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Improving the physical health of people living with severe mental illness

Guidance for integrated care systems

[Publication \(/publication\)](#)

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10 key actions

Read our [10 key actions for improving the physical health of people living with severe mental illness](https://www.england.nhs.uk/long-read/10-key-actions-improving-the-physical-health-of-people-living-with-severe-mental-illness/) (<https://www.england.nhs.uk/long-read/10-key-actions-improving-the-physical-health-of-people-living-with-severe-mental-illness/>).

Summary

This guidance supports integrated care systems (ICSs) and service providers to improve the physical health care of adults living with severe mental illness (SMI), through improved physical health checks and supported follow-up interventions.

People living with SMI face [one of the greatest health equality gaps in England](https://www.gov.uk/government/statistics/severe-mental-illness-smi-profile-may-2022-update) (<https://www.gov.uk/government/statistics/severe-mental-illness-smi-profile-may-2022-update>). Their life expectancy is 15–20 years shorter than that for the general population, [1] and this disparity is largely due to preventable physical illnesses. [2] Work to address this inequality is part of [Core20PLUS5](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>), NHS England's flagship approach for tackling health inequalities.

ICSs are strongly encouraged to consider the physical health needs of all people severely affected by their mental illness, in line with [community mental health transformation](https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>) commitments. NICE guidance (CG185 (<https://www.nice.org.uk/guidance/cg185>), CG178 (<https://www.nice.org.uk/guidance/cg178>) and NG181 (<https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#person-centred-care-planning-through-assessment-and-formulation>)) recommends that primary care should keep an up-to-date register of people living with bipolar disorder, schizophrenia and other psychoses who require monitoring of their physical and mental health.

It is important that the SMI physical health checks start at the point of initial diagnosis. The 6 elements of the 'core' annual SMI physical health check are:

- alcohol consumption status
- blood glucose or HbA1c test (as clinically appropriate)
- blood pressure
- body mass index
- lipid profile
- smoking status.

Anyone prescribed antipsychotics or mood stabilisers (regardless of diagnosis) should also have their physical health monitored from initiation of these medications in line with [British National Formulary guidelines \(https://bnf.nice.org.uk/\)](https://bnf.nice.org.uk/) or summary of product characteristics (SmPC).

It is recommended that ICSs commission services to deliver a more comprehensive annual physical health check, one that also includes:

- medical and family history
- blood-borne virus and liver function screening
- cardiovascular risk assessment (including QRisk)
- relevant national immunisation programmes
- support to access relevant national screening programmes, including cancer screening
- oral health advice and brief interventions
- assessment of physical activity levels
- sexual and reproductive health assessment and advice (including contraception)
- substance use assessment
- medicines reconciliation and monitoring.

Support should not end with the physical health check. Rather, '[don't just screen, intervene](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4)' (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4), by supporting people living with SMI to access follow-up interventions that are tailored to their needs. This guidance outlines best practice in providing tailored physical health support, including by signposting to relevant NICE guidance for follow-up interventions for all aspects of the check. All follow-up support should form part of [personalised care and support planning \(https://www.england.nhs.uk/long-read/personalised-care-and-support-planning-a-brief-summary-guide/\)](https://www.england.nhs.uk/long-read/personalised-care-and-support-planning-a-brief-summary-guide/), in line with shared decision-making. Local areas should consider the use of [patient decision aids \(https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids\)](https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids) and a [personal health budget \(https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/\)](https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/) where a person is eligible for this.

People offered an SMI annual physical health check may have a history of trauma. It is vital that delivery of the checks and follow-up care is [trauma informed \(https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice\)](https://www.gov.uk/government/publications/working-definition-of-trauma-informed-practice/working-definition-of-trauma-informed-practice) and considers how someone's mental health may impact on how they experience their physical health, the health check and ability to make lifestyle changes. Reasonable adjustments should be made to assist people to access SMI annual physical health checks and follow-up interventions (a statutory anticipatory duty under the [Equality Act](https://www.legislation.gov.uk/ukpga/2010/15/notes/division/3/16/19)). (<https://www.legislation.gov.uk/ukpga/2010/15/notes/division/3/16/19>)

Service design considerations include:

- **Care that advances health equality.** The premature mortality experienced by people living with SMI is a persistent inequality, but other inequalities can add to this. For example, people from racialised and ethnically and culturally diverse communities or LGBTQ+ people can have a poorer experience of care and outcomes. Health equality for all should be factored into care provision (see [section: Care that advances equality](#)).
- **Clarity on roles and responsibilities.** The physical health care of people living with SMI can fall into a gap between services. ICSs should ensure a local comprehensive model of care and develop a protocol defining roles and responsibilities across primary care, secondary care (mental health and acute) and voluntary, community and social enterprise (VCSE) services to optimise the physical health care of people living with SMI and improve both physical and mental health outcomes (see [section: Roles and responsibilities](#)).
- **Dedicated services.** Commissioning locally enhanced or dedicated services to deliver SMI annual physical health checks and support to access follow-up interventions improves both the quantity of checks delivered and the experience of those receiving checks (see [section: Dedicated services and outreach programmes](#)).
- **Outreach.** Given the barriers that people living with SMI face in accessing services, including SMI annual physical health checks, it is recommended that outreach programmes are co-produced with people with lived experience. These can include proactive communications and support to attend appointments, as well as delivery of checks in homes and at community hubs (see [section: Dedicated services and outreach programmes](#)).

A range of roles can deliver the SMI annual physical health checks and support for follow-up interventions, and some may also be well placed to deliver proactive outreach. Roles include GPs, nurses, pharmacists, occupational therapists, healthcare assistants, health coaches and VCSE staff. Consider:

- workforce capacity and multidisciplinary team functions
- whether the person can administer all or only certain elements of the 'core' check
- access to relevant IT systems
- review and follow-up of the results by an appropriately trained professional and an action plan agreed with the patient
- cost effectiveness
- appropriate training including increasing understanding of SMI and how SMI affects physical health. For information on training, see [section: Leadership, workforce and training](#).

SMI annual physical health checks and support to access follow-up interventions require ICS leadership to address persistent inequality and drive improvements.

Purpose of this guidance

An [NHS Long Term Plan](https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/) (https://www.longtermplan.nhs.uk/publication/nhs-mental-health-implementation-plan-2019-20-2023-24/) commitment is that 390,000 people living with SMI will receive an annual physical health check by 2023/24. This guidance supports ICSs and service providers to improve the physical health care of adults living with SMI, through improved physical health checks and supported follow-up interventions. This includes ICSs clearly outlining roles and responsibilities across primary care, secondary care and VCSE services. Annual SMI physical health checks are also a clinical focus of [Core20PLUS5](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) (https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/), NHS England's flagship approach for tackling health inequalities.

This guidance has been developed in partnership with people who have experience of mental illness and frontline clinicians (see [section: Contributors](#)) to ensure that it meets the needs of those requiring and delivering SMI annual physical health checks and follow-up interventions.

Adults living with SMI have an almost five times increased risk of dying prematurely compared to those living without SMI, and premature deaths of people living with SMI are increasing.[3] An estimated 50% of deaths in people living with SMI are attributable to smoking.[4] The best single modifiable candidate for increasing life expectancy of people living with schizophrenia is smoking, and for people living with bipolar disorder it is sedentary behaviour.[5]

People living with SMI have:

- 6.6 times increased risk of respiratory disease
- 6.5 times increased risk of liver disease
- 4.1 times increased risk of cardiovascular disease
- 2.3 times increased risk of cancer[6]
- are 3 times more likely to lose their natural teeth [7]

Medication has a nuanced role in the physical health and life expectancy of people living with SMI. For example, antipsychotics and mood stabilisers increase life expectancy, likely due to both the treatment of mental health symptoms and more timely access to healthcare interventions due to continued medication monitoring. [8] However, medication has side effects that impact on people's physical health, including weight gain, diabetes and increased lipids. Side effects can be mitigated and treated if identified. Therefore, monitoring someone's physical health and acting early to address problems is vital to improve health outcomes and quality of life. This needs to be done through a process of shared decision-making, and people should be supported to make lifestyle changes and access treatments and care.

Moreover, physical illnesses can be underdiagnosed and undertreated in those living with SMI, because the co-occurring psychiatric diagnosis overshadows recognition of physical health symptoms. This diagnostic overshadowing also undermines trust in health services, resulting in people not making or attending appointments. [9]

The SMI register and SMI annual physical health checks

The 'core' check

ICSs are **strongly encouraged** to consider the physical health needs of all people severely affected by their mental illness, in line with [community mental health transformation](https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf) (https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf) commitments. This includes, but is not limited to, those with a diagnosis of personality disorder, eating disorder or severe depression, and people with mental health rehabilitation needs – some of whom may have co-existing conditions; for example, frailty, cognitive impairment, neurodevelopmental conditions or substance use.

NICE guidance ([CG185 \(https://www.nice.org.uk/guidance/cg185\)](https://www.nice.org.uk/guidance/cg185), [CG178 \(https://www.nice.org.uk/guidance/cg178\)](https://www.nice.org.uk/guidance/cg178) and [NG181 \(https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#person-centred-care-planning-through-assessment-and-formulation\)](https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#person-centred-care-planning-through-assessment-and-formulation)) recommends that primary care should keep an up-to-date register of people living with bipolar disorder, schizophrenia and other psychoses who require monitoring of their physical and mental health (the 'SMI register'). For more information on diagnostic terms and SNOMED codes, [please see annex C](#).

At a minimum the 6 elements of the core annual physical health check should be provided to those on the SMI register:

- alcohol consumption status
- blood glucose or HbA1c test (as clinically appropriate)
- blood pressure
- body mass index
- lipid profile
- smoking status.

Importantly, **all** patients taking antipsychotics or mood stabilisers (regardless of whether they are on the SMI register or not) should have medication reviews and their physical health monitored in line with summary of product characteristics (SmPC) and/or British National Formulary guidelines on:

- [antipsychotics \(https://bnf.nice.org.uk/treatment-summaries/psychoses-and-related-disorders/#monitoring\)](https://bnf.nice.org.uk/treatment-summaries/psychoses-and-related-disorders/#monitoring) (includes those prescribed antipsychotics without a mental health diagnosis, such as people with a learning disability whose behaviour challenges; see [NICE guideline NG11 \(https://www.nice.org.uk/guidance/ng11/\)](https://www.nice.org.uk/guidance/ng11/))
- [lithium \(https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbnf.nice.org.uk%2Fdrugs%2Flithium-carbonate%2F&data=05%7C01%7Ccleila.reyburn%40nhs.net%7Cd6b6915866c54eb658ba08db1b0b29ad%7C37c354b2\)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbnf.nice.org.uk%2Fdrugs%2Flithium-carbonate%2F&data=05%7C01%7Ccleila.reyburn%40nhs.net%7Cd6b6915866c54eb658ba08db1b0b29ad%7C37c354b2)
- [sodium valproate \(https://bnf.nice.org.uk/drugs/sodium-valproate/\)](https://bnf.nice.org.uk/drugs/sodium-valproate/) (should not be used in women/girls of childbearing potential unless conditions of the Pregnancy Prevention Programme are met; [MHRA drug safety update April 2018](#)) (<https://assets.publishing.service.gov.uk/media/5adee63eed915d0ba92893c4/DSU-April-2018-PDF.pdf>).

The above guidelines specify the required elements of physical health monitoring and their frequency for each type of medication.

It is important that secondary care services notify the general practice a patient is registered with promptly and in writing when they initiate a person on any mental health medication. This should include Early Intervention in Psychosis (EIP) services, which may prescribe antipsychotics to patients. This communication is needed irrespective of whether ongoing prescribing is to be managed in secondary or primary care. Secondary care also needs to inform primary care of a new diagnosis, or in the case of EIP a first episode of psychosis, so that the individual can be added to the SMI register and thus be invited for physical health checks.

Adults on the SMI register should be offered all 6 recommended physical health assessments as part of a routine check at least annually (NICE clinical guidelines [CG185 \(https://www.nice.org.uk/guidance/cg185\)](https://www.nice.org.uk/guidance/cg185), [CG178 \(https://www.nice.org.uk/guidance/cg178\)](https://www.nice.org.uk/guidance/cg178) and [NG181 \(https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#person-centred-care-planning-through-assessment-and-formulation\)](https://www.nice.org.uk/guidance/ng181/chapter/Recommendations#person-centred-care-planning-through-assessment-and-formulation)). Assessments should be more frequent if required based on clinical need:

- a. to monitor specific antipsychotics or other medications (local policies and procedures may apply according to the local Drug and Therapeutic Monitoring Committee); or
- b. for those with co-existing SMI and substance use, or where a significant physical illness or risk of a physical illness has already been identified ([NICE clinical guideline CG120 \(https://www.nice.org.uk/guidance/cg120?unlid=768649178201512254048\)](https://www.nice.org.uk/guidance/cg120?unlid=768649178201512254048)).

For physical health checks for young people under the age of 18, please see:

- [NICE clinical guideline CG155 \(https://www.nice.org.uk/guidance/cg155\)](https://www.nice.org.uk/guidance/cg155)
- [NICE quality standard QS102 \(https://www.nice.org.uk/guidance/qs102\)](https://www.nice.org.uk/guidance/qs102)
- [Implementing the early intervention in psychosis access and waiting time standard \(https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf\)](https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf).

The 6 elements of the 'core' health check can be delivered separately within a 12-month time period, but it is highly recommended that they are completed during one appointment (unless this is not the patient's preference). This supports the [Making Every Contact Count \(https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf\)](https://www.england.nhs.uk/wp-content/uploads/2016/04/making-every-contact-count.pdf) approach and reduces the number of visits a patient needs to make. A core health check delivered within primary care will often require a longer than standard appointment. Further appointment(s) may be required to discuss results and any appropriate follow-up interventions.

People who are in remission will remain on the SMI register in case they relapse, but should not be invited for an annual physical health check. A remission code (under the SNOMED cluster MHREM_COD) should only be applied if the patient has had none of the following for at least 5 years:

- record of antipsychotic or mood stabiliser medication
- mental health inpatient episode
- secondary or community care mental health follow-up.

Please note the above definition of remission is for guidance and clinical discretion should be applied. A small group of patients may not have any of the above, are seen solely in primary care, are still unwell and should not be coded as in remission.

If after reviewing the patient record a clinician considers that someone is incorrectly on the SMI register (eg due to an incorrect diagnosis), they can apply a code of 'unsuitable' and record the reason for this.

General practices should validate their SMI register on an annual basis to ensure it is accurate and up to date. This should include a review of people coded as 'in remission' in case they have relapsed, and searches for patients who have no record of medication or secondary mental health intervention for more than 5 years as they can have the 'in remission' code applied. Other searches may include those for patients taking antipsychotic medication who are not on the SMI register as on review by a clinician they may qualify to be added. Applying and removing 'in remission' codes or considering whether someone should be included or removed from an SMI register should be carried out by a clinician, although searches to aid the process may be carried out by a member of the broader primary care team.

The 'comprehensive' check

Beyond the 'core' health assessments, best practice supports a comprehensive health check, which builds on the [Lester positive cardiometabolic health resource](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4) (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4) (updated in 2023). It is recommended that ICSs commission services to deliver a more comprehensive annual health check, with consideration given to inclusion of the following:

- **Medical and family history**
- **Blood-borne virus and liver function screening**
 - Blood-borne viruses are prevalent among those living with SMI.[10] Be alert to the possibility of blood-borne infectious diseases in people who could be at risk, eg because of homelessness, intravenous drug use or a history of sexually transmitted disease (in line with [NICE guidance NG181](https://www.nice.org.uk/guidance/ng181) (https://www.nice.org.uk/guidance/ng181)).
- **Cardiometabolic risk assessment**
 - Approved risk assessment tools such as [QRISK3](https://qrisk.org/) (https://qrisk.org/), which calculates an individual's 10-year risk of having a heart attack or stroke, can be used to assess cardiometabolic risk. Until electronic clinical systems with QRISK2 embedded are updated with QRISK3, it may be necessary to use the online version of QRISK3.
 - Both QRISK2 and QRISK3 may underestimate the 10-year CVD risk in these populations, although QRISK3 is recommended by NICE as it performs better than QRISK2 (see [NICE guidance CG181](https://www.nice.org.uk/guidance/cg181) (https://www.nice.org.uk/guidance/cg181)).
- **Relevant immunisation programmes**
 - The Joint Committee on Vaccination and Immunisation has identified those with schizophrenia, bipolar disorder or any mental illness that causes severe functional impairment (and their carers) as a priority cohort for Covid vaccinations (within cohort 6).
 - People living with SMI are highly likely to be eligible for a flu vaccine due to co-existing long-term health conditions.
- **Support to access relevant national screening programmes**

It is important to support those living with SMI to attend relevant screening and follow-up interventions as needed:

- Abdominal aortic aneurysm (AAA) screening: local AAA screening providers send invitations to men during the year they turn 65. Older men can self-refer.
- Bowel cancer screening: for everyone aged 60 to 74. People aged 75 and over can request a screening kit every 2 years. The programme started expanding in April 2021 with the aim over 4 years of making this screening available to everyone aged 50 to 59 years.
- Breast screening: for women aged 50 up until their 71st birthday. Women aged 71 and over can self-refer.
- Cervical screening: offered to women and people with a cervix aged 25 to 64: every 3 years for those aged 25 to 49, and every 5 years from 50 to 64.
- Diabetic eye screening: for anyone with diabetes aged 12 or over.

The [population screening timeline](https://www.gov.uk/guidance/population-screening-explained#printable-screening-information-resourceoutlines) (https://www.gov.uk/guidance/population-screening-explained#printable-screening-information-resourceoutlines) outlines all the [NHS screening programmes](https://www.gov.uk/government/collections/population-screening-programmes-document-collection) (https://www.gov.uk/government/collections/population-screening-programmes-document-collection) offered in England.

- **Oral health advice and brief interventions**

- Enquire about oral health and signposting to a dental service for those not attending regular check-ups (in line with [NICE guidance NG181](https://www.nice.org.uk/guidance/ng181) (<https://www.nice.org.uk/guidance/ng181>)). See [Right to smile consensus statement](https://www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/fhm/spectrum/RightToSmileV1.3b.pdf) (<https://www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/fhm/spectrum/RightToSmileV1.3b.pdf>) for more information and [Annex B](#) for information on 'Restart Smiling', an oral health training resource for staff delivering physical health checks and/or supporting the physical health of people living with SMI.
- **Levels of physical activity**
 - Clinicians can use the [general practice physical activity questionnaire \(GPPAQ\)](https://www.gov.uk/government/publications/general-practice-physical-activity-questionnaire-gppaq). (<https://www.gov.uk/government/publications/general-practice-physical-activity-questionnaire-gppaq>)
- **Sexual and reproductive health assessment and advice (including contraception)**
- **Substance use assessment (illicit or non-prescribed drug use)**

See [NICE guideline CG120](https://www.nice.org.uk/guidance/cg120/chapter/Key-priorities-for-implementation) (<https://www.nice.org.uk/guidance/cg120/chapter/Key-priorities-for-implementation>), which recommends that if a person has been identified as having used substances they should be asked the following:

 - particular substance(s) used
 - quantity, frequency and pattern of use
 - route of administration
 - duration of current level of use
 - and an assessment of dependency conducted.
- **Medicines reconciliation and monitoring**
 - Ensure medication is up to date, accurately recorded and this is cross-checked with all electronic records. Conduct any additional medication monitoring according to the particular medication summaries of product characteristics (SmPC), eg lithium level, U&Es, LFTs, prolactin, ECG if indicated. Clinicians can use the [Glasgow antipsychotic side-effect scale \(GASS\)](https://www.phenxtoolkit.org/protocols/view/661701) (<https://www.phenxtoolkit.org/protocols/view/661701>) or [LUNSERS](https://innovation.ox.ac.uk/outcome-measures/liverpool-university-neuroleptic-side-effect-rating-scale-lunsers/) (<https://innovation.ox.ac.uk/outcome-measures/liverpool-university-neuroleptic-side-effect-rating-scale-lunsers/>).
- **Open questions on what is important to their health and wellbeing**
 - A physical health check is an important opportunity to identify wider social and economic factors that may be impacting on someone's physical or mental health and wellbeing, such as isolation, housing or employment. Consider referral to relevant social and community support; for instance, a social prescribing link worker or other relevant services such as Welfare Benefits Advice and Individual Placement and Support (IPS).
 - Consider asking whether they have a carer and if they do whether the carer may want to apply for a [carer's assessment](https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carers-assessments/) (<https://www.nhs.uk/conditions/social-care-and-support-guide/support-and-benefits-for-carers/carers-assessments/>). For carers, consider offering a carer-focused education and support programme, which may be part of a family intervention for psychosis and schizophrenia, as early as possible (see [NICE guideline CG178](https://www.nice.org.uk/guidance/cg178) (<https://www.nice.org.uk/guidance/cg178>) and [quality standard QS80](https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-8-carer-focused-education-and-support/) (<https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-8-carer-focused-education-and-support/>)).

All physical health assessment results and agreed actions should be entered into the electronic patient record (EPR).

Trauma-informed delivery and reasonable adjustments

Annual SMI physical health checks are an important opportunity to build relationships with people who may struggle to access support for their health needs. People eligible for these checks may also present with a history of trauma. This may include emotional, physical and/or sexual trauma and a range of other adverse life experiences. [11]

It is vital that delivery of the physical health checks is trauma-informed and considers how someone's mental health may impact on how they experience the check and their physical health. A positive experience of the annual SMI physical health check (and follow-up support) will greatly increase the likelihood that people will partake in these checks in future years. Continuity of professional providing the annual SMI physical health checks and support to access follow-up interventions is highly recommended where possible within a service.

Under the [Equality Act](https://www.legislation.gov.uk/ukpga/2010/15/notes/division/3/16/19) (<https://www.legislation.gov.uk/ukpga/2010/15/notes/division/3/16/19>) there is a statutory anticipatory duty to make reasonable adjustments, meaning services must plan in advance to meet the access needs of disabled people, including those living with SMI.

Things to consider when inviting people for and delivering a physical health check are:

- different and proactive ways of inviting people for an annual SMI physical health check – letters, texts, phone calls – and the content of these invitations
- providing clear information on why someone has been invited for an annual SMI physical health check
- explaining the reasons for each element of the check
- explaining how each element of the check is carried out
- explaining what will happen based on the results and how the person will be supported to implement suggested actions
- explaining that reasonable adjustments can be made, what these may be, agreeing what the person would find helpful and recording this on their record (the [Reasonable Adjustment Flag](https://digital.nhs.uk/services/reasonable-) (<https://digital.nhs.uk/services/reasonable->

[adjustment-flag](#)) can be used to indicate that an individual requires reasonable adjustments and, optionally, include details of their significant impairments and key adjustments that should be considered)

- asking if they have any questions
- where possible, continuity of professional providing the different elements of the health check and follow-up interventions
- the [Mental Capacity Act 2005](https://www.legislation.gov.uk/ukpga/2005/9/contents) (<https://www.legislation.gov.uk/ukpga/2005/9/contents>).

Examples of reasonable adjustments that can be made when delivering the annual SMI physical health check include:

- tailored communications; all communications should as a minimum meet the [Accessible Information Standard](https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/) (<https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/accessibleinfo/>)
- a longer appointment and/or an appointment at the start of the day to avoid the person needing to sit in a busy waiting room, or an appointment later in the day if medication side effects make early appointments more challenging for them
- if possible, offering a quieter place to wait when the waiting room is busy
- offer choice in how to access an appointment (face to face, telephone/virtual appointments) for appropriate aspects of the health check
- support with transport to the GP surgery
- a home visit if a person is unable to leave their home
- consideration of sensory needs (see [Sensory-friendly resource pack](https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/) (<https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/>))
- offering that a carer, family member, friend or trusted professional (eg support worker) attends with the person
- additional reassurance or support for those afraid of needles who are having a blood test or vaccination
- a sign language or translation service.

Follow-up interventions, support and care

‘Don’t just screen, intervene’

It is important to intervene early. For instance, people living with SMI are vulnerable to obesity related to sedentary behaviours, poor diet and social factors such as poverty. People can experience rapid weight gain when starting antipsychotic medications, [12] but this is not an inevitable side effect and tailored support can help prevent obesity. [13] Importantly dietitian-led interventions have greatest impact on weight gain if offered as soon as antipsychotics are initiated. [14]

As well as supporting people to access generic sources of support for improving their health, such as those on the [Better Health website](https://www.nhs.uk/better-health/) (<https://www.nhs.uk/better-health/>), ICSs should commission tailored support to meet the needs of their local population living with SMI. Likewise, mental health trusts should consider how they can embed into their services tailored support for the physical health of their patients, including for inpatients.

Case study 1: [A weight off your mind: achieving a healthy weight for people living with SMI](https://www.england.nhs.uk/long-read/a-weight-off-your-mind-achieving-a-healthy-weight-for-people-living-with-smi/) (<https://www.england.nhs.uk/long-read/a-weight-off-your-mind-achieving-a-healthy-weight-for-people-living-with-smi/>) and case study 2: [community mental health team improving SMI physical health checks](https://www.england.nhs.uk/long-read/a-community-mental-health-team-improving-smi-physical-health-checks/) (<https://www.england.nhs.uk/long-read/a-community-mental-health-team-improving-smi-physical-health-checks/>) provide examples of how mental health trusts have addressed the physical health of the patients they work with.

Access to follow-up interventions should be enabled through:

- ICS protocols clearly outlining roles and responsibilities across primary care, secondary care and VCSE services regarding onward referral and treatment
- clear and effective communications (such as texts and phone calls, not just paper letters) with patients and carers (when consent is in place) about the recommended follow-up
- clear and robust referral processes to NHS, relevant local authority provided services (for instance, stop smoking services) and locally commissioned services where appropriate.

See:

- [Annex D for all relevant NICE clinical guidance](#), including for the comprehensive annual physical health check
- [Implementing the early intervention in psychosis access and waiting time standard](https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf). (<https://www.england.nhs.uk/wp-content/uploads/2023/03/B1954-implementing-the-early-intervention-in-psychosis-access-and-waiting-time-standard.pdf>)

SMI physical health check	NICE guidelines	Evidence-based follow-up interventions and resources
Alcohol consumption status	<u>Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [CG120]</u> (https://www.nice.org.uk/guidance/cg120?unlid=768649178201512254048). <u>Alcohol-use disorders: diagnosis, assessment and management of harmful drinking (high-risk drinking) and alcohol dependence [CG115]</u> (https://www.nice.org.uk/guidance/cg115).	Consider referral to specialist substance misuse service, psychological interventions and medication as appropriate, and signposting to relevant VCSE support where available.
Blood glucose or HbA1c test (as clinically appropriate)	Type 1 diabetes diagnosis and management [NG17] (https://www.nice.org.uk/guidance/ng17), NG18 (https://www.nice.org.uk/guidance/ng18) and NG19 (https://www.nice.org.uk/guidance/ng19)] Type 2 diabetes prevention and treatment [PH38] (https://www.nice.org.uk/guidance/ph38) and NG28 (https://www.nice.org.uk/guidance/ng28)]	For those at risk of developing Type 2 diabetes, consider referral to <u>Healthier You</u> (https://www.england.nhs.uk/diabetes/diabetes-prevention/) (NHS Diabetes Prevention Programme), a 9-month, evidence-based lifestyle change programme. It is a joint service from NHS England and Diabetes UK. Care for those at high risk of diabetes and diabetic care should include integrating diabetes action plans into care planning and providing adequate psychological support to help people with SMI manage their diabetes.[15] Follow-up interventions should include: 1. Referral to weight management lifestyle change programmes (see body mass index below). For example, <u>Diabetes awareness and rehabilitation training (DART)</u> (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3881287/) is a 24-week, group-based, diabetes management intervention designed for middle-aged and older patients with schizophrenia and schizoaffective disorder and Type 2 diabetes, and has been shown to achieve significant health-related improvements. 2. Eye screening for anyone with diabetes aged 12 or over (this is particularly important as diabetic eye screening is significantly lower for people living with bipolar disorder.[16])
Blood pressure	<u>Hypertension in adults: diagnosis and management [NG136]</u> (https://www.nice.org.uk/guidance/ng136).	Offer lifestyle advice (diet, physical activity, stop smoking, and reducing alcohol, caffeine and salt). Offer antihypertensive therapy if safe and appropriate.

SMI physical health check	NICE guidelines	Evidence-based follow-up interventions and resources
Body mass index	<u>Overweight and obesity management [NG246]</u> (https://www.nice.org.uk/guidance/ng246). <u>Physical activity: brief advice for adults in primary care [PH44]</u> (https://www.nice.org.uk/guidance/ph44).	Tailored weight management is an important intervention for people living with SMI, especially when delivered at the start of initiating antipsychotic medications. <u>The Equally Well UK review</u> (https://equallywell.co.uk/wp-content/uploads/2020/05/Equally-Well_Healthy-Weight-Management_Review-1.pdf) of healthy weight management in people living with a SMI found that lifestyle interventions such as exercise and dietary advice can reduce the BMI of people living with SMI, but the impact is small unless the intervention lasts for longer than 6 months. Qualified professionals such as dietitians are more effective than other health professionals in helping people reduce their BMI. Support available will be different in each area. Consider referral to: 1. local authority commissioned weight management programmes. 2. the national <u>NHS Digital Weight Management Programme</u> (https://www.england.nhs.uk/digital-weight-management/), which supports adults living with obesity who also have a diagnosis of diabetes. 3. local VCSE organisations that provide tailored support; for example, see <u>case study 3: VCSE organisations supporting people living with SMI to improve their physical health</u> (https://www.england.nhs.uk/long-read/vcse-organisations-supporting-people-living-with-smi-to-improve-their-physical-health/). Rethink has produced a <u>physical activity toolkit</u> (https://www.rethink.org/media/5333/rethink-mental-illness-physical-activity-toolkit.pdf) for support groups helping people living with SMI to become more active.
Lipid profile	<u>Cardiovascular disease: risk assessment and reduction, including lipid modification [NG238]</u> (https://www.nice.org.uk/guidance/ng238).	Offer lifestyle advice (diet, physical activity, weight management (see above), stop smoking, reducing alcohol). Offer lipid lowering therapy if safe, appropriate and can be monitored.

SMI physical health check	NICE guidelines	Evidence-based follow-up interventions and resources
Smoking status	Tobacco: preventing uptake, promoting quitting and treating dependence [NG209] (https://www.nice.org.uk/guidance/ng209).	Tobacco dependence treatment is effective in people living with SMI, [17] particularly when support is tailored to their needs. NHS England is implementing 7 specialist mental health tobacco dependency service pilots, informed by the SCIMITAR+ (https://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(19)30047-1/fulltext) model which has been shown to increase quit rates among people living with SMI. Importantly, any intervention that seeks to reduce or stop the tobacco dependence of someone living with SMI must factor in interactions with medications. Smoking can affect the metabolism of psychotropic medications. Change in smoking status may require prompt dose alteration of certain antipsychotics, especially clozapine which can have rapid and serious toxicity (within a week).

Personalised care

People living with SMI will need tailored support to access follow-up interventions to support their physical health. Services must consider that individuals who have pre-existing co-morbid physical and mental health problems may vary in their ability to self-manage their conditions and may also face social challenges. [18]

A range of roles may assist people living with SMI to get the best out of the follow-up interventions they have been referred to. For example:

- Peer support workers can help reduce barriers to engagement, address social isolation and support behaviour change.
- Health and wellbeing coaches can support people to increase their ability and motivation to self-manage, and work with people to set personalised goals.
- Care co-ordinators can play a key role in improving the pathway for people living with SMI. With their in-depth knowledge of local services, they can point people in the right direction, approach services on an individual's behalf and support people to attend appointments where appropriate.
- Social prescribing link workers can work across health, social care and VCSE organisations, including faith groups, to help people find the support that best meets their needs.

Non-clinical staff should be supported to be aware of the access routes and appropriateness of activities they sign post and support access to, based on the physical health check.

Personalised care and support planning can support people living with SMI to make the lifestyle and behaviour changes needed to achieve and sustain better physical health. It aims to have a better or different conversation between a person and their health and social care practitioner to create a more equal relationship. It should address the full needs of the individual, taking steps to combat loneliness, isolation and promoting wider engagement with self-care, exercise, healthy eating and lifestyle. Crucially, this should involve shared decision-making between the patient and the professionals supporting them (see [NICE guidelines on shared decision making](https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making) (<https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>)).

Personalised support and care planning should include jointly agreeing:

- what matters to the person and what good support looks like for them
- personal physical health goals (motivational interviewing techniques can help people decide what their personal health goals are)
- approaches to self-care, eg health coaching
- referrals to follow-up interventions, social prescribing or onward signposting
- follow-up appointments

- roles and responsibilities of other named supporting professionals
- addressing social factors that might be impacting on someone's physical and mental health such as isolation, employment or housing.

The [Rethink Mental Illness – Physical health check tool](https://www.rethink.org/media/4862/interactive-physical-health-check-tool.pdf) (<https://www.rethink.org/media/4862/interactive-physical-health-check-tool.pdf>) can help personalise support for a SMI physical health check and follow on interventions. It has been co-produced with people with lived experience.

The NICE [patient decision aids](https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids) (<https://www.nice.org.uk/about/nice-communities/nice-and-the-public/making-decisions-about-your-care/patient-decision-aids>) can support conversations and help patients make informed choices. If eligible, a [personal health budget](https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/) (<https://www.nhs.uk/nhs-services/help-with-health-costs/what-is-a-personal-health-budget/>) may be appropriate to enable people to access follow-up support for their physical health goals. See [case study 4: Mental health personal health budgets: redesigning the recovery pathway](https://www.england.nhs.uk/long-read/mental-health-personal-health-budgets-redesigning-the-recovery-pathway/) (<https://www.england.nhs.uk/long-read/mental-health-personal-health-budgets-redesigning-the-recovery-pathway/>) for an illustration of the role of personal health budgets in supporting the physical health of people living with SMI.

Service design considerations

Care that advances equality

The NHS is committed to ensuring that everyone receives high quality healthcare, regardless of their background. There is also a legal duty to advance equality, diversity and inclusion for everyone accessing health services, as laid out in the [Equality Act](https://www.legislation.gov.uk/ukpga/2010/15/contents) (<https://www.legislation.gov.uk/ukpga/2010/15/contents>), including by providing reasonable adjustments, and in the [Health and Care Act 2022](https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted) (<https://www.legislation.gov.uk/ukpga/2022/31/contents/enacted>). NHS England has set out its plan to deliver more equitable access, experience and outcomes in mental health services in its [Advancing mental health equalities strategy](https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf) (<https://www.england.nhs.uk/wp-content/uploads/2020/10/00159-advancing-mental-health-equalities-strategy.pdf>), and has launched the [patient and carer race equality framework \(PCREF\)](https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/) (<https://www.england.nhs.uk/mental-health/advancing-mental-health-equalities/pcref/>) to improve the experiences of mental health services among racialised and ethnically and culturally diverse communities.

Providing annual SMI physical health checks is also a core clinical focus of [Core20PLUS5](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/>), NHS England's flagship approach for tackling health inequalities, which includes the [Core20PLUS Connector Programme](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-community-connectors/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus5-community-connectors/>) and [Core20PLUS ambassadors](https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus-ambassadors/) (<https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/core20plus-ambassadors/>). Importantly, socioeconomic disadvantages and stigma and discrimination associated with living with SMI can themselves influence the health of and access to healthcare among this population.^[19]

To support progress in advancing health equality, this section provides guidance on ways to tailor services to improve access and outcomes for:

- people from racialised and ethnically and culturally diverse communities
- people with a learning disability and autistic people
- people with a co-occurring alcohol and/or drug problem
- LGBTQ+ communities
- older adults
- young people
- people in [inclusion health](https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health) (<https://www.gov.uk/government/publications/inclusion-health-applying-all-our-health/inclusion-health-applying-all-our-health>) groups who are less likely to be registered with a GP or consistently accounted for in electronic health databases (such as people who experience homelessness, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery).

It is also important to recognise that people's identities and experiences are multifaceted, and that being a member of multiple groups that experience inequalities may compound poorer experiences and outcomes of care. These group-level considerations should always be applied in the context of seeing people as individuals, avoiding blanket assumptions, and working with people to understand and put in place support that meets their needs and aspirations, and considers their strengths.

People from racialised and ethnically and culturally diverse communities

Research indicates that people living with SMI from certain ethnic groups are more likely to experience multimorbidity. For instance, a 2022 study found that among people with psychosis (controlling for sociodemographic factors and duration of care), those of Black African, Black Caribbean and Black British ethnicity have higher odds of multimorbidity than White British people. [20] (https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#_ftn20).

Despite having higher rates of multimorbidity, a [Race Equality Foundation report](https://raceequalityfoundation.org.uk/health-and-care/physical-health-checks-report/) (<https://raceequalityfoundation.org.uk/health-and-care/physical-health-checks-report/>) in 2022 found that Black African and Black Caribbean people living with SMI had variable or low awareness of annual SMI physical health checks and were apprehensive about using services based on previous bad experiences.

Racialised and ethnically and culturally diverse communities include people with very different cultural backgrounds and identities. The suggestions below are therefore general, with the overarching aim to centre care on people's individual needs in relation to their race, ethnicity and faith:

- Provide co-produced culturally appropriate resources that explain why annual SMI physical health checks are important and what they involve, including in non-written formats such as videos (see [resources developed by the Race Equality Foundation](https://raceequalityfoundation.org.uk/health-care/physical-health-checks-for-people-with-severe-mental-illness/) (<https://raceequalityfoundation.org.uk/health-care/physical-health-checks-for-people-with-severe-mental-illness/>)).
- Provide key information in different languages and formats and ensure ready access to independent interpreters (instead of relying on family members to translate).
- Engage with VCSE organisations that support people from racialised and ethnically and culturally diverse communities who are living with SMI, and work with community assets (such as faith buildings and community centres) to raise awareness of the importance of annual SMI physical health checks, what they involve and how they can support people to access them.
- Tailored outreach programmes to support people from racialised and ethnically and culturally diverse communities to access annual SMI physical health checks, including using community assets to deliver the checks and follow-up interventions (see [section: Dedicated services and outreach programmes](https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#dedicated) (<https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#dedicated>)).
- Provide staff training to develop cultural competency and the skills needed to plan and deliver care in a way that is culturally appropriate.
- Improve recording and monitoring of ethnicity data, including in primary care records, to help identify variation in uptake of the annual SMI physical health checks to inform actions to reduce this.
- Review organisational policies, procedures and practices to ensure that training, interventions and care delivery are anti-racist, and improve the experience and outcomes of people from racialised and ethnic minority communities.

People with a learning disability

People with a learning disability are more likely to experience poorer physical health and die at a younger age than the general population, and there is also sizeable cross-over between people living with SMI and having a learning disability. Data from GP records found that 7.5% of those with a recorded learning disability also had a SMI diagnosis. [21] (https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#_ftn21).

In line with the Health and Care Act 2022, all NHS staff should receive training on learning disability and autism that is appropriate to the person's role, including the [Oliver McGowan mandatory training](https://www.e-lfh.org.uk/programmes/the-oliver-mcgowan-mandatory-training-on-learning-disability-and-autism/) (<https://www.e-lfh.org.uk/programmes/the-oliver-mcgowan-mandatory-training-on-learning-disability-and-autism/>).

To improve the support that people with a learning disability receive, you may want to consider the following:

- People aged 14 and over with both a learning disability and SMI should receive a health check that combines the elements of both the learning disability and SMI health checks (avoiding duplication of checks). More information on the learning disability health checks is available on the [NHS England website](https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/) (<https://www.england.nhs.uk/learning-disabilities/improving-health/annual-health-checks/>).
- Staff skills to support someone with a learning disability to access a check, such as speech and language therapists to support communication issues and understanding of the check, results from the check and ongoing interventions.

Autistic people

Autistic people experience poorer health than the general population, and are over 6.7 times more likely to be treated with antipsychotics than those not recorded as having autism. [22] (https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#_ftn22).

To improve the support that autistic people receive, you may want to consider the following:

- As part of the NHS Long Term Plan, an autism health check has been co-developed and is being tested in a randomised controlled trial with Newcastle University. This study is due to complete in summer 2024. The autism health check has been piloted with primary care to explore the challenges and enablers to future implementation with varying workforces.
- Autistic people living with SMI should currently receive the annual SMI physical health check. They may need certain reasonable adjustments to help them access this check. Work with the autistic person and their chosen carer(s) to understand their individual needs and what adjustments should be made, such as using the [Sensory-friendly resource pack](https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/) (<https://www.england.nhs.uk/publication/sensory-friendly-resource-pack/>) or [Green Light Toolkit](https://surveys.ndti.org.uk/) (<https://surveys.ndti.org.uk/>), and record key preferences as an alert on the person's EPR.
- Autism peer education for parents and carers – [Autism Central](https://www.autismcentral.org.uk/). (<https://www.autismcentral.org.uk/>)
- [Autism peer support workers](https://www.hee.nhs.uk/our-work/autism/current-projects/developing-autism-peer-support-worker-roles) (<https://www.hee.nhs.uk/our-work/autism/current-projects/developing-autism-peer-support-worker-roles>).

People with co-occurring substance use

Substance use is common among people with mental health problems, and often leads to poor health and earlier death. [23] (https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#_ftn23) People experiencing co-occurring mental health challenges and substance use often experience other challenges, such as homelessness, frequent contact with the criminal justice system and domestic abuse, all of which can increase social exclusion. They can mistrust services following previous poor experiences of traditional services that do not meet their needs. People with co-occurring substance use may not prioritise annual SMI physical health checks, meaning more proactive communication is required about why health checks are important.

To improve the support that people with co-occurring substance use receive, you may want to consider the following:

- Services should act on the principles of 'no wrong door' and 'everybody's job' so that people can access holistic care for their mental health, physical health and substance use problems. [24] (https://www.england.nhs.uk/wp-admin/post.php?post=237184&action=edit#_ftn24)
- To adopt a 'no wrong door' approach, there is a need for robust and proactive joint working by professionals working with people experiencing co-occurring substance use and referral processes should be agreed.
- Consider the need for outreach services for these individuals, including:
 - use of a variety of approaches to communicate with people (especially as they may change their phone numbers and addresses more frequently than others)
 - provision of easy read materials for people with brain injury or low literacy
 - provision of annual SMI physical health checks in non-traditional settings, such as homelessness accommodation, community substance use treatment services or other settings where people with co-occurring substance use are more likely to be and feel more comfortable
 - being flexible if appointments are repeatedly missed.
- Follow-up interventions are supported and tailored to consider living conditions and other support needs.

LGBTQ+ communities

LGBTQ+ people are more likely to develop mental health problems than the general population. The reasons for this are complex, but one contributory factor is that they often experience prejudice and discrimination.

To improve the support that LGBTQ+ people receive, you may want to consider the following:

- Have clear posters and signage within services to show that they are LGBTQ+ friendly, to help create an open environment.
- Use inclusive language, ask about preferred pronouns and name, and do not make assumptions about people's relationships and gender.
- Signpost people to support from LGBTQ+ VCSE organisations.
- Provide staff training to develop understanding of the health inequalities experienced by LGBTQ+ people and the challenges they may face accessing healthcare.
- Review organisational policies, procedures and practices to ensure that all training, interventions and care improve the experiences and outcomes of people from LGBTQ+ communities.

Older adults

SMI in older adults can be long-standing or may present for the first time in later life. Psychotic depression is more common in later life, with an estimated average age of onset of 51.2 years, and older adults with schizoaffective disorder appear to have more severe illness with worse outcomes.^[25]

To improve the support that older adults receive, you may want to consider the following:

- Different methods for inviting someone to an SMI physical health check. Older adults are more likely to experience digital exclusion.
- Physical access needs, such as adequate transport and accessibility of a building. Home visits may sometimes be appropriate.
- Timing of the appointment, eg some older adults may find it difficult to attend an early appointment or may not want to travel when it is dark.
- Longer appointments, as some older adults may need more time, eg to remove clothes to have a blood pressure reading taken.

The need to ensure reasonable adjustments are in place for people who have any cognitive or sensory difficulties; these are more common in older adults.

Young people

Schizophrenia and bipolar disorder usually start in late adolescence and early adulthood.^[26]^[27]

To improve the support that young people receive, you may want to consider the following:

- Recognise the importance of transitions in a young person's life, and how these might impact on their mental and physical health, including the effect of transitioning between CYP and adult mental health services.
- Ensure there is a strong interface, relationship and joint working protocols with EIP teams. Regular liaison and training arrangements across services can help colleagues to be confident in identifying first episode psychosis and at-risk mental states in young people, leading to rapid referrals and reduced durations of untreated psychosis.
- Young people may be more transient, for instance university students may reside and move between two locations and this can affect contact with a GP and other services. Support transitions for young people taking up university places and ensure appropriate signposting and referral to university health and welfare services. Transitions and transfers of care should be ably supported through care planning across teams.

Make sure arrangements are in place to support care leavers; that is, joint working between primary care, mental health services and local authority social care.

People in inclusion health groups

A range of people may be less likely to be registered with a GP or consistently accounted for in electronic health databases, which means they will be less likely to be invited to a SMI annual physical health check. Local areas should identify such groups in their area, but they are likely to include (non-exhaustive list):

- people who experience homelessness
- vulnerable migrants
- Gypsy, Roma and Traveller communities
- sex workers
- people in contact with the justice system
- victims of modern slavery.

To improve the support that these communities receive, you may want to consider the following:

- Work with system partners to gather quantitative and qualitative data to understand the characteristics and needs of inclusion health groups locally and to target resources to improve access, experience and outcomes.
- Translate materials into different languages, and provide interpreters and other communication options for those who cannot read.
- Ensure it is clearly communicated to primary care staff that there is no regulatory requirement for people to prove their identity, address or immigration status to register at a GP surgery.
- Set up drop-in sessions to see a GP at convenient times without having booked an appointment, where possible.

Roles and responsibilities

Joint working between primary care, secondary mental health providers and VCSE organisations is at the heart of the [Community Mental Health Framework \(https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/\)](https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/), and is essential for improving the physical health care of people living with SMI. By working together these services can ensure:

- patients get the right care, at the right time
- people do not fall into gaps in our care, or need to repeat their stories and undergo duplicate tests and examinations
- patients are provided with consistent advice as they move between services
- an exchange of learning between healthcare professionals, eg improving mental health clinicians' understanding of physical health and primary care clinicians' understanding of mental health
- work is not duplicated by different services, creating inefficiencies and unnecessary burden to patients.

Mental health practitioners within primary care can play a role in upskilling the wider primary care workforce in delivering SMI annual physical health checks and supporting access to follow-up interventions in a tailored and trauma-informed way. However, given the limited mental health workforce, particularly within primary care, they should not deliver physical health care checks, other than by exception when this is identified as the only way someone will access their annual physical health check.

SMI annual physical health checks are expected to be delivered mostly in primary care and are included in the Quality and Outcomes Framework (QOF). Specialist mental health care can support people to engage with primary care and, in certain situations, it will be appropriate for secondary care or VCSE services to deliver these checks.

ICSs should ensure a local comprehensive model of care is provided so that people living with SMI receive an annual physical health check in a way that meets their needs. The model should include a protocol outlining roles and responsibilities across primary care, secondary care and VCSE services to optimise the physical health care of people living with SMI. The protocol should:

- Follow the principles of [NICE guidance CG178](#), which ensures clarity on who is responsible for the physical health monitoring of patients.
- Include information sharing and data flow requirements. This will enable alignment of the SMI register between primary and secondary care, allowing accurate and timely identification of patients requiring an annual SMI physical health check (or elements of the check), and avoiding duplication.
- Clarify who is responsible for each step, including undertaking the check, analysing the results, and supporting the patient to access further support, interventions and care as required (eg services such as smoking cessation and personal health budgets).

If someone is an **inpatient in a mental health setting**, options may include:

- Physical health checks are delivered by secondary care services, with data flowed to primary care SMI registers to ensure primary care services can refer or deliver follow-up interventions as required.

- Primary care provides an in-reach service to deliver annual SMI physical health checks within mental health inpatient settings, and arranges referral or follow-up interventions as required.

If someone is **supported by a community mental health team** but is struggling to engage with primary care services, options may include:

- Physical health checks are delivered by secondary care services, with data flowed to primary care SMI registers to ensure primary care services can refer or deliver follow-up interventions as required.
- Secondary care or a VCSE organisation supports someone to attend a primary care delivered physical health check.
- A commissioned dedicated service delivers physical health checks 'remotely' in homes or hubs where people feel comfortable, and data is flowed to primary care SMI registers to ensure primary care services can refer or deliver follow-up interventions as required.

If someone is **not responding to invitations** to a primary care delivered annual SMI physical health check, options may include:

- Outreach supports someone to attend a primary care delivered physical health check. This may be through primary care, secondary care or a VCSE organisation.
- A commissioned dedicated service delivers physical health checks 'remotely' in homes or hubs where people feel comfortable, and data is flowed to primary care SMI registers to ensure primary care services can refer or deliver follow-up interventions as required.

Dedicated services and outreach programmes

To increase uptake of SMI physical health checks and follow-up interventions, ICSs should consider commissioning enhanced or dedicated services and outreach programmes.

Before considering commissioning arrangements, undertake strategic planning including:

- use local data (eg from Joint Strategic Needs Assessments and OHID's Fingertips Profile) to understand the health needs of the local SMI population and existing inequalities
- establish relationships with parallel programmes such as NHS Health Check and Learning Disability Annual Health Check
- review current performance and plans for future delivery
- develop a plan to improve levels of interoperability and effective information sharing between primary and secondary care (see [section: Data sharing](#)).

Consider the most effective models for commissioning improvements in the context of local needs. This may include commissioning one or more of the following:

a) **A local enhanced service** as an addition to the core primary care contract. This might include services that go beyond the existing QOF indicators, such as:

- delivery of a comprehensive annual physical health check beyond the 'core' 6 elements of the SMI physical health check.
- delivery of SMI physical health checks to a wider group than those on the primary care SMI register.

b) **A dedicated service** commissioned for delivery of SMI physical health checks. This could be commissioned from a primary care provider, secondary mental health care provider or a VCSE organisation, which may deliver this service within or linked into primary care settings.

See [case study 5: A dedicated physical health check service for people with severe mental illness](#) (<https://www.england.nhs.uk/long-read/a-dedicated-physical-health-check-service-for-people-with-severe-mental-illness/>).

c) **An outreach programme** to support people to access SMI physical health checks and follow-up interventions delivered in primary care (see below).

See [case study 6: Using peer mentors to increase engagement with SMI physical health checks](#) (<https://www.england.nhs.uk/long-read/using-peer-mentors-to-increase-engagement-with-smi-physical-health-checks/>) and [case study 7: VCSE outreach supporting person-centred SMI physical health checks](#) (<https://www.england.nhs.uk/long-read/vcse-outreach-supporting-person-centred-smi-physical-health-checks/>).

When designing your service or programme, consider the following:

- Co-production with people living with SMI and people from their support networks, including family and carers.
- Developing and promoting clinical leadership and collaborative working between provider organisations, eg by appointing a clinical mental health lead within each primary care network (PCN) to liaise with secondary mental health teams (see [section: Leadership, workforce and training](#)).

- Develop a clear protocol outlining roles and responsibilities across primary and secondary care and VCSE organisations, as well as communications and information sharing requirements, ensuring robust shared care arrangements are in place, so that people do not fall into gaps in care.
- Staffing requirements, including which roles would be suitable to deliver the services, training needs, where they will work from and how to refer to follow-up interventions, including information sharing with other staff who make referrals or deliver physical and mental health treatments (see [section: Leadership, workforce and training](#)).
- Key deliverables and outcomes (including uptake of a more comprehensive annual physical health check, and support to access follow-up interventions) and an evaluation which includes patient and staff experience.

Outreach programmes

A range of barriers can prevent people living with SMI from accessing annual physical health checks and follow-up interventions, and outreach programmes can be designed to overcome these.

Barriers can include:

- previous poor experiences of statutory services, including health services
- lack of awareness of physical health check provision
- lack of understanding of the reasons for the check and why it is important (including the relationship between their mental and physical health)
- difficulty engaging with invitations sent via traditional routes (for instance, not opening post)
- previous poor experiences of the check, or expectation that the check will not be tailored to the needs of someone with mental illness
- concerns about the check itself (that it will only provide 'bad news') and what it will involve (eg fears about blood tests, being weighed)
- poor mental health at the time of being invited (eg low motivation, psychosis, anxiety)
- access barriers such as finding it difficult to get to an appointment, language barriers, transportation, etc
- lack of confidence or support to access follow-up interventions.

This is a non-exhaustive list, and other barriers may be more common for communities in your area, which is why co-producing an outreach service is so important.

Strategic planning and co-production with people with lived experience can identify the key communities that may benefit from an outreach programme in your area. These may include those less likely to be registered with a GP or consistently accounted for in electronic health databases, who mistrust services or have language barriers. This may include groups outlined in [section: Care that advances equality](#).

Working with the VCSE sector

It can be valuable to commission VCSE organisation(s) to run outreach programmes as they have expertise in reaching people in communities and overcoming barriers to service access. Things to consider when commissioning a VCSE organisation(s) include:

- Development of a robust partnership agreement, including the role of lived experience and how co-production will be undertaken.
- Different commissioning options when commissioning smaller organisations (which may be particularly skilled in reaching certain communities), eg commissioning a larger VCSE provider to act as a lead provider that subcontracts delivery to smaller, more specialist organisations.
- Find a common ground for risk management that balances strong NHS processes and VCSE flexibility and innovation.
- Data sharing – involve IT and HR staff early in implementation, as VCSE staff may require honorary contracts and NHS email addresses where current IT systems do not easily facilitate data sharing through other mechanisms (see [section: Data sharing](#)).

See [A framework for addressing practical barriers to integration of VCSE organisations in integrated care systems](https://www.england.nhs.uk/long-read/a-framework-for-addressing-practical-barriers-to-integration-of-vcse-organisations-in-integrated-care-systems/) (<https://www.england.nhs.uk/long-read/a-framework-for-addressing-practical-barriers-to-integration-of-vcse-organisations-in-integrated-care-systems/>) for a range of case studies.

Staff training

Outreach work may require additional staff training on the relationship between mental and physical health, the importance of the health checks and how to provide reasonable adjustments and support people to access follow-up interventions. It is advised that training is co-produced and delivered with people with lived experience. See [Annex B for training resources](#).

Patient and carer awareness

Many people living with SMI may be unaware that they should be receiving an annual physical health check and why it is important. They may also be unaware that they are on an 'SMI register' and what this means. Co-producing communications with people with lived experience, their families and carers, and VCSE organisations can help promote awareness. This includes invitations to annual SMI physical health checks to make sure they are seen as relevant, welcoming and safe. Also consider different communication formats, including videos, easy reads and translated resources.

Building trust

Some people may not be accessing SMI physical health checks because they mistrust services. Effective outreach services will need to build trusting relationships with identified individuals, and this may be most effectively done by local VCSE organisations, including peer support workers, and staff members who reflect the demographics of the communities they are trying to reach.

Building trust can take time and may require multiple attempts through multiple communication channels, including:

- letters
- texts/SMS2
- phone calls
- attendance at secondary care mental health clinics (such as depot and clozapine clinics, which people may be accessing already)
- attendance at community 'hubs' such as those hosted by VCSE organisations
- engaging community leaders to reach people from particular backgrounds
- home visits.

Outreach will need to follow-up those who do not attend booked appointments to understand the reasons why and to try and put support in place to ensure attendance at a future appointment.

Supporting people to attend appointments and reasonable adjustments

Many people will require support and a range of reasonable adjustments to attend an annual SMI physical health check and follow-up interventions. See [section: Trauma-informed delivery and reasonable adjustments](#) for examples of reasonable adjustments.

Remote delivery of SMI physical health checks

Remote delivery of annual SMI physical health checks outside a clinical setting can support outreach programmes to reach people who may be less likely to come to a primary care setting. One way to deliver remote checks is through using portable technologies and point of care testing (POCT) equipment. POCT equipment can often record results electronically, reducing clinical time and transcription error where there is interoperability with local electronic patient records (EPRs). POCT blood test equipment does not rely on the need for pathology labs and can provide a result which can be actioned at the time of contact.

Having worked to understand which communities you should try to reach through remote checks (see section: [Care that advances equality](#)), engage PCNs and clinicians, including pathology teams, in your area to understand which portable equipment and technology (testing and digital integration) options are compatible with their systems and needs, and provide the required diagnostic value.

Assessments to consider when procuring POCT equipment and designing a programme for delivery of remote annual SMI physical health checks include:

- Does the technology/equipment have the capability to undertake every element of the annual SMI physical health check ('core' and comprehensive) that you wish to be delivered?
- Does the remote delivery of elements of the check, including blood tests, meet local clinical safety and governance requirements (clinical benchmarks, safety processes and testing governance)?
- If remote delivery of some elements of the check do not meet diagnostic clinical requirements, are you happy for parts of the check to be used as an initial screening to aid outreach.
- Is the recorded data compatible with local primary care IT systems (electronic patient records), and can it populate these or does it need to be downloaded and entered into records?
- Does the recording and sharing of data when using this equipment meet local information governance requirements?
- How will results be actioned and linked to referrals and follow-up interventions?
- Who will deliver the remote annual SMI physical health checks and what training and support do they need to use this equipment?
- What ongoing calibration, checks, maintenance or quality control of the equipment will be required?

Other practical aspects to consider when procuring equipment include:

- portability (size, weight)
- testing times
- testing and sampling processes
- accuracy and precision
- alignment with laboratory results where applicable
- limitations, including issues regarding contamination
- IT equipment and functions provided
- interface and/or integration requirements for results
- consumable storage requirements
- warranty
- costs (equipment, consumables, maintenance, laboratory support if required).

As an example, see [using POCT equipment for SMI annual physical health checks in Greater Manchester](https://transform.england.nhs.uk/covid-19-response/technology-nhs/bringing-holistic-services-within-reach-for-people-with-severe-mental-illness/). (<https://transform.england.nhs.uk/covid-19-response/technology-nhs/bringing-holistic-services-within-reach-for-people-with-severe-mental-illness/>).

Data sharing

For safe, effective and joined-up care between primary care, secondary care and VCSE services, appropriate sharing and exchange of accurate and up-to-date information between practitioners is key. Data from annual SMI physical health checks conducted outside primary care should flow back to the individual's primary care record. Non-primary care staff may also need to access primary care data systems so they can run reports or audits to identify patients on the SMI register and those yet to receive an annual physical health check.

Data sharing should be a key component of any protocol outlining roles and responsibilities across primary care, secondary care and VCSE services. This should cover sharing results including interpretation of health assessments and how relevant information entered into IT databases will reach the right healthcare professional(s) promptly for follow-up care. Consider if data needs to be shared across multiple organisations at a system or regional level.

Data can be shared in a variety of ways with different degrees of interoperability. Considerations when designing how data on annual SMI physical health checks and follow-up interventions will be shared include:

- A clear and consistent template for inputting data. See [case study 8: Standardising the monitoring of SMI physical health to improve interoperability](https://www.england.nhs.uk/long-read/standardising-the-monitoring-of-smi-physical-health-to-improve-interoperability/) (<https://www.england.nhs.uk/long-read/standardising-the-monitoring-of-smi-physical-health-to-improve-interoperability/>).
- Facilitating secondary care and VCSE providers to input data directly into primary care information systems. Third party organisations may need to be granted network access, including through honorary contracts, and provided with laptops with NHS smartcards to enable access to patient records and data sharing.
- Integration of annual SMI physical health check data into local shared care records.

Patient records should only be shared in accordance with local information governance agreements and with due regard to confidentiality, as outlined in the EU General Data Protection Regulation (GDPR), the Data Protection Act 1998 and human rights legislation.

It is vital to work with any commissioned VCSE organisations from the start to address data sharing challenges. It is advised that:

- Data requirements are built into contracting processes.
- Commissioners take responsibility for providing guidance and relevant IT equipment to meet the requirements of VCSE organisations.

- Consideration is given to commissioning a VCSE Alliance to help with data flow where a large number of small VCSE providers are involved.

Leadership, workforce and training

Leadership

Improvements in the physical health of people living with SMI need to be driven by embedding leadership in this area at integrated care board (ICBs), mental health provider and PCN level. Mental health leads and health inequality leads in ICBs should recognise this as a strategic priority in line with Core20PLUS5. It is also recommended that non-executive directors on ICBs and the boards of mental health providers are supported to understand the importance of improving the physical health of those living with SMI, and to seek assurance from and hold the executives to account for tackling this health inequality. Consideration should also be given to lived experience leadership roles to support work in this area.

A group or forum that brings together the different stakeholders focused on the physical health of people living with SMI is recommended. These stakeholders will include representatives from primary care, secondary mental health care, the VCSE sector and the local authority, including public health teams, as well as those with lived experience and clinical leads.

Workforce

A wide range of roles across primary care, secondary care and the VCSE sector can be involved in the delivery of the annual SMI physical health check and support for follow-up interventions, including GPs, nurses, pharmacists, occupational therapists, healthcare assistants, health coaches and VCSE staff.

When deciding which roles can deliver the physical health check, it will be important to consider:

- The whole multidisciplinary team – you may want to use roles other than GPs to deliver the checks due to workforce capacity.
- Whether a role is trained to deliver all or some of the elements of the physical health check. Some services may use roles that can deliver all elements of the check. Others may use roles that can deliver the check other than the blood tests, which they book this with colleagues.
- Whether a role has access to the relevant IT systems to record the checks or a system for the data to flow into the IT systems.
- Whether a role can analyse and action the results, or there is a process for this to be done by an appropriately trained colleague. This should include whether a role can support access follow-up interventions.
- Whether a role can consider the wider needs of an individual and provide or refer to those who can assist with personalised support and care planning (see [section: Personalised care](#)).
- Cost effectiveness of using particular roles.
- The training roles will require, including on increasing understanding of SMI and how SMI affects physical health.

Training

Ensuring that practitioners have the correct knowledge, skills and attitudes is essential to delivering high quality care and addressing the stigma that contributes to the known mortality gap for people living with SMI.

All staff delivering annual SMI physical health checks and supporting access to follow-up interventions should feel competent and confident to support people to better manage their physical health. Staff need to:

- Understand what SMI is and how it might be experienced by people.
- Understand the excess risks of poor physical health, including oral health, and how people can be engaged and supported to access appropriate physical health care.
- Feel confident and empowered to talk about health holistically, including mental and physical health, healthy lifestyles and risk reduction.
- Have the technical skills and expertise to carry out physical health assessments, and action and communicate the results as required.
- Understand the appropriate next steps following delivery of an annual SMI physical health check in line with their role to ensure a person is supported to access follow-up interventions as required.

To achieve this a comprehensive approach to workforce development could include:

- A high-quality training offer covering core mental health awareness, physical health promotion and behaviour change for people living with SMI.
- Protected time for staff to access relevant training.
- Appropriate supervision and opportunities for reflective practice.
- Access to multidisciplinary team structures as part of continued development.

Co-producing training with people with lived experience – and seeking participation from those who are less frequently heard – can ensure that staff fully understand why people living with SMI need an annual SMI physical health check, have a positive experience of the check and are supported to access follow-up interventions. Training delivered by those with lived experience can be particularly effective as it brings real-life examples of challenges and ideas for service delivery.

Areas where training has been developed collaboratively between primary care, secondary care and the VCSE sector have shown that this is not only invaluable for sharing knowledge but also for promoting closer working relationships, which increases the effectiveness of shared care delivery.

See [Annex B](#) for a list of available training resources, and [Annex E](#) for further tools and resources.

Annex A: Case studies

You can read [8 case study examples](https://www.england.nhs.uk/publication/case-studies-physical-health-support-services-for-people-living-with-severe-mental-illness) (<https://www.england.nhs.uk/publication/case-studies-physical-health-support-services-for-people-living-with-severe-mental-illness>) of the collaborative work taking place to deliver physical health support services for people living with severe mental illness (SMI).

Annex B: Training resources

UCLP-Primrose resources

UCLP-Primrose is a framework for primary care teams to maximise the benefit of physical health checks for people living with SMI and improve their outcomes. [Training resources](https://uclpartners.com/our-priorities/cardiovascular/proactive-care/uclpartners-primrose-implementation-guide/uclpartners-primrose-e-learning-training-and-resources-for-clinical-staff/what-training-resources-are-available-to-support-delivery-of-uclp-primrose/) (<https://uclpartners.com/our-priorities/cardiovascular/proactive-care/uclpartners-primrose-implementation-guide/uclpartners-primrose-e-learning-training-and-resources-for-clinical-staff/what-training-resources-are-available-to-support-delivery-of-uclp-primrose/>) support use of the framework.

Mental health nurse training to promote good physical health for people living with SMI in their care (The Charlie Waller Trust)

[Training for mental health nurses](https://www.charliewaller.org/what-we-offer/nurses-and-allied-health-care-professionals/training/physical-health-in-smi) (<https://www.charliewaller.org/what-we-offer/nurses-and-allied-health-care-professionals/training/physical-health-in-smi>) covers:

- why the physical health of people with SMI is our problem
- physical health and keeping healthy
- supporting someone with SMI to be healthy
- the annual health check
- making the physical health of a person with SMI part of our everyday care.

How to improve the physical health of people with SMI (NHS England South East, The Charlie Waller Trust and Health Education England)

Endorsed by the Royal College of Nursing (RCN), this free [online 30-minute training film for primary care professionals](http://www.southeastclinicalnetworks.nhs.uk/phsmi/) (<http://www.southeastclinicalnetworks.nhs.uk/phsmi/>) covers:

- factual information about the main types of severe mental illness
- practical advice on how to talk and respond to people with severe mental illness
- how to encourage people with severe mental illness to attend appointments
- how to do physical health checks and medication reviews
- how to offer a care plan and ongoing support.

Primary care training to ensure patients with mental health problems receive appropriate help (The Charlie Waller Trust)

[Training for nurses and allied healthcare professionals](http://www.charliewaller.org/what-we-offer/nurses/training/primary-care-training) (<http://www.charliewaller.org/what-we-offer/nurses/training/primary-care-training>), working in primary care to ensure patients with mental health problems receive appropriate help. This training can also be used in a train the trainer programme. It covers:

- promoting wellbeing: includes factors that contribute to wellbeing and how to help people maintain their wellbeing
- encouraging healthy behaviour: includes lifestyle behaviours that keep people healthy, and how to assess readiness to change behaviour, motivate change at each stage of readiness, and support people to change their behaviour
- common mental disorder: includes a definition of common mental disorder and how to recognise, measure and treat common mental disorder

- severe mental illness: includes how a person with SMI might be affected, recognising relapse in mental health and how to improve their physical health.

Physical health in mental illness (the Royal College of Nursing (RCN) in collaboration with the Charlie Waller Memorial Trust)

Three short e-learning sessions (<https://www.rcn.org.uk/Log-In?returnUrl=https%3a%2f%2fscadmin.rcn.org.uk%2fclinical-topics%2fmental-health%2fphysical-health-in-mental-illness>), presented by Dr Sheila Hardy, that encourage nurses to proactively consider the physical health needs of people with severe mental illness. You need to be a RCN member to access this resource.

Restart Smiling, oral health training for staff supporting the physical health of people living with SMI

Co-developed with experts by experience, mental health and dental professionals, this 2-hour training resource covers:

- importance of good oral health for people living with SMI
- links between oral health, mental health and physical health
- barriers to maintaining good oral health in people living with SMI
- responsibility for promoting good oral health in people living with SMI
- key questions to ask, and key advice to give and actions to take for supporting good oral health in people living with SMI (including oral hygiene, dry mouth, mouth cancer, diet and accessing dental care)
- importance of promoting good oral hygiene in people living with SMI
- oral hygiene equipment
- delivery of oral hygiene advice through a step-by-step behavioural change approach.

To access Restart Smiling, please contact RESTART Smiling on restartsmiling1@gmail.com (<mailto:restartsmiling1@gmail.com>).

Core20PLUS5 (NHS England)

Free e-learning training for NHS health and care organisation staff on the Core20PLUS5 (<http://www.e-lfh.org.uk/programmes/health-inequalities/>) approach.

Physical health competency framework for mental health and learning disability settings (Health Education England)

Framework of knowledge and skills (<http://www.e-lfh.org.uk/wp-content/uploads/2020/04/Physical-Health-Competency-Framework-v2.9.pdf>) for registered clinical staff working in mental healthcare and/or learning disability settings who need to be able to meet the physical health needs of service users with SMI and/or a learning disability.

National Centre for Smoking Cessation and Training Mental Health Specialty Module

An [online training module and resource for anyone who works with smokers with mental health issues](https://elearning.ncsct.co.uk/england). (<https://elearning.ncsct.co.uk/england>) It focuses on supporting clients with a diagnosed mental health condition, who may be treated in the community or a specialist setting.

The mental health and smoking course is open to NCSCT certified stop smoking practitioners, who have taken the training and passed the assessment.

NHS Health Check competency framework

The [NHS Health Check Competency Framework](https://www.e-lfh.org.uk/wp-content/uploads/2020/04/Physical-Health-Competency-Framework-v2.9.pdf) (<https://www.e-lfh.org.uk/wp-content/uploads/2020/04/Physical-Health-Competency-Framework-v2.9.pdf>) outlines the core competence required to carry out the NHS Health Check. It also provides a template for minimum standards when commissioning or creating training packages, highlighting training needs for staff delivering the NHS Health Check programme. It is supported by the [NHS Health Check – national](https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/) (<https://www.healthcheck.nhs.uk/commissioners-and-providers/national-guidance/>) guidance (updated March 2020) and an [NHS Health Check Training Hub](https://www.e-lfh.org.uk/programmes/nhs-health-check/). (<https://www.e-lfh.org.uk/programmes/nhs-health-check/>)

Annex C: Clinical terminology, definitions and codes

The term severe mental illness (SMI) in this guidance refers to all individuals who have received a diagnosis of psychosis, schizophrenia or bipolar affective disorder. This definition should not be seen to imply that other diagnoses are not 'serious' or 'severe', or that they do not carry any associated physical health risk, but is used to align this guidance with NICE guidance for physical health checks and the scope of the Quality and Outcome Framework SMI register.

The SMI register should comprise all people with a recorded diagnosis of psychosis, schizophrenia or bipolar affective disorder: QOF register name – MH1 REG. Other patients on lithium therapy are recorded under QOF register MH2 REG.

- [antipsychotics \(https://bnf.nice.org.uk/treatment-summaries/psychoses-and-related-disorders/#monitoring\)](https://bnf.nice.org.uk/treatment-summaries/psychoses-and-related-disorders/#monitoring) (includes those prescribed antipsychotics without a mental health diagnosis, such as people with a learning disability whose behaviour challenges; see [NICE guideline NG11 \(https://www.nice.org.uk/guidance/ng11/\)](https://www.nice.org.uk/guidance/ng11/))
- [lithium \(https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbnf.nice.org.uk%2Fdrugs%2Flithium-carbonate%2F&data=05%7C01%7Cleila.reyburn%40nhs.net%7Cd6b6915866c54eb658ba08db1b0b29ad%7C37c354b2\)](https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fbnf.nice.org.uk%2Fdrugs%2Flithium-carbonate%2F&data=05%7C01%7Cleila.reyburn%40nhs.net%7Cd6b6915866c54eb658ba08db1b0b29ad%7C37c354b2)
- [sodium valproate \(https://bnf.nice.org.uk/drugs/sodium-valproate/\)](https://bnf.nice.org.uk/drugs/sodium-valproate/) (should not be used in women/girls of childbearing potential unless conditions of the Pregnancy Prevention Programme are met; [MHRA, Drug Safety Update April 2018](https://assets.publishing.service.gov.uk/media/5adee63eed915d0ba92893c4/DSU-April-2018-PDF.pdf)) (<https://assets.publishing.service.gov.uk/media/5adee63eed915d0ba92893c4/DSU-April-2018-PDF.pdf>).

In respect of SMI registers, all SNOMED codes under the SNOMED Cluster MH_COD have been used to define this cohort, minus all SNOMED codes under the SNOMED Cluster MH_REM (those in remission). All relevant SNOMED codes under the MH_COD cluster can be found on the [Primary Care Domain Reference Set Portal](https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/primary-care-domain-reference-set-portal). (<https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-collections/quality-and-outcomes-framework-qof/quality-and-outcome-framework-qof-business-rules/primary-care-domain-reference-set-portal>) The content of clusters is dynamic and can be updated several times throughout the year. Please refer to the portal/txt files for the most up to date content.

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

- Psychosis and schizophrenia in adults: prevention and management [CG178 (<https://www.nice.org.uk/guidance/cg178>)]
- Psychosis and schizophrenia in adults [QS80 (<https://www.nice.org.uk/guidance/qs80>)]
- Bipolar disorder: assessment and management [CG185 (<https://www.nice.org.uk/guidance/cg185>)]
- Bipolar disorder in adults [QS95 (<https://www.nice.org.uk/guidance/qs95>)]
- Bipolar disorder, psychosis and schizophrenia in children and young people [QS102 (<https://www.nice.org.uk/guidance/qs102>)]
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [CG120 (<https://www.nice.org.uk/guidance/cg120>)]
- Coexisting severe mental illness (psychosis) and substance misuse: community health and social care settings [NG58 (<https://www.nice.org.uk/guidance/ng58>)]

- Overweight and obesity management [NG246] (<https://www.nice.org.uk/guidance/ng246>)
- Cardiovascular disease: risk assessment and reduction, including lipid modification [NG238] (<https://www.nice.org.uk/guidance/ng238>)
- Type 2 diabetes: prevention in people at high risk [PH38] (<https://www.nice.org.uk/guidance/ph38>)
- Hypertension in adults: diagnosis and management [NG136] (<https://www.nice.org.uk/guidance/ng136>)
- Physical activity: brief advice for adults in primary care [PH44] (<https://www.nice.org.uk/guidance/ph44>)
- Diagnosis and management of type 1 diabetes in children, young people and adults [NG17] (<https://www.nice.org.uk/guidance/ng17>), NG18 (<https://www.nice.org.uk/guidance/ng18>) and NG19 (<https://www.nice.org.uk/guidance/ng19>)
- Type 2 diabetes in adults: management [NG28] (<https://www.nice.org.uk/guidance/ng28>)

Relevant NICE clinical guidance to deliver interventions for smoking, alcohol or substance use, and oral health

- [Tobacco: preventing uptake, promoting quitting and treating dependence \[NG209\]](https://www.nice.org.uk/guidance/ng209) (<https://www.nice.org.uk/guidance/ng209>)
 - [Tobacco: treating dependence \[QS207\]](https://www.nice.org.uk/guidance/qs207) (<https://www.nice.org.uk/guidance/qs207>)
 - [Alcohol-use disorders: prevention \[PH24\]](https://www.nice.org.uk/guidance/ph24) (<https://www.nice.org.uk/guidance/ph24>)
 - [Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications \[CG100\]](https://www.nice.org.uk/guidance/cg100) (<https://www.nice.org.uk/guidance/cg100>)
 - [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence \[CG115\]](https://www.nice.org.uk/guidance/cg115) (<https://www.nice.org.uk/guidance/cg115>)
 - [Drug misuse in over 16s: psychosocial interventions \[CG51\]](https://www.nice.org.uk/guidance/cg51) (<https://www.nice.org.uk/guidance/cg51>)
 - [Drug misuse in over 16s: opioid detoxification \[CG52\]](https://www.nice.org.uk/guidance/cg52) (<https://www.nice.org.uk/guidance/cg52>)
 - [Oral health: local authorities and partners \[PH55\]](https://www.nice.org.uk/guidance/ph55) (<https://www.nice.org.uk/guidance/ph55>)
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Annex E: Tools and resources

The Lester Tool (2023)

The [Lester Positive Cardiometabolic Health Resource](https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4) (https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/national-clinical-audits/ncap-library/lester-tool-june-2023.pdf?sfvrsn=c08e2847_4) provides practitioners with a simple assessment and intervention framework to protect the cardiovascular and metabolic health of people living with SMI receiving antipsychotic medication.

Supporting indicators to assess own performance

ICSs should use indicators and datasets to assess their performance in improving the physical health care for people with SMI within primary care, for example:

- [Excess under 75 mortality rate in adults with SMI](http://www.data.gov.uk/dataset/6d638303-458c-4215-96e1-84319496d15f/excess-under-75-mortality-rate-in-adults-with-serious-mental-illness-formerly-indicator-1-5-nhsf-1-5-i) (<http://www.data.gov.uk/dataset/6d638303-458c-4215-96e1-84319496d15f/excess-under-75-mortality-rate-in-adults-with-serious-mental-illness-formerly-indicator-1-5-nhsf-1-5-i>)
- [Quality and Outcomes Framework data](https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data#about-this-publication) (<https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data#about-this-publication>)

Equally Well resources

Equally Well has produced a range of [resources](http://www.equallywell.co.uk/resources/) (<http://www.equallywell.co.uk/resources/>) on the physical health of people with mental illness.

Rethink Mental Illness resources

Rethink Mental Illness has developed resources to build confidence and raise awareness of the physical health needs of people living with SMI, including:

- [Physical health guide for carers, families and friends](https://www.rethink.org/media/2255/physical-health-guide-for-carers.pdf) (<https://www.rethink.org/media/2255/physical-health-guide-for-carers.pdf>)
- [Take the first step... towards control of your physical health](https://www.rethink.org/media/4865/take-the-first-step-towards-taking-charge-of-your-ph-handout.pdf) (<https://www.rethink.org/media/4865/take-the-first-step-towards-taking-charge-of-your-ph-handout.pdf>) – information leaflet explaining what the SMI physical health check is and FAQs
- [Physical Health Check Tool](https://www.rethink.org/media/4862/interactive-physical-health-check-tool.pdf) (<https://www.rethink.org/media/4862/interactive-physical-health-check-tool.pdf>) – supports people living with SMI before, during and after their physical health check
- [What's reasonable?](https://www.rethink.org/media/4808/whats_reasonable_-_gp_adjustments_guide.pdf) (https://www.rethink.org/media/4808/whats_reasonable_-_gp_adjustments_guide.pdf) – resource for GP surgeries on making reasonable adjustments for people affected by mental illness.

Physical health assessment invitation letters

- Hardy S, Gray R (2012). [Is the use of an invitation letter effective in promoting patients with severe mental illness to attend a primary care physical health check?](https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/is-the-use-of-an-invitation-letter-effective-in-prompting-patients-with-severe-mental-illness-to-attend-a-primary-care-physical-health-check/CF93E69755E2853DC67C2963D1BB504F) (<https://www.cambridge.org/core/journals/primary-health-care-research-and-development/article/is-the-use-of-an-invitation-letter-effective-in-prompting-patients-with-severe-mental-illness-to-attend-a-primary-care-physical-health-check/CF93E69755E2853DC67C2963D1BB504F>) *Prim Health Care Res Dev* 13(4): 347-352.
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