NHS

A PRACTICAL GUIDE TO DELIVERING

PHYSICAL HEALTH CHECKS

FOR PEOPLE WITH A SEVERE MENTAL ILLNESS

Improving update, outcomes and patient experience

DO THEY KNOW?

www.lancashireandsouthcumbria.icb.nhs.uk/PHSMI

Contents

Introduction

It has been identified over many years that patients with a severe mental illness (SMI) have much poorer health outcomes than the general population. They have a significantly reduced lifespan and are at increased risk of many long-term conditions that are preventable or treatable, such as hypertension, diabetes and heart disease.

The SMI health check can identify these diseases at an early stage or can enable people to make lifestyle changes that can prevent them from developing the conditions. People with SMI are also at an increased risk of suicide.

By conducting health checks and follow-up interventions we can make a huge difference and reduce the health inequalities for this vulnerable group.

Background

The term SMI (severe mental illness) refers to individuals who have received a diagnosis of schizophrenia, other psychosis, bipolar affective disorder and all patients on lithium.

The SMI register should consist of all the people who have a recorded diagnosis or other long-term psychotic illness. Use of antipsychotic or mood-stabilising medication including lithium may help to identify this population.

However, there are patients with conditions such as personality disorder who may be on antipsychotic drugs. These **should not** be on the register, but the monitoring of the drugs includes the same tests and interventions as the SMI health check, and these individuals may be equally at risk.

Annual physical health checks are recommended for people of all ages with SMI. The use of anti-psychotic or mood-stabilising medication increases the risk of physical health problems such as obesity, diabetes and heart disease.

People with a SMI are also more likely to smoke and drink more heavily, affecting their health and life expectancy. They may also be more likely to have a history of past or current drug abuse. They may find access to health improvement services more challenging and may face barriers in accessing national screening programmes.

A physical health check can be an important opportunity to identify physical health problems and offer support.

Responsibility for SMI physical health checks

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

1. Patients with SMI who are not in contact with secondary mental health services, including:
    a. Those whose care has always been solely in primary care.
    b. Those who have been discharged from secondary care back to primary care.
2. Patients with SMI who have been in contact with secondary care mental health teams (with shared-care arrangements in place) for more than 12 months and/or whose condition has stabilised.

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

1. Patients with SMI under care of a mental health team for fewer than 12 months and/or whose condition has not yet stabilised.
2. Mental health inpatients.

Practices may wish to offer an enhanced SMI check to patients at their clinical discretion and risk stratifications.

The key objective of the enhanced SMI check is to deliver an enhanced review to provide more in-depth care planning, risk stratification and patient management. It also helps to expand the data collection with additional fields as recommended by national guidance and including an enhanced health check via a second appointment where results are discussed, and a health action plan is agreed.

Six sub-components of SMI physical health check

This SMI indicator specifies national reporting on the delivery of:

- The core physical health check.
- The six individual sub-components supporting measures:

    1. A measurement of weight (BMI or BMI plus waist circumference).
    2. A blood pressure and pulse check (diastolic and systolic blood pressure recording or diastolic and systolic blood pressure plus pulse rate).
    3. A blood lipid including cholesterol test (cholesterol measurement or QRISK® measurement).
    4. A blood glucose test (blood glucose or HbA1c measurement).
    5. An assessment of alcohol consumption.
    6. An assessment of smoking status.

Additional elements of an enhanced SMI check

These additional elements include:

1. An assessment of nutritional status, diet and level of physical activity (nutrition/diet status plus physical activity/exercise) status.
2. An assessment of use of illicit substance/non prescribed drugs (substance misuse status).
3. Medicines reconciliation or review.

Follow-up interventions

The relevant follow-up interventions are indicated by the physical health assessment.

Access to national screening programmes

Access to national screening programmes (breast cancer, bowel cancer, cervical cancer). Patients with SMI may need extra support and encouragement to attend.

Remission

The guidance outlines that clinicians should only consider using the remission codes if the patient has been in remission for at least five years. This means there is:

- no record of anti-psychotic medication,
- no mental health in-patient episodes,
- no secondary or community care mental health follow-up.

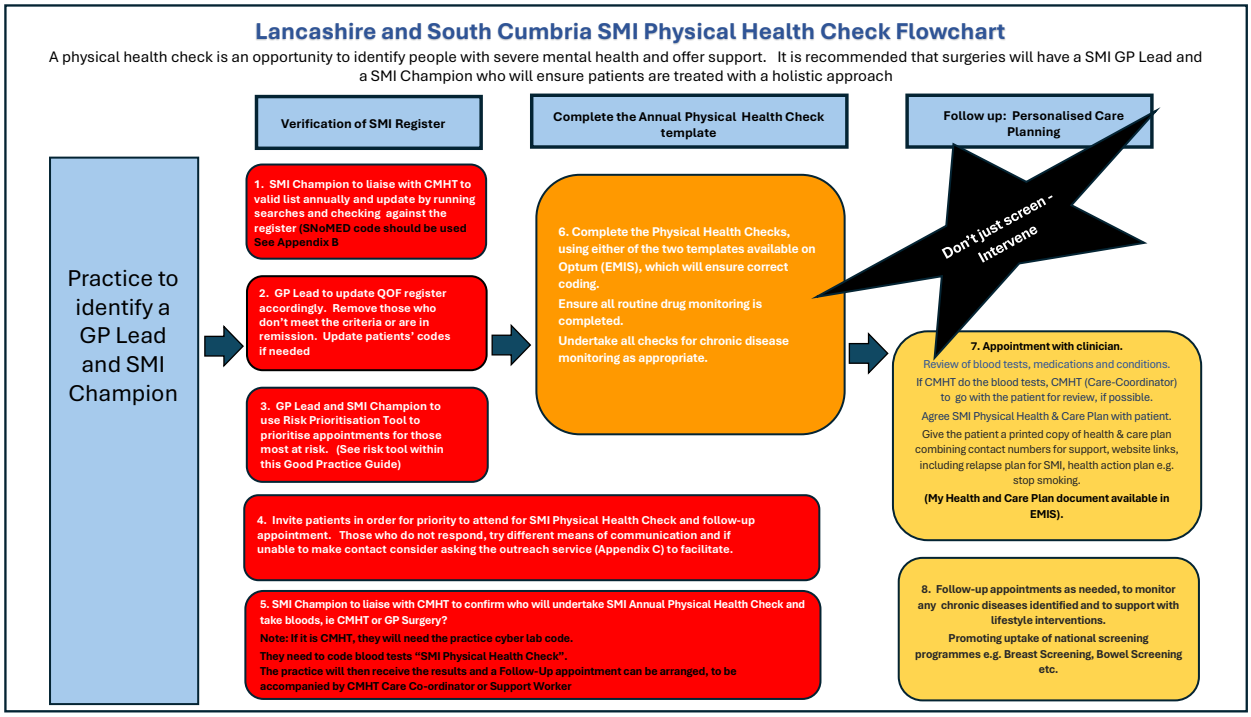
Diagnostic overshadowing

People with mental health problems experience diagnostic overshadowing. This is reports of physical ill health being viewed as part of the mental health problem or learning disability and therefore not investigated or treated.

Undertaking a full physical health check for patients with SMI helps identify opportunities for evidence-based interventions which can reduce people's risk of death, avoidable ill health and reduce health inequalities.

SMI physical health check flow chart

The SMI annual health check process is described below to help identify people with SMI and offer support. It is recommended each surgery will have an SMI champion and a GP mental health lead who will ensure patients are treated with a holistic approach**.**



You can access the MLSCU Data Quality SMI Resources pack (references the SNoMED codes and searches) here: www.healthierlsc.co.uk/download_file/11593/0

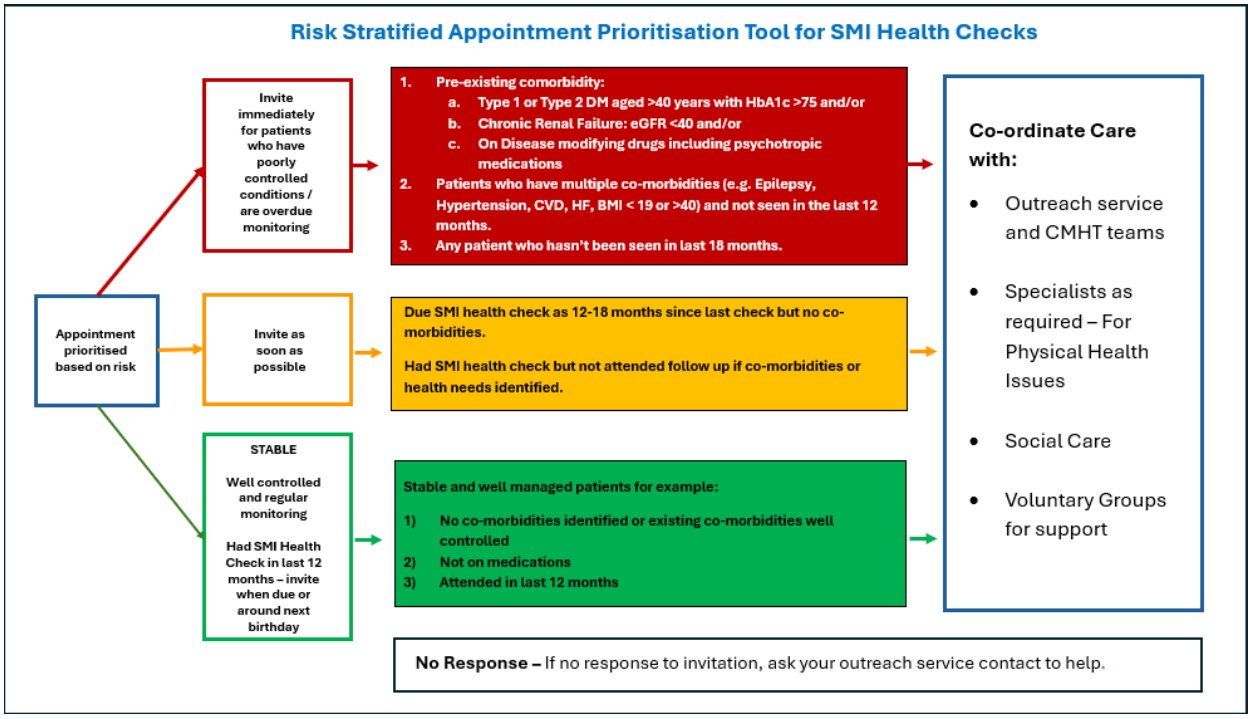
See Appendix A for a larger version of the flow chart.

Risk stratified appointment prioritisation tool

The risk prioritisation tool below can be used to prioritise appointments for those most at risk.

- You may wish to make reasonable adjustments to increase uptake such as longer appointments, using different ways to contact patients and encouragement of attending with someone to support the person, etc.

- Consider doing all long-term conditions health checks at the same time as the physical health check.
- Liaise with your community mental health team or mental health link worker.



See Appendix B for a larger version of the prioritisation tool.

SMI physical health check templates

For the full annual severe mental health review, it is recommended practices use the ***EMIS GP Contract Mental Health 2024/25*** template.

The HCA or nurse has the option of using the simplified ***ML DQ SMI Physical Health Check v1.0*** for all the basic observations. This template is for the six core elements if they are not completing the full review. These details will transfer to the GP contract template. The HCA or nurse can fill in all the basic observations, diet and exercise information, alcohol screening, smoking information, etc, and take all the relevant blood tests and ECG if needed. The later sections will be completed by the GP once all the results are received and a physical health and care plan (***My Health and Care Plan Form template)*** can then be co-produced with the patient.

The above templates can be found in the MLSCU Data Quality SMI Resources pack (references the SNoMED codes and searches) here:
www.healthierlsc.co.uk/download_file/11593/0

For practices using Ardens, it also has a similar template.

SMI physical health and care plan

An important element of a physical health check is for the person and their GP or mental health link-worker to co-produce a health and care plan as a summary of personalised care and support.

Follow-up care and promotion of national screening programmes

Follow-up appointments are needed to monitor any chronic diseases identified and to support with lifestyle interventions. Promote uptake of national screening programmes, such as breast cancer, bowel cancer and cervical cancer.

Anti-psychotic shared care guidelines

Many patients who attend SMI health checks will be on anti-psychotic medication which may be prescribed by the community mental health team, the practice or on a shared care agreement. Full guidance on prescribing and monitoring is available here: **Antipsychotics Shared Care Guidelines Version 1.4.pdf**

Physical health check monitoring and recording in secondary care

The community mental health teams or other local services monitor patients on depot medication and Clozaril. Bloods are checked on a regular basis for those on Clozaril and this information is sent to the GP by the path lab.

When the patient is monitored by secondary care, they will complete the six elements of the physical health check and send this information to the GP practice*. (The process for sending the information to the GP practice is under review by Lancashire and South Cumbria NHS Foundation Trust (LSCFT). Once the process has been revised, this document will be updated.)*

When the patient is stable and has been on treatment for a minimum period of 12 months with the community mental health team (with exception for those on depot injection or Clozaril), a request can be sent to the GP practice requesting the prescribing and monitoring of the medication and the undertaking of the health check is transferred to the patient's registered GP.

Suicide prevention

Suicide rates across Lancashire and South Cumbria are the third highest in England. Men are three times more likely to take their life by suicide than women. It is the biggest killer of men under 49.

There are several common suicide risk factors. Particular importance should be paid if any of these are evident for someone with a severe mental illness.

Common risk factors include:

- Mental illness
- Depression
- Alcohol and substance misuse
- Previously self-harmed
- Occupation
- Relationship breakdown
- Bereavement
- Financial difficulty

NHS Lancashire and South Cumbria Integrated Care Board (ICB) is currently (May 2025) developing a 'Suicide Postvention Support Pack for General Practice'. While this pack focuses on providing support for primary care clinicians after the death of a patient by suicide, it does cover suicide prevention, including:

- Suicide prevention through safe prescribing and withdrawal.
- Suicide prevention through personal safety planning.
- Information sharing best practice.

This pack will be shared with practices when finalised.
You can find out more about wider suicide prevention work in Lancashire and South Cumbria on the ICB website: www.lancashireandsouthcumbria.icb.nhs.uk/suicideprevention

Individual placement service (IPS)

IPS is a research-based specialist employment service providing individually tailored support to people with severe mental illness or those being severely impacted by their mental health.

The service offers employment advice and bespoke 1:1 specialist support to help those with an SMI help find and retain a new job that is right for them or receive help to stay in their current role. IPS offers 12-18 months of support, with an unlimited follow-on support once the individual is in work; making employment a vital part of their long-term recovery.

For further information or to referral into the service email: IPSService@blackpool.gov.uk. Alternatively, you can refer via the referral form embedded in EMIS.

Useful links

Below are links to several webpages which you may find useful in terms of signposting to mental health support and training:

- **ICB mental health support page**
  www.lancashireandsouthcumbria.icb.nhs.uk/mentalhealthsupport

- **Lancashire and South Cumbria mental health support directory**
  www.lancashireandsouthcumbria.icb.nhs.uk/our-work/mental-health/support/lsc-mh-directory

- **Lancashire and South Cumbria NHS Talking Therapy services**
  www.lancashireandsouthcumbria.icb.nhs.uk/talkingtherapies

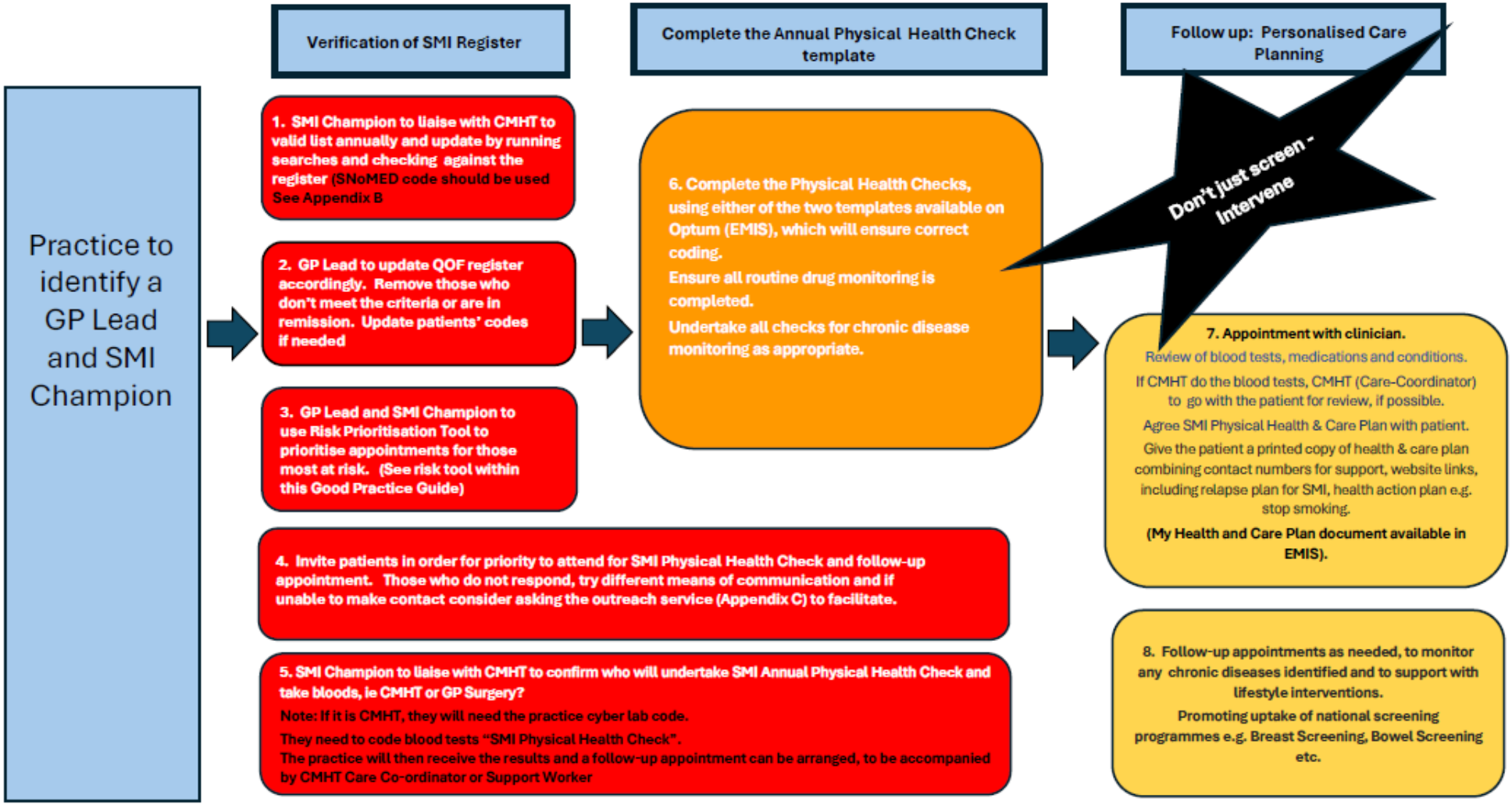
- **Orange Button**
  www.healthierlsc.co.uk/icb/orangebutton or email lscicb.orangebutton@nhs.net

- **National mental health support**
  www.hubofhope.co.uk

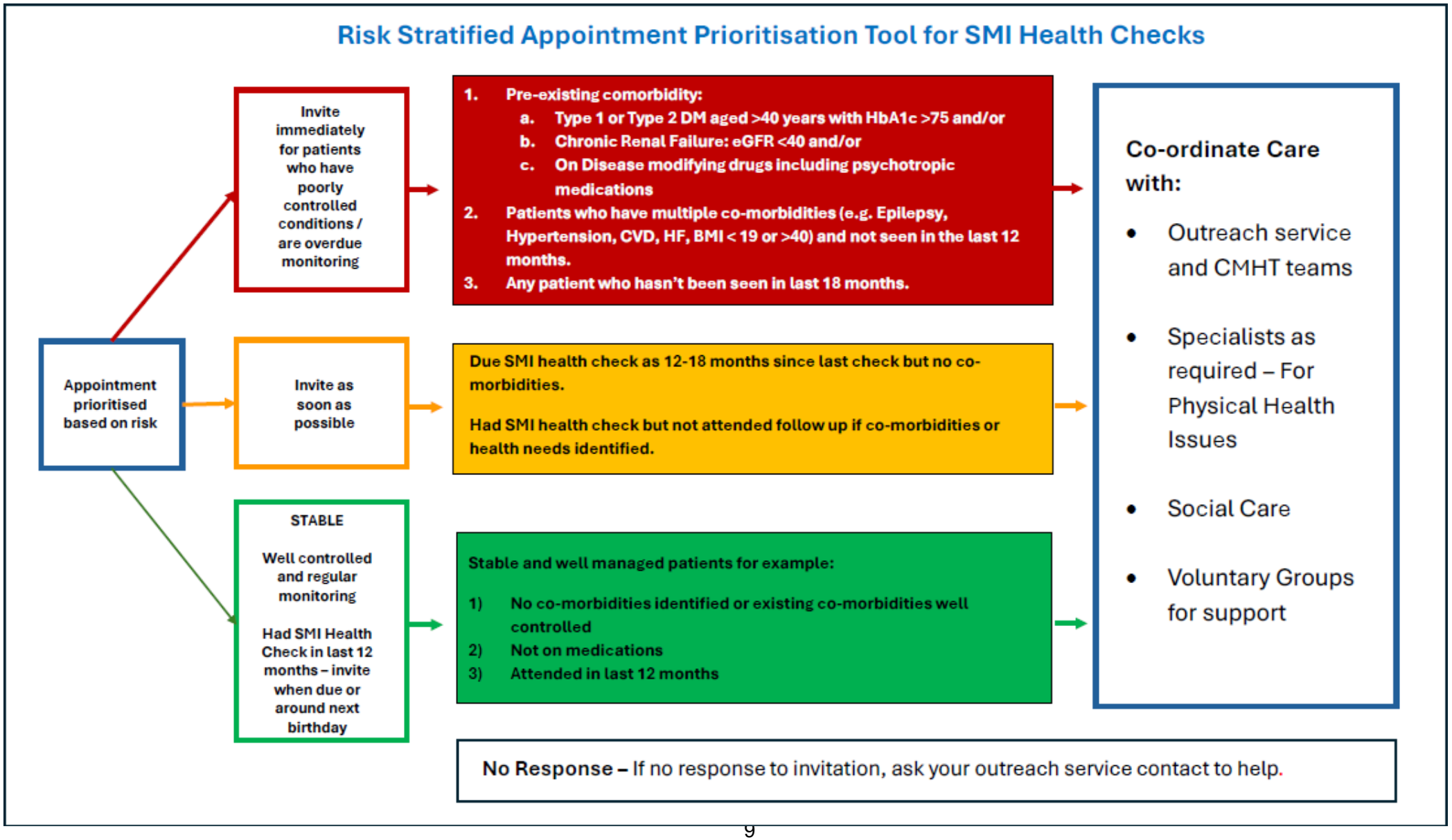
Appendix A

Lancashire and South Cumbria SMI Physical Health Check Flowchart

A physical health check is an opportunity to identify people with severe mental health and offer support. It is recommended that surgeries will have a SMI GP Lead and a SMI Champion who will ensure patients are treated with a holistic approach



Appendix B


Risk Stratified Appointment Prioritisation Tool for SMI Health Checks
Appointment prioritised based on risk
Invite immediately for patients who have poorly controlled conditions / are overdue monitoring
Invite as soon as possible
STABLE
Well controlled and regular monitoring
Had SMI Health Check in last 12 months – invite when due or around next birthday
1. Pre-existing comorbidity:
a. Type 1 or Type 2 DM aged >40 years with HbA1c >75 and/or
b. Chronic Renal Failure: eGFR <40 and/or
c. On Disease modifying drugs including psychotropic medications
2. Patients who have multiple co-morbidities (e.g. Epilepsy, Hypertension, CVD, HF, BMI < 19 or >40) and not seen in the last 12 months.
3. Any patient who hasn't been seen in last 18 months.
Due SMI health check as 12-18 months since last check but no co-morbidities.
Had SMI health check but not attended follow up if co-morbidities or health needs identified.
Stable and well managed patients for example:
1) No co-morbidities identified or existing co-morbidities well controlled
2) Not on medications
3) Attended in last 12 months
Co-ordinate Care with:
• Outreach service and CMHT teams
• Specialists as required – For Physical Health Issues
• Social Care
• Voluntary Groups for support
No Response – If no response to invitation, ask your outreach service contact to help.