

# Parity of Esteem Overview and Report

## Improving the Physical Health of People with Serious Mental Illness in the East Midlands

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November 2016



# About the Author

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Sohrab is the GP Clinical Lead for Parity of Esteem, East Midlands Mental Health Clinical Network.

Originally he worked as a GP Principal in a large city practice in Peterborough for 21 years, where he led the development of a primary care service for refugees. He clinically led the commissioning of mental health, learning disabilities and substance misuse for Peterborough and bordering areas. He also chaired the Cambridgeshire Suicide Prevention Implementation Group for 2 years.

Sohrab's passion for parity of esteem was born out of his experience in primary care managing people suffering from complex mental health problems.

After relocating to Derbyshire, he was appointed as Clinical Lead for Hardwick CCG in 2014 leading on Mental Health Clinical Commissioning. He continues to enjoy clinical work in both general practices and prisons within Derbyshire.



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# Foreword



As 2016 draws to a close there is much to reflect upon concerning how mental health services fit within the changing landscape of health and social care provision as defined by the emerging Sustainability and Transformation Planning process, and by the Five Year Forward View for Mental Health published at the beginning of the year. It is therefore timely to present to clinicians, managers and commissioners in the East Midlands an authoritative and impassioned overview of Parity of Esteem for Mental Health written by our Clinical Lead Dr Sohrab Panday.

Although many of the challenges currently facing mental health services can be framed in terms of Parity of Esteem (or the lack of it) between physical and mental health, the central topic which rightly dominates the agenda is the appalling disparity in physical health experience and outcomes for people with severe and enduring mental health problems.

This report brings together the national context and drivers together with local and regional data and experience; I hope you will agree with me that this makes a compelling narrative which will inspire us to consolidate our efforts and extend our ambitions in this vital area.



**Dr Richard Prettyman**, Clinical Director, Mental Health and Dementia,  
East Midlands Clinical Network

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## 1. 'What is Parity of Esteem?'

The title begs a basic question you may say, yet one which is frequently asked. The Royal College of Psychiatrists report in 2013, *Whole-Person Care: From Rhetoric to Reality*<sup>1</sup> highlights the significant inequalities that exist between physical and mental health care, including preventable premature deaths, lower treatment rates for mental health conditions and an underfunding of mental healthcare relative to the scale and impact of mental health problems.

**In essence, 'parity of esteem' is best described as: 'Valuing mental health equally with physical health'.**

More fully, parity of esteem means that, when compared with physical healthcare, mental healthcare is characterised by:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care
- the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes

The range of topics legitimately covered by parity of esteem are varied and many. In order to meet this challenge, NHS England has established a Parity of Esteem Programme, the ambition of which is to ensure that mental health is valued equally and on the same terms as physical health, with a commitment to promote the delivery of person-centered and coordinated health and social care, leading to improved outcomes for people with mental health conditions.

The East Midlands Clinical Network (EMCN) has Mental Health as its *raison d'être* and so many of its work streams are geared towards parity of esteem including Crisis Concordat, Dementia, Early Intervention Psychosis and Perinatal Mental Health.

A specific EMCN Parity of Esteem Programme was developed in order to address the key issue of premature mortality from physical disease in serious mental illness (SMI). This is the main focus of this project. This longstanding challenge was selected because it is of paramount importance from a moral, clinical and equality perspective. The solutions require innovative partnership and shared learning approaches.

## 2. Premature Mortality in SMI

Data and numbers are key to appreciate the scale of the problem under discussion; however, it must be kept firmly in mind that each statistic represents a person with a family and loved ones, who has suffered an illness which stole years from their life. Disparities in mortality have been recognised for at least 25 years<sup>2</sup>, the causes of which are often linked to poor physical health<sup>3</sup>. Mental ill health does not occur in isolation. It has been estimated that 46% of people with a mental health condition also have a long-term physical health diagnosis; and conversely 30% of people with a physical long term condition have a mental health problem<sup>4 5</sup>.

In particular, those with mental ill health have high rates of respiratory, circulatory and infectious disease, obesity, abnormal lipids and diabetes<sup>6</sup>. A Finnish study estimated that up to 50% of the increased mortality in those with mental ill health was due to underlying physical health conditions.<sup>7</sup> Thornicroft<sup>8</sup> (2011) poignantly described premature mortality in SMI as a 'scandal'.

The root causes of the premature mortality are a combination of:

- **Lifestyle Choices** – Prevalence of cardiovascular disease risk factors is very high amongst the SMI population due to smoking, obesity and diabetes.
- **Poverty** – Such factors are more common in areas of socioeconomic deprivation where mental disorders are also most prevalent; as presented by Professor Sir Michael Marmot in his review "Fair Society, Healthy Lives".<sup>9</sup>
- **Ineffective Prevention** – Prevention is not targeted at the SMI population. The standard approach of prevention for the general population is ineffective in patients with SMI and substance misuse.
- **Poor Access to Effective Care** – Access is hindered through a lack of reasonable adjustments. Often lack of engagement is described unhelpfully as patients being 'hard to reach' rather than a service that may not meet the illness specific needs of the individuals concerned.
- **Poor Commissioning of Services** – Physical as well as mental healthcare services have been commissioned separately and services have not been routinely co-produced with SMI service users and their carers.
- **Stigma** – Healthcare Professionals and Staff also have preconceived ideas about people with SMI which commonly leads to so called 'Diagnostic Overshadowing', a misinterpretation of symptoms as being part of the mental illness hence leading to delay in diagnosis of physical co-morbidities.

- **Iatrogenic Risk Factors** – All anti-psychotics are diabetogenic and obesogenic to varying degrees. Prescribers of the drugs which cause or exacerbate physical disorders can fail to take responsibility for mitigating these risks and involve the patients and carers to allow fully informed choices to be made.
- **Ethnicity** – The worse prognosis for patients with SMI is even more pronounced in certain ethnic minority groups and a UK study is currently looking into the exact causes of this in detail so the prognosis can be improved.<sup>10</sup>

## 2.1 Premature Mortality: The Current State of Play

An up to date picture of premature mortality has been created by the Health and Social Care Information Centre (now called NHS Digital) which provided a Report in February 2013 based on data from the Mental Health Minimum Data Set (MHMDS).<sup>11</sup>

A special feature in that year's report uses a linked dataset (based on MHMDS and ONS mortality data) to compare mortality rates of those in contact with mental health services with the general population in 2010/11. This is the first time that it has been possible to use routinely collected administrative data at national level for this purpose; the analysis is below.

People in contact with specialist mental health services have a **mortality rate that is 3.6 times higher than** the general population 4007/100,000 (83,393 deaths) c.f. 1,121/100,000.

The difference in mortality rates was largest among **people aged 30-39**, where the mortality rate for those in contact with services was **five times as high** 300/100,000, c.f. 63/100,000.

The causes of the increased deaths in service users included **all ICD10 Chapters** particularly for mental, behavioural or nervous system disorders e.g. Alzheimer's disease.

**Rates were more than double for lifestyle-related diseases including:**

- **4 times** higher death rate from **respiratory** diseases (142 /100,000 c.f.37/100,000)
- **4 times** higher death rate from **digestive system** diseases (126/100,000, c.f.28/100,000)
- **2.5 times** higher death rate from **circulatory system** (at 254/100,000 c.f. 101/100,000)

## 2.2 Use of Healthcare Services by people with SMI: an insight into the problem

A large study by **Quality Watch** in 2013/14 produced a report published in 2015 which has illuminated the scale of the problem beyond question.<sup>12</sup>

- People with mental ill health use more emergency hospital care than those without mental ill health; 3.2 times for accident and emergency (A&E) attendances and 4.9 times for emergency inpatient admissions.
- Only 19 % of emergency inpatient admissions for those with mental ill health were to explicitly support their mental health. Most care was used to support physical health and equated to 3.9 times the emergency inpatient care expected for someone without a mental health problem.
- Deprivation is strongly associated with hospital use including emergency care. The most deprived people with mental ill health visited A&E 1.8 times more than the least deprived and had 1.5 times more emergency inpatient admissions.
- People with mental ill health had 3.6 times more potentially preventable emergency admissions than those without mental ill health in 2013/14.

Part of the problem may be that our current health and social care system is not designed to ensure the delivery of "whole systems" packages of care. Despite there being large public health drives to ensure that all people have knowledge of, and access to, physical health checks, the majority of people with serious mental illness do not receive a complete physical health check. A recent publication by the National Audit of Schizophrenia found that only 29% of service users receive proper metabolic monitoring<sup>13</sup> (**Appendix 1**). Mental and physical health care and services are often not adequately designed nor correctly aligned to collectively meet the wider needs of those with mental health disorders. Later, the East Midlands picture of acute hospital use by those with SMI will be elaborated and show an even greater use than the estimated national picture.





### 3. Background and National Drivers

Whilst the disparity for mental health and the mortality gap has been known for decades, recently there has been a welcome escalation of focus at both national and local levels to achieve 'parity of esteem' for physical and mental health to ensure that people are enabled to maintain both their physical and mental wellbeing. For example:

A number of National Drivers and initiatives have been responsible for this improved momentum. I have divided these drivers into 3 main groups; General Parity for Mental Health, General Cardiovascular Disease and Specific Physical Health in SMI.

#### 3.1 General 'Parity of Esteem' Drivers

- In 2007, **Time to Change** began their impressive campaign against mental health stigma<sup>14</sup>
- In 2010, **Healthy Lives, Healthy People** was the first public health strategy to give equal weight to both physical and mental health (HM Government, 2010)<sup>15</sup>
- In 2011, **No Health Without Mental Health** – a cross-government strategy on mental health was published which included a key objective; people with mental health problems will have good physical health (HM Government, 2011)<sup>16</sup>
- In 2013, NHS England Parity of Esteem Programme Board – **Valuing Mental Health Equally**, Martin McShane describes the true nature of what parity means<sup>17</sup>

In 2013, **NHS England's Strategic Plan to address Premature Mortality** includes a focus on early identification and prevention of co-morbidities and reducing mortality for people with SMI (NHS England 2013a)<sup>18</sup>

In 2013 the **Health and Social Care Information Centre (HSCIC)** released new data on the increased mortality in SMI by cause of death 11. The HSCIC was renamed NHS Digital in July 2016.

- In 2014, the **National Crisis Concordat** was launched to improve cross organisational responses to mental health crises<sup>19</sup>
- In 2014, **Closing the Gap; priorities for essential change in mental health** was launched by the Department of Health; Nick Clegg and Norman Lamb<sup>20</sup>
- In 2015, **Parity in Progress? The All Party Parliamentary Group for Mental Health Inquiry into Parity** identified Premature Mortality in SMI as a key priority alongside crisis care and public mental health.<sup>21</sup>

#### 2016 a pivotal year for change

- The **Mental Health Taskforce** published **the five-year forward view for mental health for NHS England in February**<sup>22</sup>, covering access, choice of treatments and prevention and elevates mental health to be a key priority in the new Sustainability and Transformation Plans (STPs) of every area. In addition it clearly identifies the need to improve the physical health of patients with SMI. By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62% cent to 82%, although the proportion of patients who receive the full range of NICE approved interventions is much lower (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.
- In July 2016 'Implementing the Five Year Forward View for Mental Health' was published by NHS England<sup>23</sup>. This stated the following commitments.
  - 'Funding to deliver **physical health checks for people with severe mental illness** (SMI) will enable CCGs 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. The costs (relating to the additional training and capacity needed for the workforce to deliver checks) are based on a pilot enhanced service offered in North East London, the results of which are soon to be published. Development work is ongoing, with the intention to publish further detail on proposed delivery models for this objective by December 2016.'

- The 2016/17 CQUIN on improving physical healthcare to reduce premature mortality in people with severe mental illness is an important lever in addressing the issue of physical health care for this group. It covers in-patient wards, EIP services and community mental health services. NHS England will seek to extend the CQUIN beyond 2016/17, learning lessons about effective delivery and measurement from working with providers and the appointed CQUIN audit partner.
- Then in October NHS England published the **Mental Health Dashboard** in response to the 5 year forwards view for mental health.<sup>24</sup>
- This paper gives clear guidance on the assurance processes to be met by CCGs with respect to a variety of aspects of mental health. Specifically, in regards to the subject to hand, it states “Community-based adult mental health services: working with partners to improve access to high-quality, evidence-based care which considers people’s physical and mental health needs and wellbeing, reducing premature mortality among people with severe mental illness and doubling the reach of Individual Placement and Support (IPS).”

#### The Kings Fund published in March the **10 priority areas for Integrated Care:**

- Incorporating mental health into public health programmes
- Health promotion and prevention among people with severe mental illnesses
- Improving management of ‘medically unexplained symptoms’ in primary care
- Strengthening primary care for the physical health needs of people with severe mental illnesses
- Supporting the mental health of people with long-term conditions
- Supporting the mental health and wellbeing of carers
- Mental health in acute general hospitals
- Physical health in mental health inpatient facilities
- Integrated support for perinatal mental health
- Supporting the mental health needs of people in residential care

## 3.2 General Population Cardiovascular Screening Drivers

Dr Huon Gray; National Clinical Director for Cardiovascular Disease describes how cardiovascular disease rates have improved considerably since the introduction of the National Service Framework in 2000 and the investment that followed. However cardiovascular disease still causes 25% of the deaths in under 75 years old people and the emphasis for cardiology is now moving towards caring for an older population, living longer but with several co-morbidities including cardiovascular disease. This includes the SMI population.

NHS England has a mandate of health objectives from the Department of Health comprised over several domains.

### Domain 1: Preventing people from dying prematurely

Key Performance Indicator = Mortality < 75 years old

Preventing people from dying prematurely (Domain 1 of the NHS Outcomes Framework)
<b>Overarching indicators</b>
1a Potential years of life lost (PYLL) from causes considered amenable to healthcare i Adults ii Children and young people
1b Life expectancy at 75 i Males ii Females
1c Neonatal mortality and stillbirths
<b>Improvement areas</b>
Reducing premature mortality from the major causes of death
1.1 Under 75 mortality rate from cardiovascular disease (PHOF 4.4)
1.2 Under 75 mortality rate from respiratory disease (PHOF 4.7)
1.3 Under 75 mortality rate from liver disease (PHOF 4.6)
1.4 Under 75 mortality rate from cancer (PHOF 4.5) i One and ii Five-year survival from all cancers iii One and iv Five-year survival from breast, lung and colorectal cancer v One and vi Five-year survival from cancers diagnosed at stage 1&2 (PHOF 2.19)
Reducing premature death in people with mental illness
1.5 i Excess under 75 mortality rate in adults with serious mental illness (PHOF 4.9) ii Excess under 75 mortality rate in adults with common mental illness iii Suicide and mortality from injury of undetermined intent among people with recent contact from NHS services (PHOF 4.10)
Reducing deaths in babies and young children
1.6 i Infant mortality (PHOF 4.1) ii Five year survival from all cancers in children
Reducing premature death in people with a learning disability
1.7 Excess under 60 mortality rate in adults with a learning disability



In 2009, **the NHS Health Checks Programme** was introduced which provided screening and intervention for **40-75** year olds.<sup>25</sup> Many patients with SMI are of course under 40 years old and are less likely to attend a clinic geared towards the general population therefore this approach is less than perfect for them.

In 2013, **Living Well for Longer: a call for action; National Support for Local Action to Reduce Premature Avoidable Mortality** was prepared by The Reducing Premature Mortality Programme in The Department of Health. This placed the emphasis on local initiatives to address the link between poverty, mental health and premature mortality<sup>26</sup>.

### 3.3 Specific Drivers regarding CVD Risk and Premature Mortality in SMI

These include the following:

- The NHS England Mandate from DH ; Domain 1 - To Reduce Excess Premature Mortality in people with SMI
- The Lester CVD Risk Tool, pioneered in the UK by Professor Helen Lester,
- The National Audit on Schizophrenia 2012 and 2014
- The NICE Quality Standard (QS100) published September 2015
- The NHS England Sustainable Improvement Team (previously NHS IQ)
- Four NHS Trust Pilots in 2014-15.

The issue of premature mortality is the number one priority for the NHS and cardiovascular disease is still responsible for 25% of such deaths. People with diabetes or familial hypercholesterolaemia are rightly given proactive preventative care. However, those with SMI are also high risk and just as deserving of targeted prevention. Just as a diabetic gets his cardiovascular disease risk managed by both primary and secondary care, the responsibility to help SMI patients with their lifestyle is with us all. **The National Audit of Schizophrenia (NAS)**<sup>9</sup> exposed a poor coverage of physical health screening and interventions in 2012. Sadly, in 2014 the re-audit showed no significant improvement. Since this study was specifically on SMI in secondary care the findings reflect a combination of barriers, prescriber indifference, services that are not user friendly, lack of joined up care, clinician responsibility confusion. The fact is, services need to be designed with the service user in mind, indeed they need to be coproduced with service users if they are to be effective and subsequently value for money.

**NICE Guidance in 2014 (Appendix 2)** states that in the first year physical health checks are the specialist's responsibility whereas after 12 months (or once the patient is stable) it becomes the responsibility of Primary Care. It is the responsibility of the Clinical Commissioning Groups to ensure that clear local arrangements are in place to support the transfer of care from the Trust to Primary Care (or commission another equivalent provider in their locality). It is the responsibility of both the Trust and the GPs to communicate and share information with each other regarding the physical health data and needs of patients with SMI. This is not happening reliably in part due to IT issues for which solutions can and must be found.



QOF statistics show again that the take up of the annual health checks is very variable and can be as low as 50%. Primary care is simply not resourced under the standard GMS contract to provide an outreach style service to those patients who DNA or are 'hard to reach'.

## 3.4 Financial Incentive Drivers

### 3.4.1 CQUIN

CQUIN is the Commissioning for Quality and Innovation payment framework for providers. Mental Health Trusts were offered a CQUIN to improve the physical healthcare of people with SMI. This was introduced in 2014/15 and 2015/16, in order to demonstrate full implementation of appropriate processes for assessing, documenting and acting on cardio-metabolic risk **factors in inpatients with psychoses and community patients in early intervention psychosis teams.**

It is worth emphasising that it focuses on all patients with psychosis, including schizophrenia and bipolar affective disorder, in all **inpatient beds** in all NHS commissioned sectors including the independent sector. It does not cover patients once discharged into the community.(NHS England, 2013b; Contracting and Incentives Team, 2015).<sup>27</sup> There are two components:

- cardio-metabolic assessment and treatment for patients with psychoses, and
- communication with general practitioners

In 2016/17 the CQUIN is being continued for a third year and expanded to include patients under **community mental health services** (under a care planned approach).<sup>28</sup>

### 3.4.2 QOF (Quality and Outcomes Framework)

QOF is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results. It is not about performance management but resourcing and then rewarding good practice. QOF includes payment for keeping a register and offering annual checks of patients with an SMI. The health check includes blood pressure, smoking, and alcohol but in contrast to NICE guidelines QOF does not include weight, glucose and lipids (**Appendix 3**).<sup>29</sup> Somewhat disappointingly, QOF remains unchanged for 2016/17 and is still limited to these few indicators. Nevertheless, incentive schemes within primary care are bound to change with the development of federations, new models of care and the STPs.

### 3.4.3 Additional NHS England Investment in Parity 2015/16

National Waiting Time Standards were introduced for the first time into mental health which signifies a step change in pace forwards. £80M additional funding has been provided for Liaison Psychiatry, Early Intervention in Psychosis and IAPT.<sup>30</sup>

## 4. The Importance of Integrated 'wrap around' Services

For these policy measures to be effective, we must better understand how those with mental ill health are using services and in particular whether they are able to access care for their physical health needs. There have been many studies looking at differences in health outcomes for people with mental ill health but they have mainly focused on those with the most severe mental health needs. The study by the Health and Social Care Information Centre in 2013 (see section 2.1 of this document) found higher rates of access to hospital services for those with mental ill health compared with those without – but no distinction was made to compare hospital use for underlying physical or mental healthcare diagnoses. Additionally, as the care services/pathways for physical and mental health are often not linked, data is captured in different ways, in different systems, making it difficult to explore quality of care for physical health in those with mental ill health. Therefore, the recent aforementioned Quality Watch Study<sup>8</sup> is very welcome but further research is indeed needed.

Patients with SMI are largely ill served by our health service due to a combination of factors such as stigma, lack of primary care resource, lack of employment opportunities or whole person care in the community. Primary care and secondary care services are separate systems with separate priorities. There is all too often a lack of clarity and accountability with gaps in services leaving patients and carers lost and feeling dejected. As a result of the Health and Social Care Act 2012 Clinical Commissioning Groups together with Local Authorities (incorporating Public Health) have the responsibility and the power to create an integrated system which wraps around such vulnerable patients and their families. The **Health and Wellbeing Board (HWBB)** structure was created as a forum to have a strategic overview of the care provision of their population ensuring that local priorities are met and inequalities in health are addressed. The **Joint Strategic Needs Assessment (JSNA)** determines the population needs whilst the **Joint Health and Wellbeing Strategy (JHWS)** outlines the strategy and partnership working required.

In December 2015 NHS Planning Guidance for 2016/17 –2020/21 outlined a new approach to help ensure health and care services work together to deliver 'place-based' plans for locally defined footprints, based on natural communities, existing working relationships and centred on the needs of local population; these are called Sustainability and Transformation Plans (STPs). The organisations in STP areas have been working together to develop plans for sustainable transformation in the experience of those receiving services and longer term health outcomes and these plans were being produced, as this report was being finalised.

STPs do not replace existing organisations or accountabilities. They provide a forum for collective discussion and collaboration to deliver improved health and care, including for mental health. Therefore, STPs will make a key contribution to the implementation of the Five Year Forward View. From April 2017, STPs will become the single application and approval process for accessing NHS transformation funding.

Commissioners and providers are required to achieve and maintain the **mental health access and waiting time standards**: more than 50% of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75% of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95% treated within 18 weeks.

The development of new models of care features in STPs. Some areas of the country have secondary mental healthcare providers which are testing new care models in tertiary mental health services. These will enable closer integration between care pathways.<sup>31</sup>

## 5. Primary Care

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in waiting times; for example, in 2015-16 these ranged from 5 days to 102 days. Of those adults with more severe mental health problems 90% are supported by community services.

Now that CCGs have begun to take on levels of delegated authority from NHS England to **co-commission primary care services** there is a unique opportunity for CCGs to support Primary Care to deliver whole person care. The role of primary care in mental health is crucial but has been neglected to date. Mental health accounts for a fifth to a third of all primary care activity and supporting the workforce to manage this with confidence and skill will go a long way to helping the demand to be effectively met. The Royal College of Psychiatrists Recommendations on Primary Care to the Mental Health Taskforce NHS England (**Appendix 4**) includes a robust evidence research base for the case for primary mental health care. The East of England SCN has just published a report on the Interface between Primary Care and Mental Health Services (**Appendix 5**). This outlines the different models of working together with their strengths, risks and weaknesses, based on user experience and professional opinion. Meanwhile the educational needs of GPs in mental health are well described by Dr Walton.<sup>32</sup>

## 6. Workforce Training

The separation of mental health training from physical health training over the last few decades has been made the delivery of holistic care for people with SMI more challenging.

Health Education England (HEE) has a clear mandate from the Department of Health to train the workforce in mental health, dementia, learning disabilities and autism. The East Midlands Clinical Network are working with Health Education England across the East Midlands to support them in their delivery of this mandate (**Appendix 6**).



Primary Care is incentivised to provide annual physical health checks in the Quality and Outcomes Framework (QOF) (**Appendix 3**). However, it must be remembered that QOF is voluntary. The number of practice nurse and GPs with additional training in the physical health of with additional training SMI is small and dependent on passionate local champions. Nevertheless, there are pockets of brilliant practice in the country with Master Classes for nurses, diplomas for GPs, and CCG mandated mental health CPD as part of local enhanced services as described later.

## 7. Evidence based interventions for managing and maintaining the physical health of people with SMI

### 7.1 Lifestyle

Of course the causes of cardiovascular disease in SMI are the same as that of the rest of the population. The key risk factors of hypertension, obesity, sedentary lifestyle, poor diet, diabetes and hyperlipidaemia are the same. Alcohol in excess is also a factor and is more common in the mentally unwell. Patients with both severe mental illness and a severe alcohol or drug addiction are described as having a dual diagnosis. Such patients are difficult to manage well and find services particularly hard to access.

### 7.2 Iatrogenic Factors

Of paramount importance is the fact that patients with psychosis and some other complex mental health disorders are treated with drugs which unfortunately change their appetite, energy levels and metabolic function increasing their risk of weight gain, hypercholesterolaemia and hyperglycaemia. Such patients are at a much higher risk of metabolic syndrome (insulin resistance), dyslipidaemia and diabetes mellitus.

Therefore, the prescriber has a professional and moral duty to explain the risks to the patient and their carer, and to involve them in the decision making; balancing the pros and cons of the treatment offered for their mental condition against the physical side effects. The clinician should also fully support every means of mitigation of these effects from day one of prescribing. The information must be given in a way it can be understood verbally and in writing and offered repeated reviews.

Leucht et al (2013)<sup>33</sup> wrote a tremendous article in the Lancet comparing anti-psychotics which compared efficacy with all cause discontinuation. Interestingly discontinuation was more commonly ascribed to inefficacy than to intolerability due to the five major adverse effects;



namely weight gain, sedation, prolonged QT interval, extrapyramidal effects and hyperprolactinaemia; the last of which leads to amenorrhoea, galactorrhoea, sexual dysfunction and osteoporosis.

Derbyshire Healthcare Foundation Trust Pharmacy Department prepared some tremendous colour spider diagrams that illustrate the relative efficacy and side effects of common antipsychotics to patients visually.<sup>34</sup>

The British Association of Psychopharmacology (BAP) published guidelines on the Management of weight gain, metabolic disturbances and cardiovascular risk associated with psychosis and antipsychotic drug treatment in 2016.<sup>35</sup>

Lifestyle choices and judicious use of antipsychotics remain the mainstay of treatment rather than seeking pharmacological antidotes to the iatrogenic problems.

Worthy of particular note is the effectiveness of an integrated lifestyle intervention in young people who are started on an antipsychotic in whom weight gain was mitigated.<sup>36</sup>

The monitoring of the physical health using the Lester Tool or Positive Cardio-metabolic Health Resource provides a crucial intervention framework for clinicians and is applicable to all SMI patients managed in both primary and secondary care (**Appendix 7**).



## 7.3 Weight Management

Firstly, it is worth emphasising that there is a bidirectional relationship between obesity and mental health problems as detailed by the 2011 National Observatory Obesity Report; Obesity and Mental Health.<sup>37</sup> In other words there is linkage or association between obesity and mental illness in general.

The next question is to address the management of obesity in people with serious mental illness. A systematic review of the literature on weight control in SMI was conducted in Toronto in 2003.<sup>38</sup> Weight loss in this population may be difficult but this systematic review suggests that small effects are possible. Individuals taking antipsychotic medication should be monitored for weight gain and where possible be prescribed medication that is least likely to cause weight gain in patients who are already overweight. However, if weight gain does occur, both dietary and exercise counselling set within a behavioural modification programme is necessary for sustained weight control. Individualised counselling, participant education, and regular contact may also be required.

It is accepted that the introduction of antipsychotics causes weight gain which can be very rapid in the first few months and that clinicians need to be extremely vigilant about this. The baseline parameters of somebody when they are first diagnosed with psychosis would be above average for their age. However rather than having a high Body Mass Index (obesity) they are likely to have a high waist circumference indicating excess intra-abdominal fat and therefore metabolic syndrome. So the patients are already disadvantaged even before they start their anti-psychotic. A paper by Alvarez-Jimenez et al in 2008 clearly demonstrated weight gain up to four times faster in first episode psychosis where patients are drug naive. The weight gained on olanzapine was 7.1-9.1 Kg at 12 weeks and 10-15 Kg at 1-2 years.<sup>39</sup> The good news is that Bruins demonstrated that lifestyle interventions have a significant, beneficial effect on weight loss.<sup>40</sup>

Pharmacological approaches to weight management have been trialled using various drugs but none are convincingly effective and are not for general recommendation.

Specifically, however, the use of metformin has been positively advocated as a method of helping both weight and metabolic complications.<sup>41</sup> Lifestyle intervention and metformin, alone and in combination, demonstrated efficacy for antipsychotic-induced weight gain. Lifestyle intervention plus metformin showed the best effect on weight loss. Metformin alone was more effective in weight loss and improving insulin sensitivity than lifestyle intervention alone. Many other medications have been tried to mitigate obesity caused by antipsychotics however no evidence for their efficacy exists.<sup>42</sup>

## 7.4 A Mediterranean Diet for all

In the 'Adherence to the Mediterranean Diet and Quality of Life in the Sun Study' 11,015 people were followed up for four years. A significant direct association between adherence to Mediterranean diet and both mental and physical health reported quality of life; such as vitality, social functioning, emotion wellbeing and physical functioning. This raises an important question; diet effects much more than just ones weight. It also affects wellbeing. It is already known that a Mediterranean diet is healthy from a cardiovascular point of view so in addition to the needed weight loss measures it would seem uncontroversial to promote this diet to all SMI patients unless contraindicated.<sup>43</sup>

## 7.5 Exercise

There is much evidence that exercise is good for both our physical and mental wellbeing in general. Indeed, Dr Mark Batt of the East Midlands Clinical Senate has published a document to that effect giving guidance on what should be commissioned and highlighting some excellent areas of practice in the region.<sup>44</sup>

However, the use of exercise to actually treat mental illness per se is not justified. One key study showed the addition of facilitated physical activity intervention to usual care does not demonstrably improve depression outcome or reduce use of antidepressants compared with usual care alone.<sup>45</sup>

There are, however, plenty of studies that show exercise in people with SMI is beneficial as shown by a literature review in 2012.<sup>46</sup> Exercise in SMI can contribute to improvements in symptoms, including mood, alertness, concentration, sleep patterns and psychotic symptoms. Exercise can also contribute to improved quality of life through social interaction, meaningful use of time, purposeful activity and empowerment.

A study by Firth et al (2015) performed a meta-analysis and a systematic review to look into the effects of exercise on mental health in areas such as positive and negative symptoms, co-morbid disorders (depression and anxiety) and psychosocial functioning (quality of life, overall illness severity).

The results of the study revealed that the positive and negative symptoms of schizophrenia were significantly reduced by 90 minutes of moderate to vigorous exercise a week i.e. jogging, resistance training and cycling. The results also discovered that there were significant improvements to psychosocial functioning and co-morbid disorders, making this a convincing argument to provide exercise interventions for the treatment of schizophrenia.<sup>47</sup>



## 7.6 Smoking

40% of all cigarettes are consumed by people with mental health problems

There is a strong association between smoking and mental health disorders. It is arguably the greatest of all negative factors in causing morbidity. Overall smoking prevalence among psychiatric patients is two to three times higher than among the general population, ranging from 40-50% among people with depressive and anxiety disorders to 70% or higher among patients with schizophrenia. This contributes to a shameful inequality in outcomes for people with serious mental illness' who have a 20-year shorter life expectancy than the general population.<sup>48</sup>

Smoking and Mental Health: A joint report by the Royal College of Physicians and the Royal College of Psychiatrists<sup>49</sup> highlighted that:

- Smoking is around twice as common among people with mental disorders, and more so in those with more severe disease.
- Up to 3 million smokers in the UK, 30% of all smokers have a mental disorder and 1 million have longstanding disease.
- 40% of all cigarettes smoked in England are smoked by people with a mental disorder.
- In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years.
- Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking and to anticipate difficulty quitting smoking, and historically much less likely to succeed in any quit attempt.
- Over the course of a year, smokers with mental disorders are more likely to receive advice from their GP to quit smoking, and be prescribed cessation medications, but this reflects the increased frequency of their consultations. Overall, only a minority receive cessation pharmacotherapy.

## 8. Evaluation of Current Provision in the East Midlands

Data on physical health parameters are now vastly improved with 4 key sources of relevant data accessible by the general public:

- **Atlas of Variation**<sup>50</sup>; which includes the Opportunity Locator
- **My NHS**; which includes NAS data<sup>51</sup>
- **RSA Open Data Network**; 'mind and body'<sup>52 53</sup>
- MH Intelligence **eNetwork**; 'Fingertips'<sup>54</sup>

Meanwhile the data collected by providers as part of their incentive schemes includes:

- **QOF** for General Practitioners
- **CQUIN** for Mental Health Trusts

### The East Midlands Clinical Network Parity of Esteem Programme

This is a regional programme of work on parity of esteem, as part of the Network's wider mental health portfolio. The aim of this programme will be to help achieve parity between mental health and physical health on agreed indicators, and to improve health care outcomes and quality of life for people with serious mental illness in the East Midlands.

### The East Midlands Clinical Network Innovation Pilots for Parity of Esteem

The East Midlands parity programme has supported a number of projects to date: The details are on the East Midlands Clinical Network website<sup>55</sup>. A full evaluation of their success is in progress and will be available on the website shortly.

- In total there were five innovation projects to support improvements in meeting the physical health care needs of people with serious mental illness. Projects include developing a clinic to improve access and monitoring of physical health needs of mental health patients, developing smoking cessation services for people with serious mental illness and increase the uptake of physical health checks and help develop care pathways and services for people with serious mental illness and learning disabilities, through Experts by Experience champions.
- The Steering Group has engaged with all the CCGs and HWBBs to prioritise parity of esteem whilst exploring each locality's individual strengths and challenges.

The outcomes of the above provided a better understanding of:

- Current provision of services in the East Midlands and what needs to be done to improve health outcomes of people with serious mental illness.
- Implementation of best practice solutions and innovative models of service provision and delivery
- An agreed action plan for the Network to support commissioners and providers to achieve improvements

The programme has also set up a Parity of Esteem Steering Group with representation from key organisations, providing a much needed network of expertise across our region.

## 8.1 What's been happening in the East Midlands? An awful lot!

The scoping work that has been undertaken so far as described above shows that substantial improvements in meeting the needs of people with serious mental illness have been made at a local level. These will be summarised below for each county. The likelihood is that the below will be out of date by the time of publication and only serves to offer a flavour of activities in the region.

### 8.1.1 Nottinghamshire

- Development of Physform, an annual physical health summary that is recorded by GPs for patients with serious mental illness, generating an action plan in collaboration with the mental health trust, in order to agree health priorities for the patient. The project focuses on health outcomes linked to the risk of cardiometabolic illness, measuring improvement in monitoring and intervention for 6 key indicators: smoking, lifestyle (activity/ work), BMI, blood pressure, glucose regulation and blood lipids (Nottingham City CCG/Nottinghamshire Healthcare NHS Trust)
- Implemented a project in Jan 2016 to incentivise GPs to promote use of **Physform** with patients with serious mental illness and to engage more proactively with the mental health trust (Nottingham City)
- The Mental Health Trust contract includes reference to physical health through the national CQUIN and quality schedule which requires that physical health for all in-patients is monitored (Nottinghamshire County and City CCGs, Nottinghamshire Healthcare NHS Trust)
- Local authority commissioned Healthy Change service which supports health behaviour change in patients with serious mental illness (Nottingham City Council)
- Local stop smoking service, New Leaf, proactively supports people with SMI and monitors referrals of people with mental health problems (Nottingham City)

- Implementation of a physical healthcare team which offers support, advice and training to secondary care mental health services on the physical health care of patients with SMI (Nottinghamshire Healthcare NHS Trust)
- Closer working with secondary care to ensure that risk factors for physical illness in patients with SMI are flagged up to primary care teams (Nottingham West)
- The Physform Project was shared with the EM Parity of Esteem Steering Group and is available on the East Midlands Clinical Network website.<sup>55</sup>

### 8.1.2 Leicester, Leicestershire and Rutland

- Liaison mental health services at the acute hospital now has access to primary care records, ensuring that the current physical health status of people with SMI attending hospital can be checked (Leicestershire Partnership NHS Trust)
- Leicester City commissions local STOP smoking service to support people with SMI, covering three areas of work:
  - Mental health facilitators can refer directly to STOP
  - Focus on adult mental health service users has led to an increasing number of referrals to STOP
  - Specific activity around tobacco harm reduction and brief interventions for people with SMI, recording smoking status and training frontline staff
- Commissioned primary care mental health facilitators who play a lead role in supporting physical health follow-up for people on the GP SMI register (Leicester City)
- Initiative jointly funded by the CCG and local authority to support social prescribing for patients with mental illness from the voluntary sector (West Leicestershire, Leicestershire County Council)
- Implementation of voluntary sector peer support workers who provide support for welfare, housing and employment (East Leicestershire and Rutland)
- Developing a five year workforce training and development strategy that includes a focus on the physical health needs of people with SMI (ELR)
- Implementation of the Leicestershire Physical Health Register (LPHR), a centralised electronic database designed to improve the rate of physical health screening and related interventions for service users with serious mental illness (which is managed by a Specialist Mental Health Pharmacist)
  - Flags up when screening is required or outstanding and when physical health interventions are needed
  - Achieved a 97% rate on the national CQUIN for 2014/2015 – the highest rate of any Trust in the country.

## Leicestershire Innovation Pilot

- Project: Targeting and engaging BME men and women with serious mental illness, using literature and music based interventions to improve well-being and engagement
- Lead Organisation: Leicestershire Partnership NHS Trust
- Deliverables: 28 x 2 hour weekly creative writing sessions and art sessions and music, rapping and filming sessions  
Production of a small, illustrated publication generated by the group  
Launch event for the book and film – September/October 2015
- Promotion of healthy living across themes of diet/ healthy eating, exercise, smoking, drinking and drug use
- Better engagement of hard to reach service users with healthy living services (eg: smoking cessation, drug and alcohol advice)
- Better engagement of hard to reach service users with both mainstream and non-traditional (e.g. 'Showcase Smoothie') mental health services
- Linking inpatients to main project, supporting them to attend sessions following discharge
- Increased involvement of mental health service users in meaningful activity
- See EMCN website for PowerPoint presentation and evaluation.<sup>55</sup>

### 8.1.3 Lincolnshire

- The lead mental health GP is working with the Head of Planning and Corporate Governance to develop a strategy for parity of esteem that links to and informs the Specialist Delivery Board's planning intentions for all four CCGs and the local authority.
- Appointing a psychiatric liaison nurse to manage the SMI register at a CCG level, including monitoring the number of physical health checks in the last year and liaising with public health around smoking cessation
- Appointing two Experts by Experience for Learning Disabilities and Serious Mental Illness to improve service responsiveness and flexibility to the needs of people with SMI
- Reprourement of smoking cessation services, the new service was implemented in January 2016. Commissioning specification provides for specific priority services that focus on people with SMI, which includes giving tobacco control and stop smoking advice to all providers of mental health services e.g. NHS and independent providers within the county
- Lincolnshire Partnership Foundation Trust (LPFT) has appointed a physical health care lead and board lead

for the organisation

- Quality schedule in the contract details the need for improved physical health care for people with SMI. A further CQUIN is being considered
- Liaison mental health services are commissioned for all acute hospitals, the model adopted varies by site
- LPFT are supporting a recovery in rehabilitation service and have rolled out *MyOutcomes*, a new tool which was developed for CAMHS, across all services
- Running three workshops on parity of esteem in collaboration with Implementing Recovery through organisational change (IMROC).

## Lincolnshire Innovation Pilot

- Project: To increase uptake of physical health checks and help develop care pathways and services for people with serious mental illness/learning disabilities through two champions (Experts by Experience)
- Lead Organisation: Lincolnshire West CCG  
Objectives: Provide early intervention and preventative advice and support for primary health care teams
- Act as champions in the design/development of MH/LD in Neighbourhood Teams
- Involvement of patients and carers in service development
- Expand existing Recovery College to include health advice, activities and training on mental health and well-being and systems for onward
- Deliverables: Training delivered to all surgery staff  
Training and information given to all local Third Sector organisations  
4000 leaflets produced and distributed
- 265 direct referrals for difficult to engage patients
- See EMCN website for PowerPoint presentation and evaluation.<sup>55</sup>



#### 8.1.4 Derbyshire

- Plans are in place to provide a primary care mental health worker in each practice in the North High Peaks, who will undertake health checks and follow-up for people with SMI, signpost accordingly, and ensure that the practice SMI register is up to date (North Derbyshire)
- Connected with the Wellbeing Workers pilot being undertaken by Derbyshire County Council, which is aimed at providing support to people on the SMI register in the form of social prescribing (North Derbyshire)
- Developing a clinic to improve access and monitoring of physical health needs of mental health patients (North Derbyshire)
- Clozapine clinic – British Heart Foundation are providing exercise and activities groups (Chesterfield)
- The Mental Health Trust is fully signed up to the Physical Health Checks CQUIN
- Training of the Single Point of Access to the Voluntary Sector in Mental Health needs and reasonable adjustments
- Training all smoking cessation advisors on SMI using the Northamptonshire model

#### Erewash Innovation Project

- Project: Enhancement of Voluntary Single Point of Access (VSPA) service to support patient with mild, moderate and serious mental illness
- Lead Organisation: Hardwick CCG
- Objectives: To develop an integrated approach to support that embeds parity of esteem for people with mental health conditions across voluntary and statutory services and evidences health and social outcomes in a locality.
- Outcomes: Improved access for mental health and long term conditions into voluntary sector Service users experiencing improved health and social outcomes
- Service users achieving personal outcomes
- Improved joint working
- See EMCN website for PowerPoint presentation and evaluation.<sup>55</sup>



## North Derbyshire Innovation Project

- Project: Develop a clinic to improve access and monitoring of physical health needs of mental health patients under the Care and Home Treatment Team
- Lead Organisation: Derbyshire Healthcare NHS Foundation Trust
- Objectives: Provide clients with integrated service and referral to appropriate team
- Act as “physical health champions” within the Crisis Team and the wider Trust and provide a tailored service around the client (home/hospital based clinic)
- Outcomes:  
Improved knowledge and understanding of physical health needs of patients with SMI  
Involvement of service users in the design of the service  
Better engagement of service users with physical health services post CHTT discharge
- See EMCN website for PowerPoint presentation and evaluation.<sup>55</sup>

### 8.1.5 Northamptonshire

- Supporting the national CQUIN for monitoring the physical health care of mental health in-patients (Northamptonshire Healthcare Trust)
- Developing a recovery college for people with SMI which incorporates a smoking cessation service (Nene and Corby)
- Wellbeing and community interest project that supports the prevention agenda through smoking cessation and weight management is currently out for public consultation, with a view to developing an operational policy (supported by the NHS, public health, county council and higher education)
- Implementation of a ‘train the trainer’ programme in mental health and wellbeing for practice and community nurses led by Dr Sheila Hardy and accredited by the Royal College of General Practitioners (RCGP). Healthcare professionals from interested organisations are trained in five modules including physical health in mental illness which covers best practice guidance in carrying out physical health checks and how to use the appropriate tools.

## Northamptonshire Innovation Project

- Project: Incorporating smoking cessation services provided in Northamptonshire within the new well-being service
- Lead Organisations: Northamptonshire Healthcare NHS Foundation Trust and Nene CCG
- Objectives: Smoking cessation advisors to understand SMI and manage consultations  
Develop governance and process for peer led course  
People with SMI to coproduce/deliver course with coordinators and to learn from experiences – also to raise awareness of the peer led course
- Wellbeing Education Network – together stakeholders to develop a potential recovery college model
- A number of barriers affected the project which impacted on the ability to have an effect on patient outcomes.
- See EMCN website for PowerPoint presentation and evaluation.<sup>55</sup>



## 9. Identification of best practice models and innovative interventions that help address shortfalls and meet national guidelines/standards

Dr Geraldine Strathdee the former National Clinical Director for Mental Health has five recommendations for implementing change in physical health and serious mental illness:

- Board to floor commitment and accountability
- Program Manager PID agreed with commissioners
- Clinical Team Dashboard
- Employment of Champion Specialists who provide Master Classes to mental health teams and GP practices
- Smoke free policy by the Mental Health Trusts

### 9.1 National Examples of Good Practice

There is no shortage of such evidence from which we can learn and develop. I have chosen a few examples to illustrate the main lessons. Many other examples of good practice will exist which may well be of equal merit.

The overall picture of good quality involves addressing the whole pathway from prevention, early intervention, evidence based treatment, supported access and care, and needs to cover primary and secondary care. Since the medication is a pathogenic factor prescribers and pharmacists play a key role.

#### 9.1.1 Supportive Toolkits and Information (Appendix 7)

Excellent helpful evidence based Toolkits have been developed and are widely used to support clinicians, patients, Trusts and Health and Wellbeing Boards to facilitate and promote evidence based comprehensive health checks as recommended by National Audit on Schizophrenia (NAS).

Rethink Mental Illness and NHS England have developed a free toolkit to support implementation of the Physical Health CQUIN.<sup>56</sup>

The toolkit is full of practical resources such as:

- The Integrated Physical Health Pathway which supports primary and secondary care services to work together to monitor and address the physical health needs of people affected by mental illness
- A poster which outlines the physical health tests that need to be done and what should happen next. This should be used in inpatient mental health wards and GP treatment rooms
- A Self-Assessment of Readiness to **Implement (SARIT)** for providers introducing the CQUIN, and a physical health check tool to structure discussions and assessment of physical health concerns.

#### 9.1.2 Cardiac Risk Calculator

QRISK2 gives a patient a 10 year combined risk of heart disease or stroke. The usual threshold for concern is 10% and then interventions are offered starting with lifestyle. However, with respect to young people the QRISK2 may seem quite un-concerning if it is say 3 or 5% over 10 years as an absolute risk. The JBS3 calculator (Joint British Societies for the Prevention of Cardiovascular Disease) provides a 10 year risk and also a lifetime risk or cardiovascular age. Professor Huon Gray, the National Clinical Director for Cardiology suggests this is a more persuasive approach and QRISK2 for younger adults with SMI, as being told that their heart is relatively 5 or 10 years older than their chronological age is more motivational (personal communication).<sup>57</sup>

### 9.2 Secondary Care Examples

It is one thing to have the tools, but another to train your staff to use them systematically. Many Trusts have already started to prioritise physical health care of SMI and are making progress. There are some examples worth mentioning below:

#### 9.2.1 Leicestershire Partnership NHS Trust (Appendix 8)

Ms Dolly Sud was employed as a liaison pharmacist by the Trust to help achieve the Cardiometabolic CQUIN. In order to improve the rate of physical health screening and related interventions for service users with severe mental illness we created a centralised electronic database for the Leicestershire Physical Health Register (LPHR) which is managed by the Liaison Specialist Mental Health Pharmacist. The database flags up the screening required/ outstanding and we are proactive in making sure this happens. The system also flags up when physical health interventions are needed which we ensure are acted on. The Trust achieved a superb 97% rate on the National CQUIN for 2014/2015 – the highest rate of any Trust in the country. The pathway to achieving success is described in Monitoring the Physical Health of People with Mental Illness, Leicester Partnership NHS Trust, Dolly Sud, September 2015.<sup>58</sup>

### 9.2.2 Boroughs Mental Health Trust

The Northwest of England commissioned Advancing Quality Alliance AQuA<sup>59</sup> in 2012 to improve cardiovascular checks throughout their two localities. An audit, recommendations and then a re-audit was done of the level of physical health screening of SMI including early intervention psychosis. A robust and comprehensive recording system was developed, resulting in more service users receiving appropriate screening and physical health monitoring. Better links and working relationships were established with primary care services and increased awareness of the need for physical health monitoring in staff and users. Regular, well-equipped physical health clinics with well-trained staff were established.<sup>60</sup>

### 9.2.3 The South East Essex Model (Appendix 9)

South East Essex have set a high standard of care with excellent uptake of health checks. Critical to the success of rolling out this service was the setting up of an Executive Steering Group and a Physical Health Action Implementation Group. Without this high level leadership and operational accountability success would not be achieved. The multidisciplinary group check all the pathways are operational and escalate issues that require high level input.

In addition to using the Lester Tool they developed a Physical Health Passport for their patients with SMI. The passport was a success with the service users and was subsequently recommended by the NAS.

They however still faced a problem with the interface and transference of good care over to the community and primary care and a project was initiated in Bradford to address this as described below.

### 9.2.4 The Bradford Model (Appendix 10)

One of the most impressive examples of best practice is in Bradford where Kate Dale and Kate Beedle developed an award winning template for the processing, collecting and sharing of data around physical health which could be used in both primary and secondary care alike. The information was therefore shared and available empowering joint collaborative working between the services and substantial improvements in the coverage of the health care interventions required. The data capture and IT template are critical to capturing and sharing information with primary care. However, it should be carefully noted that Bradford invest significantly in training and support of their Trust staff and offer training to general practice nurses.<sup>61</sup>

A significant proportion of SMI patients were excluded from the SMI register and only a third of people on the register had an annual physical health check recorded. The screening template was taken up by 75% of GP practices and was associated with better quality screening than usual care, doubling the rate of cardiovascular risk recording and the early detection of high cardiovascular risk.



### 9.2.5 The NHS England Pilot Sites (Appendix 11)

The above successful local models stimulated great interest in NHS England. The 'Sustainable Improvement Team' (previously NHSIQ) aim to improve outcomes across England by providing improvement and change expertise. They in turn commissioned the Royal College of Psychiatrists to pilot the introduction of cardiovascular disease screening and interventions into four Mental Health Trust sites. The aim was to establish the feasibility of rolling out the Lester Tool to all patients with SMI in an inpatient setting. The findings were presented in London on 27 January 2016 at 'Improving Physical Health Screening and Intervention Levels for People with Serious Mental Illness' which has determined a number of successful approaches (**Appendix 12**). The full report was published in April 2016.<sup>62</sup>

The pilots were broadly successful in demonstrating how the general mental health workforce can deliver physical health care screening and interventions at scale for people with SMI under the care of a secondary mental health trust. Inpatients receiving all five recommended CVD screens increased from a baseline of 46% across all sites to 83% at follow up. The culture of the workforce has demonstrably changed so that physical healthcare is now automatically considered alongside the mental health or illness. Documenting interventions easily and contemporaneously was shown to be possible and important. Over 90% of service users warmly welcomed the physical health screening and interventions.

Following this evaluation Dr Ben Thomas has written a report in May 2016 for the Department of Health and Public Health England; '**Improving the physical health of people with mental health problems: Actions for mental health nurses**'. This timely and welcome toolkit pulls together all the screening, interventions and rationale for implementing the Lester Tool as well as screening for alcohol, sexual dysfunction and falls.<sup>63</sup>



## 9.2.6 The Crucial Secondary Care – GP Interface

Areas of difficulty still exist, unsurprisingly, such as a lack of follow up of interventions and investigations in the community. This is because the patients move on to their homes and GP care and there is propensity to a lack of continuity; which is why a collaborative approach is critical to avoid patients falling through the gaps.

If the system is to work the interaction between the secondary care screening, data and interventional pathways needs to be streamlined with the processes in primary care. This is potentially the greatest challenge of all. So by now the mental health inpatient has a physical health screen and plan with the relevant follow up in place. The IT template allows the clinicians to see the plan in secondary care and primary care. Clear expectations of who is responsible for which test and when are needed to avoid pathway confusion and patient drop out. The GP practice will take on the care of the patients according to NICE guidance or other locally agreed commissioned arrangements. The GP practice nurses require some additional training to understand SMI and their specific requirements and to make reasonable adjustments where needed. Such training has been produced to an exceptional level as follows and has been shown to be transferable at scale via a train the trainer model.

Of course whilst physical health checks by Mental Health Trusts are of paramount importance the recognition that this group of patients have a unique set of personal hurdles to overcome with respect to their capacity, motivation, emotions, employment, isolation, relationships, communication and social circumstances makes it all the more necessary that the services commissioned are geared towards meeting their particular needs. 'Off the shelf' approaches will not, and clearly have not worked to date, whereas, flexible, innovative, highly committed approaches are needed to be effective.

## 9.3 Primary Care Examples of Best Practice

### 9.3.1 Training for Practice Nurses – Masterclasses (Appendix 13)

Dr Sheila Hardy Senior Research Fellow at Northamptonshire Healthcare NHS Foundation Trust developed with commissioners the approach to training the trainers, provisionally with Community Psychiatrist Nurses through to practice nurses to identify the physical health checks needs using The Lester Tool. The tool originated in New Zealand and was modified by Dr Helen Lester for guiding a practitioner using a comprehensive physical health check.<sup>64</sup>

Dr Lester was Professor of Primary Care at the University of Birmingham, a GP and the Founder of the Joint Commissioning Panel for Mental Health who championed the improvement of physical health in SMI and introduced the New Zealand screening approach to the UK which is now posthumously named after her.

The cardiovascular risk and interventions in patients with SMI have their QRISK2 measured. This gives a 10 year combined cardio-cerebrovascular risk. The recommended therapeutic threshold for interventions is 10%; however, these should begin with lifestyle measures and only later medication.

Dr Sheila Hardy has devised a range of masterclasses for practice nurses<sup>65</sup> and has developed a train the trainer module so the skills can be cascaded at scale and pace. She has trained hundreds of practice nurses on behalf of UCL. The London report includes a section on the audit done by Dr Hardy, working for UCL at the time, who trained almost 200 practice nurses.

Research by Dr Hardy has gained insights into the views of those with SMI and reveals what they would find the most useful effective approach by practice nurses. Continuity of care is unsurprisingly top of the list. See The Northampton Physical Health and Wellbeing Project: The views of patients with severe mental illness about their physical health check.<sup>66</sup>

### 9.3.2 General Practitioners

General Practitioners are most usually the best placed clinicians to offer expert general medical care to their patients. They have the breadth of knowledge and understand holistic care since they are not specialists and patients present with their psychosocial as well as biological issues. They are ideally placed to consider the impact on and needs of family members and carers in addition to the patient.

## Cultivating Mental Health Promotion and Prevention in General Practice Report October 2015

These valuable proposals were created by an expert Think Tank, convened by ETHICS in collaboration with the London Journal of Primary Care and Royal College of General Practitioners. The Think Tank included professionals from primary care, public health, psychiatry, community development, clinical practice and commissioning. There was expertise in qualitative and quantitative research, epidemiology, guideline development, education and training, inter-sectoral collaboration, situation appraisal and policy development. The detailed recommendations made by the Think Tank for each level of the service (community, GP, practice, cluster of practices, CCG and HWB) and each stage of the life course (preconception to end of life) and the background briefing supporting them can be found on the ETHICS website ([www.ethicsfoundation.org](http://www.ethicsfoundation.org)).





### **The twelve messages to achieve improved mental health for all and to save lives:**

1. Mental health promotion and prevention are too important to wait
2. Work with your community to map risk factors, resources and assets
3. Good health care, medicine and best practice are biopsychosocial rather than purely physical
4. Integrate mental health promotion and prevention into your daily work
5. Boost resilience in your community through approaches such as community development
6. Identify people at increased risk of mental disorder for support and screening.
7. Support early intervention for people of all ages with signs of illness
8. Maintain your biopsychosocial skills
9. Ensure good communication, interdisciplinary team working and intersectoral working with other staff, teams and agencies
10. Lead by example, taking action to promote the resilience of the general practice workforce
11. Ensure mental health is appropriately included in the strategic agenda for your cluster, at the Clinical Commissioning Groups, and the Health and Wellbeing Board
12. Be aware of national mental health strategies and localise them, including action to destigmatise mental illness within the context of community development

General practitioners would surely recognise all these as useful and valid messages given the daily workload of intermingled mental and physical health care issues.

### **9.3.3 Training**

General Practitioners on the whole are better trained in physical health than mental health and yet they spend about 30% of their time managing mental disorders. CCGs need to provide support for their Continuing Professional Development. There are impressive examples of this happening around the country such as Kingston CCG and Hackney CCG. Oxleas has run popular integrated physical and mental health GP Masterclasses for 10 years (personal communication, Dr Geraldine Strathdee).

Dr Ian Walton has developed Primary Mental Health Care courses for GPs through **Primary Care Mental Health Education, PRIMHE**, with good uptake by CCGs.<sup>67</sup>

### **9.3.4 Funding**

General Practitioners do get a small payment for SMI physical health checks via QOF but this does not require the LESTER Tool to be used or a Physical Health Care Plan. Hackney CCG has a Locally Enhanced Service for GPs to offer an extended health check and plan with extremely good uptake and feedback from staff and patients. As part of the scheme GPs receive mandatory mental health training. This has achieved widespread uptake of GP mental health training and SMI health checks in Hackney.



### 9.3.5 Federations and New Models of Care

GP practices are increasingly working together with other practices in federated organisations, sharing 'back office' functions and some services. Federations or large practices will be an ideal opportunity to enhance the mental health training and services. In addition, meeting the needs of patients in the communities rather than at the hospital door requires new models of delivering care such as below:

**Multispecialty Community Provider Groups (MSCPs)** - GPs and nurses, community health services, hospital specialists and hopefully mental health and social care to create integrated out-of-hospital care.

**Primary and Acute Care Systems** - integrated hospital primary care provider- general practice and hospital services working together.

**Redesigning of Urgent and Emergency Care** - These services will be redesigned to enable Accident and Emergency departments, GP out-of-hours services, urgent care centres, NHS 111 and ambulance.

**Enhanced health in Care Homes** - NHS England will work with the local NHS and the care home sector to develop shared models of in-reach support, including medical reviews, medication reviews and rehabilitation services.

**Specialised Care** - NHS England will work with local partners to create specialist providers to develop a network of services over an area; integrating different organisations and services.

### 9.3.6 Smoking Cessation

Smoking cessation is of paramount importance for SMI as it is the single most negative factor with respect to cardiovascular disease.

"Smoking remains the primary cause of preventable illness and premature death in England, and evidence shows that people living with mental health problems are more likely to smoke. Public Health England believe it is vital to reduce smoking rates among people living with mental health problems" Seamus Watson, national programme manager for wellbeing and mental health at Public Health England, October 2014.

Sheila Hardy has demonstrated that through training of practice nurses in SMI there is an increase in the nurse's skill and enthusiasm which translates into more advice being given to patients.<sup>68</sup>

When compared with diabetics in primary care her research shows SMI receive a much reduced screening and advice experience.<sup>69</sup>

Thereafter, the patients once motivated access a smoking cessation advisor. Standard training of such advisors does not include education on mental health, SMI or antipsychotics. Sheila Hardy has developed a training module for the advisors which simply supplements their existing training such that they have the understanding, knowledge and skills to support smoking cessation in patients on clozapine. This includes understanding the mental state changes which require signposting to the GP and that dosage of clozapine may need to be adjusted as nicotine levels fall. This work is one of the East Midlands Clinical Network Innovation Pilots for Parity.

### 9.3.7 Smoke-free Trusts

Increasingly mental health trusts are adopting a Trust-wide Smoke-free Policy including Broadmoor, the Maudsley and Lancashire. Secure mental health units have led the way on better physical care and smoke free wards. This has resulted in improved uptake of smoking cessation services for patients, greater awareness of CVD risk and other risk factors. The IT systems are adapted to ensure prompt referral is made to cessation services. Several East Midland Trusts have followed suit this year. Some Trusts extend this to general health promotion including football, dance, aerobics skills, and wellbeing events for staff. Rotherham, Doncaster, Oxleas and South Humber NHS Foundation Trusts have programmes of increased gym and exercise class availability for patients, and support staff use.

## 10. Summary and Next Steps

Achieving parity of esteem is an ongoing project for everyone and needs to be embedded into our everyday practice of commissioning and providing health and social care.

There is much to celebrate about the efforts and successes in the East Midlands. This report brings together and highlights the evidence base on effective measures to achieve parity of esteem. The aim is to motivate and empower the adoption of best practice throughout the region.

### 10.1 Report on Parity of Esteem and Infographics

The report provides a summary of the historical, political and scientific story of parity of esteem and provides an overview of the current and evolving picture of parity in our region. The story is a fascinating one rooted in human rights and the need for equity. Achieving parity of esteem requires a collaborative effort which is demonstrated by the willingness of colleagues across the country to share their work, examples of which I have included in this document. The description of the current shortfalls and the evidence base for effective interventions makes the case for change compelling.

As the health and social care structure continues to evolve there is a really wonderful opportunity, right now, for all parties to align their priorities through the vehicle of Sustainability and Transformation Plans. The plans require organisations to work together to achieve real change for the communities they serve, bringing about a comprehensive and seamless pathway of care for patients. They will share joint system priorities which emphasise mental health, primary care, prevention and cost effectiveness.

Key data on mental health is more readily available than it was even a year ago and this, alongside the Infographics produced by the East Midlands Mental Health Network at CCG and regional level<sup>70</sup>, provides us with a clear vision of the inequitable outcomes for individuals with a Long Term Condition, who also have an SMI. The data also brings into focus the impact on acute services that can result from people not receiving the tailored preventative care they require. Such persons are few in number but significant in their impact on services. The hypothesis is clear: people affected with SMI and a long term condition receive less effective community-based preventative physical care. Our challenge and commitment is to address this through a wide variety of approaches that have been shown to be effective.

We need to target care for this group of patients and tackle the inverse care law in order to achieve parity of esteem. The voice of service users is of paramount importance in achieving effective change. With this in mind, the London Strategic Clinical Networks have consulted the National Service User Network in order to co-produce helpful guidelines for commissioners called 'Stolen Years' on the services needed for physical health care needs of people with serious mental illness.<sup>71</sup>

### The East Midlands Parity of Esteem Infographic for people with severe mental illness in the East Midlands





# Parity of esteem for people with severe mental illness



The **life expectancy** of people with mental health problems is **significantly lower** than average. Men with a mental health problem die **11 years** earlier than average and women die **10 years** earlier than average.

People with schizophrenia are:

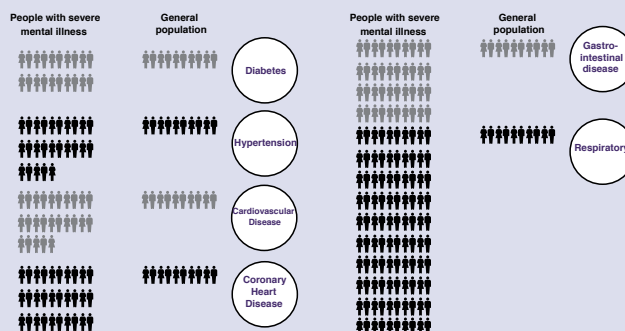
**2x** more likely to die from cardiovascular disease.

**3x** more likely to die from respiratory disease.

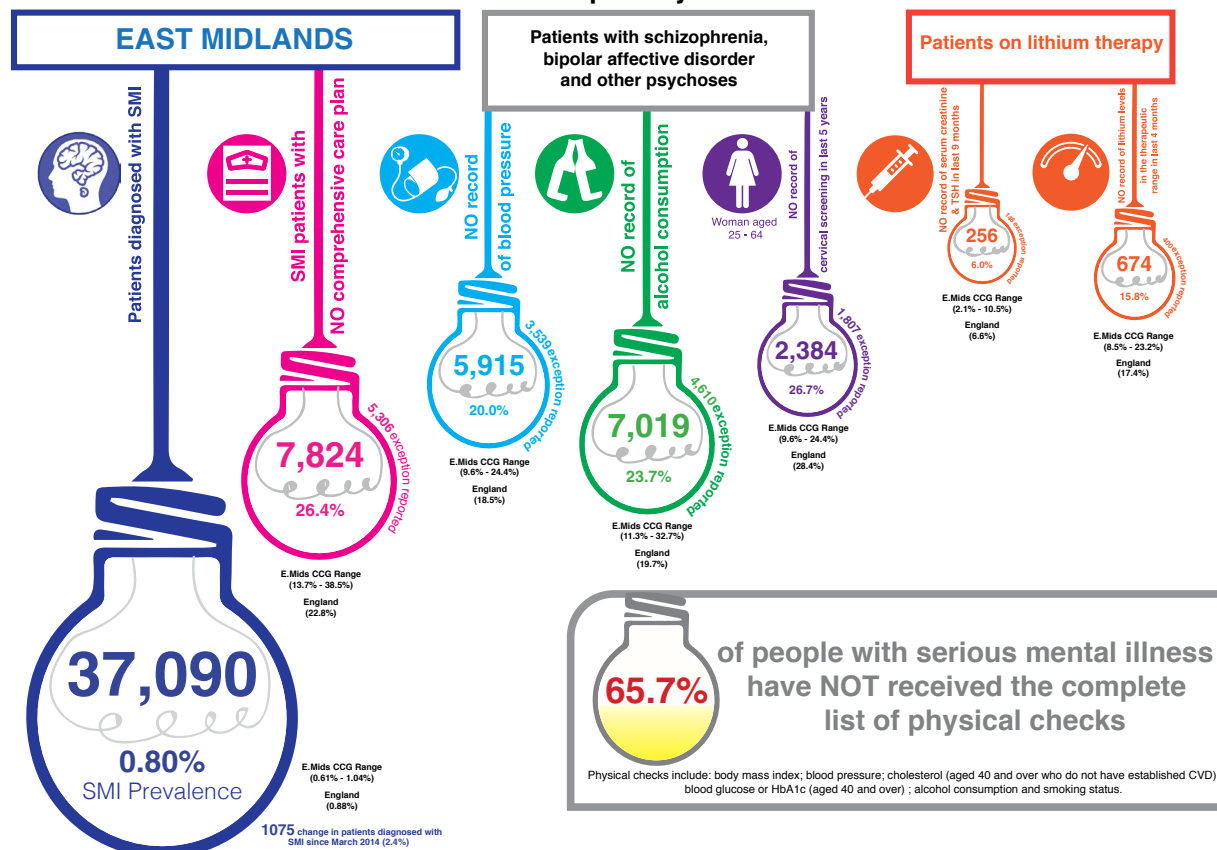
Smoking is the single biggest factor in **reduced life expectancy** in people with psychosis  
**40%** of this group are smokers

**42%** of all cigarettes are smoked by someone with a mental illness.

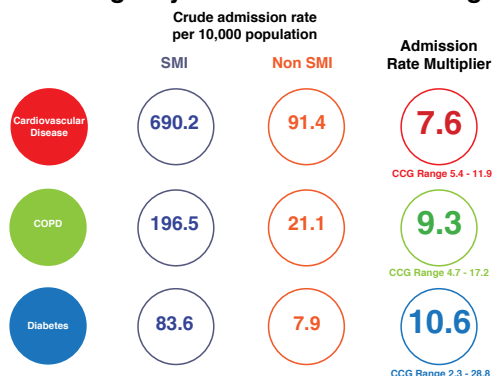
## Relative physical health risks for people with SMI



## Severe mental illness in primary care 2014 - 2015



## Comparative emergency admission rates for long term conditions



NHS

Produced by East Midlands Clinical Networks



This infographic of the East Midlands has been distributed to each CCG in the East Midlands. CCGs also received an infographic specific to their population in order to focus on their own area. These are available on the EMCN website.<sup>55</sup>

Already the sharing of this information has acted as a stimulus to include parity in their commissioning. Business plans around parity are emerging. Conversations have started around the variation between CCGs which may, or may not, be warranted.

Hopefully the key priorities are clear; namely smoking cessation, comprehensive health checks, lifestyle advice in primary or secondary care, information sharing, personal health care plans, hospital liaison psychiatry, integrated approaches to care, bespoke smoking cessation services and commissioning of proven community interventions that adopt reasonable adjustments for people with SMI.

The lack of physical health checks in primary care are no doubt a single, yet significant, factor in the poor community health of people with SMI. The result is under-recognised or untreated chronic illness and eventually frequent emergency hospital attendances for physical ailments. The need for acute admission is in the region of tenfold higher than for an equivalent cohort of people who have the same long term conditions but no SMI. The length of stay is also longer; no doubt due to a combination of factors such as complex management and a lack of discharge support.

So what can be done to improve GP health checks? Firstly, it should be recognised that primary care is under pressure and facing unprecedented change. There is a need for community care, the third sector and local communities to become part of the solution in providing equity of access. Practices need to make reasonable adjustments and offer a personalised service. Where needed, support workers should be able to help patients to attend primary care and the interventions thereafter. Only if patients are given a personalised plan and access to evidence based services that understand and meet their specific needs, will the health checks ultimately produce the desired outcome. Primary Care has gone a long way to achieving this already for patients with learning disabilities; and now it's 'time to change' and do it for the mentally ill.

When analysing the QOF data for East Midlands there exists a high degree of variance between CCGs with respect to Exemption Reporting. For example; the percentage of patients on a practice SMI register who are exempt from Blood Pressure checks ranges from 3.3 % to 18.8%. In general exemptions are higher in the East Midlands than in England as a whole.

Rates of attendance by SMI patients to annual checks is lower than that of diabetic patients.<sup>72</sup> This perhaps explains why the 'exemption rate' is also higher for this group of patients. When patients do not attend an appointment or refuse care they can be 'exempt from the QOF register'. Exemption rates for those on SMI registers are significantly higher than the rates for those on the diabetic or other long term condition register. There is wide variation in the rate of exemptions between different GP practices and this needs to be understood, a cause for reflection and perhaps even challenge. The population demographics, availability of resources in primary care, or the need for reasonable adjustments may explain patient lack of engagement.

## 10.2 East Midlands Clinical Network Parity of Esteem Steering Group

In February 2016 the East Midlands Mental Health Clinical Network launched the Parity of Esteem Steering Group, comprised of clinicians, commissioners, quality improvement managers and providers from CCGs, public health, local authorities, mental health trusts and primary care representing all the localities in the East Midlands.

The group acknowledges the need to continually grow and develop and recognises the importance of fostering the engagement of non-mental health providers and commissioners in the parity of esteem agenda. This, in turn, will support the development of properly integrated mental and physical health care provision that will help to eliminate stigma and ensure the development of integrated services providing holistic care.

The steering group holds a 'learning exchange' every two months and all the shared learning will be available on line via the Clinical Networks website. Every area has examples of working to meet the challenges we face and whether successful or not the experiences are valid lessons. Some really exciting, pioneering work is happening and as it comes to fruition it will add to the body of evidence.

**Shared Learning Events** so far include presentations on the following:

### April 2016 Nottinghamshire

Physform is an annual physical health summary that is recorded by GPs for patients with serious mental illness, generating an action plan in collaboration with the mental health trust in order to agree health priorities for the patient. A two year project.

## June 2016 Lincolnshire

### IT Portal for Integrated Care

Development of a care portal that will link all clinical systems across Lincolnshire as part of the Lincolnshire Health and Care programme.

### Re-procurement of smoking cessation services

Commissioning specification provides for specific priority services that focus on people with SMI, which includes giving tobacco control and stop smoking advice to all providers of mental health services.

## August 2016 Derbyshire

### Bite sized Clinical Ward Teaching

Satisfying the appetite for ward based knowledge of physical health problems. Innovative work via brief tutorials on physical health problems to nursing and healthcare assistants delivered in 10 minute sessions on the ward.

### The Erewash Mental Health Innovation Project

The shared learning from year 1 of the project. Developed to improve access into voluntary sector support for people with mental health conditions through enhancements to v-SPA (Voluntary sector Single Point of Access). It has also utilised the council for voluntary services to support mainstream groups in becoming mental health friendly through champions, buddies and befrienders.

## October 2016 Northamptonshire

### The Nene CCG Primary Care Quality Contract

For the first time the primary care quality contract has a specific mental health element to it which incentivises primary care in a number of areas related to mental health and wellbeing.

### Suicide Awareness and Mitigation Training

A programme of training which is being rolled out across primary care that sits alongside the Suicide Assessment E-Tool Triage version. This is an evidence based assessment framework that helps to apply research evidence to clinical practice and guides clinicians through a 10 minute triage assessment process to determine the appropriate response to an individual who is experiencing symptoms of depression or are at risk of suicide.

## 10.3 Parting Words

Finally, Parity of Esteem is an exciting prospect and achievable goal. The momentum of change is at its highest as evidenced by the encouraging wave of reports that came out only last month.

- A Joint Report published on 23 October 2016 by the Royal College of Psychiatrists and the Academy of Medical Royal Colleges sets out essential actions to improve the physical health of adults with severe mental illness.<sup>73</sup> This report is timely and welcome and gives simple clear achievable actions for each organisation to do including strategies, workforce education and policies.

- NHS England published their Mental Health Dashboard<sup>24</sup> as mentioned earlier.
- Public Health England have published a 'Psychosis Data Report – describing variation in numbers of people with psychosis and their access to care in England'.<sup>74</sup>
- MIND have published a report called 'Better equipped, better care'<sup>75</sup> highlighting the desperate need for a co-ordinated comprehensive approach to training the workforce in primary care in matters of mental health. This followed on from their 'find the words' campaign<sup>76</sup> to encourage and assist people to be better able to discuss their emotions and feelings with staff.

The list goes on as the momentum is unstoppable.

Do check out the East Midlands Clinical website on **Parity of Esteem**<sup>55</sup> where you will find links to all the innovation pilots, our regional conferences on innovation, parity and integration, the parity of esteem infographics for the region and this report complete with references and appendices.

Thank you for reading the report and for working so hard together towards our goal; to empower people with severe mental illness to enjoy the healthier longer lives they deserve.

Lastly, thank you to the wonderful team of colleagues I work with at the East Midlands Clinical Network without whom this report would still be just a pipedream.

*'Enjoy your achievements as well as your plans. Keep interested in your own career, however humble; it is a real possession in the changing fortunes of time.'*

Desiderata; Max Ehrmann

Report written by:



### Dr Sohrab Panday

Clinical Lead – Parity of Esteem,  
East Midlands Mental Health Clinical Network  
November 2016

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# Appendices

## Appendix 1

### Second National Audit on Schizophrenia 2014

<http://www.rcpsych.ac.uk/pdf/FINAL%20report%20for%20the%20second%20round%20of%20the%20National%20Audit%20of%20Schizophrenia%20-%208.10.14v2.pdf>

A major finding from both rounds of the audit is the lack of monitoring and intervention for key physical health indicators for this patient group. This finding prompted the College to work with NHS England, Public Health England, and other professional bodies to develop a quality improvement tool to promote better physical health care for people with psychosis. The Lester Cardio-metabolic Resource is included on page 165 of the report.

### Monitoring and intervention for physical health problems

Diabetes and cardiovascular disease are more prevalent in people with schizophrenia and are significant contributors to the premature mortality suffered by this population. It is important that service users are monitored for six important risk factors for these disorders. Clinicians should enquire about family history of diabetes and cardiovascular disease as well as assessing five other factors: smoking, elevated body mass index (BMI), blood glucose control, blood lipids and blood pressure. This monitoring should be carried out on at least an annual basis. Yet reports such as NAS1 have demonstrated that such monitoring frequently does not occur.

In NAS2, 33% had five of these factors (excluding family history) monitored, compared to 29% in NAS1, demonstrating some improvement but also the considerable ground that secondary care and primary care services need to make up to reach an acceptable provision of care.

- Only 9% of service users in NAS2 had all six of the above risk factors, including family history, assessed in the previous year. For 6% there was no evidence that any of these had been monitored. This is not adequate.
- Even monitoring of something as basic as a service user's BMI was only recorded for 52% in NAS2, and 51% in NAS1.
- The provision of interventions when evidence of health risks is found is also poor. For example, in NAS2 only 36% of service users with evidence of impaired control of blood glucose (suggesting diabetes or pre-diabetic) had evidence of intervention. This was 53% in NAS1.

Clearly the provision of such monitoring and appropriate intervention needs to be improved. Three barriers in this area are: (i) availability of staff time, appropriate facilities and equipment; (ii) the need for formal systems to review physical health data and interventions required on at least an annual basis; and (iii) the need for more formal arrangements regarding collaboration between primary and secondary care in relation to physical health. The new NICE guideline (NICE CG178, 2014) gives clear guidance regarding this last issue.

## Appendix 2

### NICE GUIDELINES CG 178 Published February 2014

#### *Psychosis and schizophrenia in adults: treatment and management*

<https://www.nice.org.uk/guidance/CG178>

NICE QUALITY STANDARD QS80 Published February 2015

<http://www.nice.org.uk/guidance/qs80>

### List of Quality Statements

**Statement 1.** Adults with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral.

**Statement 2.** Adults with psychosis or schizophrenia are offered cognitive behavioral therapy for psychosis (CBTp).

**Statement 3.** Family members of adults with psychosis or schizophrenia are offered family intervention.

**Statement 4.** Adults with schizophrenia that has not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine.

**Statement 5.** Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.

**Statement 6.** Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.

**Statement 7.** Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

**Statement 8.** Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

## What the quality statement means for service providers, health and social care practitioners, and commissioners

***Service providers (such as GPs, community health services and mental health services) ensure that protocols are in place to carry out comprehensive physical health assessments in adults with psychosis or schizophrenia, and share the results (under shared care arrangements) when the service user is in the care of primary and secondary services.***

Health and social care practitioners ensure that they carry out comprehensive physical health assessments in adults with psychosis or schizophrenia, and share the results (under shared care arrangements) when the service user is in the care of primary and secondary services.

Commissioners (such as NHS England local area teams and local authorities) ensure that they commission services that can demonstrate they are carrying out comprehensive physical health assessments in adults with psychosis or schizophrenia, and include this requirement in continuous training programmes. They should also ensure that **shared care arrangements** are in place when the service user is in the care of primary and secondary services, to ensure that the results of assessments are shared.

## What the quality statement means for patients, service users and carers

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

## Appendix 3

### ***2015/16 General Medical Services (GMS) contract Quality and Outcomes Framework (QOF)***

Guidance for GMS contract 2015/16 March 2015

Note: These requirements remain unchanged for 2016/17 QOF

<http://www.nhsemployers.org/your-workforce/primary-care-contacts/general-medical-services/quality-and-outcomes-framework>

See pages 87-95 for Mental Health

## Summary:

Mental Illness for the purposes of QOF comprises of all cases of Severe Mental Illness

NICE clinical guideline on psychosis and schizophrenia in adults recommends primary care utilise registers to monitor the physical health of patients with psychosis or schizophrenia.

The NICE clinical guideline on bipolar disorder recommends that patients with bipolar affective disorder have a physical health review, normally in primary care, performed at least annually, including the following health checks:

- weight or BMI, diet, nutritional status and level of physical activity
- cardiovascular status, including pulse and blood pressure
- metabolic status, including glycosylated haemoglobin (HbA1c) and lipid profile
- liver function
- renal and thyroid function, and calcium levels, for people taking long-term lithium.

Meanwhile QOF continues to only incentivise annual monitoring of blood pressure, alcohol and smoking status for patients with schizophrenia, bipolar affective disorder and other psychoses. Clinicians should use their professional judgement to decide when and how frequently checks of lipid levels, glucose levels and weight should be carried out, in accordance with the needs of each patient. NHS Employers are still to reconsider if these should be adopted by QOF.

In addition to lifestyle factors, such as smoking, poor diet and lack of exercise, antipsychotic drugs vary in their liability for metabolic side effects such as weight gain, lipid abnormalities and disturbance of glucose regulation. Specifically, they increase the risk of the metabolic syndrome, a recognised cluster of features (hypertension, central obesity, glucose intolerance or insulin resistance or dyslipidaemia) which is a predictor of type 2 diabetes and CHD113.

NICE CG178. Psychosis and schizophrenia in adults: treatment and management 2014.

<https://www.nice.org.uk/guidance/CG178>



## Appendix 4

Written evidence submitted by the Royal College of General Practitioners mental health training and education advisory group (PRI0216)

### The evidence base in primary care mental health-what works?

<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/primary-care/written/20512.html>

## Appendix 5

The EOE SCN Report on Primary Care - Mental Health Interface Models and Toolkit for Commissioners

<http://www.slcsn.nhs.uk/scn/mental-health/london-mh-scn-primary-care-commiss-072014.pdf>

## Appendix 6

DOH Mandate to Health Education England on Mental Health

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/411200/HEE\\_Mandate.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/411200/HEE_Mandate.pdf)

### 1. Mental Health

- 1.1 All health professionals need to have understanding of mental health conditions. HEE has developed training programmes that will enable health and care employers to ensure that all staff have an awareness of mental health problems and how they may affect their patients. These programmes include an awareness of the links between patients' mental and physical health and the impact of co-morbidity and the importance of work to health and health outcomes as well as the actions they can take to ensure that patients receive appropriate support. HEE will continue to work to increase the numbers of doctors in foundation training undertaking placements in psychiatry.
- 1.2 Training should raise awareness of the increased likelihood of mental health problems presenting themselves in those people with long-term conditions, including dementia, and the need for care to address both issues concurrently. It is vital that psychiatric treatments are integrated into existing service delivery and care for people with long-term conditions. As part of the Shape of Training review, HEE will explore with relevant stakeholders, including the royal colleges and professional bodies, how education and training can best support clinicians to identify and deal with mental health conditions in patients with long term conditions, including training in dementia. Focus should also be given to support autism awareness in line with Think Autism13, the April 2014 update to the 2010 Adult Autism Strategy.

- 1.3 Continuing to work with the Royal College of General Practitioners, HEE should continue to support the inclusion of compulsory work-based training in mental health (including dementia) in GP training.

- 1.4 HEE will continue to work with the Royal College of Psychiatrists to further enhance bespoke training courses to allow GPs to develop a specialist interest in the care of patients with mental health conditions.

- 1.5 HEE, working with the Royal College of Psychiatrists and Royal College of General Practitioners has developed an e-learning package to support continuing professional development for GPs in mental health ensuring that GPs have ready access to the most up to date knowledge available in this vitally important area of health care. This will enable recognition of mental illness and access to the right care pathway including IAPT and specialist mental health services.

## Appendix 7

### Toolkits and Resources

A number of helpful evidence based Toolkits have been developed and widely used to support Trusts and Health and Wellbeing Boards to facilitate and promote evidence based comprehensive health checks and are recommended by NAS.

<http://www.rcpsych.ac.uk/quality/nationalclinicalaudits/schizophrenia/nationalschizophreniaaudit/nasresources.aspx#LesterResource>

The **Lester Cardiometabolic Tool** was developed by Helen Lester for the Royal College of Psychiatrists to aid the physical health checks and interventions for those with psychosis.

**The Integrated Physical Health Pathway** was developed by Rethink Mental Illness, is a resource that supports health professionals to coordinate physical health monitoring for people affected by mental illness and ensure information is communicated effectively between services. The resource was designed in collaboration with the Royal College of GPs, the Royal College of Nursing and the Royal College of Psychiatrists. It sets out a template for services across primary and secondary care to work together to ensure the physical health needs of people affected by mental illness are identified and addressed. Further resources and information can be found at [www.rethink.org/phc](http://www.rethink.org/phc)

**The Healthy Active Lives (HeAL) Leaflet** on 'Keeping the body in mind in youth with psychosis' is aimed at prescribers, particularly for prescribing for first episode psychosis.

[www.iphys.org.au/SHI\\_13030\\_HeAL\\_update\\_8\\_download.pdf](http://www.iphys.org.au/SHI_13030_HeAL_update_8_download.pdf)

**Rethink Mental Illness** has a suit of relevant leaflets and posters on physical health in SMI. The Self-Assessment of Readiness for Implementation Tool (SARIT) aids CQUIN delivery.

[www.rethink.org/about-us/health-professionals/physical-health-resources](http://www.rethink.org/about-us/health-professionals/physical-health-resources)

'Essentials of Physical Health in Psychiatry' book.

[www.rcpsych.ac.uk/usefulresources/publications/books/rcpp/9781908020406.aspx](http://www.rcpsych.ac.uk/usefulresources/publications/books/rcpp/9781908020406.aspx)

Physical health monitoring in primary care: A guide for Practice Nurses Dr Sheila Hardy.

<http://physicalsmi.webeden.co.uk/>

### Resources on Pharmacology

Evidence-based guidelines for the pharmacological treatment of schizophrenia: recommendations from the British Association for Psychopharmacology.

[www.bap.org.uk/docdetails.php?docID=47](http://www.bap.org.uk/docdetails.php?docID=47)

The Prescribing Observatory for Mental Health (POMH-UK) ready reckoner is available to member Trusts (POMH-UK member logon and password required).

<http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/prescribingpomh/prescribingobservatorypomh.aspx>

### Resources for service users and carers

South Essex Partnership University NHS Foundation Trust (SEPT) have developed a Health and Wellbeing booklet for service users.

<http://www.rcpsych.ac.uk/pdf/wellbeing%20booklet%20new.pdf>

## Appendix 8

### ***Mental Health Pharmacist facilitation of SMI PH Checks Dolly Sud Leicester Partnership Trust – Pharmacist***

#### **How we achieved the Cardiometabolic CQUIN at Leicestershire Partnership NHS Trust**

In order to improve our rate of physical health screening and related interventions for service users with Severe Mental Illness (SMI) we created a centralised electronic database the Leicestershire Physical Health Register (LPHR). This database is managed by a Specialist Mental Health Pharmacist.

The database flags up the screening required/outstanding and we are proactive in making sure this happens. The system also flags up when physical health interventions are needed which we make sure are acted on. We managed to achieve a 97% rate on the national CQUIN for 2014/2015 – the highest rate of any Trust in the country.

Here are **TOP TEN TIPS** for how this was achieved:

1. Identify one or two dedicated health care professionals committed to the ideas of Parity of Esteem and improving Physical Health. Allocate time and money to carry out this role
2. Sign-up and support from your own department and board level; this support should be ongoing allowing for flexibility as well as access to mentoring and resources
3. Good working relationships within the trust between ALL healthcare professionals – this is a must, along with an understanding of organisational cultures and infrastructure to allow effective networks to be established and maintained long term
4. Establish pathways for interventions – including smoking cessation, diabetes control, alcohol and drug misuse promoting an active lifestyle and healthy living.
5. Establish a fit-for purpose IT network – to record screening, interventions & outcomes
6. Establish links with your local Primary care services and Acute Medical Trust and any intermediate services to get expertise and access to local services such as diabetes nurses. Integrate these into the service as far as possible. Develop a knowledge of relevant local guidelines on managing physical health conditions
7. Business and financial planning – produce a business plan for the service
8. Have belief and drive to achieve what is possible and to overcome barriers which will undoubtedly occur! Understand that a service user whilst at one point in time may not be receptive to screening and/or interventions then at some point they will – even a small change is better than nothing
9. Interventions need to be personalised. Whilst a consistent approach to screening and interventions is required recognise that each service user may have individual needs and wishes
10. Awareness of national events and innovations - network with others to share experiences and knowledge – we are all working to one goal

## Appendix 9

*Dr Llewelyn, South Essex Partnership University NHS Foundation Trust (SEPT)*

*Personal Communication*

### Best Practice in South Essex Partnership Trust

Creating parity of esteem between mental and physical health

Dr Catherine Rowlands, St4 Psychiatry SEPT

Quality Improvement Fellow 2012-13

East of England Prize for best project - creation of SEPT Wellbeing Booklet

This project demonstrated that the Mental Health Trust attained **over 90%** compliance with the NAS quality indicators by the adoption of a Health Booklet which was patient held, universally welcomed by service users.

This success within the Trust was maintained by the **Executive Physical Health Steering Group overseeing a Physical Health Action Implementation Group** which ensures physical health maintains highest importance.

Functions of the Physical Health Action Implementation Group:

1. Comprehensive physical health guidelines to update the current physical healthcare policy.
2. Support appropriate assessment of physical healthcare throughout the Trust to meet CQUIN requirements and NICE standards.
3. Ensure all Mental Health and Learning Disability service users will have a standard assessment of health risk factors and offered appropriate interventions
4. To identify training and development needs of Mental Health and Learning Disabilities staff so as to ensure the effective delivery of the standard assessment of physical health risk factors and the appropriate interventions
5. Ensure development of tools and information, including electronic information, to support physical healthcare of Mental Health and Learning Disability services.
6. Identify appropriate equipment to assess and manage physical healthcare and make recommendation to the Steering Group.
7. Develop proposals for effective implementation of the Trusts ECG guidelines Implement ECG guidelines.
8. Develop a proposal for an integrated response to the Resuscitation Council Quality Standards for Mental Health In-patients.
9. Agree a set of KPIs to assure the Board of the quality of physical healthcare provision and a reporting platform/ dashboard to ensure compliance.

## Appendix 10

*The Story of Mental/Physical Health Project Bradford District Care Trust (BDCT) courtesy of Kate Dale*

The National Institute for Health and Clinical Excellence (NICE) recommends annual physical health checks for people with serious mental illness (SMI). Evidence shows that people with SMI die up to twenty years younger than the average population Evidence also suggests that these individuals receive a lesser standard of health promotion and physical health care. Awareness of this and national guidelines have not reduced early mortality. BDCT are continuing to work on a project which aims to improve the physical health of people with SMI in Bradford and Airedale; we believe we have successfully developed and implemented **a physical health check data entry template for those people with SMI to access an appropriate physical health check.**

In 2009 an audit was conducted looking at base line physical health measures used in primary care and found that the current measures taking place at that time did not reflect the patient's needs. In 2012 an electronic Mental Health Physical Review Template was developed and introduced within **SystmOne** in Bradford and Airedale to help primary care teams carry out a specified, high quality, systematic annual physical health check, including a calculation of the risk of dying from Cardiovascular Disease (CVD); this is known as a QRisk2 score. Following implementation of the template, the number of annual physical health checks carried out increased and the quality of the checks improved; resulting in significantly better quality outcomes. The template is now in use by GPs and Practice Nurses across **80 GP practices** in Bradford and Airedale. It is believed that this intervention demonstrates service improvement and will target primary prevention of the cardiovascular high risk group with SMI. This will reduce the existing health inequality of premature death, in line with NICE. There is a robust monitoring process running quarterly reports centrally to gain detailed outcome data.

Physical Health has been vastly audited during the past few years in BDCT, both locally and as part of the NHS Standard contract. Audit findings repeatedly highlighted that the completion of appropriate physical health checks was somewhat sporadic, highlighting the need for change. The Mental Health Physical Review Template implemented in primary care has recently been implemented in BDCT and clinicians are now completing the template when carrying out physical health checks for both community patients and inpatients. The template guides clinicians through the completion of an appropriate comprehensive check and ensures that physical health information is stored centrally in a locatable place in the electronic patient record system (RiO). The nationally recognised 'Lester' tool is used as a guidance document in BDCT and ensures appropriate interventions are carried out.

**Five Physical Health/Wellbeing Clinics** have recently been set up across Bradford and Airedale. Community adult patients initiated on antipsychotics are now being referred to the clinics for appropriate baseline physical health checks. It is intended that this referral process will be rolled out wider throughout BDCT in the near future, so that all patients requiring not only baseline physical health checks but monitoring checks are referred to these clinics. This will benefit patient care and ensure that appropriate checks are conducted. The Mental Health Physical Review Template is being used in the clinics to record the checks and tests results.

Traditionally mental and physical health has been treated separately with services designed around conditions rather than patients. **BDCT invested in two whole-time equivalent Band 7 Mental Health Nurses specialising in Physical Health** to ensure the appropriate training and development exists and continues across both inpatient and community services.

A Mental/Physical Health Project Lead for **Community** and a Mental/Physical Health Project Lead for **Inpatients**. Staff working in the clinics have been trained how to perform phlebotomy, ECGs, base line tests and lifestyle advice to include appropriate referral. Electrocardiogram (ECG) machines have been purchased along with necessary IT equipment to use these in clinics.

**Service Level Agreements (SLA)** have been set up in order for the results to be stored in the “Cloud” and then interpreted by **Cardiology** experts. Clinic staff have been trained by the Mental/Physical Health Project Leads to carry out ECGs and some clinic staff have decided to expand their knowledge and continued to attend further modules to include learning how to interpret the results. Nursing staff are attending Phlebotomy training in order to take blood samples in the new Physical Health/Wellbeing Clinics within the CMHTs and within the inpatient setting. There will be a medical device inventory with medical physics department checking and calibrating the equipment as required. BDCT have a protocol/algorithm and care pathways to ensure good safe practice. All appropriate mandatory training is kept up dated for clinical staff to include Basic Life Support and Advanced Life Support, appropriate to grade.

The same processes and systems is being rolled out in the **in-patient environment** supported by the Mental/Physical Health Project Lead for Inpatients who will educate the staff in using **the template on RIO**. All secondary Care Health Care Support Workers have been trained in physical health monitoring and recognising the deteriorating patient within the Calderdale Competency Framework; with supported by qualified staff mentors within each ward or department.

**In 2013 BDCT developed The Antipsychotic Shared Care and Physical Health Monitoring Recommendations**, which highlights the specific responsibilities of both primary and secondary care staff when carrying out physical health checks. These guidelines are in line with the Mental Health Physical Review Template. BDCT are working with this shared care protocol in order to truly manage the physical health of patients and are now focusing on new systems and processes to ensure effective communication of the physical health results between primary and secondary. Working jointly will lead to a better standard of care and improved outcomes.

BDCT have a **‘Physical Health Work Stream’ group** that meet on a monthly basis; this group feed into the **Community Mental Health Team Steering Group** on a monthly basis to ensure that Physical Health remains on the agenda at a strategic level. BDCT have funding to further enhance the qualified nurses in recognising when a mental health patient may be deteriorating physically. This training will be delivered within the ‘Recognising and Assessing Medical Problems in a Psychiatric Setting Framework’.

In view of the success in rolling this work out across 80 GP Practices, and the recent successful role out of five clinics within secondary care CMHT with the further addition and the current implementation within the in-patient setting within BDCT, this is a true demonstration offering a standardised systematic approach to caring for the physical health needs of this population in both primary and secondary care. This will enhance effective communication between Primary and Secondary Care, reducing the risk of repetition or overlap.

The Mental Health Physical Review Template can be replicated onto other IT systems, we have first-hand experience of this being written for **SystmOne, EMIS Webb and more recently for RIO**. This work is being show cased nationally to include NHS England who are demonstrating this work an example of “Good Practice”. Publication “The Psychiatrist Bulletin” 2014.

NHS England are show casing this work as an example of good practice and promoting “Parity of Esteem”. We have influenced other organisations both locally and nationally to pilot this template. Within BDCT **Learning Disabilities (LD)** services have adopted the template with a few minor changes to meet the needs of patients who experience LD.



## Appendix 11

### **NHS England Pilot Sites Conference London January 2016**

The presentations used on the day are available using the following links:

[CVD – Still a national priority – Huon Gray](#)

[Evaluation of the Lester tool in psychiatric inpatient settings – Royal College of Psychiatrists](#)

[Practical strategies for physical healthcare improvement – Geraldine Strathdee](#)

[Reducing the CVD risk for people with SMI – the NTW perspective](#)

[Physical Health – Action at last, the TEWV experience](#)

[Delivering change in a challenging environment – Mersey Care](#)

[The patient journey from a physical health perspective – 2gether](#)

[Three dimensions of care for diabetes – Kings College](#)

[Going smokefree in a mental health trust 1 of 2 – Jane Beenstock](#)

[Going smokefree in a mental health trust 2 of 2 – Jane Beenstock](#)

[Improving the physical health of SMI patients in primary care – Rhiannon England](#)

#### **The Full Report is as below**

Improving the physical health of people with Serious Mental Illness – A practical toolkit, NHS England, March 2016

<https://www.england.nhs.uk/mentalhealth/wp-content/uploads/sites/29/2016/05/serious-mental-hlth-toolkit-may16.pdf>

## Appendix 12

### **The NHS England Sustainable Improvement Team Pilots: A Brief Summary by Sohrab Panday**

Four Mental Health Providers involved:

- 2gether NHS FT Gloucestershire
- Northumberland Tyne & Wear NHS FT
- Tees, Esk & Wear NHS FT
- Mersey NHS FT

The pilots were tasked with rolling out the LESTER Tool to their SMI population.

The tool screens for 5 parameters – Blood Pressure, Weight, Smoking, Glucose and Cholesterol.

Staff were trained in how to offer the screen and offer the appropriate intervention. Electronic Health Records were used.

Two pilots took a focussed inpatient ward approach whilst two took a whole workforce approach.

The full report on the findings of the pilots will be published in March 2016 along with some helpful Case Studies. Meanwhile the key findings have been presented on 27 01 2016 identified.

89% of SMI users wanted to have physical health checks.

### **Results and Successes**

In summary the pilots showed an improvement in the uptake of PH screening and data recording.

The proportion of SMI within the pilots who received all five baseline parameters increased from 46% to 83%.

The proportion needing an intervention who were offered it increased from 79% to 94%.

Less successful was the follow up of patients a month later to see if the recommended intervention had actually taken place; only 41% received a follow up BP and 33% a follow up Glucose.

The LESTER Tool was found to be suitable for roll out at scale. Case Studies were useful in determining the right approach to getting SMI patients into the right pathways.

Link workers were successful as Organisational Champions for Change. They were using a Train the Trainer Approach.

Service pathway mapping and gap analysis to establish where the difficulties in follow up. The challenge is to ensure Equality of Access to the physical health pathways for SMI users.

MH Trusts found having a Physical Health and Wellbeing Group to ensure service improvement needs were identified and addressed.

It is vital to clarify accountability for each action:

‘Which test?’ ‘When is it due?’ ‘Who is responsible?’

Data needs to be patient held in a Physical Health Care Plan and on organisational IT systems.

Barriers to Lester identified included – a lack of staff skills, difficulty in communication with hospital or GP, challenges in engaging service users in coproduction, confusion about responsibility for tasks.

Limitations of the Pilots – Each pilot took a different approach, neither GPs or pharmacists included.

**For the full report by NHS Sustainable Improvement Team please see *Improving the physical health of people with Serious Mental Illness – A practical toolkit, NHS England, March 2016***

## Appendix 13

### ***Bespoke mental health and wellbeing training package - practice nurses***

Dr Sheila Hardy; Education Fellow, UCL Partners Sheila.hardy@uclpartners.com

#### **Aims**

For patients seen in primary care to be treated by a health care professional who understands their mental, physical, emotional, spiritual and social needs and can respond effectively.

To create a sustainable model of capacity building through the creation of a community of nurse educators engaged with improving the capability for mental health in primary care.

To improve integration between primary and secondary care for mental health patients.

#### **Rationale**

To understand the training requirements of practice nurses regarding mental health and wellbeing, a national needs assessment was undertaken in the format of a survey. Responses were attained from 390 nurses. Key findings - 82 per cent of practice nurses have responsibilities for aspects of mental health and wellbeing in which they have not had training with 98 per cent of these nurses stating they would like to undertake at least one aspect of training in mental health and wellbeing.

#### **Development**

The project was funded by the Health Education North Central East London (HENCEL); £250,000 was secured to establish a sustainable network of nurse educators, develop a 10 module training and train the trainer programme and educate practice nurses in the region. A steering and expert reference group (ERG) were set up with representatives from all participating partners (HENCEL; the Academic Health Science Network, UCLPartners; the Mental Health Trusts, Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS Foundation Trust, East London NHS Foundation Trust, North East London NHS Foundation Trust; and GP practices).

Practice nurses views from the survey have been used to help shape the programme of learning (consisting of 10 RCGP accredited modules, five of which are available as eLearning through the BMJ), developed by Dr Sheila Hardy, with the support of the ERG. Mental health nurses from the four trusts were trained to become Nurse Educators and they delivered the programme. These Nurse Educators have been supported by UCLPartners to develop a network, which has initially been achieved through creation of action learning sets. In doing so, they have created a system of support and ongoing learning. To create a sustainable solution to capability and capacity building for mental health in primary care, this network is being supported to form a community of practice (COP) to help practice nurses and nurse trainers to continue their development in mental health.

To achieve implementation at pace and scale, a tool kit will be developed to enable replication: to include: train the trainer, educational materials; a guide to creation of the COP; operational guidelines; evaluation tools; membership to the online community of nurses.

#### **Outcomes**

We have achieved our aims in that:

- 199 practice nurses completed module 1 and 282 have gone through modules 2 to 5.
- 98% will apply the learning to practice.
- 23 mental health nurses trained in North Central & East London to become Nurse Educators.
- 17% of practice nurses are now contacting mental health nurses regarding
- The project was shortlisted for the Patient Safety Care Awards 2014

#### **Top tips for commissioners**

Use of the adoption tool kit enables creation of a highly cost effective, sustainable approach to building capacity for mental health in primary care, while improving integration, through building relationships between primary and mental health trusts nurses.

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