

Physical health checks and serious mental illness: Equality benchmarking report

London Mental Health Trusts

Health Innovation Network South London

August 2024

1. Foreword

"The issue of premature mortality for people with severe mental illness is one of the greatest health inequities. It has been a focus for providers and policy makers for a number of years now. For people living with, or caring for someone with, a severe mental illness, the impact not just of the prospect of an early death but of living with long term physical conditions is consistently cited as one of the greatest stressors.

In London, with its large and rich population along with its significant areas of deprivation and inequality, we have been organising for several years to try and reverse this trend. The Physical Health Leads' Network has brought together staff from specialist mental health services with an interest in this area for almost 10 years. During that time, we have focused not just on physical health checks, but other key conditions like diabetes and cancer, as well as providing a vital source of rapid learning during the Covid-19 pandemic. We are hugely grateful to The HIN south London for their ongoing support including on this project and for the network more widely.

Similarly, we are grateful to the Chief Medical Officers of the Cavendish Square Group, who have supported not just this project but our work in general, acknowledging the particular role specialist mental health teams and trusts can play in reaching some of the most marginalised people in our communities. This project is a joint effort in the very best sense, and we hope it adds to our shared knowledge base about how to serve our population better.

Dr Ed Beveridge

Chair, Pan London Physical Health Leads' Network

Presidential Lead for Physical Health, Royal College of Psychiatrists

Cavendish Square Group

The stark inequity of physical health outcomes in those with severe mental illness scarcely need restating, except to emphasise how, despite our longstanding knowledge of this, the needle remains stubbornly stuck. The question remains how we effect change. Understanding our local data, seeing differences, both sociodemographically and in clinical practice, learning from good practice, and reducing variation, are key starting points. Some things are best done at a larger scale, and the London region offers a testing ground for its mental health NHS Trusts, under the umbrella of the Cavendish Square Group (CSG), to come together in such a manner. We are really pleased to see this report, although the findings remain problematic and with too much cross-organisation variation. However, they underline our commitment to work together, at scale and across traditional barriers and boundaries; to have the courage to show our data even when

they are not as good as we would like; and to commit to learning from each other with the end goal of improving patient outcomes. This report represents a first step: it is the first time the CSG has acted in this manner for a clinical issue, and many challenges were encountered that will serve as learning for future endeavours. We are grateful to those who lead the work, and the leadership of the HIN in supporting it. As the leaders of secondary mental health care in the capital, we commit to continue to work together with these findings and others, to improve care, reduce these inequities, and to improve the lives and well-being of our patients.

Dr Abi Fadipe, Chief Medical Officer Oxleas NHS Foundation Trust, Chair of the Cavendish Square Group of Chief Medical Officers

Professor Derek Tracy, Chief Medical Officer, West London NHS Trust, Deputy Chair of the Cavendish Square Group of Chief Medical Officers, Senior Responsible Officer for the physical health checks' project

2. Background

In 2016, the [Five Year Forward View for Mental Health \(MHFYFV\)](#)¹ 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 rest of the population, largely due to preventable or treatable physical health problems. In the MHFYFV NHS England was 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 across primary and secondary care.

In many areas of London this 60% target has yet to be met. The urgency and importance of addressing the physical health needs of people with SMI is highlighted in a UK literature review conducted in 2024 by King's Health Partners Mind and Body programme². This review identified that:

"At diagnosis, people with schizophrenia had increased odds of five of 24 chronic physical conditions compared with matched controls and people with BPD [Borderline Personality Disorder] and other psychoses had increased odds of 15 conditions at diagnosis. At 5 years after severe mental illness diagnosis, these numbers had increased to 13 conditions for schizophrenia,

¹ <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

² ["An overview of the data on physical health inequalities for people living with serious mental illness in South East London"](#)

2.1. Equity of access

It is recognised nationally that more needs to be done to ensure people with SMI receive their annual health check, however little is known about the equity of access to a ‘complete’ physical health check for people with SMI. In 2024 the Health Innovation Network South London (HIN) were commissioned by the [Cavendish Square Group](#), to carry out an analysis to identify which demographic groups within the SMI cohort at the 9 London mental health trusts may be more likely to miss or have an incomplete annual physical health check. The demographics of interest included gender, age, ethnicity, deprivation, and SMI diagnosis.

This report details the methodology and findings for London. Individual trusts were also each provided with a report based only on their trust’s data.

2.2. Definition of serious mental illness

SMI is defined as all patients with a diagnosis of schizophrenia, bipolar affective disorder and other psychoses and other patients on lithium therapy. For the purpose of this analysis this includes patients with ICD-10 diagnosis codes defined in Table 1.

Table 1: ICD-10 diagnosis codes indicative of serious mental illness.

ICD-10 code	Description
F2*	Schizophrenia, schizotypal and delusional disorders
F30*	Manic episode
F31*	Bipolar affective disorder
F32.3	Severe depressive episode with psychotic symptoms
F33.3	Recurrent depressive disorder, current episode severe with psychotic symptoms

2.3. Definition of physical health checks

The complete physical health check has six elements:

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

These may be completed all at once or individually as part of other appointments.

3. Methodology

3.1. Data specification

Nine mental health trusts across London were provided with a data specification request and offered additional guidance by the HIN where required. Patient level data provided by 7 trusts was combined into a London-wide dataset. The other trusts provided data returns but owing to data quality issues these were not included in the aggregate analysis.

The trusts included in this dataset are:

- Central and North West London NHS Foundation Trust
- East London NHS Foundation Trust
- North East London NHS Foundation Trust
- Oxleas NHS Foundation Trust
- South London and Maudsley NHS Foundation Trust (SLaM)
- South West London and St George's Mental Health NHS Trust
- West London NHS Foundation Trust

3.1.1. Inclusion criteria

The dataset included all current mental health trust patients meeting the following criteria:

- Latest psychiatric primary diagnosis was any of: F2*, F30*, F31*, F32.3, F33.3 (see Table 1 for details).
- An active referral at the Trust for the year reporting period.
- Aged 18 years or older.

These criteria aimed to capture the patients with serious mental illness that were currently cared for by the trusts and should have had the 6 physical health checks within the reporting period.

3.1.2. Demographics

The dataset included the following demographic information on each patient:

- Gender
- Ethnicity
- Age at extraction date
- Index of multiple deprivation (IMD) 2019 decile
- Latest SMI diagnosis code (ICD-10 F2*, F30*, F31*, F32.3, F33.3)

3.1.3. Physical health checks

The dataset included the latest date that patients received each of the 6 health checks within the reporting period. From this data it was possible to calculate whether each patient had received each check, whether they had received no checks, and whether they had received all 6 checks.

3.1.4. Time periods

The reporting period for most Trust's data is 01/01/2023 - 31/12/2024. However, since the analysis was initially piloted with the SLaM patient cohort, the reporting period for the SLaM dataset is 06/12/2022 - 05/12/2023. The slight difference in reporting period should not affect the validity of the results of this analysis.

3.2. Analysis

The number of patients missing each/all checks within each demographic group and subgroup was calculated, and the proportion missing checks was calculated.

Demographic groups/subgroups that were more likely than average to miss checks were highlighted. Those meeting the following thresholds were drawn out in the analysis:

- A minimum of 50 patients missed the check(s).
- A minimum of 5 percentage point increase in proportion of people missing checks compared to average across all patients.

3.2.1. Number of patients vs proportion of patients

The majority of patients who are missing their physical health checks are likely to belong to the demographic groups that are most represented within the SMI population, for example male patients, black patients, and those within the most deprived IMD deciles (see section '4.2 Demographics' for a breakdown of the demographics of the London-wide SMI patient cohort). However, this does not necessarily mean that patients within these demographic groups are more likely than others to miss their checks.

This analysis looks at which demographic groups are more likely to have missed their checks, regardless of the size of that group within the SMI population. This is demonstrated in Table 2 which shows that while a larger number of patients who missed all checks belong to the demographic group of black ethnicity, this equates to only 28% of black SMI patients. Meanwhile, a smaller total number of patients aged 75+ have missed all their checks, however this equates to a higher proportion (47%) indicating that patients aged 75+ were more likely to have missed their checks and would therefore be highlighted in this analysis.

*Table 2: An example of the difference between the number of patients missing checks and the proportion of patients missing checks in two demographic groups (patients with an ethnicity of black and patients aged 75+) within the SMI cohort. *The 75+ group would be highlighted in this analysis since the percentage of patients missing all checks (47%) is more than 5 percentage points higher than the percentage for all SMI patients (34%).*

Demographic group	Total number of SMI patients	Number of patients missing all 6 checks	Percentage of patients missing all 6 checks
All SMI patients	36,619	12,448	34%
Black ethnicity	9,870	2,801	28%
Aged 75+	1,954	920	47%*

3.3. Caveats and limitations

Physical health checks may be completed in either primary or secondary care. The scope of this analysis includes secondary care data only. The inclusion criteria used in this analysis limits the cohort to only patients with an active referral at the mental health trust as these patients would be under the care of the trust and therefore could be offered their physical health check via the trust.

However, it is important to bear in mind when interpreting the findings that patients who had not received their checks according to the trust's data may have received them in primary care, and this should not be interpreted as a measure of the trust's performance. Patients may choose to attend their GP practice to complete the physical health check. The inability of primary care and secondary mental health systems to integrate data is a limiting factor for this analysis.

4. Findings

4.1. Data Quality

There was a total of 36,619 patients in the combined data extract, covering 7 London Mental Health Trusts. The demographic data was generally very complete, with only 5% of patients missing data on any individual demographic. IMD decile was missing for 5% (1,702) of patients, ethnicity was missing for 1% (522) of patients, and age and gender were each missing for 0.1% (21) of patients.

4.2. Demographics

A breakdown of the demographic categories of the patient cohort is shown in Table 3. Some categories were combined for the purpose of analysis if they met the following criteria:

- a. Small numbers of patients that would otherwise likely be excluded from the analysis due to group size.
- b. Similar proportions of patients in adjacent demographic groups that were missing checks, for example combining age groups 75-84 and 85+ into one group of 75+.

Table 3: Demographic breakdown of the patient cohort.

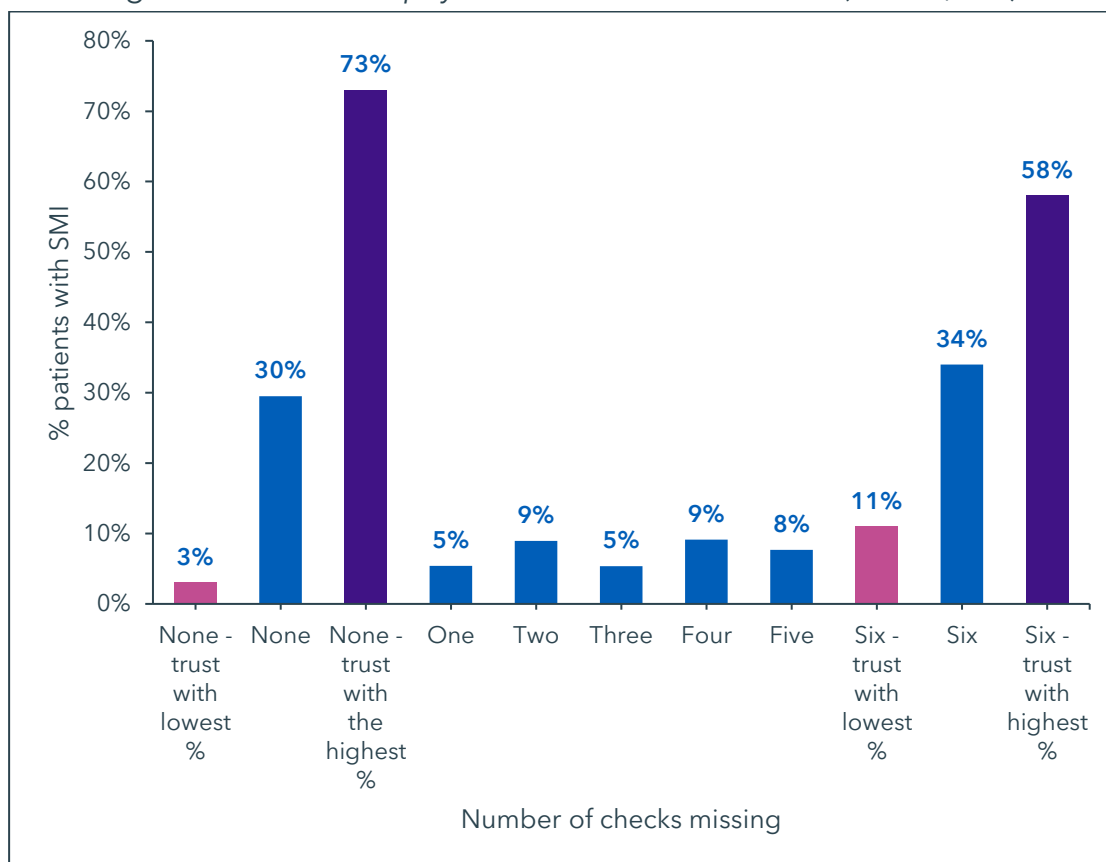
	N	%	Notes
<i>Gender</i>			
Male	20,618	56%	
Female	15,980	44%	
<i>Total</i>	36,598		
<i>Age group</i>			
18-24	2,094	6%	Age groups were combining where applicable for the purpose of analysis.
25-34	6,673	18%	
35-44	8,171	22%	
45-54	7,662	21%	
55-64	6,777	19%	
65-74	3,267	9%	
75-84	1,591	4%	
85+	363	1%	
<i>Total</i>	36,598		
<i>Ethnic group</i>			
White	14,110	39%	
Black	9,870	27%	
Asian	6,628	18%	
Mixed	2,283	6%	
Other	3,206	9%	
<i>Total</i>	36,097		
<i>IMD decile</i>			
1-2 (most deprived)	9,418	27%	IMD deciles were grouped where applicable for the purpose of analysis
3-4	13,265	38%	
5-6	6,890	20%	
7-8	3,664	10%	
9-10 (least deprived)	1,680	5%	
<i>Total</i>	34,917		
<i>ICD-10 diagnosis code</i>			
F2*	27,996	76%	F32.3 and F33.3 were combined into one category for the purpose of analysis.
F30*	354	1%	
F31*	6,011	16%	
F32.3 / F33.3	2,258	6%	See Table 1 for diagnosis code descriptions.
<i>Total</i>	36,619		

4.3. Checks completed by SMI patients

Of the 36,619-patient cohort, 30% received all 6 checks within the reporting period, and therefore the remaining 70% missed at least one physical health check. Figure 1 shows the breakdown by number of checks missed by patients.

There was great variance between trusts, with the trust with the highest proportion of patients having had all checks having 73% of SMI patients having completed checks, compared to only 3% for the trust with the lowest proportion.

Figure 1: Number of physical health checks missed (n = 36,619).



The average (median) number of checks per patient was 2 checks. The trust with the lowest median had 0 checks and the highest was all 6 checks.

Figure 2: Average (median) number of checks conducted (n = 36,619).

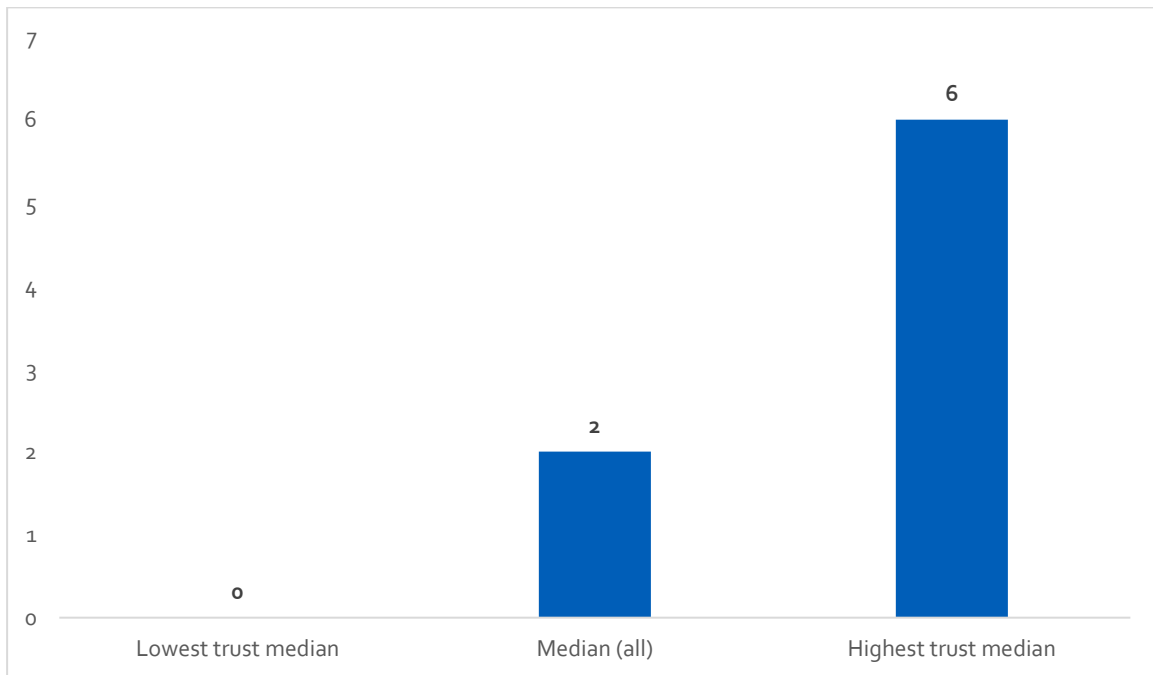
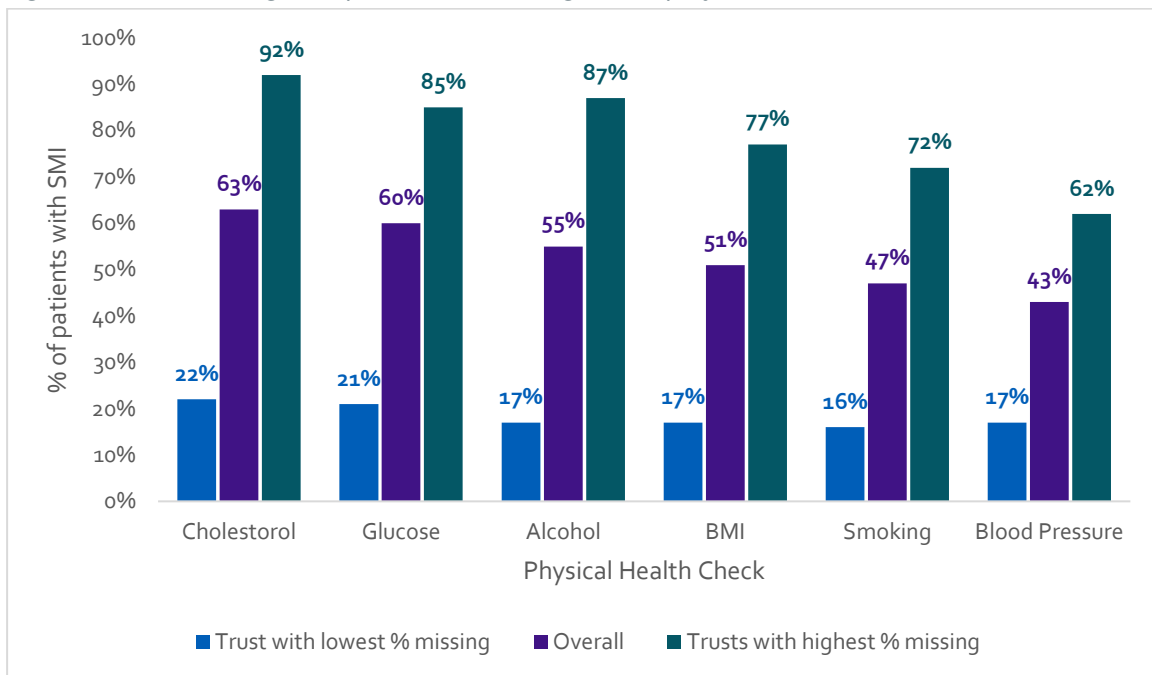


Figure 3 shows the percentage of patients that missed each of the 6 physical health checks. The health check missed by the most patients was cholesterol, which was missed by 63% of patients, closely followed by blood glucose (missed by 60%). The check missed by the least patients was blood pressure (missed by 43%).

Again, there was great variance between the trust with the highest uptake of each check and those with the lowest uptake, with one trust having 92% of SMI patients having missed a cholesterol check, whilst another trust had 16% missing their smoking status.

Figure 3: Percentage of patients missing each physical health check (n = 36,619).



4.4. Patients missing checks by demographic category

Demographic groups that were more likely to have missed each physical health check were identified according to the methodology detailed in section 3.2. These groups are listed in Appendix 1. This section summarises which demographic groups are more likely to have missed all 6 physical health checks and each of the 6 individual checks, grouped by demographic characteristic.

4.4.1. Gender

Neither male nor female patients were more likely to have missed their checks based purely on gender. However, when combined with other demographic categories the following differences were identified:

4.4.1.1. Gender and age

Female patients aged 65-74 were more likely than male patients in the same age category to have missed all 6 checks, as well as BMI, blood pressure and cholesterol checks.

4.4.1.2. Gender and ethnicity

Female white patients were more likely than males to have missed all 6 checks as well as each of the 6 checks individually, and female Asian patients were more likely to

have missed all 6 checks, BMI, blood pressure, alcohol, and smoking checks.

4.4.1.3. Gender and SMI diagnosis

Male patients with a diagnosis of a manic episode (F30*) were more likely to have missed blood pressure, cholesterol, and glucose checks, while female patients with a diagnosis of bipolar disorder (F31*) were more likely to have missed BMI and smoking checks.

4.4.2. Age

Patients aged 65+ were more likely than those younger to have missed their BMI and blood pressure checks, and patients aged 75+ were more likely to have missed all 6 checks, as well as individual cholesterol, blood glucose, alcohol, and smoking checks. When combining age with other demographic categories the following differences were identified:

4.4.2.1. Age and gender

See section 4.4.1.1 Gender and age.

4.4.2.2. Age and ethnicity

Patients aged 65+ who were white or Asian were more likely to have missed all 6 checks as well as each individual check, and those who were black were more likely to have missed their BMI and cholesterol checks.

Asian patients aged 35-44 were more likely to have missed all 6 checks, and those aged 45-54 were more likely to have missed alcohol and smoking checks.

4.4.2.3. Age and SMI diagnosis

Patients aged 75+ and diagnosed with schizophrenia, schizotypal and delusional disorders (ICD-10 F2*) were more likely to have missed all 6 checks and each individual check than those who were younger.

4.4.3. Ethnicity

Asian patients were more likely to have missed all 6 checks or their smoking check than patients of other ethnic groups. When combining age with other demographic categories

the following differences were identified:

4.4.3.1. Ethnicity and gender

See section 4.4.1.2 Gender and ethnicity.

4.4.3.2. Ethnicity and age

See section 4.4.2.2 Age and ethnicity.

4.4.3.3. Ethnicity and deprivation

White patients in the IMD deciles 1-6 (1 being most deprived) were more likely to have missed their BMI, blood pressure, cholesterol, and blood glucose checks, and those in deciles 1-4 were also more likely to have missed their alcohol check. Additionally, white patients in the least deprived deciles (9-10) were also more likely to have missed their BMI check.

Asian patients in the most deprived deciles (1-2) were more likely to have missed all 6 checks and each check individually, and additionally those in deciles 3-4 were more likely to have missed their cholesterol, alcohol, and smoking checks.

4.4.3.4. Ethnicity and SMI diagnosis

White and Asian patients diagnosed with affective disorders (ICD-10 F30*, F31*, F32.3 and F33.3) were more likely to have missed all 6 checks as well as each individual check. Additionally, Black patients diagnosed with affective disorders were more likely to have missed their blood pressure check than those of other ethnic groups and SMI diagnoses.

4.4.4. Deprivation

There were no notable differences in completion of physical health checks based purely on IMD decile. However, when combining IMD decile with other demographic categories the following differences were identified:

4.4.4.1. Deprivation and ethnicity

See section 4.4.3.3 Ethnicity and deprivation.

4.4.4.2. Deprivation and SMI diagnosis

Patients diagnosed with bipolar disorder (ICD-10 F31*) who were in IMD deciles 1-2

(1 being most deprived) were more likely to have missed their cholesterol check, those in deciles 1-4 were more likely to have missed their alcohol check, and those in deciles 3-6 were more likely to have missed their blood glucose or smoking checks.

4.4.5. SMI diagnosis

Patients diagnosed with affective disorders (ICD-10 F30*, F31*, F32.3 and F33.3) were more likely to have missed all 6 checks as well as individual BMI and blood pressure checks. Additionally, those diagnosed with a manic episode (ICD-10 F30*) were more likely to have missed their cholesterol, blood glucose and alcohol checks, and those diagnosed with severe depressive episode with psychotic symptoms or recurrent depressive disorder, current episode severe with psychotic symptoms (ICD-10 32.3/33.3) were more likely to have missed their cholesterol, blood glucose, alcohol, and smoking checks. When combining SMI diagnosis with other demographic categories the following differences were identified:

4.4.5.1. SMI diagnosis and gender

See section 4.4.1.3 Gender and SMI diagnosis.

4.4.5.2. SMI diagnosis and age

See section 4.4.2.3 Age and SMI diagnosis.

4.4.5.3. SMI diagnosis and ethnicity

See section 4.4.3.4 Ethnicity and SMI diagnosis.

4.4.5.4. SMI diagnosis and deprivation

See section 4.4.4.2 Deprivation and SMI diagnosis.

5. Discussion

5.1. Data quality

Demographic information was generally well-recorded within the Trusts' systems, with only up to 5% of patients in the cohort missing any individual demographic. The most commonly missed demographic was IMD decile which was calculated from patients' home address. It is important to note that patients who are homeless are unlikely to have an IMD decile recorded.

During the data collection process, some Trusts raised that an actual SMI diagnosis was not coded for all patients on their SMI register. Due to the inclusion criteria for this analysis, these patients were excluded from the dataset. Therefore, there may have been an unknown subset of SMI patients that were not included in this analysis due to their diagnosis not being coded.

5.2. Demographic groups missing checks

Demographic groups that were repeatedly highlighted as being more likely than average to miss their physical health checks were:

- Patients aged 65 and over were more likely to have missed their checks than younger patients, and this was more pronounced for females than males.
- Asian patients were more likely to have missed all of their checks.
- Both white and Asian patients who were also female, aged 65+, or in the more deprived IMD deciles (1-4) were more likely than average to have missed some or all their checks.
- Patients diagnosed with mood/affective disorders (ICD-10 F30*, F31*, F32.3 or F33.3) were more likely to have missed their checks than those with schizophrenia, schizotypal and delusional disorders (ICD-10 F2*), except in the older age groups (75+) where those with an F2* diagnosis were also more likely than average to have missed their checks.

5.3. Interoperability

It should be noted that the data analysed does not account for physical health checks that have been conducted in general practice and it is therefore not possible to determine whether the missing checks are being completed in primary care. It may be the case that patients who are flagged in this analysis as missing their checks may have received them through their general practice, and therefore decline to have them in secondary care.

Whether patients had declined the offer of a physical health check was not included within this data collection and analysis.

Currently, the trusts inform the GP of the person with a SMI by letter/email that their PH check has been completed, which means there are data flows for secondary care data into primary care. However, there is no current data flow from general practice to secondary mental health for PH checks completed in primary care. As such, mental health trusts are not aware of PH check undertaken through a person's general practice

6. Recommendations

The following recommendations were formulated from the data analysis within this research and from a London Physical Health Leads Workshop held on 11th June 2024.

Trusts are recommended to consider:

1. Sharing this London report with their patient and public involvement team and system partners to inform their approach to all the recommendations below, to improve the completion of physical health checks.
2. Proactively holding conversations with senior Integrated Care Board members to urgently address interoperability issues. Interoperability of clinical data systems and primary care data flow into secondary care (and vice versa) is critical to understanding which patients have received their physical health checks. This is key to improving patient outcomes, equity in access, and to ensuring a patient with SMI is only being asked to attend one centre for their check and/or given the choice of location.
3. Proactively focussing on offering all 6 checks to their patient population. All 6 checks need a dedicated structured methodological approach to understand why patients defined in this report may be likely to miss them. Interventions following a 'Plan Do Study Act' methodology to test and improve their completion are recommended.
4. Offering physical health checks in trusted community settings, particularly for their Asian population, such as, Mosques, Temples, and Faith Centres.
5. Exploring opportunities to improve physical health checks for older adults through community older adult teams.

6. Understanding when and where friends and families (informal carers) can be informed to support physical health checks, and to have an action plan to address those less likely to have this support (e.g. older adults).
7. Reviewing the accessibility of provision of blood tests and the recording of blood tests. The analysis indicates that a 60% - 63% of patients are missing checks that require blood tests (cholesterol, glucose).
8. Consider using mobile technology, such as, point of care testing to facilitate delivery of physical health checks in the community.
9. Addressing the gap in checks that may be viewed as lifestyle choices, such as BMI and weight, smoking and alcohol assessment.
10. Reviewing whether people with SMI are being offered interventions, such as smoking/ alcohol cessation, diabetes prevention/education.
11. Work collaboratively to learn from Trusts who are achieving a higher rate of completed checks, and to embed the required changes in practice.

7. Acknowledgements

Thank you too all:

- The nine London Mental Health Trusts who participated in this project and proactively contributed to the discussion.
- Our lived experience partners.
- The Cavendish Square Group for providing leadership and funding for this project

8. Appendices

8.1. Appendix 1: Demographic groups more likely to have missed checks

The table below lists the demographic groups and sub-groups that were more likely to have missed all 6 physical health checks and each physical health check, along with the percentage and number of patients in each group that missed the check.

Demographic group	Patients missing physical health check	
	Percentage	Number
<i>All 6 physical health checks</i>		
Total patient cohort	34%	12,448
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	49%	737
Asian patients aged 65+	48%	395
Patients aged 75+	47%	920
Patients aged 75+ with diagnosis code F2*	47%	599
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	47%	2,019
Patients with diagnosis codes F30*, F31, F32.3 or F33.3	44%	3,828
Female Asian patients	43%	1,263
White patients aged 65+	43%	1,260
Female patients aged 65-74	41%	733
Female white patients	41%	2,610
Asian patients in IMD deciles 1-4	41%	1,695
Asian patients aged 35-44	39%	680
Asian patients	39%	2,604
<i>BMI check</i>		
Total patient cohort	51%	18,520
Patients aged 75+ with diagnosis code F2*	69%	867
Asian patients aged 65+	64%	527
White patients aged 65+	63%	1,850
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	63%	2,680

Demographic group	Patients missing physical health check	
	Percentage	Number
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	61%	920
Female patients aged 65-74	60%	1,074
Female patients with diagnosis code F31*	60%	2,224
Patients aged 65+	60%	3,158
Female white patients	59%	3,719
Patients with diagnosis codes F30*, F31, F32.3 or F33.3	59%	5,067
White patients in IMD deciles 1-6	57%	6,038
Female Asian patients	56%	1,670
Black patients aged 65+	56%	437
White patients in IMD deciles 9-10	56%	580
Asian patients in IMD deciles 1-2	56%	899
<i>Blood pressure check</i>		
Total patient cohort	43%	15,734
Patients aged 75+ with diagnosis code F2*	58%	727
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	57%	2,430
Asian patients aged 65+	55%	456
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	55%	835
White patients aged 65+	53%	1,567
Patients with diagnosis codes F30*, F31, F32.3 or F33.3	53%	4,588
Female white patients	51%	3,212
Male patients with diagnosis code F30*	51%	89
Patients aged 65+	51%	2,688
Female patients aged 65-74	50%	889
Female Asian patients	49%	1,463
Asian patients in IMD deciles 1-2	49%	789
White patients in IMD deciles 1-6	48%	5,137
Black patients with diagnosis codes F30*, F31, F32.3 or F33.3	48%	627

Demographic group	Patients missing physical health check	
	Percentage	Number
<i>Cholesterol check</i>		
Total patient cohort	63%	23,073
Male patients with diagnosis code F30*	76%	133
Patients aged 75+ with diagnosis code F2*	75%	946
Patients aged 75+	73%	1,432
White patients aged 65+	72%	2,118
Asian patients aged 65+	71%	589
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	71%	3,027
White patients in IMD deciles 1-6	70%	7,417
Asian patients in IMD deciles 1-4	70%	2,888
Patients with diagnosis code F30*	70%	247
Female patients aged 65-74	69%	1,227
Female white patients	69%	4,361
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	69%	1,040
Patients with diagnosis codes F32.3/F33.3	69%	1,557
Black patients aged 65+	68%	536
Patients with diagnosis code F31* in IMD deciles 1-2	68%	912
<i>Blood glucose check</i>		
Total patient cohort	60%	22,100
Patients aged 75+ with diagnosis code F2*	72%	908
Male patients with diagnosis code F30*	70%	124
Patients aged 75+	70%	1,360
Asian patients in IMD deciles 1-2	70%	1,112
White patients aged 65+	68%	2,005
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	68%	2,927
Asian patients aged 65+	67%	552
Patients with diagnosis codes F32.3/F33.3	67%	1,507
Female white patients	66%	4,166
White patients in IMD deciles 1-6	66%	7,032

Demographic group	Patients missing physical health check	
	Percentage	Number
Patients with diagnosis code F31* in IMD deciles 3-6	66%	2,131
Patients with diagnosis code F30*	66%	232
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	65%	993
<i>Alcohol check</i>		
Total patient cohort	55%	20,031
Patients aged 75+ with diagnosis code F2*	65%	816
Asian patients aged 65+	64%	531
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	64%	964
Patients aged 75+	63%	1,240
White patients aged 65+	63%	1,840
Asian patients in IMD deciles 1-4	63%	2,597
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	63%	2,698
Patients with diagnosis codes F32.3/F33.3	63%	1,416
Asian patients aged 45-54	61%	831
White patients in IMD deciles 1-4	61%	4,834
Female white patients	60%	3,816
Female Asian patients	60%	1,793
Patients with diagnosis code F31* in IMD deciles 1-4	60%	2,051
Patients with diagnosis code F30*	60%	214
<i>Smoking check</i>		
Total patient cohort	47%	17,044
Patients aged 75+ with diagnosis code F2*	59%	747
Patients aged 75+	58%	1,126
Asian patients aged 65+	57%	474
Asian patients with diagnosis codes F30*, F31, F32.3 or F33.3	57%	872
Patients with diagnosis codes F32.3/F33.3	56%	1,270
Asian patients in IMD deciles 1-4	55%	2,266

Demographic group	Patients missing physical health check	
	Percentage	Number
White patients with diagnosis codes F30*, F31, F32.3 or F33.3	55%	2,360
Female Asian patients	54%	1,590
White patients aged 65+	54%	1,588
Patients with diagnosis code F31* in IMD deciles 3-6	53%	1,715
Female white patients	52%	3,312
Female patients with diagnosis code F31*	52%	1,957
Asian patients aged 45-54	52%	712
Asian patients	52%	3,419

9. About us

The Health Innovation Network south London is one of 15 Health Innovation Networks across England. As the only bodies that connect NHS and academic organisations, local authorities, the third sector and industry, we are catalysts that create the right conditions to facilitate change across whole health and social care economies, with a clear focus on improving outcomes for patients.

This means we are uniquely placed to identify and spread health innovation at pace and scale; driving the adoption and spread of innovative ideas and technologies across large populations.

Our staff bring together a broad range of skills including clinical and lived experience partners, and subject matter expertise in evaluation, commercial, digital transformation, quality improvement, user involvement, communications and engagement, community and capacity building, research and data analytics, project, and programme management.