Shared Care Approach
Improving Physical Health and Wellbeing for Patients with Severe Mental Illness in Oxfordshire for Adults 18 Years and Above

There is significant evidence in the literature that patients with a Serious (and enduring) Mental Illness (SMI) diagnosis are less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

SMI in this context includes bipolar disorder, active psychosis and those on lithium medication for mood control. Those who are in remission will not be included in this cohort. A patient is considered to be in remission if for at least five years, there is:

- no record of use of antipsychotic medication,
- no mental health in-patient episodes; and
- no secondary or community care mental health follow-up for at least five years.

Compared to the general population, individuals with SMI:

- Face a shorter life expectancy by an average of 15-20 years
- Are three times more likely to smoke
- Are at double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome and five times the risk of dyslipidaemia (imbalance of lipids in the blood stream)

Why?

- Increased levels of smoking, lack of activity, and medication with metabolic effects
- Lack of clarity around responsibilities in health care provision in Primary and Secondary care.
- Gaps in training among primary and secondary care clinicians
- Lack of confidence across the workforce to deliver physical health checks among people with SMI.

Oxfordshire Goals (in line with NHS MH FYFV)

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

Responsibility in Oxfordshire for physical health assessment in line with national guidance from NHSE

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

- patients with SMI who are not in contact with secondary mental health services, including both:
  - those whose care has always been solely in primary care, and
  - those who have been discharged from secondary care to primary care
- patients with SMI who have been in contact with secondary care mental health teams for more than 12 months and whose condition has stabilised (Secondary care cluster 11).

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

- patients with SMI who are under the care of a mental health team for less than 12 months and those whose condition has not yet stabilised. (including all those in clusters 10,12 13, 16, 17)
- patients with SMI under the care of mental health teams who's medication is being changed (increased or decreased), a new medication commenced or a medication stopped – until the change has stabilised.
- inpatients within the adult mental health service.

Although these are guidance, there is a clear need for all teams in both mental health services and primary care, to aim to improve the quality of life for their patients. Furthering this aim, rigid lines of responsibility need to be flexed so that THE MOST APPROPRIATE PERSON seeing the patient feels confident in either performing an appropriate health check or have the time and ability to make sure that a health check is carried out by someone who is better able to do this. Due to the nature of the mental health illness, often patients may need to be taken to or actively encouraged to attend a health check at an appropriate venue.

Expectations for patients where primary care have responsibility

The list below covers the general care of those with SMI illustrating in particular some special elements relating to issues for those with SMI. It is likely there will be one annual health and wellbeing check, however other appointments may be required for follow up on issues defined by the health check and/or management of long term conditions. Care is likely to involve elements of the following: -

- Yearly comprehensive cardio-metabolic risk assessment in line with the NHS health check.
- Where indicated, relevant national screening programmes to be delivered or followed up
- Medicine reconciliation and monitoring

- General physical health enquiry including monitoring of any long-term conditions e.g. Diabetes

Personalised care planning in primary care, engagement and psychosocial support are key components of physical health care for people with SMI. This includes:

- Setting personal physical health goals
- Agreeing approaches to self-care, e.g. health coaching
- Physical health referrals, social prescribing or onward signposting
- Follow-up care over the next 12 months
- Clearly identifying roles and responsibilities of named supporting professionals
- Proactive follow up on the results of assessments
- Proactive outreach: peer support and voluntary sector support for those struggling to attend appointments and engage in interventions perhaps using social prescribing

It is extremely helpful if primary care informs the mental health team if a patient is diagnosed and/ or treated for a medical condition which may impact on the patient's mental health or where the treatment may interact with current, or future, mental health treatment options e.g. newly diagnosed diabetes, epilepsy.

Expectations for patients where Adult Mental Health Team/Older Adult Community Mental Health Team/Early Intervention Service have responsibility

- To ensure the monitoring and screening for aspects of physical health and wellbeing including a yearly cardio-metabolic risk
- To offer appropriate interventions within our remit/ expertise
- To signpost to other organisations and GPs for further input/interventions where indicated. Smoking cessation, exercise and weight management and drugs and alcohol can be made direct to the appropriate organisations. Pre-diabetes (GlyHbA1c) can be referred to the National diabetes prevention programmes.
- Where the mental health team thinks a referral back to GP's is necessary a letter should be sent to the GP with the results of the health check and indicating the problem. This is likely to include raised blood pressure, raised QRISK2>10% (NB this is essential to calculate QRISK2 alongside cholesterol checks) and possible diabetes. It is important that the mental health team make sure the patient has made an appointment and attended the GP – the team might even make the appointment and possibly a care co-ordinator can take the patient to the GP appointment.

Secondary care **must** feedback the outcomes of the physical and wellbeing checks when they are completed, even if no specific action is required and the latest information **will** be included in all communications including clinic letters (a separate section drawn from the record on Care Notes will be included with dates).

If the mental health team and GP's have a **collaborative relationship**, for the benefit of patients', they may agree in certain circumstances which one of them is better placed to deliver a health check for an individual patient. Discussion will need to have occurred between clinicians.

Regardless of who has the responsibility to perform the physical health checks for the patient, any staff seeing the patient should be interested in their physical (plus mental and social) health and well-being and enquire about these, providing interventions and signposting where necessary.