The Physical Health Check

The UCLPartners-Primrose guide to improving the physical health of people with Severe Mental Illness

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

Person with lived experience of severe mental illness

Welcome to the UCLPartners-Primrose Physical Health Check Manual

This guide is to support HCAs or other staff providing the physical health check to people with SMI.

Health checks and support to improve overall physical health are important for everyone but especially for patients with Severe Mental Illness (SMI) because people with SMI in England die on average 15 to 20 years younger than the rest of the population.

It is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented. Recent evidence about the under-75 population in England shows that patients with SMI are 3 times more likely to die early from cardiovascular illness such as heart attacks or strokes; twice as likely to die of cancer; and nearly 5 times as likely to die of respiratory illness and liver disease than the general population.[1]

Video:
What is SMI? See page 4

This represents one of the worst health inequalities facing patients in the UK and across the world[2] but while this population have significant risk factors for physical illness, these risk factors can be reduced.

The UCLPartners-Primrose (UCLP-Primrose) framework has been developed to help people with severe mental illness receive the best care for their physical health as well as their mental health.

This training manual outlines how a ‘health check’ can be used as a tool to help patients to identify their own physical health risk factors and also, how to give patients support to reduce these risks.

Video:
The link between SMI and CVD?
See page 6

You’ll find in this short manual both physical and mental health information, videos about SMI, aid memoires and signposts to other resources to help you support patients with SMI reduce their physical health risk factors.

1. Excess under 75 mortality rates in adults with serious mental illness - NHS Digital
2. Disparities in COVID-19 infection, hospitalisation and death in people with schizophrenia, bipolar disorder, and major depressive disorder: a cohort study of the UK Biobank - PubMed (nih.gov)

Video resources:

Explaination and advice videos with consultant psychiatrist Ed Beveridge.

What is SMI?

2 minutes

https://bit.ly/3x7Rfd1

What is the link between SMI and CVD?

3.4 minutes

https://bit.ly/3sRfwTd

Advice on working with those who have an SMI.

3.2 minutes

https://bit.ly/3yYyKtV

The physical health check & supporting self management

Some people have a very high risk of cardiovascular disease while others may be at lower risk but everyone can reduce their risk of cardiovascular disease. The purpose of this health check is to prevent serious cardiovascular disease from developing or getting any worse.

The Health Check involves measuring things like weight, height and blood pressure; doing some blood tests and reviewing medication; and talking with patients about their health and how they could improve it. Reducing cardiovascular risks and improving health always involves changing behaviours, (like stopping smoking, losing weight or taking regular medication) and these can be very difficult changes to make.

There are three parts to this Physical Health Check:

1

Find patient's health information before the appointment (on file)

2

Meet the patient (face-to-face):

a. For Physical Measurements

b. To discuss health goals and support the patient in self-managing their health

3

Make onward referrals as needed and order additional tests as indicated

You'll find a section below guiding you through each part.

Find health information before the appointment

Review the Electronic Patient Record and start filling out the Physical Health Check template with up to date information on file

Make a note of anything that's missing

You'll find a list of all the information needed under Appendix a: Physical Health Check Measurement

Meet the patient (face-to-face)

Booking an Appointment

Call the patient and ask them whether they'd like to meet you for a routine check-up. Ask them if there is anything concerning them about their health at present and encourage them to come to the surgery so you and the primary care team can support them.

Make a note in their file of your conversation.

Talk to a GP or Practice Nurse about what you have found out about the patient prior to the health check.

Considerations you might need to make:

Be flexible: some mental health medicines can be quite sedating, meaning afternoon appointments are better than the morning – ask the patient what would be best.

Video:
Working with those who have an SMI

Make longer/multiple appointment times: many patients with SMI will need a longer appointment than is generally given – as they may take longer to express themselves or take on board your explanations about their health check. You may need a second appointment to complete the check.

Invite them to bring someone they trust: some patients with SMI may struggle to trust someone they do not know. They may need additional help from a friend, family member or someone else in their network to engage with their appointment(s). Check with them who else is involved and whether they are happy for you to speak with them if you need to.

Ask the patient to share their health concerns, make a note of their priority:

- Lose weight
- Stop smoking
- Reduce their blood pressure
- Reduce their cholesterol
- Control their diabetes
- Managing any other health conditions
- Any other concerns

At the Appointment

Talk with them about their health – ask **open** questions encouraging them to share their opinion of their physical health and how they'd like it to change.

Ask permission to check some physical health measurements (weight/height/BP/HR) and do some blood tests. **These tests will help the patient and you better understand their current health.**

Complete as much of the physical health check as you can using local templates and Appendix A [p20] as a memory aid. You might be limited by the appointment time or the patient may not want you to do any more. Listen for red flags – anything the patient says or you find out about their physical health or mental health which puts them in danger. The following page lists some things to watch out for and escalate to a clinician the same day.

Either in the time left over or by booking a second appointment, discuss the relevant areas of health that the patient would like to talk about and improve. They might want information, signposting or advice. Use the Physical Health Crib Sheets (p11–21) for guidance.

Don't forget to make sure you have a plan for outstanding test results (e.g. blood tests you have taken at this appointment) to be fed back to the patient.

Mental Health Red Flags

Patients may disclose information or staff may notice changes in behaviour or appearance during the course of the consultation that may be signs of mental health deterioration.

Examples may include:

- Thoughts of harming themselves or others
- Safeguarding concern (meaning that the patient may be subject to abuse or neglect from someone else)
- Self-neglect, such as poor hygiene
- Becoming less communicative/more withdrawn
- Poor sleep
- Irritability, hostility, changes in how they relate to you
- Appearing distracted or responding to unseen stimuli
- Their speech making less sense, words becoming muddled
- Any other changes in how they appear or behave which you are concerned about
- If in doubt about any change in the patient's mental state or presentation – discuss case with GP or MH nurse who may wish to see the patient or refer on for specialist intervention

Escalate concerns/red flags urgently to a GP or MH nurse

Physical Health Red Flags

Please refer to a clinician the **same day** if you find:

- A repeated blood pressured reading is **above 180/110**
- The patient feels unwell (e.g. headache or chest pain or dizziness)
- The BP is **below 90/60**

Raised cholesterol:

If a patient is known to have had a heart attack or stroke they should be taking high dose statins regardless of their blood cholesterol level.
If they are not on a statin – please refer to a clinician

If patient has not had a previous heart attack or stroke) but has **QRISK >10% please refer to a clinician for consideration of statins**

Known Atrial fibrillation:

Is the patient currently taking a blood thinner such as Apixaban, Dabigatran, Edoxaban, Rivaroxaban or Warfarin?

If No, calculate CHA2DS2VASc and refer to GP

If their pulse irregular and not known AF – refer to a clinician

Video resource:

Consultant psychiatrist Ed Beveridge talks through Mental health red flags and what to do if you're worried.

2 minutes
https://bit.ly/39SX4CN

3

Make onward referrals as needed and order additional tests as indicated

Check whether any of the additional monitoring or further follow up is needed. Discuss this with a clinician if you are unsure.

Following the appointment, you will have agreed some next steps. This might include blood tests, referral, follow up appointments or urgent conversations with a GP or practice nurse.

Supporting Lifestyle Change

Advice and resources to support education and self management

Discuss the following sections if they are relevant

Obesity

Defined as BMI above 30kg/m2.

Knowledge

It is very important to take steps to tackle obesity because, as well as causing obvious physical changes, it can lead to a number of serious and potentially life-threatening conditions including diabetes, heart disease, stroke and some types of cancer

Obesity can also affect quality of life and lead to psychological problems, such as depression and low self-esteem.

Obesity is generally caused by consuming more calories, than you burn off through physical activity. The excess energy is stored by the body as fat.

The best way to treat obesity is to exercise regularly and eat a healthy reduced-calorie diet.

Resources to share

Patient education on above and management – **see Exercise and Diet sections to follow.**

Exercise

Knowledge

Aim for at least 150 minutes of moderate intensity activity a week or 75 minutes of vigorous intensity activity a week

Moderate activity will raise your heart rate, and make you breathe faster and feel warmer. One way to tell if you're working at a moderate intensity level is if you can still talk, but not sing.

Examples of moderate intensity activities include brisk walking water aerobics or riding a bike

Vigorous intensity activity makes you breathe hard and fast. If you're working at this level, you will not be able to say more than a few words without pausing for breath

In general, 75 minutes of vigorous intensity activity a week can give similar health benefits to 150 minutes of moderate intensity activity.

Examples of vigorous activities include: running, swimming, riding a bike fast or on hills

Resources to share

Resources:

- http://nhs.uk/live-well/exercise/
- http://nhs.uk/better-health/get-active/

Consider referral to exercise on prescription if indicated.

Diet

Knowledge

Consuming more calories than we burn, causes our bodies to store any extra as fat. Over time this will mean weight gain. The calorie content can usually be found on the nutrition label under energy and shown as a number of kcals.

Check the labels and swap in foods that are lower in saturated fat and Kcal. Ensure the diet contains fresh fruit and vegetables.

Healthier snacks include fresh fruit, unsalted nuts or seeds, plain rice cakes and low-fat yoghurt

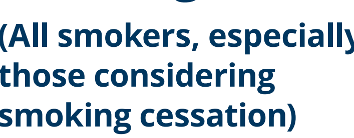
Resources to share

Resources on healthy eating:

- http://nhs.uk/oneyou/for-your-body/eat-better/
- http://heartuk.org.uk/healthy-living/introduction
- http://bhf.org.uk/informationsupport/support/healthy-living/healthy-eating/salt

Smoking

(All smokers, especially those considering smoking cessation)



Knowledge

Stopping smoking is one of the best things you can do for your health. Within days of stopping smoking, your health will begin to improve and within a year their risk of heart disease will be halved.

It's never too late to benefit from stopping. Being smoke-free not only adds years to your life, but also greatly improves your chances of a disease-free, mobile, happier old age.

Within 2 to 12 weeks of stopping smoking, your blood circulation improves. This makes all physical activity, including walking and running, much easier. Other benefits include improved fertility, better sex and protecting your family from the effects of second hand smoke.

Resources to share

Resources to help stop smoking:

- http://nhs.uk/better-health/quit-smoking/(also contains a free downloadable app to support you.)
- http://nhs.uk/conditions/stop-smoking-treatments/

Refer to a clinician/smoking cessation service if they wish to consider smoking cessation.

Alcohol

Knowledge

Both men and women are advised not to regularly drink more than 14 units a week.

A small 125ml glass of wine, for example is 1.6 units and there are around 10 units in the average bottle of wine.

An average pint of beer is around 2 units depending on how strong it is. For a very strong pint of beer this rises to 3.5 units.

A single gin and tonic is approximately 1 unit.

Drinking too much alcohol increases the risk of serious health conditions including heart disease, stoke, cancer and pancreatitis.

If someone loses control over their drinking and has an excessive desire to drink, it's known as dependent drinking (alcoholism).

Dependent drinking usually affects a person's quality of life and relationships, but they may not always find it easy to see or accept this.

A dependent drinker usually experiences physical and psychological withdrawal symptoms if they suddenly cut down or stop drinking, including: hand tremors – "the shakes", sweating, depression, anxiety and difficulty sleeping. This often leads to "relief drinking" to avoid withdrawal symptoms.

Resources to share

Resources to help reduce drinking:

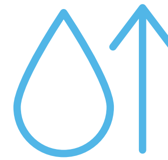
- https://www.nhs.uk/conditions/alcohol-misuse/treatment/

Refer patients to a clinician if the wish to consider medications to help reduce drinking alcohol

Health Conditions

Advice and resources to support education and self management

Raised cholesterol



Knowledge

Cholesterol is a fatty substance which is made in the liver. It is also found in some foods. Having too much cholesterol in our blood can clog up arteries and lead to health problems in the future.

Some of our cholesterol comes from the food we eat, but most is made in the liver.

Your cholesterol can become raised for a number of reasons:

1. A diet high in saturated fats.
2. Not being active enough so the fats you eat are not used up.
3. Genetic conditions which mean the fats are not processed in the usual way.

In addition to lifestyle changes, medications will also help reduce the cholesterol levels in your blood.

If a patient is known to have cardiovascular disease (previous heart attack or stroke) they should be taking high dose statins regardless of their blood cholesterol level. If they are not on a statin – refer to a clinician

If the Qrisk >10% - consider diet and lifestyle changes AND medications (such as statins) to reduce cardiovascular risk. If Qrisk>10% - refer to a clinician.

Resources to share

- https://hf.org.uk/informationsupport/risk-factors/high-cholesterol
- https://heartuk.org.uk/cholesterol/what-is-high-cholesterol

Hypertension

(high blood pressure)

Knowledge

A blood pressure reading has 2 numbers, for example 130/80. The top number is the force of blood against your artery walls when your heart contracts. The lower number is the force when your heart relaxes.

Prolonged high blood pressure damages your arteries and increases your risk of heart attack, stroke and dementia.

Normal blood pressure for adults aged under 80 years is below 135/85 mmHg.

Normal blood pressure for adults aged 80 years and over is below 145/85 mmHg.

Please note that the above values are for home blood pressure monitoring. The acceptable blood pressure values in the clinic are slightly higher.

Home blood pressure monitoring:

The patient will need an approved BP machine less than 5 years old.

- https://bihsoc.org/bp-monitors/for-home-use/

If they are willing to purchase a machine – please direct them to this website:

- https://giftshop.bhf.org.uk/medical-devices/blood-pressure-monitors

Please ensure you measure your cuff size to for accurate BP measurement.

- bhf.org.uk/informationsupport/heart-matters-magazine/medical/tests/blood-pressure-measuring-at-home

Here is a helpful video on home BP measurement:

- bhf.org.uk/informationsupport/heart-matters-magazine/medical/tests/blood-pressure-measuring-at-home

Take a total of three blood pressure readings, waiting 1-2 minutes between each reading and then record the lowest of the 3 measurements.

Please refer to a clinician the same day:

If a patient's repeated BP reading is above 180/110 (or similar) AND/OR the patient feels unwell (e.g. headache or chest pain).

If the BP is below 90/60 (or similar) AND/OR the patient feels unwell (e.g. dizziness.

Resources to share

Resources:

- https://bhf.org.uk/informationsupport/risk-factors/high-blood-pressure
- https://stroke.org.uk/what-is-stroke/are-you-at-risk-of-stroke/high-blood-pressure

Atrial fibrillation

Knowledge

Atrial fibrillation or AF is a common abnormal heart rhythm. AF happens when electrical impulses fire off from different places in the top chambers of the heart (the atria) in a disorganised way. It causes an irregular and sometimes very fast pulse.

AF increases your risk of a blood clot developing in your heart which can travel to your brain and cause a stroke.

People with AF are usually prescribed a blood thinning medicine to reduce the risk of stroke.

Is the patient currently taking a blood thinner such as Apixaban, Dabigatran, Edoxaban, Rivaroxaban or Warfarin?

- if No, calculate CHA2DS2VASc and refer to GP.
- If pulse irregular and not known AF – refer to a clinician

Resources to share

- https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/living-with-atrial-fibrillation
- https://uclpartners.com/work/anti-coagulation-videos/

Diabetes

Knowledge

Type 2 diabetes is a condition where blood sugar levels keep rising and because the insulin your body does not make enough insulin or it does not work as effectively.

If left untreated, high sugar levels in the blood can seriously damage parts of the body, including eyes, heart and feet. These are called the complications of diabetes.

With the right treatment and care, the effects of diabetes and high blood sugar levels can potentially be reversed and certainly managed.

Foot checks
With diabetes, patients are much more likely to develop problems with their feet such as ulcers. With regular foot checks and good care, they can reduce their risk of developing foot problems.

Encourage patients to check their feet at least once a month and if they see any changes or anything unusual, please contact their GP

Eyesight
It is important to attend regular eye screening appointments when invited as this is the best way of picking up problems early.

Resources to share

NHS UK video library:
- https://player.vimeo.comvideo/215821359

Healthy eating with Diabetes:
- https://www.diabetes.org.uk/preventing-type-2-diabetes/ten-tips-for-healthy-eating

NHS UK video library:
- Fats and Oils https://player.vimeo.comvideo/215816344

Type 2 Diabetes and exercise

NHS UK video library:
- https://player.vimeo.com/video/215817415 www.diabetes.org.uk/preventing-type-2-diabetes/move-more

Public Health England Resources to support exercise at home:
- https://campaignresources.phegov.uk/resources/campaigns/50resourceordering/resources/5118
- https://diabetes.org.uk/Preventing-Type-2-diabetes/Waist-measurement
- https://nhs.uk/oneyou/for-your-bodymove-more/

Additional resources

Hypertension:
- https://s31836.pcdn.co/wp-content/uploads/Resources-for-hypertension.pdf

Diabetes
- https://s31836.pcdn.co/wp-content/uploads/Resources-for-T2-Diabetes.pdf

Atrial Fibrillation
- https://s31836.pcdn.co/wp-content/uploads/Resources-for-AF.pdf

Lipid Management
- https://s31836.pcdn.co/wp-content/uploads/Resources-for-Cholesterol.pdf

Appendix a: Physical Health Check Measurement

Measurement	Refer if:
Weight and BMI	
An assessment of alcohol consumption	Wishes to reduce alcohol consumption
An assessment of smoking	Wishes to stop smoking
Blood pressure	BP > 140/90
Screen if pulse is regular or irregular.	Pulse irregular – Not known AF
Check if taking medication regularly'	Refer if not taking medication regularly or if concerns
Annual blood llpids and QRisk score	If the patient: • has a CVD (eg previous heart attack or stroke) and is not on statins • does not have CVD and the QRisk is >10%
Annual Blood glucose test or HbA1c Renal function and thyroid function tests if on lithium.	
Check to ensure has been offered usual screening – breast screening, cervical screening and bowel cancer screening	

Additional Monitoring:

For patients known to have ANY of Hypertension, Raised cholesterol, Atrial Fibrillation or Diabetes – please ensure the following monitoring is up to date.

Measurement	Test results
Hypertension	Annual Renal function, urine albumin:creatinine ratio (ACR), and lipid profile*
Raised cholesterol	Check if on statin – refer if not. Annual Lipid profile
Atrial Fibrillation	Blood tests (full blood count, liver function test, lipid profile* and renal function) (NB: May require more frequent renal function tests if on blood thinning medication). Check if on anticoagulant – refer if not with CHA2DS2VASc Score, HASBLED Score
Type 2 Diabetes	HBA1c, urine ACR, lipid profile*, and renal function
Anti psychotics	Patients taking antipsychotics (e.g. as Olanzapine or Risperidone) or mood stabilisers (e.g. Lithium or Sodium Valproate) may need additional monitoring - please refer to local guidelines for relevant medicines or ask a nurse or GP for further advice)

* Lipid profile = Serum cholesterol, serum cholesterol/HDL ratio, HDL cholesterol, LDL cholesterol, serum triglycerides, non-HDL cholesterol

UCLPartners –Primrose: The Pathway

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)

Clinical Review: Nurse/pharmacist/GP

- Review clinical conditions
- Manage clinical risk factors & co-morbidities
- Optimise medication
- 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.

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

170 Tottenham Court Road
London
W1T 7HA
uclpartners.com
contact@uclpartners.com