

# Building a comprehensive and integrated physical health offer for serious mental illness (SMI) in the community- Pan London learning

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**Healthy London  
Partnership**

## Background and policy context

Healthy London Partnership held a pan-London event to bring together key partners focused on the **physical and mental health (MH) inequalities faced by people with serious mental illness (SMI) and complex MH needs.**

**This included conversations around access to care, engagement in care and our understanding of complex physical and mental health needs. As well as roles and responsibilities and existing infrastructure to deliver care—all within the context of a post-pandemic environment**

### Who did we engage with?

Primary care, secondary care, CCGs, voluntary and community organisations, service users and carers and NHSE/I



This work draws on [The Community Mental Health Framework for Adults and Older Adults](#) and the opportunity to address radical change in the design of community MH care.

The framework aims to understand how to best deliver integrated, personalised, place-based and well coordinated care by breaking down the barriers between:



Mental and  
physical health



Health, social care,  
voluntary and local  
communities



Primary and  
secondary care

# Purpose of this document

## What does this report tell you?

- From pan-London conversations we have identified six overarching statements in response to the collective challenges and barriers that have been identified by London's healthcare professionals and people with lived experience.
- The first three are from a lived experience perspective and the last three are from a healthcare professional perspective.
- Each statement provides detail on why this is considered a challenge or barrier and the recommendation or action needed in response. The lived experience statements contain 'I statements' to express the views of the people we engaged with lived experience.

## Aims and next steps

**The findings from this document are intended to be a start of continued local and regional conversations**



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We hope that the information in this report will help those involved in the delivery of community MH transformation to consider:

**How a more comprehensive physical health SMI offer can be built into integrated community MH services, beyond physical health checks?**

# Summary of statements

Below are the 6 overarching statements. Slides 5- 10 provide a breakdown of each statement.

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Making every contact count to address my physical & mental health needs

Defining roles & responsibilities in a new structure

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2

Understanding my mental & physical health needs as a whole

Clear advice and information to support meaningful interventions

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3

Building a relationship to help me feel comfortable & confident to discuss my mental & physical health needs

The post-pandemic infrastructure is not aligned to higher volume and higher acuity of need

6

# Making every contact count to address my physical & mental health needs

The first point of contact is key for a person with SMI or complex MH needs- PH checks may be the first and only point of contact for a person. Considerations need to be made on the place and person that will be most appropriate to support a person with more complex MH needs in the context of the COVID-19 pandemic.

## Why is this a barrier for me?

- It is more difficult to access help and support for mental health care compared to physical health care which can lead to a persons mental health getting worse
- It is impractical booking an appointment over the phone or online for a person with complex MH needs or SMI. This is more challenging post-pandemic
- It is intimidating explaining my complex MH needs to a person that is unfamiliar to me and not trained. This is particularly a barrier post-pandemic when trying to book an appointment with the GP. It can be easier to do this in person but not in a busy GP surgery where people can hear
- GP appointments are not flexible enough to meet my complex MH needs e.g being held on the phone, difficulty finding an appointment at a convenient time and only 10 minutes to explain my complex needs



“ I want to talk to somebody at first contact who has a good understanding of how to communicate and support a person with SMI - it is already difficult for me to understand what I am going through and what help I may need, particularly in a time of need or distress ”



“ I want to be able to book an appointment that is easy and personal that allows me to explain my needs in my own words, particularly when I am in a time of need ”



“ I want to be able to explain my needs and seek support without having to wait a long time so that it is responsive and with enough time to discuss my complex MH needs, particularly when I am in a time of need ”

## How can your ICS offer a more comprehensive physical and MH community service?

- Where does a person with SMI currently access care as a first point of contact?
- How can we strengthen that first experience / contact to engage those with SMI to have conversation about their PH/MH?
- Where is the best place to access care (including PH checks) to meet their complex MH needs and whom is the most suitable person?
- Where does a person with SMI want to access care (including PH check appointments) and who are they most likely to engage with?

# Understanding my mental & physical health needs as a whole

Parity of esteem between mental and physical health can be difficult for a person with SMI because it can be easier to address a person's physical health needs compared to their MH needs- it's important that PH checks are recognised as only one aspect of a person's care with SMI

“ Healthcare professionals do not look into the person's whole needs. Physical health checks are just seen from a PH perspective rather than holistically ”

## Why is this a barrier for me?

- Describing my physical health needs can feel easier particularly with a person that I do not know well but this may cause a gap in my mental health needs that only makes my MH worse
- Many healthcare professionals that I regularly come into contact with do not understand my complex physical and mental health needs, for example receptionists and GPs which can exacerbate a feeling of mistrust and a feeling of not being listened to and taken seriously
- It can be difficult to find out important information about my medication, it is important for me to understand how my medication impacts my physical and mental health but my GP may not always be sure of the complex side effects



“ I would like to be able to have an open conversation with a person who helps me to understand both my physical and mental health needs; this person needs to have a good understanding of my physical and mental health as a whole ”



“ I would like physical health checks to be considered together with my important mental health needs so they can be discussed as a whole in one place and I do not have to repeat the same things to different people ”



“ I would like to be able to discuss important information about the medication that is being given to me and the impact that it may be having together with my choices so that I have the ability to discuss and understand my treatment ”

## How can your ICS offer a more comprehensive physical and MH community service?

- How do we ensure that the PH checks are not exacerbating disparity of esteem?
- How do we ensure that service users can have a holistic conversation around their physical and mental health that helps them to manage their own health?
- What skillset/knowledge is needed for a healthcare professional to allow a person to have an open conversation around their physical and mental health?

Building a relationship of trust can be a key enabler to help a person seek and engage with their complex mental and physical health care- talking to someone that is familiar and who can relate to an individual may improve a meaningful conversation

Why is this a barrier for me?

- **Receiving care with a person and setting that is unfamiliar to a person with SMI** can exacerbate a feeling of mistrust if they feel that they are not being listened to and understood which may put someone off trying to access medical help
- **High staff turnover can make it harder to feel comfortable and familiar with a healthcare professional-** consistency in seeing the same person or in the same setting is an important part of relationship-building and having a meaningful conversation to seek physical and mental health support
- **When it feels like actions are not followed-up or written into care notes and shared with the appropriate people** this leads to repeated stories and a feeling of mistrust
- **Carers or family members are not always included in conversations to help support a person with SMI seek mental and physical health support** – this may be particularly important when a person is feeling suspicious of healthcare professionals and may not want to engage with care



“ Trust is developed by getting to know someone over a period of time and being able to develop personal chemistry but a person may not always be able to express their concerns, answer questions and put forward their case with someone new who you have a natural suspicion of ”

“ I would like to have an open conversation with someone that I can relate to and in a place that is familiar and comfortable to me – I would prefer if this person is someone that I see regularly which will help me open up about my mental and physical health needs ”

“ I would like to be involved in my physical and mental health care so I can see where actions have been followed up- including an understanding of my options alongside the healthcare professional ”

“ As a carer I want to be involved in my loved one’s care plan from the beginning and would like healthcare professionals to consider how to involve me as a person of insight – I would like healthcare professionals to actively consider the triangle of care ”

## How can your ICS offer a more comprehensive physical and MH community service?

- What is the appropriate place and person to have a holistic conversation that will best encourage a person to engage with their health and care?
- What role can DIALOG/+ play to support a person and healthcare professionals to understand the wider physical and mental health needs of a person- how can this help support a holistic conversation?
- How can carers better be involved to support a persons physical and mental health needs- how can the ‘triangle of care’ better support collaboration and involvement of carers?

# Defining roles & responsibilities in a new structure

Having a collective understanding of roles and responsibilities in the context of new models of community MH transformation is not yet understood across key partners as an ICS- this may benefit from a pan London understanding. This involves both clinical and non-clinical roles across NHS and non-NHS organisations including what this means to work as an MDT to develop an integrated and comprehensive offer

“ Really starting to look at who does what. Until we make that very clear it is going to be very challenging to move things forward ”

## Why is this a challenge?

- **Roles and responsibilities are not aligned to the impact of the COVID-19 pandemic** as primary care and community services are seeing higher volumes and acuity of MH patients – this means that skills, knowledge and capacity does not match the expectations of these roles and responsibilities
- **Key stakeholders and partners (such as secondary care) are not fully being involved in community MH transformation plans** but it is recognised that a bottom-up approach is needed to develop a culture of service improvement and manage expectations of different roles
- **Partnership working takes dedicated time but many healthcare professionals are feeling stretched and still responding to the impact of the COVID-19 pandemic** which means that the time to develop meaningful relationships and work as a system is challenging
- **There are many roles with similar titles or responsibilities but it is unclear what the remit is**, this may be causing duplication and an inconsistent approach



## Action/ recommendation

**Establish a sustainable forum/network that allows ICSs (including primary care, secondary care, CCGs, VCSE) to collaborate to drive improvement and innovation (that does not duplicate efforts). The first aim should focus on gaining a collective understanding at an ICS and pan-London level of the roles and responsibilities of clinical and non-clinical staff to build in a more integrated and comprehensive SMI offer including:**

- ✓ Defining roles and responsibilities for a consistent approach across London- providing recommendations for clinical and non-clinical roles across boundaries
- ✓ Connecting the patient pathways- particularly across primary and secondary care
- ✓ Engage with local communities to understand expectations of roles
- ✓ Share and pilot good practice to spread work across London in response to COVID-19 pressures

# Clear advice and information to support meaningful interventions

Getting the right advice and information is key (for service users and healthcare professionals) to ensure that people with SMI get the right support and treatment. SMI PH checks may be the first step but this needs to go beyond this for meaningful interventions for physical and mental health

“ I have a tick box about how many people have had all six checks but does that lead to meaningful intervention beyond a typical NHS intervention? How can we build on a range of voluntary care and public health offers that people are likely to take up, a menu that people want to engage with that's relevant to them? ”

## Why is this a challenge?

- **Healthcare are having to manage increased need and complexity**, what are the opportunities to strengthen knowledge and capacity through joined up working (e.g., between primary care, secondary acute care, and secondary mental health teams)
- **Information on services/interventions on offer for patients with SMI is difficult to access and not all in one place.** There is a need for a central directory of offers but this often gets out of date quickly and takes a lot of research to keep updating it
- **Receptionists are often the first point of contact and therefore play a critical part of a service users' journey in healthcare.** How can receptionists be better supported to strengthen contacts they have with SMI?



## Action/ recommendation

**ICSs to review how the relevant staff can access the appropriate information and advice in line with the expectations of their roles and responsibilities to effectively support patients with SMI**

- ✓ Review the role and expectations of generalist staff- if they are required to deal with patients with more complex needs ICSs will need to ensure that they have the relevant training or support, for example use of **Connect Care** in SEL
- ✓ VCSE organisations to play a role in sharing information and advice to local communities. **Sutton Wellbeing Service** and **Coffee Afrik CIC** are examples of where this has worked well
- ✓ Provide platforms for patients to find more information and advice for their physical and mental health needs, for example **Me and My Medicines** tool that helps service users and families raise important questions around their medicine and Patient portals and apps e.g **Beth** and **Leeds Care Record**

# The post-pandemic infrastructure is not aligned to higher volume and higher acuity of need

Patients with SMI accessing their GP practice, for their PH check or wider MH needs is challenged due to the higher volume and higher acuity of needs of this population group. This is important as PH checks may be the first and only point of contact but the current infrastructure is not set up to respond to the wider physical and MH needs of this group.

“ I think primary care needs to look into ease of access. The things that we did have pre-covid are now gone- I'm not sure how we will get that back but I can completely see that that is a barrier. In that sense, 'something is being done to me and I have no control over it' which would feed into that sense that 'nobody's really that interested' so I can completely understand ”

## Why is this a challenge?

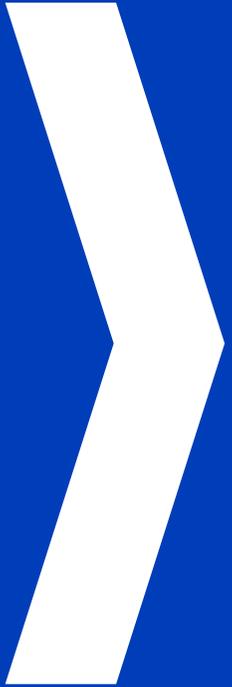
- **It is difficult to manage or triage SMI patients that need a GP appointment for both their PH check and complex MH needs-** primary care services are overwhelmed with higher volume and higher acuity of needs (due to COVID-19) which makes a PH check appointment more complex and difficult to manage (booking and the appointment itself)
- **Higher acuity of SMI patients means that current PH checks do not cover the complexity of need-** PH checks are seen as a small element of the whole picture for patients but this leaves generalist staff (including GP receptionist) underkilled during a time where COVID-19 pressures remain high
- **There is no clear process to manage or triage patients remotely-** receptionist or online booking platforms do not provide enough information on the complex MH needs of SMI patients which means both PH checks and supporting complex MH needs get missed e.g patients disengage



## Action/ recommendation

### ICSs to review and agree appropriate first point of contact access points for SMI patients – including PH checks and follow-up interventions

- ✓ Understand the appropriate access points in relation to the different levels of needs of patients with SMI so that healthcare staff are adequately supported to provide effective care; for example **Management and Supervision Tool (MaST)** dashboard that uses predictive analytics to identify patients with higher level needs
- ✓ Review alternative methods (or adaptations required) to allow SMI patients access appointments for both physical and mental health needs
- ✓ Consider alternative ways to do a physical health check with a person that has a serious mental illness/complex MH need that does not involve a letter or appointment with the GP; for example this may be an interactive app or a person that is able to meet and support that person



For more information on good practice examples, please see the following four slides.

# Good practice examples

## 1. Shared information and advice for local community through local VCSE organisation - [Coffee Afrik CIC](#)

We work alongside the NHS to bring a transformative approach to MH provisions by focusing on providing culturally sensitive signposting services. Our community-led approach looks at developing social action projects led by citizens. We have built an innovative approach to deliver the support they need when they need it, with a focused no referral pathway approach.

## 2. [Sutton Wellbeing Service](#)

Supports people to connect and access activities and resources to meet their physical, social and emotional needs provided by SWLSTG NHS MH Trust in partnership with third sector partners. They support people to cope in the present and be able to help their selves in the future. This may be through building on existing strengths, developing new skills or social relationships.

## 3. [PRIMROSE - A | Psychiatry - UCL – University College London](#)

It is an intervention which uses a series of 8-12 appointments provided in primary care to patients with SMI, to set health and wellbeing goals with a view to improving physical and mental wellbeing. The original study found that the main improvement was in people's mental health (reduced hospital admissions). An adapted version of Primrose called Primrose-A was developed after this, incorporating additional sessions with people with lived experience (e.g. peer coaches) – this was rolled out in Camden and then elsewhere in NCL.

## 4. [Proactive care frameworks | UCLPartners](#)

There is a new project underway in which UCLP are adapting their proactive care frameworks (which identify patients at high risk of ill health and ensure they have prescribing and behaviour change interventions) for patients with SMI and combining them with the Primrose model to ensure that interventions like medicines optimisation are also available to patients who need them. This is being trialled in NCL and Yorkshire and Humber (with funding from NIHR).

# Good practice examples

## 5. Salford Together

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Salford Together is a partnership between Salford City Council, NHS Salford Clinical Commissioning Group, Salford Royal NHS Foundation Trust, Salford Primary Care Together, Greater Manchester Mental Health NHS Foundation Trust and Salford CVS. The partnership is working to transform the health and social care system in Salford by integrating health and social care, bringing the services of GPs, nursing, social care, mental health, community based services and voluntary organisations into a more joined up system that focuses on a person's individual needs and provides them with the support to manage their own care.

## 6. Healthy Liverpool The Blueprint

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It is a new model of care that will transform the whole health and social care system in Liverpool leading to improving outcomes for patients and new ways of working. Their vision is for Liverpool to be the most active Core City in England by 2021, inspiring and enabling people who live and work in Liverpool to be active every day for life. Liverpool will have a health and social care system that is person-centred, supports people to stay well and provides the very best in care.

## 7. MH Trust patient portal- Beth app – Developed by SLaM

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Beth is a free and secure way for patients and carers to stay connected with their care team. Patients or service users can use Beth on mobile phone or computer to record personal goals and coping strategies, view their care plan, view appointments, track their progress, message their care team, access a secure diary, a private place for you to reflect on your health.

## 8. Multi-partners shared care records- Leeds Care Record

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A joined-up digital care record which enables clinical and care staff to view real-time health and care information across care providers and between different systems. It is a secure computer system that brings together certain important information about patients who have used services provided by their GP, at a local hospital, community healthcare, social services or MH teams.

# Good practice examples

## 9. Partnering Health Digital apps (Patient Knows Best)

Patient Knows Best (PKB) is a technology platform, designed to bring together patient data from health and social care providers and the patient's own data, into one secure personal health record. Patients can login to access everything from appointment letters and test results, to their multi-disciplinary care plans. In 2019, Patients Know Best (PKB) partnered with NHS Digital to develop a landmark integration between the PKB personal health record platform and the NHS App. This offered patients all their PKB features, functionality and data, inside the national NHS App interface.

## 10. Healthcare professional advice and information platform- Connect Care – Developed in South East London

It is a local electronic record which allows important information from separate record systems to be viewed quickly and safely, by staff directly involved in your care on a need to know basis. It does not gather new information; it makes existing information more readily available anywhere that you receive care.

## 11. Management and Supervision Tool (MaST)

It is a powerful and easy to use dashboard which uses predictive analytics to identify those people who are most likely to require crisis services such as A&E, Community Crisis Services or inpatient care. MaST supports improved caseload management. It also ensures decision-making about resource allocation is based on service user needs. MaST enables clinicians to adopt a dynamic approach to skill resourcing and prioritising care pathways. By providing insight into people's risk of using crisis services and identifying those who may benefit from a review of their care, this more structured approach to decision-making improves resource management and supports better care.

## 12. Tools to help patients raise concerns about their medication- Me and My Medicines

It is a campaign led by patients and supported by clinical staff to help people raise concerns and use their medicines better. This will help everyone benefit from more effective and safer care. 'It's OK to Ask' means patients, families and carers are encouraged to ask questions about their medicines so that they can be helped to get the most benefit. Medicines are widely used by the NHS to prevent and treat poor health. When medicines are not taken or used properly, it can lead to poor and worsening health and wellbeing. The Medicines Communication Charter is a way of encouraging the conversation around medicines between the patient and healthcare professionals.

## 13. DIALOG

It is a set of 11 questions where service users are asked to rate their satisfaction and needs for care across different parts of their life and treatment. DIALOG is simple to use and it enables proactive, personalised conversations at an individual level, supporting self-management and helping service users move forward with their journey of recovery. It has also been used to help inform the redesign of care planning processes within mental health services.