# Improving Physical Health for People with Severe Mental Illness

## Wessex Mental Health & Dementia Network

Novotel Hotel, 1 West Quay Road, Southampton
Wednesday 7th November 2018

# Contents and agenda

## This presentation aims to cover:

1. **Overview of the Five Year Forward View ambition for improving physical health in severe mental illness (SMI)**

2. **Levers for achieving goals in secondary and primary care**

3. **Monitoring the delivery of physical health checks in primary care – SDCS collection**

4. **Enablers and positive practice examples for successful delivery**

1. **An overview of the Five Year Forward View ambition for improving physical health in severe mental illness (SMI)**

# Physical health in SMI: a case for change

**People with SMI** face stark health inequalities and **are less likely to have their physical health needs met**, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

Compared to the general population, individuals with SMI (such as schizophrenia or bipolar disorder):

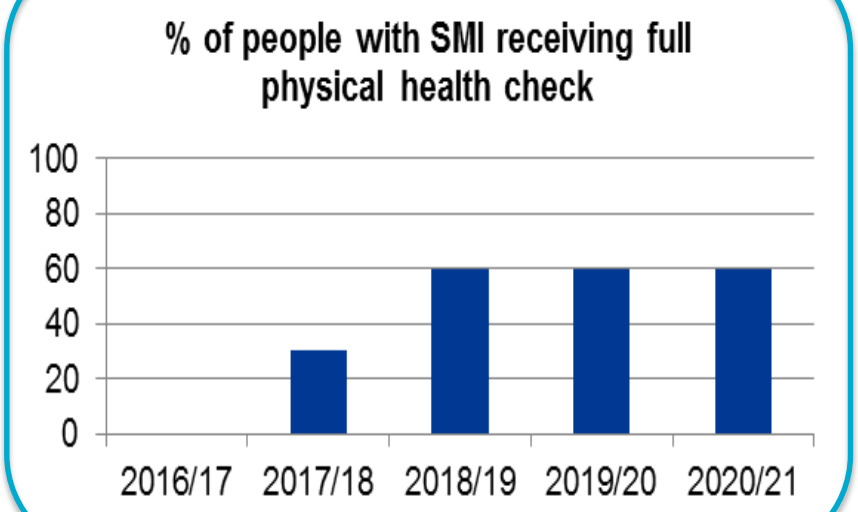
- Face a **shorter life expectancy** by an average of 15–20 years.
- Are **three times more likely to smoke**.
- Are three-and-a-half times **more likely to loose all teeth**.
- Are at double the risk of **obesity and diabetes**, three times the risk of **hypertension and metabolic syndrome**, and five times the risk of **dyslipidaemia** (imbalance of lipids in the bloodstream).

Why?

- **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.
- Lack of clarity around **responsibilities** in healthcare provision in primary and secondary care.
- **Gaps in training** among primary care clinicians.
- **Lack of confidence** across the workforce to deliver physical health checks among people with SMI.
- **Lack of integration** between primary, physical health and mental health services.
- **Poorer lifestyle choices** including limited physical exercise and **cardiometabolic risks from a younger age.**

# Mental Health Five Year Forward View Objective

***NHS England should ensure that by 2020/21, 280,000 people have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.***




CCGs are to 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 is to be delivered across primary and secondary care.

## Goal:

- To improve **access** to:
  - **physical health checks** AND **follow up interventions** for people with SMI
- To improve **the quality** of:
  - **physical health checks** AND **follow up interventions** for people with SMI

## 2. Levers for achieving goals in secondary and primary care

# What does the PH SMI CQUIN require?

**i. The % of patients with psychoses that receive a comprehensive range of cardio metabolic assessments and access to evidence based interventions where needed**

Internal provider sample submitted to National Audit provider for the CQUIN

**Weighting: 80%****

**ii. Patient care plans or comprehensive discharge summaries shared with GPs**

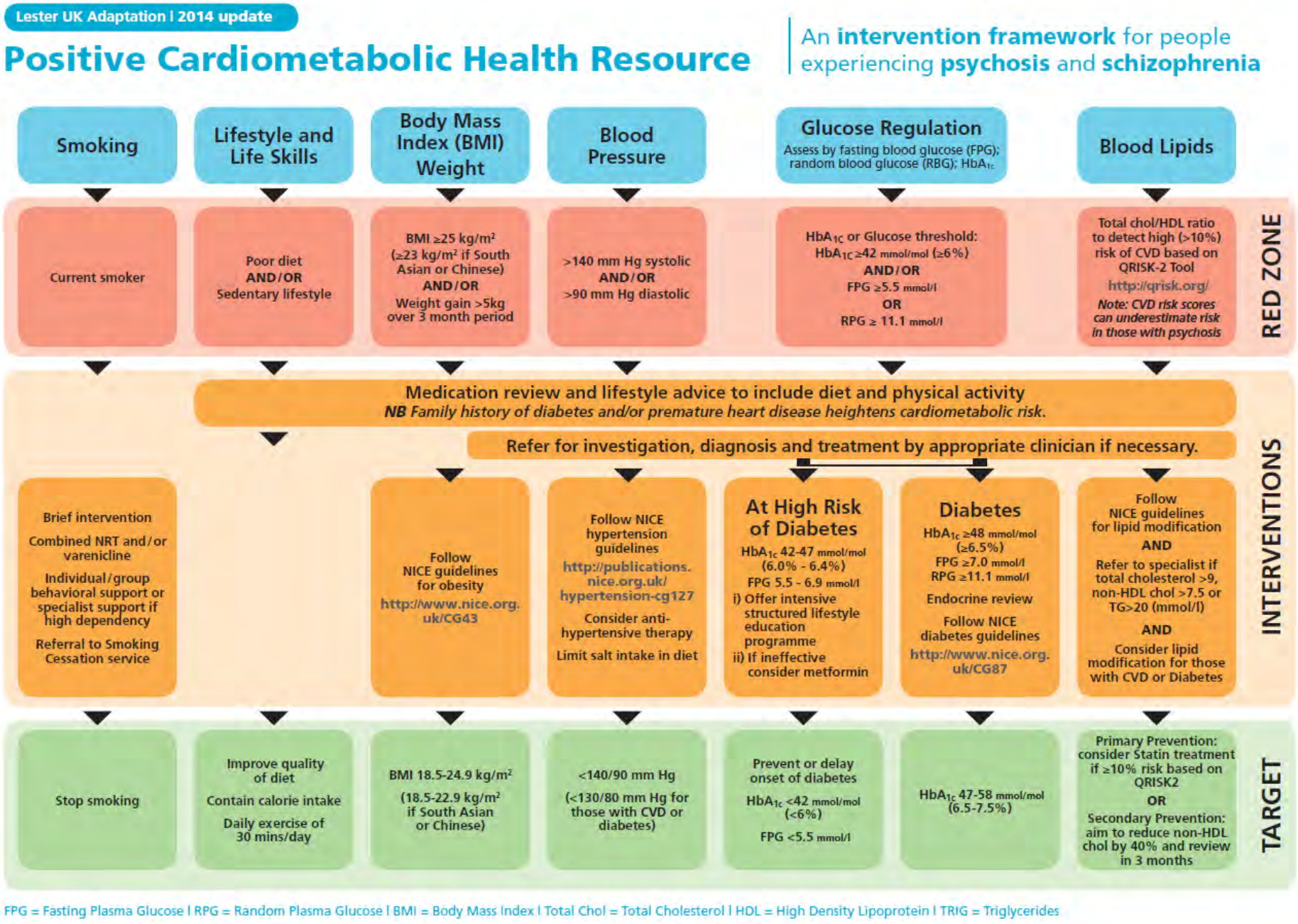
Assessed through an internal audit undertaken by providers

**Weighting: 20%****

In 15/16 EIP settings were brought within scope and for 16/17 Community Mental Health Services (Patients on CPA) were also brought within scope.

**Weighting refers to pay-out ie. each element contributes towards a percentage of potential pay-out for this indicator. This does not take into account milestones that are assessed locally

# The cardio metabolic parameters are based on the Lester tool



# National and South West region averages

The table below shows the average % of patients in each setting who received the full set of checks and follow up interventions in each year of the CQUIN scheme:

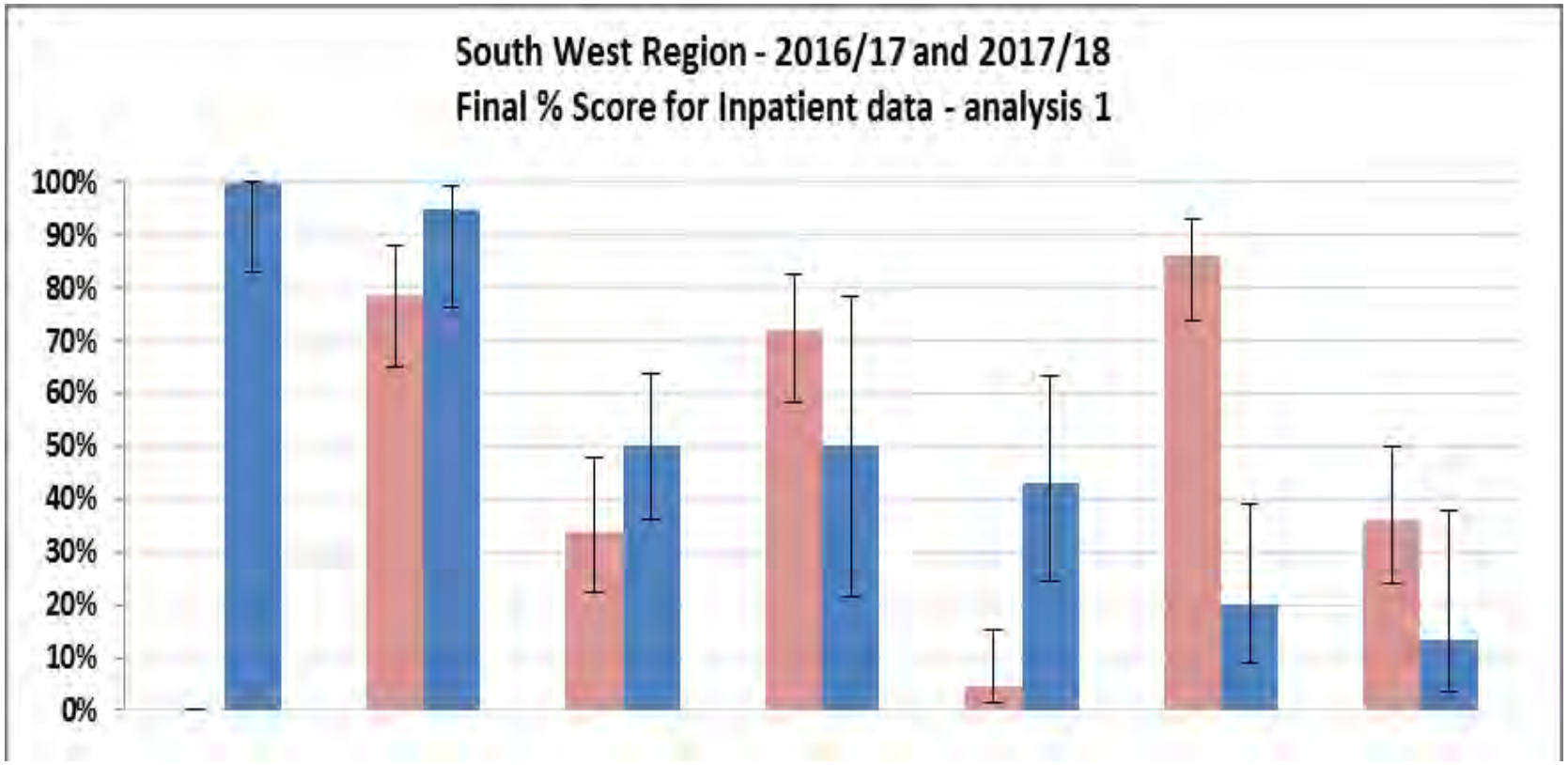
| Year | National inpatient (95% CI) | South West region inpatient | National community (95% CI) | South West region community | National EIP | South West EIP |
|---|---|---|---|---|---|---|
| 2014-15 | **38.70%** (37.5% - 40.0%) | **40.50%** (36.63% - 44.50%) | - | - | - | - |
| 2015-16 | **54.90%** (53.7% - 56.2%) | **52.70%** (48.96% - 56.41%) | - | - | - | - |
| 2016-17 | **59.40%** (57.5% - 61.2%) | **52.76%** (47.01%-58.43%) | **42.40%** (41.0% - 43.7%) | **23.15%** (19.79% - 26.89%) | - | - |
| 2017-18 | **55.70%** (53.3% - 58.1%) | **52.60%** (44.75% - 60.33%) | **43.60%** (42.2% - 45.1%) | **31.08%** (26.82% - 35.69%) | **44.18%** | **34.00%** |

- Since 2014/15, the number of people receiving the full set of physical health checks and follow up care in inpatient mental health settings has increased.
- The rate of increase has slowed since 2016/17.
- 2016/17 was the first year in which the CQUIN scheme covered community mental health teams and nationally we have similar achievement in 2016/17 and 17/18.

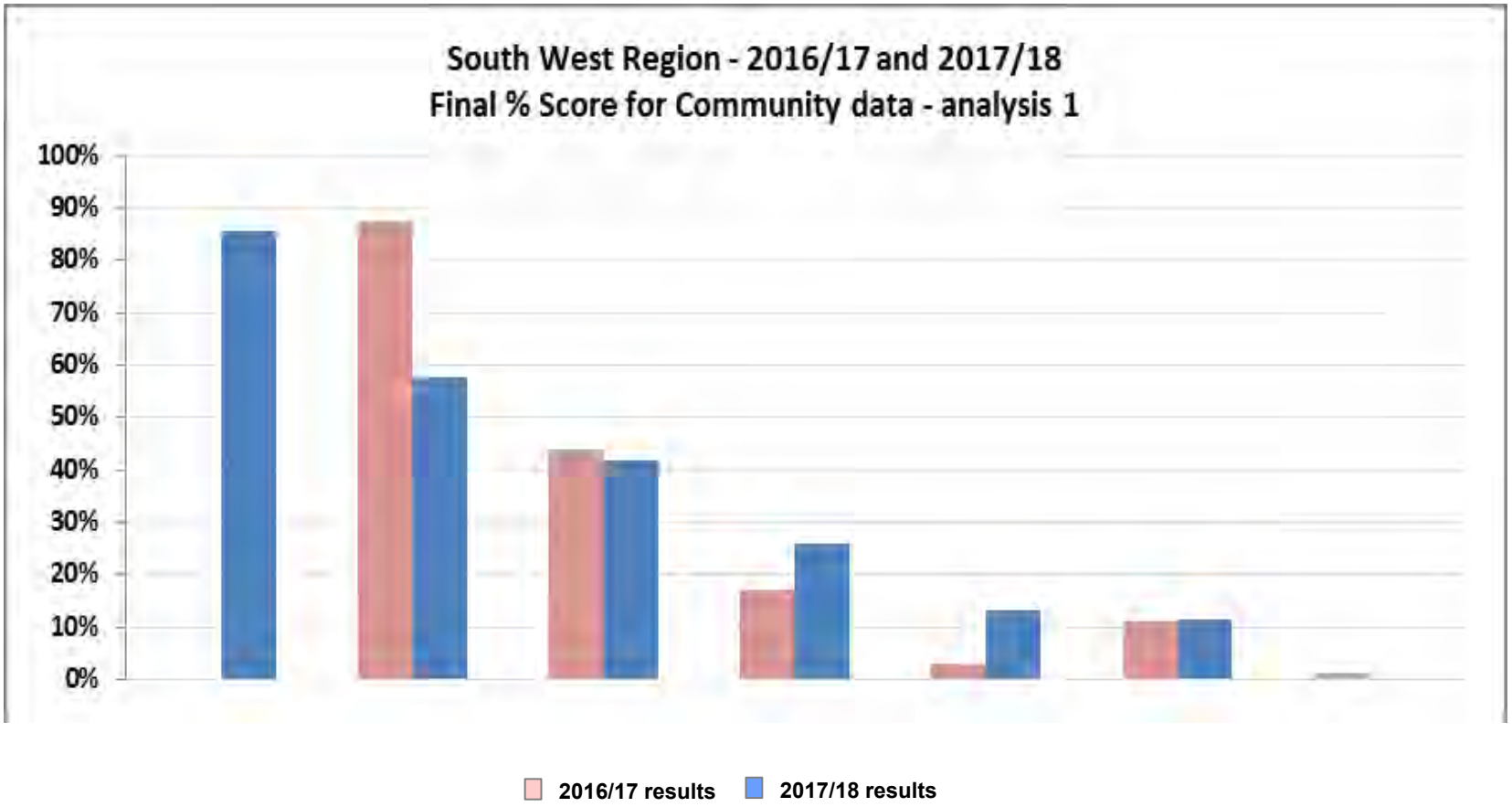
# Inpatient and community compliance by individual measures – South West

| | Q1 Smoking CQUIN compliance | Q2 Alcohol CQUIN compliance | Q3 Substance CQUIN compliance | Q4 Weight CQUIN compliance | Q5 BP CQUIN compliance | Q6 Glucose CQUIN compliance | Q7 Cholesterol CQUIN compliance |
|---|---|---|---|---|---|---|---|
| **Inpatients** | | | | | | | |
| 2017/18 | 85.1% | 92.9% | 90.9% | 75.3% | 84.4% | 71.4% | 76.6% |
| 2016/17 | 80.0% | 88.6% | 85.5% | 79.3% | 86.6% | 76.2% | 73.4% |
| **Community Patients** | | | | | | | |
| 2017/18 | 89.2% | 91.1% | 91.6% | 64.8% | 68.4% | 62.9% | 55.9% |
| 2016/17 | 59.1% | 74.4% | 67.0% | 38.9% | 47.2% | 39.8% | 41.1% |
| **EIP compliance** | | | | | | | |
| 2017/18 | 81.23% | 90.40% | 87.93% | 60.70% | 81.23% | 57.97% | 56.56% |

# Analysis 1 scores by provider in 2016/17 and 2017/18: Inpatient data



# Analysis 1 scores by provider in 2016/17 and 2017/18: Community data



# National and South East region averages

The table below shows the average % of patients in each setting who received the full set of checks and follow up interventions in each year of the CQUIN scheme:

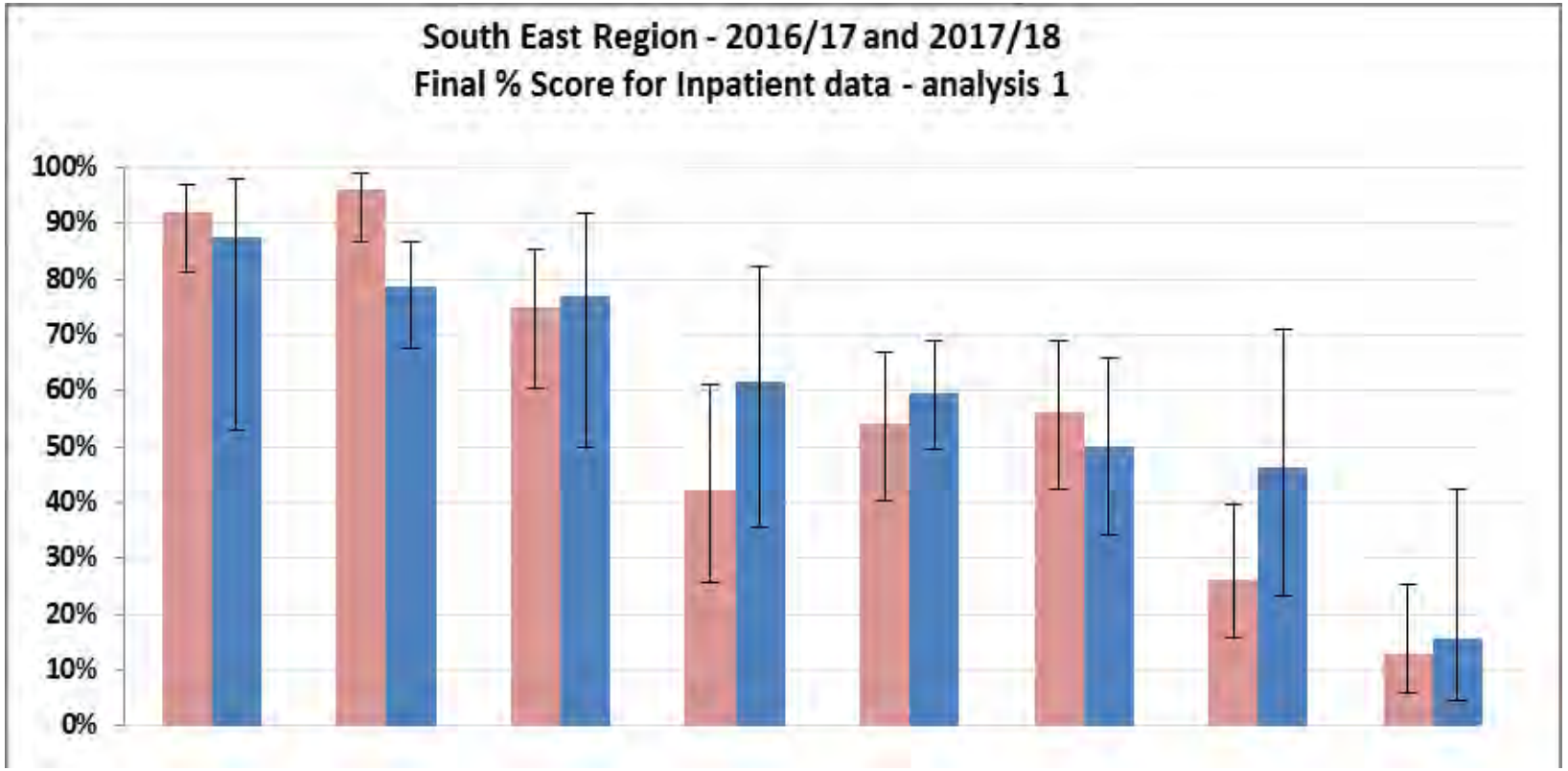
| Year | National inpatient (95% CI) | South East region inpatient | National community (95% CI) | South East region community | National EIP | South East EIP |
|---|---|---|---|---|---|---|
| 2014-15 | **38.70%** (37.5% - 40.0%) | **27.22%** (24.10% - 30.59%) | - | - | - | - |
| 2015-16 | **54.90%** (53.7% - 56.2%) | **43.00%** (38.96% - 46.16%) | - | - | - | - |
| 2016-17 | **59.40%** (57.5% - 61.2%) | **57.77%** (52.66% - 62.71%) | **42.40%** (41.0% - 43.7%) | **46.47%** (42.96% - 50.01%) | - | - |
| 2017-18 | **55.70%** (53.3% - 58.1%) | **62.42%** (56.37% - 68.11%) | **43.60%** (42.2% - 45.1%) | **40.37%** (36.60% - 44.25%) | **44.18%** | **47.68%** |

- Since 2014/15, the number of people receiving the full set of physical health checks and follow up care in inpatient mental health settings has increased.
- The rate of increase has slowed since 2016/17.
- 2016/17 was the first year in which the CQUIN scheme covered community mental health teams and nationally we have similar achievement in 2016/17 and 17/18.

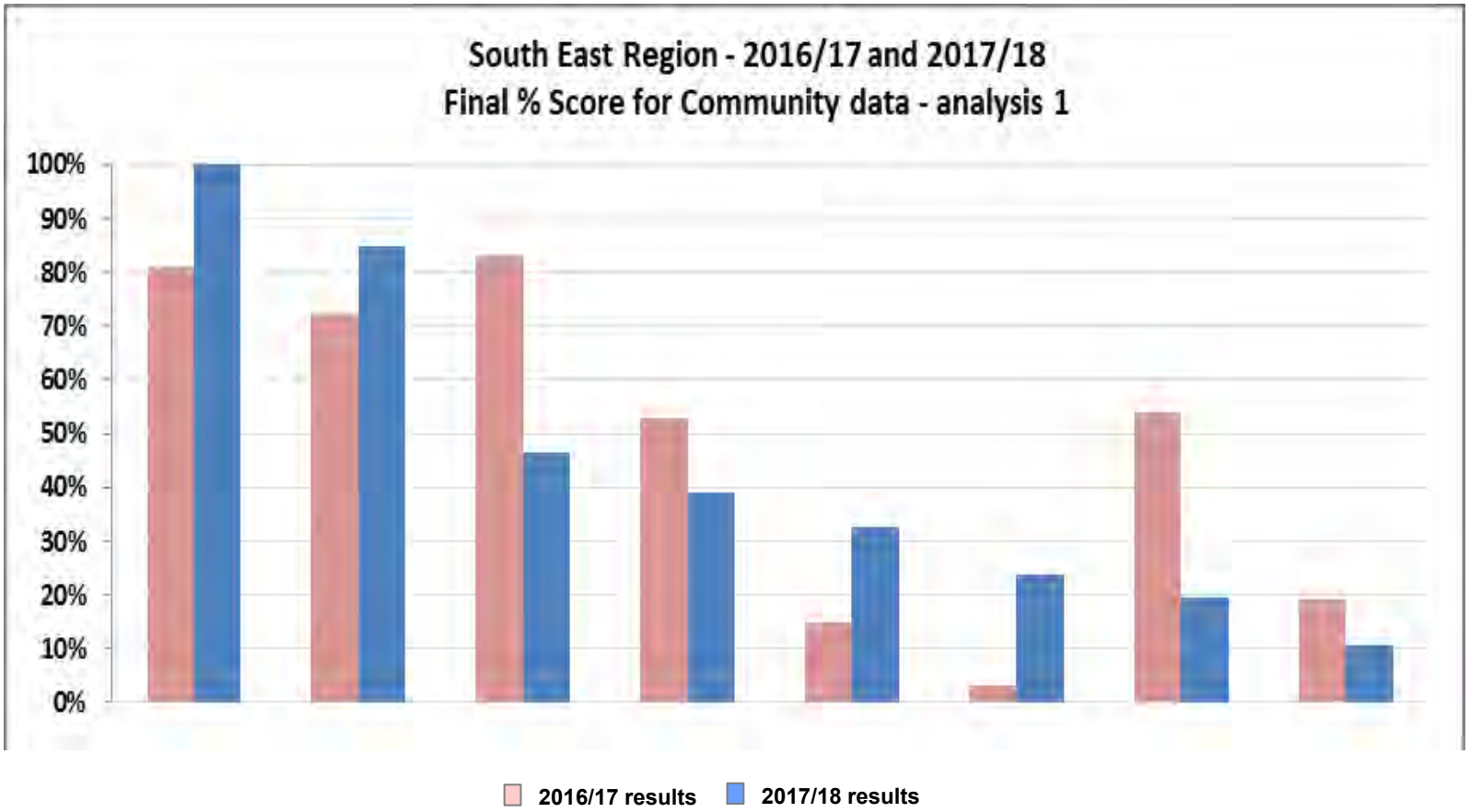
# Inpatient and community compliance by individual measures – South East region

| | Q1 Smoking CQUIN compliance | Q2 Alcohol CQUIN compliance | Q3 Substance CQUIN compliance | Q4 Weight CQUIN compliance | Q5 BP CQUIN compliance | Q6 Glucose CQUIN compliance | Q7 Cholesterol CQUIN compliance |
|---|---|---|---|---|---|---|---|
| **Inpatients** | | | | | | | |
| 2017/18 | 92.7% | 96.3% | 95.1% | 80.0% | 87.8% | 85.7% | 86.1% |
| 2016/17 | 88.3% | 94.8% | 93.5% | 77.7% | 90.5% | 82.3% | 82.3% |
| **Community Patients** | | | | | | | |
| 2017/18 | 91.1% | 91.4% | 89.4% | 78.4% | 76.7% | 66.8% | 62.4% |
| 2016/17 | 78.1% | 86.0% | 81.5% | 65.7% | 70.5% | 66.5% | 66.5% |
| **EIP compliance** | | | | | | | |
| 2017/18 | 89.57% | 93.79% | 89.97% | 70.78% | 89.57% | 67.36% | 70.54% |

# Analysis 1 scores by provider in 2016/17 and 2017/18: Inpatient data



# Analysis 1 scores by provider in 2016/17 and 2017/18: Community data



# …2018/19:

**PH SMI CQUIN continues in 18/19**

**EIP BMI outcome indicator:**

- **35%** or more patients should **gain no more than 7% body weight** in the first year of taking **antipsychotic medication**.

**EIP Smoking cessation outcome indicator;**

- **10%** or more patients who were **previously identified as in the Red Zone for smoking** on the Lester Tool should have **stopped smoking**.

# Primary care guidance: recommended physical health assessments

## A comprehensive cardio-metabolic risk assessment in line with the NHS health check

BMI, blood pressure and pulse, blood lipids including cholesterol, blood glucose, lifestyle including diet and exercise, smoking status (enquiry about presence of cough, wheeze or breathlessness), and alcohol use. Approved risk assessment tools such as the QRISK Tool can be used to assess cardio-metabolic risk. Further details on the comprehensive checks can be found in the relevant NICE guidelines.

## Where indicated, relevant national screening programmes to be delivered or followed up

Cervical and breast cancer screening for women and bowel cancer screening for men and women.

## Medicine reconciliation and monitoring

Ensure medication remains up to date and accurately recorded and is cross checked with all electronic records. Conduct any additional medication monitoring according to the particular Summaries of Product Characteristics (SPC) e.g. Lithium level, U&Es, LFTs, prolactin, ECG if indicated during this review.

## General physical health enquiry

Medical and family history, sexual health including use of contraception, substance misuse assessment (illicit or non-prescribed drug use), oral health assessment and any indicated physical examination.

Proactive engagement and psycho-social support may be required to ensure people with SMI access checks/ interventions and follow-up care including personalised care planning.

Follow-up interventions may include implementation of NICE guidelines for: Smoking cessation, Obesity, Hypertension, Lifestyle intervention, Diabetes, Lipid modification, Drug misuse, Signpost to cancer pathway.

# Responsibility for physical health care

**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:
    - those whose care has always been solely in primary care, and
    - 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 mental health team **for less than 12 months and / or whose condition has not yet stabilised*;**
2. **inpatients.**

* Please expand the notes box below for the FAQ “How do you define ‘stable’?”.

# Commissioning options

1. **Enhanced Service via GP contract**;
2. **Enhanced primary care service** e.g. commissioned from secondary mental health provider.

**Must include**:

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.**

- Funding for improving physical health in SMI in primary care is in CCG baselines.
- To support implementation, ***Refreshing NHS Plans for 2018/19*** reiterates that all CCGs must meet the Mental Health Investment Standard (MHIS), which means that each CCG's investment in mental health in 2018/19 will rise at a faster rate than their overall programme funding.
- **NHS England expects all CCGs to meet the MHIS to ensure the deliverables outlined in the planning guidance are achieved**, which includes ensuring the physical health needs of people with SMI are met through commissioning physical health assessment and follow-up in primary care.

# Delivering physical health checks for people with SMI – the economic case and a service model example

**Organisation and location:** Ipswich & East Suffolk CCG and West Suffolk CCG

**LES costs and service specifications:**

- **Collaboration** between **commissioners**, **primary care**, **secondary care**-based mental health providers and **service users** has led to the development of an 'all-encompassing' solution and service model to facilitate delivery of physical health checks.
- A payment of **£120 per check** is offered to practices **upon completing and reporting 12 elements of physical health checks** utilising the Bradford template.
- Total cost for Ipswich and East Suffolk CCG = **£397,000**;
- Total cost for West Suffolk CCG = **£199,000**;
- Finances from baseline mental health funds as a **recurrent amount**.
- LES is supported by a physical health SMI **Delivery Team**, sitting across the entire Suffolk catchment and consisting of:
  - One Band 8A Advanced Nurse Practitioner (part funded from CCG baseline pot);
  - Two Band 7 nurses (part funded from CCG baseline pot);
  - Seven Band 4 non-clinical staff.
- Physical Health Team will provide **wrap-around support to practices** completing the actual physical health checks through providing **workforce development and education**, and supporting with the engagement and communication of the SMI cohort. The non-clinical roles will be able to **attended the health check with the patient**, as and when necessary.
- The service specification **links to** the **Yorkshire & Humber Academic Health Science Network e-learning training package and the Bradford template** (for details of the Bradford template, please refer to slide 29).

Please double-click the embedded document to access the full specification for the service commissioned under Ipswich & East Suffolk CCG:

# 3. Monitoring the delivery of physical health checks in primary care – SDCS collection

# Supporting delivery in primary care settings

- A regionally led trajectory setting process has been undertaken for delivery in primary care settings

- All regions have provided assurance statements that the 5YFV ambition will be met and CCGs have submitted trajectories

- Delivery against these trajectories will be monitored via the new SDCS data collection

# Mental Health Five Year Forward View Objective

**Mental Health Five Year Forward View goal to 2018/19:**

CCGs are to **offer NICE-recommended screening and access** to physical care interventions to cover **60%** of the population with SMI on the GP register in 2018/19. This is to be delivered **across primary and secondary care**.

Due to different methods of data collection for the primary and secondary care elements of this standard, the two areas will be monitored separately. It is expected that:

- **50%** of people on GP SMI registers in England received a physical health check in a **primary care setting**.
- **10%** of people on GP SMI registers in England received a physical health check in a **secondary care setting**.

Data against the secondary care component of the MHFYFV ambition will be collected in 18/19 via a bespoke CQUIN audit starting in Q3 and reporting in Q1. This information was collected through NCAP in 2017/18.

# Primary care: SDCS collection from end of Q2 18/19

CCGs will be asked to report quarterly, via SDCS, on the delivery of physical health checks for people on the SMI register in primary care.

Across the two parts, the percentage of people receiving health checks will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

## Part 1: The standard measure

**Numerator 1:** the **number of people** on the General Practice SMI registers who have **received a comprehensive physical health assessment** in the 12 months to the end of the reporting period, delivered in a primary care setting.

**Denominator 1:** The **total number of people** on the General Practice SMI registers (on the last day of the reporting period), excluding patients recorded as 'in remission'.

For the purpose of indicator Part 1, a person is counted as having had a comprehensive physical health assessment if they have received all of the component parts listed in Part 2 below.

# Primary care: SDCS collection from end of Q2 18/19

CCGs will be asked to report quarterly, via SDCS, on the delivery of physical health checks for people on the SMI register in primary care.

Across the two parts, the percentage of people receiving health checks will be calculated as:

$$\% = 100 * \frac{Numerator}{Denominator}$$

## Part 2: Supporting measures

**Numerator 2:** the **number of people** who have **received each of the following elements** of the physical health check in the 12 months to the end of the reporting period, delivered in a primary care setting:

1. a measurement of weight (BMI or BMI + Waist circumference)
2. a blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate)
3. a blood lipid including cholesterol test (cholesterol measurement or QRISK measurement)
4. a blood glucose test (blood glucose or HbA1c measurement)
5. an assessment of alcohol consumption
6. an assessment of smoking status

**Denominator 2:** The **total number of people** on the General Practice SMI registers (on the last day of the reporting period) excluding patients recorded as 'in remission'.

# Additional components for local monitoring and development

NHS England commissioning guidance document *Improving physical healthcare for people living with severe mental illness in primary care* emphasises that the following elements must be provided for people with SMI as part of a comprehensive health check, in line with clinical evidence and consensus:

- an assessment of nutritional status, diet and level of physical activity;
- an assessment of use of illicit substance/non prescribed drugs;
- access to relevant national screenings;
- medicines reconciliation and review;
- general physical health enquiry including sexual health and oral health;
- indicated follow-up interventions.

While data on these six additional elements of the health check will not be captured nationally in 2018-19, CCGs are asked to undertake local development work to enable system reporting of all elements of the comprehensive health assessment in future years. Additionally, CCGs should locally record and monitor take-up of NICE recommended interventions (for example 'referral to smoking cessation').

**It is anticipated that from 2019/20 all elements of the physical health check and subsequent intervention data will be collected nationally.**

# 1. A measurement of weight (BMI or BMI + Waist circumference) (1/2)

For this data item, CCGs should report on **EITHER** the number of people who have had a measurement of BMI **OR** the number of people who have had a measurement of BMI plus a measurement of waist circumference.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Measurement of body mass index | 22K.. | 22K..<br><br>Xa7wG<br><br>X76CO | 60621009 Body mass index (observable)<br><br>*Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting:*<br>301331008 Finding of body mass index (finding) |

# 1. A measurement of weight (BMI or BMI + Waist circumference) (2/2)

For this data item, CCGs should report on **EITHER** the number of people who have had a measurement of BMI **OR** the number of people who have had a measurement of BMI plus a measurement of waist circumference.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Measurement of waist circumference | 22N0. | Xa041 | 276361009 Waist circumference (observable) |

# 2. Blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate) (1/3)

For this data item, CCGs should report on the number of people who have had a diastolic blood pressure recording **AND** a systolic blood pressure recording **AND** a measurement of pulse rate.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Diastolic blood pressure reading | 246A. | 246A. | 1091811000000102 Diastolic arterial pressure (observable)<br><br>*Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting: 163031004 On examination - Diastolic blood pressure reading (finding)* |

# 2. Blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate) (2/3)

For this data item, CCGs should report on the number of people who have had a diastolic blood pressure recording **AND** a systolic blood pressure recording **AND** a measurement of pulse rate.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Systolic blood pressure reading | 2469. | 2469. | 72313002 Systolic arterial pressure (observable)<br><br>*Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting: 163030003 On examination - Systolic blood pressure reading (finding)* |

# 2. Blood pressure and pulse check (diastolic and systolic blood pressure recording + pulse rate) (3/3)

For this data item, CCGs should report on the number of people who have had a diastolic blood pressure recording **AND** a systolic blood pressure recording **AND** a measurement of pulse rate.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Pulse rate | 242..<br><br>242Z. | 242..<br><br>X773s<br><br>XaIBo | 78564009 Heart rate measured at systemic artery (observable entity)<br><br>8499008 Pulse, function (observable entity)<br><br>*Observable codes should be used for SNOMED enabled systems. Due to current mapping processes, CCGs may also wish to include the relevant finding code for reporting:* 162986007 *On examination - pulse rate (finding)* |

# 3. A blood lipid including cholesterol test (cholesterol measurement or QRISK measurement) (1/2)

For this data item, CCGs should report on the number of people who have either had a cholesterol level recording **OR** have had a QRISK measurement recorded.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT) | SNOMED CT code |
|---|---|---|---|
| Cholesterol measurement | Refer to cholesterol QoF cluster for reporting.<br><br>Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'. | | |

# 3. A blood lipid including cholesterol test (cholesterol measurement or QRISK measurement) (2/2)

For this data item, CCGs should report on the number of people who have either had a cholesterol level recording **OR** have had a QRISK measurement recorded.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT | SNOMED CT code |
|---|---|---|---|
| QRISK measurement | 22W..<br><br>38DP.<br><br>8IEL.<br><br>8IEV.<br><br>9NSB. | XaYZR<br><br>XaQVY<br><br>XaYzy<br><br>XaZdA<br><br>XaZd8 | 810931000000108<br>QRISK2 calculated heart age (observable entity)<br><br>718087004<br>QRISK2 cardiovascular disease 10 year risk score (observable entity)<br><br>822541000000103<br>QRISK cardiovascular disease risk assessment declined (situation)<br><br>847241000000100<br>QRISK2 cardiovascular disease risk assessment declined (situation)<br><br>847201000000103<br>Unsuitable for QRISK2 cardiovascular disease risk assessment (finding) |

# 4. A blood glucose test (blood glucose or HbA1c measurement) (1/2)

For this data item, CCGs should report on the number of people who have had any of the following blood glucose measurement recordings OR HbA1c measurement.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT | SNOMED CT code |
|---|---|---|---|
| Blood glucose measurement | 44g..<br>44TA.<br>44g1.<br>44TJ.<br>44U..<br>44f..<br>44f1.<br>44T2.<br>44TK.<br>44Q.. | XM0ly<br>44g1.<br>X772z<br>44f..<br>44f1.<br>XE2mq<br>XE2q9 | 1010671000000102<br>Plasma glucose level (observable entity)<br>1003141000000105<br>Plasma fasting glucose level (observable entity)<br>997671000000106<br>Blood glucose level (observable entity)<br>1010611000000107<br>Serum glucose level (observable entity)<br>1003131000000101<br>Serum fasting glucose level (observable entity)<br>997681000000108<br>Fasting blood glucose level (observable entity)<br>1005691000000109<br>Serum triglycerides level (observable entity) |

# 4. A blood glucose test (blood glucose or HbA1c measurement) (2/2)

For this data item, CCGs should report on the number of people who have had any of the following blood glucose measurement recordings OR HbA1c measurement.

| | READ V2 code (provided to support transition to SNOMED CT) | CTv3 code (provided to support transition to SNOMED CT | SNOMED CT code |
|---|---|---|---|
| HbA1c measurement | 42W..<br><br>42WZ.<br><br>42W4.<br><br>42W5. | 42WZ.<br><br>XE24t<br><br>XaERp<br><br>XaPbt | 269823000<br>Haemoglobin A1C - diabetic control interpretation (observable entity)<br><br>1019431000000105<br>Haemoglobin A1c level (Diabetes Control and Complications Trial aligned) (observable entity)<br><br>999791000000106<br>Haemoglobin A1c level - International Federation of Clinical Chemistry and Laboratory Medicine standardised (observable entity) |

# 5. An assessment of alcohol consumption

For this data item, CCGs should report on the number of people who have had an alcohol consumption recording.

| | Information on codes |
|---|---|
| Alcohol consumption assessment | Run alcohol consumption QoF cluster for reporting.<br><br>*Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'.* |

# 6. An assessment of smoking status

For this data item, CCGs should report on the number of people who have had a smoking assessment recording. Please run smoker/ex-smoker/current smoker/smoking habit/never smoked QoF clusters for reporting.

| | Information on codes |
|---|---|
| Smoking status assessment | Run smoker/ex-smoker/current smoker/smoking habit/never smoked QoF clusters for reporting.<br><br>*Visit the NHS Digital website and click on 'Download the QOF V39 draft expanded cluster list for publication'.* |

# Further information to note

**As per QoF Guidance, the SMI register includes all patients with a diagnosis of:**

- schizophrenia;
- bipolar affective disorder;
- other psychoses and;
- other patients on lithium therapy.

QoF Guidance documents contain detail on when clinicians should consider **excluding patients** from the SMI register because their illness is **in remission**.

**A person who has received all elements** of the physical health check would be **reported in all of the individual numerators**.

It is recognised that people will have been on the GP SMI register for **different durations** and that some people may have had **limited opportunity to be offered physical health checks** in primary care; this is considered an acceptable limitation of the data collection.

# Primary care: SDCS collection from end of Q2 18/19

The data collection window and publication dates are set out below will be published by NHS Digital on the SDCS collection webpage:

| Data period | Collection opens | Submission deadline | Publication |
|---|---|---|---|
| Q2 2018/19 | 2018-10-01 | 2018-10-31 | n/a |
| Q3 2018/19 | 2019-01-02 | 2019-01-18 | 2019-02-14* |
| Q4 2018/19 | 2019-04-01 | 2019-04-17 | 2019-05-09* |

# 4. Enablers and positive practice examples for successful delivery

# Factors for successful implementation

- ✓ CCG baseline **funding** invested in primary care delivery.
- ✓ **Leadership**: regional clinical network, CCG board level leadership, named GP MH lead.
- ✓ Ongoing **workforce development** plans including practice nurses and community pharmacists

*"82% [of practice nurses] 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".*

- ✓ **Experts by experience** embedded in the **design** and **evaluation** of services.
- ✓ **Peer support** approaches used to support behaviour change.
- ✓ **Data** used to drive service improvement at a local and regional level.
- ✓ **Digital technology**:
  - Interoperability between primary and secondary care;
  - Standard assessment template such as Bradford template;
  - Easy to access information on local services and easy to refer;
  - Electronic health records enable easy recording of assessments and sharing of care plans.
- ✓ **Joint working**:
  - ✓ Between primary and secondary care with clear shared care protocols;
  - ✓ With third sector organisations.

# Case study: the Primrose intervention

The **Primrose programme** provides the latest evidence on CVD risk reduction and management in people with SMI. Running between May 2014 and February 2017, 376 people on the QOF SMI register participated in the trial across 76 GP practices.

**The Primose intervention** was developed based on published research around CVD risk management and positive-practice.

The intervention relies on **behaviour change theory**, with behaviour change strategies including:

- setting of **behavioural goals** via support from others (e.g. adhering to statins, improving diet, increasing physical activity, reducing alcohol, quitting smoking);
- creating an **action plan**, including via signposting;
- recording and **reviewing progress**, and providing positive **feedback**;
- learning to **cope with setbacks**;
- facilitating the **forming of habits**.

A two-day training package and manual developed for general practice nurses and health care assistants facilitated the delivery of the Primrose intervention to service users with SMI.

The full Primrose trial publication and a detailed description of the results are available under:
https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(18)30007-5/fulltext

For further details on the programme, please refer to the Primrose website.

# Case study: the Primrose intervention – findings

**Barriers to cardiovascular risk interventions**:

- Negative perceptions held by healthcare staff towards reducing CVD risk in SMI;
- Challenges faced by service users in accessing GP and community-based services;
- Reported difficulties in managing a healthy lifestyle;
- Missed appointments and follow-up;
- Lack of awareness across healthcare staff for increased CVD risk in SMI ("diagnostic over-shadowing").

**Facilitators for cardiovascular risk interventions**:

- Availability of peer support;
- Improved patient engagement with services;
- Continuity of care;
- Monitoring of results via positive feedback and partnership in setting of achievable goals.

**Outcomes**:

- High attendance rates and confident nurses.
- Delivery of both the Primrose intervention and treatment as usual resulted in reductions in mean cholesterol levels over 12 months (primary end point), highlighting the importance of equipping the primary care workforce with the skills and competencies required for the provision of routine CVD screening and follow-up care for people with SMI.
- Further focus needed on the statin initiation and adherence reviews (evidence based for statins provided by team).
- Delivery of the Primrose intervention was associated with fewer inpatient admissions, leading to potential cost-savings.

# Case study: Get Set to Go


**Mind, Loughborough University, and the University of Northampton, with the support of Sport England and the National Lottery**.

- 269 sports taster sessions and 3,242 weekly sports sessions delivered via a **mixed approach** between local Mind representatives, volunteers and community sports partners across 8 locations.
- Developed the **'Elefriends' online peer-support community**, with motivating animations, 'being active'-themed pages and searchable interest forums (i.e. 'running' or 'cycling').

**Rationale**:

- 70% of participants told Mind that **psychological barriers**, such as low self-esteem and low body confidence made it more difficult for them to become physically active. Out of the 725 participants (aged 18-80 years), 28% reported they did not take part in any form of sport or physical activity and 22% reported they did not engage in 30 minutes of moderate physical activity in the week preceding the 'Get Set to Go' programme launch.

**Outcomes**:

- **Increased number of days participants engaged in 30 minutes of physical activity** by 1.3 days a week at 12 months, with increased engagement in vigorous (from M = 1.15 at baseline to M = 2.38 at 6 month follow-up) and moderate (from M = 1.523 at baseline to M = 3.3 at 6 month follow-up) intensity activities, as recorded using the International Physical Activity Questionnaire.
- Participants reported a **perceived decrease in barriers to physical activity** and an increase in feelings of wellbeing and coping.
- The programme **helped 3,585 people become physically active**, with the 'Elefriends' platform providing online support to 8,219 people.
- 224 volunteer "Peer Navigators" with **lived experience** were recruited and trained to co-produce and facilitate programme delivery.

**Recommendations**:

- Ensure **peer support** forms parts of a comprehensive physical healthcare offer.
- Work with Mental health **charities and sports facilities** to introduce into sports setting.

For further details, please refer to https://www.mind.org.uk/GSTGResults

# Case study: North East London Local Pharmaceutical Committee and NELFT

**The project**:

- **Community pharmacist** delivered physical health assessment on-site, in line with Lester tool, with medicines review.
- Completed health and wellbeing plan using **health coaching techniques** to enable **behavioural change**.
- Booked **follow-up** to review progress against plan.
- Where necessary, community pharmacist **facilitated GP referrals**, feeding assessment results back.
- Improved access to physical health assessment through strong **links to local community**.
- 180 individuals offered check, 140 attended (40% of total population eligible population in Barking and Dagenham).

**Critical success factors**:

- **Enthusiastic** and dedicated community pharmacists.
- **Liaison officer** working between Trust and Committee.
- **Training** programme for pharmacists.
- Written and verbal i**nformation** for patients.

Please refer to the NELFT website for further information on this collaborative project. A webinar presentation entitled '*Physical health checks for people with psychosis webinar (Wednesday 28 February)'* is available on the NHS Health Check website.

# Case Study: Mental Health Enhanced Primary Care Service (EPC)

**The EPC** (ELFT, City and Hackney CCG, Tower Hamlets CCG, Newham CCG)

- Multi-disciplinary step-down service involving GPs, liaison workers, psychiatrists and service users, ensuring that the physical and mental health needs of stable secondary care patients are met as they step down into primary care.
- The EPC service in Tower Hamlets sees a caseload of 700 people, with 90% of patients stepping down from secondary care (630 people) and with 10% of service users (70 people) stepping up from primary care. The EPC supports 600 step-downs per year across City and Hackney
- Provided by ELFT, the EPC facilitates locality consultants and EPC nurses to meet with GP practices to review and discuss concerns with regards to patient care, as and when necessary
- A recovery care plan assists service users in transitioning from the more secondary care-type approach of the EPC to GMS-style primary care, with peer support worker driving completion of the recovery plan.
- Healthcare assistant completes PH check focusing on BMI, smoking status, QRISK and alcohol and non-prescribed drug use (with GP oversight).
- Record keeping is facilitated through EMIS web.
- The commissioning guidance supporting annex includes a comprehensive case study on the EPC implemented across ELFT.

# SHAPE: exercise and lifestyle programme for young people – intervention

**Organisation:** Worcester Health and Care NHS Foundation Trust

**What does the "SHAPE" programme offer:**

- 12 week programme;
- A physical health "MOT" to assess **general wellbeing** and physical health and **set goals** to improve these;
- Weekly monitoring of fitness, weight and goals and a **repeat physical health review** at 3 and 12 months;
- **Group support** and exercise sessions trying out circuit and weight training, aerobics, cross-training, badminton, basketball, walking, yoga, tai chi and pilates;
- Nutrition and diet advice to introduce **healthy eating**;
- **Smoking cessation** advice and **drug and alcohol advice**;
- **Mindfulness** and relaxation training.

For further information, please refer to the SHAPE website under:
http://www.hacw.nhs.uk/our-services/mental-health/early-intervention-service/shape/

# Next steps for local areas

- Refer to the useful resources pack for examples of primary care services delivering physical health checks to people on the GP SMI register and share best practice examples
- Review 2017/18 CQUIN performance and put in place improvement plans and plans for sustaining improvements beyond 2018/19 when the CQUIN will no longer be in place;
- Continue to bring together local primary and secondary care leads in your STP to improve joint working as a priority for making further improvements in this area, in line with the NHS England primary care commissioning guidance;
- Look out for learning from the NHSI Quality Improvement Collaborative;
- Continue to access regional clinical network workshops and support;
- Consider joining Equally Well UK