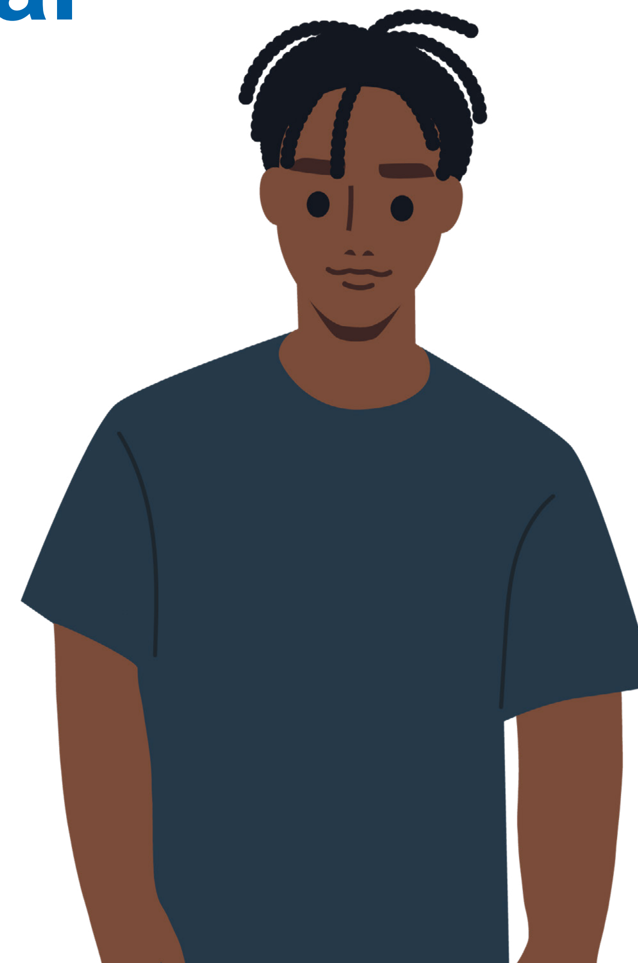
NHS RightCare

# Physical health and severe mental illness scenario

## Tom's journey: An implementation support resource that highlights the variation between optimal and suboptimal pathways

In partnership with

CORE20 PLUS 5



# Foreword

People with severe mental illness are at a much greater risk of poor physical health and die on average 15 to 20 years younger than the general population. The COVID-19 pandemic has further exacerbated this health inequality, resulting in an even wider gap.

Our challenge is to protect the physical health of patients experiencing a severe mental illness (SMI).

For people with SMI, 2 in 3 deaths are from physical illnesses that are preventable. This highlights the urgency of early intervention and supporting people to engage with regular physical health checks in order to identify and treat risk factors, and prevent longer term complications.

Cancer, cardiovascular disease, liver disease and respiratory disease accounted for around 60% of all deaths of adults with SMI before the COVID-19 pandemic (Office for Health Improvement and Disparities).

Cardiovascular disease (CVD) is the single largest cause of a widening mortality gap, and far more common than suicide, yet disorders like CVD and diabetes are predictable and potentially preventable (World Psychiatry).

There are more than 500,000 people in England living with an SMI but at local level numbers are small – a typical practice will have 60-100 patients with SMI on their register (NHS England).

Primary care can improve the physical health of those with SMI by:

- supporting a proactive engagement process for physical health checks including those patients that are hard to reach;
- supporting access to physical health interventions such as smoking cessation; and
- supporting the prevention agenda, for example immunisations and cancer screening.

I would urge everyone to protect some time to focus on improving the physical health of your local population that have severe mental illness, in order that together we can challenge the status quo and reverse the current trajectory of escalating morbidity and mortality rates in these vulnerable patients.

With the implementation of Integrated Care Systems and the focus of the Long Term Plan on integrated working between community and primary care, and specialist mental health teams, the time to seize this challenge is now.

**Dr Emma Tiffin**

National GP Advisor
Community and
Primary Care
Adult Mental Health
NHS England

> Cardiovascular disease is the single largest cause of a widening mortality gap, and far more common than suicide

# RightCare scenarios

RightCare scenarios put the person at the centre of the story. They use fictional patients to show the difference between a suboptimal, but realistic, pathway of care compared to an optimal one.

This Physical Health and Severe Mental Illness scenario is part of a series of RightCare scenarios that support local health systems to think strategically about designing optimal care for people (and their carers) with high impact conditions.

They help local systems understand how patient outcomes and quality of life can be improved as a result of shifting the care pathway from a suboptimal journey to one that consistently delivers timely, evidence-based excellence.

The suboptimal story in this scenario deliberately highlights where along the care pathway we know often requires improvement. We invite systems to consider the following questions when using this scenario:

- Do you recognise any elements of the patient journey highlighted in this scenario?
- Which journey best reflects the service within your area?
- What parts of the patient journey and experience can you improve?

This scenario has been developed with clinical, patient, carer, voluntary and community sector stakeholders using RightCare methodology.

The aim is to help clinicians and commissioners improve value and outcomes for this patient group. To see the full suite of RightCare products please visit the NHS England website.

## What is a RightCare scenario?

**Use fictional patients to show the difference between optimal and suboptimal pathways of care**

**Put the person at the centre of the story**

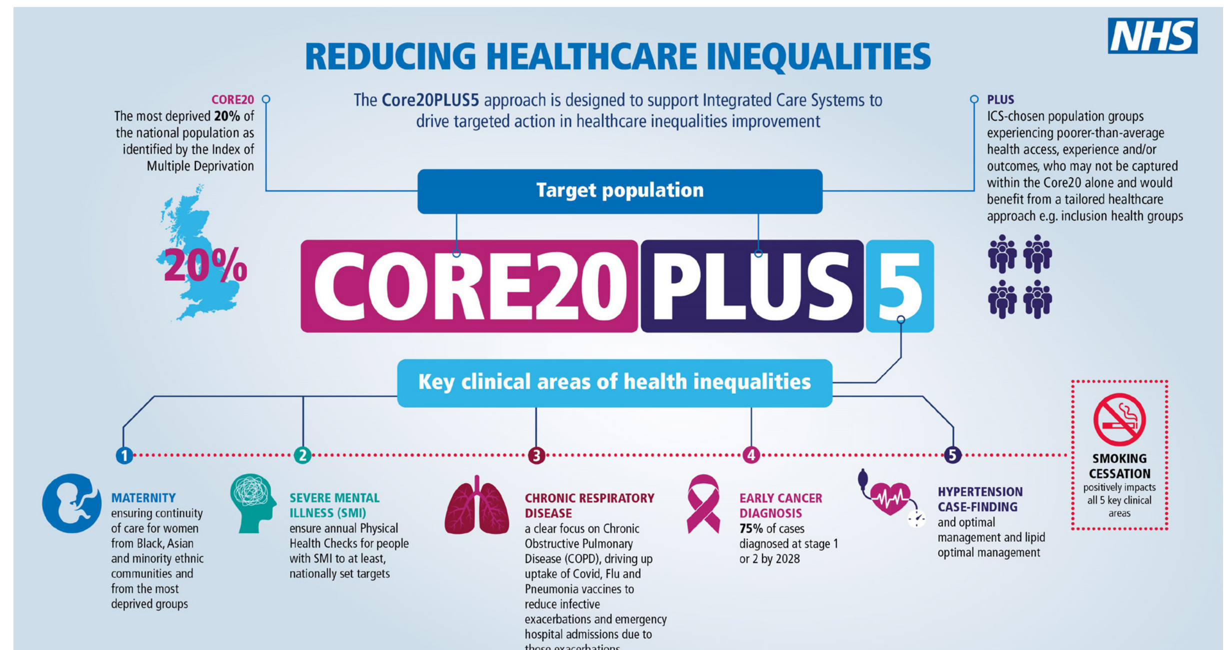
**Spark strategic questions**

- Do you recognise any elements of the patient journey?
- Which journey best reflects the service within your area?
- What parts of the patient experience can you improve?

rightcare@nhs.net

# Core20PLUS5, mental health and race

Core20PLUS5 is an NHS England approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement. One of these is severe mental illness.




**Core20:** The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

**PLUS:** PLUS population groups we would expect to see identified are ethnic minority communities; inclusion health groups; people with a learning disability and autistic people; coastal communities with pockets of deprivation; people with multi-morbidities; and protected characteristic groups; among others.

**5:** The final part sets out five clinical areas of focus: They are maternity, severe mental illness, COPD, early cancer diagnosis and hypertension case-finding.

## Mental health and race

While this scenario can be applied to a wide range of people with severe mental illness, we felt it was important to ensure Tom was representative of the Core20Plus5 populations.

The Mental Health Foundation has suggested that black men are more likely than white men to experience psychosis, and black people are four times more likely to be detained under the Mental Health Act than white people. Contributing factors could include racism (from micro-agression to offensive comments and physical violence), social and economic inequalities, and mental health stigma.

With Tom, what happens isn't due specifically to race but it may well be a contributing factor. And data shows that the outcomes for a young black man are worse than for a young white man.

# Clinical introduction

People with severe mental illness are at a greater risk of poor physical health and have a higher premature mortality than the general population. In England, they are almost 5 times as likely to die prematurely than those who do not have severe mental illness[1].

Severe mental illness frequently emerges in late adolescence to early twenties, exposing a young and vulnerable population to a toxic interaction between poor mental health, consequential unhealthy lifestyles, obesogenic and diabetogenic antipsychotic treatments, and social disadvantage (Shiers et al, 2015). This can result in an early and rapid escalation in cardiometabolic risk, putting people with severe mental illness on a path towards poor future health at a much earlier age than the general population.

Key factors contributing to worse health outcomes include:

- High rates of smoking, poor nutrition and limited physical exercise, that contribute to cardiometabolic risks from a younger age;
- Lack of support to use available health information and advice or to take up tests and interventions that reduce the risk of preventable health conditions;
- Negative effect on physical health of medication such as antipsychotics;
- Lack of robust commissioned pathways across primary and secondary care;
- Gaps in training among primary care clinicians;
- Lack of confidence across the workforce to deliver physical health checks to people with severe mental illness;
- Lack of integration between primary care, specialist physical health and community mental health services.

[1] Premature mortality in adults with SMI (OHID)

NHS

## Death rates by condition for people with severe mental illness

Compared to the general population, people aged under-75 in contact with mental health services in England have death rates that are:

6.5x higher for LIVER DISEASE

6.6x higher for RESPIRATORY DISEASE

4.1x higher for CARDIOVASCULAR DISEASE

2.3x higher for CANCER

Excess under 75 mortality rates in adults with serious mental illness - 2018-2020

# » Introducing Tom

Tom is 22 and lives on his own in a student flat in a small city. He is black and grew up in a small town, with a supportive family, a good circle of friends and played football for a local club three times a week.

He was described by his teachers as a bright and capable young man. He achieved good grades in his GCSEs and A levels and got a place at university to study mathematics before pursuing his ambition of becoming a teacher.

At university he was a regular student. He enjoyed socialising with friends and had a particular love of music gigs and festivals. He met his girlfriend Joanna in his first year who shared his love of live music. Tom smoked cigarettes and regularly drank alcohol socially with friends.

Towards the end of his first year at university he experimented with recreational drugs and began to smoke cannabis on a regular basis.

## The start of Tom's journey: first symptoms and GP appointment

When Tom was 20 he began to experience feelings of being 'on edge' and started experiencing intrusive and unwanted thoughts.

The thoughts he experienced were negative and self-critical in nature. Initially these thoughts were of being no good at anything, but gradually became more critical and intense. He started to believe he had done something very bad and worried about what this might have been. He also believed that others around him knew this too and were watching his movements and had even started following him.

Over 18 months Tom withdrew from his sporting and social activities. His attendance at university became gradually worse. His parents and girlfriend had noticed he wasn't quite right and were becoming increasingly worried about his mental health.

By the time he was 22 Tom felt so frightened he wouldn't go out for food and even stopped answering his phone. His mum became increasingly concerned, and helped Tom to contact his GP.

Read on to see how Tom experiences two very different journeys and outcomes. Look out for 'Information points' throughout the suboptimal and optimal journeys; these highlight the key themes of optimal care. More information about these can be found on pages 14 to 16.

Suboptimal

## January Year 1: GP refers Tom to mental health outpatients

Tom's GP referred him for a routine mental health outpatient appointment. The appointment was ineffective as there was no detailed discussion about Tom's actual diagnosis.

He was prescribed an atypical antipsychotic but was not given any information about the medication in terms of benefits or side effects.

A letter was sent to Tom's GP advising of the appointment but was not recorded on his primary care record.

Tom did not receive a baseline assessment of his physical health at this point. He did initially take the medication but struggled to cope with the side effects – feeling sedated, lethargy and weight gain – and stopped taking his medication.

Tom's mental health deteriorated and he was referred to the crisis team by his GP. He continued to drink heavily and smoke cannabis to cope with his symptoms. He wasn't asked at any point if he wanted to reduce his alcohol, smoking or cannabis use.

Optimal

## January Year 1: GP refers Tom to EIP service

Tom's GP got an urgent referral for him to a community-based early intervention in psychosis (EIP) service, where he received crisis and EIP support.

Following assessment by the EIP service, Tom was diagnosed as having a First Episode Psychosis. He was given the opportunity to discuss types of medications and their individual side effect profiles - such as weight gain - with the specialist mental health pharmacist, who was part of his multidisciplinary team. This shared decision-making ensured that both the clinician's expertise and Tom's preferences, personal circumstances, goals, values and beliefs, were taken into consideration. Tom was then prescribed an antipsychotic in line with NICE guidance.

His care coordinator discussed the support that was available with Tom (for example healthy eating, peer support and activity groups) and told him about Personal Health Budgets.

The lead clinician used the Lester Tool (2023) as a framework for an assessment of Tom's physical health, this included baseline measurements of his weight (BMI), blood pressure, blood lipids and cholesterol. These were all 'normal'.

1 **Information point:**
Don't just screen, intervene - The Lester Tool

As Tom said that drinking heavily helped him cope with his intrusive thoughts and anxiety he was referred to an alcohol nurse specialist. He didn't feel able to stop smoking at this point but was given information on a stop smoking support service specialising in people with severe mental illness.

He was referred to his university's Disability Advisory and Support Service for advice and support.

Suboptimal

## March Year 1: Tom struggles to attend appointments and his physical health deteriorates

Tom returned to live with his parents. They were not offered any information about carers' support or provided with any information about his illness.

He had been under the care of the crisis team and then had monthly appointments with a psychiatrist in the outpatient's clinic.

After a year Tom was discharged back to the care of his GP. A discharge letter was sent asking the GP to monitor his medication, side effects and physical health at least annually, but it did not include any baseline measurements as these had not been taken.

Tom continued to experience symptoms, of anxiety and also struggled with lack of motivation and self-confidence. He seldom went out and spent most of his time in his room listening to music, eating and drinking.

Tom continued to see his girlfriend but their relationship was becoming strained.

2 **Information point:** Tailored outreach

Optimal

## March Year 1: Co-ordinated care and the power of peer support

Tom returned to live with his parents. His care coordinator agreed with Tom to ensure his parents were included in his care planning and were offered carers support.

He received an information pack about the support he could expect to receive including specialist support from the early intervention service (for three years as per NICE guidance). This explained the importance of health checks and positive lifestyle factors.

Tom's parents were also given a carers information handbook.

Tom's GP practice agreed to take over the long term (repeat) prescribing of antipsychotic medication when requested by the EIP team.

Tom's GP provided evidence for Tom and his parents to take to his university to support a request for a break from his course due to mitigating circumstances.

3 **Information point:** Personalised care and support planning (PCSP)

During this period Tom's EIP team regularly communicated with his GP and supported him to attend annual physical health checks with his GP. These included discussing Tom's care needs and reviewing his personalised care and support plan (PCSP).

The information was recorded on the electronic primary care record.

Suboptimal

Tom's GP invited him to attend an annual health check, but Tom was worried about it and did not attend. No follow-up appointment was offered and Tom's parents were unaware of the invite.

Tom didn't see anyone professionally on discharge and received support only from his parents.

He continued to drink and smoke heavily and spent all of his time in his bedroom. His parents didn't know what to do to help as they had received very little information about Tom's illness, what to do to support him or what to expect.

Tom was taking his antipsychotic medication erratically, often forgetting to take a dose and sometimes taking extra medication. It made him very lethargic and increased his appetite. He was also inactive due to being withdrawn and as a consequence gained a considerable amount of weight.

Optimal

During the time Tom spent with the early intervention team he built up a trusting relationship with his care coordinator. Tom told him about the things he used to love doing. Together they devised a personalised care and support plan that included Tom's goals, including reducing his alcohol intake and becoming more physically active.

As well as being referred to see an alcohol specialist nurse, Tom was referred to a third sector organisation that supported individuals with mental health problems to re-engage with sporting activities and build confidence. This was shared with Tom's GP and included in his personalised care and support plan.

By connecting with other people with lived experience, especially other young black men, Tom felt less isolated.

The care co-ordinator and specialist mental health pharmacist discussed other medication options with Tom, including depot injections. Tom decided to continue to take his medication orally and this was recorded as part of his medication preferences.

## 4 **Information point:** Collaboration and alliance

Tom's early intervention team and GP worked together to ensure that information on physical health checks was shared and there was clarity on lead responsibility for the checks which was documented on one shared wellbeing with personalised care and support plan.

After three years with the early intervention team Tom was discharged back to his GP. As part of this transition Tom's care coordinator organised a handover meeting with Tom's GP and the primary care mental health specialist support worker.

Suboptimal

## **March Year 3:** Tom is isolated, drinking heavily, pre-diabetic and needs regular crisis care

At 25, Tom's relationship with his girlfriend had broken down and he was now single and isolated.

He continued to struggle to cope with his symptoms, and was inactive, drank and smoked heavily. He continued to take his antipsychotic medication and had persistent lethargy and his weight continued to increase.

Tom would often be out of breath on walking short distances and even just up the stairs.

Tom's GP continued to invite him for his physical health check, but Tom didn't attend. He was sent letters with new appointments but was never phoned to ask why he hadn't attended.

Tom had several spells of needing crisis mental health team support. The crisis team reviewed his physical health, but these checks were never reported to his GP or recorded on his primary health care record.

5 **Information point:** Review, monitoring and sharing physical health information

Optimal

## **March Year 3:** Regular assessments keep health problems in check before they escalate

Tom continued to have an annual physical health check with his GP and was supported to attend by his specialist support worker.

At his check his GP discussed whether Tom was experiencing any side effects from his medication, and it was evident that Tom had gained 10kg in the last year.

He was referred to a community dietician and his support worker arranged for him to attend extra sports activities through the third sector programme.

6 **Information point:** Regular assessment and care planning

At 25, Tom continued to have some anxiety but was otherwise well and free of psychotic symptoms.

Tom attended more sports sessions with help from his specialist support worker and soon became more confident in attending on his own. He joined their football team and started to feel the physical and psychological benefits of exercise and being part of a team.

The sports organisation supported Tom in monitoring his weight and blood pressure through a blood pressure monitor and smart watch, which he bought with his personal health budget. It also monitored his health statistics, such as pulse rate and level of physical activity, which he found really helpful.

The service had developed an app where Tom could record all his data and share this with his primary care specialist support worker who was able (with Tom's consent) to record this on his primary care health record.

Suboptimal

At his last health check with the crisis team Tom had high blood pressure, had gained a further 12 kg in weight and his blood lipid result suggested hyperlipidaemia. He was referred to cardiology but did not attend his appointment and was therefore discharged. His GP wasn't aware of this so was unable to provide a proactive management plan.

Tom now rarely left the house and relied on his parents for all of his needs. He drank at least eight cans of lager every day.

Tom's mum and dad called the GP practice but because they weren't registered carers seemed unable to get any consistent support. One evening Tom had breathlessness and chest pain.

His mum called an ambulance and he was admitted to the emergency assessment unit. He was found to have dangerously elevated cholesterol levels. He was also diagnosed as being pre-diabetic and told that he was at very high risk of having a heart attack. His liver function test was also abnormal.

Tom was referred to a liver specialist and endocrinologist. A letter was sent to his GP.

Optimal

## 7 **Information point:** Ensuring a personal health budget is explained and used

Tom felt fully informed and involved in decisions about his care. The EIP team continued to support Tom to take his antipsychotic medication and explained the importance of staying on the treatment that had helped to both get him well and keep him well.

This ongoing engagement made sure Tom understood the pros and cons of taking antipsychotics, the potential side effects, and the risks of relapse if he decided to stop taking the medication prematurely.

Tom continued to take his antipsychotic medication as he knew this was keeping him mentally well. He knew what the adverse effects of his medication were and was able to manage them more effectively. This included keeping fit, eating a balanced diet and reducing his alcohol intake.

He continued to attend walking and football groups, which he really enjoyed. His confidence had grown, he found the peer-support invaluable and he joined their cooking club. He felt less isolated and lonely. He also planned to join his local gym independently of support.

At Tom's last health check, it was noted that his cholesterol was raised. He spent time with his GP and specialist support worker talking this through and the GP proactively managed this though a medication plan to lower cholesterol and regular review. His GP explained the reason for medication and how this would help. He was also given written information regarding high cholesterol.

Suboptimal

## January Year 8: Tom develops diabetes, cardiovascular disease, and his mental health is very poor

At 29 Tom was diagnosed as having type 2 diabetes and was prescribed metformin, which he had to take daily.

Reducing his heart disease risk was a priority and required daily medication for both high cholesterol and high blood pressure. Both medications gave Tom extra side effects that needed careful monitoring, and he was now under the long-term care of the cardiology team.

He didn't like attending these appointments so often missed them.

His mum tried to manage his appointments and always had to seek support from his mental health team to take him.

Tom's GP requested that his physical health was reviewed and monitored by the mental health team due to Tom's frequent non-attendance.

Tom's mood was low, and he really struggled to get out because he lacked confidence and motivation. He felt so unfit that he feared exercising at all.

Optimal

## January Year 8: Flexible, sensitive personalised care and support planning helps Tom's mental and physical health stabilise

Tom continued to lose weight and was able to be more active. He continued to struggle with smoking but made the decision to get support from the mental health smoking cessation team, which his support worker referred him to.

It was important for Tom to be referred to a specialist smoking cessation team with access to specific pharmacy knowledge as stopping smoking can cause toxicity with some anti-psychotic medications.

Every year Tom received a text message from his GP practice inviting him for a physical health check.

The text message linked to information about what this entails and why this is important. It also stated that a home visit or assistance in attending could be arranged. In addition to this he received a phone call from his support worker.

8 **Information point:** System awareness and training

At 29 Tom's mental health had stabilised. He continued to need anti-psychotic medication and saw his GP for medication reviews on an annual basis.

There had been no need to refer him to any specialist as his care plan and support from the primary care team kept him well.

## Suboptimal

Tom and his family felt completely overwhelmed by the challenges of managing both his physical and mental illness, compounded by their uncertainty about who to go to for help.

Tom's health deteriorated to such a degree that it was unlikely he would be able to reverse his diabetes or heart disease through lifestyle changes, which would almost certainly result in Tom dying prematurely.

## Optimal

Tom successfully stopped smoking with the support of the smoking cessation team. He regularly went to his local gym and played football.

He no longer required the additional support offered by the sports group but he volunteered to help others in the programme as a peer support worker.

As a result of Tom's continued active and healthier lifestyle his cholesterol and weight reduced and he wasn't required to take any additional medication for his physical health.

Tom had one personalised care and support plan that was visible to all his primary care workers and his parents. It included details of how to manage both his physical and mental health. This was reviewed as part of his annual review.

He had moved in with his girlfriend and they were planning a future together.

Tom actively managed his physical health and monitored his own blood pressure, sugar levels and weight thanks to the equipment he purchased with his personal health budget.

Tom enjoyed his work as a volunteer and grew in self-belief and confidence. He enrolled on a college course and worked towards becoming a teaching assistant.

# Information points

## 1 Don't just screen, intervene - The Lester Tool

The Lester (2023) tool (also known as the Lester Cardio-metabolic Health Resource) helps clinicians to assess the cardiovascular health of patients with SMI and recommends the best course of intervention and treatment – including thresholds for intervention.

It brings together advice from a number of NICE guidelines and is also designed to take into account the impact of antipsychotic medication on an increased risk of cardiovascular disease in people with SMI.

System-level monitoring of the uptake and implementation of the Lester Tool, and the levels and quality of subsequent interventions, are recommended as a subject of regular audit and quality improvement programmes.

## 2 Tailored outreach

People with SMI have higher than average non-attendance for appointments. Some of these non-attendances can be avoided by addressing the individual barriers and making reasonable adjustments.

It is important that when designing service models to deliver health checks and follow-up interventions, these factors are considered, and reasonable adjustments are made to the model to support proactive engagement and offer of appointments and where necessary an assertive outreach approach. Tailored outreach is often provided by the voluntary, community and social enterprise sector (VCSE).

## 3 Personalised care and support planning (PCSP)

Personalised care and support planning (PCSP) is essential to ensure people with SMI live their lives in a way that matters to them, and are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvement in their physical health.

Personalised care and support planning should address the full needs of the service user, taking steps to combat loneliness, isolation and promoting wider engagement in self-care, exercise, healthy eating and lifestyle.

'Social prescribing' supports personalised care planning by working across health and social care organisations, voluntary sector, community and faith groups. Crucially, the process involves shared decision-making between the service user and the professionals supporting them.

For more information please visit the FutureNHS page on Personalised Care and Support Planning (free to join but registration required).

For a free 45min eLearning module on PCSP please go to Personalised Care Institute.

## 4 Collaboration and alliance

The NHS Long Term Plan identifies the need to join up services across primary, secondary, social care and voluntary and social care enterprises in order to promote equal access, early intervention, choice, and recovery based on NICE quality standards of access for people with mental health problems.

The need for this could not be more needed than in the provision of providing physical health care checks and interventions for individuals with Severe Mental Illness (SMI).

Better partnership across health and social care services and systems can help share expertise, instill confidence and also help overcome barriers to high quality care.

Good communication between all healthcare professionals involved in the care of those with mental health problems helps to avoid duplication or fragmentation of care.

## 5 Review, monitoring and sharing physical health information

It is important that clinical lead responsibility for physical health is clear between service providers, including primary care. I.e. protocols are in place to ensure comprehensive physical health assessments and management of results for adults with psychosis or schizophrenia when the service user is in the care of primary and secondary services.

The secondary care team should maintain responsibility for monitoring service users' physical health and the effects of antipsychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

Where physical health checks or interventions are delivered in one setting, there needs to be a mechanism in place to ensure that clinicians in other settings have access to the latest information about what and when physical health checks were conducted and the results of those checks.

If data is not shared effectively, people with SMI can face being subject to repeat checks, which is frustrating for service users and an inefficient use of health care resources. Primary care and secondary care should have data sharing agreements in place to specify which information about the care of people with SMI is shared and by what mechanism.

Practice-level SMI register dashboards are essential in ensuring that patients due any of the checks are pro-actively contacted in a timely manner. Many practices find it useful to set a rolling schedule for calling patients for their annual health check, e.g. based on their date of birth +/- 3 months. Undertaking a comprehensive physical health review and ensuring that this information is recorded in patient records is facilitated by the use of structured templates.

- Bradford District Health Care NHS Foundation Trust case study: Improving the quality of physical health checks for people with severe mental illness

## 6 Regular assessment and care planning

Adults with psychosis or schizophrenia should have a regular health check (at least once a year) that includes taking weight, waist, pulse and blood pressure measurements and blood tests. This checks for problems such as weight gain, diabetes, and heart, lung and breathing problems that are common in adults with psychosis or schizophrenia and often related to treatment. The results should be shared between their GP surgery and mental health team.

There should also be shared decision-making to ensure informed choice.

Please refer to NICE Quality standard (QS80) Psychosis and schizophrenia in adults, Quality statement 6: Assessing physical health.

## 7 Ensuring a personal health budget is explained and used

The Long Term Plan made a clear commitment to expand personalised care and personal health budgets, with a specific expectation that they will be offered within mental health services as part of plans for up to 200,000 people to benefit by 2023/24.

People who are eligible for section 117 aftercare under the Mental Health Act have a legal right to a personal health budget. Further guidance is available for health and social care professionals on implementing the legal rights to personal health budgets, including section 117 after-care.

Additional resources:

- Overview of Personal Health Budgets.
- FutureNHS Personalised Care Collaborative Network (please note registration is required).
- Introduction to personal health budgets (e-learning module).
- Personal health budgets Quality Framework (includes a case study on delivering personal health budgets to support mental health recovery in City and Hackney Placed-Based Partnership).

## 8 System awareness and training

All heathcare care staff should feel competent and confident to support people with SMI to better manage their physical health.

Training for staff to support 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 illness would also improve their physical healthcare.

Mental health staff have variable knowledge and skills associated with physical health checks.

While primary care staff are likely to have the required skills and expertise in relation to physical health assessments, many feel that they lack the knowledge and confidence in relation to working with people who are living with SMI.

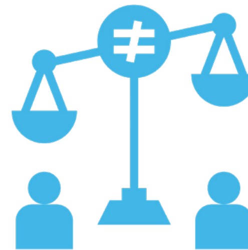
Please see: How to improve the physical health of people with SMI: A training film and Improving physical healthcare for people living with SMI in primary care: guidance for commissioners.

# The cost of mental illness in England

**£105bn**

per year for all mental health including: indirect costs of employment; direct costs of health provision; human costs of reduced quality of life[1]

## Life expectancy



- People living with SMI have a life expectancy of up to **20 years less** than the general population.[1]
- **2 in every 3** deaths for people with SMI are due to physical illnesses such as cardiovascular disease.[1]
- Excess premature mortality rates are **5x higher** among people with severe mental illness in England compared with those that do not.[3]

Lower physical activity levels and non-compliance with guidelines are associated with:

- male gender
- being single
- unemployed
- fewer years of education
- higher BMI
- longer illness duration
- medication use.[6]

Caring for people with schizophrenia could be as high as 2.8% of the total NHS budget annually.[2]

Caring for people with bipolar disorder costs the NHS c.£342 million annually.[2]

## Employment

People with SMI have low rates of employment: **8% vs 75%** in the general population[7]

Fewer than **1 in 4 people** using specialist mental health services are supported to find or keep work[5]

## Adults with SMI are more likely to have[1]:

| Condition | Likelihood |
|---|---|
| COPD | 2.1x |
| Diabetes | 1.9x |
| Obesity | 1.8x |
| Stroke | 1.6x |
| Heart failure | 1.5x |
| Asthma | 1.2x |

People with SMI spend on average **476 minutes a day sedentary** during waking hours.[6]

There are between 500,000 and 550,000 people on the GP severe mental illness registers in England (NHS England).

People with SMI between the ages of 15 and 34 are **5x** more likely to have **three or more physical health conditions.**[4]

Among people with SMI registered with a GP, smoking prevalence is 40.5% compared with 14.9% in the general population.[1]

## Screening programmes

Barriers to screening include lack of registration with a GP, and lack of confidence and knowledge about screening among health staff in some care settings.[1]

## Family intervention

12% of adults in the community who were in contact with their family were offered family intervention, and 39% of those took the offer up. For nearly half of the adults in contact with their family, there was no record of family intervention being offered or considered.[5]


*1 Office for Health Improvement and Disparities (OHID); 2 Good Governance Institute; 3 OHID; 4 OHID; 5 NICE; 6 World Psychiatry; 7 Royal College of Psychiatrists*

# Areas for systems to consider

The following questions are to support discussion and investigation within local systems. They are focused on the key optimal themes that can lead to improvement in physical healthcare for people with severe mental illness:

- Is there a clear shared care protocol in place outlining roles and responsibilities across primary and secondary care services for optimal physical healthcare of people with SMI, including information sharing requirements to enable alignment of the SMI register between primary and secondary care?
- Are local leaders developed and supported (including clinicians and experts by experience) to promote improved working between primary and secondary care services?
- Is there a clear governance structure where strategy and planning can be carried out?
- Is there a plan to address the early mortality of the SMI population? Has the importance of protecting the physical health of people with SMI in the critical early phase of psychosis, to mitigate the risk of future cardiovascular and metabolic disorders, been recognised?
- 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 for people with severe mental illness?
- Don’t just screen, intervene: Is the Lester Tool (2023) - a summary poster to guide health workers to assess the cardiometabolic health of people experiencing psychosis and schizophrenia - used routinely in your local area?
- 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 healthcare and avoid ‘diagnostic overshadowing’?
- Do you have jointly agreed physical health SMI pathways for physical health conditions such as diabetes?
- 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?
- 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?
- Are you using shared decision-making to ensure monitoring of medication and side effects is taking place?
- Is support available for people with SMI to help them access and take up public health or locally commissioned community behaviour change services - for example via peer support workers or care navigators?

# » The three components to completing the physical health check, and supporting resources

## Invitation to SMI physical health check

**Tips**

- Use tailored invitation letter to support people with severe mental illness to understand the benefits.
- Explore additional communication methods if person does not respond to letter, e.g., phone, text.
- Complete all elements of the check in one appointment to maximise opportunities to make every contact count.
- Do not exempt people who do not respond to first invitation contact.
- Liaise with regional Integrated Care System mental health leads to identify local outreach services.

**Resources**

- Example invitation letters and local system resources (available on FutureNHS - a free site that requires registration)
- Equally well resources

## Completing physical health check

**Tips**

- Ensure reasonable adjustments are made that are tailored to the needs of the individual person, such as offering appointments later in the afternoon to accommodate access.
- Ensure adequate time is made available to complete all elements of the health check in one sitting.
- Provide training and support to wider practice team on health check process including accessing local physical health interventions.
- Check to see if there's a local template for completing health-checks e.g. on EMIS/ SystmOne.

**Resources**

- Example EMIS templates (available on FutureNHS - a free site that requires registration)
- eLearning for health primary care training package for PHSMI

## Results counselling and next steps

**Tips**

- Utilise the Lester tool 2023 to guide follow-up conversations regarding cardiometabolic risk factors.
- Refer onwards to appropriate follow-up interventions as indicated in commissioning guidance and local protocols.

**Resources**

- Lester tool 2023
- Improving physical healthcare for people living with SMI in primary care - guidance for CCGs

# Supporting access to health checks: good practice examples

## Invitation to SMI physical health check

- General practice had previously had no contact with the SMI individual for 2.5 years, which was identified through checking the GP SMI register.
- Practice staff member proactively reached out to support the individual to access their health check and booked it for them. This also included follow up reminders via telephone and SMS and by offering a 'walk-in' appointment on the agreed day to promote flexibility.
- Individual attended on the day and received a comprehensive health check.

## Completing physical health check

- General practice worked with locally voluntary, community and social enterprise (VCSE) commissioned outreach service to support an individual who had previously not engaged to access the physical health check.
- A physical health support worker, employed by the local Mind charity, worked directly with the individual to provide information about the benefit of the health check and to understand the reasonable adjustments that were required to facilitate attendance.
- Direct engagement with the practice regarding the individual supported them to attend their health check.

## Results counselling and next steps

- Clinician completed SMI health check and identified that an individual was on a high-dose of anti-psychotic medication, carried out an immediate ECG.
- ECG reported ischaemic change even though the patient was asymptomatic. ECG results were shared with duty GP who arranged cardiology review, resulting in cardiac investigations and treatment.

# Additional resources, tools and links

## NICE guidance

- All adults on the SMI register are receiving the full list of recommended physical health assessments as part of a routine check at least annually (NICE clinical guidelines CG185 and CG178).
- Psychosis and Schizophrenia in adults. Prevention and Management CG178: Psychosis and Schizophrenia
- Bipolar disorder CG185 Bipolar Disorder Assessment and Management
- QS80 Psychosis and schizophrenia in adults: Quality Statement 6 Assessing Physical Health
- There is evidence that service users who have significant physical illness or risk of a physical illness are offered more frequent checks in line with clinical presentation and need (NICE clinical guideline CG120). Assessment and management in health care settings

## Commissioner and provider guidance and policy

- Improving physical health care for people with severe Mental Illness in Primary Care: guidance for CCGs (2018).
- NHS Mental Health Implementation Plan 2019/20 – 2023/24
- Quality and Outcomes Framework guidance for 2023/24

## Technical guidance

- Technical guidance and published statistics are available on the NHS England statistics website.
- Supporting information is available on the NHS Digital SDCS website.
- General Practice Extraction Service (GPES) data collection

## Primary care resources

- Rethink: What's reasonable? Mental illness and disability law in your GP practice
- Social Prescribing: NHS England
- Social Prescribing: Kings Fund
- Glasgow Antipsychotic Side-effect Scale (GASS)
- Physical activity in adults: brief advice for Primary care
- Smoking and mental health primary care guidance
- Pharmacy guidane on smoking and mental disorder

## Model Health System

- A data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.