UCLPartners

Introduction to **UCLPartners-Primrose**

For people with Severe Mental Illness

Welcome to the UCLPartners-Primrose Framework for People with Severe Mental Illness

This document provides an overview of the UCLPartners-Primrose framework (also known as UCLP-Primrose). This framework has been designed to help primary care teams to maximise the benefits of the physical health check for people with Severe Mental Illness and to improve outcomes for this vulnerable population.

The Challenge

People with Severe Mental Illness (SMI) die on average 10 to 20 years earlier than people without Severe Mental Illness. Much of this premature mortality is due to heart attack, stroke, respiratory disease and cancer. And this in turn is caused by common risk factors such as high blood pressure, high cholesterol and smoking.

These risk factors are high impact but also highly modifiable – for example, treatment to lower blood pressure or cholesterol, and help to quit smoking, substantially reduce the risk of developing and dying from these conditions. But optimal treatment in these conditions can be difficult to achieve in people with SMI – indeed late detection and under treatment is common and is likely to explain much of the premature mortality in this population.

What is UCLP-Primrose?

UCLP-Primrose brings together two major innovations:

The UCLPartners Proactive Care Frameworks that use stratification to identify patients who need priority management, and deploy the wider primary care workforce to provide structured support for patient education, self-management and behaviour change.

Primrose A, an evidence-based approach to delivering intensive, tailored support for people with SMI that has been shown to deliver improvements in mental health and reduce healthcare costs.

Primrose-A was developed and delivered collaboratively with patient and public involvement throughout including the research design, intervention development and delivery and interpretation of results with a Lived Experience Advisory Panel (LEAP).

UCLP-Primrose has been developed to maximise the benefits of the SMI physical health check and to help people with Severe Mental Illness to receive the best care for their physical health as well as their mental health.

The framework is designed so that those patients with the greatest clinical risk from physical risk factors are prioritised so that their treatment can be optimised. Alongside this, patients receive structured support for education and self-management, and holistic support for wider health and social needs.

The core principles of UCLP-Primrose:

1. Focused interventions to optimise care and prevent premature death and disability in a highly vulnerable population.
2. Integrate mental, physical and social support.
3. Risk stratify and prioritise – see those with greatest need first.
4. Focus both on patient priorities and on the high impact, highly modifiable clinical risk factors.
5. Provide intensive clinical management of risk factors.
6. Use the wider workforce (e.g. Healthcare Assistants, wellbeing coaches) with appropriate training to provide structured support for patient education and self-management of physical conditions, working with patients and supportive others.
7. Provide lifestyle behaviour change support with brief interventions and signposting for all, including patient-led targeted goal setting.
8. Provide intensive behaviour change interventions where appropriate.

Priority 1
CVD risk factors poorly controlled
Obesity on antipsychotic medication

Priority 2
No BP in 18 months (proxy for health check and possible indicator of non-engagement)

Priority 3
All others with CVD risk factors

Priority 4
All others

Invited for SMI Annual Health Check

Patient engages

Patient does not engage

The Physical Health Check: HCA* *(default pathway)*

- Physical health check e.g. BP, weight, bloods, screening
- Identify physical health red flags
- Structured support for education and self management
- Identify social concerns & mental health red flags
- Explore patient's priorities
- Assess carer/friend/formal support needed to address physical health
- Brief interventions and signposting (e.g. smoking)

*This may be a HCA or another member of the wider workforce eg wellbeing coach, social prescriber.

Clinical Review: Nurse/pharmacist/GP

- Review clinical conditions
- Optimise medication
- Manage clinical risk factors & co-morbidities
- Agree health priority and behaviour change goals

Intensive Support for Behaviour Change: Trained staff member

- Working intensively on patient-led cardiovascular goals e.g. smoking cessation, weight management, adherence
- If available, Peer Coaches to provide less structured appointments to support the CVD goal or separate recovery focused goal

Mental Health Review: MH nurse

- Undertake desktop review of patient to assess their mental health/complexity, to determine reasons they may not be engaging, and to assess their need for support
- Contact patient/ family/MH services to assess current mental health
- Review and respond to mental health needs
- Oversee and support patient journey where required
- Allocate staff member to accompany to appointments where needed
- Joint consultations with clinician or HCA type role as needed for physical health interventions
- Support behaviour change with brief and intensive interventions
- Refer for peer support if available and desired.

Outreach

- Home visits
- Accompany to appointments

Specialist Support

- Core Community Mental Health Service or Specialist Mental Health Team

Wider Social Support: Social provider

- Maximise use of existing structures (social prescribing, MIND, care navigators) to address wider wellbeing concerns e.g. isolation/ accommodation/financial concerns. All clinicians to support patients to engage with wider social support at each stage in the Pathway, if needed.

UCLPartners –Primrose: The Pathway

The UCLP-Primrose Pathway

A Risk Stratification

Patients with SMI are stratified into priority groups based on clinical criteria. In priority order, patients are invited for an SMI health check. See the **'UCLP–Primrose Search and Stratification Tool'** guide.

B The Physical Health Check

For all patients who respond to their health check invitation, the first appointment will be with an additional role staff member e.g. a healthcare assistant (HCA). The health check involves measuring things like weight, height, blood pressure; doing some blood tests and reviewing medication; and talking with patients about their health and how they could improve it. This appointment will also provide the patient/carer with structured education about their condition, support for self-management (for example blood pressure measurement, inhaler technique), explore the patient's heath and wellbeing priorities and provide brief interventions with signposting for lifestyle risk factors. This proactive care consultation is not delivered in isolation, and the HCA or other staff member will liaise closely with the GP, nurse and mental health professional to ensure that care is joined up, that patients are supported to make and keep appointments, and that the clinician is on hand when physical or mental health red flags are identified. During this appointment, it's also essential for the HCA to ask about any wider wellbeing or social support needs that the patient may have, and to support patients to access existing services as required. See **'The Physical Health Check'** manual.

C The Mental Health Review

For patients who do not respond to the physical health check invitation, a mental health (MH) nurse conducts a desktop review of their records to assess complexity and need for support to engage. They will arrange a first appointment with the patient in clinic if possible, or at home if engagement and attendance is likely to be difficult. Where the MH nurse has the initial appointment with the patient, they will assess and respond to the patient's mental health needs, explore their health and wellbeing priorities, arrange an appointment (accompanied if needed) with the HCA, and subsequently oversee support and management. The HCA will then conduct the physical health check and provide the structured support for education, self-management and behaviour change. Where needed, they will offer support to attend appointments, then arrange an appointment with a nurse, pharmacist or GP for clinical input (see D). Each of these interventions may require one or more appointments and this will be flexed according to the patient's needs. See **'The Mental Health Review'** guide.

D The Clinical Review

As a result of the physical health check, some patients will be identified as having abnormal results, or as needing further clinical input. These patients will therefore be referred for a Clinical Review so that a clinician can review their clinical conditions and optimise medication to manage the high impact risk factors such as blood pressure, cholesterol and diabetes.

E Intensive Support for Behaviour Change

From each of these consultations, the patient can be offered more intensive support for behaviour change where this is indicated and accepted – delivered by a team member with appropriate training (the 'intensive behaviour change practitioner'). Such patients will be offered up to 8 sessions on co-developed cardiovascular goals. This may include for example smoking cessation, weight management or medication adherence. If available within the practice, the patient can also be offered peer coaching to support their CVD goals, or to support with wider social or recovery goals. See the **'Intensive Support for Behaviour Change'** manual and **'Peer Coaching'** guide.

Throughout all these stages, **clinicians should be mindful of any wider needs** that the patient may have beyond their physical health. Please be alert to any need for social support, benefits, housing etc. and ensure to support the patient to address these needs using local resources, e.g. social prescribing, care navigators, VCSE groups.

Resources to support UCLP-Primrose

The **UCLP-Primrose Proactive Care website** includes a wide range of resources including guides and protocols, digital tools for patients and staff, and guidance on training that staff will need to deliver the proactive care consultations.

Please see the following links for Primrose publications:

- https://www.journalslibrary.nihr.ac.uk/pgfar/pgfar07020#/scientific-summary
- https://www.arc-nt.nihr.ac.uk/research/projects/primrose-reducing-cardiovascular-disease-risk-in-people-with-mental-illness

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