Who will perform the MH review:

Who will perform outreach? Scope for mobile PH check?

Procedure for no contact:

Do all Primrose clinicians know the support services that are available in local area? And referral/support to access process?

If participating in Primrose, do secondary care colleagues know available wider support and how to refer?

Who will do the health check?

How will they refer for a clinical review?

How will they set next appointment? And 1 year follow up?

Secondary care share results with primary care?

Who will run the search tool?

Where will the results be sent/ how will they be used? E.g. Only primary care, or ross-referencing with secondary care clinics/ CMHTs?

How will clinicians refer patients for intensive support?

Are wider workforce aware of UCLP-Primrose (social prescribers, pharmacists, GPs etc.)?

How will appointments be set?

How will they provide follow up information/results?

Do people from CMHT’s know about UCLP-Primrose?

How will you communicate with them about such patients?

Who will be the Intensive behaviour change practitioner?

Are there peer workers to support? If so, what’s the referral process?

How will the next appointments be set?

Who will send invites to the health check:

How (letter, call):

How many times:

Who will refer for MH review and when:

**Outcomes**:

* What does success look like for you, in relation to this pathway? What are you hoping for? How will you measure success?

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**UCLPartners**

**–Primrose:**

**The Pathway**

**Intensive Support for Behaviour Change:**

Trained staff member

Review clinical conditions

Manage clinical risk factors

& co-morbidities

Optimise medication

Agree health priority and

behaviour change goals

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

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

.

**Outreach**

Home

visits

Accompany

to appointments

**Patient does not engage**

**Priority 1**

CVD risk

factors poorly controlled

Obesity on antipsychotic medication

**Priority 2**

No

BP i

n 18 months (proxy

for health check and possible

indicator of non-engagement)

**Priority 3**

All others with CVD risk factors

**Priority 4**

All others

Physical

health check

e.g. BP, weight, bloods,

screening

Identify physical health

red flags

Structured support

for education and self

management

**Wider Social**

**Support:**

Social

provider

**Invited for SMI Annual Health Check**

**Patient engages**

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.

**Specialist Support**

Core Community Mental Health Service

or Specialist Mental Health Team

**The Physical Health Check:**

HCA\*

*)*

*default pathway*

*(*

**Clinical Review:**

Nurse/pharmacist/GP

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.