Derbyshire Healthcare NHS
NHS Foundation Trust

Looking after mind & body: Primary Care Toolkit – Physical Health Checks for people with severe mental illness

"More people with mental health problems will have good physical health" No Health without Mental Health (2011) DoH.

Created in partnership with Derbyshire Healthcare NHS Foundation Trust and NHS Derbyshire County.

Primary care staff have a critical role to play in helping people with mental health problems to improve their physical health.

Collaborative work with Derbyshire Healthcare NHS Foundation Trust is essential if we are to reduce the premature morbidity rate of people experiencing mental health problems.

Research tells us physical health and mental health are directly linked and research also indicates that the physical health of people with a severe mental health problem is poor.

As a GP, you are probably aware that many people with a mental illness have a reduced life expectancy and are diagnosed with, or have an increased risk of developing serious health issues such as heart disease, diabetes, cancer and obesity.

Factors that contribute to this include poor diet, lack of exercise, smoking, alcohol consumption and drug use, plus the regular use of psychotropic medication.

Poor health is also linked to their reduced access to appropriate assessment and treatment for physical health issues. Service users often feel once they have received a diagnosis for their mental illness, their physical health is neglected. Additionally, they can experience stigma and communication difficulties affecting their ability to seek medical help.

Facts

People with a severe mental illness face a greater risk of developing physical illnesses. They are:

- 2-4 times as likely to develop cardiovascular disease
- 2-4 times more at risk of developing a respiratory disease
- 2 times more at risk of developing bowel cancer
- 5 times more at risk of developing diabetes
- A person with schizophrenia can expect to live for 16- 20 years less than someone without a mental health problem.

Forty percent of people with mental illness smoke, compared with 17% of the general population

Smoking kills 96,000 people every year in the UK

Cancer of the testicles accounts for only 1% of all cancers in men however, it is the most common type of cancer within males ages 16-35

Prostate cancer is the most common in men over 40,000 new ceases every year.

27% of all cancer deaths are caused by smoking.

Taking an 'holistic' approach

In recognition of the need to improve the physical health of people with mental health problems, the General Medical Services contract and Quality Outcomes framework makes clear that the provision of Physical Health care to people with severe mental illness is the responsibility of primary care. This also underlines the need for members of the primary health care team to communicate effectively with the Community Mental Health Services.

Mental health services should consider physical health needs as part of their initial and ongoing care programme approach (CPA) assessment and should be continually liaising with primary care. A Smoking Cessation Care Plan should also be considered in supporting our patients to stop smoking within the community. Within our neighbourhood teams a number of staff are trained

to deliver Smoking Cessation Support in addition smoking cessation services are available within clozapine clinics delivered by Life Live Better.

Service users should be made aware of increased physical health risks and fully informed about the importance of health promotion, prevention and health management and signposted to appropriate health resources within the communities or mental health seivces.

Effective communication between partners is essential and is the responsibility of all

Across Derbyshire there are some excellent examples of joint working and effective interventions. Several pilot projects working on improved pathways for physical health checks are taking place in the County. From these pilots and other recognised good practises, lessons have been learned and this tool kit has been created with the aim of sharing good practice ideas and resources. Training has also been provided in “Physical Health in Mental Illness” for practice nurses in the north and county of Derbyshire to support this tool in providing the best health care for our patients who are on the SMI.

Primary care – step by step guide to physical health checks

Phase 1 Preparation for health checks

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Phase 2 Carrying out health checks

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Phase 3 Following on from health check

Step 10 – Agree any follow up appointment or annual review date in liaison with the service user.
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Phase 4 Joint care planning

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Step 12 – Share health information prior to CPA mental health review to enable joint care planning

Step 1 - Identify a clinical lead for mental health within the primary care team

This could be the nurse or GP responsible for carrying out the severe mental illness (SMI) annual health checks.

Ideally they should have completed the mental health awareness and have a clear understanding of why the physical health checks are so important for this group of patients.

Administration support is also important to ensure communication between services is continued and any information shared is robust.

Step 2 – Identify a link person within mental health teams (recovery teams, early intervention team)

Individual care co-ordinators and psychiatrists will be involved in close liaison with primary care regarding sharing of care plans and clinical concerns etc, but where possible it is good practice to have one named person to liaise regarding establishing the process of health checks and communication systems between teams.

Step 3 – Ensure the clinician who will be carrying out the health checks has mental health awareness training

This is provided by Derbyshire Health Care Foundation Trust which helps to encourage joint understanding of roles and share good practices. Each GP Practise in the north and county is connect via the Practise Manager to ensure the training is implemented and provide a clear understanding of mental illness, know the signs and symptoms and be aware of the impact of mental illness on physical health.

The mental health awareness training should include information about specific diagnosis, but also include the importance of physical health promotion and the underlying health risks associated with mental illness.

Step 4 – Identify people with a severe mental health problem from the SMI register in liaison with mental health teams

Ensure the severe mental illness (SMI) registers retained in primary care include all people entitled to an annual health check. There needs to be sharing of information between primary and secondary mental health care and the systems in place need to be secure and regularly updated. Initially when the training is provided the SMI register will be updated and ongoing information will be provided by the neighbourhood teams ensuring sustainability in providing positive outcomes for our patient's needs.

> The tablets I take caused me to put on 5 stones in 6 months, no-one warned me.... when I felt mentally well

again I then had a huge battle to face & my self confidence was very low.

Step 5 – Ensure that all patients have a care plan

Patients who are also seen by secondary care mental health services will have a care programme approach (CPA) care plan, which includes a comprehensive description of their needs and the support they receive in line with the Cardiometabolic Health Resource.

This plan will include some recommendations for physical health.

You are able to scan in the document and save it within your primary care IT system under 'care plan'.

Please refer to the plan as part of the annual check. To ensure continuity of the SMI Register a SMI form will also be sent.

CARE PLAN

Ref:

Name and address:

Care Co ordinator:
Tel:

Deputy Care Co-ordinator:
Tel:

Consultant: Dr.
Tel:

Emergency contact evenings/weekends:
Tel:

Date of Birth:
NHS No:
Other No:
Date(s) review held:
Present:
Apologies:

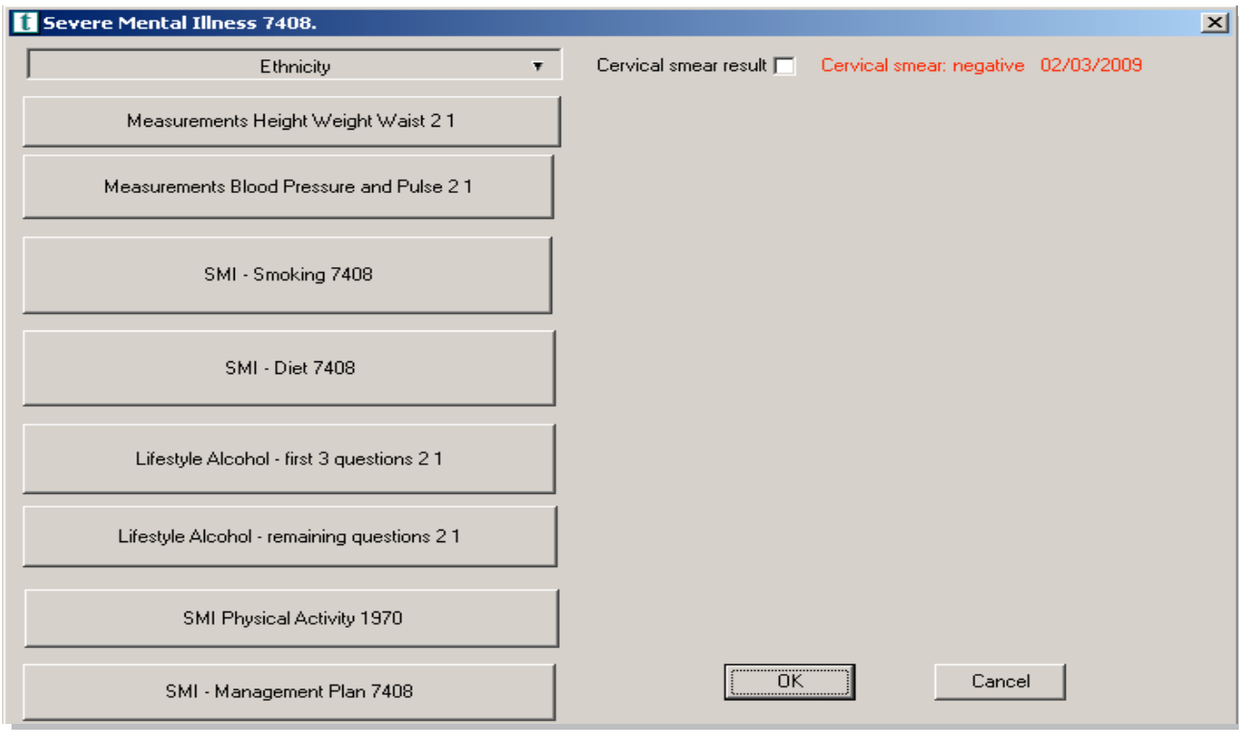
1. **Recent progress, current situation**
2. **Mental health**
3. **Medication** (including information about who prescribes and where from, and any side effects)
4. **Drug / alcohol use**
5. **Accommodation**
6. **Daytime activities, education, occupation, employment**
7. **Physical health, disability, and mobility**
8. **Activities of daily living and personal care**
9. **Social, financial, legal needs**
10. **Informal carers**
11. **Gender, cultural, ethnicity and other ongoing needs and support**

Step 6 – Ensure a standardised e-template is available for clinical systems with agreed read codes

An e-template for the annual health check ensures health checks are standardised and information is linked to other areas of health care.

In Derbyshire, a basic template has been developed for system 1 and some other practices have designed their own.

This may be an area of development.



> When I feel low I eat all the wrong things, I know it's not good for me but at the time I don't care ……
> It's only later I realise then it really gets me down.

Step 7 – Invite the patient for a health MOT and inform their mental health care co-ordinator

The invitation letter to attend a health MOT needs to clearly explain that it is a **physical** health MOT - some example text to add to the letter is included below.

Wherever possible a copy of the letter should be sent to the care co-ordinator. This will enable them to advocate, prompt, support or where appropriate accompany the patient to the appointment. The idenfied admin link from the GP link must also inform the neighbourhood admin link which patients are due their annual check-up on a monthly basis.

Dear (insert patient name)

We would like to invite you to attend the surgery for a "physical health MOT".

Your health is very important and can impact on your mental wellbeing. Your mental health can also impact on your physical health, so it is very important to look after yourself.

What will your physical health MOT involve?

At your physical health check, the practice nurse will:

- Take your blood pressure
- Take your pulse
- Do a urine or blood test
- Weigh you.

Your GP may already provide you with prescriptions for your medicines. You will be asked if your medicines are helping you and if you are having problems with any side effects.

Your practice nurse may also ask about your mental health, if it is affecting your physical health in any way.

The practice nurse will ask about your lifestyle and she can advise you on simple adjustments to your lifestyle that could help improve your physical health

Your appointment has been arranged for (insert date). Alternatively you can contact (insert name) at the surgery on (insert contact details) to arrange a suitable appointment time.

If you receive support from your mental health team and need support in attending this appointment please discuss with your care co-ordinator or contact the surgery.

Step 8 – Carry out health check

The reason for annual monitoring of physical health in patients diagnosed with schizophrenia, bi-polar and psychosis is to help reduce premature morbidities in relation to CVD, diabetes, COPD and cancer plus other health issues.

The annual health check should enable earlier detection of these illnesses or identify behaviour which will increase the risks of these illnesses.

By working together we can support people to manage both their physical and mental health to improve their health outcomes.

BMA QOF guidance

1. Enquire about smoking, alcohol and drug use
2. Blood pressure check
3. Cholesterol check where clinically indicated
4. Measurement of body mass index (BMI)
5 Enquire about diet and levels of physical activity
6. Check for the development of diabetes
7. Cervical screening where appropriate and Prostate and testicular examination
8. Enquire about cough, sputum, and wheeze
9. Check the accuracy of the record of medication prescribed by the GP and the Psychiatrist.

Offer advice or signposting for support on healthier lifestyle where appropriate, for example:

health referral, smoking cessation.

For those patients prescribed antipsychotic medication there should be annual monitoring in primary care of U&Es, FBC, LFTs, TFTs, blood glucose, ECG (for patients at higher CV risk).

A summary of health check results and any agreed actions should be sent to the mental health care co-ordinator or psychiatrist so they can be incorporated into the CPA care plan and supported to improve health.

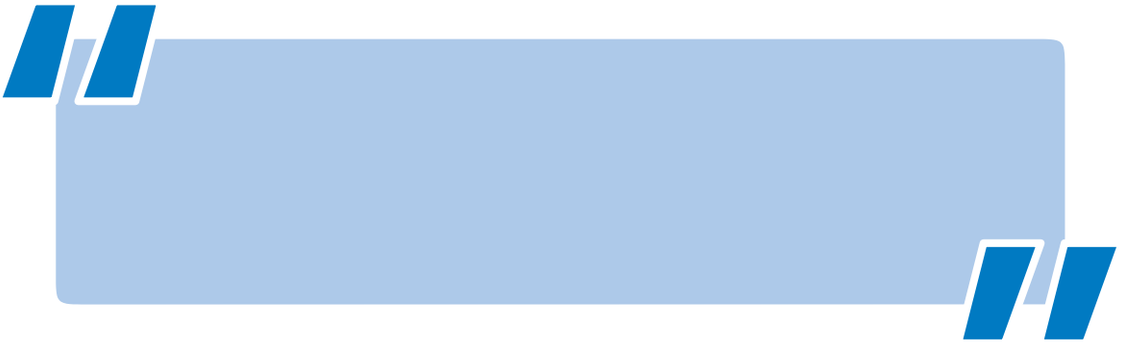
Remember: to ask about sexual health side effects of medication
Repeat prolactin if symptomatic.

Remember: cigarette smoke can alter the metabolism of some medications particularly clozapine.

Recommended resource: Lester UK Adaptation (Appendix 1) pages 11 & 12

I used to think smoking helped me to deal with stress, its only now I've stopped smoking I realise it

used to cause me stress.



Step 9 – Inform the patient of health check results and agree actions

Share this information with the care co-ordinator

Integrate this into services users medical record and inform the care co-ordinator so this can be included and reviewed as part of CPA care planning.

Personal health planners are available to help service users keep a record of their own health and to help them to consider how to keep well. They can also be used as a communication tool between patient and services.

Further copies can be obtained from April Saunders, physical health and wellbeing lead, call 01246 515976 or email april.saunders@derbyshcft.nhs.uk

> I get really stressed when I have to go to the doctor so I put it off or get out of the surgery as quick as I can.

Step 10 – Agree any follow up appointment or annual review date in liaison with the service user and inform care co-ordinator/psychiatrist Follow up any specific actions (referrals to other services, management of co-morbidities etc) in liaison with the care co-ordinator/ psychiatrist

By having a coordinated approach between primary and secondary care, support can be offered from a wider range of support services to address individual needs.

Support with health promotion interventions may be offered in both primary and secondary care. This needs to be clearly identified and appropriate to the level of needs.

Wherever possible patients should be included in mainstream services and offered an equal quality of service from appropriate specialisms.

Step 11 – For service users who do not attend: close liaison with secondary care mental health services is essential

For service users who do not attend the health checks, who are known to secondary care services, close liaison is recommended between services and this should be clearly documented as for the reasons of non –attendance.

In some circumstances the physical health monitoring can then be taken on temporarily by secondary care with a view to working towards primary care engagement.

Ongoing liaison with primary care is essential in these circumstances so that physical health monitoring can be maintained.

Step 12 – Share health information prior to CPA review to enable joint care planning to support physical health

Patients on CPA have an annual review of their mental health and planning of their care. Physical health is a key part of this review.

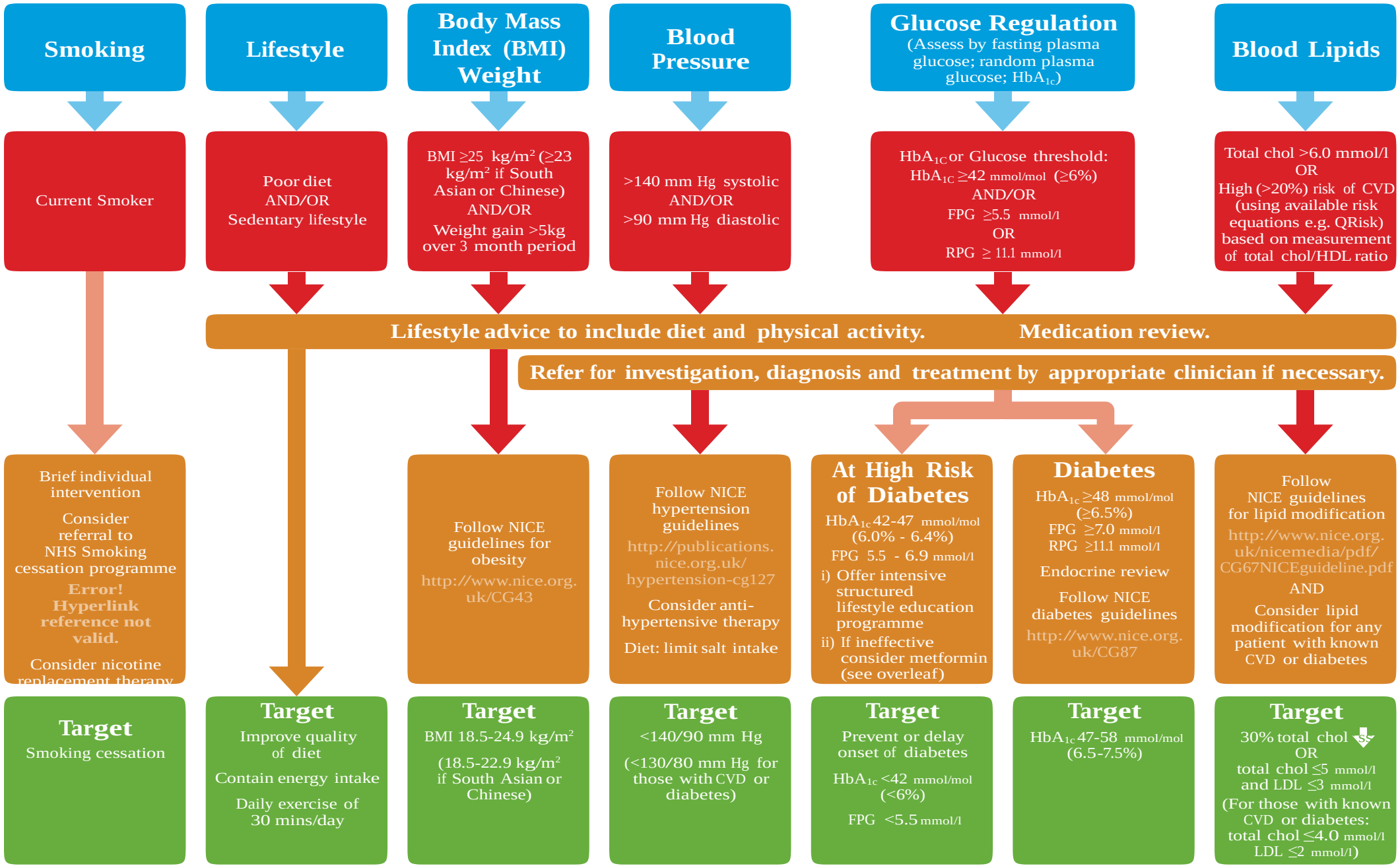
Prior to the review the mental health team will contact primary care to ask for information about the person's physical health and will confirm whether they should be on SMI register. Information requested will include:

- copy of current medication
- whether they have attended for health check and cancer screening and any recommended follow on actions
- any targeted health promotion required
- long-term condition management.

This information will be included as part of a CPA review and any actions included in the care plan.

Primary Care templates have been designed by some GP practices for this information to be electronically populated.

Lester UK Adaptation



p.t.o.

Although this clinical resource tool targets antipsychotic medication, many of the principles apply to other psychotropic medicines given to people with long term mental disorders.

The general practitioner and psychiatrist will work together to ensure appropriate monitoring and interventions are provided and communicated. The general practitioner will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medicines.

Primary care's **Quality and Outcomes Framework (QOF)** includes four physical health indicators in the mental health domain: BMI (MH12); blood pressure (MH13); total to HDL cholesterol ratio (MH14); Blood glucose (MH15). Currently MH14 and MH15 are only for those aged over 40yrs.

History and examination following initiation or change of antipsychotic medication

Frequency: as a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.

Ideally weight should be assessed 1-2 weekly in the first 8 weeks of taking a new antipsychotic as rapid early weight gain may predict severe weight gain in the longer term.

Subsequent review should take place annually unless an abnormality of physical health emerges, which should then prompt appropriate action and/or continuing review at least every 3 months.

At review

History: Seek history of substantial weight gain (e.g. 5kg) and particularly where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree relatives <60 yrs) and gestational diabetes. Note ethnicity.

Examination: Weight, BMI, BP.

Investigations: Fasting estimates of plasma glucose (FPG), HbA $_{1c}$, and lipids (total cholesterol, LDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for LDL or triglycerides.

ECG: Include if history of CVD, family history of CVD, or if patient taking certain antipsychotics (see Summary of Product Characteristics) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrythmics – see British National Formulary for further information).

Interventions

Nutritional counselling: reduce take away and "junk" food, reduce energy intake to prevent weight gain, stop soft drinks and juices, increase fibre intake.

Physical activity: structured education-lifestyle intervention. Advise physical activity: e.g. Advise a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS).

If unsuccessful after 3 months in reaching targets, then consider specific pharmacological interventions (see below).

Specific Pharmacological Interventions

Anti-hypertensive therapy: Normally GP supervised. Follow NICE recommendations http://publications.nice.org.uk/hypertension-cg127.

Lipid lowering therapy: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf.

Treatment of Diabetes: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/CG87.

Treatment of those at high risk of diabetes: FPG 5.5-6.9 mmol/l; HbA$_{1c}$ 42-47 mmol/mol (6.0-6.4%)
Follow NICE guideline PH 38 *Preventing type 2 diabetes: risk identification and interventions for individuals at high risk* (recommendation 19) – http://guidance.nice.org.uk/PH38.

- Where intensive lifestyle intervention has failed **consider metformin trial** (this would normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, http://www.gmc-uk.org/static/documents/content/Good_Practice_in_Prescribing_Medicines_0911.pdf. These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate). Start with a low dose e.g 500 mg once daily and build up, as tolerated, to 1500–2000 mg daily.

Review of antipsychotic medication: Normally psychiatrist supervised. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effect:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic requires careful clinical judgment to weigh benefits against risk of relapse of the psychosis.
- Benefit from changing antipsychotic for those on the drug for a long time (>1 year) is likely to be minimal.
- If clinical judgment and patient preference support continuing with the same treatment then ensure appropriate further monitoring and clinical considerations.

Don't just SCREEN – INTERVENE for all patients in the "red zone"

RC PSYCH Royal College of Psychiatrists · RC GP Royal College of General Practitioners · Royal College of Nursing · NAS CCQI · Rethink Mental Illness. · HQIP Healthcare Quality Improvement Partnership · Royal College of Physicians · DIABETES UK CARE. CONNECT. CAMPAIGN.

Download Lester UK Adaptation:
www.rcpsych.ac.uk/quality/NAS/resources

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UCLPartners. February 2014 www.uclpartners.com

Ash.org.uk.

Useful websites

Mental wellbeing
www.mentalhealth.org.uk/information/how-to-look-after-your-mental-health/talk-about-your-feelings

Health checks
www.rethink.org/living_with_mental_illness/everyday_living/physical_health_and_wellbeing/health_checks.html
www.nhs.uk/livewell/Pages/Livewellhub.aspx

Healthy eating
www.mentalhealth.org.uk/information/how-to-look-after-your-mental-health/eat-well
www.rethink.org/living_with_mental_illness/everyday_living/physical_health_and_wellbeing

Alcohol
www.mentalhealth.org.uk/information/how-to-look-after-your-mental-health/drink-sensibly

Physical activity
www.mentalhealth.org.uk/information/how-to-look-after-your-mental-health/keep-active

Core Care Standards
www.corecarestandards.co.uk/keeping-well

Ash.org.uk.
https://en.wikipedia.org/wiki/Action_on_Smoking_and_Health

British Heart Foundation
www.bhf.org.uk/support-us

Acknowledgements

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- Dr G Walton, Littlewick Practice working with Erewash adult and older adults mental health teams.
- Dr Hartley, Buxton Medical Practice working with High Peak recovery team

Consultation with practice nurses at the following practices:

Avenue House, Chesterfield,
Whittington Moor, Chesterfield,
Tideswell, Derbyshire Dales

Shires, Shirebrook.
High peak and Dales

Healthy Body Health Mind programme aims to continue to support and spread the good joint working practices between primary care and secondary care across the county. If any practices would like further assistance regarding this topic please contact Karen Wheeler, Physical Health & Wellbeing Lead for Mental Health on 01246 515976 or email April. saunders@derbyshcft.nhs.uk