NHS England

Improving physical healthcare for people living with severe mental illness (SMI) in primary care

Guidance for CCGs

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1. Introduction

People living with severe mental illness (SMI)[1] face one of the greatest health inequality gaps in England. The life expectancy for people with SMI is 15–20 years lower than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked. Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. Individuals with SMI also 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.

Individuals living with SMI are not consistently being offered appropriate or timely physical health assessments despite their higher risk of poor physical health. They are not being supported to use available health information and advice or to take up tests and interventions that reduce the risk of preventable health conditions [1].

Therefore in the **Five Year Forward View for Mental Health** [1], NHS England committed to leading work to ensure that **by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.**

In Implementing the Five Year Forward View for Mental Health [2] and the **NHS Operational Planning and Contracting Guidance 2017-19** [3], NHS England stated that **"CCGs should offer NICE-recommended screening and access to physical care interventions to cover 30% of the population with SMI on the GP register in 2017/18, moving to 60% population from the following year".** This commitment was reiterated in the March 2017 publication of the **Next Steps on the NHS Five Year Forward View** [4]. Further, the guidance on **Refreshing NHS Plans for 2018/19** published in February 2018 highlighted the same requirement to deliver annual physical health checks and interventions, in line with this guidance, to at least 280,000 with SMI in 18/19**.** The table below sets out the anticipated trajectory for achieving this objective:

Objective	2017/18	2018/19	2019/20	2020/21
Minimum number of people with an SMI receiving a full annual physical health assessment and appropriate follow-up care	140,000	280,000	280,000	280,000
Percentage of people on the GP SMI register	30%	60%	60%	60%

[1] 'SMI' refers to all individuals who have received a diagnosis of schizophrenia or bipolar affective disorder, or who have experienced an episode of non-organic psychosis. In parallel to addressing the needs of people on the SMI register, commissioners are strongly encouraged to consider the physical health needs of people with other diagnoses including, for example, personality disorder and mental health needs. See Annex D in the separate document for further detail.

To support planning, in line with **Refreshing NHS Plans for 2018/19**, CCGs will be provided with figures on the numbers of people on GP practice SMI Registers. This will enable development of a robust quarterly trajectory for each CCG throughout 2018/19 and beyond.

From April 2017, transformation funds entered all CCGs' baselines to support increasing the delivery of required physical health screening, improving access to physical health interventions, beyond the currently incentivised assessments within the **Quality and Outcomes Framework (QOF)** and ensuring that high quality training is in place for staff responsible for undertaking the screening.

The table below shows the year-on-year anticipated investment to deliver the objective as well as the expected savings to be released derived from the 2015 **QualityWatch report** [5].

Funding type	2016/17	2017/18	2018/19	2019/20	2020/21
CCG baseline allocations for improving the physical healthcare of people living with SMI	-	£41m	£83m	£83m	£83m
Expected savings: physical healthcare for people with SMI		-£27m	-£81m	-£108m	-£108m

CCGs have a delegated responsibility to improve physical healthcare for people with SMI in line with their legislative duties for addressing equalities and health inequalities. In accordance with the Public Sector Equality Duty, section 149 (1) of the **Equality Act 2010** [6] and the **Health and Social Care 2012** [7], CCGs alongside other bodies have duties regarding:

- eliminating unlawful discrimination under the Equality Act 2010;
- advancing equality of opportunity;
- fostering good relations;
- reducing health inequalities in access to health and health outcomes; and
- improving services and developing more integrated services.

CCGs' responsibilities to improve the quality of physical healthcare for people with SMI is one important part of a broader commitment across STPs to reduce premature mortality and address health inequalities.

2. Purpose of this guidance

This guidance is focused on securing improvements in physical health care for people with SMI within primary care, where the majority of people living with an SMI receive their care and treatment, through supporting CCGs to use transformation

funds to commission enhanced provision to better address physical health risks and needs. This guidance does not recommend one specific model for how physical healthcare for people with SMI should be commissioned and delivered in primary care but sets out what good quality physical healthcare provision in primary care must include in terms of:

1. Completion of recommended physical health assessments
2. Follow-up: delivery of or referral to appropriate NICE-recommended interventions
3. Follow-up: personalised care planning, engagement and psychosocial support

Best practice evidence indicates that where primary care teams deliver care collaboratively with secondary care services outcomes are improved. The lead responsibility for assessing and supporting physical health will transfer depending on where an individual is in their pathway of care, as set out below.

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

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

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

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

The Annexes to this guidance (published separately) provide further detail to support implementation, including:

- case studies describing good practice from across the country and demonstrating how barriers have been overcome (Annex A);
- a detailed implementation checklist for CCGs and providers (Annex B); and
- workforce development tools and resources for primary care staff (Annex C).
- links to relevant NICE guidance (Annex D) and further tools and resources (Annex E)

Support for local areas is available from NHS England's regional teams, clinical networks and Academic Health Science Networks. For information about support in your region, please contact: england.adultmh@nhs.net

[2] NICE clinical guidance **CG178**

3. Priority actions for improving physical healthcare for people with SMI

The below table summarises the key priority actions for a CCG in addressing the need for improved physical healthcare for people with SMI within primary care settings. Further detail can be found within a more detailed checklist within Annex B.

Actions	Further information
Strategic planning • Use local data (e.g. from Joint Strategic Needs Assessments and PHE's **Fingertips Profile**) [8] to understand the health needs of the local SMI population and existing inequalities. • Establish relationships with parallel programmes such as **NHS Health Check** [9]. • Review current performance and plans for future delivery, with a focus on plans for 18/19 including quarterly trajectories for PH checks in primary care to be submitted as part of 18/19 planning • Develop a plan to improve levels of interoperability and effective information sharing between primary and secondary care.	See case study 4 & 5, Annex A
Designing service models • Ensure service user and carer views are embedded in the design and evaluation of services. • Develop and promote clinical leadership and collaborative working between provider organisations, such as through appointing a clinical GP mental health lead within primary care to liaise with the physical health leads within secondary mental health services. • Develop clear protocols outlining roles and responsibilities across primary and secondary care, communications and information sharing requirements, ensuring robust shared care arrangements are in place.	See case study 1 & 2, Annex A

Commissioning • Consider the most effective models for commissioning improvements in the context of local needs and develop a service specification. This may include either: a) Commissioning a Local Enhanced Service as an addition to the core primary care contract b) Commissioning an **enhanced primary care mental health service from, for example, a secondary MH care provider to deliver this service within primary care settings** • Ensure service provision includes: 1. Completion of recommended physical health assessments, 2. Follow-up: delivery of or referral to appropriate NICE concordant interventions 3. Follow-up: personalised care planning, engagement and psychosocial support.	See case study 1, 3 Annex A See Section 4
Preparing for implementation • **Improve joint working across the primary and secondary care interfaces** - considering use of shared care protocol as was developed in Bradford. • Make a plan to **develop the primary care workforce to improve physical healthcare for people with SMI**, ensuring comprehensive training opportunities are in place. • Review resources required to deliver the full package of care such as standard assessment templates e.g. **Bradford template** [10], appointment invitation **templates** [11], engagement strategy, care plan templates, data collection mechanisms.	See section 5 Case study 2, Annex A Annex C

Monitoring, evaluation and improvement • Establish a transparent and robust mechanism for collecting data and monitoring progress on physical health checks and follow up care within primary care. • This may involve use of a standardised template embedded across primary care providers, or flowing of READ or SNOMED-CT codes. • Report to NHS England on a quarterly basis on delivery of PH checks and follow up care in primary care, in order to support tracking of progress towards delivery of our national commitment. Further information on the construction of this indicator will be provided in the Joint technical definitions for performance and activity 2018-19. • Locally track the quality, impact and outcomes of services over time with regular reviews to identify areas for improvement locally. • Continue to ensure appropriate and relevant workforce training and professional development is available to staff.	Annex B

4. Commissioning comprehensive physical healthcare for people with SMI

Accessible, comprehensive and evidence-based physical healthcare includes three key elements which CCGs will need to include in their service design and commissioning plans:

1. Completion of recommended physical health assessments

All adults on the SMI register should receive the full list of recommended physical health assessments as part of a routine check at least annually (NICE clinical guidelines **CG185** and **CG178**). Assessments should be undertaken more frequently as required:

a) for the purposes of monitoring specific antipsychotics or other medications (local policies and procedures may apply according to local Drug and Therapeutic Monitoring Committee); or
b) where a significant physical illness or risk of a physical illness has already been identified (NICE clinical guideline **CG120**).

Figure 1 provides a summary of the recommended physical health assessments for people living with SMI, which has been developed with the input of a clinical reference group. A comprehensive physical health check includes a number of assessments not currently featured within the **Quality and Outcomes Framework for primary care**. It builds upon the **Lester Positive Cardiometabolic Health Resource** for use in secondary care [13] and the **NHS Health Check** in primary care

[9]. The recommended assessments include cardiovascular risk scoring, however, it is important to note that existing cardiovascular disease risk scores can underestimate risk in those with psychosis [14, 15].

The recommended physical health assessment aligns to the **NHS Health Check** [9] but unlike the NHS Health Check it should be offered annually to all age groups (rather than every 4 years to people aged 40-74). In addition to the NHS Health Check assessments the physical health assessment for people with SMI should include: relevant national screening and immunisation programmes, as recommended by Public Health England (PHE), medicines reconciliation, and additional general physical health enquiry into sexual health, oral health and substance misuse.

All physical health assessment results and agreed actions are to be entered into the patient electronic record. Case Study 2 in Annex A, demonstrates how the use of a standardised template for physical health checks has helped to ensure consistency of checks and will support collection of monitoring data. Unless the patient actively disagrees, assessment and actions are to be shared with relevant healthcare professionals in line with information sharing and information governance protocols.

2. Follow-up: delivery of or referral to appropriate NICE concordant interventions: "don't just screen, intervene"

Appropriate evidence-based physical care interventions should be provided for all physical health risk(s) or conditions identified during the assessment including:

- For alcohol and illicit/non-prescribed drug use: follow guidance on co-occurring substance misuse and SMI (NICE Clinical Guideline **CG120**).
- For **Obesity** prevention [**NICE CG43**]
- For **Physical activity**: brief advice for adults in primary care [**NICE PH44**]
- For **Hypertension** in adults: diagnosis and management [**NICE CG127**,
- For Type 2 diabetes prevention and treatment **NICE PH38**, **NICE NG28**, and [**NICE NG28**]
- For Type 1 diabetes diagnosis and management [**NICE NG17**, **NG18** and **NG19**]
- For **Lipid modification** [**NICE CG181**]
- For current smokers: facilitate smoking cessation through pharmacotherapies, intensive behavioural support, and methods such as carbon monoxide monitoring (NICE Public Health Guideline **PH 48**).

See Annex E for all relevant NICE clinical guidance.

Access to secondary physical health interventions should be enabled through:

- clear and effective communications (such as texts and phone calls, not just paper letters) with service users and carers about the required follow-up
- clear and robust referral systems to specialist physical healthcare

3. Follow-up: personalised care planning, engagement and psychosocial support

Personalised care planning is necessary to ensure people with SMI are supported to make the lifestyle and behaviour changes needed to achieve and sustain improvements in their physical health. Personalised care 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. CCGs can use the following check list to monitor delivery of personalised care planning which should include jointly agreeing:

- ✓ personal physical health goals
- ✓ approaches to self-care, e.g. **health coaching**
- ✓ a list of physical health referrals, social prescribing or onward signposting
- ✓ follow-up over the next 12 months
- ✓ roles and responsibilities of other named supporting professionals

Consideration must be given to individuals who have pre-existing co-morbid physical and mental health problems, whose ability to self-manage their conditions may vary and who may also face additional social challenges [16].

Integrated Personal Commissioning is one way of ensuring that people with the most complex mental and physical health needs experience a coordinated, integrated approach to discussing, planning and delivering care.

Voluntary sector organisations can also play a crucial role in effective care planning and providing follow up support. For example:

- **Peer supporters** can help to reduce barriers in engagement, address social isolation and support behaviour change.
- **Care navigators** can play a key role in improving the pathway for people with SMI. With their in-depth knowledge of local services, they can point people in the right direction, approach services on an individual's behalf and support people to attend appointments where appropriate.

A key feature of **Tower Hamlets Together** Multispecialty Community Provider (MCP) step-down primary care service for people living with SMI is the role of care navigators and peer support services [17]. This is an example of an enhanced primary care service which offers recovery-oriented support, with case managers and care navigators co-ordinating care. Similarly, a triage service in Lambeth consisting of a **'Community Options Team'** is focused on action planning, social inclusion and access to mainstream services through peer support services, and has demonstrated cost savings and positive patient experience [18].

To help ensure people are fully engaged in physical healthcare, services should:

- ✓ Undertake proactive follow up on the results of all assessments
- ✓ 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

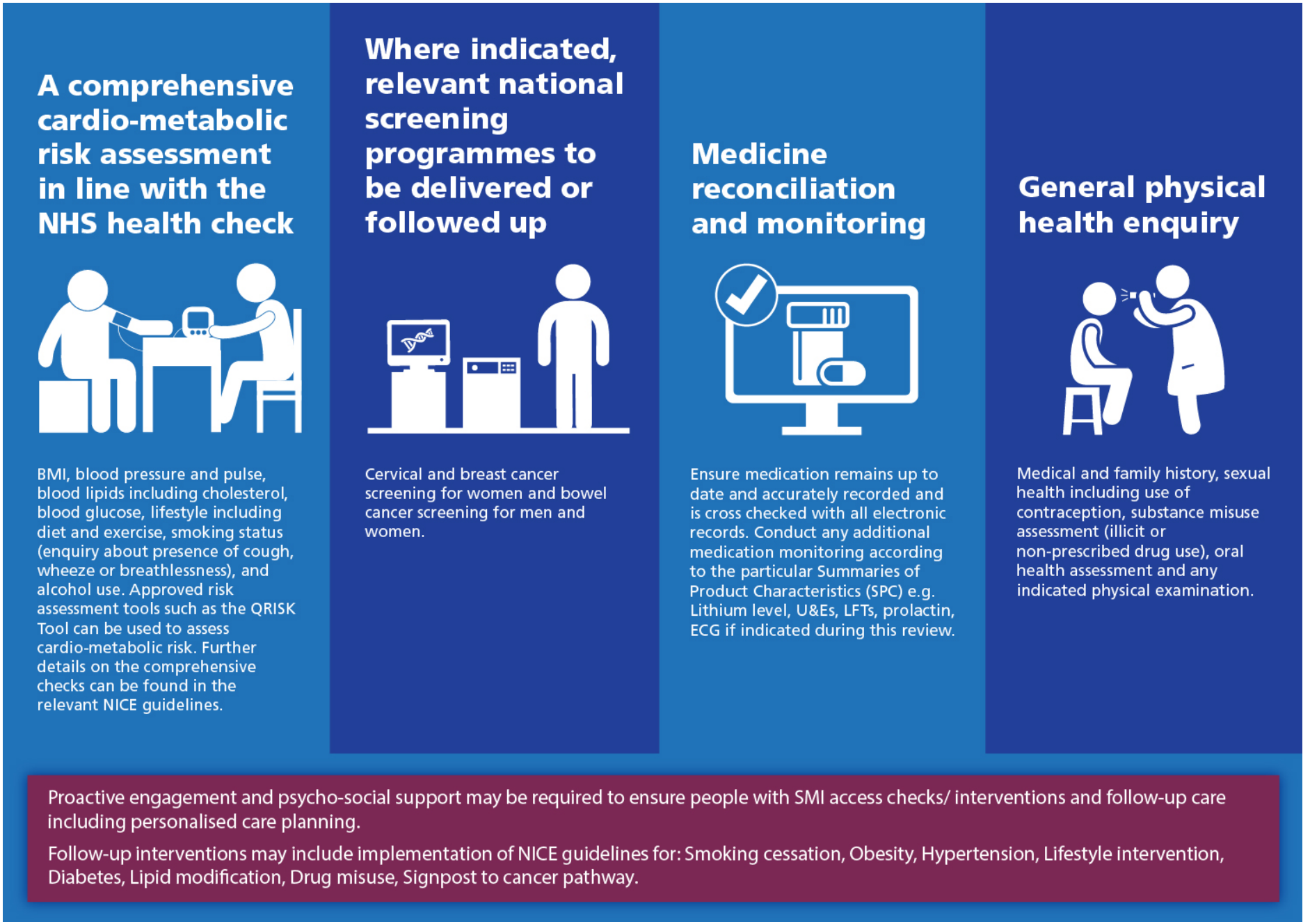

Figure 1: The recommended physical health assessments for people on the SMI register

5. Preparing for implementation

Improving joint working across primary and secondary care

Joint working between primary care and secondary mental health providers is essential to improve physical healthcare for people living with SMI. Local shared care protocols or agreements can provide clarity on roles and responsibilities. CCGs have an important role in supporting the development of these protocols and agreements.

To ensure safe, effective and joined-up care between primary and secondary care teams, appropriate sharing and exchanging of accurate and up-to-date information between practitioners is key. This is supported by:

- a clear protocol for sharing results including interpretation of health assessments and ensuring that the relevant information entered into IT databases can reach the right healthcare professional(s) promptly for follow-up care.
- integration of local databases to facilitate sharing of screening results and care plans, for example as with the Southwark and Lambeth Local Care Record (see case study 4 in Annex A).
- Use of alternative communication channels in the absence of integrated systems to share results, such as written correspondence. This could include emails (scanning results), letters or telephone calls.

The **Improving physical healthcare to reduce premature mortality in people with serious mental illness (PSMI) CQUIN 2017-2019** [19] includes a focus on interoperability between primary and secondary care, providing a financial incentive to drive further integration to improve physical health care for people with SMI. Cross-checking SMI Quality and Outcomes Framework (QoF) and Care Programme Approach (CPA) registers, implementing shared care protocols, reviewing interoperability of data and IT systems and developing clear action plans to address any gaps are all set milestones to be achieved as part of the CQUIN scheme.

The sharing of patient records should be done in accordance with local information governance agreements and with due regard given to confidentiality issues as outlined within the Data Protection Act 1998 and human rights legislation.

Developing the primary care workforce to improve physical healthcare for people with SMI

Ensuring that practitioners have the correct knowledge, skills and attitudes is essential to delivering high quality care and addressing the stigma that contributes to the known mortality gap.

Whilst 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. Illustrative of this is the 2014 survey of practice nurses which found that *"82% have responsibilities for aspects of mental health and wellbeing for which they had no training, and 42% have had no training in mental health and wellbeing at all".* This can lead to 'diagnostic overshadowing', in which staff overlook physical symptoms as a result of an individual's existing mental health diagnosis [20].

All primary care staff should feel competent and confident to support people with SMI to better manage their physical health. This requires staff to:

- understand what SMI is and how it might be experienced;
- understand the excess risks of poor physical health and how best to support people with SMI to engage and access appropriate physical healthcare;
- feel confident and empowered to talk about health holistically including mental health, healthy lifestyles, risk reduction and physical health; and
- have technical skills and expertise in relation to carrying out physical health assessments and obtaining and communicating the results.

To achieve this a comprehensive approach to workforce development could include:

- a high quality training offer covering core mental health awareness, physical health promotion and behaviour change for people living with SMI;
- protected time for staff to access relevant training;
- appropriate supervision and opportunities for reflective practice;
- access to multi-disciplinary team structures as part of continued development.

Areas that have developed training collaboratively between primary and secondary care have shown that it is not only invaluable for knowledge share but also for promoting closer working relationships which can increase the likelihood of more effective shared care delivery.

In relation to workforce development in this area, Health Education England has:

- made freely available an online training resource accredited by the Royal College of General Practitioners. This can be accessed through the **e-learning for Health website** [21]. While the training modules are particularly aimed at nurses, they are very relevant to other primary care staff;
- published a **Mental Health Core Skills Training framework** [22], which identifies learning outcomes to be achieved by various individuals when

addressing the physical health care needs of people with SMI, in collaboration with Skills for Health.

Please refer to Annex C for a fuller list of available resources and links in relation to workforce development.

Multi-disciplinary approach

Effective primary care teams will offer a multi-disciplinary approach to improving physical healthcare for people with SMI in recognition of the need to deliver a holistic approach to care planning and follow-up. This multi-disciplinary approach could include input from:

- Service users
- Carers
- GPs
- Practice nurses
- Pharmacists
- Healthcare assistants
- Care navigators
- Peer supporters

Team structures should promote collaborative working whereby skills merge across mental and physical pathways of care.

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