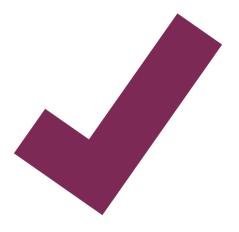# Improving physical healthcare for people living with severe mental illness (SMI) in primary care

Guidance for CCGs: Supporting Annexes

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

Supporting Annexes to guidance for CCGs

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Contents

Introduction

This document supports the publication *Improving physical healthcare for people living with severe mental illness (SMI) in primary care: Guidance for CCGs* and provides further detail in a series of Annexes.

Annex A: Case studies

Appreciating the diverse range of population needs and the different commissioning arrangements and service configurations in place, this guidance does not recommend one single commissioning and delivery model to suit all CCGs. Instead, below are the following case studies, signposting good practice from across the country.

Case study 1: **Mental Health Enhanced Primary Care Service** in East London/City and Hackney. The service has sought to improve the transition for people with SMI who are leaving secondary care services.

Case study 2: **Bradford standardised physical health template** has sought to ensure consistency in the delivery of physical health assessments.

Case study 3: **Get Set to Go** UK-wide sport and exercise activities provided by Mind to address the lack of physical exercise schemes and peer support.

Case study 4: **Southwark and Lambeth Local Care Record** to improve access to patient electronic records across primary and secondary care.

Case study 5: **Care Information Exchange** to enable patients to securely access their medical records, helping people feel more in control of their healthcare.

Case study 1: Mental Health Enhanced Primary Care Service
Organisation: City and Hackney CCG, East London NHS Foundation Trust (ELFT)
Location: East London
Model: An enhanced primary care service (EPC)
Aim: To ensure that stable secondary care patients are provided with the support they require, including the support needed to meet their physical health needs, as they step down into primary care. This is a multi-disciplinary offer, delivered by psychiatrists, GPs, liaison workers, in partnership with the person using the service.
Rationale: Patients with SMI can benefit from a step-down approach that facilitates transition into primary care, while catering both for mental health and physical health needs. CCGs are responsible for ensuring treatment is offered in a normalised setting close to home, integrating mental health and physical health treatments, as part of a whole person approach.
Solution: • Contract between City and Hackney GP Confederation, ELFT and City and Hackney CCG to set up an enhanced primary care service (EPC). • On admission to EPC, the healthcare assistant completes a physical health check package, focusing on BMI, smoking, QRISK and alcohol and non-prescribed drug use. This is overseen by the GP. • Lifestyle guidance, health education literature, or referral to appropriate lifestyle services offered upon the pre-admission physical health check. • Patients are encouraged to achieve their own recovery goals through joint planning of a Recovery Care Plan with a GP and a liaison worker. • GP to complete a meeting to review progress against the Recovery Care Plan 1 year after EPC admission. • GPs to meet quarterly with lead consultant psychiatrist to discuss EPC patients and any mental health patients of concern. • Record keeping facilitated by EMIS web, with GP Confederation and CCG monitoring data transfer, accuracy and quality.
Outcomes: • Improved service outcomes and user experience. • Between Nov ember 2012 and March 2016, a total of 1261 patients received EPC service. • Within the 2015-2016 EPC caseload, 37% of patients were identified as current smokers. • Within the 2015-2016 caseload, 333 patients exceeded the at-high-risk BMI, QRisk, drug and alcohol use or smoker threshold. 65% of these high-risk patients were offered lifestyle intervention as part of the EPC service, with 89% also accepting the intervention. • Discharge from EPC after one year is considered a patient achievement and is the main goal in the Recovery Care Plan, with readiness for discharge jointly monitored by the liaison worker and the GP.

Recommendations to others:
- CCGs in other regions could consider commissioning the development of similar enhanced primary care services for people with SMI.
- Be explicit about which physical health outcomes are to be monitored and ensure evaluation methods are in place to capture these.
- Provide a named liaison worker for each EPC patient.
- Link psychiatrists to practices to offer GPs advice on EPC patients
- Promote recovery planning, accurate EPC record-keeping, as well as medicines and risk management.
- Provide peer support as part of the offer within primary care

Contact: Dr Rhiannon England, rhiannon.england@nhs.net

Case study 2: Living longer lives: Bradford standardised physical health template
Organisation: Bradford District Care NHS Trust
Location: Bradford and Airedale
Model: A [standardised template](#) [1] to ensure consistency in physical health checks
Aim: To design and implement a new physical health template with associated training, driving interoperability between the primary and secondary care to provide good physical healthcare for patients with SMI.
Rationale: Following a clinical audit in some of the local general practices, the physical healthcare of people living with SMI was identified as not being consistently monitored. Two thirds of patients with SMI were not receiving the annual physical health check recommended by NICE. Records from physical health checks were found to be incomplete.

Solution:

- Assembled working group (GP mental health lead, consultant psychiatrist, data quality specialist, lead pharmacist, mental health project lead) to develop the template and implementation plan for the template and the approach.
- Developed a short, consistent electronic physical health template to prompt clinicians to undertake all the NICE recommended elements of a physical health check.
- Ensured compatibility with a range of databases. Delivered first through SystmOne for primary care and RIO for secondary care, later translated for EMIS Web.
- Developed framework of training across primary and secondary care to support implementation.
- Promoted annual physical health check for patients in primary care via educational and training events aimed at GPs, practice nurses and managers, supporting practices to load the template onto the system. A local incentive scheme helped to increase use of the template.
- The physical health template guides GPs in collecting relevant clinical information relating to physical morbidity and health risks, without the need to learn detailed Quality and Outcomes Framework (QoF) requirements. This therefore helps GPs submit QoF data returns, with the prospect of individual practices driving the provision of quality care, and the potential for Federations or Super Practices to centralise QoF going forward.
- CCGs can run quarterly reports, reviewing implementation across primary care.

Outcomes:

- The template has been rolled out to 80 GP practices in Bradford and Airedale
- Outcomes are monitored centrally and anonymously, with feedback provided to practices to drive performance improvement
- Within a 12-month period, from July 2012, 335 template-based physical health reviews were carried out, amounting to an additional 20.5% of patients receiving a physical health review.
- The template QRisk®2 score of 20).
- QRisk®2 scores greater than 20% (i.e. indicating a high risk of fatal cardiovascular event within 10 years) were identified in 3.9% of template-based physical health reviews over the 12-month period, compared to 1.5% in non-template physical health reviews. This suggests an increase in timely detection of CVD risks and an overall improvement in the delivery of physical health assessments.
- The demand to share, promote and review the impact of the template remains high in national events and conferences, with the EMIS version of the template used over 1,033 times by 151 customers across 73 CCGs between September 2016 and February 2017.

Recommendations to others:
- Ensure training is available on the template, for practice nurses – see Annex C.
- Maximise the role of GPs in championing and leading engagement.
- Ensure a clear, agreed shared care protocol with clarity on who is responsible for what in follow-up of test results.
- Ensure appropriate sharing of information to reduce risk of overlap and duplication.

Contact: Kate Dale, Kate.Dale@bdct.nhs.uk
To view SystmOne screenshots: www.tpp-uk.com/mhpr [1].
The template was produced by Bradford District Care Foundation Trust in collaboration with Bradford CCG.

Case study 3: Get Set to Go: Role of peer support
Get Set to Go 2014-2017
Organisation: Mind (National Association for Mental Health), Loughborough University, and the University of Northampton, with the support of Sport England and the National Lottery.
Location: UK-wide: a federated network of independent local Minds.
Model: Local Get Set to Go delivery model including peer support navigators, supported by the 'Elefriends' online peer-support community and information resources.
Aim: To understand the relationship between sport and mental health recovery, the effectiveness of peer navigator model in encouraging sustained sports participation, and the impact of online peer support for people with mental ill health on engagement in physical activity.
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) that completed the baseline-setting local delivery Mind Monitoring Data and Programme Evaluation Form, 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.
Solution: • 269 sports taster sessions and 3,242 weekly sports sessions delivered via a mixed approach between local Mind representations, volunteers and community sports partners across 8 locations. • To record levels of physical activity and establish a baseline at the programme start, participants answered Sport England's single-item measure question of whether or not they have engaged in 30 minutes of physical activity in the past week, alongside the International Physical Activity Questionnaire (IPAQ) for vigorous and moderate activities, with follow-up performance monitoring after 3, 6 and 12 months. • 224 volunteer peer sports navigators (PSNs) were trained, with first-hand experience with mental health problems to help participants stay physically active via one-to-one and group support. • The 'Elefriends' online peer-support community was developed, with motivating animations, 'being active'-themed pages and searchable interest forums (i.e. 'running' or 'cycling'). • The '*Mental Health Awareness for Sport and Physical Activity*' training was delivered (3 hour Continuing Professional Development course) to 325 coaches and leaders.
Outcomes: **Outcome data provided is based on the end of programme evaluation published in November 2017 [2].** • On average, participants increased the number of days they engaged in 30 minutes of physical activity by 1.3 days a week. As measured with Sport England's single-item measure question. • Participants reported a perceived decrease in barriers to physical activity and an increase in feelings of wellbeing and coping. • Participants became increasingly keen to access group-based as opposed to one-to-one peer support. • Qualitative data showed that participants saw 'Get Set to Go' as an important first step in their recovery process.

Recommendations to others:
- The evaluation report identifies a number of key active ingredients and recommendations for future programmes including the role of peer support, the need for co-design, and the need for sport and mental health sectors to work together to provide supportive, inclusive physical activity sessions.
- CCGs should consider how peer support forms parts of a comprehensive physical healthcare offer and ensure the availability of peer support in sports settings. This can be achieved through joint working between mental health services and sports providers to share learning, training and resources.

Contact: Hayley Jarvis, h.jarvis@mind.org.uk or visit mind.org.uk/GSTGResults [3].

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Case study 4: Collaborative and integrated Local Care Record (LCR)
Organisation: Lambeth and Southwark Partnership including: Southwark and Lambeth CCG, South London and Maudsley (SLaM), King's College Hospital (KCH), Guy's and St Thomas' NHS Foundation Trusts (GSTT) and community services.
Location: Southwark and Lambeth
Model: Joining up electronic patient records across the primary and secondary care interface.
Aim: To join up patients' physical and mental health records across acute, community and primary care, to provide real-time electronic access to shared service user records for professional and clinical staff at the point of care and to facilitate service delivery.
Rationale: A referral letter is often the only source of patient information available to a particular treatment team. Such a letter would not normally hold the results of all previous investigations undertaken, forcing GPs to contact secondary care for additional details and clarification. Similarly, secondary care and emergency departments will not always have a full picture of patient medications prescribed by the GP, or any noted allergies, while community teams may unnecessarily duplicate investigations. Data showed that 47% of SLaM patients also had records at GSTT, while 43% of patients had records at KCH, highlighting disjointed health pathways.

Solution:
- Developed and successfully rolled out the LCR electronic, real-time clinical portal
- The LCR joins all participating providers, including 86 GP practices in Southwark and Lambeth (and 40 now in Bromley), with shared service user records obtained from within respective electronic health record systems.
- Directly involved and consulted patients, carers, staff and Southwark and Lambeth Citizens Fora in development discussions, obtaining feedback on the development and use of the LCR.
- Shared records include clinical notes, investigations, X-rays, scans and appointment information.
- Clinical notes from SLAM are accessible to all participating organisations at the point of care without additional logins, while visits details, results and essential documents are visible to acute hospitals and letters, medications and results are visible to primary care providers.
- Regularly review utilisation data to understand what data is used, how, where, when and by which teams.
- Over 3 months, 960 primary care users began relying on the portal, viewing 477 unique integrated patient records per day; this has since grown substantially.

Outcomes:
- Increased appreciation of dual mental health – physical health needs, as reported by users.
- Reduction in unnecessary duplication of investigations/assessments in community teams.
- Improved communications between GPs and acute mental health and community teams.
- Reduced unnecessary phone calls from GPs to hospitals by up to 75%, improving the quality and speed of decision-making.
- Reduced numbers of repeat appointments and out-of-date administrative processes.

Recommendations to others:
- Ensure buy-in and agreement to an overarching Information Sharing Agreement between all parties.

- Establish close cross-institutional working relationships to develop a system of trust and engaged stakeholders.
- Encourage strong Project Board-level support and ownership from every stakeholder organisation and from citizens.

Put in place a dedicated team clinical and professional staff, information governance leads and communication professionals, with robust delivery and change management support for frontline staff.

Contact: Dean Holliday, dean.holliday@nhs.net and Nancy Kuchemann, nancy.kuchemann@nhs.net

Case study 5: Care Information Exchange; Patient involvement
Organisation: The Imperial College Healthcare Charity
Location: North West London
Model: Care Information Exchange: A secure online platform to access and share medical records
Aim: To eliminate unnecessary tests, reduce the need for redundant routine appointments, facilitate information flow and improve integrated health and social care across North West London.
Rationale: The Imperial College Healthcare Charity has funded the development and launch of the Care Information Exchange. An online platform providing secure online access to medical records, the Care Information Exchange empowers patients to feel more in control of their health.

Solution:
- Patients can establish personalised privacy settings, defining what health records they would like to make visible to which speciality team (for example renal or rheumatology team), carers and relatives; these settings can be overridden in life-threatening emergency situations.
- Patients and their health and care professionals can develop a library of health and wellbeing resources, linking online leaflets, audio and video files to their Care Information Exchange profile.
- Home healthcare devices, including blood pressure and glucose monitors, or Fitbit trackers can sync with the Care Information Exchange.
- Patients can record their thoughts and observations about their health, keeping their own up-to-date 'health journal'.
- Care plans, including medication requirements are accessible from the patient's Care Information Exchange account.
- Test results can be saved on patient profiles (for hospitals and general practices with a secure IT link to the Care Information Exchange).
- Patient appointments can be updated and tracked automatically on the platform (in the case of Care Information Exchange-enabled hospitals or general practices), or can be entered and logged manually.
- The Care Information Exchange system offers messaging and video conferencing features, improving communication between patients, carers and healthcare professionals.

Scope:
Patient information is encrypted and hosted within the NHS network. The type and nature of medical records shared on the Care Information Exchange varies between organisations. The current scope and list of patient information is:

Chelsea and Westminster Hospital NHS Foundation Trust	- Blood test and radiology results
Hillingdon Hospitals NHS Foundation Trust	- Outpatient appointments - Inpatient attendances
Imperial College Healthcare NHS Trust	- Outpatient appointments* - Inpatient attendances - Blood test and radiology results - Patient education material

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	(* Excludes chemotherapy, community and radiology appointments)
London North West Healthcare NHS Trust	• Blood test and radiology results • Patient education material
Central and North West London NHS Foundation Trust	• Patient education material

Contact: Stephen Janering, stephen.janering@nhs.net

Annex B: Checklist for CCGs and providers

The checklist below details a number of specific tasks, for both commissioners and providers, that can help localities achieve the recommended physical healthcare offer outlined in this guidance. This is not a mandatory list but a menu of activities and considerations that can guide CCGs in delivering good quality physical healthcare provision across primary care. It highlights key areas for development and suggested tasks that can drive local improvement alongside supportive resources and tools.

Commissioning headline	Example activities for Commissioners	Example activities for Providers	Resources
Use local data to understand the health needs of the local SMI population and existing inequalities.	Map existing provision for people with SMI using local data. Assess existing assets including coverage, quality, effectiveness and cost of current services.	Align practice mental illness registers (SMI register and CPA register) and ensure up to date.	Refer to PHE's online fingertips tool to explore local data [4]. Review data in STP data packs, "making the case for integrating mental and physical healthcare" from Mids & Lancs CSU [5]. Review local Joint Strategic Needs Assessments to view data regarding prevalence, risk, prevention, early detection, assessment, outcomes, service costs etc. Refer to 'Guidance for NHS commissioners on equality and health inequalities legal duties' 2015 [6].
Review current performance and plan for future delivery.	Analyse indicators around access, experience and outcomes in relation to physical healthcare for people with SMI including local data around:		To support CCG level planning, areas will be provided with information about the size of their SMI register locally so they can calculate trajectories for 18/19 and beyond. Local data on achievement of existing QoF indicators. And exception rates.
Develop a plan to improve levels of interoperability and effective information sharing between primary and secondary care.	Develop plans for interoperable systems that support the facilitation/ transfer of accurate and up-to-date patient records.	Make data accessible in accordance with local Information Governance (IG) arrangements and relevant legislation frameworks around privacy and data sharing.	Case studies 4 and 5 in Annex A

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Establish relationships and links with parallel programmes such as the NHS Health Check.	Map supporting initiatives underway within local area from health & wellbeing strategies plans, to ensure maximum alignment and to identify opportunities for mutual support, e.g. – joint training and development.		NHS Health Check – Best Practice Guide [7].
Ensure service user, carer and public voices are embedded in the design and evaluation of services.	Embed service user voice in commissioning decisions, including carers, friends, family and the public.		Rethink's Co-Production Commissioning toolkit [8].
Develop and promote clinical leadership and local champions including experts by experience to improve collaborative working between provider organisations, such as through appointing a clinical GP mental health lead within primary care to liaise with the physical health leads within secondary mental health services.	Embed clinical leadership to champion the healthcare of people with SMI.	Consider identifying at least one clinical lead for mental health within primary and one within secondary care to drive implementation of changes to physical health care pathways.	
Develop clear protocols outlining roles and responsibilities across primary and secondary care, communications and information-sharing requirements, ensuring robust shared care arrangements are in place.	Oversee and ensure the development of shared care arrangements.	Develop shared care protocols between primary and secondary care that include: • Communication channels locally • Resource requirements • Roles and responsibilities including frequency of follow up Sharing and exchanging information via patient records in accordance with IG practices and relevant legislation.	Reference: PSMI CQUIN 2017-2019: Indicator 3b [9]. Case studies 1 and 2 in Annex A
Consider the most effective models for commissioning improvements in the context of local needs and develop	Consider potential benefits and disbenefits of different commissioning approaches including:		

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service specification. This may include either: **a) Commissioning an Local Enhanced Service as an addition to the core primary care contract** **b) Commissioning an enhanced primary care service from, for example, a secondary MH care provider to deliver this service within primary care settings**	• Additions to core primary care service contract • Commissioning an Enhanced Primary Care services Consider building into NCM contracts, e.g. Multi-speciality community providers and Primary Care Homes		
Ensure service provision includes: 1. Completion of recommended physical health assessments, 2. Follow-up: delivery of or referral to appropriate NICE-concordant interventions 3. Follow-up: personalised care planning, engagement and psychosocial support. Further detail on each of these three elements is outlined in section 4 of the Guidance for CCGs.	Ensure that primary care providers are resourced to provide the full package of care as outlined in the Guidance for CCGs via chosen commissioning vehicle chosen.		
Establish a transparent and robust mechanism for collecting data and monitoring progress within primary care.	Review existing templates for physical health assessment and follow up in primary care, e.g. Bradford Template – which will facilitate monitoring from primary care. Agree monitoring and evaluation framework with provider that includes: • Activity • Outcomes in relation to health and wellbeing and resource use • Equality of access		Right Care In Depth MH Pack [10]. PHE fingertips SMI profiling tool [4].

| Report to NHS England quarterly to track progress towards delivery of the national commitment to ensure that by 2020/21, 280,000 people living with severe mental illness (SMI) have their physical health needs met. | Reporting will include CCG level quarterly reports on the number of people on the SMI register within each CCG who have received a comprehensive physical health assessment in primary care as defined within this guidance

CCGs will also be asked for financial data on investment in improving physical health for people with SMI,

Both these pieces of data may be included in future iterations of the Mental Health Dashboard [11]. | | Further detail on the technical description of the indicator to be required from CCGs will be provided in the *Joint technical definitions for performance and activity 2018-19.*. |
|---|---|---|---|
| Track the impact and outcomes of services over time | Involve service users, carers and the public in the evaluation process. | | |
| Ensure appropriate and relevant workforce training and professional development is accessible to staff. | Make a plan to develop the primary care workforce to improve physical healthcare for people with SMI. Ensure comprehensive training opportunities are in place for all primary care clinicians including community pharmacists where appropriate. | Consider joint training events for shared learning between primary care teams and secondary mental health services. | Case study 2 in Annex A

Workforce development tools and resources below in Annex C. |

Annex C: Workforce development tools and resources

Workforce training programmes:

1. **Mental health and wellbeing 'train the trainer' programme, The Charlie Waller Memorial Trust, Health Education England (HEE)**. Training package includes health promotion, behaviour change and addressing co-morbidities. Originally developed solely for practice nurses it has now extended to all health and social care professionals. HEE has commissioned an update of these training materials which will be made freely available. Modules cover: mental health awareness, behaviour change to improve health, physical health checks and interventions in mental illness, wellbeing and stress prevention, and holistic approach to managing common comorbidities. HEE are also developing a toolkit covering mental health and wellbeing education in primary care.
Contact: Lynne Hall (lynne.hall@hee.nhs.uk), Sheila Hardy, (Sheila.hardy@cwmt.org)
http://www.cwmt.org.uk/practice-nurse-training [12].

2. **'Breaking down the barriers' programme. UCLPartners (UCLP), Health Education England (HEE).** A mental and physical health awareness training and taught modules package designed to be delivered through reciprocal local arrangements across GP practices, acute and mental health trusts to improve staff awareness, confidence, skills and knowledge. Training materials are free and can be downloaded. Flexible taught modules are delivered in bite-sizes from 30mins - 2hrs to alleviate issues around clinical time constraints and through a mixture of presentations, practical exercises, videos tutorials, case studies, scenarios, quizzes, etc.
Contact: Julian Walker, julian.walker@uclpartners.com, http://uclpartners.com/what-we-do/clinical-themes/mental-health/breaking-down-the-barriers/ [13].

3. **Yorkshire and Humber e-learning package, Yorkshire & Humber Academic Health Science Network (AHSN).** Free online e-learning module for primary care professionals in addressing physical health needs of people with SMI to improve clinical outcomes. Contact: Stephen Stericker – stephen.stericker@yhahsn.com
http://www.yhahsn.org.uk/new-elearning-package-launched/ [14].

4. **Health Education England (HEE) training resources, frameworks and toolkits**
To provide workforce training needs support to primary care organisations, HEE has freely made available an online training resource accredited by the Royal College of GPs. This can be accessed through the e-Learning for Health website (http://portal.e-lfh.org.uk) [15]. While the training modules are particularly aimed at nurses, it is very relevant to other primary health and care staff.

5. **NHS Health Check competence framework**
In February 2017, Public Health England published the 'NHS Health Check – Best Practice Guide' [7] which refers to the NHS Health Check competence

framework [16]. The framework outlines the core and a technical competence required for carrying out the NHS Health Check. It also provides a template for minimum standards when commissioning or creating training packages, highlighting training needs for staff delivering the NHS Health Check programme.

6. **Patient Centred Assessment Method (PCAM) training tool for practice nurses**
An 'action-orientated' tool to help practice nurses assess a range of physical, mental wellbeing and social needs and supports assessment of lifestyle behaviours, social environment, health literacy and communication. http://www.pcamonline.org [17].
The tool has been evaluated and is used in (Keep Well) health check clinics in Scotland [18].

7. **Physical health check e-learning package (Rethink)**
An e-learning package designed to fill a training gap and give health professionals the confidence to address the physical health of people living with mental illness. The free training package highlights key physical health issues and risks for people living with SMI, complementing and promoting the Physical Health Check tool. Contact: Charli Hadden (charli.hadden@rethink.org)
https://www.rethink.org/phc [19].

8. **Physical health in mental illness (the Royal College of Nursing, in collaboration with the Charlie Waller Memorial Trust)**
In collaboration with the Charlie Waller Memorial Trust, the Royal College of Nursing's Mental Health forum steering group has developed three short web sessions [20]. Presented by Dr. Sheila Hardy, the e-learning sessions aim to encourage nurses to proactively consider the physical health needs of people with severe mental illness.

Annex D: Clinical terminology and definitions

For the purposes of this guidance, and for the monitoring of the MHFYFV objective set out above, the definition of the term 'SMI' has been aligned to the existing definition used to construct the Quality and Outcome Framework (QoF) SMI register.

The term SMI, within this guidance, refers to all individuals who have received a diagnosis of schizophrenia, bipolar affective disorder or who have experienced an episode of non-organic psychosis. Diagnoses, including diagnoses of personality disorder (other than schizotypal personality disorder), substance misuse disorders without co-morbid psychosis, eating disorders or recurrent depression are not included in the definition.

This should not be seen to imply that these excluded diagnoses are not 'serious' or 'severe', or that they do not carry any associated physical health risk. Rather the use of this definition of the term SMI is intended to ensure alignment with the current policy evidence base for physical health checks, which is driven in part by the cardio-metabolic risks associated with antipsychotics and also to ensure alignment with the existing scope of the QoF SMI register.

NICE specifies that primary care must keep an up-to-date register of all individuals living with SMI. This has informed current QoF indicator MH001 which requires contractors to establish and maintain a register of individuals with a diagnosis of serious mental illness, e.g. schizophrenia, bipolar or other affective disorders and other patients on lithium therapy.

The SMI register should consist of all the people who have a recorded diagnosis of schizophrenia, bipolar affective disorder or other long term psychotic illness. Use of antipsychotic or mood stabilising medication including lithium are also used to identify this population. In respect of coding for QoF SMI disease registers the following diagnostic read codes have been used to define this cohort:

- Schizophrenia   Eu20
- Schizotypal personality   Eu21
- Persistent delusional disorder   Eu22
- Acute/transient psychotic disorders   Eu23
- Induced delusional disorder   Eu24
- Schizoaffective disorders   Eu25
- Manic episodes   Eu30
- Bipolar disorder   Eu31
- Severe depression with psychosis   Eu323
- Non-organic psychosis   E1 (and all subsets)

The primary care codes for non-organic psychosis and bipolar in UK general practices do identify the expected number of people with these disorders. This reinforces the needs for regular SMI register cleansing and review [21].

Annex E: NICE Guidelines and Quality Standards

There are a number of interfacing NICE guidance and standards which are relevant for improving the physical health care of people with SMI. These are set out below.

Identification of risk for or presence of a disease following the recommended assessments should be managed in according with the relevant disease-specific NICE clinical guidelines.

Core NICE Guidelines and Quality Standards addressing the physical health needs of those living with SMI:
- 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 [**NICE CG120**]
- 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**]

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**]
- Type 2 diabetes: prevention in people at high risk [**NICE PH38**]
- Hypertension in adults: diagnosis and management [**NICE CG127**]
- Physical activity: brief advice for adults in primary care [**NICE PH44**]
- Diagnosis and management of type 1 diabetes in children, young people and adults [**NICE NG17, NG18** and **NG19**]
- Type 2 diabetes [**NICE NG28**]
- Type 2 diabetes – newer agents [**NICE NG28**]

Relevant NICE clinical guidance to deliver interventions for smoking, alcohol or substance use:
- Smoking: harm reduction. [**NICE PH45**]
- Smoking: harm reduction [**NICE QS92**]
- 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**]

Annex F: CCG tools and resources

Supporting indicators to assess own performance

CCGs should also use other supporting indicators and datasets to assess their own performance in relation to improving the physical health care for people with SMI within primary care, for example;

- Excess under 75 mortality rate in adults with SMI (formerly indicator 1.5) https://data.gov.uk/dataset/excess-under-75-mortality-rate-in-adults-with-serious-mental-illness-formerly-indicator-1-5-nhs [22].
- QoF exception rates for physical health checks for people with SMI Atlas of Variation: https://www.england.nhs.uk/rightcare/intel/cfv/atlas/ [23]. Data from QoF: http://content.digital.nhs.uk/qof [24].

Physical health assessment invitation templates:

- Refer to QoF Mental Health and Depression Toolkit [25] developed by Sheffield Primary Care Trust.
- Hardy S, Gray R. *Is the use of an invitation letter effective in prompting patients with severe mental illness to attend a primary care physical health check*? Prim Health Care Res Dev. 2012;13(4): 347-352. [26].

Template letter for Did Not Attends (DNAs)

- Refer to QoF Mental Health and Depression Toolkit [25] developed by Sheffield Primary Care Trust.

Care plan template

- Refer to QoF Mental Health and Depression Toolkit [25] developed by Sheffield Primary Care Trust.

Additional resources

Rethink Mental Illness have developed a number of resources to build confidence and raise awareness of the physical health needs of people with SMI including;

- Physical health guide for carers, families and friends [27].
- Physical health check flyer – basic facts which can be shared online, in GP waiting rooms [28].
- My physical health checklist – to help people with SMI and healthcare professionals jointly identify physical health needs. Includes an action plan [29].
- POMH-UK's Young people and medication booklet [30].
- 'What's reasonable?' – for GP surgeries on making reasonable adjustments for people affected by mental illness [31].

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