Public Health England

NHS RightCare

NHS RightCare Toolkit:

Physical ill-health and CVD prevention in people with severe mental Illness (SMI)

This toolkit will provide you with expert practical advice and guidance to support system wide improvement to help improve physical health for people with severe mental illness (SMI) and reduce health inequalities.

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Informed by relevant NICE recommendations

NICE National Institute for Health and Care Excellence

NHS RightCare Toolkit: **Physical ill-health and CVD prevention in people with severe mental illness**

This Toolkit

This NHS RightCare system toolkit will support systems to understand the priorities in physical ill health and CVD prevention for people living with severe mental illness. It provides the opportunity to assess and benchmark current systems to find opportunities for improvement. **In this NHS RightCare toolkit each priority has supporting slides that contain 'key areas for focus' and 'actions to take'.** It has been produced by NHS RightCare and Public Health England (PHE) in collaboration with an expert group of stakeholders, including NHS England, health professionals and mental health partner organisations (see slide 35) and is supported by NICE.

The National Challenges:

- Shortened life expectancy of up to 20 years [NHS Long Term Plan 3.93, p69]
- Lack of early identification of CVD risk factors
- Inconsistent long term management of modifiable CVD risk factors
- Lack of regular education and training for all staff
- Sub-optimal personalised care planning
- High rates of unplanned and emergency care use
- Stigma and impact of diagnostic overshadowing

The National NHS RightCare Opportunity for Improvement

- By 2020/21, **280,000 more people living with SMI have their physical health needs met**
- By 2023/24 an **additional 110,000 people per year to have a physical health check** (bringing the total to 390,000 checks delivered each year) in line with the NHS Long Term Plan [see 2.30, p41]
- **10,000 more SMI patients on GP register to receive a blood pressure check** if CCGs achieved rate of 5 best peers
- **15,000 more SMI patients on GP register to receive an alcohol consumption check** if CCGs achieved rate of 5 best peers
- **60% of people on SMI register to receive physical health check** across primary and secondary care
- **Reduction in number of SMI patients attending secondary care** for CVD conditions

System Enablers required to implement the toolkit – *see slide 15 for actions to take*

- CCG commitment to delivering the MH FYFV goal to ensure 60% of people on GP SMI register receive a comprehensive physical health check and follow-up care.
- CCG commitment to the Mental Health Investment Standard.
- Improving Physical Health SMI CQUIN and Preventing ill health by risky behaviours CQUIN
- Joint working across a skilled primary and secondary care workforce competent and confident to deliver physical healthcare

Physical ill-health and CVD prevention in people with severe mental illness: **Key Messages for Commissioners**

- The life expectancy for people with SMI is up to **15–20 years shorter** than the general population, mainly due to preventable physical health conditions such as CVD, which are associated with modifiable risk factors.
- Excess premature mortality rates are **more than three times higher** amongst people with mental illness in England compared to the general population
- People with SMI show a **53% higher risk** of having CVD, **78% higher risk** for developing CVD, and an **85% higher risk** of death from CVD compared to the general population.
- CVD risk is present at an earlier age and so people with SMI should be systematically screened for risk factors with regular recording, monitoring and support provided to reduce risk where appropriate.
- People with mental ill health have **3.6 times** more potentially preventable emergency admissions than those without mental ill health in 2013/14 (Quality Watch, 2014)
- Ensure that people with SMI are consistently offered appropriate and timely physical health assessments, including follow up support, to improve their physical health.
- Action is needed to address these health inequalities. Every section in the following slides, provides an opportunity for health gain and to close inequalities for people with SMI.
- The reasons for the increased burden of physical ill-health and reduced life expectancy are complex, involving interrelated factors such as wider social factors, health risks, effects of medication and stigma and discrimination.

Definition of Severe Mental Illness (SMI):

The term SMI within this guidance refers to all individuals who have received a diagnosis of schizophrenia bipolar affective disorder or who have experienced an episode of non-organic psychosis

Risk Factors for CVD are:

• Smoking • Obesity • Increased alcohol consumption • High blood pressure • Raised cholesterol levels • Atrial fibrillation

Having more than one of these risk factors has a disproportionate multiplicative effect on your risk of developing cardiovascular disease

Physical ill-health and CVD prevention in people with severe mental Illness (SMI):

System Improvement Priorities

- Early identification of CVD risk factors
- Consistent long term management of modifiable CVD risk factors
- Regular education and training for staff to support people with SMI
- Effective personalised care planning
- Reduced rates of unplanned and emergency care use
- Reduced stigma and impact of diagnostic overshadowing

Self assessment checklist

System Improvement Priority: **Early identification of CVD risk factors**

Rationale: In England over 550,000 people with severe mental illness are registered with a GP. They are more likely to develop CVD than the general population and at an earlier age. CVD is the biggest cause of premature mortality in this group. The risk factors for CVD are: **Smoking - Obesity - High alcohol consumption - High blood pressure - Raised cholesterol - Atrial fibrillation.** Having more than one of these risk factors has a disproportionate multiplicative effect on one's risk of developing cardiovascular disease. The increased risk of CVD can also be related to effects of psychotropic medication. All adults on the severe mental illness register should receive the full list of recommended Annual Physical Health Assessments as part of a routine check at least annually. Assessments should be undertaken more frequently as required. The recommended physical health assessment for people with SMI aligns to the NHS Health Check but is more comprehensive. It is offered annually, to all ages and includes additional checks, personalised care planning and psychosocial support. Consider streamlining the delivery arrangements for the two processes where possible for those eligible. The responsibility for assessing and supporting physical health will transfer between primary and secondary care depending on where an individual is in their pathway of care (see pg7 of the NHSE guidance for details).

Key areas for focus:

Targeted case finding to identify patients requiring physical health review

There is no complete accurate baseline data for a comprehensive physical health check in primary care, including assessment of CVD risk factors for people with a severe mental illness. The national ambition is for 60% of people with severe mental illness to have recommended annual screening and access to physical care interventions.

Guidance & best practice

Data Indicators

Offer options to access health checks including community pharmacies

Some people may have difficulty accessing GP and other services or receive appointments at a convenient time. Consider offering services in different ways and in different settings for greater accessibility. Community pharmacy can play a role in facilitating behaviour change, health promotion, health monitoring and interventions to mitigate the physical health consequences of anti-psychotic and other medications.

Guidance & best practice

Data Indicators

Implement the NHS RightCare CVD Prevention Pathway

Systematic quality improvement across six high risk conditions is likely to have a cumulative impact in reducing incidence of stroke and heart attack.

Guidance & best practice

Actions to take

System Improvement Priority: **Early identification of CVD risk factors (continued)**

Key areas for focus:

Implement standard reporting templates to systematically record screening information
Standardised templates for the annual physical health checks can help ensure consistency of checks and support collection of monitoring data.

Guidance & best practice

Data Indicators

Embed Making Every Contact Count (MECC) in all settings
Training mental health staff in Making Every Contact Count will give them the confidence to have brief conversations with patients about how to improve their overall health and wellbeing.

Guidance & best practice

Ensure tailored communication for engagement
Improved access to physical health checks and interventions can be enabled through clear and effective communications (such as tailored texts and phone calls) with patients and carers about the required follow-up.

Guidance & best practice

Actions to take

System Improvement Priority: **Early identification of CVD risk factors**

Actions to take:	
Targeted case finding to identify patients requiring physical health review	▪ Embed a systematic approach to proactively identify, reach and support people with SMI with physical health assessments, particularly those most at risk of poor health, or who struggle to attend appointments. ▪ Have a system in place to regularly monitor the number of people on GP practice SMI registers who have and have not received an annual physical health review and where indicated follow-up care.
Offer options to access health checks including community pharmacies	▪ Ensure that there are a range of options offered/ commissioned for people with SMI to access physical health checks e.g. through community pharmacies, at medication clinics and other routine appointments. *Data Indicators*
Embed the NHS RightCare Prevention Pathway	▪ Implement the CVD prevention in primary care pathway with the SMI population *Data Indicators*
Implement standard reporting templates to systematically record screening information	▪ Have an electronic patient record template in place to systematically record the annual health check and follow-up information consistently.
Embed Making Every Contact Count (MECC) in all settings	▪ Embed the culture of Make Every Contact Count across the local system. *Data Indicators*
Ensure tailored communication for engagement	▪ Have a range of methods to effectively communicate and engage people with SMI about assessments and follow up e.g. peer support approaches, tailored invitation letters, tailored text messages and phone calls, opportunistic delivery of health checks during other contacts e.g. for repeat prescriptions, multiple contacts and communications between appointments, or home visits where indicated.

Guidance and best practice examples

System Improvement Priority: **Consistent long term management of modifiable CVD risk factors**

Rationale: Individuals with severe mental illness have 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) than the general population. Smoking in the general population is at an all-time low at 14.9%, however amongst people with SMI registered with a GP, it is more than double at 40.5%. Smoking contributes significantly to this difference in life expectancy and years living with ill health. It is the largest avoidable cause of premature mortality. There is a need for improved prescribing and monitoring of statins and anti-hypertensives (in line with general population guidelines and lifetime CVD risk calculation) and medicine optimisation is particularly key to older people who are more likely to be at risk from inappropriate polypharmacy.

Key areas for focus:

Proactive engagement and support to take up healthy behaviour interventions
Health care professionals should support access and referral of severe mental illness patients with identified risk factors to age-appropriate physical health and healthy behaviour interventions. To help ensure people are fully engaged in physical healthcare, services should provide proactive outreach, drawing on resources from peer support and voluntary sector organisations for those struggling to attend appointments or engage with activities to improve overall health and wellbeing.

Guidance & best practice

Smoking Cessation
There is strong evidence that expert support from a stop smoking advisor combined with one or more stop smoking aids is the most effective quitting method.

Guidance & best practice

Data Indicators

Alcohol Misuse
Alcohol misuse is a significant risk factor contributing to ill health. Alcohol may also exacerbate psychiatric symptoms and/or interact with medication. There is evidence that assessing alcohol use and offering brief advice can reduce consumption and reduce risk.

Guidance & best practice

Utilise community assets and third sector to support healthy behaviours
Voluntary and community sector organisations can also play a crucial role in effective care planning and providing follow up support. e.g. peer supporters can help to reduce barriers in engagement, address social isolation and support behaviour change. There are many examples of where community approaches have worked well to improve healthy behaviours and address inequalities. Examples of community centred approaches can be found in the PHE/NHSE guide.

Guidance & best practice

Actions to take

System Improvement Priority: **Consistent long term management of modifiable CVD risk factors**

Optimise use of medications to manage risk factors

Treatment with antipsychotic drugs can lead to weight gain which is an important risk factor for diabetes and CVD in people with schizophrenia particularly olanzapine and clozapine. They can also have a negative impact on blood lipids. Staff should have a good understanding of the issues surrounding weight gain, weight management and CVD risk and monitor an individual's physical health and the effects of antipsychotic medication. Involve individuals in decisions about their treatment and care. This includes offering accessible information about medication, its benefits and side-effects and discussing this with individuals so they can make an informed choice about their treatment.

Guidance & best practice

Actions to take:

Proactive engagement and support to take up healthy behaviour interventions	▪ Have public health or CCG commissioned community behaviour change services in the area that are in line with intervention thresholds as set out in the Lester tool (e.g. a BMI over 25 for weight management intervention) that people with SMI area able to access. ▪ Ensure that there is local support available for people with SMI to help them access and take up public health or CCG commissioned community behaviour change services e.g. via peer support workers, care navigators.
Smoking Cessation	▪ Screen and record smoking status of patients and know the proportion of people with SMI who smoke. ▪ Prescribe stop smoking medicines to support quitting or temporary abstinence. ▪ Provide or actively refer to behavioural support to smokers who want to quit. ▪ Have commissioned local stop smoking services available in your area to refer patients to, and ensure that patients with SMI have equitable access. ▪ Provide alternative methods stop smoking support where there are no local services available.

Data Indicators

Guidance and best practice examples

System Improvement Priority: **Consistent long term management of modifiable CVD risk factors**

Actions to take:	
Alcohol Misuse	▪ Work with local services to ensure that they use a validated screening tool to assess drug use where this might be a factor and/or contributor towards physical ill health. Ensure local services offer tailored harm reduction advice where appropriate. ▪ Have an agreed a joint working protocol and pathway between mental health and drug and alcohol services.to collaboratively support people with co-occurring mental ill health and substance misuse. ▪ Provide brief advice to people with SMI who consume alcohol above low risk (but who would not reach the threshold for specialist services) on how they can reduce their risk of alcohol related harm.
Utilise community assets and third sector to support healthy behaviours	▪ Involve individuals with SMI in the design and delivery of intervention services ▪ Make full use of community services and resources provided by the voluntary sector to support people with SMI with optimal physical health e.g. care navigators and social prescribing ▪ Have self-management education and services available within the local community to enhance patient activation/empowerment. ▪ Ensure that there is a process in place for statutory services to be able to easily make referrals and receive feedback on progress where these are led by third sector organisations
Optimise use of medications to manage risk factors	▪ Undertake regular reviews of patient's medication including any side effects. ▪ Involve individuals in decisions about their treatment and care, including for example offering accessible information about medication, its benefits and side-effects and discussing this with individuals so they can make an informed choice about their treatment.

Guidance and best practice examples

System Improvement Priority: **Regular education and training for all staff**

Rationale:
Training for staff to support of people with mental illness is not as widely embedded as training for staff in supporting physical health conditions. Annual training for staff to support those with mental heath conditions would also improve their physical healthcare. Mental health staff have variable knowledge and skills associated with physical health checks.

Key areas for focus:

Regular education and training for all staff that engage with, support and/ or provide services to, people with severe mental Illness which includes prevention knowledge and skills e.g. MECC

A comprehensive approach to workforce development is needed to ensure primary care staff feel knowledgeable and confident to work with people with severe mental illness and to avoid 'diagnostic overshadowing' (whereby staff overlook physical symptoms as a result of an individual's existing mental health diagnosis).

Guidance & best practice

Actions to take:

Regular education and training for all staff that engage with, support and/ or provide services to, people with severe mental Illness, which includes prevention knowledge and skills e.g. MECC

- Ensure that staff in primary and secondary care (physical and mental health settings) have a shared awareness and understanding of the key risk factors associated with physical ill-health and CVD for people with SMI.
- Have a comprehensive workforce development plan or work towards implementing one that will ensure staff feel confident and competent to work with people with SMI and provide optimal physical health care and avoid 'diagnostic overshadowing'.
- Provide training to staff on a regular basis to understand the physical health needs of people with SMI

System Improvement Priority: **Effective personalised care planning**

Rationale:
Personalised care planning is important to ensure people with SMI are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health.

Key areas for focus:

Ensure effective personalised care planning with patients and shared decision making

Personalised care planning should address the full needs of the individual, taking steps to address loneliness, isolation, healthy behaviours etc. The process should involve shared decision-making between the individual and the professionals supporting them, putting the patient at the centre of decisions about their own care. Voluntary sector organisations can also play an important role in effective care planning and providing follow up support.

Guidance & best practice

Actions to take:

Ensure effective personalised care planning with patients and shared decision making

- Use a systematic approach to promote awareness and understanding of physical ill health and CVD risk with individuals, carers, families, partners in health and social care, voluntary sector and the wider public services.
- Health and social care professionals should work with people with SMI to jointly develop a care plan, share a copy and agree a review date.
- Ensure that people with SMI are actively involved in shared decision-making and are supported to undertake self-management.
- Personalised care planning should address the full needs of the individual, including wider social issues such as housing problems that may impact on health.
- Ensure that staff are aware of local services that they can refer / signpost people with SMI on to, in order to help meet needs and support with wider social issues such as problem debt, housing.

Guidance and best practice examples

System Improvement Priority: **Reduced rates of unplanned and emergency care use**

Rationale:

The Quality Watch report, Mental ill health and hospital use, identified that people with mental ill health use more emergency care than people without mental ill health. They also use less planned inpatient care than people without. The majority of visits were for non-mental health needs.

Key areas for focus:

Optimise *planned* care for physical health conditions to reduce emergency admissions People with mental ill health and physical health needs are more likely to use emergency care than those without mental ill health.	**Guidance & best practice**
Commission fully integrated liaison mental health services Liaison services with pathways to further care can help improve the integrated care of physical and mental health problems, and improve the patient / carer experience.	**Guidance & best practice**
Co-produce whole system and integrated seamless pathways Drive integration between health and care services, with effective pathways in place from one service to another to improve physical health care for people with SMI. Ensure pathways are developed in collaboration with service users and carers.	**Guidance & best practice**

Actions to take:

Optimise *planned* care for physical health conditions to reduce emergency admissions	▪ Monitor the physical health outcomes of people with SMI within physical health condition pathways e.g. do individuals with SMI have the same diabetes admission rates and patient experience feedback?
Commission fully integrated liaison mental health services	▪ Commission liaison mental health services in your area so that they are available to people with SMI.
Coproduce whole system and integrated seamless pathways	▪ Commission services in collaboration with local authorities, primary, secondary and community care to ensure that the patient pathway is seamless so that patients don't "fall through the gaps".

Guidance and best practice examples

System Improvement Priority: **Reduced stigma and impact of diagnostic overshadowing**

Rationale:
Stigma, discrimination, isolation and exclusion are all factors that can prevent people with a mental health problem from seeking help and accessing timely and appropriate physical health care and treatment.

People with SMI can also experience diagnostic overshadowing. This is the misattribution of physical health symptoms to part of an existing mental health diagnosis, rather than a genuine physical health problem requiring treatment

Key areas for focus:

Reduction in staff misattributing a patient's physical symptoms to their mental illness A comprehensive approach to workforce development is needed to ensure primary care staff feel knowledgeable and confident to work with people with SMI and to avoid 'diagnostic overshadowing'.	**Guidance & best practice**	**Actions to take**

System Enablers

System enablers are what are required to be in place for a successful implementation of the system improvement priorities identified in this toolkit.

Actions to take:	
CCG commitment to delivering the MH FYFV goal to ensure 60% of people on GP SMI register receive a comprehensive physical health check and follow-up care.	▪ Have a clear shared care protocol in place outlining roles and responsibilities across primary and secondary care services for optimal physical health care of people with SMI, including information sharing requirements to enable alignment of the SMI register between primary and secondary care. ▪ Embed electronic patient record systems that are interoperable enabling clinicians to access information on individuals with SMI in primary and secondary care settings.
CCG commitment to the Mental Health Investment Standard.	▪ CCG to ensure that their requirement to increase investment in Mental Health services in line with their overall increase in allocation each year is included within annual plans.
Improving Physical Health SMI CQUIN and Preventing ill health by risky behaviours CQUIN	▪ Put in place robust data collection mechanisms for monitoring delivery of health checks and follow-up in different settings.
Joint working across a skilled primary and secondary care workforce competent and confident to deliver physical healthcare	▪ Jointly agree physical health SMI pathways for physical health conditions such as diabetes across primary and secondary care. ▪ Support local leaders (including clinicians and experts by experience) to promote improved working between primary and secondary care services.

Guidance and Best Practice

This section contains all the relevant guidance, evidence and case studies aligned to each of this toolkit's system improvement priorities and key areas for focus. It supports development of improvement actions when system priorities have been identified.

Key Guidance referenced throughout document

NICE

- **NICE Guidance**: CG43, CG120, CG127, CG136, CG138, CG178, CG181, CG185, CG189, NG7, NG17, NG27, NG44, NG53, NG92, NG108, PH15, PH42, PH44, PH48, PH53, PH46
- NICEimpact *cardiovascular disease prevention* – Spotlight on severe mental illness p17
- NICE Quality Standards
- Resources for STPs and ICSs on CVD Prevention and Mental Health

NHS England - Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. (2018)

Public Health England

- Better care for people with co-occurring mental health and alcohol/drug use conditions (2017)
- Health matters: reducing health inequalities in mental illness (2018)
- MHIN Severe mental illness and physical health inequalities (2018)
- Smoking cessation in secondary care: mental health settings (2018)

Guidance

Implementation & Practice Examples

System Improvement Priority: **Identification of CVD risk factors**

Targeted case finding to identify patients requiring physical health review

NHS England:

- Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. (2018)
- Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) CQUIN 2017-19
- Mental Health 5 year forward view dashboard

NHS Midlands and Lancashire: Making the Case for Integrating Mental and Physical Health Care (2017)

NICE guidelines:

- CG178 Psychosis and schizophrenia in adults: prevention and management (recommendation 1.5.3.1, 1.5.3.3)
- CG185 Bipolar disorder: assessment and management
- PH15 Cardiovascular disease: Identifying and supporting people most at risk of dying prematurely
- QS80 Psychosis and schizophrenia in adults, statement 6: Assessing physical health
- QS95 Bipolar in adults, statement 3 – involving carers in care planning

Bradford District Care Foundation Trust: physical health review template in EMIS and SystmOne– improves consistency in the delivery of physical health assessment.

Hardy S, Gray R. *Is the use of an invitation letter effective in prompting patients with severe mental illness to attend a primary care physical health check?* Prim Health Care Res Dev. 2012;13(4): 347-352. [27].

NHS Cambridgeshire and Peterborough: Primary Care Mental health Service (PRISM) (2018)

NICE Shared Learning Database:

- Bradford District Care NHS Foundation Trust & Yorkshire & Humber Academic Health Science Network: Improving Physical Health for People with Serious Mental Illness (SMI) (2018)
- Central and North West London NHS Foundation Trust: Improving the physical health of people with serious mental illness: A quality improvement approach
- Tees, Esk & Wear Valleys NHS Foundation Trust: Recognising and responding to physical deterioration of patients within a mental health and learning disability NHS Foundation Trust using a physiological track and trigger system.

Royal College of Psychiatrists: Lester UK Adaptation: Positive Cardiometabolic Health Resource (NICE endorsed resource)

Sheffield Primary Care Trust: QOF Mental Health and Depression Toolkit (2009) - Template letter for DNAs [15]

Guidance	Implementation & Practical Examples
Offer options to access health checks including community pharmacies	
NHS England: Personalised care and support planning handbook - the journey to person centred care (2016) NICE guideline: NG102 Community pharmacies: promoting health and wellbeing (2018) Mental Health Partnerships: • Physical health checks for people with severe mental illness: a primary care guide • Safe management of people with SMI by training practice nurses in primary care	Bradford District Care NHS Foundation Trust & Yorkshire & Humber Academic Health Science Network: Improving Physical Health for People with Serious Mental Illness (SMI) North East London Foundation Trust: Use of community pharmacy for Physical Health Care for Patients with psychosis.
Implement the NHS RightCare CVD Prevention Pathway	
NHS RightCare CVD Prevention Pathway (2016)	See the individual high intervention pages under the CVD prevention pathway for various casebooks on the six high risk conditions.
Implement standard reporting templates to systematically record screening information.	
NHS England: • Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. (2018) • Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) CQUIN 2017-19 NHS RightCare: Mental health conditions packs NHS Midlands and Lancashire: Making the Case for Integrating Mental and Physical Health Care (2017)	Bradford District Care Foundation Trust (BDCFT) electronic physical health template in EMIS and SystmOne

Guidance	Implementation & Practical Examples
Embed Making Every Contact Count (MECC) in all settings	
Health Education England: Making Every Contact Count NICE: STP Making Every Contact Count Resource	Public Health England: Making Every Contact Count (MECC): practical resources
See also resourced on shared decision making on slide 25.	
Ensure tailored communication for engagement	
NICE CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	Sheffield Primary Care Trust: QOF Mental Health and Depression Toolkit (2009), [10] Hardy S, Gray R. *Is the use of an invitation letter effective in prompting patients with severe mental illness to attend a primary care physical health check*? Prim Health Care Res Dev. 2012;13(4): 347-352. [27].
System Improvement Priority: **Consistent long term management of modifiable CVD risk factors**	
Proactive engagement and support to take up healthy behaviour interventions	
NHS England: • Preventing ill health by risky behaviours – alcohol and tobacco CQUIN • Improving physical healthcare to reduce premature mortality in people with SMI • Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. NICE Pathways: • Lifestyle changes for preventing cardiovascular disease • Behaviour change	ABL Health Ltd.: Choose to Change weight management intervention. Health Education England: Making Every Contact Count MIND: Get Set Go Moving Medicine - an initiative by the Faculty of Sport & Exercise Medicine UK in partnership with Public Health England and Sport England

Guidance

Implementation & Practical Examples

Proactive engagement and support to take up healthy behaviour interventions (Cont.)

NICE Guidelines:

- PH44 Physical activity: brief advice for adults in primary care
- NG102 Community pharmacies: promoting health and wellbeing
- Obesity prevention, assessment and management - CG43, CG189, PH53, NG7, PH46, PH42, QS111
- Type 2 diabetes prevention and treatment – PH38, NG28, PH35
- NG17 Type 1 diabetes diagnosis and management
- QS6 Diabetes in adults
- Cardiovascular risk assessment and lipid modification CG181, QS100
- CG185 Bipolar disorder: assessment and management (recommendations 1.8.4, 1.2.13, 1.2.14).
- CG178 Psychosis and schizophrenia in adults: prevention and management (recommendations 1.1.3.1, 1.1.3.2, 1.1.3.6, 1.1.3.7, 1.5.3.4)
- QS80 Psychosis and schizophrenia in adults, statement 7: promoting healthy eating, physical activity and smoking cessation
- CG127 Hypertension in adults
- Hypertension indicator pack

Public Health England: Better care for people with co-occurring mental health and alcohol/drug use conditions

NHS England, NHS Improving Quality, PHE, National Audit of Schizophrenia Team: Positive Cardiometabolic Health Resource (2014)

NHS Midlands and Lancashire: Making the Case for Integrating Mental and Physical Health Care (2017)

NICE Shared Learning:

- Dudley CCG: Optimising Hypertension management in Dudley
- NHS North: Making Every Contact Count - implementing NICE behaviour change guidance

NICE: Return on investment tool for physical activity programme planning

PHE and NICE resource - Weight management: guidance for commissioners and providers

Royal College of General Practitioners: RCGP Introductory certificate in obesity, malnutrition and health for health professionals (endorsed by NICE).

Worcestershire Health and Care NHS Trust: SHAPE – Supporting Health and Promoting Exercise (for people with SMI)

Guidance

Implementation & Practical Examples

Smoking Cessation

Care Quality Commission: Brief guide: Smokefree policies in mental health inpatient services

Mental Health and Smoking Partnership resources

National Centre for Smoking Cessation and Training:
- Very Brief Advice training module
- Smoking cessation and smokefree policies: Good practice for mental health services

NICE pathways
- Stop smoking intervention and services

Other NICE guidelines:
- NG92: Smoking cessation interventions and services
- PH48 Smoking: acute, maternity and mental health services
- PH45 Smoking: Harm reduction
- QS92 smoking: harm reduction
- CG178 Psychosis and schizophrenia in adults: prevention and management (recommendations 1.1.3.3, 1.1.3.4, 1.1.3.5)
- QS80 Psychosis and schizophrenia in adults statement 7: promoting healthy eating, physical activity and smoking cessation
- QS82 – smoking: reducing and preventing tobacco use
- QS43 smoking: supporting people to stop

Public Health England: Smoking cessation in secondary care: mental health settings

Royal College of psychiatrists and partners: Improving the physical health of adults with severe mental illness: essential actions

Leicestershire Partnership NHS Trust: using e-cigarettes as a tool to go smokefree. See also NICE website for more details.

NICE: return on investment tool for tobacco

South London and Maudsley NHS Foundation Trust: Journey to become Tobacco-free (2017)

Tees Esk and Wear Valley NHS Foundation Trust: Innovative ways to support smokers requiring nicotine management in a mental health organisation (2017)

Guidance	Implementation & Practical Examples
Alcohol Misuse	
NHS England: Preventing ill health by risky behaviours – alcohol and tobacco CQUIN NICE Guidelines relating to alcohol use: • PH24 Alcohol-use disorders: prevention • CG100 Alcohol-use disorders: diagnosis and management of physical complications, • CG120 Coexisting severe mental illness (psychosis) and substance misuse • CG115 Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence • NG50 Cirrhosis in over 16s: assessment and management Public Health England: Better care for people with co-occurring mental health and alcohol/drug use conditions	Health Education England: • New E-Learning programme (to support CQUIN) • Video clips from E-Learning • Existing E-learning programmes NHS England: • CQUIN Guidance • CQUIN Indicator Specification • CQUIN Supplementary Guidance • Health Matters (to support CQUIN) Public Health England: • Knowledge Hub (forum and resource library) • Referral Pathway Guidance
Utilise community assets and third sector to support healthy behaviours	
NHS England: Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. PHE, NHSE: Guide to evidence-based community-centred approaches NICE: NG44 Community engagement: improving health and wellbeing and reducing health inequalities, QS148, statements 3 and 4	Leeds Beckett University review of Bradford District Care Foundation Trust's PPI: From Innovation to Mainstream – taking forward Patient and Public Involvement in Bradford District Care Trust Tower Hamlets partnership: Tower Hamlets Together Patient resources: • Essex Partnership University NHS Foundation Trust: Your Life, Your Health - Health and Wellbeing Booklet (2017) • Rethink Mental Illness: My physical health - Physical Health Check Tool (2014)

Guidance

Implementation & Practical Examples

Optimise use of medications to manage modifiable CVD risk factors

British Association for Psychopharmacology (BAP): guidelines for on the management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment (2016)

The King's Fund: Polypharmacy and medicines optimisation (2013)

NHS England: Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. (2018)

NICE guidance

- CG178 – Psychosis and schizophrenia in adults: prevention and management Recommendations 1.3.5, 1.3.6
- CG185 – Bipolar disorder: assessment and management Recommendations 1.10.5 – 1.10.13
- PH15 - Cardiovascular disease: identifying and supporting people most at risk of dying early
- Medicines optimisation and adherence, CG76, NG5, QS120

Royal Pharmaceutical Society: Medicines Optimisation Hub

Leeds Teaching Hospitals NHS Trust and University of Leeds: Re-engineering the Post-Myocardial Infarction Medicines Optimisation Pathway (2018)

North East London Foundation Trust: Use of community pharmacy for Physical Health Care for Patients with psychosis. (2017)

Oxford Academic Science Network: Targeted medicines support reduces readmissions (2016)

Guidance

Implementation & Practical Examples

System Improvement Priority: **Education and training for staff**

Regular education and training for all staff that engage with, support and/or provide services to, people with severe mental illness

DH, PHE, NHSE Improving the physical health of people with mental health problems: Actions for mental health nurses (2016)

E-learning for healthcare: Alcohol and Tobacco Brief Interventions - e-Learning for Healthcare

Health Education England: Mental Health Core Skills Training framework

Mental health partnerships: Physical health checks for people with Severe Mental Illness: a primary care guide

NHS England: Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs.

NHS Health Education England/ UCLPartners: Breaking Down the Barriers

NHS Health Education England/ PHE: e-learning on Community-centred approached to health improvement

NHS Improvement and Care Quality Commission: Quality Improvement Collaborative

NICE:

- PH15 Cardiovascular disease: Identifying and supporting people most at risk of dying prematurely (recommendation 5)
- CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
- NG108 Decision-making and mental capacity

Royal College of psychiatrists and partners: Improving the physical health of adults with severe mental illness: essential actions (2016)

NHS Cambridgeshire and Peterborough Primary Care Mental health Service (PRISM) (2018)

NHS England: Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. – see examples in Annex

- City and Hackney CCG: Mental Health Primary Care service - Improving physical health care for SMI in primary care [6]

NICE Shared Learning:

- South London and Maudsley NHS Foundation Trust: The Changing Minds Training as Trainers Programme
- Together for mental wellbeing: Good Practice in Service User Involvement Training
- Bradford District Care NHS Foundation Trust & Yorkshire & Humber Academic Health Science Network: Improving Physical Health for People with SMI

Guidance	Implementation & Practical Examples

System Improvement Priority: **Effective personalised care planning**

Ensure effective personalised care planning with patients and shared decision making

NHS England: Shared decision making

NICE guidance:

- NG108: Decision-making and mental capacity
- Service user experience in adult mental health CG136, QS14
- Patient experience in adult NHS services: improving the experience of care for people using adult NHS services, CG138, QS15

NICE evidence services: What is shared decision making?

Mental health partnerships - Physical health checks for people with Severe Mental Illness: a primary care guide

Advancing Quality Alliance (AQuA): Embedding Shared Decision Making (SDM) in 32 national clinical teams

The Health Foundation shared decision making programme: MAGIC: shared decision making

NHS England: Guidance on delivering personalised care and support – contains a number of personalised care case studies

Sheffield Primary Care Trust: QOF Mental Health and Depression Toolkit (2009)- Care plan template [10]

Worcestershire Health and Care NHS Trust: SHAPE, Supporting Health and Promoting Exercise - shared care protocol example

The University of Manchester: Enhancing the quality of service user involved care planning in Mental Health Services (EQUIP)

System Improvement Priority: **Reduced rates of unplanned and emergency care use**

Effective *planned* care for physical health conditions to reduce emergency admissions

QualityWatch: People with mental ill health and hospital use (2015)

NICE guidance:

- NG53 (crisis plans rec 1.2.9 and 1.3.1) and QS159 Transition between inpatient mental health settings and community or care home settings
- NG27 and QS136 Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Health Watch Birmingham: Improvement in Care Plans for People with SMI in Birmingham

The King's Fund: Delivering better services for people with long term conditions

Mental Health Wales: Care and Treatment Planning

Guidance	Implementation & Practical Examples
Commission fully integrated liaison mental health services	
NHS England: Improving services for people with mental health needs who present to A&E CQUIN NHS Midlands and Lancashire: Making the Case for Integrating Mental and Physical Health Care (2017) NICE guidance: NG94 Emergency and acute medical care in over 16s: service delivery and organisation Joint Commissioning Panel for Mental Health: Guidance for Commissioners of liaison mental health services to acute hospitals	The King's Fund: Bringing together physical and mental health (2016) - see Appendix UCL: PRIMROSE trial
Coproduce whole system and integrated seamless pathways	
NHS England: Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Implementation guidance for CCGs. NICE: CG136 Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Royal College of psychiatrists and partners: Improving the physical health of adults with severe mental illness: essential actions	Central and North West London NHS Foundation Trust: Improving the physical health of people with serious mental illness: A quality improvement approach

Guidance	Implementation & Practical Examples
System Improvement Priority: **Reduced stigma and impact of diagnostic overshadowing**	
Reduction in staff misattributing a patient's physical symptoms to their mental illness	
DH, PHE, NHSE: Improving the physical health of people with mental health problems The King's Fund: Bringing together physical and mental health (2016) NHS Health Education England and UCLPartners: Breaking Down the Barriers NICE CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services	See also slide on 'regular education and training of all staff'.

Data Indicators

This section contains all the national data indicators relevant to this NHS RightCare toolkit. They can be used to support understanding of improvement priorities instigated from using this toolkit.

Key Areas for Focus	Indicators
System Improvement Priority: **Early identification of CVD risk factors**	
Targeted case finding to identify patients requiring physical health review	There is a QOF mental health register for people with SMI **2019/20 NICE Menu Indicators:** NM15 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 15 months. Removed from QOF and added to INLIQ for 2019/20 (MH007 data) NM16 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 15 months. In 2019/20 QOF (MH006 data) NM17 The % of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 15 months. In 2019/20 QOF (MH003 data) NM108 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. In 2019/20 QOF (MH002 data) NM129 – The percentage of patients aged 18 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of total cholesterol: HDL ratio in the preceding 12 months. Indicator no longer in QOF (INLIQ - MH004 data) NM130 The percentage of patients aged 18 years and over with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose or HbA1c in the preceding 12 months. Indicator no longer in QOF (INLIQ - MH005 data)
Offer options to access health checks including community pharmacies	NM120 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged 25-84 (excluding those with pre-existing CHD, diabetes, stroke and/or TIA) who have had a CVD risk assessment performed in the preceding 12 months (using an assessment tool agreed with NHS England). NICE menu indicator.

Data Indicators

Key Areas for Focus	Indicators
Implement standard reporting templates to systematically record screening information	NM108 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. In 2019/20 QOF (MH002 data)
System Improvement Priority: **Consistent long term management of modifiable CVD risk factors**	
Smoking Cessation	NM38 - The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months. In 2019/20 QOF (SMOK002 data) NM39 The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record of an offer of support and treatment within the preceding 15 months. In 2019/20 QOF (SMOK005 data) NM124 - The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months. NICE menu indicator. NM125 - The percentage of patients with schizophrenia, bipolar affective disorder or other psychoses who are recorded as current smokers who have a record of an offer of support and treatment within the preceding 12 months. NICE menu indicator.
System Improvement Priority: **Optimised personalised care planning**	
Ensure personalised care planning with patients and shared decision making	NM108 - The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive care plan documented in the record, in the preceding 12 months, agreed between individuals, their family and/or carers as appropriate. In 2019/20 QOF (MH002 data)

Physical ill-health and CVD prevention in people with severe mental illness – Self Assessment Questionnaire

This self assessment checklist is intended to support local areas to understand areas of strength and challenge in their system in providing optimal physical health care for people with severe mental illness (SMI) so that they can live long and healthy lives.

The tool can be used to support improvements in planning and delivery in various ways: as a 'light-touch' review, as the basis for more in-depth analysis, by individual organisations or as a method to engage a wider group of stakeholders and system partners, including NHS and local authority commissioners, front line staff, housing, voluntary and community sector and people living with SMI and their carers. The aim of the tool is to help local areas (including STPs, ICSs and PCNs) to:

- Identify and assess existing systems and services to support optimal physical health care for people with SMI.
- Identify any current gaps in provision and/or current opportunities to enhance or develop services to support optimal physical health care
- Consider future demand, using local intelligence alongside projected data
- Support prioritisation and facilitate resource allocation
- Assess progress over time

Rating Key: 1 = Fully met, 2 = Partially met, 3, Not met, 4 = Not applicable

Section	Self-assessment questions	Rating (1, 2, 3, 4)
System enablers *See Slide 14 and NHSE guidance*	1. Is there a clear shared care protocol in place outlining roles and responsibilities across primary and secondary care services for optimal physical health care of people with SMI, including information sharing requirements to enable alignment of the SMI register between primary and secondary care? 2. Are electronic patient record systems interoperable enabling clinicians to access information on individuals with SMI in primary and secondary care settings? 3. Do you have robust data collection mechanisms in place for monitoring delivery of health checks and follow-up in different settings? 4. Do you have jointly agreed physical health SMI pathways for physical health conditions such as diabetes? 5. Are local leaders developed and supported (including clinicians and experts by experience) to promote improved working between primary and secondary care services?	

Physical ill-health and CVD prevention in people with severe mental illness – Self Assessment Questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Early identification of CVD risk factors *See slides 5 & 6*	6. Is a systematic approach taken to proactively identify, reach and support people with SMI with physical health assessments, particularly those most at risk of poor health, or who struggle to attend appointments? 7. Are a range of methods used to effectively communicate and engage people with SMI about assessments and follow up e.g. peer support approaches, tailored invitation letters, tailored text messages and phone calls, opportunistic delivery of health checks during other contacts e.g. for repeat prescriptions, multiple contacts and communications between appointments, or home visits where indicated? 8. Is there a system in place to regularly monitor the number of people on GP practice SMI registers who have and have not received an annual physical health review and where indicated follow-up care? 9. Are there a range of options offered/ commissioned for people with SMI to access physical health checks e.g. through community pharmacies, at medication clinics and other routine appointments? 10. Is the CVD prevention in primary care pathway being implemented with the SMI population? 11. Are there electronic patient record templates in place to systematically record the annual health check and follow-up information consistently?	
Consistent long term management of modifiable risk factors *See slides 7- 9*	12. Are people with SMI able to access public health or CCG commissioned community behaviour change services in the area in line with intervention thresholds as set out in the Lester tool (e.g. a BMI over 25 for weight management intervention)? 13. Is support available for people with SMI to help them access and take up public health or CCG commissioned community behaviour change services e.g. via peer support workers, care navigators?	

Physical ill-health and CVD prevention in people with severe mental illness – Self Assessment Questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Consistent long term management of modifiable risk factors (continued) *See slides 7- 9*	14. Do you screen and record smoking status of patients and know the proportion of people with SMI who smoke? 15. Do you prescribe stop smoking medicines to support quitting or temporary abstinence? 16. Do you provide or actively refer to behavioural support for smokers who want to quit? 17. Are local stop smoking services available in your area to refer patients to, and do patients with SMI have equitable access? 18. Do you have alternative methods of providing stop smoking support where there are no local services available? 19. Is Make Every Contact Count embedded across the local system? 20. Do local services use a validated screening tool to assess drug use where this might be a factor and/or contributor towards physical ill health, and offer tailored harm reduction advice where appropriate? 21. Do local services use a validated screening tool to assess drug use where this might be a factor and/or contributor towards physical ill health, and offer tailored harm reduction advice where appropriate? 22. Have mental health and drug and alcohol services agreed a joint working protocol and pathway to collaboratively support people with co-occurring mental ill health and substance misuse? 23. Do people with SMI who consume alcohol above low risk (but who would not reach the threshold for specialist services) receive brief advice on how they can reduce their risk of alcohol related harm?	

Physical ill-health and CVD prevention in people with severe mental illness – Self Assessment Questionnaire

Section	Self-assessment questions	Rating (1,2,3,4)
Consistent long term management of modifiable risk factors (continued) *See slides 7- 9*	24. Are individuals with SMI involved in the design and delivery of intervention services? 25. Is full use made of community services and resources provided by the voluntary sector to support people with SMI with optimal physical health e.g. care navigators and social prescribing? 26. What self-management education and services are available within the local community to enhance patient activation/empowerment? Can statutory services easily make referrals and receive feedback on progress where these are led by third sector organisations? 27. Are there regular reviews undertaken of patients' medication and any side effects? 28. Are individuals involved in decisions about their treatment and care, including for example: offering accessible information about medication, its benefits and side-effects and discussing this with individuals so they can make an informed choice about their treatment?	
Regular training and education for all staff *See Slide 10*	29. Do staff in primary and secondary care (physical and mental health settings) have a shared awareness and understanding of the key risk factors associated with physical ill-health and CVD for people with SMI? 30. Is there a comprehensive workforce development plan being implemented that will ensure staff feel confident and competent to work with people with SMI and provide optimal physical health care and avoid 'diagnostic overshadowing'? 31. Do staff in primary and secondary care (physical and mental health settings) have a shared awareness and understanding of the key risk factors associated with physical ill-health and CVD for people with SMI? 32. Is there a comprehensive workforce development plan being implemented that will ensure staff feel confident and competent to work with people with SMI and provide optimal physical health care and avoid 'diagnostic overshadowing'? 33. Is training provided to staff on a regular basis to understand the physical health needs of people with SMI?	

Physical ill-health and CVD prevention in people with severe mental illness – Self Assessment Questionnaire

Section	Self-assessment questions	Rating (1, 2, 3, 4)
Effective personalised care planning *See slide 11*	34. Has there been a systematic approach to promote awareness and understanding of physical ill health and CVD risk with individuals, carers, families, partners in health and social care, voluntary sector and the wider public services? 35. Are people with SMI working with health and social care professionals to: jointly develop a care plan, receive a copy and agree a review date? 36. Are people with SMI actively involved in shared decision−making and supported in self−management? 37. Does personalised care planning address the full needs of the individual, including wider social issues such as housing problems that may impact on health? 38. Are staff aware of local services that they can refer / signpost people with SMI on to, in order to help meet needs and support with wider social issues such as problem debt, housing?	
Reduce rates of unplanned and emergency care use *See slide 12*	39. Are liaison mental health services available in your area? 40. Are services commissioned in collaboration with local authorities, primary, secondary and community care to ensure that the patient pathway is seamless so that patients don't "fall through the gaps? 41. Do you monitor the physical health outcomes of people with SMI within physical health condition pathways e.g. do individuals with SMI have the same diabetes admission rates and patient experience feedback?	

Public Health England

NHS RightCare

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- Public Health England Centres
- Rethink Mental Illness
- The National Institute for Health and Care Excellence (NICE)
- University College London

Informed by relevant NICE recommendations

NICE National Institute for Health and Care Excellence

Public Health England

NHS RightCare

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Or visit the NHS RightCare website:
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NICE National Institute for Health and Care Excellence