Joint Strategic Needs Assessment

Physical health in those with a diagnosed mental health problem

Focus paper

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Executive summary

Consistent with national trends, the number of people with a serious mental illness has increased across Cornwall and the Isles of Scilly. People with a diagnosed mental health illness experience, higher physical health inequalities and lower life expectancies. For example, those with severe and prolonged mental illness die on average 15 to 20 years earlier than those without, which represents one of the greatest health inequalities in England. It is estimated that two thirds of these deaths are from avoidable physical illnesses, including treatable heart disease, diabetes, respiratory disease, cancer and infections. These co-morbid mental and physical health conditions also increase the risk of considering suicide. Cornwall and the Isles of Scilly have higher rates of self-harm and suicide when compared to England.

Around 46% of people with serious mental illness (SMI) have one or more long-term conditions. This means that approximately 2,251 people in Cornwall and the Isles of Scilly could have an SMI and long-term condition. This increases to approximately 47,907 (8.5% of the total population) when considering other estimates for the number of people with a mental health problem and long-term physical condition. This equates to 452,035 people with co-existing long-term physical and mental health conditions across the South West of England.

The exacerbation and/or development of physical long-term conditions may in part be due to higher rates of unhealthy lifestyles such as smoking, physical inactivity, poor diet, alcohol consumption and substance misuse. People with a mental illness may also miss out on life opportunities such as education and employment, which may further compound co-morbid physical and mental health conditions.

The impact of these chronic diseases and missed opportunities is largely preventable and represents an opportunity to reduce the burden of ill-health on people and health care services. This could be achieved through improved collaborative working across the health sector and the delivery of effective interventions.

It is clear that this is a significant opportunity to address both health inequalities and reduce costs in this area. The development of an Integrated Care System provides an opportunity to prioritise, review and address this issue in a joined up way. Addressing the physical health needs of those with a mental health illness is reflected across a range of policy, and the need to meet the demands of the estimated rise in prevalence rates across Cornwall and the Isles of Scilly. Assessing the needs of this patient population has informed a series of recommendations to be considered by the health and care system.

Key messages / summary of recommendations

This focus paper has raised a number of recommendations to help inform future policy, service delivery and the effectiveness of interventions targeting the physical health outcomes of people with a SMI. These recommendations should be considered in the forthcoming Mental Health Strategy for Cornwall.

1. The physical health of people with serious mental health problems should be a key priority in the emerging integrated care system and partnership, which could improve outcomes for people and reduce costs of care.
2. Local strategies need to target key risk factors that worsen or protect mental health outcomes and ensure parity of esteem across physical and mental health services, which address the multiple health needs of those with a dual diagnosis.
3. Cornwall's integrated care system should adopt the principles of the Equally Well UK Charter and address areas highlighted as requiring improvement in the 2018 Care Quality Commission report.
4. It is important that there are systems in place to recognise the risk of suicide amongst people with SMI and comorbid conditions, and self-harming behaviour.
5. Interventions or programmes which focus on improving the social and economic opportunities for people with SMI should be systematically prioritised. These include education or employment opportunities (via Individual Placement Support), appropriate housing and reducing social isolation.
6. Service providers should use a variety of methods to assess potential barriers experienced by this population in accessing high quality health care, including health equity audits, patient experience and research.
7. Increase the uptake of annual physical health checks for people with SMI across all risk factors (including e.g. blood glucose) by improved data sharing and collaboration between specialist mental health and primary care (such as in Bradford using a standardised physical health check template and shared care protocol).
8. Provide access to integrated lifestyle behaviour change support (addressing all risk factors together e.g. smoking, physical activity) for people with SMI at risk of cardiovascular or metabolic syndrome (in the community).
9. Understanding the long-term trends associated with service use by this population will help inform future service planning and strategies. This will require a joint programme of work to analyse mental health data as a system.
10. Increased focus on people with psychosis presenting at A&E and enhanced role of mental health liaison services could explore this further. The management of health of people with dementia should continue to be a focus of multidisciplinary integrated care teams at locality level.
11. Increase the involvement of people with experience of mental ill health and patients and carers experiences to help co-produce, quality assure and transform services.
12. Ensure the new Mental Health Strategy for Cornwall includes a physical health priority for people with mental health problems; and healthcare providers offer accessible services, undertake regular physical health assessments, provide appropriate resources and training.

Scope of Focus Paper

The term mental health is used to describe a spectrum from positive to negative states of mental health. The term 'mental health problem' is used synonymously with poor mental health. Mental health problems can cover a range of negative mental health states including, mental disorder (those meeting a diagnosis criteria), and mental health problems which fall short of diagnostic criteria threshold (Better Mental Health for All, 2016).

This paper focuses on adults aged 18+ years **who have a serious mental illness (SMI) and those accessing secondary care services in Cornwall and the Isles of Scilly**. Due to the availability of data on those with an SMI, this focus paper also draws on evidence from adults with a mild to moderate mental health problem, those with a moderate/serious mental illness and SMI. This is important to distinguish because of the different health needs of these different mental health populations.

This focus paper is one part of a planned suite of documents on mental health in Cornwall's Joint Strategic Needs Assessment[1]. It identifies key issues that should be addressed to improve and develop future services to address poor health outcomes for people with an SMI.

To achieve this, the paper provides a summary of key policy developments that should be considered to inform future commissioning. This is put into context with an overview of existing literature on factors influencing health outcomes among individuals with a mental health condition. Local mental health data is reviewed and a case made to ensure physical health is considered alongside mental health needs. This is followed by an overview of local service provision, a community voice section and potential interventions.

[1] Cornwall Council (2018). JSNA. Online: https://www.cornwall.gov.uk/jsna [Accessed: 11/09/2018]

1.0 Introduction

Mental health problems are widespread, at times disabling, yet often hidden. In the United Kingdom, one in four adults experiences at least one diagnosable mental health problem in any given year (NHS, 2016a). However, prevalence estimates have also ranged from between 38% and 50%, depending on the country and measurement process used (Better Mental Health for All, 2016). Anybody can be affected, including new mothers, children, young people, adults and older adults. Mental health problems represent the largest single cause of disability in the UK and costs to the economy are estimated at £105 billion (NHS, 2016a).

A range of factors influence the physical health of those with a mental health problem. The increased burden of ill-health may be due to the side-effects of antipsychotic medication, as well as the chronic stress and high cortisol of longstanding mental illness. The mental and physical health needs of those accessing mental health services may also be influenced by wider determinants of health such as housing, poverty, social isolation and higher rates of unhealthy lifestyles (Department of health, 2011, Knapp, 2012).

Consequently, people with mental health problems experience poorer physical health and are at increased risk of developing and/or exacerbating one or more long-term conditions such as heart disease, diabetes, respiratory and cardiovascular disease, cancer and infections (Mental Health Foundation, 2016). Having these co-morbid conditions significantly impacts people's sense of security, comfort, ability to undertake day-to-day activities, reach ambitions, and create family and financial strains (Chief Medical Officer, 2013b).

Promoting physical wellbeing and improving the management of co-morbid mental and physical health problems would have a high impact in terms of patient experience and clinical outcomes, and reduce costs related to physical long-term conditions. This requires increased collaboration in the management of physical long-term conditions and mental health (Imison et al., 2011), which is reflected throughout national policies and strategies listed in the following section.

2.0 Policy

There has been a transformation in mental health over the last 50 years with a shift towards a 'parity of esteem' between both physical and mental health needs. A range of legislation and strategies exists to prevent poor physical and mental well-being (Appendix 1), which includes for example;

- The Royal College of Psychiatrists report (2009);
- No Health Without Mental Health (2011);
- Health and Social Care Act (2012);
- Chief Medical Officer report (2013);
- Five Year Forward View (2014);
- Five Year Forward View for mental health (2016);
- Suicide prevention interim report (2016);
- Better Mental Health for All (2016);
- Next steps on the NHS five year forward (2017);
- Sustainable Transformation Plans (2017);
- Prevention Concordat for Better Mental Health programme (2017);
- Stepping forward to 2020/21 (2017);
- 'Stocktake of local strategic planning arrangements' (2017);

- NHS long-term plan (NHS, 2019).

3.0 Context

The changing policy and legislative framework has resulted from the historical disconnect within healthcare of the mind and body. Mental health and physical health are co-dependent, with the mind and body being intrinsically linked on a physiological level. In response to this, the Health and Social Care Act 2012 created a new legal responsibility for the NHS to deliver 'parity of esteem' between physical and mental health by 2020. The case for seeking to support physical and mental health in a more integrated way is compelling, and is based on four related challenges (Naylor et al., 2016):

- High rates of mental health conditions among people with long-term physical health problems;
- Poor management of 'medically unexplained symptoms';
- Poor physical health and reduced life expectancy among people with SMI; and
- Limited support for the wider psychological aspects of physical health.

Delivering 'parity of esteem' between physical and mental health (The King's Fund, 2017a) is being achieved by a range of policy, including the Five Year Forward View for Mental Health (NHS, 2016a) and the Five Year Forward View (NHS, 2014a). Mental health is now recognised as being profoundly important to growth, development, learning and resilience. This means that good mental well-being protects the body from the impact of life's stresses and traumatic events, and enables the adoption of healthy lifestyles and the management of long-term illness (Better Mental Health for All, 2016). Therefore, neglecting the impact of mental health and well-being undermines interventions to reduce health inequalities and prevent premature death from preventable conditions (Marmot and Bell, 2012).

3.1 Mental health as a determinant of physical health

Mental health problems have increasingly been shown to precede, and be important in the recovery from physical health problems (Faculty of Public Health, 2017). For example, good mental health or positive psychological well-being has been associated with reduced cardiovascular mortality in healthy populations, and with reduced death rates in patients with renal failure and with human immunodeficiency virus-infection (Chida and Steptoe, 2008). People's mental health, therefore, has a profound effect on resilience and susceptibility to disease (Better Mental Health for All, 2016).

This patient population experience higher mortality and morbidity rates when compared to the general population. It seems that lifestyle and treatment specific factors (e.g. lack of standard care and appropriate screening) may partly account for patients having higher prevalence rates of one or more of the following conditions (Hert et al., 2011);

- Nutritional & metabolic diseases;
- Cardiovascular diseases;
- Viral diseases;
- Respiratory tract diseases; Musculoskeletal diseases;
- Sexual dysfunction;
- Pregnancy complications;
- Teeth and jaw diseases; and
- Obesity-related cancers.

Compared to the prevalence of physical health conditions among all patients, prevalence rates of obesity, asthma, diabetes, chronic obstructive pulmonary disorder, coronary heart disease, stroke and

heart failure are significantly higher in those with an SMI (PHE, 2018d). However, few local studies have attempted to understand the actual local health needs of this population and burden on society and healthcare. Future work should assess the physical health needs of individuals with an SMI, which should include self-reported measures, patient demographics, impact and burden of co-morbidities across Cornwall and the Isles of Scilly.

3.2 Estimated cost of co-morbid conditions

These co-morbid physical and mental health problems have been associated with between a 50% (Katon, 2003) and 75% (Naylor et al., 2012) increase in service costs. The management of long-term conditions that are related to poor mental health and well-being costs the NHS between £8 and £13 billion each year (Naylor et al., 2012), which fails to fully account for the impact on society as a whole (Better Mental Health for All, 2016). A large proportion of the additional cost is thought to be associated with more severe and complex mental health patients (Naylor et al., 2012).

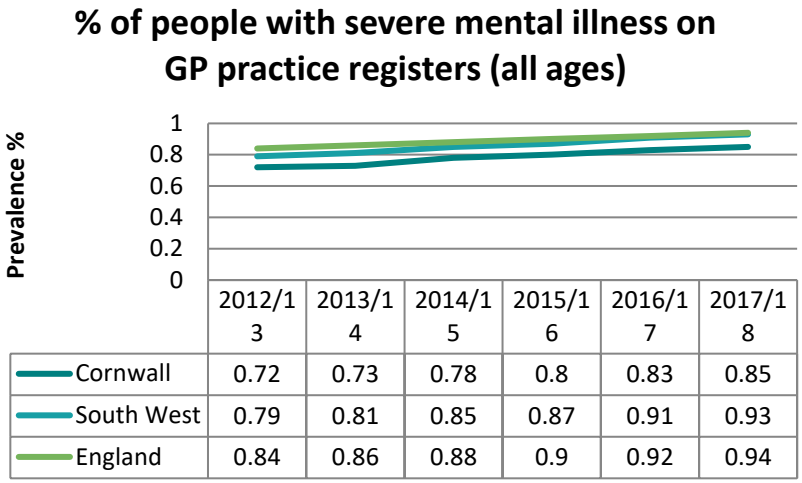
A high proportion of the cost associated with mental health is avoidable (Chief Medical Officer, 2013b). For example, reducing mental health service users hospital activity to the same levels of the rest of the population in Cornwall could save up to £539,000 in A&E attendances and up to £12.7 million in patient care (The Strategy Unit, 2017). It is clear that this is a significant opportunity to both address health inequalities and reduce costs in this area. The development of an Integrated Care System provides an opportunity to prioritise, review and address this issue in a joined up way.

3.3 Number of people with poor mental and physical health

According to NHS Digital[2] there were 579,008 general practice (GP) patients registered across Cornwall and the Isles of Scilly in December 2018. In 2017/18, 0.94% of people (all ages) on GP registers had an SMI in England. While the SMI prevalence has been increasing since 2012/13 (Figure 3.3a), the proportion of SMI patients across Cornwall and the Isles of Scilly is lower than in England (0.85%) (PHE, 2018c). This equates to 4,894 people with an SMI. While there are limitations of using this data (e.g. under reporting in primary care), this is currently the best available estimate. Consequently, better reporting and data sharing within primary care will help inform future service delivery. There was also a lower proportion of the population in contact with specialist mental health services during quarter 1 of 2018/19 when compared to England (1,824 vs. 2,297 per 100,000), which appears to be a consistent trend over time.

[2] NHS Digital (2018). Patients Registered at a GP Practice in England. Online https://digital.nhs.uk/data-and-information/data-tools-and-services/data-services/general-practice-data-hub/patients-registered-at-a-gp-practice [Accessed 13/09/2018].

Figure 3.3a Prevalence of SMI (QOF) (PHE, 2018c)



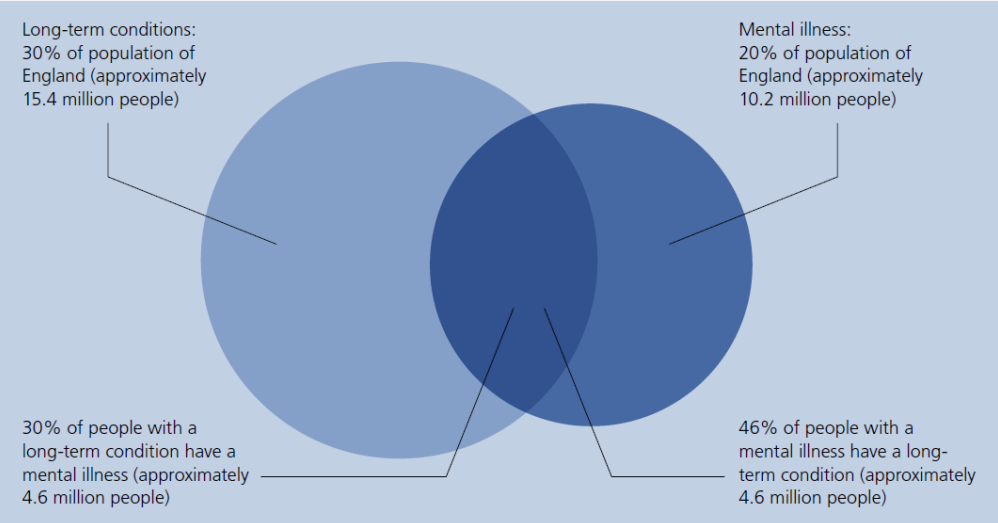
	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Cornwall	0.72	0.73	0.78	0.8	0.83	0.85
South West	0.79	0.81	0.85	0.87	0.91	0.93
England	0.84	0.86	0.88	0.9	0.92	0.94

While the severity of having a moderate mental illness differs from having a diagnosable SMI, the modelling of co-existing conditions (Naylor et al., 2012, PHE, 2018a) provides a methodology for estimating the number of people with both a physical health problem and SMI. For example, it is thought that in England 46% of people **with a moderate and severe mental illness** have a long-term physical health problem (Figure 3.3b) (Naylor et al., 2012). Assuming this applies to those with an SMI and given that there were 4,894 people (all ages) with an SMI (registered with a GP) across Cornwall and the Isles of Scilly in 2017/18, there could be approximately 2,251 people with an SMI and long-term condition (46% of those with an SMI).

In another modelling study by Public Health England, it was estimated that around 452,035 people (8.5% of the total population) have a **coexisting long-term physical and mental health condition** in the South West of England. The estimates differed by gender (with girls and women having a significantly higher prevalence [10.4%] than boys and men [6.6%]) (PHE, 2018a) and further influenced by other factors such as age and levels of deprivation (PHE, 2018d). This means that of the 563,608 people living across Cornwall and the Isles of Scilly (mid 2017 estimates) there could be 47,907 people with co-existing physical and mental health comorbidity (all ages).

The number of people with physical and mental health comorbidity is likely to be influenced by the severity of the mental illness and/or physical health condition. In summary, applying these estimates to Cornwall's population there is likely to be between 2,251 and 47,907 number of people (all ages) with a mental health problem and living with long-term physical condition.

Figure 3.3b Overlap between long-term conditions and mental health (Chief Medical Officer, 2013b), adapted from (Naylor et al., 2012)



Note: The definition of mental illness includes moderate mental health as well as severe mental illness

3.4 Dual diagnosis

Dual diagnosis refers to people with a serious "mental illness (including schizophrenia, schizotypal and delusional disorders, bipolar affective disorder and severe depressive episodes with or without psychotic episodes) combined with misuse of substances (the use of legal or illicit drugs, including alcohol and medicine, in a way that causes mental or physical damage)" (Megnin-Viggars et al., 2015). There is a complex interplay between co-occurring mental illness and substance misuse, which means that someone may have (NICE, 2016):

- A mental illness that has led to substance misuse;
- A substance misuse problem that has led to a mental illness; or
- Two initially unrelated disorders (a mental illness and a substance misuse problem) that interact with and exacerbate each other.

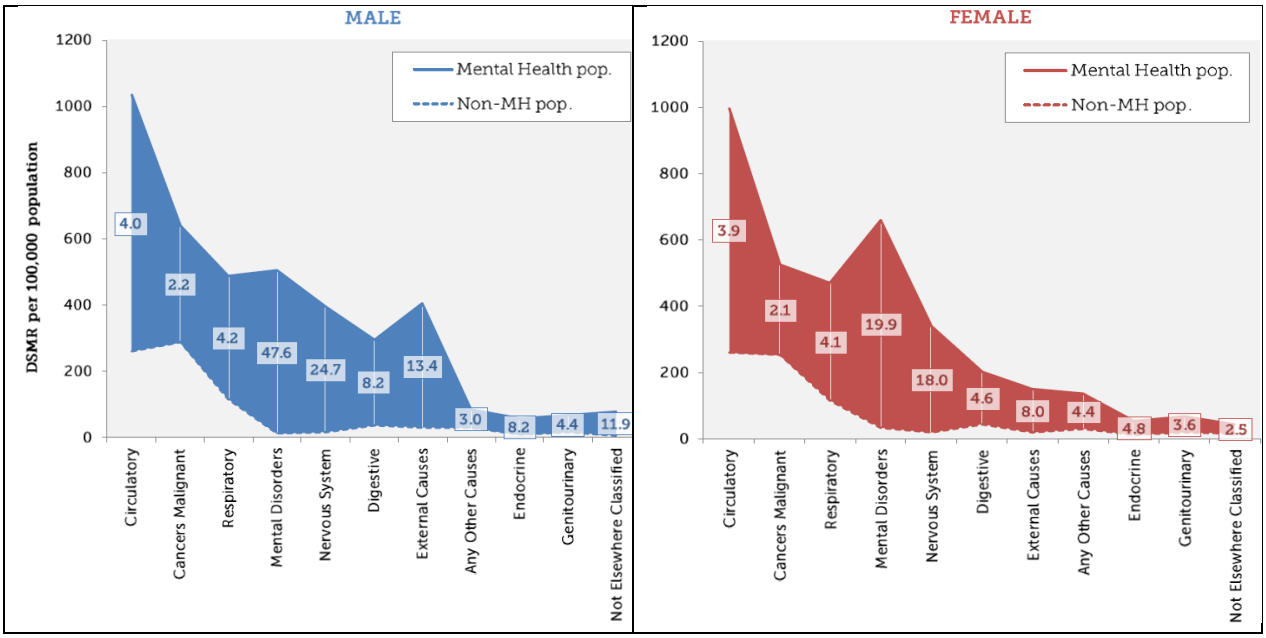
The proportion of dual diagnoses has been estimated to effect between 20% and 44% of community adult mental health patients who have a problem with drug use and/or harmful alcohol use (Strathdee et al., 2002, Weaver et al., 2003). Similarly, 75% of drug service and 85% of alcohol service patients have been found to have a psychiatric disorder (Weaver et al., 2003). Addressing the health needs of this population across Cornwall and the Isles of Scilly must be addressed in future strategies. This should include integrated support for adults with concurrent mental health and drug or alcohol problems, which also addresses the needs of those with multiple needs (UKDPC, 2019).

3.5 Life expectancy of people with mental and physical health problems

People living with a mental health problem die on average 5-10 years younger than the general population (Mental Health Foundation, 2016). Whereas people with severe and prolonged mental illness die on average 15 to 20 years earlier, this represents one of the greatest health inequalities in England. It has been estimated that two thirds of these deaths are from avoidable physical illnesses, including treatable cardiovascular, pulmonary, infectious diseases and cancer (PHE, 2017a, NHS, 2016a, Royal College of Psychiatrists, 2016). The life expectancy of people with a serious mental illness in Cornwall and the Isles of Scilly is lower than those in comparable local authority areas and England. Men and women in contact with mental health services have a life expectancy 20.6 and 18 years less

than the rest of the population, which is largely due to physical health conditions such as respiratory and cardiovascular diseases (Figure 3.5a) (The Strategy Unit, 2017).

Figure 3.5a Directly Standardised Mortality Rate (DSMR) per 100,000 population over 15years by gender and cause of death



Note: the values across the middle of the charts indicate the rate ratio of mortality rates between mental health service users and the rest of the population. For example, the DSMR for circulatory disease is 4 times higher in male mental health service users.

Improvements in service delivery, promotion of effective preventive interventions and improving access to healthcare could make a difference to these top physical causes of death, particularly with respect to cardiovascular diseases. It is also important to consider the impact of co-morbid physical and mental health problems and risk of self-harm and suicide in this patient population.

3.6 Self-harm and suicide

People who self-harm are 100 times more likely to die by suicide within the following year than people who don't self-harm (Public Health, 2014). Co-morbid mental and physical health conditions have also been shown to increase risk of considering suicide (Kavalidou et al., 2017). Cornwall and the Isles of Scilly have significantly higher rates of self-harm and suicide when compared to England (PHE, 2018e):

- Emergency hospital admissions for intentional self-harm (241.7 per 100,000) than across England (185.3 per 100,000) in 2016/17;
- Higher rates of people dying by suicide (16.1 per 100,000 persons) than England (9.9 per 100,000) during 2014/16 (highest amongst men).

While there are some data quality issues with suicide data held by Cornwall Council (e.g. a proportion of suicide records that are incomplete or left blank), the data provides some insight into factors possibly contributing to suicide cases over the last 3 years. Excluding cases where there is no or an incomplete suicide record on file, around 50% of cases had a recorded diagnosed mental health problem. Self-harm and having a long-term condition seemed to be more prevalent among the suicide cases where there was a diagnosed mental health illness. To help improve future policy and practice, there is a need to review recorded self-harm and suicide cases with both a mental health diagnosis and

physical health condition. It is important that there are systems in place to recognise the increase risk of suicide of people with SMI and comorbid conditions, and self-harming behaviour.

3.7 Wider determinants of health

Mild, moderate and serious mental health conditions are shaped by the social, economic and the physical environments where people live – often referred to as the 'wider determinants of health'. Wider determinants of health have an influence across the life course (from early childhood and adulthood) and can act at the household (e.g. nutrition, housing, education and employment) and community (e.g. violence/crime and deprivation) and environmental (e.g. natural/built environments) level. Other wider social determinants include those associated with local services (e.g. education, social services and healthcare) and wider country level factors (e.g. national policies) (WHO, 2014). There is a complex interaction between these wider determinants of health and someone's mental health and physical well-being (Figure 3.7a). Interventions or programmes which focus on improving the social and economic opportunities for people with serious mental illness should be systematically prioritised. These include education, training and employment opportunities and housing including with support.

Figure 3.7a Factors affecting people's physical health (Nursing Midwifery and Allied Health Professions Policy Unit, 2016)

Lifestyle factors such as lifestyle choices including diet, smoking, physical inactivity and substance misuse can further exacerbate physical and mental health outcomes. Many of these lifestyle factors and triggers are more common amongst people with mental illness. For example, approximately a third (33%) of people with a mental health problem regularly smoke, compared with just over a fifth (22%) of the English population as a whole (McManus et al., 2010). Unhealthy choices around diet and substance misuse can also be addictive because the lifestyle alleviates emotional distress (Faculty of Public Health, 2018). This means that people may be unwilling to change their behaviours or lifestyles (e.g. in diet or substance use) because these may provide short-term release of stress. Equally these can also lead to negative spirals in stress and impact self-esteem, which can affect self-management practices for example. Understanding the impact of these wider determinants may help target potential risk or protective factors influencing mental health outcomes.

Future efforts should also investigate the impact of other wider determinants influencing the physical health of those accessing mental health services. This should be delivered alongside a more holistic and joined up approach to the mental health prevention agenda, including improved quality and access to healthcare. Future approaches need to consider potential barriers experienced by this population.

Considerable barriers are faced by this population in accessing healthcare and the quality of care they receive. People with severe mental illnesses suffer from;

- A lack of motivation towards self-management or self-care of existing conditions (DiMatteo et al., 2000);
- Poor medical regimes (Katon, 2003);
- Low attendance rates for medical appointments (Naylor et al., 2012); and
- Poor access to standard levels of care (Hert et al., 2011, NHS, 2016b, Agnew-Blais et al., 2018)

Service commissioners should undertake a variety of methods to assess potential barriers experienced by this population in accessing high quality health care.

3.8 Risk and protective factors influencing mental well-being in Cornwall and Isles of Scilly

Public Health England provide an overview of known risk and protective factors for mental well-being across Cornwall and the Isles of Scilly (PHE, 2018b), which is an important in preventing developing a mild, moderate or serious mental illness. Important risk factors for poor mental well-being across Cornwall and the Isles of Scilly includes having a long-term health problem, risky lifestyle behaviours, social isolation, deprivation and limited use of outdoor spaces (Table 3.8a). Targeting these risk factors locally provides an opportunity to intervene and inform future interventions to improve mental health and physical health outcomes across Cornwall and the Isles of Scilly.

Table 3.8a Comparing risk and protective factors for mental wellbeing in Cornwall and Isles of Scilly against England (PHE, 2018b)

	Cornwall and Isles of Scilly	England
Risk factors		
Long-term health problem or disability (all ages)	**21.4%**	17.6%
Adults having three or more risky behaviours	**19.8%**	15.9%
Older people living alone	**6.5%**	5.2%
People on employment support allowance	**6.7%**	5.7%
Lower weekly earnings	**£368**	£440
Fuel poverty	**14.2%**	11.0
Protective factors		
Lower proportion of people using outdoor spaces for exercise or health	**12.3%**	17.9%
People reporting low life satisfaction	**6.1%**	4.5%
Low worthwhile score (to what extent do you feel the things you do in your life are worthwhile?)	**6.2%**	3.6%

Note: Data in bold represents a significant difference

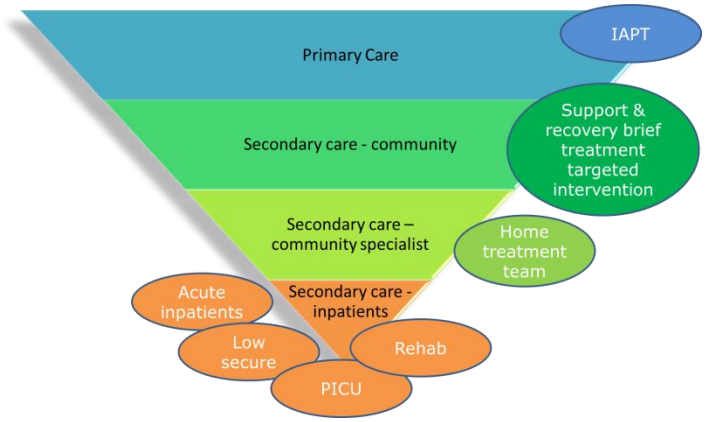
There is local evidence that these factors can influence mental well-being outcomes. Based on a commissioned survey of people living in Cornwall (sample of 11,247 adults) it was found that a range of risk and protective factors influenced people's mental-wellbeing (Cornwall Council, 2017). Whilst it is impossible to identify any SMI patient participants within a local resident survey, participants with a mental health condition and long-term condition were more likely to have lower mental well-being when compared to those without a mental and physical health condition. Having a low mental well-being score was also associated with;

- Younger adults, men and living in deprivation;
- Social isolation;
- Safety e.g. victim of online crime, feeling unsafe and discrimination;
- Living in social or privately rented housing;
- Being unsatisfied with the repair of the home;
- Feeling confident to self-manage health;
- Ability to participate in voluntary or unpaid work; and
- Physical inactivity.

4.0 Secondary mental health services

Secondary care services are those which patients are referred to by their GP, A&E or other organisations for more specialist support. This can include community mental health teams, hospital care or support from other mental health services (PHE, 2017d). In Cornwall and the Isles of Scilly, these services are provided by Cornwall Partnership Foundation Trust (CPFT, 2014) who operates a range of mental health services (Figure 4.0a).

Figure 4.0a Secondary care services



The Mental Health Services Dataset (MHSDS) (NHS Digital, 2018) provides the most timely statistics relating to these services. At the end of October 2018, there were 8,180 people in contact with the adult mental health services (NHS Digital, 2018).

Local analyses using 2014/15 MHSDS data (The Strategy Unit, 2017) showed that the age and sex profile varied by conditions (Table 4.0a). People who use mental health services (7% of the population) utilise 15% of A&E attendances and 15% emergency admissions, which is greatest among those with cognitive impairment and psychosis (The Strategy Unit, 2017). However, there is no data on the number of people with a physical health condition, their demographic profile or the reasons behind these admissions. Understanding the long-term trends associated with service use will help inform future service planning and strategies. This will require a joint programme of work to analyse mental health service data as a system.

Increased focus on people with psychosis presenting at A&E and enhanced role of mental health liaison services could explore this further. The management of health of people with dementia should continue to be a focus of multidisciplinary integrated care teams at locality level.

Table 4.0a Age and sex profiles (MHSDS 2014/15)					
	No. of people	%	Mean age	Women %	Men %
All mental health cohorts	31,055	7	60	56	44
Cognitive impairment including dementia	11,230	2	83	61	39
Psychoses	7,493	2	47	55	45
Personality disorders	479	0	37	61	39
Common & other mental health conditions	6,802	1	43	61	39
Mental health conditions, unassignable	5,051	1	53	52	48
All non-mental health cohorts	445,265	93	50	51	49
Patients with physical health needs but no mental health problems	216,044	45	53	54	46
Well population (patients without a mental or physical health problem)	229,221	48	46	48	52

4.1 Health checks for people with serious mental illness

It is a national priority that adults accessing mental health services are offered physical health checks. Nationally, around 62% to 82% of people with a SMI receive an annual physical health check (NHS, 2016a). According to national data, the coverage of health checks across Cornwall and the Isles of Scilly varied during 2017/18 (below) and can fluctuate over time (Figure 4.1a);

- A slightly lower number of patients (78.0%) had an alcohol consumption check compared to England (80.6%);
- There is a declining trend over time for the number of blood pressure checks being completed in Cornwall (80.5%) and across England (81.5%);
- When compared to England (94.9%), a similar proportion of patients were offered smoking cessation support and treatment in Cornwall (95.1%); and
- More women had a cervical screening test in the preceding 5 years (74.0%) than across England (69.6%).

There is no up to date data on the number of patients receiving the complete list of physical health checks, or data on checks such as the blood glucose or HbA1c (PHE, 2017d), which has historically been quite low (Figure 4.1b).

Extra effort should also be made in the low up take rates of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer in this populations (NHS, 2016a), particularly to reduce smoking. This is one of the most significant causes of poorer physical health in this group (NHS, 2016a). This should include an assessment of the level of unmet health needs including weight, diet, alcohol, smoking rates, and physical health risk factors.

Figure 4.1a Health checks among those with an SMI (PHE, 2018c)

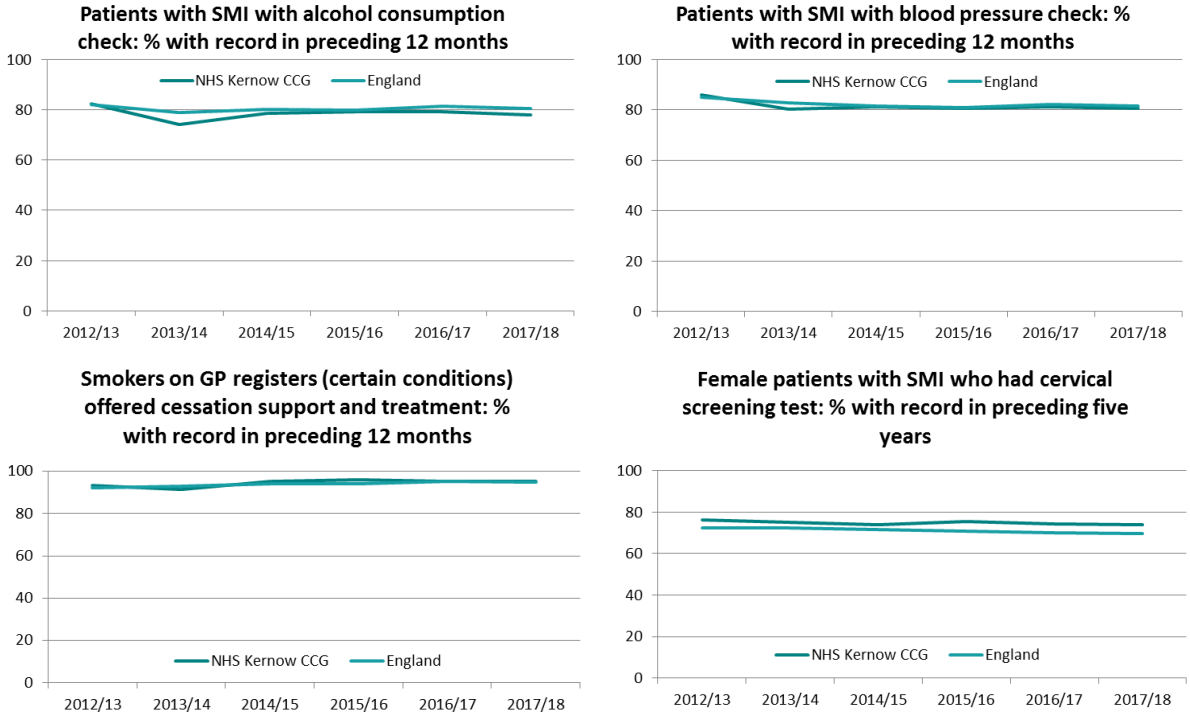
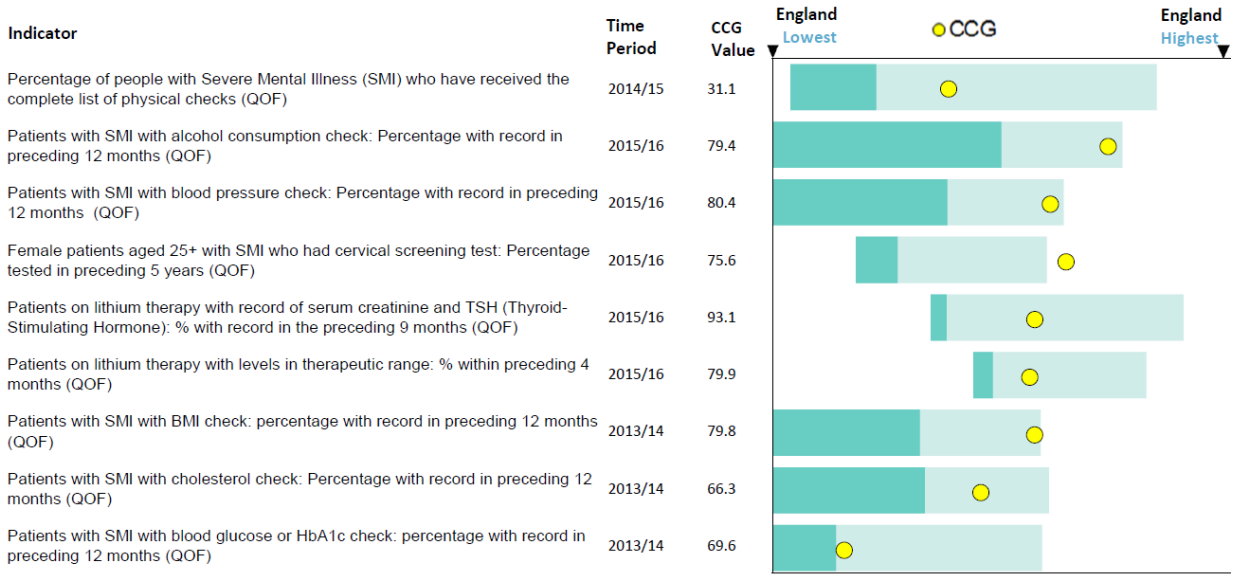


Figure 4.1b Physical health of people with severe mental illness



Improved understanding between primary and secondary care can help improve detection rates. For example, a collaborative model between specialist mental health and primary care in Bradford (using a standardised physical health check template and shared care protocol) has doubled the detection rate of cardiovascular disease for patients with SMI (PHE, 2017d). Improved data sharing and collaborative working between organisations may help improve outcomes for SMI patients. This may also help increase the uptake of health checks across primary and secondary care.

4.2 Local audits

The commissioning for quality and innovation (CQUIN) standard (on cardio metabolic assessment and treatment of patients with psychoses) (NHS, 2017b) requires that in at least 80% of the patient case notes, there is a documented assessment of the cardio metabolic risk factors and that intervention had been provided when appropriate (NHS, 2017a). These follow the NCAP standards and outcome indicators for the core audit (Royal Colleage of Physicians, 2017) and the Lester tool (NHS, 2016b).

A 2016 audit of 100 patient case notes by the Community Partnership Foundation Trust (CPFT) demonstrated that the assessments of all recommended cardio metabolic risk factors were achieved, with the exception of the diet and exercise aspects of lifestyle (Table 4.2a). Intervention for those who smoke, use illicit drugs and who have a BMI in the overweight or obese range are in excess of the 80% requirement for the CQUIN and have, therefore, been achieved. Interventions for the remaining risk factors - alcohol, blood pressure, blood glucose and blood lipids were recommended prior to re-audit. A re-audit using a comparable sample and methodology to the national audits would help identify whether these areas have improved.

Table 4.2a Summary of audit results

CQUIN standard	% documented	CQUIN achieved?	Documented intervention, of those required	CQUIN achieved?
Smoking status	93%	Yes	53/54 (98%)	Yes
Alcohol	93%	Yes	3/4 (75%)	No
Illicit drugs	93%	Yes	25/28 (89%)	Yes
Diet	-	No	N/A	No
Exercise	-	No	N/A	No
Body Mass Index	90%	Yes	30/36 (83%)	Yes

A local physical health care audit for Complex Care and Dementia (CCD) patients admitted to Carbis, Perran and Fletcher Wards (adult functional wards) was also undertaken by CPFT in 2016 for cases recorded between April 2015 and February 2016. Recommendations were made to ensure physical health conditions (e.g. Epilepsy, Asthma, Urinary Tract Infections), as well as smoking, alcohol and substance use are included in patient care plans. A re-audit would help to assess whether these recommendations have been implemented.

A case load audit of early intervention in psychosis physical health compliance (NICE standard QS80) was completed in 2017. A sample group of 30 clients were taken to review whether they had either had an initial physical health check or an annual review. The audit found that not all staff had recorded the physical health checks using the same format, and that there was a need for a consistent method for identifying patients requiring a review and need for developing care plans. A review of these action plans would help determine whether the physical health needs of patients with a mental health condition are being met.

4.3 National Audit of Schizophrenia

The proportion of health checks being completed among schizophrenia patients varies considerably across England, particularly among patients with a known physical health problem. The proportion of patients requiring an intervention and offered an intervention also varied across the national sample (between 52% and 89%).

There is no data on the proportion of family history checks being completed locally, but there were a slightly higher proportion of health checks being completed for BMI, blood pressure, alcohol consumption and substance misuse, compared to nationally. A lower proportion of checks were completed for smoking status, blood glucose and lipids when compared to the national average. Furthermore, just over 30% of patients received health checks for all five of the cardio metabolic health risks (smoking, BMI, glucose, lipids, and blood pressure) in the past 12 months.

To adhere to NICE guidance, each patient with schizophrenia should have all of these risk factors monitored, the information recorded (at least once annually) and offered an intervention (NCAP, 2018). Further investigations are needed to understand the barriers and facilitators of the coverage of health checks conducted (including refusals to attend and where there are no records) and number of interventions delivered (including outcome measures).

4.4 The prescribing observatory for mental health (POMH-UK)

POMH-UK aims to work with Trusts to improve prescription practice and have conducted a number of audits covering the physical health of mental health patients. Relevant audits include those on the use of antipsychotic medication in adult psychiatric wards (Prescribing Observatory for Mental Health, 2017). In the last year, the majority of adult patients' prescribed high-dose medication had physical health checks. This included blood pressure and pulse (100%), weight/BMI (80%) and plasma lipids (80%). However, only 60% of patients had their plasma glucose checked in the last 12 months, which was one of the lowest of the participating Trusts.

6.0 Future demand

According to the PANSI & POPPI projections (IPC, 2017), the adult population with a mental health condition in Cornwall and the Isles of Scilly is set to rise (Table 6.0a). The estimated number of adults with a mental and physical health condition has also been estimated (Table 6.0b) using the co-morbidity estimate of 46% (Naylor et al., 2012). Improved access to patient profiles (by age and sex) would improve our estimations on the number of patients with a mental and physical health condition, and future demand for services.

Table 6.0a Modelled estimates of common mental health conditions (adults 18-64) in Cornwall and IoS

Condition	2017	2020	2025	2030	2035
Common mental disorder	51,189	51,486	51,742	51,920	51,804
Borderline personality disorder	1,435	1,443	1,450	1,454	1,450
Antisocial personality disorder	1,087	1,093	1,100	1,106	1,109
Psychotic disorder	1,272	1,280	1,286	1,291	1,288
Two or more psychiatric disorders	22,790	22,920	23,041	23,126	23,099

Table 6.0b Estimated number of adults (18-64) with a physical & mental health condition					
Condition	2017	2020	2025	2030	2035
Common mental disorder	23,647	23,784	23,901	23,983	23,930
Borderline personality disorder	760	764	767	769	767
Antisocial personality disorder	600	603	606	609	610
Psychotic disorder	685	689	692	694	692
Two or more psychiatric disorders	10,583	10643	10,699	10,738	10,726

7.0 Community Voice

In terms of SMI Patient feedback, Cornwall Partnership Foundation Trust (CPFT) follows a Patient Experience Cycle. The Trust collects information about complaints, incidents, safe staffing and the friends and family test, which provides an overview of patient experience and informs strategic planning. In 2016, the Trust registered 233 complaints, which represents an increase of 54% on the previous year. During the same reporting period a total of 797 Patient Advice and Liaison (PALS) contacts were recorded (a 36% increase compared to 2015). These have been raised and addressed in the 2016/17 strategy (Cornwall Foundation Partnership Trust, 2016), but no specific detail is reported, particularly with respect to SMI patients.

Drawing from other national examples, SMI patients have previously expressed the need for service improvements (Gould, 2016), which should be used to inform the delivery of mental health services across Cornwall and the Isles of Scilly. Important factors include:

- Having better involvement, influence and control over treatment, and having a voice about physical healthcare services on offer at the personal, service and commissioning level;
- Better support from family members, friends and peers to make better use of the options to improve physical health;
- Professional assistance for a range of areas including support with; physical health checks; healthy eating; exercise; weight reduction; side effects of medications; and alternatives to psychiatric medication. Other areas highlighted were healthy teeth; stopping smoking; sexual health; and substance misuse;
- Availability of alternatives to medical model approaches and a shift away from treating the symptoms;
- Use of holistic approaches and taking a whole person approach to treating mental and physical health needs;
- Improved professional qualities and environments including better understanding, respect, use of non-judgemental approaches, compassion, support and encouragement;
- Need to meet the diverse needs for people of all ages and backgrounds;
- Use of alternative venues ranging from at home to centres offering alternative therapies, including the use of community-led resources, local GP surgeries or community based medical facilities;
- Availability of information about public health resources; and
- Training of professionals.

This is important to consider because a national survey conducted in 2017 highlighted that people's experiences of the care they receive from community-based mental health services have continued to deteriorate (Care Quality Commission, 2017). Locally, CPFT performed similarly to other Trusts in respect to better planning of care. Potential areas highlighted as requiring some improvement included the organisation of care and services, and the delivery of help or advice on finding or keeping work (Care Quality Commission, 2018).

It is essential that the lived experiences of SMI patients are considered during service improvements (Centre for Mental Health, 2016). Information from complaints and the Patient Experience Team (available via 'Meridian') can help provide the views and experiences of local service users. This feedback will help inform future strategies to address the uptake of health checks, the number of interventions offered and physical health status of patients.

Further improvements may be achieved by signing up to the recent voluntary Charter entitled the 'Equally Well UK Charter'. This may help ensure people with mental health conditions get access to high quality care that can improve their physical well-being and prevent, treat and manage physical health problems. The Charter aims to share what works and aims to improve the health outcomes of mental health patients (Equally Well UK, 2018a). A principle of Equally Well is to co-produce solutions and work with local service user groups to understand the challenges people face and develop future interventions. This is particularly important in more rural areas with dispersed settlement patterns and practical transport difficulties.

8.0 Effectiveness of interventions

Improving people's mental health acts as a protective factor for physical health outcomes (Better Mental Health for All, 2016). Public Health England recently assessed the Return on investment of a number of mental health prevention (PHE, 2017c, Gov.UK, 2017) and supported the use of:

- Addressing bullying targeted at children and young people;
- School-based social and emotional learning programmes;
- Promoting mental health and well-being in the workplace;
- Workplace interventions to prevent stress, depression and anxiety problems;
- Protecting the mental health of people with long-term physical health problems;
- Addressing loneliness to protect the mental health of older people;
- Providing debt advice to protect mental health; and
- Suicide and self-harm prevention.

While each of these interventions may provide good value for money when compared to quality of life improvement programmes, they do not specifically address the physical health needs of SMI patients. A review of available interventions and advice may help improve future service delivery and patient outcomes. The following provides an overview of some of the interventions and guidelines concerning the physical health needs of mental health patients.

There are guidelines to specifically improve the physical health of patients with a mental health condition (Royal College of Psychiatrists, 2016, Nursing Midwifery and Allied Health Professions Policy Unit, 2016). The Nursing Midwifery and Allied Health Professions Policy Unit (2016) highlight eight key areas of action, which aim to address particular risk factors associated with reduced physical health and life expectancy. The action areas required to lower the impact of metabolic syndrome (i.e. obesity, high blood pressure, raised blood sugar levels & abnormal cholesterol levels) and associated physical health problems are:

1. Support to quit smoking;
2. Tackling obesity;
3. Improving physical activity levels;
4. Reducing alcohol and substance use;
5. Sexual and reproductive health;
6. Medicine optimisation;
7. Dental and oral health; and
8. Reducing falls.

A recent review of SMI highlights that the underlying reasons for poorer physical health are not fully understood (PHE, 2018d). While this overlaps with the above key areas, the report provides further justification for improving the physical health of SMI patients. In addition to addressing the above healthier lifestyles, this can be achieved by addressing and reducing the impact of;

- Multiple risk behaviours rather than one health risk factor at a time;
- Side effects of antipsychotic medication, including weight gain, glucose intolerance and cardiovascular effects;
- Difficulties in accessing treatment;
- Disconnected and irregular approach to health and care provisions, and other support;
- Non-compliance with care process, for example for Type 2 diabetes and mental health care providers should work with people who have SMI;
- The effect of SMI on poor self-management of conditions, including seeking and adherence to treatment; and
- Socio-economic determinants and consequences of suffering from a mental health conditions. This may include areas such as poverty, poor housing, reduced social networks, lack of employment and social stigma.

Physical health outcomes can be improved through annual health checks and use of tools such as the LESTER toolkit, which is currently in use by CPFT. There appears to be particularly strong evidence about the benefits of smoking cessation therapy (tailored to meet the needs of this group) and use of the Lester Tool (for people during first episode, when problems first begin to develop). The tool helps front line staff to make assessments of cardiac and metabolic health (NHS, 2014b). There is also a variation of the Lester tool where it is completed by the patient (Equally Well UK, 2018b). Increased physical activity can also help improve patient outcomes. For example, the project 'Coping Through Football' provided a low-cost intervention for mental health patients. The cost of one person attending the programme every week for a year was £1,700, which is equivalent to four days in a mental health inpatient bed, or five A&E attendances (Centre for Mental Health, 2018).

There is also the framework for action (Nursing Midwifery and Allied Health Professions Policy Unit, 2016) and recommendations from the Royal College of Psychiatrists (2016). These call for:

1. Healthcare commissioners - to set clear expectations for the provision of physical health services in mental health settings and, training and improved collaboration;
2. Providers of physical healthcare services - to develop a physical health strategy for people with mental health problems; provide accessible services, undertake regular physical health assessments, provide appropriate resources and training;
3. Information technology - electronic patient records, prescribing, enhanced data sharing and facilitate training for example;
4. Physical healthcare - advice for mental healthcare and acute service providers; and

5. The training of healthcare professionals across a range of disciplines covering areas from the assessment and monitoring of physical health through to patient rehabilitation.

Local policy, commissioning and service providers should ensure these key action areas and recommendations are reviewed and used to improve physical health outcomes of those accessing mental health services. Furthermore, taking a 'community development' approach is gathering recognition across health improvement and should be considered. These help to empower individuals, and help ensure interventions take into account people's experiences and expectations, which could include the Asset Based Community Development and Co-production (Better Mental Health for All, 2016). There should also be a greater focus on other vulnerable populations such as older adults at risk of cognitive decline (PHE, 2017b). These may include (Mental Health Foundation, 2016);

- Providing reminiscence therapy for older people in health care settings;
- Accessible and appropriate physical activity programmes for older people;
- Promoting access to liaison mental health teams for people being supported in specialist old-age acute physical health services; and
- Ensuring older people are able to access addiction services.

However, further research is a need to assess the effectiveness of some of the interventions targeting patients with a mental illness. For example, there is insufficient evidence supporting the use of self-management interventions in patients with diabetes **and** severe mental illness (McBain et al., 2014). Another study found that whilst people with schizophrenia were recruited and retained into a STEPWISE (group education programme) weight reduction interaction, the STEPWISE intervention was neither clinically nor cost-effective (Holt et al., 2018). A further review into the effectiveness of interventions targeting the physical health needs of SMI patients is needed.

Appendix 1.0 Policy overview

There has been a transformation in mental health over the last 50 years. In the 1990's the Care Programme Approach was developed to provide support to people with severe and enduring mental health (NHS, 2016a). The National Framework for Mental Health was published in 1999, which was followed by the NHS Plan in 2000 and the 2004 National Service Framework for Children, Young People and Maternity Services. In 2011, the mental health strategy was launched to deliver improvements in physical health outcomes and experience of care of people with mental health problems and to have a reduction in avoidable harm and stigma (NHS, 2016a).

Improvements in mental health care across the NHS and the prioritisation of both mental and physical health is articulated by a range of policy drivers and the prevention agenda. These make the strong moral and economic case for action beyond the treatment of physical and mental health problems; to intervene early, support recovery and prevent mental illness and poor physical and mental well-being.

Current relevant **legislation** includes the 1983 Mental Health Act, which covers the assessment, treatment and rights of people with a mental health problem. The revised code of practice shows professionals how to carry out their roles and responsibilities under this act and aims to provide stronger protection for patients (Department of Health and Social Care, 2015). This is supported by the revised guidance on the Act, which provided the main provisions under the 1983 Act, as amended in 2015. This included the Mental Health Act 2007, Health and Social Care Acts 2008 and 2012 and Care Act 2014 (Department of Health and Social Care, 2015). Also, the 2005 Mental Capacity Act is designed to protect and empower individuals aged over 16 years who may lack the mental capacity to make their own decisions (Scie, 2016).

The new **NHS long-term plan** (NHS, 2019) sets out a range of commitments to improve adult mental health, which includes those with a severe mental health problem. Under SMI's this includes new and integrated models of primary and community mental health care to support adults and older adults with SMI.

The **Five Year Forward View** called for a radical upgrade in the prevention agenda and to break down barriers in the way care is provided between family doctors and hospitals, between physical and mental health, between health and social care. There was a clear ambition to drive towards an equal response to mental and physical health, and towards the two being treated together (NHS, 2014a). Despite some progress, the Next steps on the NHS five year forward view aims to build on this and sets an ambition towards integrated care incorporating approaches to improved mental health care (NHS, 2017c).
The development of 'New Models of Care', introduced by the NHS five year forward view, create an opportunity to delivery whole-person care; recognising that priority should be given to addressing close links between physical health and mental health. New models of care and the emergence of Accountable Care Systems (ACS) or Accountable Care Organisations (ACO) may provide an opportunity to improve care through integrated approaches to mental health. Future models of care could make a number of improvements (Naylor and Taggart, 2017) including:

- increasing capacity and capabilities to meet existing needs,
- making mental health a core component of enhanced models of primary care,
- strengthen mental health components in secondary care such as urgent and emergency care pathways and emergency departments; and
- focus on perinatal mental health, children and young people.

Sustainable Transformation Plans (STP) are the main mechanism for delivering the Forward View (Naylor and Taggart, 2017). STP's include a broad range of themes, ranging from prevention and primary care to specialised services in hospitals. All STPs include proposals to strengthen primary and community services and to integrate NHS and social care services more closely around the needs of patients. The plans also describe ambitions to improve the broader health and well-being of the populations they serve (The King's Fund, 2017b).

The **Five Year Forward View for mental health** sets out the required service improvements to be implemented by 2021 (NHS, 2016a);

- improved access to services at an earlier stage;
- services accessible at the right time;
- services delivered in a more integrated way; and
- embedding mental health services into the NHS.

The Five Year Forward View for mental health made a range of recommendations, including the development of a national Prevention Concordat programme (see below) that will support all Health and Well-being Boards (along with Clinical Commissioning Groups) to put in place updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing. It recommends that by 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. The recommendations also include a need for commissioners to (NHS, 2016a);

- work in partnership with local stakeholders and voluntary organisations;
- co-produce with clinicians, experts-by-experience and carers;
- consider mental and physical health needs;
- plan for effective transitions between services;
- enable integration;
- draw on the best evidence, quality standards and NICE guidelines;
- make use of financial incentives to improve quality;
- emphasise early intervention, choice and personalisation and recovery; and
- ensure services are provided with humanity, dignity and respect.

Appropriate delivery mechanisms are required to deliver this ambition. **Stepping forward to 2020/21**, the mental health work force plan for England sets out a high level road map for regions, STPs and local areas. It highlights the need for multi-disciplinary staff across providers, commissioners, 'arm's length bodies', local authorities and third sector organisations to work together to deliver the transformation set out in the Five Year Forward View for Mental Health (NHS, 2017d). The mental health workforce plan provides a workforce plan and sets out;

- overall number, skills and location of current workforce in mental health;
- service growth including the number and type of skills required to provide mental health services; and
- how and when to achieve the net growth in staff – with clear actions for local and national partners.

The Prevention Concordat for Better Mental Health Programme was launched in August 2017 with 30 signatories. The programme takes a prevention-focused approach to improving the public's mental health through reducing health inequalities. The sustainability and cost effectiveness of this approach will be enhanced by the inclusion of action that impacts on the wider determinants of mental health and well-being. It aims to facilitate local and national action around preventing mental health problems and promoting good mental health (PHE, 2017e). The programme is underpinned by an evidence base, which demonstrates that a prevention-focused approach to improving the public's mental health makes a valuable contribution to achieving a fairer and more equitable society. This prevention-focused transformation will be achieved by increasing impact through commissioning decisions and evidence based planning. It is intended to provide a focus for cross-sector action to deliver a tangible increase in the adoption of public mental health approaches across the whole system (White, 2017).

The **suicide prevention interim report** (House of Commons Health Committee, 2016) highlighted five key areas for inclusion into the Government's suicide strategy. The report included a recommendation for services to support people who are vulnerable to suicide. This included wider support for public mental health and well-being alongside the identification of and targeted support for at risk groups; early intervention services, access to help in non-clinical settings, and improvements in both primary and secondary care; and services for those bereaved by suicide.

The 2013 Chief Medical Officer report called to integrate mental and physical health across primary and secondary services, supported by improved intelligence on mental health nationally and in Joint Strategic Needs Assessments. The report highlighted the increased risks of poor physical health and premature death experienced by people with mental illness and the increased risk of poor mental health among people with physical health problems. It recognised that these links have been ignored for far too long and required fundamental change towards the links between physical and mental health (Chief Medical Officer, 2013a).

No Health Without Mental Health was a cross government mental health strategy introduced in 2010, which set out six key objectives (Department of health, 2011):

- more people will have good mental health;
- more people with mental health problems will recover;
- more people with mental health problems will have good physical health;
- more people will have a positive experience of care and support;
- fewer people will suffer from avoidable harm; and
- fewer people will experience stigma and discrimination.

The strategy aims to ensure that those with mental health problems are provided with services that improve outcomes both mentally and physically, and that the mental health and well-being of the population as a whole is improved.

A 2009 report commissioned by the Royal College of Psychiatrists from the Academy of Medical Colleges (Royal College of Psychiatrists and Academy of Medical Royal Colleges, 2009) preceded 'No Health without Mental Health' and reinforced the need to improve the physical health of those with mental health problems. It highlighted that 'there is a clear link between mental and physical health and an urgent need to strengthen both the provision of mental health care to people with physical illness and the quality of physical healthcare to those with mental health problems in general hospitals and primary care'.

A report entitled ‘stocktake of local strategic planning arrangements’ aimed to provide a high-level summary of how local areas are currently incorporating mental health promotion and prevention of mental health problems in their planning process (Public Health England and King's Fund, 2017). The report highlighted that the overall level of priority given to mental health and/or prevention of mental health problems varied by local authority.

There are also wide ranging guidelines related to other areas of mental health, which have recently been reviewed as part of the prevention concordat by Public Health England (PHE, 2017f). However, there does not appear to be any specific NICE guidelines relating to the prevention and promotion of physical health and mental health.

The Better Mental Health for All report focuses on what can be done individually and collectively to enhance the mental health of individuals, families and communities by using a public health approach. It is intended as a resource for public health practitioners to support the development of knowledge and skills in public mental health (Better Mental Health for All, 2016). There are also useful reports and guidance on mental health, as well as a range of other resources to support the promotion of mental well-being and the primary prevention of mental illness (The UK's Faculty of Public Health, 2017).

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