SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	***11J/0253***
Service	*Serious Mental Illness (SMI) Annual Physical Health Assessments – Pan Dorset Pilot*
Commissioner Lead	*NHS Dorset CCG/ICB*
Provider Lead	*Dorset Healthcare*
Period	*1st October 2019 – 31st March 2024*
Date of Review	*March 2022*

1. Population Needs

1.1 National/local context and evidence base

People living with serious mental illness (SMI) face one of the greatest health inequality gaps in England. The **life expectancy** for people with SMI is **15–20 years lower** than the general population. This disparity in health outcomes is partly due to physical health needs being overlooked.

Smoking is the largest avoidable cause of premature death, with more than 40% of adults with SMI smoking. Individuals with SMI also have double the risk of obesity and diabetes, three times the risk of hypertension and metabolic syndrome, and five times the risk of dyslipidaemia (imbalance of lipids in the bloodstream) than the general population. They are also less likely to have their physical health needs met, both in terms of identification of physical health concerns and delivery of the appropriate, timely screening and treatment.

In the NHSE/I Five-Year Forward and NHS Long Term Plan (NHS LTP) the aim is that by 2023/24 390,000 people living with serious mental illness (SMI) should have their physical health needs met. This is by increasing early detection and expanding access to evidence-based physical care assessment and NICE guided interventions each year.

1.2 Local context and evidence base

The current Dorset population is 822,079 (25th October 2022) based on those registered with a Dorset General Practitioner (GP) practice. Of this current population, those with an SMI recorded on the GP Quality & Outcomes (QoF) Mental Health (MH) register is 8,653 (September 2022).

The top 5 other Long-Term Condition or Co-morbidities for those with an SMI are (October 2022):

Depression	4,702
Hypertension	1,619
Asthma	1,464
Diabetes	1,117
Coronary Heart Disease (CHD)	431

The Public Health England (PHE) shows national prevalence of 0.95% (2020/21) whereas in Dorset we are slightly higher with a 1.05% (September 2022) of our Dorset population with an SMI.

The annual number of predicted new cases of SMI (estimated incidence rate per 100,000 aged 16 – 64) for NHS Dorset is 18.5 which is higher than the South West region at 17.7 and slightly higher than the England average at 18.1.

As outlined in the Public Health England (PHE) fingertips socio-economic deprivation is a risk factor for serious mental illness. There are several domains to deprivation and each weighted as follows:

- Employment. (22.5%)
- Education. (13.5%)
- Health. (13.5%)
- Crime. (9.3%)
- Barriers to Housing and Services. (9.3%)
- Living Environment. (9.3%)

With 1 being the most deprived area and 32,844 being least deprived area, Dorset ranks quite highly at 17 in the IMD (2019/20). Dorset is also higher in terms of deprivation levels than the South West (19.6) and England (21.7) average. The areas with most significant deprivation are mainly located in the urban areas of Bournemouth, Poole and the Weymouth & Portland.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	

Specifically, Domain 1:

- 1.5.i Excess under 75 mortality rate in adults with serious mental illness (formerly indicator 1.5): A measure of the extent to which adults with a serious mental illness die younger than adults in the general population. To measure premature mortality in adults diagnosed with serious mental illness.

Related and linked to:

Domain 1
- Under 75 mortality rate from cardiovascular disease
- Under 75 mortality rate from respiratory disease
- Under 75 mortality rate from liver disease

Domain 2
- 2 Health-related quality of life for people with long-term conditions
- 2.1 Proportion of people feeling supported to manage their condition
- 2.1 Proportion of people feeling supported to manage their condition

Domain 4
- 4.7 Patient experience of community mental health services
- 4a.i Patient experience of GP services

Public Health Outcomes Framework

Specifically, E - Healthcare and premature mortality:

- E09a - Premature mortality in adults with severe mental illness (SMI)
- E07b - Under 75 mortality rate from respiratory disease considered preventable (2019 definition)

Related and linked to:

- C15 2.11i Proportion of the population meeting the recommended '5-a-day' on a 'usual day' (adults)
- C16 2.12 Percentage of adults (aged 18+) classified as overweight or obese
- C17a 2.13i Percentage of physically active adults
- C17b 2.13ii Percentage of physically inactive adults
- C18 2.14 Smoking Prevalence in adults (18+) - current smokers (APS)
- C22 2.17 Estimated diabetes diagnosis rate
- E04a 4.04i Under 75 mortality rate from all cardiovascular diseases
- E04b 4.04ii Under 75 mortality rate from cardiovascular diseases considered preventable
- E06 4.06i Under 75 mortality rate from liver disease
- E06b 4.06ii Under 75 mortality rate from liver disease considered preventable

2.2 Local defined outcomes

- Deliver the integrated care model to physical health assessments across both community mental health teams (CMHTs) and primary care networks (PCNs) & their associated practices.
- Deliver against set trajectories to meet a minimum Dorset average of 60% of all 6 health checks complete by end March 2023.
- Embed the 3 additional health checks and health promotion initiatives (cancer screening, covid & flu vaccination, oral & sexual health) with the annual health assessment offer in phased approach.

3. Scope

3.1 Aims and objectives of service

The aim of the pilot is to ensure all individuals with a serious mental illness on the GP Mental Health QoF register are receiving an annual comprehensive physical health assessment regardless of whether under the care of community mental team or primary care. This is part of a wider aim to develop a collaborative approach to reducing the 15–20-year mortality gap and health inequalities that individuals with an SMI face.

To achieve this aim the main objectives are as follows:

- Successfully roll out over 3 phases (19/20, 20/21 and 21/22) SMI physical health support workers (PHSWs) across Dorset
- Role model a new integrated way of working by fully training, inducting, and embedding PHSWs into CMHTs and primary care networks (& associated practices).
- Leading the culture change by developing and fostering positive relationships between CMHTs and Primary Care Networks (& associated practices)
- Raising the profile and importance of these health assessments across clinicians in Dorset (primary and secondary care)

Specific Objectives

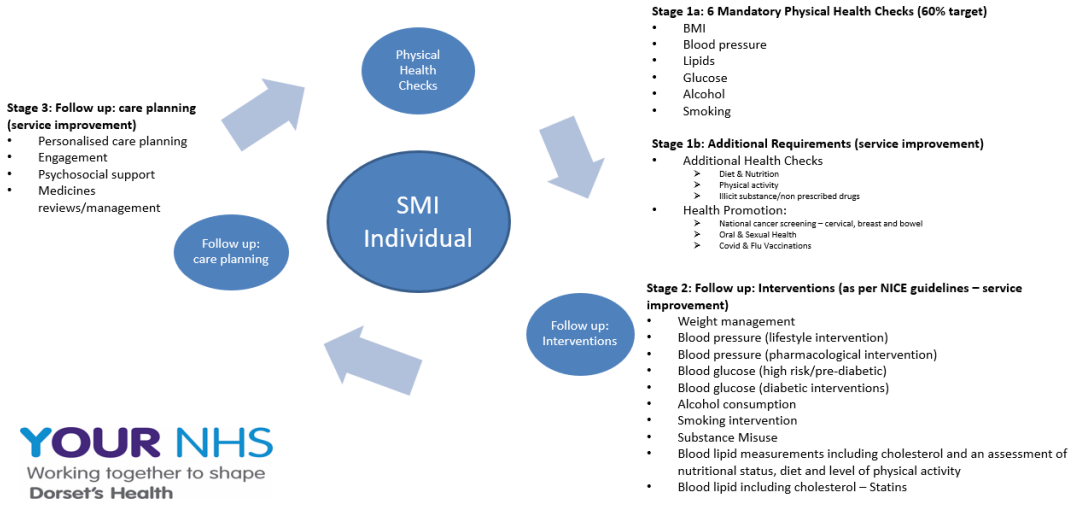
- Manage and implement necessarily mitigations for the impact of covid and other implications on the service

- Proactively supporting and ensuring the SMI PHSWs are working alongside the outreach team (supporting to reduce Did Not Attends (DNAs), the introduction of point of care testing and improving marketing of health assessments)
- Support developments of stages 2 & 3 of the pathway to ensure integration of the SMI PHSWs into the full pathway

3.2 Service description/care pathway

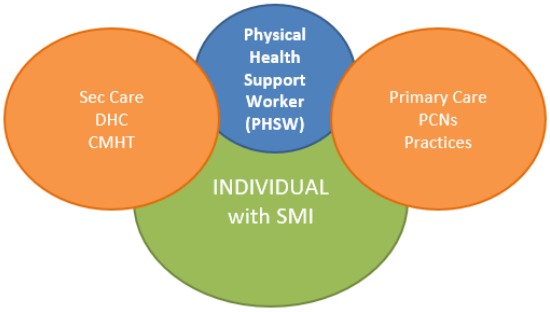
There are 3 stages to the annual care pathway as follows:

1. Completion of recommended physical health assessments (6 mandatory, 3 additional and health promotion initiatives)
2. Follow-up: delivery of or referral to appropriate NICE-recommended interventions
3. Follow-up: personalised care planning, engagement and psychosocial support.



The SMI PHSWs and pilot focuses on Stage 1 a and b of the pathway and will be delivered as per diagram 1.
Stages 2 & 3 will be provided by existing ICS organisations and care pathways in Dorset. SMI PHSWs are expected to be embedded into these pathways.

Diagram 1



Stage 1 of the pathway – Physical Health Assessment:

First 0-12months each Phase

1st Appointments (45mins each)
(15mins admin time per patient/duplicate entry RiO)

6 mandatory physical health checks assessment:

1. a measurement of weight (BMI or BMI + Waist circumference)
2. a blood pressure and/or pulse check (diastolic and systolic blood pressure recording pulse rate)
3. a blood lipid including cholesterol test (cholesterol measurement)
4. a blood glucose test (blood glucose or HbA1c measurement)
5. an assessment of alcohol consumption
6. an assessment of smoking status

Using motivational interviewing and behavioural change skills to encourage and support individuals with lifestyle advice, guidance, brief interventions for weight management, smoking and alcohol. Also, referring where appropriate lifestyle interventions such as to LiveWell Dorset.

12+months each Phase

Offer 3 additional physical health checks:
7. an assessment of Diet & nutrition
8. an assessment of physical activity
9. an assessment of illicit substance misuse and non-prescribed drugs

Support & signpost SMI individuals to national cancer screening (bowel, breast and cervical), covid & flu jabs and oral & sexual health.

24+months each Phase

Follow-ups (15mins each)

- Each SMI Individual to receive a follow-up telephone call post physical health check and to discuss any remaining concerns.
- SMI individuals who are referred for interventions to receive a follow-up telephone call post referral and after intervention to support with engagement and discuss any concerns.

Delivery & Approach

- Ensure PCNs/practices are engaged in recruitment & induction and in developing the operational processes for when SMI PHSWs are working in primary care.
- Ensure SMI PHSWs are working in an integrated way of a 40% CMHT and 60% PCN basis but allowing for flexibility based on patient need where required
- Ensure PHSWs are appropriately equipped to deliver physical health assessment in various settings including within clinic environments, care homes and community settings along with home visits
- Ensure SMI PHSWs accurately record physical health assessments and case notes on their primary system GP SystmOne. Duplicate entry to RiO for those open to mental health services

3.3 Population Covered

Anyone who has an active or in remission serious mental illness, is registered with a Dorset GP and is on the GP Mental Health register under the Quality & outcomes Framework (QoF) contract. The register is aimed at adults of 18+, however there a small number who will be on register aged 16 and 17 who are included.

The register includes the following diagnoses:

- Schizophrenia
- Schizotypal personality
- Persistent delusional disorder
- Acute/transient psychotic disorders
- Induced delusional disorder
- Schizoaffective disorders
- Manic episodes
- Bipolar disorder
- Severe depression with psychosis
- Non-organic psychosis
- Use of antipsychotic or mood stabilising medication

In addition, anyone:

- On lithium therapy for the last 6 months

3.4 Any acceptance and exclusion criteria.

- Excludes anyone with a primary diagnosis of personality disorder (will be included where dual diagnosis with another condition listed above)
- Excludes anyone classified under Mental Health Clustering as SMI until primary care are notified and individual is added to the GP QoF MH register
- Excludes anyone with depression or anxiety unless they also have a formal diagnosis of one of the above conditions (then they would be included)
- Excludes anyone who opt outs (patient choice) from the annual physical health assessment

3.5 Interdependence with other services/providers

- Mental health QoF contract – points and payment for all 6 physical health checks
- Standard NHS Contract Service Condition 8 (see Section 5) for mental health providers (DHC)
- Cardiovascular disease and Diabetes QoF contract and care pathways – for individuals on multiple registers and for clinical interventions
- NHS Health check aged 40-74 every 5 years – for individuals on multiple registers
- Mental Health Integration Community Care (MHICC) programme

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

NICE & Quality Guidance

For the pilot, the core & Stage 1: addressing the physical health needs of those living with SMI:

- Psychosis and schizophrenia in adults: prevention and management. [NICE CG178]
- Psychosis and schizophrenia in adults [NICE QS80]
- Bipolar disorder: assessment and management [NICE CG185]

- Bipolar disorder in adults [NICE QS95]
- Bipolar disorder, psychosis and schizophrenia in children and young people [NICE QS102]
- Coexisting severe mental illness (psychosis) and substance misuse: assessment and management in healthcare settings [NICE CG120]
- Coexisting severe mental illness (psychosis) and substance misuse: community health and social care settings [NICE NG58]
- Smoking: acute, maternity, and mental health services. Public health guideline [NICE PH48]

For stages 2: to deliver interventions for presence or raised risk of cardio-metabolic disease identified during physical health assessments:

- Obesity prevention [NICE CG43]
- Lipid modification [NICE CG181]
- Type 2 diabetes: prevention in people at high risk [NICE PH38]
- Hypertension in adults: diagnosis and management [NICE CG127]
- Physical activity: brief advice for adults in primary care [NICE PH44]
- Diagnosis and management of type 1 diabetes in children, young people and adults [NICE NG17, NG18 and NG19]
- Type 2 diabetes [NICE NG28] Type 2 diabetes – newer agents [NICE NG28]

Relevant NICE clinical guidance to deliver interventions for smoking, alcohol or substance use:

- Smoking: harm reduction. [NICE PH45]
- Smoking: harm reduction [NICE QS92]
- Alcohol-use disorders: prevention [NICE PH24]
- Alcohol-use disorders: diagnosis and clinical management of alcohol-related physical complications [NICE CG100]
- Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence [NICE CG115]
- Drug misuse in over 16s: psychosocial interventions [NICE CG51]
- Drug misuse in over 16s: opioid detoxification [NICE CG52]

QoF Contract Indicators

- Primary Care QoF Contract includes 6 mandatory health checks

Health Inequalities

- NHS Reducing Healthcare Inequalities Core20PLUS5 programme

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

- Royal College Psychiatrists Lester Tool (2014) Positive Cardiometabolic Health

4.3 Applicable local standards

Please see **SMI Physical Health Clinical Protocol** document (see schedule 2G)

5. Location of Provider Premises

The Provider's Premises are located at:

Delivery of the physical health checks will be in multiple locations based on CMHT bases (24 for adult & older people) and primary care network (18 networks) practices (73 practices) are spread across Dorset. PHSWs will be allocated to the relevant PCNs and aligning CMHTs to cover these areas.

ROLL OUT PHASE	PRIMARY CARE NETWORK	CMHTs
1 (2019/20)	Weymouth & Portland PCN	Weymouth Adult & OPCMHT
	Bournemouth East Collaborative	Christchurch Adult CMHT Christchurch Older Peoples' CMHT Bournemouth East CMHT Bournemouth East Older Peoples' CMHT
	South Coast Medical Group	Christchurch Adult CMHT Christchurch Older Peoples' CMHT Bournemouth East CMHT Bournemouth East Older Peoples' CMHT
	Blandford PCN	Blandford Adult & OPMH CMHT
	Sherborne Area Network	Sherborne Adult & OPMH CMHT
	The Vale PCN	Sherborne Adult Shaftesbury OPMH
2 (2020/21)	Poole Central PCN	Purbeck Adult CMHT Wimborne & Purbeck OPCMHT OP CMHT Poole North OPCMHT Poole South
	Shore Medical	OP CMHT Poole North OP CMHT Poole South Bmth North OPCMHT Bmth West Adult

	North Bournemouth PCN	Bournemouth West Adult CMHT Bournemouth North Older Peoples' CMHT
	Poole Bay and Bournemouth PCN	Bournemouth West Adult CMHT Bournemouth North Older Peoples' CMHT
	Central Bournemouth	Bournemouth West Adult CMHT Bournemouth North Older Peoples' CMHT Christchurch Adult CMHT
	Poole North PCN	OP CMHT Poole North Wimborne Adult CMHT Wimborne & Purbeck OPCMHT
3 (2021/22)	Jurassic Coast PCN	Bridport Adults CMHT Weymouth Older Persons CMHT Dorchester Adult & OPCMHT
	Christchurch	Christchurch Adult CMHT Christchurch Older Peoples' CMHT
	Mid Dorset PCN	Dorchester Adult & OPCMHT Blandford Adult & OPMH CMHT
	Purbeck PCN	Purbeck Adult Wimborne & Purbeck OPCMHT
	Wimborne and Ferndown PCN	Wimborne Adult CMHT Wimborne & Purbeck OPCMHT Ferndown & West Moors OPCMHT
	The Crane Valley PCN	Wimborne Adult CMHT Ferndown & West Moors OPCMHT

Delivery of the physical health checks should be flexible to suit individual needs and in a variety of settings: clinics, practices, home visits, care homes and community opportunities utilising both primary and secondary care estates where required.