Improving the physical health of people living with Severe Mental Illness: Guidance for Integrated Care Systems

30 April 2024, 12:30pm – 14:00pm

- **Mark Farmer:** Co-Lead Adult Mental Health Advisory Network, NHS England
- **Dr David Shiers:** Retired GP and carer to his daughter with schizophrenia
- **Dr Emma Tiffin:** National GP Advisor, Community and Primary Care Adult Mental Health, NHS England
- **Dr Ed Beveridge:** Presidential Lead for Physical Health, Royal College of Psychiatrists

Agenda

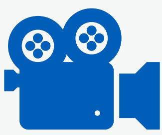
Item	Presenter	Time
Welcome and introduction	Mark Farmer Co-Lead Adult Mental Health Advisory Network, NHS England	12:30-12.45
Through the eyes of a carer	Dr David Shiers Retired GP and carer to his daughter with schizophrenia	12.45-13.00
SMI physical health check service in primary care	Dr Emma Tiffin National GP Advisor, Community and Primary Care Adult Mental Health, NHS England	13.00-13.15
The role of secondary care	Dr Ed Beveridge Presidential Lead for Physical Health, Royal College of Psychiatrists	13.15-13.30
Whole system approach: 10 key actions from the new guidance	Dr Emma Tiffin National GP Advisor, Community and Primary Care Adult Mental Health, NHS England	13.30-13.40
Q&As	All	13.40-13.55
Close	Mark Farmer Co-Lead Adult Mental Health Advisory Network, NHS England	13.55-14.00

Housekeeping

- This is a live event; therefore, you will be on mute unless you're a designated speaker.

- Please use the chat function to ask any questions, and vote for the ones you want answered during the Q&A.

- If you can't access the chat box, please email england.adultmh@nhs.net and we'll pick up your questions.



- This event will be recorded, and we will share the recording and slides afterwards. It will also be uploaded to NHS Futures.

Introduction

Mark Farmer

The physical health of people living with Severe mental illness

6.6 Times increased risk of respiratory disease

6.5 Times increased risk of liver disease

4.1 Times increased risk of cardiovascular disease

2.1 Times increased risk of cancer

3 Times more likely to lose their natural teeth

People living with severe mental illness (SMI) die 15 to 20 years younger than the general population.

This is a persistent inequality and is predominantly due to preventable or treatable physical health conditions.

Smoking is the largest avoidable cause of premature death, with an estimated 50 per cent of deaths in people living with SMI attributable to smoking.

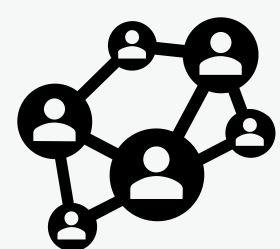
New guidance on SMI physical health

- Previous guidance was published in 2018.
- Since then, the landscape of the NHS has changed, with the establishment of Integrated Care Boards, plus systems were asking for more clarity on a range of areas.
- Established a Task and Finish group co-chaired by an Expert by Experience and an NHSE GP Clinical Advisor. Membership included NHSE colleagues (mental health, learning disability, primary care, healthcare inequalities), clinicians, VCSE reps, experts by experience and others.
- The Task and Finish Group updated the previous guidance and added new sections. The guidance includes an annex which includes best practice case studies.
- The new guidance can be found here.
- SMI physical health checks are also part of operational planning for 2024/25.

What was important to people with Lived Experience

1. Closing the life expectancy gap: We advocated for guidance that empowers systems to proactively address physical and mental health needs through early detection and prevention, particularly by fully leveraging health checks.
2. Equitable access: We promoted inclusivity in health checks, ensuring that individuals currently not accessing SMI physical health checks receive the necessary support. This entails accommodating diverse needs such to ensure universal access.

3. Involvement of support networks: Recognising the significance of patient support networks, including carers, family, and friends, we stressed the importance of integrating them into the care planning process, respecting patient preferences.
4. Collaborative local systems: We championed the need for a collaborative approach, where individuals with lived experience and their support networks are equal partners alongside clinicians and local NHS leadership, to ensure a holistic perspective and effective implementation.

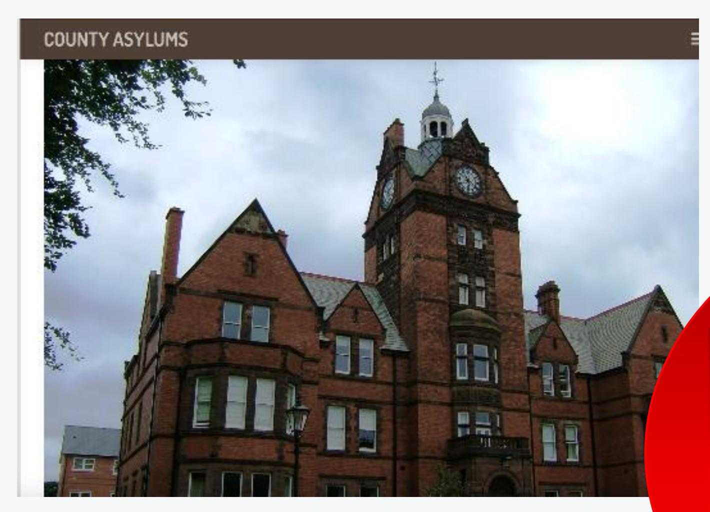


5. Tailored support: We advocated for collaborative decision-making between individuals, their support networks, and clinicians, and utilisation of resources, such as personal health budgets to tailor support strategies to individual circumstances and preferences.

Through the eyes of a carer

Dr David Shiers

Fattened, flattened and forgotten



Severe Mental Illness Annual Physical Health Check Service in primary care

Dr Emma Tiffin

Specialist Health Care Assistants (SHCAs) - SMI Annual Physical Health Checks (and Eating Disorder Medical Monitoring)

The 6 core elements SMI PHC

- Weight / BMI
- BP / pulse
- Blood lipids including cholesterol
- Blood glucose
- Alcohol consumption
- Smoking status

Additional assessments / measures

- ECG if indicated
- Assessment of use of illicit substances / non prescribed medications
- Nutritional status, diet & level of physical activity
- Access to national screening
- Medicine reconciliation
- General physical health enquiry, to incl. sexual health/contraception, oral health
- Indicated follow up
- Personalised Care and Support Plans

Host trained SHCAs within GP Federations.

Dual SMI and ED role:

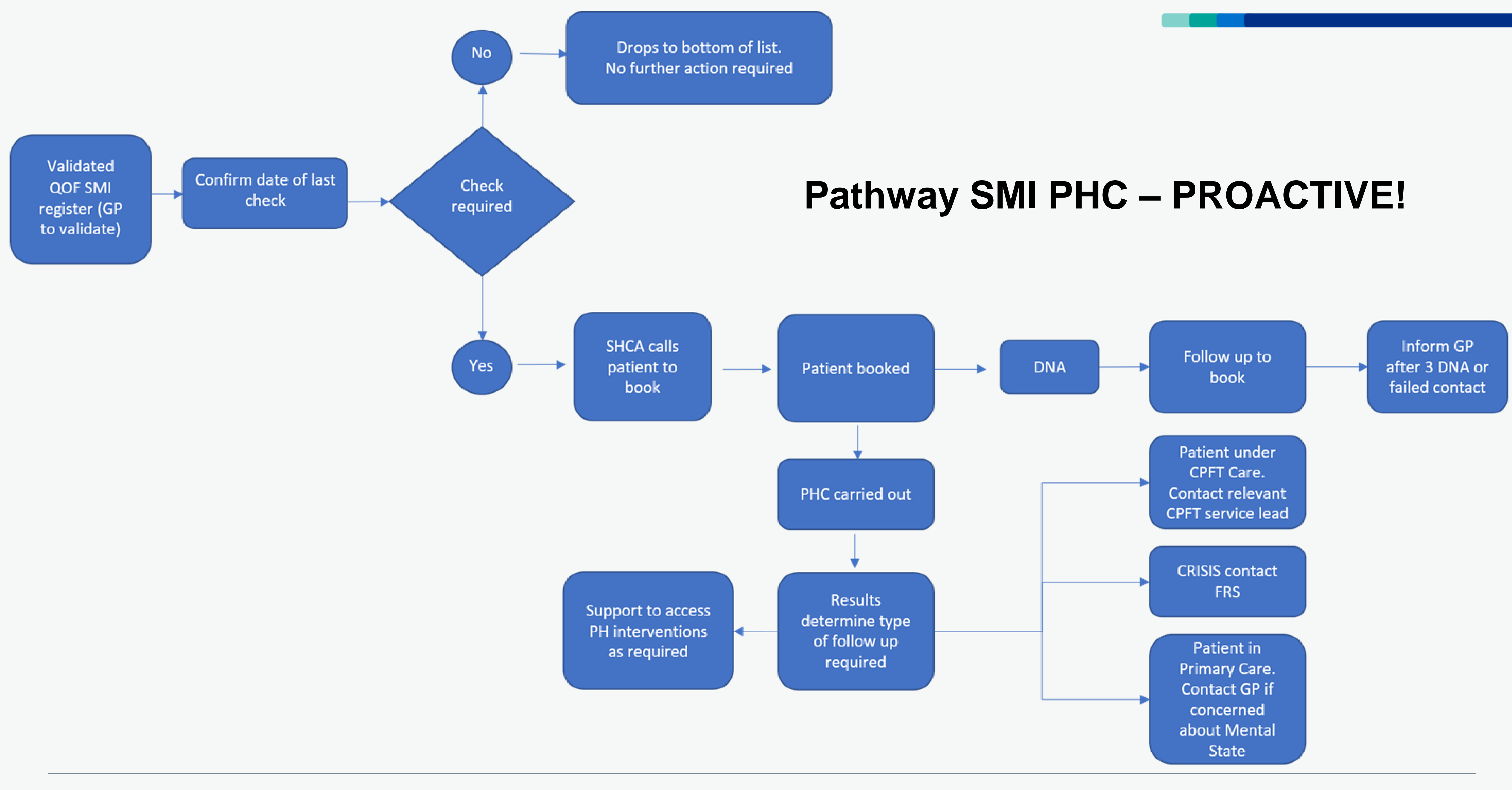
- Annual SMI physical health check, immunisations.
- Operational management of SHCAs provided by GP Fed, clinical supervision provided by MH trust.

Key features:

- Appt length: 45 minute check, 20 min follow ups.
- Home visit option.
- Follow up appointments - support interventions.
- KPIs - 80% SMI, 100% ED MM.
- Robust pathways/links to VCSE and LA resources including digital resources.
- SMI Population @31/3/23 **7128** delivery of service with 10.5 SHCA's + clinical support & admin support

Benefits

- Intensive support to promote engagement
- Patients monitored in local primary care setting
- Supports patient access/choice
- Reduces stigma and promotes equity/parity of esteem
- Quality – MH trained SHCA
- Supports joint working - primary care & SC
- Clear discharge plan, fast access to AEDS
- Specialist BAME workers
- Support patients to attend additional LTC health checks, med reviews, cancer screening
- Upskilled workforce in SMI and ED across the system



Pathway SMI PHC – PROACTIVE!
Validated QOF SMI register (GP to validate)
Confirm date of last check
Check required
No
Drops to bottom of list. No further action required
Yes
SHCA calls patient to book
Patient booked
DNA
Follow up to book
Inform GP after 3 DNA or failed contact
PHC carried out
Results determine type of follow up required
Support to access PH interventions as required
Patient under CPFT Care. Contact relevant CPFT service lead
CRISIS contact FRS
Patient in Primary Care. Contact GP if concerned about Mental State

Interface with other community mental health services – Specialist Mental Health, Local Authority, VCSE

PCMH

- Specialist Health Care Assistants (SHCAs) receive monthly mentoring sessions from the Primary Care Mental Health Service (PCMH)

Collaboration

- Working with CMHTs to ensure that patients who struggle to engage with the GP practice have their APHC at home/community venue
- SHCA team attend PALT team bimonthly meetings
- Neighbourhood MH Hubs co-hosted by PCMHS & H.A.Y

Local Authority/VCSE

- SHCAs link with “Healthy You” (LA commissioned)
- Work with CPSL Mind to support referrals to VCSE
- Collaboration with SUN Network/SMI SU to create Personal Care Support Plan

Outcome Data April 22 – March 23

C&P ICB – 22/23 uptake of APHC – achieved 115% LTP target

- @31st March 2023 – 7,128 patients on SMI register, 4,667 received a full health check during previous 12 months (65%)
- As a system we saw a 7% increase in the number of patients on the SMI register during 22/23

12 month System snapshot 22/23 - of the 4,667 patients who received APHC

- **575** patients supported to access Lifestyle choice services : smoking, weight, exercise, walking
- **1,135** patients supported to access physical health services :.cancer screening, LTC checks, CV risk assessment, dental
- **1,241** 12 Lead ECGs undertaken
- **217** APHC delivered as home visits
- **8** patients had an SHCA physically assist them attending on a visit to a screening service/physical health appointment
- **96** patients supported to access COVID vaccinations
- **165** patients given flu vaccination as part of the APHC appointment
- **378** patients attended 20min follow up appt to explore lifestyle choice /physical health services that would benefit their wellbeing

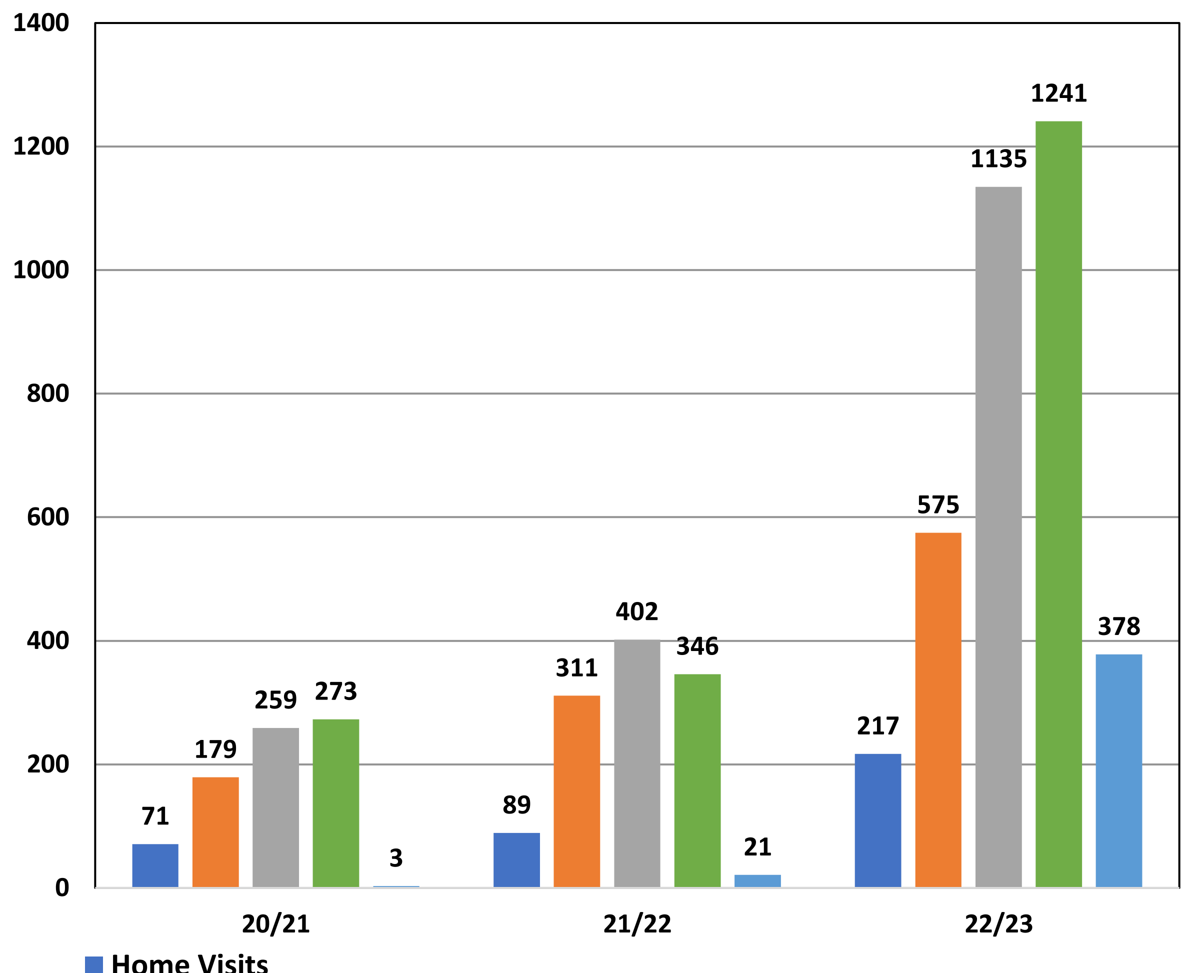
C&P ICS – 88 GP practices – all signed up to this model

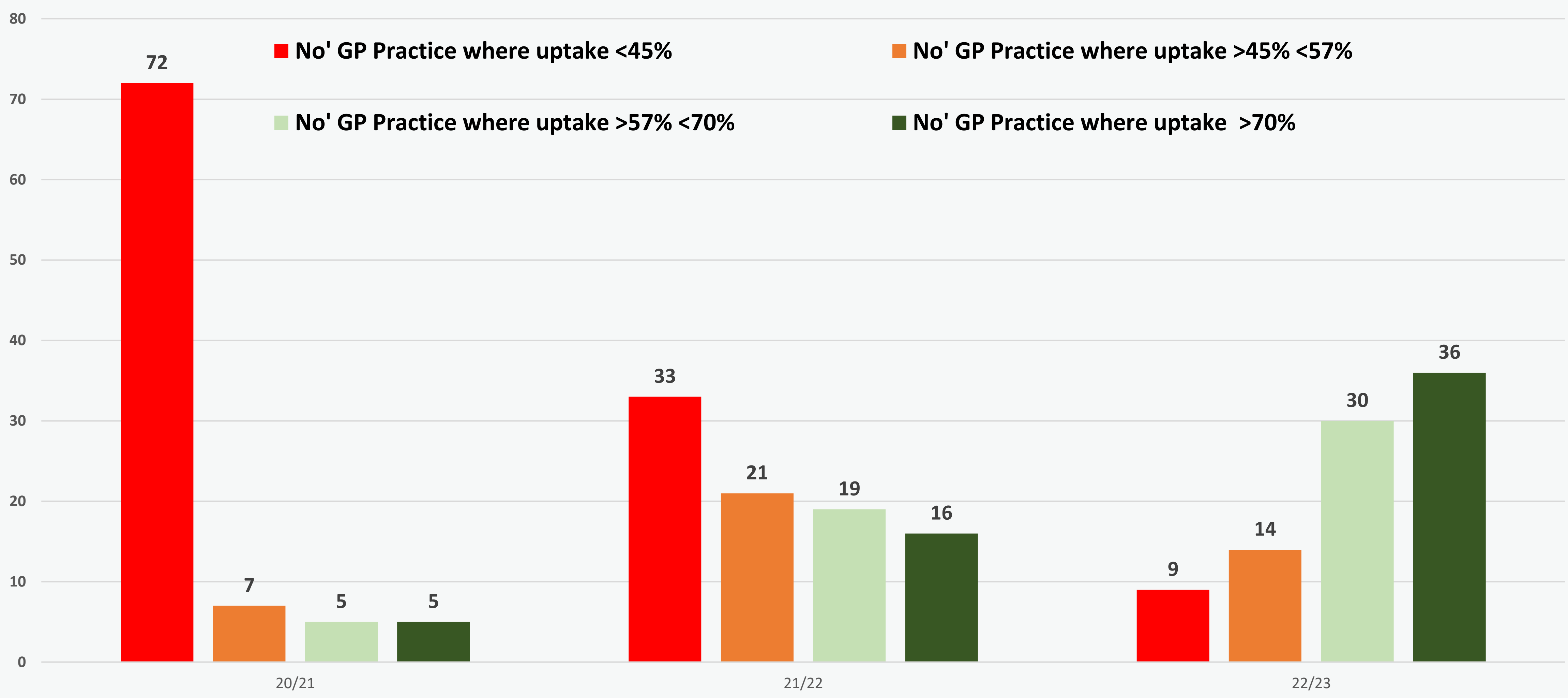
The SMI APHC team delivered 80% of the 4,667 APHC delivered, GP practices delivered the remaining 20% due to patient choice/circumstances

Addressing health inequalities

The Cambridgeshire and Peterborough model offers an enhanced 12 point annual physical health check, and since the launch of this service we have seen a remarkable increase in service users actively addressing their lifestyle, social and physical wellbeing with the support of the SHCA team.

221% increase in those service users accessing lifestyle services like "Healthy You" to get fitter, give up smoking, reduce alcohol intake.





In the last three years of the implementation project, the increase in uptake of the APHC has been seen across all practices, across the system. The team will continue to support practices with the aim to achieve above 80% uptake in 23/24

Engagement / reasonable adjustments / safeguarding

Practice had no contact with patient for 2.5 years, SHCA successfully booked the patient in for their SMI APHC patient with phone contact, text reminder day before / morning of appt, offered walk in appointment on agreed day, leaflet sent via AccuRX explaining the health check.

Patient presented at the practice appearing malnourished, unkempt, confused as well as appearing distressed. They were accompanied by their ‘partner’ who was well groomed and appeared controlling.

Patient referred to safeguarding team, support services put in place.

ECG Delivery

Patient received ECG due to medication as part of the APHC, found to have QT prolongation patient was asymptomatic. Required an urgent referral to cardiology. Patient’s medication was adjusted, and he thanked the team for what they had done.

Home Visits

SHCA team visit a supported living unit and delivered annual physical health check and covid immunisations to 17 resident SMI patients.

Make Every Contact Count / upskilling workforce

Nurse saw SMI patient for a dressing and felt that a full physical health check needed + additional blood tests. Patient unhappy to attend GP surgery. Nurse discussed physical and mental health needs of patient (with consent) with SHCA who arranged a home visit and carried out an annual SMI physical health check, covid immunisation and additional b/t. Liaison with GP.

Patient information leaflet to explain what to expect from and SMI APHC

Cambridgeshire and Peterborough
Clinical Commissioning Group

Your Annual Physical Health Check Explained

For Patients with a Severe Mental Illness

The link between mental health and physical health is often misunderstood and they are often thought of as separate things.

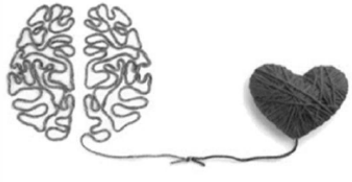
The World Health Organization defines health as "A state of complete physical, mental and social well-being"

Did you know that if you have been diagnosed with a severe mental illness you may be entitled to have a Free Annual Physical Health Check?

This is undertaken at your GP practice by a specially trained member of the team. You will be offered one every year to support you to manage your health.

We often feel run down when our mental health is not in a good place. It is important to look after your overall health and wellbeing. Your physical health check is there for us to support you to have better physical and mental health.

Eating healthily as well as taking regular exercise and any prescribed medications will benefit our overall general health.



The annual health check can identify current and future health concerns. We are working together to discuss your health as a whole.

We are working closely with our mental & physical health colleagues, as well as community based voluntary organisations to support your individual needs.

The team is here to assess your physical and mental wellbeing, along with offering support, encouragement, and motivation to access other services that are available to you free of charge in your local area.

With your permission they can share information to enable you to access other services such as lifestyle and physical groups that you my benefit from, and the team knows how to access these services.

What does your physical health check look like?

Your appointment takes around 45 minutes and you will be seen by a Specialist Health Care Assistants (SHCA) the SHCA team will carry out the health check.

At your annual health check you may be offered the following:

Blood pressure, pulse, urine sample, weight, height and sometimes an ECG test that can be used to check your heart's rhythm and electrical activity. You may also have a blood test including, cholesterol, diabetes, liver function.

The health check can be flexible, you can use the session to talk about any health concern you may have. The SHCA knows all about how to find the right support for you, you may be given advice to help you lower your risk of a stroke, kidney disease, heart disease, diabetes along with support to maintain or improve your health.

You may also be offered:

- Personalised lifestyle advice and support
- An appointment with another clinician – such as your GP or mental health worker
- An invitation and support to access national screening programmes
- Support to access community groups
- Seasonal vaccinations.

You may be offered a second 20 minute follow up appointment with the SHCA to give you that extra time and support to access those services to help you to get on with your life, and support you to self-manage your mental and physical wellbeing.

If you would like more information on what the check might involve or what other support there is out there for you, visit the following websites:

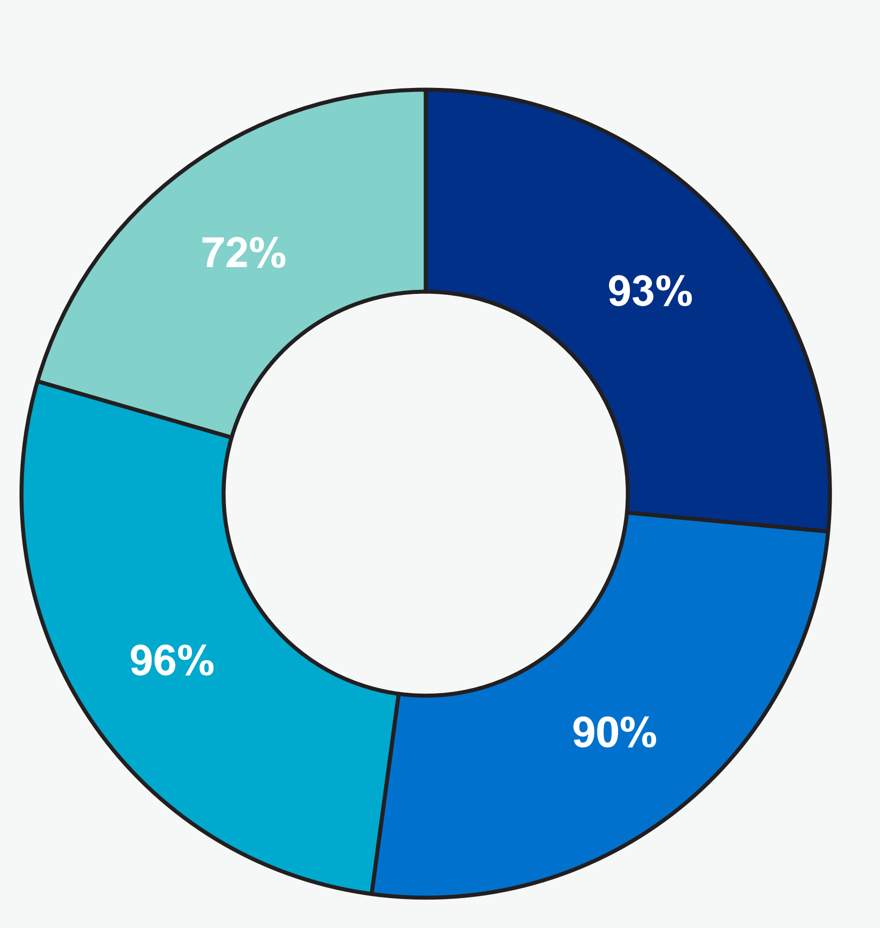
- www.keep-your-head.com
- www.HAYCambsPboro.co.uk
- www.cpft.nhs.uk
- www.cpslmind.org.uk

If you have any questions or concerns about attending, the physical health check team are there to support you to access your appointment.

Contact your practice and ask to speak to the specialist health care assistant.

- Translated into 12 languages
- Paper or digitally shared via AccuRX
- Written in collaboration with SU, PC & SC clinical teams & Feds

Service specific survey feedback 22/23 - 289 replies



Were you listened to…

Do you feel the Specialist Health Care Assistant listened to you and understood any concerns you may have had around you mental or physical wellbeing? **93% said Yes**

Do we know you...

Were you contacted about your appointment in a way that was right for you? **96% said yes**

Did we meet your expectations…

Based on your experience today did your appointment meet your expectations? **90% said Yes**

Did we explain ourselves…

Before you attended your appointment, do you feel you were given enough information about the appointment and why you had been invited? **72% said yes**

Service user feedback

- The help I received was fantastic. Some of the best help I have had since being under the mental health act.
- I found the nurse at my annual review to be kind, thoughtful and she listened to all of my concerns and gave very good advice. Happy with the nurse I saw. She saw me last year too, and I appreciated this continuity in my review as she remembered me from last year.
- I received a lot of support from the nurse. She was very thoughtful, and I really appreciated the new way that the appointments are caried out. Thank you so much
- Friendly, personable SHCA who listened to me & asked follow up questions (showing she'd listened to me) rather than just following a script. Useful information & service.
- The healthcare assistant understood the seriousness of the situation and did suitable referrals thank you very much for your great support and guidance!
- An excellent opportunity & time was given to go through your yearly medicine review & your physical & mental well-being all being addressed.

Staff feedback

- I'm PCN lead for health inequalities. So pleased to hear you are doing this work with our patents. I spoke to one lady who saw you last week and she said how lovely you were and how good it felt to have the health check.
- Dear Practice - Just to inform you our last SMI clinic date is the 29th, the SHCA only has 2 patients to call after this date

  Dear SMI PHC team that is fantastic news, thank you so much to you all for the hard work in serving our patients.

The role of secondary care

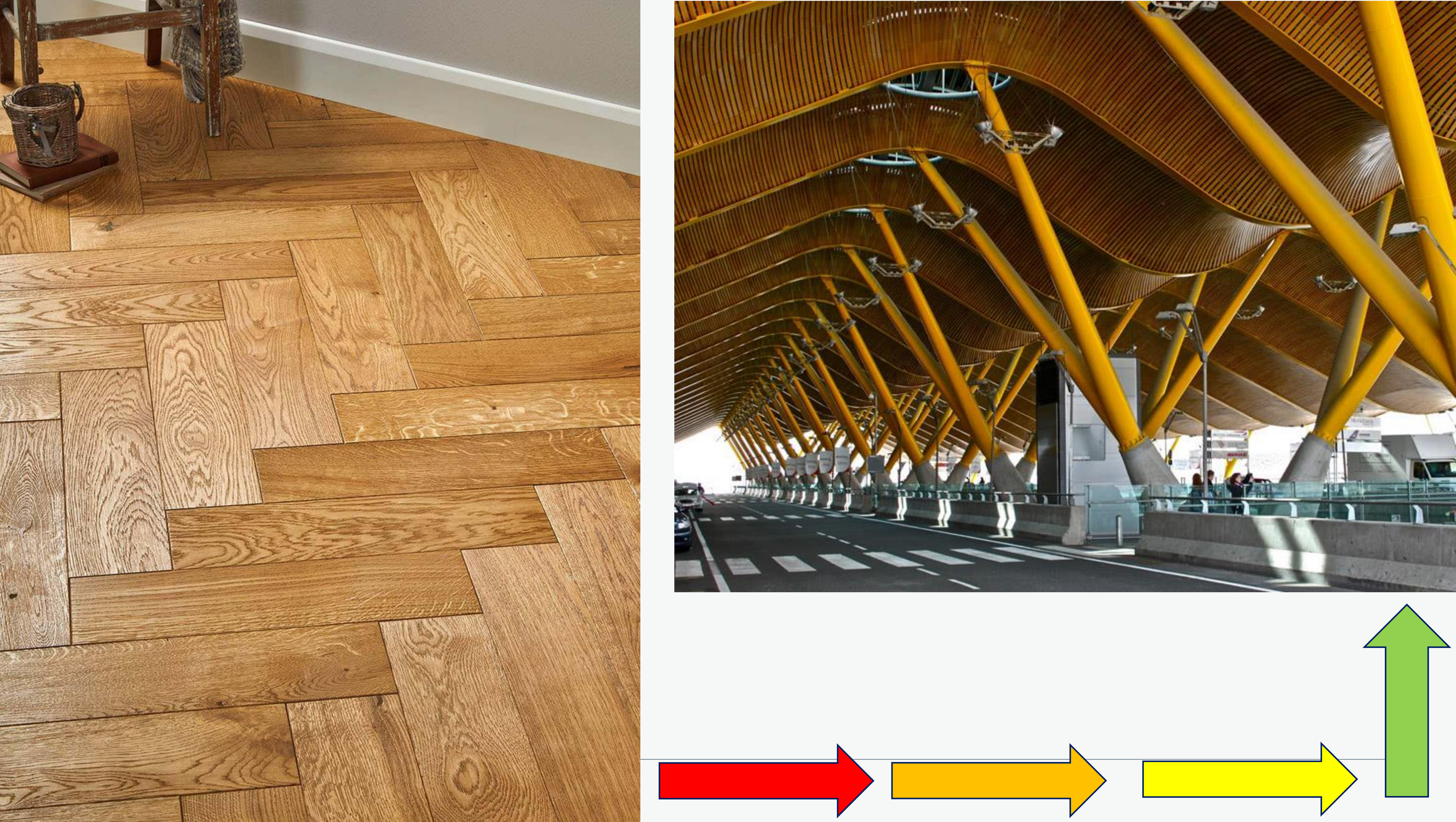
Dr Ed Beveridge

What are the ‘levers’?

- **Nation**: NHSE (and equivalent) policy, messaging
- **System**: ICS policy, strategy, leadership and performance management, LES/DES in primary care
- **Trust**: Policy, performance, leadership, health checks, data sharing, work within system
- **Team**: Commitment, foregrounding of PH care, “champions”, local QI, performance
- **Individual**: Discussing PH with my clients, reviewing results, communicating with other parts of the system

Some solutions

- **Build on current policy** - scope of checks and cohort
- Drive forward a **whole system** approach to this problem
- Focus on **addressing inequalities** at a national and system level (who aren’t we reaching?)
- Focus on **early intervention** – prevention of mental and physical ill health – look beyond health and at education and local government for example
- Focus on **R & D and innovation** – harness the power of industry and academia – drugs, pathways, technology



What value can secondary care add?

- We can undertake some complete checks (e.g. people in long term inpatient care) – especially if data flows more easily.
- We can support our patients in accessing checks and interventions from primary care.
- We have expertise in reaching people not usually reached by our standard offer.
- We can use our specialist knowledge to help systems to develop models that can reach people we are not currently reaching.

Whole system approach: 10 key actions

Key themes for optimal care

Co-production and lived experience	Provide care that advances equality	Tailored Outreach and Health Promotion	Provide a comprehensive health check for those severely affected by mental illness	Make Every Contact Count
Design services to address the physical health of people living with SMI in equal partnership with people with lived experience and those who support them.	Understand and address the needs of different groups and communities (link to Core20PLUS5) – new section provides guidance on tailoring services to improve access and outcomes for different groups and communities.	Address barriers faced by people living with SMI in accessing physical health checks, other physical health services and adopting positive health behaviours. It can be particularly effective to work with peer support workers and voluntary community and social enterprise (VCSE) organisations to do this. New section on reasonable adjustments and dedicated services and outreach programmes (includes remote delivery of checks).	Consider the need to provide an annual physical health check for everyone severely affected by mental illness (minimum bipolar, schizophrenia or other psychoses). Care should always be person-centred, tailoring discussion to the needs of the person to enable shared decision-making. Delivery of physical checks should be trauma-informed and reasonable adjustments provided. Information on core check and comprehensive check - have added blood-borne virus and liver function screening and open questions what is important to health and wellbeing. More information to clarify what qualifies someone as being in remission.	Reduce the need for patients to make repeat visits to a service by delivering all elements of an annual physical health check in one appointment (unless this is not the patient's preference). Use data to track progress and identify and address potential gaps.

Key themes for optimal care

Don't just screen, intervene	Carers and people's support networks	Deliver joined up care	Personalised care and support planning	Workforce and leadership
Ensure people are supported to access relevant follow-up interventions (see the Lester Tool). This should include: • Offering medical interventions (such as statins) • A discussion on possible side effects of medications, e.g. rapid weight gain following initiation of new antipsychotic treatment • Support and resources for adopting positive health behaviours (such as regular exercise, balanced nutrition, smoking cessation, moderation of alcohol consumption)	Provide a carer's assessment for people supporting a patient, with consideration of their physical, mental health and social needs. Offering for a carer, family member, friend or trusted professional (e.g. support worker) to attend appointments as a reasonable adjustment.	For best physical health care for people living with SMI, services need to work collaboratively, incl. MH, primary care, VCSE and LA providers. Encourage regular communication and information sharing (including data sharing) to ensure co-ordinated and holistic care. Information on medications, diagnoses and delivery of the SMI physical health check should be shared. ICSs should ensure a local comprehensive model of care and develop a protocol defining roles and responsibilities across primary care, secondary care, VCSE and local authority services (new section on roles and responsibilities in the guidance).	Develop personalised care and support plans that address the full needs of the individual, including mental, physical and social needs such as loneliness and isolation. These should involve shared decision-making between patients, family and friends, and the professionals supporting them. Access to personal health budgets should be supported where it is collectively agreed that this is the best way to meet needs.	Allocate resources to train staff in the importance of physical health of people living with SMI, how to manage their needs and how they can engage with services for support. Ensure improving the physical health of people living with SMI is embedded in the leadership of integrated care boards, to maintain focus on tackling this health inequality.

Q&A

Thank You

www.england.nhs.uk/rightcare

www.future.nhs.uk/NationalRightCare

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