UCLPartners

Intensive Support for Behaviour Change

The UCLPartners-Primrose guide to providing intensive support for behaviour change for a person with a Severe Mental Illness

Contents

Welcome to UCLPartners-Primrose. This manual focuses on the Intensive Support for Behaviour Change part of the UCLP-Primrose pathway. Please familiarise yourself with the manual. It will guide you through each stage of carrying out the Intensive Support for Behaviour Change process.

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Welcome to the UCLPartners-Primrose Intensive Support for Behaviour Change Manual

What is UCLPartners-Primrose?

The UCLPartners-Primrose (UCLP-Primrose) framework has been developed to help people with Severe Mental Illness (SMI) receive the best care for their physical health as well as their mental health. The framework is based on two existing programmes: the "Primrose Study," a programme of NHS and National Institute for Health Research (NIHR) funded projects, coordinated by University College London and the Primary Care Research Network between 2011 and 2017, and from which many of these documents originate; and UCLPartners Proactive Care Frameworks – a novel approach to managing long term conditions in primary care.

The UCLP-Primrose framework is designed so that those patients with the greatest clinical risk from physical risk factors are prioritised. This work is essential as people with SMI are dying much earlier than the general population (up to 20 years earlier), in most cases due to highly preventable causes, like poorly controlled diabetes, high cholesterol, high blood pressure and smoking. Working with the framework ensures that patients receive the treatment they need at the right time. Lowering blood pressure and cholesterol for example will lead to rapid reduction in risk of a heart attack or stroke.

All patients with a diagnosis of an SMI should be invited to an annual Physical Health Check. Based on the results of this, some patients will require more intensive support to make changes to their behaviour to help their physical health. This manual will describe this intensive support and how to provide it. The person appointed to the role of Intensive Behaviour Change practitioner will receive training on how to carry out the Intensive Support for Behaviour Change work.

How will UCLPartners-Primrose be provided?

UCLP-Primrose consists of multiple components depending on the needs of the patient, including the Physical Health Check, the Clinical Review, the Mental Health Review, Intensive Support for Behaviour Change, and signposting to other support services (see page 44-45 for how these components fit together).

For the Intensive Support for Behaviour Change component, over 6 months patients will receive:

8 x 30 minute consultations with the Intensive Behaviour Change practitioner

What role will you play?

Following the Physical Health Check and during the Clinical Review, the clinician may decide with the patient that more intensive support is needed to improve the patient's physical health. In this case, they will arrange with you, the Intensive Behaviour Change practitioner **(this may be a nurse, HCA, or other who has been trained in the Intensive Support for Behaviour Change delivery),** to work with the patient. Through goal identification, intensive support, and motivational feedback, you will help to support the patient to make the changes needed to really impact their physical health.

The Intensive Behaviour Change practitioners will communicate with all other clinicians involved with UCLP-Primrose throughout the process, explaining the goals the patient has decided to focus on and the progress they're making, as well as finding ways to overcome setbacks together.

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Organising and Providing Intensive Behaviour Change Appointments

Intensive Behaviour Change Appointments

The Intensive Behaviour Change practitioner will provide eight 30 minute consultations over a six month period. During your appointment with the patient, you will identify and agree patient-led goals to improve their cardiovascular health.

The goal will be different for each patient and will depend on their preference and on which factors are most important to their health.

This may include:

- Helping them to take statins, blood pressure or antidiabetic medication
- Stopping smoking
- Improving their diet
- Increasing their physical activity
- Reducing their alcohol intake

The Cardiovascular Health Goals (page 6) shows a variety of Cardiovascular Goals and actions that can be worked on with the patient. See the Appendix for Help Sheets that explain why each of these goals are important for physical health.

Once you have identified a goal, the patient will determine the type of support they think will best help them to achieve it. Patients may wish to receive support from you directly (e.g., to take statins, blood pressure or anti-diabetes medication, to stop smoking etc.), but it's important to also inform them about other support services that can help. Where possible, also make use of other support services (diabetes services, stop smoking, improve diet, or others) if they're available and the patient thinks they'll be useful. Please support patients to access these services.

Organising Intensive Behaviour Change Appointments

Check when patients would prefer to see you; this will be different for each individual.

To follow is a **suggested** appointment schedule for intensive support. In general, the length and number of appointments will depend on the patient. Some patients may want more/fewer appointments than the suggested schedule.

Please make sure you arrange the next appointment with the patient each time you see them. Record this in the patient's 'My Health Plan' (See page 29).

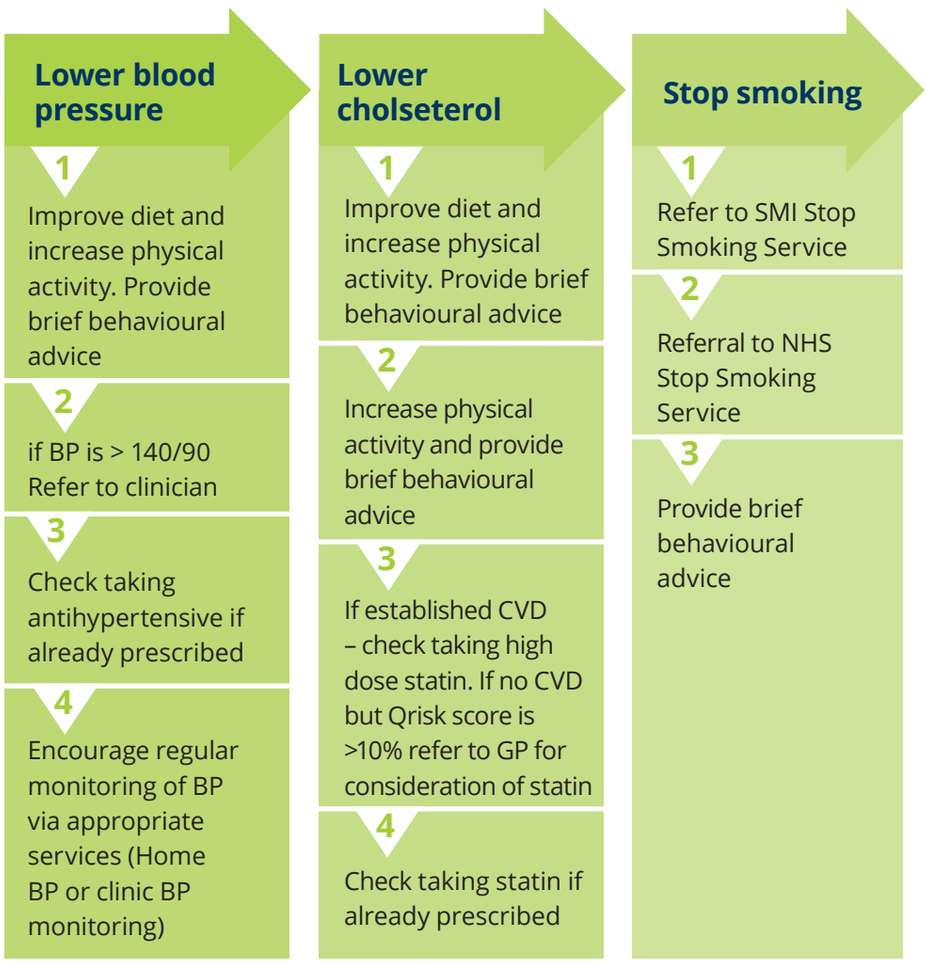
Suggested Appointment Schedule for Intensive Behaviour Change Sessions

Please arrange to see the patient over **eight appointments**. Aim to arrange the first four appointments fortnightly and then decrease them to every two to four weeks, depending on patient preference and progress.

If the patient would like help in attending diabetes services or a support service, they may want fewer appointments. If you are **providing behavioural advice** and support (e.g., to take statins, blood pressure or anti-diabetes medication, stop smoking etc.) **more intensive support may be needed.** Evaluate whether more sessions are needed at the end of each appointment.

UCLPartners-Primrose Flow Chart: Cardiovascular Health Goals

These are suggested behavioural goals to be covered in the **Intensive Behaviour Change appointments.** Choose one **initial behavioural goal with each patient**. **Encourage prioritisation of the outcome on the left** – this will have an earlier/larger impact on CVD risk. Move to the right if the outcomes are not relevant to the patient and their health. In some instances, the patient might choose a goal that is less of a priority according to this flow chart. Note that some behavioural goals will impact on more than one outcome – e.g., taking medication regularly, improving diet and physical activity.



Flow Chart 1

Suggested Appointment Schedule for Intensive Behaviour Change Sessions

First appointment	Appointments 2–4	Appointments 5–7	Final Appointments
Length: 30–40 mins	**Length:** 20–30 mins	**Length:** 20–30 mins	**Length:** 30 mins
When: Week 1	**When:** Fortnightly	**When:** 2–4 weeks	**When:** Week 24

Manage diabetes

1. Improve diet and increase physical activity. Provide brief behavioural advice
2. Check taking medication as prescribed.
3. Encourage engagement with screening – eye and kidney screening

Manage prediabetes

1. Improve diet and provide brief behavioural advice
2. Increase physical activity and provide brief behavioural advice
3. Refer to and support engagement with Diabetes Prevention Programme
4. Confirm they have engaged with diabetes self management course

Lose weight

1. Improve diet and increase physical activity. Provide brief behavioural advice
2. Refer to SMI Weight Management Service if available
3. Referral to generic Weight Management Service if meets criteria.

Reduce alcohol intake

1. Calculate weekly alcohol intake in units
2. Perform AUDIT-C tool if drinking above 14 units/ week or binge drinking*
3. If AUDIT C score > 20Refer to specialist alcohol service if available
4. Give advice on practical tips to reduce alcohol intake

Monitor attendance at support services

Monitor progress using **'My Health Plan'**

Involve supportive others

3

The First Appointments

Preparing for the First Intensive Behaviour Change Appointment

Update your Local Resource Directory: Some patients will need a referral to specialist services. You may have or want to create a **Local Resource Directory** with any additional services you find, such as:

Specialist services for SMI (stop smoking, physical activity, healthy eating programmes etc.)

Specialist weight management services

Diabetes prevention services

Local opportunities for support with weight reduction such as incentivised gym referrals, healthy living groups, dietician services

Local voluntary sector providers e.g. MIND

Ask other staff at your GP practice, search your NHS provider website and local council website and contact mental health workers to identify mental health specific services in your area. Please update this list (and keep an online directory) as you find more opportunities, and share your findings with other UCLP-Primrose clinicians.

Please call the patient the day before the appointment to check that they can still attend. If not, please rearrange. Send a text reminder on the day of the appointment if able to do so.

Before you see your first UCLP-Primrose patient, please **read through the manual again** so that you know what to do before and during the first appointment.

Ensure you have copies of **'My Health Plan'** (see page 29).

Familiarise yourself with each patient's physical and mental health

Check on the Electronic Patient Records if the patient has had their **physical health check.** If not, offer them a health check as their first UCLP-Primrose appointment

If the patient has had their health check, check for any treatment decisions (e.g. prescription of a statin or blood pressure medication, referral to a support service)

It might help you to have more information about the patient's mental health so you can spot early signs of the patient becoming unwell. Read the medical records, discharge letters, letters from the psychiatrist and note whether there have been any recent hospital admissions

If you are concerned about anything in the patient's medical records (e.g. abnormally high cholesterol, glucose or blood pressure, their mental health) speak to the patient's GP

Providing the First Intensive Behaviour Change Appointment

The first Intensive Behaviour Change appointment aims to: 1 engage the patient; 2 set a patient-led goal to improve cardiovascular health (set a behavioural goal, make an action plan and record behaviour); and 3 use strategies to encourage the maintenance of behaviour (give positive feedback and involve supportive others).

The first Intensive Behaviour Change appointment is summarised on the next page (page 10). Cardiovascular Disease (CVD) health help sheets to support you and the patient to change specific behaviours can be found on pages 32-42.

Engaging with the Patient

Engage the patient in a friendly and supportive way. You'll already have these communication skills but to follow some tips are listed:

Provide general positive feedback to promote engagement – for example, when attending appointments: 'it's good to see you', 'well done on coming to this appointment'

Ask the patient if there is anything they'd like to make sure is discussed. Explain your priorities, and then agree together what you will focus on

Active listening – repeat in a clear way what the patient says to you and check that you have understood them

Ask open questions – ask questions that require more than a 'yes' or 'no' answer. For example: 'what are your health needs?', 'what are you hoping to get out of the appointments?'

Help the patient identify their own goals – don't say 'you should do this'; just telling the patient that they should change can put people off. Ask how they think they could improve their health.

Give patients time to answer – some patients may take time to think about things. Don't be afraid of silences!

Use positive body language – use open and welcoming gestures and expressions, for example, smiling and looking at the client when they are talking. Avoid gestures that might be interpreted as defensive, aggressive or uninterested, for example, folding your arms or finger pointing.

The Intensive Behaviour Change Appointment Flow Chart

If the patient has not had their physical health check, this should be provided at the first appointment. There will not be time to provide the health check and go through the seven steps of the first appointment. Instead, provide the physical health check, explain the purpose of UCLP-Primrose and the types of behavioural goals. Note that some behavioural goals will impact on more than one outcome – e.g. taking medication regularly, improving diet and physical activity. Book the patient in for another appointment in two weeks to talk about the findings of their physical health check and start talking about behavioural goals. **If the patient has had their physical health check, there are seven steps to work through in the first Intensive Support appointment.**

1 Introduction	Introduce yourself and explain the purpose of UCLP-Primrose.
	Agree what you will cover in the appointment, ask for the patient's priorities and explain yours
2 Set a Cardio-vascular health goal	Talk through the findings of the patient's physical health check
	Ask which area of their cardiovascular health they would like to focus on
	With the patient, generate a list of possible behaviours and start with one behavioural goal (see UCLP-Primrose Cardiovascular Goals Flow Chart, page 5)
	Ensure that the goal is SMART
	Record the goal in the 'My goal' section of 'My Health Plan'
	See HELP SHEET 1: Setting a Behavioural Goal
3 Involve supportive friends or family	Ask if the patient would like to involve anyone else and in what way (this could be one or more people, including their mental health worker, carer or friend) – see HELP SHEET 2: Involving Supportive Others
	Record how they would like them to be involved in 'My Health Plan'
	Record their contact details
4 Involve the peer coach (if available)	If peer coaching is available, explain that the UCLP-Primrose service also offers sessions with a Peer Coach, someone with lived experience of mental health conditions who can provide practical and emotional support. Explain the role of a Peer Coach and that they may focus on additional goals to improve quality of life
	Ask the patient if they'd be happy for the Peer Coach to phone them to arrange a first peer coaching appointment (this may be during the next Intensive Behaviour Change appointment)
5 Develop an action plan	Together with the patient, make an action plan as to when, where and with whom the target behaviour will be performed – see HELP SHEET 3: Action Planning
	Record the action plan in the My Action Plan section of the 'My Health Plan'
	Encourage habit formation (see HELP SHEET 8: Forming Habits)
6 Encourage recording	Together with the patient decide how progress towards the goal will be recorded – see HELP SHEET 4: Recording Behaviour
	Encourage the patient to complete the My Progress section of 'My Health Plan'
7 Arrange the next appt.	Ask the patient if they are happy with the decisions made and if they have any questions
	Arrange the next appointment. Record the time and date on 'My Health Plan'
	Provide two copies of the 'My Health Plan' – a physical copy for the patient and an electronic copy for you

4

Subsequent Intensive Behaviour Change Appointments

Preparing for Subsequent Intensive Behaviour Change Appointments

SMART:
Specific: Clearly defined
Measurable: Such as measuring the number of minutes walked per day.
Attainable: Set a realistic, attainable goal then work up to more ambitious goals.
Relevant: Set a goal that is relevant to the patient so they can see the link between their behaviour and the health benefit.
Timely: Set the goal within a time frame that works for the patient.

a If the patient would like to involve others in their care, contact them to explain the service and agree their level of involvement based on patient preference and the person's availability. Tell them the appointment date and time and discuss progress. Invite them to the appointment only if the patient has agreed (see HELP SHEET 2: Involving Supportive Others)

b If the patient has agreed for you to contact their mental health worker, ask if they are aware of any specialist physical health services available for SMI patients – add these to your Local Resource Directory

c Telephone each patient the day before the appointment and remind them to bring their 'My Mental Health Plan' If they can't attend, rearrange the appointment. Send a text reminder on the day of the appointment if your practice has this facility

d Please make sure you have the help sheets you'll need.

Providing Subsequent Intensive Behaviour Change Appointments

Subsequent **Intensive Behaviour Change** appointments are split into three sections: 1 engaging the patient; 2 using strategies to change behaviour to improve cardiovascular health (setting a behavioural goal, making an action plan and recording behaviour); 3 using strategies to maintain the change in behaviour (reviewing progress, involving others and coping with setbacks).

The aim of subsequent appointments is to review patient progress toward their goal and modify or set new goals as appropriate:

Appointments should be face-to-face where ever possible. Only if you are having problems engaging the patient to attend appointments, please consider a telephone consultation depending on the specific goals agreed (e.g. if an agreed goal is that you will weigh the patient, they will need to attend the appointment)

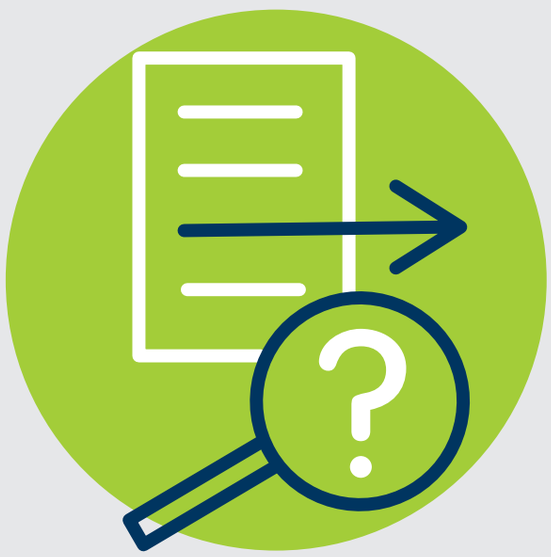
Please refer to **page 13** for the schedule of all subsequent appointments

Check the best time for each patient

Provide general positive feedback at each appointment, e.g. 'it's good to see you', 'well done on last week', 'well done for coming back' to promote engagement with UCLP-Primrose

The process for carrying out subsequent appointments is summarised on **page 13.** This includes strategies that can help to change behaviour.

Behaviour help sheets to support you and the patient to change specific behaviours such as taking statins, blood pressure or anti-diabetic medication, stopping smoking, healthy eating, physical activity and drinking less alcohol can be found on **page 17-24.**



Subsequent Intensive Behaviour Change Appointments Flow Chart

There are seven steps to work through with each patient at subsequent Intensive Support appointments.

1 Introduction	If the patient has invited their supportive other to the appointment, introduce yourself and explain the purpose of UCLP-Primrose/the chosen behavioural goal
	If the patient has invited their Peer Coach to the (second) appointment, introduce them to the patient and explain the chosen behavioural goal
2 Review progress	Use 'My Health Plan' to review progress towards their goal – see HELP SHEET 5: Reviewing Progress
	Give positive feedback on progress – see HELP SHEET 6: Giving Positive Feedback
	If the goal is achieved, either set another or maintain the same goal
	If the goal is partly or not achieved, revise the action plan to reduce or set a new goal
3 Coping with Setbacks	Be positive about setbacks
	Tell the patient that change is rarely a smooth process and there are often setbacks along the way – see HELP SHEET 7: Coping with Setbacks
4 Develop an action plan	Together with the patient make an action plan as to when, where and with whom the target behaviour will be performed – see HELP SHEET 3: Action Planning
	Record the action plan in the My Action Plan section of the 'My Health Plan'
	Encourage habit formation – see HELP SHEET 8: Forming habits
5 Encourage recording	Together with the patient decide how progress towards the goal will be recorded – see HELP SHEET 4: Recording Behaviour
	Encourage the patient to complete the My Progress section of 'My Health Plan'
6 Arrange the next appointment	Ask the patient if they are happy with the decisions made and if they have further questions
	Arrange the next appointment. Record the time and date on MY HEALTH PLAN
	Provide two copies of the 'My Health Plan' – a physical copy for the patient and an electronic copy for you
7 Follow-up friends or family	If the patient wanted their supportive other to attend but they were unable to, ask if you can phone them to discuss progress made and how the patient would like to be supported – SEE HELP SHEET 2: Involving Supportive Others
	If the patient did not want to invite their Peer Coach to the appointment, ask them if they have arranged to see their Peer Coach at another time
	Invite the supportive Friend or Family member/the Peer Coach to attend the next appointment if the patient requests this

The Final Intensive Behaviour Change Appointment Flow Chart

The aim of the final Intensive Behaviour Change appointment is to review and praise achievements over the past six months and discuss how the patient can maintain behaviour change.

The final appointment is split into two sections: 1 reviewing progress using strategies to change behaviour to improve cardiovascular health (Setting a behavioural goal, making an action plan and recording behaviour); 2 using strategies to maintain the change in behaviour (reviewing progress, involving others and coping with setbacks). The final appointment should always be face-to-face where possible.

The process for carrying out the final appointment is summarised in the flow chart below. This includes strategies that can help to change behaviour. The corresponding help sheets give you more information and guidance on using each strategy.

There are six steps to work through with each patient at the final Intensive Behaviour Change appointment

1. **1 Review progress**
2. **Coping with setbacks**
3. **Maintaining an action plan**
4. **Encourage recording**
5. **Follow-up friends or family**
6. **Complete the final appointment assessments**

Explain that this is the final appointment but patients should feel encouraged to continue to progress towards their goal
Use 'My Health Plan' to review progress towards the patient's goal – see HELP SHEET 5: Reviewing Progress
Give positive feedback on progress – see HELP SHEET 6: Giving Positive Feedback
If the goal is achieved either set another or maintain the same goal
If the goal is partly or not achieved, revise the action plan to reduce or set a new goal
Be positive about setbacks
Tell the patient that change is rarely a smooth process and there are often setbacks along the way – see HELP SHEET 7: Coping with Setbacks
Together with the patient make an action plan as to when, where and with whom the target behaviour will continue to be performed now that Primrose appointments are over – see HELP SHEET 3: Action Planning
Record the action plan in the My Action Plan section of the 'My Health Plan'
Encourage habit formation – see HELP SHEET 8: Forming Habits
Together with the patient decide how they will continue to record progress towards the goal – see HELP SHEET 4: Recording Behaviour
Encourage the patient to complete the My Progress section of 'My Health Plan'
Provide extra copies of the 'My Health Plan' for the patient to use at home
If the patient wanted their supportive friend or family member to attend but they were unable to, ask if you can phone them to discuss progress made and how the patient would like to be supported – see HELP SHEET 2: Involving Supportive Others
Thank the patient for attending UCLP-Primrose appointments
Ask the patient if they are happy with the decisions made and if they have further questions
Ask the patient to complete a client satisfaction questionnaire – keep a copy for your files

5

Behaviour Change Help Sheets

There are eight Help Sheets in this section which describe strategies that you can use at each appointment to help and encourage patients to change their behaviour. Specific Help Sheets (and when you might need to use them) are suggested within each appointment flowchart.

HELP SHEET 1:
Setting a Behavioural Goal

Why set goals?

Goal setting helps to agree specific targets and gives the patient a greater sense of control over their health.

How to set a goal:

Together with the patient, generate a list of possible behaviours and look at the pros and cons of each – getting the patient to actively consider the advantages to change can help when a patient is initially resistant to change.

Help the patient choose a clinically relevant behaviour that also matters to them. Avoid choosing the behaviour yourself!
Set one behaviour at a time rather than try to do too much, too soon.

In general, goals are easier to achieve if they relate to a specific behaviour, such as taking medication every day or stopping smoking, rather than to the outcome of behaviour such as weight loss or reduction in blood pressure.

Set a 'SMART' goal that is:

SPECIFIC: State who, what, where, when, how often, with whom, in what context: e.g. 'Steven will take his statin before he goes to bed every night' rather than 'take statin'.

MEASURABLE: Establish criteria so you and the patient know when the goal has been achieved.

For instance go for a 30 minute walk three times a week. This is easier to measure than a vaguely specified goal like 'walk more'.

ATTAINABLE: Set a realistic, attainable goal. Make the first goal very easy for the patient to achieve to build the patient's self- confidence.
Relevant: Set a goal that is relevant to the patient.

TIMELY: The goal should be set within a time frame that works for the patient.
Record the agreed goal on the **'My Health Plan'** and in your notes.

The best way of changing behaviour and maintaining change is to build on small successes so start easy and gradually build up.

HELP SHEET 2:
Involving supportive others

Why involve supportive others?

Patients may benefit from involvement of supportive family, friends, carers, support workers and mental health workers in their care, who can help to encourage behaviour change. You should only involve supportive others in the patient's care if the patient has agreed to this.

How to involve supportive others:

At the first appointment: Ask the patient if they would like to involve someone in their care. This could be their carer, mental health worker, friend and/or support worker. It could be more than one person.

Explain that involving others may make it easier for them to achieve their goals.

Discuss ways in which this person could be involved e.g:

Accompany them to appointments

Remind them of their appointments

Help them to take their medication

Help them to monitor progress with their goal

Identify activities that could be done together to help them achieve their goal (e.g. exercise together/cook meals or go food shopping together)

If they would like someone involved, ask if you can invite them to the appointments.

If they do not want the person to come to the appointments, ask if you can contact the person to discuss how they can help.

Document who will be involved and how in 'My Health Plan'

HELP SHEET 3:
Action Planning

An action plan states exactly where, when and with whom the target behaviour will be performed.

Why form an action plan?

Research shows that detailed action plans are helpful in achieving goals.

How to form an action plan:

Explain what an action plan is and that it will help the patient achieve his/her goal.

As an example, if the goal set is *'Jose will go for a 30 minute walk three days a week with his mental health worker Olu'* an action plan to achieve this goal might look like this:

Where: In the park

When: On Monday, Thursday and Saturday after breakfast

With whom: With Olu

For how long: 30 minutes

Develop the action plan in collaboration with the patient.

Record the agreed action plan on **'My Health Plan'** and in your notes.

HELP SHEET 4:
Recording Behaviour

Why record behaviour?

Once a goal and action plan have been set, it is important that the patient measures and records progress.

People often underestimate or overestimate changes in their behaviour, e.g. underestimate the number of cigarettes smoked or overestimate the time they spend exercising. If people record their behaviour (self-monitor), they gain a realistic picture.

Measuring behaviour can motivate patients when they see successes.

Measuring behaviour can also identify any problems achieving goals.

How to record behaviour:

Decide with the patient how the target behaviour might be measured.

For example, if the goal is physical activity, a way of measuring progress might be to record the number of minutes spent walking briskly each day.

Record this unit of measurement (for example, number of minutes walked a day) next to 'How I will check how I'm doing' on 'My Health Plan'.

Encourage the patient to complete the daily diary on My Health Plan'. Where the goal is to do something a few times a week rather than daily – they can indicate 'non-behaviour days' by putting an 'X'.

HELP SHEET 5:
Reviewing Progress

Why review goals?

This is an opportunity to reflect on progress, identify any problems and generate solutions.

How to review progress:

Decide with the patient how the target behaviour might be measured.

Use the 'My Progress' and 'How I am Getting On' sections on 'My Health Plan' to review the goal

Ask open questions that allow the patient to talk about their experience of trying to achieve their goal, e.g. 'how did you get on last week?' rather than 'did you take your statin every day last week?'

Praise the patient for any progress or effort made towards achieving the goal. You may have to probe to identify something to praise

If the patient has achieved their goal discuss either setting a new goal (see HELP SHEET 1: Setting a Behavioural Goal) or maintain the same goal

If the patient has partly achieved their goal (e.g. taking their statin 5 times a week, but not 7) or has made some progress towards their goal (e.g. reducing the number of biscuits eaten per day to 4 when the goal was 2) congratulate them on progress and identify lessons learnt.

Identifying factors influencing the patient's behaviour:

Help the patient to decide whether increasing capability, opportunity and/or motivation would help them achieve their goal. This can be done by asking 'What could help you achieve what you want to achieve?' and asking about these three components.

"Would you be able to achieve your goal if you were more physically **able** to or if you had more information?'

"Would you be able to achieve your goal if you had more **opportunity** or felt it was more acceptable to?"

"Would you be able to achieve your goal if you **wanted** to do it more and didn't want to do something else more?'

Generating solutions:

Having identified barriers/ facilitators, solutions can be generated, e.g. identify specific triggers that generate the urge (motivation) to eat unhealthy food and develop strategies to avoid these triggers.

Translate the solution into a SMART goal and action plan (see **HELP SHEET 1: Setting a Behavioural Goal** and **HELP SHEET 3: Action Planning**).

If solutions to achieving this goal can't be identified, break it down into smaller steps, or consider setting a new more achievable goal (**HELP SHEET 1: Setting a Behavioural Goal**).

HELP SHEET 6:
Giving Positive Feedback

Why give positive feedback?

We all like positive feedback – it is motivating. It promotes engagement and encourages progress towards the patient's goal.

How to give positive feedback:

Providing positive feedback on a goal:

Feedback on the behaviour: draw attention to how many fewer calories they consumed based on their recording of the number of biscuits eaten than previously.

Feedback on effort: praise the strategies they used to cut down on the number of biscuits eaten.

Feedback on the outcome of the behaviour: weighing the patient and telling them how much weight they have lost or that they have not gained weight.

HELP SHEET 7:
Coping with Setbacks

Why prepare for setbacks?

Being prepared for setbacks before they happen helps the patient to get back on track after the setback. The two main aspects are identifying possible setbacks and to think about how they can avoid or manage situations which may cause setbacks.

How to cope with setbacks:

Explain that setbacks often occur but that there are ways of getting back on track.

Reassure the patient that change is rarely a smooth process with ups and down, but the key is to be moving in the right direction overall.

Encourage the patient to see the setback as an opportunity to learn about the situations that are likely to lead to setbacks and what they can do to avoid setbacks in the future.

Some strategies for coping with situations that could lead to a setback:

Avoid the situation
For example, food shopping when hungry might encourage buying unhealthy food

Develop strategies to manage risky situation
For example, if the patient says they smoked because they were stressed, develop a plan with the patient to do something else when they are next stressed, such as go for a walk or phone a friend

Problem-solving
For example, if the patient says they're struggling to exercise as planned, support them to identify and explore what's getting in the way of their exercise plan and explore ideas as to how they could get around that.

HELP SHEET 8:
Forming Habits

Why is it important to form habits?

Making a behaviour a habit can make us more likely to do it. For example, patients are more likely to take their medication as prescribed if they get into the habit of taking it.

How to form habits:

Habits can be formed by repeating a behaviour in the same context (same time and/or place) repeatedly so that the context prompts the behaviour. Patients may also want to reverse existing habits. Habits can be reversed by repeating an alternative behaviour to replace them.

How to form habits:

Work with the patient to create 'If-then' rules. If-then rules work by creating a rule that IF the patient is in a particular situation, THEN they will perform a particular behaviour. For example: "IF I have finished brushing my teeth in the evening, THEN I will take my tablet." The situation becomes a trigger, or reminder, to perform the behaviour and through repetition the behaviour will become automatic and the habit is formed.

Ask the patient if they could replace an existing habit with a healthier alternative. For example, if they always take the lift at work, could they consider sometimes using the stairs instead?

6

Frequently Asked Questions

1

What should I do if the patient wants to stop attending the appointments or attend less frequently?

Offer the patient a telephone follow-up if they are finding it difficult to attend face to face. Alternatively, agree a different follow up time. Try not to extend the gap to more than one month between appointments.

2

What should I do if I'm concerned about the patient's mental health?

Firstly talk to the patient. Discuss how the patient would like to deal with this and who you should contact. If you still have concerns, speak to the Mental Health Nurse or GP.

3

What should I do if the patient has not shown up to their appointment?

Telephone the patient to find out why they didn't attend. They may have forgotten or become unwell. Reassure them this is OK and offer another appointment. Tell the patient you will call or text (depending on which method the patient would prefer) to remind them.

4

What should I do if I have tried to contact the patient but they are not available?

Leave a message with your name and contact details and ask the patient to call you back. Reassure them that everything is okay and that you are calling to rearrange the appointment. If the patient does not call back after a few days and they have identified a supportive other (e.g. carer, mental health worker, friend), contact this person and ask if they have any information or have had any recent communication with the patient.

5

What should I do if the patient wants to stop taking their antipsychotic medication or try a different antipsychotic medication?

Explore the reasons why the patient wants to stop or change their medication. Advise them that you would like them to see their GP or psychiatrist to discuss their physical health and antipsychotic medication further.

6

What should I do if the patient tells me they have stopped taking their antipsychotic medication?

Tell the patient that you need to talk to their GP or psychiatrist and that you would like them to see their GP or psychiatrist as soon as possible so that they can discuss the antipsychotic medication.

7

What should I do if the patient isn't motivated to change?

You may meet patients who do not want to make any changes. It may be that nobody has taken an interest in their physical health before or that they can't see how to change. Emphasise that the patient is in control of making decisions, and that your role is to encourage them to explore their feelings and ideas around changing their behaviour.

Ask the patient to think about the advantages of changing their behaviour. Refer to HELP SHEETS 1-7 for strategies on how to support patients who may not be motivated to change (e.g. if the patient finds it difficult to identify a goal refer to HELP SHEET 1: Setting a Behavioural Goal).

8

What should I do if the patient isn't progressing towards their goals?

Refer to HELP SHEET 5: Reviewing Progress and HELP SHEET 7: Coping with Setbacks for tips on how to explore and address this.

7

Definition of Terms

Anti-diabetic medication	Anti-diabetic drugs are medicines used to treat patients with diabetes. They include: : ● Oral hypoglycemics (tablets) ● Insulin (injectable) ● GLP-1 receptor agonists (such as Byetta and Victoza) (injectable)
Anti-hypertensive medication	Anti-hypertensive drugs treat hypertension (high blood pressure). The most important and most widely used are: ● ACE Inhibitors ● Angiotensin Receptor Blockers (ARBs) ● Calcium channel blockers ● Beta blockers ● Thiazide diuretics
Anti-psychotic medication	Antipsychotic medication is prescribed to control psychotic symptoms and prevent relapse. Older or "First Generation" medications are called typical antipsychotics while newer or "second generation" medications are called atypical. ● Both typical and atypical antipsychotics are effective at controlling positive symptoms of schizophrenia. ● Atypical medications seem to be more effective at controlling negative symptoms and may be helpful for treating mood symptoms of schizophrenia.
Bipolar Disorder	Formerly known as manic depression, this is a severe mood disorder (sometimes known as an affective disorder). It causes episodic shifts in a person's mood which last for a few days to weeks. These episodes may be a high (mania) or low (depression) There are usually periods of normal mood in between. ● Symptoms of mania include: increased energy, elated mood, impulsive behaviour and enhanced self-esteem and belief in own powers. ● Symptoms of depression include: low mood, poor sleep, lack of energy, feelings of worthlessness, low self-esteem and sometimes suicidal thoughts. Psychotic symptoms, such as paranoid beliefs or hearing voices can occasionally be experienced in bipolar disorder. ● It is thought that genetics, brain chemicals and environmental factors play a role in the illness. Mood stabilisers, antidepressants and antipsychotics are commonly prescribed to treat bipolar. Often a combination of medication can be useful. Psychological treatments also have a role to help people overcome depressive periods as well as understanding the illness and promoting self-care.
Cardio-vascular Disease (CVD)	Includes all the diseases of the heart and circulation including coronary heart disease (angina and heart attack),stroke and peripheral vascular disease. It is also known as heart and circulatory disease.
Impaired glucose tolerance (pre-diabetes)	Impaired glucose tolerance refers to raised blood glucose beyond the normal range but not yet high enough to diagnose diabetes. However, the risk of developing diabetes and cardiovascular disease is raised. If impaired glucose tolerance is treated, it can help to prevent the development of diabetes and cardiovascular disease. The most effective treatment is lifestyle changes including eating a healthy balanced diet or doing regular physical activity.
Psychosis	Psychosis is a medical term used to describe hallucinations (e.g. hearing or seeing things), or delusions (holding unusual beliefs that other people do not share). Common examples include hearing voices or believing that people are trying to do harm, delusions. Psychosis can be due to having a mental illness such as schizophrenia or bipolar disorder. It can also be caused by drug use, brain injury or extreme stress. People experiencing psychosis usually receive medication and talking therapy.
Schizophrenia	A mental illness that affects the way someone thinks. It affects about 1 in every 100 people. ● The symptoms of schizophrenia can be divided into 'positive' and 'negative' symptoms. ● Positive symptoms include hearing or seeing things that are not real (hallucinations) and having ● unusual beliefs (delusions) ● Negative symptoms include lack of motivation and becoming withdrawn. These symptoms are generally more long-lasting and persistent. ● Schizophrenia is usually treated using antipsychotic medication and talking therapies.
Severe Mental Illness (SMI)	Refers to a group of mental illnesses which includes schizophrenia, bipolar disorder and other psychoses
Statins	Statins are a group of medicines that can help lower rates of low-density lipoprotein (LDL) cholesterol (so called 'bad cholesterol') in the blood. They do this by reducing the production of LDL cholesterol inside the liver.

8

List of Appendices

APPENDIX 1:
My Health Plan
How I Am Getting On

APPENDIX 2:
CVD Health Help sheets

APPENDIX 1:
My Health Plan

Patients will be provided with a **'My Health Plan'** booklet – the front half of the booklet should be used when setting/reviewing cardiovascular health goals, and the back half when setting/reviewing quality of life goals.

Patients should take home and use their **'My Health Plan'**, and bring it to each appointment. Intensive Behaviour Change practitioners must keep a copy too – either electronically or on paper. Intensive Support clinicians should also make note of any agreed goals and any referrals they make to other services.

In the 'My Behavioural Goal' section of **'My Health Plan'**, patients should record their action plan and how they're going to monitor progress:

My Behavioural Goal

My goal is to:

My Action Plan

Where
I am going to go:

When
I am going to do it:

How long
I am going to do it
(if relevant):

With whom
I am going to do it:

How
I will be supported by
the people listed above

My Progress

How
I will check how I'm doing
(e.g. number of minutes spent
doing physical activity):

My Next Appointment

Date

APPENDIX 2:
How I Am Getting On

Patients can also use 'My Health Plan' to record activity:

Option 1: Once a Day

Patients can record activity once a day in the How I Am Getting On: Once a Day section, such as whether or not they took their statin that day. Remind patients that it might be helpful to write down their activity each day, rather than trying to remember at the end of the week.

Week number	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1							
2							

Option 2: Once a Day

Patients can record activity once a day in the How I Am Getting On: Once a Day section, such as whether or not they took their statin that day. Remind patients that it might be helpful to write down their activity each day, rather than trying to remember at the end of the week.

Week number	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	am	am	am	am	am	am	am
	pm	pm	pm	pm	pm	pm	pm
	eve	eve	eve	eve	eve	eve	eve
2	am	am	am	am	am	am	am
	pm	pm	pm	pm	pm	pm	pm
	eve	eve	eve	eve	eve	eve	eve

APPENDIX 2:
CVD Health Help sheets

HELP SHEET 9:
Lower Blood Pressure (BP)

Hypertension is a condition where the blood vessels have persistently raised blood pressure.

Prolonged hypertension can lead to damage of blood vessels leading to heart attacks and stroke.

Blood pressure can be reduced by:

Eating a healthy diet, particularly reducing salt intake and the excessive consumption of caffeine rich drinks such as coffee or coca cola

Regular physical activity

Stopping smoking

Reducing excessive drinking of alcohol

Anti-hypertensive medication

Please refer to Help Sheets 12-15 to help the patient to manage their lifestyle to help reduce blood pressure.

If blood pressure is higher than 140/90mmHg and they are not already on an antihypertensive prescription, ask them if you can refer them to the GP to discuss if needed.

Aim for a target blood pressure below 140/90 mmHg. Offer to measure their blood pressure at each appointment to monitor their response. Record this in 'My Health Plan'.

If the patient is already prescribed an antihypertensive, you should support them to take it regularly and to monitor their own blood pressure.

They may be able to obtain a BP monitor from the practice or purchase a validated BP monitor from this list. This will enable accurate home monitoring of blood pressure (target <135/85)

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

If the patient is not taking their medication regularly, ask why.

See HELP SHEET 5: Reviewing Progress might help to understand if they are not taking their medication because they can't (capability or opportunity) or don't want to (motivation).

Explain that they are more likely to take their medication as prescribed if they get into the habit of taking it (see HELP SHEET 8: Forming Habits).

Other Resources:

- https://www.bhf.org.uk/informationsupport/heart-matters-magazine/medical/tests/blood-pressure-measuring-at-home
- https://www.youtube.com/watch?v=edKbuoZPNyg
- https://giftshop.bhf.org.uk/medical-devices/blood-pressure-monitors#buyingguide

HELP SHEET 10:
Lower Cholesterol

Raised cholesterol is a risk factor for heart disease and stroke. Reducing cholesterol is achieved by dietary change and physical activity. Please refer to **HELP SHEET 13: Healthy Eating** and **HELP SHEET 14: Physical Activity** for further information.

If a patient has a CVD risk score (QRISK) >10%, in addition to dietary change and physical activity, lipid lowering medications such as a statin should be considered. If these patients have not already received a statin prescription, ask them if you can refer them to the GP to discuss this option.

Patients who have established cardiovascular disease (Previous heart attacks, stroke, peripheral vascular disease) should be taking high dose high intensity statins (80mg atorvastatin or 20mg rosuvastatin). Please discuss with a clinician if a patient with known cardiovascular disease is not taking the correct dose statin.into the habit of taking it (see HELP SHEET 8: Forming Habits).

Supporting the patient to take their statin

You may need to help patients monitor taking statins and any potential side effects.

Some patients might be concerned about side effects (e.g. concerns that statins might have an impact on mental health).

Help patients to access high quality information: A good resource for statins and side effects:

- https://www.heartuk.org.uk/getting-treatment/questions-about-statins

Discuss referring the patient back to their GP if side effects persist or worsen or if the patient develops pain, tenderness or weakness of muscles.
If the patient is not taking their medication as prescribed, ask them why.

See HELP SHEET 5: Reviewing Progress might help to understand whether they are not taking their medication because they can't (capability or opportunity) or don't want to (motivation).

Explain that they are more likely to take their medication as prescribed if they get into the habit of taking it (see HELP SHEET 8: Forming Habits).

Other Resources:

- https://www.heartuk.org.uk/downloads/health-professionals/publications/blood-fats-explained.pdf
- https://www.heartuk.org.uk/downloads/health-professionals/publications/understanding-cholesterol.pdf
- https://www.bhf.org.uk/informationsupport/publications/heart-conditions/understanding-cholesterol

HELP SHEET 11:
Stop Smoking

Smoking increases this risk of multiple conditions including cardiovascular, respiratory disease and many cancers. Stopping smoking is one of the most effective ways of improving health.

How to support patients to give up smoking

You can usually access stop smoking services via you GP or pharmacist. These will provide behavioural support on a one-to-one basis or in a group plus medications.

Tell patients they are four times more likely to stop smoking if they use if they use the NHS Stop Smoking Services than attempting to quit alone. Patients who wish to stop smoking should be referred to a clinician to discuss medications to help stop smoking.

In addition to referring patients, direct patients to this resource to help get started to stop smoking:

- https://www.nhs.uk/better-health/quit-smoking/

This resource contains free expert support, stop smoking aids, tools and practical tips

HELP SHEET 12:
Diabetes and Pre-Diabetes Management

Diabetes is a condition where the insulin made in the pancreas doesn't work properly, or the pancreas cannot make enough insulin. This causes blood sugar levels to remain elevated and causes damage to blood vessels. Damage to large blood vessels increases the risk of heart attacks and strokes. Damage to smaller blood vessels can damage eyes, kidneys and nerves.

Diabetes is monitored using a non-fasting blood sample for HBA1c which measures glucose control over 3 months. HBA1c >= 48mmol/litre is diagnostic for diabetes.

Prediabetes is diagnosed if HBA1c is between 42-48 mmol/litre. Patients with prediabetes are at risk of developing diabetes.

Discuss that their blood sugar control can be improved by:

Eating a healthy diet

Increasing fibre intake

Reducing the consumption of fat, particularly saturated fat

Increasing physical activity

HELP SHEET 13: Healthy Eating and HELP SHEET 14: Physical Activity cover these.

Specific dietary advice for patients with diabetes:

- https://www.diabetes.org.uk/guide-to-diabetes/enjoy-food/eating-with-diabetes/i-have-type-2-diabetes

In addition to lifestyle changes, medications play an important role in managing diabetes.

Ask the patient if you can refer them to the GP to discuss their care if they have an HBA1c >48 mmol/litre.

If the patient is already prescribed antidiabetic medications , you should support them to take it regularly.

If the patient has a diagnosis of diabetes or prediabetes, you should also check the following:

Have they been offered or received a patient education programme? If not, and if this programme is available, ask the patient if they would like to be referred to this.

For patients with diabetes, ensure they are attending their diabetes screening which detects complications of diabetes early and prevents their deterioration. This includes eye checks, urine and blood pressure checks and blood tests.

If the patient is not taking their medication regularly, ask why.

Give accurate information about side effects and monitor for them. Refer to the clinical pharmacist, diabetes nurse of GP if side effects are troublesome.

See HELP SHEET 5: Reviewing Progress might help to understand if they are not taking their medication because they can't (capability or opportunity) or don't want to (motivation)

Explain that they are more likely to take their medication as prescribed if they get into the habit of taking it (see HELP SHEET 8: Forming Habits).

Other Resources:

- https://www.diabetes.org.uk/diabetes-the-basics
- https://www.diabetes.org.uk/guide-to-diabetes/complications/feet/taking-care-of-your-feet
- https://www.diabetes.org.uk/preventing-type-2-diabetes/ten-tips-for-healthy-eating
- https://www.diabetes.org.uk/preventing-type-2-diabetes/move-more
- https://player.vimeo.com/video/215816727

HELP SHEET 13:
Healthy Eating

How to support patients to eat healthily:

Give advice on eating a balanced diet reducing saturated fat and ensuring they are consuming fruit and vegetables in their diet.

A good resource to get started is the eat well guide:

- https://www.nhs.uk/live-well/eat-well/

It contains information on eating a balanced diet, 5 a day and information about food labels,

Some patients (BMI >30 or BMI >28 with hypertension or diabetes) may be eligible for additional medications and services to help with weight loss. Check your local guidelines and refer if appropriate

If specialist services are not available or if the patient does not want to be referred:

Identify goals – ask the patient to talk through the food and drink they have consumed over the last two days in order to identify any high calorie food/ drink

Help the patient to set a goal to reduce or cut out one of the high calorie items and replace with a healthier item, e.g. swapping butter for low fat spread or sugary fizzy drinks for diet fizzy drinks (see HELP SHEET 1: Setting a Behavioural Goal)

Start with a goal that is easy for the patient to achieve such as having a healthy snack instead of a high calorie snack once a day. This will build the patient's self-confidence to set more ambitious goals

Tell the patient about positive examples of other patients and participants in studies of interventions to promote healthy lifestyles in people with severe mental illness (a technique known as social comparison). This may help them to develop more positive beliefs about their capabilities

Some patients report an increase in appetite soon after taking their antipsychotic medication and a corresponding belief that they are not capable of doing anything about this.

Introduce the following techniques to change patients' beliefs:

Tell the patient: "other people who take antipsychotics have expressed the same concerns but have managed to deal with this using the following methods...I believe you can too"

Suggest the patient has healthy food and drinks available to snack on rather than sugary snacks and drinks. If appropriate suggest the patient asks those they live with to support them by not keeping unhealthy or high calorie food and drinks in the house

Suggest that the patient takes their antipsychotic medication when they go to bed, so the increase in appetite happens when they are asleep

Suggest the patient talks to the GP or psychiatrist about other medication that might not have the same impact on their appetite

Ask the patient to record their behaviour – if the goal is to reduce the amount of cola drunk to one glass per day, ask the patient to keep a 'drink diary' recording what they had to drink and when. This will document any progress towards the goal or identify problems (see HELP SHEET 4: Recording Behaviour and 'My Health Plan')

If the patient wants to record their behaviour in more detail, encourage them to complete 'How I Am Getting On' where they can record more information about progress

Give the patient feedback on the outcome of their behaviour by weighing the patient during the appointment or encouraging them to weigh themselves

Other Resources:

The following websites offer advice on healthy eating:

- https://www.heartuk.org.uk/downloads/health-professionals/publications/healthy-eating-guide.pdf
- https://www.bhf.org.uk/informationsupport/support/healthy-living/healthy-eating
- https://www.heartuk.org.uk/healthy-diets/south-asian-diets-and-cholesterol
- https://www.bhf.org.uk/informationsupport/support/healthy-living/healthy-eating/salt

HELP SHEET 14:
Physical Activity

How to support patients to engage in physical activity:

Specialist services e.g. 'exercise on referral' are often available for patients with specific criteria:

If available, refer the patient to relevant specialist local services to promote physical activity.

Help the patient to make the first goal set quite easy to build their self-confidence and encourage them to carry on with an achieved goal for a period of time before setting more ambitious goals

The overall target is for 150 minutes of moderate intensity activity (enough to make you slightly out of breath) per week to reduce the risk of CVD. However, if their current activity levels are low, this can be worked towards over time.

You will have commonly heard advice for 5 x 30minute sessions per week but this can feel unachievable or unsustainable for many, and evidence suggests that the same effects can be gained by much shorter but more frequent activity (e.g. regular 5-10 minute brisk walks)

A common problem patients report is feeling 'sluggish' or 'lethargic' because of antipsychotic medication and holding the belief that they don't have the capability to engage in physical activity.

Advise that physical activity gives you more energy, so it is important to do it even if feeling tired and that you can start with lower intensity/shorter periods and build up slowly as energy levels improve

Many people are put off by the thought of 'exercise', especially those who are sedentary for much of the time; and it is better to discuss increasing levels of physical activity more generally (including housework, gardening, walking etc.) that they could sustain longer term.

Ask the patient to identify the benefits of physical activity. Tell them about positive examples of other patients and participants in studies of interventions to promote healthy lifestyles in people with severe mental illness (a technique known as social comparison). This may help them to develop more positive beliefs about their capabilities

When working with the patient to form an action plan, ask them about the best time of day to engage in physical activity. Encourage the patient to avoid setting a goal for a time when the sedative effects of their medication is at a maximum.

Encourage the patient to record progress towards their goal (see **HELP SHEET 4: Recording Behaviour** and **'My Health Plan'**) by recording the number of minutes spent engaged in physical activity such as the minutes per day spent going for a walk

If the patient wants to record their behaviour in more detail, encourage them to complete 'How I Am Getting On' every day

Encourage the patient to use an aid such as a pedometer that will give them feedback on their progress

Other Resources:

- https://www.nhs.uk/better-health/get-active/
- https://www.bhf.org.uk/informationsupport/support/healthy-living/staying-active
- https://weareundefeatable.co.uk
- https://www.nhs.uk/live-well/exercise/running-and-aerobic-exercises/get-running-with-couch-to-5k/

HELP SHEET 15:
Reduce Alcohol Intake

Confirm the patient's alcohol intake in units.

If they are consuming more than the recommended amount of alcohol (14 units/week) or they are binge drinking (more than 8 units in a single session for men and 6 units for women), consider using the AUDIT Screening tool:

If the patient has scored above 20 on the AUDIT screening tool and specialist services are available:

Discuss referring the patient to a local alcohol support service or a clinician if local services are unavailable.

If the patient has scored between 8 and 19 on the AUDIT screening tool or if the patient does not want to be referred: .

Encourage patients to set a goal to reduce their units

Refer to the resource below:

- https://www.nhs.uk/better-health/drink-less/#tips-to-help-you-cut-down-on-alcohol

Increase the intention to stop drinking by asking the patient to identify the benefits of stopping drinking. If they do not identify any benefits, provide 'myth-busting' information about the consequences of giving up, i.e. evidence that it improves sleep.

Ask the patient to identify practical strategies to reduce drinking. If they do not identify any, suggest alternating soft drinks with alcoholic drinks when out with friends, changing to low-alcohol beer or reducing drink size (e.g. a half pint instead of a pint). Ask the patient to suggest alternative ways they could socialise/unwind that do not involve drinking.

Encourage the patient to record progress towards their goal (see **HELP SHEET 4: Recording Behaviour** and **'My Health Plan'**) by recording how many units they drink a week

If the patient wants to record their behaviour in more detail, encourage them to complete 'How I Am Getting On' to record more information about progress towards their goal

Other Resources:

The following websites offer advice on alcohol reduction that is consistent with Department of Health advice.

- https://www.nhs.uk/live-well/alcohol-advice/
- https://www.drinkaware.co.uk

Notes

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)

Invited for SMI A

Patient engages

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.

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

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

Wider Social Support: Social provider

Priority 3
All others with CVD risk factors

Priority 4
All others

l Annual Health Check

Patient does not engage

- 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

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

Notes



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