Physical health checks for people living with severe mental illness

A partnership approach to improving health checks in Primary Care

v1 [30/11/2021]

Contents

1. Aim, purpose and audience

Aim

The aim of the documents is to help Integrated Care Systems* (ICS), General Practitioners (GPs) and other primary care staff; and Local Authorities (Councils) to help adults living with severe mental illness to improve their physical health.

*From April 2022 Integrated Care Systems will have statutory requirements and responsibility for delivery

Purpose

The purpose of this document is to provide:

a) Guidance on the prioritised action required to prevent premature mortality, morbidity and inequalities experienced by people with severe mental illness

b) Information, data and intelligence about the nature and extent of preventable premature mortality and morbidity and the inequalities experienced by people with mental illness

c) A summary of key strategic drivers and the policy commitments for people with severe mental illness related to improved physical health and mental wellbeing

d) A self-assessment checklist to support improvement activity relating to physical health checks for those with severe mental illness.

Audience

The key audiences for this document are:

- Integrated Care Systems
- General Practitioners (GPs) and other primary care staff
- Local Authorities (Councils)
- Voluntary, Community and Social Enterprise organisations

2. Introduction

Annual physical health checks

Anyone with a severe mental illness who is registered with a GP (General Practitioner) is entitled to a physical health check once a year.

The physical health check has a core standard comprising of 6 elements measuring or assessing:

1. weight (BMI or BMI + waist circumference)
2. blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate)

3. blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement)
4. blood glucose test (blood glucose or HbA1c measurement)
5. alcohol consumption
6. smoking status.

And additional elements of a comprehensive health assessment that includes:

7. an assessment of nutritional status, diet and level of physical activity (nutrition/diet that includes status + physical activity/exercise) status
8. an assessment of use of illicit substance/non prescribed drugs (substance misuse status)
9. medicines reconciliation or review.

Only the core components (1-6) are part of QOF payments.

Severe mental illness GP registrations

More than half a million people in England live with a severe mental illness. This is likely to be an underestimate as figures only include those who are diagnosed and recorded on GP registers[1].

The average GP surgery (with a list size of around 5,000 to 7,000 patients) is likely to have 50-70 registered patients on its severe mental illness register. This is likely to be higher in more deprived areas. This equates to an average of one to two health checks per week for each practice.

Defining Severe mental illness

Severe mental illness is a term which is used by the NHS to refer to a mental health condition that has a significant impact on a person's health and daily life, and which may be long-term. For annual health checks this includes patients of any age with a diagnosis of schizophrenia, bipolar affective disorder, and other psychoses and patients on lithium therapy[2]

Whilst people diagnosed with Borderline Personality Disorder are not included on the severe mental illness register, given the association of BPD with a substantially reduced life expectancy, mostly due to physical health conditions, particularly cardiovascular disease, annual health checks should be considered for people who have been given a BPD diagnosis.

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[1] Health and Care of People with Learning Disabilities, Experimental Statistics: 2018 to 2019. https://digital.nhs.uk/data-and-information/publications/statistical/health-and-care-of-people-with-learning-disabilities/experimental-statistics-2018-to-2019

[2] NHSE (2019) Physical health check and follow-up interventions for people with severe mental illness Technical guidance NHS England report template - data icon

Diagnostic overshadowing

Diagnostic overshadowing can happen if someone has more than one health condition at the same time, one or more of which is overlooked and under-treated.

For some people with a mental illness, physical ill-health is seen only as part of the mental health condition or related medication e.g. fatigue, headaches, stomach pain, sleep disturbances, loss of appetite, even when their symptoms could mean there is of a physical health problem.

Others report that their mental health is prioritised over their physical health and the latter is not seen as part of their care.

Diagnostic overshadowing can lead to inadequate medical treatment for physical health conditions in people with mental illnesses, leading to increased mortality and poorer treatment outcomes [3].

Undertaking a full physical health check for patients with severe mental illness helps identify opportunities for evidence-based interventions that can reduce people's risk of death, prevent avoidable ill health and reduce health inequalities.

A Prevention Approach

A prevention and public mental health approach includes:

1. Promoting the population's mental health and wellbeing
2. Preventing suicide and mental health problems
3. Reducing mental health inequalities[4] [5]

Taking a public mental health approach is fundamental to public health in general because good mental health is a determinant and consequence of our physical health, as well as a resource for living.

Improving the lives of people with mental health problems, supporting their recovery and inclusion

Improving the lives and life expectancies of people with severe mental illness is a key element of this public mental health approach. Everyone living with a long-term mental health condition should have access to effective, timely, consistent and responsive help at every stage of their life for their physical health and have an equal chance of enjoying a healthy life and equal life expectancy.

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[3] Guerin, Bernard (2017-03-16). *How to Rethink Mental Illness* doi:10.4324/9781315462615. ISBN 9781315462615.

4 PHE (2017) Prevention Concordat for Better Mental Health: Prevention planning resource for local areas

5 Faculty of Public Health and Mental Health Foundation (2016) Better Mental Health for All: A Public Health Approach to Mental Health Improvement

Collaboration across local systems

A new duty to promote collaboration across the health care, public health and social care system is being introduced as part the White Paper, Integration and innovation: working together to improve health and social care for all (DHSC, 2021).[6]

Undertaking physical health checks for people with severe mental illness is primarily the responsibility of primary care as set out in the Quality Outcomes Framework. The Quality Outcomes Framework recommends what should be included in each physical health check; however, it does not specify what interventions should be delivered following the physical health check.

Most interventions will fall outside of the remit for primary care: e.g. stop smoking services, alcohol treatment and some weight management services are commissioned by local authorities; whilst some diabetes services are commissioned by clinical commissioning groups or integrated care systems. Physical health checks are more likely to improve physical health outcomes when they are part of a system-wide pathway whereby those identified at risk can access the right care for their needs. Therefore, collaboration between primary care, integrated care systems and local authorities will enable the best physical health outcomes for people with severe mental illness.

3. Poor health outcomes for people with mental illness

Premature deaths

Data

New indicators on premature mortality of adults with severe mental illness show that in every local authority in England, adults with severe mental illness are more likely to die younger than those without. In areas with higher deprivation, the chances of people with severe mental illness dying younger rise to almost seven times more than those without.

Impact of COVID-19

The Spotlight report shows that adults with pre-existing mental health conditions appear to be at greater risk of death and hospitalisation from COVID-19 than the general population.

6 Department of Health and Social Care (2021). Integration and innovation: working together to improve health and social care for all.

Causes of premature mortality

Major causes of death in people with severe mental illness include chronic physical medical conditions such as cardiovascular disease, respiratory disease, diabetes and hypertension.[7]

Smoking

Smoking prevalence for people with severe mental illness registered with a GP is almost three times higher than the general population at 40.5%. Smoking increases the risk of asthma, COPD and other respiratory illnesses that may also contribute to a worsened prognosis if they contract COVID-19.

It also contributes to a heightened risk of mortality from lung cancer[8].

Physical activity

People living with severe mental illness are less likely than those without to do any moderate or vigorous physical activity[9].

Healthy weight management

People living with severe mental illness are more likely to have difficulties managing a healthy weight than the general population, and the gap is greatest among young people (aged 15-34)[10].

Infectious diseases

Infectious diseases appear to contribute to an increased risk of death in people with severe mental illness, with a 4- to 8-fold risk of death due to infection compared to the general population.[11]

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[7] John A et al (2018) 'Premature mortality among people with severe mental illness' Schizophrenia Research

[8] Arffman et al . The impact of severe mental illness on lung cancer mortality of patients with lung cancer in Finland in 1990-2013: a register-based cohort study. Eur J Cancer. 2019 Sep;118:105-111. doi: 10.1016/j.ejca.2019.06.018. Epub 2019 Jul 19. PMID: 31326729 . The impact of severe mental illness on lung cancer mortality of patients with lung cancer in Finland in 1990-2013: a register-based cohort study - PubMed (nih.gov)

[9] Vancampfort D, et al. Sedentary behavior and physical activity levels in people with schizophrenia, bipolar disorder and major depressive disorder: a global systematic review and meta-analysis. World Psychiatry. 2017;16(3):308–15. https://pubmed.ncbi.nlm.nih.gov/28941119/

[10] PHE (2018) Severe mental illness (SMI) and physical health inequalities: briefing Severe mental illness (SMI) and physical health inequalities: briefing - GOV.UK (www.gov.uk)

[11] WHO (2015) Evidence on vulnerability of people with Severe Mental Illness to flu Extracted from 'Meeting Report on WHO Headquarters, Nov 2015 Titled 'Excess Mortality in Persons with Severe Mental Disorders (SMD)'

COVID-19

The COVID-19: review of disparities in risks and outcomes found that people with severe mental illness are more likely to be at risk of infection and poorer health outcomes from COVID-19, including mortality from the illness.

Cancer

A recent large international study found people with mental illness are almost twice as likely to die from cancer as the general population, even though they are no more likely to develop the disease. Those with mental illness are also nearly 25% less likely to receive cancer screening than those in the general population.

The biggest inequalities in physical health compared with the general population are among people aged 15-34[12]. This is why it is important that physical health checks are offered to people with severe mental illness of all ages[13].

Digital and Health Literacy Inequalities

Digital inequalities mirror health inequalities. There are 12.6 million people in the UK who don't have basic digital skills and likely to be further disadvantaged by age, education, income, disability, or unemployment[14].

Seventy percent of people with severe mental illness have low levels of health literacy[15].

[12] PHE (2018) Severe mental illness (SEVERE MENTAL ILLNESS) and physical health inequalities: briefing, https://www.gov.uk/government/publications/severe-mental-illness-severe mental illness - physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing (Accessed 09 June 2020)

[13] NHS England (2018). Improving physical healthcare for people living with severe mental illness in primary care: Guidance for CCGs

[14] Tinder Foundation (2016). Health and Digital: Reducing Inequalities, Improving Society: An evaluation of the Widening Digital Participation Programme

[15] Clausen, W., Watanabe-Galloway, S., Bill Baerentzen, M. *et al.* (2016) Health Literacy Among People with Severe Mental Illness. *Community Ment Health J* **52,** 399–405 (2016) https://link.springer.com/content/pdf/10.1007/s10597-015-9951-8.pdf

4.Strategic drivers, policy and guidance

Department of Health and Social Care White Paper (2021) Integration and innovation: working together to improve health and social care for all

The underlying principles of this white paper are:

- A population health approach, where local health and care systems do not just offer treatments and interventions, but support people to stay healthy.
- Integration within the NHS (between different NHS organisations) and integration between the NHS and local government (and wider partners).
- Place based approaches to meet local needs, leaving decisions to local systems and leaders

Quality and Outcomes Framework

The Quality and Outcomes Framework specifies a physical health check within the last 12 months should be undertaken for patients on the severe mental illness register. This physical health check recommends recording:

- Alcohol consumption
- Body Mass Index
- Blood Pressure
- Cholesterol**/** High Density Lipoprotein
- Blood Glucose
- Cytology Recordings, including the results of cancer screening (does not include cervical cytology)
- Smoking status

NHS Long Term Plan (2019)

- **Physical Health Checks** - by 2020/21, the NHS will ensure that at least 280,000 people living with severe mental illness have their physical health needs met.
- **New and integrated models** of primary and community mental health care will support adults and older adults with severe mental illness. A new community-based offer will support local areas to redesign and reorganise core community mental health teams to move towards a new place-based, multidisciplinary service across health and social care aligned with primary care networks.

- **Smoking cessation** - a new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of mental health and learning disability services.
- **Social Prescribing** - the range of support available to people will widen, diversify and become more accessible. Link workers within primary care networks will work with people to develop tailored plans and connect them to local groups and support services to facilitate improved mental and physical health outcomes.

NHS Outcomes Framework (NHSOF)

The 5 domains of the NHSOF are:

1) Preventing people from dying prematurely; by reducing avoidable deaths
2) Enhancing quality of life for people with long-term conditions; by supporting people with long-term conditions to live a normal a life as possible
3) Helping people to recover from episodes of ill health or following injury**;** and where possible prevent ill health or injury
4) Ensuring that people have a positive experience of care; including patients, service users and carers
5) Treating and caring for people in a safe environment and protecting them from avoidable harm; by delivering quality of care to deliver better health outcomes

Undertaking annual physical health checks for people with severe mental illness helps contribute to all these domains by identifying and treating a range of physical health conditions; and thereby reducing avoidable deaths and improving physical health outcomes.

The Care Act (2014)

The Care Act sets out the duty of Local Authorities to promote people's wellbeing, including physical and mental health and emotional wellbeing and participation in work, training and education, recreation and suitability of living accommodation. It also sets out the importance of promoting integration of care and support with health services.

5.Integrated Care Systems

Role and functions

A key function of Integrated Care Systems in supporting the delivery of physical health checks for people with severe mental illness will be to:

- support integration including improving the interface between primary and secondary care
- develop a local plan to improve the physical health of people with severe mental illness, including the delivery of the annual physical health checks,
- improve the link to community-based support services including voluntary, community and social enterprise organisations following the physical health check
- ensure system wide adoption
- provide quality improvement, assurance and leadership

Physical Health Severe mental illness Checklist

Introduction

The physical health severe mental illness checklist has been created for Integrated Care Systems leads to support continuous improvement of the physical health severe mental illness service offer and most importantly improve outcomes for service users. The checklist is a tool to support quality improvement and action planning.

It is designed as a simple checklist to aid improvement activity: to identify key actions needed to ensure that practice is meeting the national standards required to deliver quality services.

Scope/intended audience

The checklist has been developed for use by those leading service development and delivery at an Integrated Care Systems level e.g. physical health severe mental illness clinical leads, programme leads and lead commissioners (while CCGs remain) responsible for programme delivery.

The scope however should not be limited to these individuals and could be widened to include delivery partners in secondary care and the voluntary sector where appropriate. The checklist has been designed to embrace the spirit of collaborative working and therefore needs to be viewed as a partnership and collaborative activity between system partners.

Purpose of the checklist

To provide a framework to support physical health and severe mental illness leads (up to or at Integrated Care System level) to identify high impact actions through

the discovery of any gaps/barriers and best practice that would support the development of improvement and delivery plans.

Limitations

The checklist is not exhaustive and should be a framework to support continuous improvement that can be added to in the spirit of continuous development, learning and improvement.

The checklist's primary purpose is to support improvement and should not be seen as an assurance tool but should contribute to the establishment of assurance in relation to the delivery of physical health severe mental illness checklists and interventions.

Checklist for Integrated Care Systems / Sustainability Transformation Partnerships in establishing effective Physical Health - Severe mental illness checks

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
The commissioner landscape across the Integrated Care Systems		
There is a comprehensive model or models planned or in place for physical health checks and follow-on interventions that address the various delivery challenges		
System governance and leadership		
There is a clear governance structure that includes all system partners in the oversight of strategy, planning and delivery		
There is an explicit target to reduce premature mortality in the severe mental illness population by a specific value, within a specific time period, using the premature mortality data within the Public Health England fingertips severe mental illness mortality indicators		
There is an organigram that shows Leadership structure within the Integrated Care System specific to physical health and severe mental illness		
There is evidence of collaborative relationships with partner organisations e.g. Local Authority, Voluntary,		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Community and Social Enterprise community and patient voices around the agenda of physical health checks for people living with severe mental illness		
The Integrated Care System partnership for Physical Health and severe mental illness is representative of all key partner organisations and there is shared ownership		
There is an effective link between the Integrated Care System and primary care with shared ownership to improve the position		
Commissioning and finances		
The commissioning arrangements are clear and transparently understood, i.e.: • There is an identified lead commissioner in each Clinical Commissioning Group • There is a service specification for a model and delivery of physical health checks for people with Severe mental illness that complies with the Adult Mental Health framework and the specification: • has been reviewed in the last 2 years • has been co-produced • includes expected activity levels of physical health checks and follow-on interventions • includes requirements about workforce planning and		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
development • includes information sharing/partnership working • includes quality metrics • includes outcome measures		
The system leadership understand: a) Where Clinical Commissioning Group baseline funding investment been spent or ICS baseline funding from April 2022 b) Where other partners commission services to support the 'intervene' following the health check e.g. Local Authority funding for stop smoking services c) Whether these services adequately cater to the needs of people with severe mental illness		
Specific investments have been made by the Integrated Care System and other partners to maximise opportunities for new workforce to support delivery, e.g. healthcare support workers orientated to Primary Care Networks For example: a) There is a clear service specification and investment envelope underpins the workforce requirements and quality performance outputs b) A specific workforce model has been commissioned from Primary Care Networks or a lead provider (e.g. Secondary Care Mental Health Trust has been		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
commissioned to deliver physical health checks and interventions across the Integrated Care System footprint)		
Health Impact Assessments, Health Equity Assessments and the Public Health England HEAT tool are utilised to better understand the needs of the local population, including those with protected characteristics, and enable effective targeting to ensure take up of physical health checks for those with severe mental illness		
Data Analysis and flows: Understanding local need		
The Integrated Care System has a clear understanding of the prevalence and need of the local populations and agreed priorities for action		
The Integrated Care System have a clear understanding of what people with Severe mental illness are dying from and corresponding treatment pathways have been prioritised for review and improvement		
Clear processes are in place in each Clinical Commissioning Group for the recording of activity related to physical health checks and follow up interventions		
Processes and permissions are in place in each Clinical Commissioning Group for the sharing of secondary care		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
data with primary care for activity related to physical health checks and follow up interventions for patients with severe mental illness that occurs within secondary care		
Processes and permissions are in place in each Clinical Commissioning Group for the sharing of required information between primary/secondary care and any Voluntary, Community and Social Enterprise providers who may be supporting part of the pathway		
Reports / dashboards are in place enable each GP practice to track for their practice: • which patients have had which physical health checks (either in primary or secondary care) • which eligible patients have received the appropriate follow up intervention (either in primary or secondary care)		
Patient level reports /dashboards are in place that enable secondary care providers to track for their cohort of patients: • which patients have had which physical health checks (either in primary or secondary care) • which eligible patients have received the appropriate follow up intervention (either in primary or secondary care)		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Data Submissions		
Each Clinical Commissioning Group has an understanding of their gaps in General Practice Extraction Service sign up and a plan to reach maximal sign up within a reasonable timeframe		
Each Clinical Commissioning Group has a process for the validation and reconciliation of their General Practice Extraction Service and Strategic Data Collection Service submissions		
Physical Health Checks		
Performance dashboards are in place that enable each Clinical Commissioning Group to view summary percentage reports per practice for: • which patients have had which physical health checks (either in primary or secondary care) • which eligible patients have received the appropriate follow up intervention (either in primary or secondary care)		
The Integrated Care System has access data on practice level performance for physical health checks for Severe mental illness		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
A robust system is in place to address any performance issues relating to low performance of physical health checks		
The analysis of performance data by commissioners/ Integrated Care System includes: a) stratification of the data by certain demographics to understand gaps – geography, Mental Health condition and protected characteristics including age, gender, ethnicity b) monitoring onward referrals as a result of physical health checks and outcomes of these interventions c) identifying the gaps for targeted improvement activity d) identifying areas of success and effective practice that can be shared		
Interventions		
All specifications for physical health checks and the services that provide treatment and support ensure that providers use culturally appropriate ways to promote access and deliver interventions, e.g. access to interpreters, resources in multiple languages		
The Integrated Care System has a strategy and plans for digital inclusion and addressing digital poverty		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
The Integrated Care System has worked with key partners to develop pathways into community-based services (for example Voluntary Community and Social Enterprise Local Authority, Secondary Mental Health Services, Community lifestyle services		
Service user experience		
There is a clearly understood patient journey including: a) entry into the system b) experience of physical health checks c) movement from physical health checks in primary care to brief interventions offered in primary care and referral on to community-based services		
Pathways are commissioned across the Integrated Care System that meet the requirements of the community mental health framework in supporting all people with Severe mental illness to access interventions to support their physical health, including but not limited to: • Stop smoking services • Weight management services • Drug and alcohol Services • Physical activity programmes • Cancer screening • Cardiac monitoring including regular ECGs		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Service user feedback, reflecting the protected characteristics of the cohort, is regularly collected and analysed to understand what is most valued and what is frustrating to service users		
Service users are involved in the co-production of: a) any Health Impact Assessments (HIA) or Health Equity Assessments (HEAs) b) resources and information relating to physical health checks for severe mental illness c) physical health checks for severe mental illness interventions d) pathways following physical health checks		
The main barriers and enablers to accessing physical health checks and interventions are understood and action is taken accordingly		
There is an active programme of service improvement projects / initiatives		
TOTAL		

6. GPs and primary care teams

Role and function

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

1. Patients with severe mental illness who are not in contact with secondary mental health services, including:
    a) People whose care has always been solely in primary care
    b) People who have been discharged from secondary care back to primary care
2. People with severe mental illness 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.[16]

All adults on the severe mental illness register should receive the full list of recommended physical health check at least annually (NICE clinical guidelines **CG185** and **CG178**).

Physical health checks may 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**).

The recommended physical health check goes beyond the Quality and Outcomes Framework targets for people with severe mental illness and aligns to the NHS Health Check. However, 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, the physical health check for people with severe mental illness 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.

Effective primary care teams offer a multi-disciplinary approach to improving physical healthcare for people with severe mental illness in recognition of the need to deliver a holistic approach to care planning and follow-up. Primary care teams should collaborate across service users, carers, GPs, practice nurses, pharmacists, healthcare assistants, care navigators and peer supporters. GP practice leads should

[16] NHS England. (2018). Improving physical healthcare for people living with severe mental illness in primary care Guidance for CCGs. improving-physical-health-care-for-severe mental illness -in-primary-care.pdf (england.nhs.uk)

advocate for people with severe mental illness as part of their representation on Primary Care Networks and new community models for mental health.

Physical Health Severe Mental Illness Checklist

Introduction

The physical health severe mental illness checklist has been created for primary care to support continuous improvement of the physical health and severe mental illness service offer and most importantly improve outcomes for service users.

It is designed as a simple checklist to aid improvement activity: to identify key actions needed to ensure that practice is meeting the national standards required to deliver quality services.

Scope/intended audience

The checklist has been developed for use by those leading service development and delivery at general practice level, including GPs and practice managers.

The scope however should not be limited to these individuals and could be widened to include delivery partners in secondary care and the voluntary sector where appropriate. The checklist has been designed to embrace the spirit of collaborative working and therefore needs to be viewed as a partnership and collaborative activity between system partners.

Purpose of the document

To provide a framework to support physical health and severe mental illness leads at practice level to identify high impact actions through the discovery of any gaps/barriers and best practice. The aim would be to develop an improvement and delivery plan.

Limitations

The checklist is not exhaustive and should be seen as a framework to support continuous improvement that can be added to in the spirit of continuous development, learning and improvement.

The checklist's primary purpose is to support improvement and should not be seen as an assurance tool but should contribute to the establishment of assurance in relation to the delivery of physical health severe mental illness checklists and interventions.

Checklist for Primary Care to implement effective Physical Health - Severe mental illness checks

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Governance and leadership		
There is a dedicated mental health and health check lead within the GP surgery or practice		
Data – Better understanding the people on your Severe mental illness register		
The practice maintains a Severe mental illness that is regularly cleansed/validated and includes full data on protected characteristics		
Patients on the Severe mental illness register have been risk stratified, identifying those in need of most intensive support based on the clinical risks to their physical health (using physical health diagnoses, QRISK3 scores and/or Primrose A scores as indicators) and their level of engagement in monitoring/treatment		
The practice knows the number of patients on the Severe mental illness register needing physical health checks in order to meet the 60% target		
The practice has a plan and performance oversight process in place to monitor delivery of the upper threshold (90%) of all of the Physical Health in Severe mental illness Quality Outcome Framework incentives		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
The practice knows the % of your patients on the Severe mental illness register who have been offered a health check		
The practice knows which population groups on the Severe mental illness register are least likely to attend for their physical health check		
The practice knows the % of your patients on the Severe mental illness register who have had a full health check in the last 12 months		
The practice knows the % of your patients on the Severe mental illness register that have had a partial health check in the last 12 months		
The practice knows the % of patients on the Severe mental illness register that have had each of the individual checks in the last 12 months, i.e.: a) a measurement of weight (BMI or BMI + waist circumference); b) a blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure + pulse rate); c) a blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement);		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
d) a blood glucose test (blood glucose or HbA1c measurement) e) an assessment of alcohol consumption; f) an assessment of smoking status; g) an assessment of nutritional status, diet and level of physical activity (nutrition/diet status + physical activity/exercise) status; h) an assessment of use of illicit substance/non-prescribed drugs (substance misuse status); i) medicines reconciliation		
Engagement with patients registered with Severe mental illness		
The practice uses data to engage with and target those population groups on your Severe mental illness register who are least likely to take up the offer of a physical health check		
The practice knows the barriers and facilitators are to enable patients to take up their physical health check		
The practice has a plan for prioritising equity of access by protected characteristics		
The practice has co-producing culturally appropriate services to suit the needs of patients		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Physical Health Checks		
A system in place to ensure that everyone who is eligible for a physical health check is offered one		
A variety of communication methods are used in order to reach your patient cohort who are eligible for a physical health check, including non-English speakers		
A system is in place that follows up those who do not take up the offer of the health check		
Information for those on the severe mental illness register on physical health checks is available in a range of formats		
Text messaging is used to invite/remind people of their physical health checks		
The practice has a robust system for recording completed physical health checks using a structured template e.g. the Bradford template		
The ASSIST-Lite screening tool for alcohol is embedded into the local electronic patient record system to drive screening and reporting		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
The ASSIST-Lite screening tool for substance misuse embedded into the local electronic patient record system to drive screening and reporting?		
Offer of brief interventions		
The Making Every Contact Count framework is used to offer brief interventions relating to: • Alcohol • Drug misuse • Diet • Physical Activity • Stop smoking • Lowering blood pressure		
Offers of interventions and interventions delivered are recorded in patient records		
Pathways into community services for those identified as requiring support via their physical health check		
Following a physical health check, there is a clear pathway for patients of the Severe mental illness register into relevant community services, i.e.		
1) Social prescribing provision		
2) Stop Smoking Services		
3) Alcohol services		
4) Drug misuse services		
5) Weight management services		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
6) Physical activity services including exercise on referral schemes		
Pathways into acute/specialist services for those identified as requiring support via their physical health check		
Following a physical health check, there is a clear pathway for patients of the Severe mental illness register into relevant specialist services and patients are supported to access: a) Cancer screening programmes (breast, bowel, cervical) b) Specialist consultant led services, e.g. cardiology, endocrinology c) LTC clinics e.g. diabetes and asthma annual reviews		
Staff training		
Practice staff access training to support them to work with people with Severe mental illness, e.g. Making Every Contact Count training and training to support interventions related to smoking and alcohol. APHC staff training around engagement with patients living with a diagnosis of severe mental illness and supporting adoption of healthier lifestyle where possible		

7. Local Authorities

Role and functions

Residents with severe mental illness experience a higher prevalence of physical co-morbidities and multi-morbidities and therefore there is a need for integrated and holistic care delivery which considers their mental and physical health needs.[17][18] The role of local authorities is to improve access to evidence-based public health interventions and improve outcomes for people with severe mental illness in order to reduce risk factors that lead to poorer physical health and increase inequalities. As per the NICE concordant interventions[19], appropriate evidence-based physical care interventions should be provided for all physical health risks or conditions identified during the assessment. See Appendix B for relevant NICE guidance.

Health improvement services commissioned by local authority public health teams play a key role in this integrated and holistic approach, ensuring that residents with severe mental illness are able to access services and experience improved outcomes in stopping smoking, support with drug or alcohol misuse, weight management support and promoting increased activity levels.

The role of local authorities as part of a system-wide approach to improving the physical health of those with severe mental illness is to understand the needs of their local population and advocate for these needs at a system-level; ensure that commissioning of services is co-produced with residents with severe mental illness; to monitor access to services for those with severe mental illness; and to tailor services based on the latest evidence base to achieve improved outcomes.

Physical Health Severe mental illness Checklist

Introduction

The physical health severe mental illness checklist has been created for local authority public health leads to support continuous improvement of the physical health severe mental illness service offer and most importantly improve outcomes for local residents with severe mental illness. The physical health check for residents with severe mental illness will potentially identify areas where people might need additional support, including support to stop smoking, support with drug or alcohol misuse, weight management support or enabling people to increase physical activity levels. Services need to be equitable, inclusive and co-produced. And pathways to

[17] Bahorik AL et al (2017) . 'Severe mental illness and medical comorbidities: Findings from an integrated healthcare system' Journal of Psychosomatic Research: volume 100, pages 25 to 45
[18] NHS Digital (2018) . 'National Diabetes Audit, 2016 to 17 Report 1: Care Processes and Treatment Targets (Severe Mental Illness - Supplementary Information)'
[19] NHSE (2018) Improving physical healthcare for people living with severe mental illness (SEVERE MENTAL ILLNESS) in primary care Guidance for CCGs https://www.england.nhs.uk/wp-content/uploads/2018/02/improving-physical-health-care-for-severe mental illness -in-primary-care.pdf

these services following a physical health check need to be effective, in order to ensure outcomes for people with severe mental illness are improved.

It is designed as a simple checklist to aid improvement activity to identify key actions needed to:

- support and improve the physical health check programme for residents with severe mental illness delivered by primary care
- improve the quality of the pathways to a range of health improvement services and programmes including stop smoking services, substance misuse services, physical activity and weight management programmes
- identify key actions needed to reduce inequalities in access and improve outcomes for people with severe mental illness who access improvement services and programmes.

Scope/intended audience

The checklist has been developed for use by those delivering public mental health programmes within the local authority, those leading on public health and/or mental health programmes and by those addressing health inequalities programmes across local authorities e.g. physical health and severe mental illness programme leads and lead commissioners responsible for commissioning stop smoking services, substance misuse services, physical activity and weight management programmes.

The checklist has been designed to embrace the spirit of collaborative working and therefore needs to be viewed as a partnership and collaborative activity between system partners for example your local Integrated Care System (ICS), Primary Care Networks, mental health services and community, voluntary and faith sectors where appropriate.

Purpose of the document

The purpose of this document is to provide a framework to identify high impact actions through the identification of any gaps/barriers and propose best practice that would support the development of local improvement and delivery plans to improve outcomes for residents with severe mental illness.

Limitations

The checklist is not exhaustive and should be seen as a framework to support continuous improvement, learning and development.

The primary purpose of the checklist is to support improvement and it should not be seen as an assurance tool but should contribute to the establishment of assurance in relation to the delivery of interventions that will improve physical health of local residents with severe mental illness.

Checklist of key actions for Local Authorities to improve the physical health of residents with severe mental illness

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
The commissioner landscape across the Local Authority		
There is specific reference to residents with Severe mental illness in the following Local Authority health improvement services and programmes: • stop smoking services, • substance misuse services • physical activity programmes • weight management programmes		
System governance and leadership		
The Local Authority is part of the Integrated Care System governance structure for the physical health check programme for local residents with severe mental illness		
Improving the physical health of people with severe mental illness is included in local strategies and plans i.e. Health Inequalities Strategy, Public Mental Health Strategy, Health and Wellbeing Board Strategy		
There is a clear internal governance structure in place within the Local Authority with oversight of planned activity to improve outcomes for residents with Severe mental illness		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
There is an explicit target to reduce premature mortality in the Severe Mental Illness population by a specific value, within a specific time period		
There is a Senior Leader or Champion within your Local Authority for improving the physical health of residents living with severe mental illness		
There is collaboration internally and with external partner organisations e.g. Adult Social Care, the Community, Voluntary and Social Enterprise sectors and the voices of lived experience		
There are explicit links with primary care, Primary Care Networks and social prescribing in order to support interventions following the physical health check for residents living with severe mental illness		
Commissioning and finances		
The commissioning arrangements are clear and transparently understood? For example: • There is an identified lead officer or commissioner for improving the physical health of residents with Severe mental illness in the Local Authority		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
• All relevant contracts include access and completion data for residents with a Severe mental illness All specifications relevant to improving the physical health of residents with Severe mental illness o have been reviewed in the last 2years o have been co-produced o include data on referrals from primary care following a physical health check o include activity levels of interventions o include requirements about workforce planning and development o include info sharing/partnership working o include quality metrics o Include outcomes		
Commissioners understand whether these services adequately cater to the needs of residents with Severe mental illness		
Local Authority commissioners understand what the main barriers and facilitators are to accessing physical health checks and specifically the subsequent interventions		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Relevant services and programmes that would improve outcomes have been prioritised for review and improvement		
Data Analysis and flows: Understanding local need		
Health Impact Assessments, Health Equity Assessments and the Public Health England HEAT tool are utilised to better understand the needs of the local population, including those with protected characteristics, and enable effective targeting to ensure take up of physical health checks for those with severe mental illness		
Health Impact Assessments, Health Equity Assessments and the Public Health England HEAT tool are used to agreed priorities for action		
The Local Authority and local commissioners have a clear understanding around the causes of death for people diagnosed with severe mental illness		
Local Authority consults with residents with Severe mental illness to understand what helps and hinders them to improve their physical health		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
Pathways		
The Local Authority works with key partners and people with lived experience to develop pathways into community-based services		
Pathways have been developed and commissioned across the Local Authority that meet the requirements of the community mental health framework in supporting all people with Severe mental illness to access interventions to support their physical health, including but not limited to: • Stop smoking services • Weight management programmes • Drug and alcohol services • Physical activity programmes		
Interventions		
All specifications ensure staff access training to support them to deliver Making Every Contact Count approaches and Identification and Brief Advice for a range of health improvement areas i.e. Substance Misuse services deliver Smoking Cessation Identification and Brief Advice		
All specifications that help improve the physical health of residents with severe mental illness ensure that		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
providers use culturally appropriate ways to promote access and deliver interventions i.e. access to interpreters, resources in multiple languages		
Providers use a variety of communication methods and different languages in order to reach all residents with Severe mental illness who have been referred to local health improvement services		
The Local Authority has information for residents in a variety of formats and languages about how they can improve their physical health		
The Local Authority considers residents with Severe mental illness in its digital poverty strategy and plans for digital inclusion		
Service user experience		
The experience of residents living with a severe mental illness id fully understood fully understood; including: • Their experience of accessing services • Their experience of the available health improvement services and programmes		
Service user feedback, reflects the protected characteristics of the cohort, is regularly collected and		

Key Lines of Inquiry	1. Fully 2.Partially 3.Limited 4.No	Any additional comments
analysed to understand what is most valued and what is frustrating to service users		
Residents with severe mental illness are involved in the co-production of: • any Health Impact Assessments (HIA) or Health Equity Assessments (HEAs) • resources and information relating to improving the physical health for residents with Severe mental illness for residents, their family and staff • pathways • interventions and programmes		
TOTAL		

8. Glossary of terms

Clinical Commissioning Groups are groups of general practices (GPs) which come together in each area to commission the best services for their patients and population. They buy services for their local community from any service provider that meets NHS standards and costs – these could be NHS hospitals, social enterprises, voluntary organisations or private sector providers.

The **General Practice Extraction Service** collects information for a wide range of purposes, including providing GP payments.

Health Equity Assessment Tool in public health and health care to:
1. address health inequalities and equity-related to a programme of work or service
2. identify what action can be taken to reduce health inequalities and promote equality and inclusion

Health Impact Assessment is a tool to assess how a proposed decision will affect the health of a population and whether vulnerable populations are more likely to be impacted [or whether the health impacts are distributed evenly within the population.

Identification and brief advice aims to identify and influence patients who are drinking above the UK chief medical officers' low risk guidelines. identify those individuals whose health-behaviours might impact negatively their health, now or in the future e.g. smoking, drinking too much, and to deliver simple, structured advice aimed at reducing this risk.

Integrated care systems (ICSs) are partnerships that bring together providers and commissioners of NHS services across a geographical area with local authorities and other local partners to collectively plan health and care services to meet the needs of their population. The central aim of ICSs is to integrate care across different organisations and settings, joining up hospital and community-based services, physical and mental health, and health and social care.

Making Every Contact Count is an evidence-based approach to improving people's health and wellbeing by helping them change their behaviour.

Primary care is the first point of contact for health care for most people. It is mainly provided by GPs (general practitioners).

QRISK score will measure low, moderate or high risk of developing cardiovascular disease in the next 10 years.

Quality and Outcomes Framework is a set of measures that are agreed as part of the General Practice contract. Each measure has points attached that are given to GP practices based on how they are doing against these measures.

The framework includes:

- management of some of the most common chronic conditions, for example asthma and diabetes
- management of major public health concerns, for example smoking and obesity
- providing preventative services such as screening or blood pressure checks

The **Strategic Data Collection Service** is a secure data collection system used by health and social care organisations to submit data.

Sustainability and Transformation Partnerships bring together local NHS organisations and local authorities (county/ unitary councils) to develop proposals to improve health and the quality of care to provide better services for patients in the areas they serve

9. Further resources

Bradford Template

The Bradford Template, is an example of an annual physical health for people with a severe mental illness. It includes questions about alcohol, drugs and smoking behaviour, blood pressure, body mass index, blood test for diabetes, cholesterol and cervical screening if appropriate.

Centre for Mental Health

Commission for Equality in Mental Health | Centre for Mental Health

Experiences of weight management among people with severe mental illness
https://www.centreformentalhealth.org.uk/publications/more-number

Experiences of smoking cessation support among people with severe mental illness
https://www.centreformentalhealth.org.uk/publications/time-quit

Equally Well

Equally Well resource section including

1) The Leicestershire Physical Health Register – Case Study
2) Top tips for building effective engagement between people, communities and health services
3) Mental health-friendly health check resources for health and social care professionals

Local Government Association

Mental health How do you know your council is doing all it can to improve mental health?

Public Health England

Twitter graphics.

Infographics.

Presentation slides.

Improving physical healthcare for people living with severe mental illness in primary care.

Royal College of Psychiatrists

Advancing Mental Health Equalities (AMHE) resource to support commissioners and providers to tackle mental health inequalities in their local areas.

Yorkshire and the Humber Clinical Network

Has an e-Learning for Health online training package https://portal.e-lfh.org.uk/Component/Details/707252 aimed at primary care colleagues to:

a) Raise awareness of the importance of a full physical health check for people with severe mental illness
b) Provide them with the confidence to take positive action to reach this hard to reach population and in undertaking a full physical health check

9. Appendices

Appendix A – Physical Heath in Severe mental illness Excel checklist Integrated Care System and Primary Care

MH SIT Physical Health SMI Checklist

Appendix B - NICE Guidelines and Quality Standards

The following NICE guidelines and standards are relevant for improving the physical health care of people with severe mental illness.

1. **Core NICE Guidelines and Quality Standards addressing the physical health needs of those living with severe mental illness:**

- Psychosis and schizophrenia in adults: prevention and management. [**NICE CG178**].
- Psychosis and schizophrenia in adults [**NICE QS80**].
- Bipolar disorder: assessment and management [**NICE CG185**].
- Bipolar disorder in adults [**NICE QS95**].
- Bipolar disorder, psychosis and schizophrenia in children and young people [**NICE QS102**].
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [NICECG120]
- Coexisting severe mental illness (psychosis) and substance misuse: community health and social care settings [**NICE NG58**]
- Smoking: acute, maternity and mental health services. Public health guideline [**NICE PH48**]

2. **Relevant NICE clinical guidance to deliver interventions for presence or raised risk of cardio-metabolic disease identified during physical health assessments:**

- Obesity prevention NICE CG43
- Lipid modification [NICE CG181]
- Hypertension in adults: diagnosis and management [NICE CG127]
- Physical activity: brief advice for adults in primary care [NICE PH44]
- Prevention and treatment for Type 2 diabetes [NICE PH38 and NICE NG28]
- Diagnosis and management for Type 1 diabetes [NICE NG17, NG18 and NG19]

3. **Relevant NICE clinical guidance to deliver interventions for smoking, alcohol or substance use:**

- Smoking: harm reduction. [**NICE PH45**]
- Smoking: harm reduction [**NICE QS92**]
- Smoking cessation through pharmacotherapies, intensive behavioural support, and methods such as carbon monoxide monitoring (NICE Public Health Guideline PH 48).
- Alcohol-use disorders: prevention [**NICE PH24**]
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications [**NICE CG100**]
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [**NICE CG115**]
- Drug misuse in over 16s: psychosocial interventions [**NICE CG51**]
- Drug misuse in over 16s: opioid detoxification [**NICE CG52**]

Co-Authors

- Sarah Brennan (NHSE/I)
- Simon Bristow (NHSE/I)
- Julie Daneshyar (PHE)
- Helen Garnham (PHE)
- Laura Hodgson (PHE)
- Annie Murray (PHE)

Contributors

- Emma Bailey (Centre for Mental Health & Equally Well UK)
- Dr Wendy Burn (Royal College of Psychiatrists & Equally Well UK)
- Fleur Carney (Healthier Lancashire and South Cumbria)
- Zohra Dempsey (Blackpool Council Public Health Team)
- Vicki Dodds (NHSE/I)
- Nichola Gambles (PHE)
- Kevin James (Equally Well UK)
- Corrine Harvey (PHE)
- Gabbi Hasham (Rethink Mental Illness & Equally Well UK)
- Dr Nicholas Hicks (Cobic Consultant on behalf of NHSE/I)
- Amanda Lomas (Fylde Coast CCG)
- Marsha McAdam (Equally Well UK Expert by Experience group and Co-chair of GM Borderline Personality Disorder Working Group)
- Kate O' Hagan (PHE)
- Lucy Schonegevel (Rethink)
- Paula Sheriff (NHSE)
- Lewis Smith-Connell (PHE)
- Nicolas Ventosa (PHE)