster_List_for_Publication'.		

1.10.3 Access to national screening – bowel cancer screening

Denominator: The total number of **people aged 60 to 74** on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

Numerator: Out of the denominator, the number of people who have received bowel cancer screening in the preceding **24 months**.

Information on the codes associated with bowel cancer screening are set out in the table below.

Box 22	READ V2 code	CTv3 code	SNOMED CT code
Bowel cancer screening	Run colorectal cancer screening Learning Disabilities Observatory (LDO) cluster for reporting. Visit the Learning Disabilities Observatory (LDO) website and click on 'LDO_v1.1_Expanded_Cluster_List_for_Publication'.		

2 Monitoring

2.1.1 Monitoring Frequency

Quarterly

The first CCG submission is expected in July 2019 and will cover the 12-month period until the end of June 2019. Subsequent submission will be quarterly thereafter.

2.1.2 Monitoring Data Source

This data is to be submitted via the Strategic Data Collection Service (SDCS). Data breaches will be captured and recorded according to SDCS protocols.

The collection will capture the numerators and denominators required for all parts, including:

- Part 1: the core physical health check (the core standard measure);
- Part 2: individual subcomponents of the core physical health check;
- Part 3: additional elements of a comprehensive health assessment;
- Part 4: follow-up interventions;
- Part 5: access to national screening.

CCGs will be required to obtain data on the delivery of physical health assessments, follow-up interventions and access to national screening from their commissioned provider(s). This technical guidance provides a list of the appropriate codes to support reporting.

Data will be transmitted from NHS Digital to NHS England following the standard mechanism for SDCS data collections. Analysis will be undertaken by NHS England and published at national and CCG levels. It is expected that data will be published as official statistics, in line with the NHS England publication schedule.

3 Annex: Summary list of codes for Parts 1 – 5

3.1 Codes for reporting against Parts 1 & 2

3.1.1 A measurement of weight (BMI or BMI + waist circumference)

Box 1	READ V2 code	CTv3 code	SNOMED CT code
Measurement of body mass index	22K..	22K.. Xa7wG X76CO	60621009 Body mass index (observable) 301331008 Finding of body mass index (finding)
Measurement of waist circumference	22N0.	Xa041	276361009 Waist circumference (observable)

3.1.2 A blood pressure and pulse check

Box 2	READ V2 code	CTv3 code	SNOMED CT code
Diastolic blood pressure reading	246A.	246A.	1091811000000102 Diastolic arterial pressure (observable) 163031004 On examination - Diastolic blood pressure reading (finding)
Systolic blood pressure reading	2469.	2469.	72313002 Systolic arterial pressure (observable) 163030003 On examination - Systolic blood pressure reading (finding)
Pulse rate	242.. 242Z.	242.. X773s XaIBo	78564009 Heart rate measured at systemic artery (observable entity) 8499008 Pulse, function (observable entity)

Box 2	READ V2 code	CTv3 code	SNOMED CT code
			162986007 On examination - pulse rate (finding)

3.1.3 A blood lipid including cholesterol test

Box 3	READ V2 code	CTv3 code	SNOMED CT code
Cholesterol measurement	Refer to cholesterol QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		
QRISK® measurement	22W.. 38DP. 8IEL. 8IEV. 9NSB.	XaYZR XaQVY XaYzy XaZdA XaZd8	810931000000108 QRISK2 calculated heart age (observable entity) 718087004 QRISK2 cardiovascular disease 10 year risk score (observable entity) 847201000000103 Unsuitable for QRISK2 cardiovascular disease risk assessment (finding)

3.1.4 A blood glucose test

Box 4	READ V2 code	CTv3 code	SNOMED CT code
Blood glucose measurement	44g.. 44TA. 44g1. 44TJ. 44U.. 44f.. 44f1. 44T2.	XM0ly 44g1. X772z 44f.. 44f1. XE2mq	1010671000000102 Plasma glucose level (observable entity) 1003141000000105 Plasma fasting glucose level (observable entity) 997671000000106 Blood glucose level (observable entity)

Box 4	READ V2 code	CTv3 code	SNOMED CT code
	44TK.		1010611000000107 Serum glucose level (observable entity) 1003131000000101 Serum fasting glucose level (observable entity) 997681000000108 Fasting blood glucose level (observable entity)
HbA1c measurement	42W.. 42WZ. 42W4. 42W5.	42WZ. XE24t XaERp XaPbt	269823000 Haemoglobin A1C - diabetic control interpretation (observable entity) 1019431000000105 Haemoglobin A1c level (Diabetes Control and Complications Trial aligned) (observable entity) 999791000000106 Haemoglobin A1c level - International Federation of Clinical Chemistry and Laboratory Medicine standardised (observable entity)

3.1.5 An assessment of alcohol consumption

Box 5	Information on codes
Alcohol consumption assessment	Run alcohol consumption QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.

3.1.6 An assessment of smoking status

Box 6	Information on codes
Smoking status assessment	Run smoker/ex-smoker/current smoker/smoking habit/never smoked QOF clusters for reporting. Visit the NHS Digital website and click on 'Download the QOF V41 expanded cluster list for publication'.

3.2 Codes for reporting against Part 3

3.2.1 An assessment of nutritional status or diet and level of physical activity

Box 7	READ V2 code	CTv3 code	SNOMED CT code
Nutritional status or diet	1F11. 1FA.. 1FB.. 1FC.. 1FE0. 1FE1. 1FE2. 1FH.. 3893.	XaCIx XaCIz XaCJ0 XaIUr XaIyg XaNJ6 XaNJ7 XaIUu	16208003 Diet - low in fat 310500000 Diet good 310502008 Diet poor 310503003 Diet average 401070008 Number of portions of fruit and vegetables daily 301961000000107 Intake of fruit and vegetables at least 5 portions daily 301991000000101 Intake of fruit and vegetables less than 5 portions daily 226234005 Healthy diet 391129005 Fruit and vegetable intake 391132008 Nutritional

Box 7	READ V2 code	CTv3 code	SNOMED CT code
			assessment completed
Level of physical activity	138..%	XE0os%	266930008 Exercise history 160628002 Exercise grading

3.2.2 An assessment of use of illicit substance/non-prescribed drugs

Box 8	READ V2 code	CTv3 code	SNOMED CT code
Illicit substance/non-prescribed drug use	13c..% 1V...%, E24..% E25..% Eu1..% *Excluding: E250.%, E251.%, Eu10.%, Eu17.%*	X00Rd% Ub0mp% *Excluding: X00Rl%, Xa17m%, E01..%, XE1YQ%, Xabi7, Xabi8, Xabi9, E251.%*	<<228366006 Finding relating to drug misuse behaviour <<191816009 Drug dependence <<363908000 Details of drug misuse behaviour <<228367002 Does not misuse drugs <<11061003 Psychoactive substance use disorder

3.2.3 Medicines reconciliation and review

Box 9	READ V2 code	CTv3 code	SNOMED CT code
Medicines reconciliation or review	8B314 8B318 8B3S.% 8B3V. 8B3h. 8B3x. 8B3y. 8BM0.%	XaK6e XaF8d 8B314% XaJr3%	<<182836005 Review of medication <<413143000 Mental health medication review <<314530002 Medication review done <<430193006 Medication reconciliation

Box 9	READ V2 code	CTv3 code	SNOMED CT code
	9H91.		

3.3 Codes for reporting against Part 4

3.3.1 Follow-up intervention – weight management

Box 10	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	8H76. 8HHH. 8HHH0	XaAdX XaJSu XaXZ9	306163007 Referral to dietetics service 103699006 Refer to dietician 408289007 Refer to weight management programme 771491000000104 Referral to local authority weight management programme
Referral for exercise therapy	8H7q. 8HHc. 8HkX. 8H7s. 8BAH. 8Hlu. 8HlF.	XaIPu XaREh 8HkX. 8H7s. 8BAH. 8Hlu. 8HlF.	390864007 Referral for exercise therapy 416974006 Referred for exercise programme 526151000000109 Referral to exercise on referral programme 390893007 Referral to physical activity programme 310882002 Exercise on prescription 892281000000101 Referral to healthy lifestyle programme

Box 10	READ V2 code	CTv3 code	SNOMED CT code
			492861000000101 Referral to health trainer
Dietary or weight management advice	6799. 67H7.	6799. XaQaU	11816003 Diet health education 443288003 Lifestyle advice regarding diet
Exercise advice	6798. 67H2. 8CA5.	6798. XaJIt 8CA5. XM18T	304507003 Health education – exercise 183073003 Patient advised about exercise

3.3.2 Follow-up interventions – blood pressure – Part A (lifestyle intervention)

Box 11	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			
Dietary or weight management advice			
Exercise advice			

3.3.3 Follow-up interventions – blood pressure – Part B (pharmacological intervention)

Box 12	READ V2 code	CTv3 code	SNOMED CT code
Anti-hypertensive medication	Run the National Diabetes Audit and National Health Service Health Checks general practice extraction - antihypertensive medication simple reference set [Refset ID 999000941000001104] for reporting. Please visit the NHS Digital SNOMED CT Browser for individual refset members.		

3.3.4 Follow-up interventions – blood glucose – Part A (high risk/prediabetic interventions)

Box 13	READ V2 code	CTv3 code	SNOMED CT code
Referral to NHS Diabetes Prevention Programme	679m4	XaeDH	1025321000000109 Referral to NHS Diabetes Prevention Programme
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			
Dietary or weight management advice			
Exercise advice			

3.3.5 Follow-up interventions – blood glucose – Part B (diabetic interventions)

Box 14	READ V2 code	CTv3 code	SNOMED CT code
Intensive structured lifestyle education programme	Run referred for diabetes structured education programme QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		
Oral diabetes medication or insulin	Run the Enhanced services general practice extraction – Diabetic drugs simple reference set [Refset ID 999000851000001109] Please visit the NHS Digital SNOMED CT Browser for individual Enhanced Services Diabetic drugs extraction refset members.		

3.3.6 Follow-up interventions – alcohol consumption

Box 15	READ V2 code	CTv3 code	SNOMED CT code
Alcohol health education	6792. 67H0. 8CAM. 9k1A.	Yac8O 67H0. 8CAM. XaPPv	408947007 Health education – alcohol 281078001 Education about alcohol consumption

Box 15	READ V2 code	CTv3 code	SNOMED CT code
			366371000000105 Brief intervention for excessive alcohol consumption completed
Referral to alcohol cessation service	8HkG.	XaORR	431260004 Referral to specialist alcohol treatment service

3.3.7 Follow-up interventions – smoking

Box 16	READ V2 code	CTv3 code	SNOMED CT code
Smoking cessation advice or referral to smoking cessation services	Run 'support and refer stop smoking service and advisor' QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		
Smoking cessation drug therapy or nicotine replacement therapy (NRT)	Run 'pharmacotherapy codes' QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		

3.3.8 Follow-up interventions – substance misuse intervention

Box 17	READ V2 code	CTv3 code	SNOMED CT code
Under the care of substance misuse services	9k5..%	Xaa66 XaPe7 XaQVn XaK9q XaPe8 XaKAI	176811000000105 Drug misuse enhanced services administration 176831000000102 Drug misuse enhanced service completed 372511000000103 Shared care drug misuse treatment 372541000000102 Drug misuse treatment in primary care

Box 17	READ V2 code	CTv3 code	SNOMED CT code
			507041000000101 Pharmacy attended for drug misuse 372541000000102 Drug misuse treatment in primary care 135828009 Under care of community drug team 744857009 Under care of drug misuse service 866391000000106 Seen by community drug team
Substance misuse advice	677W. 677T.	XaEBy XaNH9	313071005 Substance abuse counselling 299941000000103 Substance misuse structured counselling
Referral to substance misuse services	8HkF. 8Hh1.	XaLKJ XaNPH	201521000000104 Referral to substance misuse service 304301000000105 Self-referral to substance misuse service

3.3.9 Other follow-up interventions related to blood lipid measurements and an assessment of nutritional status, diet and level of physical activity

Box 18	READ V2 code	CTv3 code	SNOMED CT code
Referral to weight management services	The relevant READ V2, CTv3 and SNOMED CT codes are outlined in section 1.8.1, Box 10 above.		
Referral for exercise therapy			

Box 18	READ V2 code	CTv3 code	SNOMED CT code
Dietary or weight management advice			
Exercise advice			

3.3.10 Other follow-up interventions related to blood lipid (including cholesterol)

Box 19	READ V2 code	CTv3 code	SNOMED CT code
Statins	Run the QOF general practice extraction – statins prescribable within general practice simple reference set [Refset ID 12464001000001103] for reporting. Please visit the NHS Digital SNOMED CT Browser for individual refset members.		

3.4 Codes for reporting against Part 5

3.4.1 Access to national screening – cervical cancer screening

Box 20	READ V2 code	CTv3 code	SNOMED CT code
Cervical cancer screening	Run cervical smear QOF cluster for reporting. Visit the NHS Digital website and click on 'Download the QOF v41 expanded cluster list for publication'.		

3.4.2 Access to national screening – breast cancer screening

Box 21	READ V2 code	CTv3 code	SNOMED CT code
Breast cancer screening	Run breast cancer screening Learning Disabilities Observatory (LDO) cluster for reporting. Visit the Learning Disabilities Observatory (LDO) website and click on 'LDO_v1.1_Expanded_Cluster_List_for_Publication'.		

3.4.3 Access to national screening – bowel cancer screening

Box 22	READ V2 code	CTv3 code	SNOMED CT code
Bowel cancer screening	Run colorectal cancer screening Learning Disabilities Observatory (LDO) cluster for reporting. Visit the Learning Disabilities Observatory (LDO) website and click on 'LDO_v1.1_Expanded_Cluster_List_for_Publication'.		