

Healthcare Policy and Strategy Directorate

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5 February 2008

Dear Colleague

MENTAL HEALTH IN SCOTLAND

CONSULTATION: IMPROVING THE PHYSICAL HEALTH OF THOSE WITH MENTAL ILLNESS

I am writing to advise you that the Scottish Government is undertaking a consultation on the draft report, *Improving the Physical Health of Those with Mental Illness*.

The 2006 published targets and commitments for mental health in Scotland www.scotland.gov.uk/Publications/2007/01/09114002/0 include an undertaking at Commitment 5 to take steps to improve the physical health of those with severe and enduring mental illness.

A draft report is now available for consultation with a view to final publication later this year once all comments and suggestions received have been considered. The draft report (and all other Scottish Government current consultation documents) can be viewed online on at <http://www.scotland.gov.uk/consultations>. **This consultation closes on Wednesday 14 May 2008.**

(Freephone 0800 77 1234 will advise on your nearest public internet access point).

Formats

This document is available in a range of formats. Please contact Mike Murray (see below) to arrange this. If you require this document in a community language see Annex C.

Draft Report

Among other issues the draft report covers and includes: the evidence base on the need for change; aspects of care management; proposals for review of performance; steps to ensuring equity and other dimensions. The report also makes 6 clear recommendations for forward attention and action to bring about early change and improvement.

The report when published will be the outcome of that action, will provide the basis for a planning and audit tool for planners, commissioners and others in their combined work to deliver change and improvement in the way services respond to the physical health needs of those with mental illness.

St Andrew's House, Regent Road, Edinburgh EH1 3DG
www.scotland.gov.uk



Other Written responses

Written responses are also invited to this consultation by the **Wednesday 14 May 2008**

closing date and should be addressed to:

Mike Murray

Directorate of Primary and Community Care

Mental Health Division

3ER, St Andrews House

Regent Road

Edinburgh

EH1 3DG

Email responses

Please send your comments by e-mail to mike.d.murray@scotland.gsi.gov.uk by the same closing date.

Handling your response

We will need to know whether you are content for others to see your response. Please complete and return the attached **Respondent Information Form** with your response or if responding on line you will be invited to indicate your preference in this regard.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and is bound to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Disclosure

The responses from those content that their comments be seen by others will be made available for public viewing in the Scottish Government Library and on the Scottish Government web pages shortly after the closing date.

Arrangements to view responses can be made by contacting the Scottish Government Library (early July 2008) on 0131 244 4565. If you wish, the responses can be copied and sent to you, but a charge may be made for this service.

Analysis and outcomes

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us reach a decision on the final shape of the report. We aim to issue the final report before the year end.

Comments on process

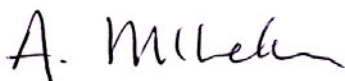
If you have any comments about how this consultation exercise is being conducted, please contact Mike Murray (see contact details above).

Wider arrangements

Finally and more generally, the Scottish Government has an email alert system for consultations ([SEconsult: http://www.scotland.gov.uk/consultations/seconsult.aspx](http://www.scotland.gov.uk/consultations/seconsult.aspx)). Once registered you will receive a weekly email containing details of all new consultations (including web links).

These arrangements complement, but in no way replace existing distribution lists or arrangements.

Yours faithfully



ALEX MCMAHON

Name:

Postal Address:

Consultation Title: Mental Health in Scotland – Improving the Physical Health of those with a Mental Illness

1. Are you responding as:

(a) An Individual (go to 1a)

(b) On behalf of a group or organisation (go to 1b)

1a. INDIVIDUALS

Do you agree to your response being made available to the public (in SG library and/or on SG website)?

YES (go to 2b below)

NO, not at all

Where confidentiality is not requested we will make your response available to the public on the following basis (please tick one of the following boxes)

Yes, make my response, name and address all available

Yes make my response available but not my name and address

Yes make my response and name available but not my address

1b. ON BEHALF OF GROUPS OR ORGANISATIONS

Your name and address WILL be made available to the public (in the SG library and/or on the SG website).

Are you content for your response to be made available also?

YES NO

2. SHARING RESPONSES/FUTURE ENGAGEMENT

We will share your response internally with other SG policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so.

Are you content for the Scottish Government to contact you again in the future in relation to your consultation response?

YES NO

STAKEHOLDER COMMENT FORM-

ANNEX B

Stakeholder Comments

Please use this form to submit comments or suggestions.

1. Please put each new comment in a new row.
2. Please do not paste other tables into this table, as your comments could get lost - type directly into this table.
3. Please always refer to section titles (and not page numbers.) Insert the section title and paragraph (within each section) in the first column.
4. If your comment relates to the document as a whole, please put **'general'** in this column.

To be considered your completed form MUST be returned by Wednesday 14 May 2008

Name: _____	Organisation _____
SECTION	COMMENT
Introduction/ Appreciation	
Recommendations for Best Outcomes	
Evidence Base	
Service Users and Carers	
Stigma and Discrimination	
Management and Treatment of Physical Health and Wellbeing	
Performance Management and Delivery	
Equity of Access for Delivery of Care	
Linked Initiatives	
Health Improvement - Key Policies and Evidence	
General Medical Services Contract for Primary Medical Services	



Annex A: Practice Examples	
Annex B: Guidance for QOF indicators – NHS GG&C	
Annex C: Evidence base	
General	

DOCUMENTS IN COMMUNITY LANGUAGES

ANNEX C

This publication is available on request in community language versions and alternative formats. Please contact **0845 612 6460** for this to be arranged.

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'ਤੇ ਉਪਲਬਧ ਹਨ। ਇਸਦਾ ਪ੍ਰਬੰਧ ਕਰਾਉਣ ਲਈ ਕਿਰਪਾ ਕਰਕੇ
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Mental Health in Scotland

Improving the Physical Health of those with a Mental Illness

“We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.”

5 February 2008



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Introduction

This guidance focuses on the need to improve the physical health of people with mental illness and responds to the published commitment (2006)

“We will improve the physical health of those with severe and enduring mental illness by ensuring that every such patient, where possible and appropriate, has a physical health assessment at least once every 15 months.”

This guidance offers 6 deliverable recommendations for change and improvement; the context in which they are set; linked initiatives; some practice examples already underway; and the evidence base.

Attention to the physical health of those with a mental health problem is driven by the need for systematic support for those with long-term conditions, a reduction in health inequality and better management of care.

Successful delivery of the recommendations made rely on health, local authority and other agencies working together and on the ongoing participation and engagement of people experiencing mental illness and their carers.

All approaches must take account of equality and diversity issues to ensure compliance with Disability Discrimination legislation. For example there may be specific issues to address with regard to language, cultural, ethnic or gender related issues. All prevention care and support approaches should be designed and delivered in a non stigmatising; non discriminating way which value people and encourage the individual.

Appreciation

Thanks goes to all contributors commentators and advisers who participated in the production of this report and are too extensive to list in this document. This support and input has been invaluable. Particular thanks however go to Dr Moira Connelly Consultant Psychiatrist and Clinical Director, NHS Greater Glasgow and Clyde.

Recommendations for best outcomes

- 1. Community Health Partnerships (CHPs) must; raise awareness among staff, partner organisations, service users and carers of the increased rate of common physical illnesses and poorer outcomes in people with severe mental health problems; and must provide this population group with lifestyle and other health promotion interventions within the context of their Health Promotion Strategies and programmes locally.**
- 2. CHPs and General Practices should use existing processes to review and make improvements to the physical health of those with severe mental illness. They should do this on an annual basis, and record and communicate their findings to ensure appropriate follow up where required including by partner providers.**
- 3. CHPs, Mental Health Services and partner organisations should remove barriers to accessing care and ensure a non-discriminatory delivery of care. Available resources should be utilised to follow up people who are more difficult to engage in health care.**
- 4. Mental Health Services must make or co-ordinate arrangements for the additional screening of patients whose treatment requires that they receive more than an annual review, or lithium monitoring, in primary care.**
- 5. The Scottish Government Mental Health Division will work with the 'Keep Well' programme to identify opportunities to integrate initiatives such as this with local Mental Health Services in order to widen opportunities for this population group during 2008 and beyond by building on the work that will be taken forward by the RCGP in relation to diabetes, CHD and depression.**
- 6. CHPs and other agencies or services involved in health promotion and health screening activity for people with severe mental illnesses must have in place robust monitoring and review arrangements through audit, Integrated Care Pathways (ICPs) or other means of validation and tracking variances in care.**

Evidence Base

The mortality rate from physical illness for those with mental health problems is significantly higher than in the general population. Schizophrenia is generally acknowledged as a life shortening illness with sufferers dying on average 10 years earlier than the general population. Two thirds of this excess mortality is due to poor physical health.

Equal Treatment: Closing the Gap (2006) includes an analysis of 8 million health records by the Disability Rights Commission (DRC) in England and Wales. It confirms that for people with schizophrenia and bipolar disorder the rates of ischaemic heart disease, stroke, high blood pressure and diabetes are higher than in the general population, with diabetes 2 to 3 times more common than expected. Bowel cancer is 90% more likely in someone with schizophrenia and women with schizophrenia are 42% more likely than other women to get breast cancer.

People with major mental health problems are also developing these illnesses at a younger age and are dying from them earlier with 5 year survival rates reduced by up to 16%.

This and other studies of general practice based populations have shown that increased mortality rates from cardiovascular disease in people with severe mental illness is a robust finding even when smoking rates and deprivation are taken into account.

There may be a range of factors contributing to elevated levels of obesity and diabetes including medication and related weight gain. These factors are also involved in the development of cardiovascular disease, the leading cause of excess mortality due to physical illness. Some causal factors are potentially amenable to change. These include lifestyle factors, in particular smoking (where rates among this care group are up to twice that of the general population), poor diet and lack of exercise. Where the presence of cardiovascular disease has been established there is evidence that those with additional mental health problems are less likely to receive quality interventions which could improve outcomes.

Given this evidenced context it is important for primary care and mental health services to respond to the clearly established health needs of this group in a targeted way, with reasonable adjustments for disability status and with clearly communicated responsibilities.

The Quality and Outcomes Framework (see section on *GMS Contract for Primary Medical Services* for context), Mental Health indicators provide incentives for General Practices to offer regular reviews with, 'routine

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health promotion and prevention advice appropriate to age, gender and health status for people with a diagnosis of schizophrenia, bipolar disorder or other forms of psychosis'. Though delivery is entirely voluntary, encouragingly, the uptake is high.

Key papers outlining the suggested content of annual physical reviews for people with severe mental health problems and the evidence base for increased physical morbidity and premature mortality within this patient group are listed in Annex C: Evidence base. Examples of how some services have responded are shown in Annex B: Practice examples and Annex C.

Added attention is needed for people who may not absorb the public health and other initiatives targeted at the wider population through established mediums and approaches. The shortcomings of such blanket approaches have been highlighted by the initial reports from the Keep Well, Anticipatory Care Initiative- *Have a Heart Paisley*.

Consideration must be given to the importance of opportunistic brief health promotion and screening interventions, for example at routine GP or outpatient appointments. It is clear, that even for those in contact with services opportunities are being missed.

Service Users and Carers

Many service users confirm they want attention paid to their general health and wellbeing including smoking cessation input, dietary and other lifestyle advice and physical screening. They are also becoming increasingly aware of the potential for improved mental health if their physical health is optimal.

Service users, carers and families must be given all opportunities to learn of the importance of maintaining and improving their physical health and the beneficial effects on mental health. Information must be provided in accessible formats to help illustrate ways to reduce possible risks to health.

Stigma and Discrimination

People with a mental illness have often found that when it comes to their physical health needs they can be subject to unequal access to services and can often feel stigmatised and discriminated against when they try to access general health care services.

Legislation is in place to counteract and deal with discrimination on the grounds of disability, including mental disability. There is also now a legal

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duty on all public agencies including the NHS to be proactive in supporting the rights of people with disabilities.

Management and Treatment of Physical Health and Wellbeing

Improving the management of physical health and wellbeing for people with a mental illness should be embedded within existing health improvement policies and practice, and health promotion, screening and recovery initiatives must be equally available to all.

Keep Well

Keep Well is a 3 year anticipatory care programme that focuses on tackling the main risk factors associated with the early onset of cardiovascular disease within areas of multiple deprivation. The programme represents a key component of the Scottish Government's drive to reduce health inequalities. The initiative is already piloted across 7 NHS Board areas with a stated aim to increase the rate of health improvement, with a particular focus on early intervention for those at a high risk of coronary heart disease and its main risk factors in the age group 45-64 years.

Communities selected for the initial stage involve Community Health Partnership (CHP) populations in North Glasgow, East Glasgow, Edinburgh, Dundee and North Lanarkshire.

Currently 166 practices are proposed for Wave 2. This would provide the opportunity for up to 44,000 individuals to go through the Keep Well process. Health Checks commenced in November 2007.

The Keep Well Health Check includes 3 main assessment areas; clinical (e.g. Height, Weight, Blood Glucose and Cholesterol), lifestyle (e.g. Smoking, Physical Activity and Diet) and life circumstance (Learning, Employability and Income Maximisation). Based on assessed need a range of NHS and non-NHS treatments, services and supports are offered thereafter.

(See Annex B for the overlap/omissions between the Keep Well health check information and the guidance for the Quality and Outcomes Framework Mental Health Indicators currently used by GPs in Greater Glasgow and Clyde).

In developing planned and tailored interventions for individuals, the Keep well approach takes account of the importance of co-morbidity, which often involves both physical and mental health elements, and therefore the need to take account of mental health issues in tackling risk factors for physical diseases.

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The shared objectives to improve the physical health of those with mental illness are considerable, and there is a requirement to ensure that key elements such as engagement, health assessment and care and support are progressed in concert.

To support this objective it is proposed that a logical set of actions are considered between National representatives, Keep Well Wave 1 & 2 areas and local Mental Health services. This consultative process would be facilitated via the Keep Well Delivery Infrastructure.

This process would not only inform health check plans for individuals with an enduring mental illness within the Keep Well target populations, but might also assist in establishing a way forward for this work for the population served by Community Mental Health Services as a whole.

To support 'Keep Well' areas a commitment in the Keep Well Delivery Plan 2007/08 has already been agreed with financial investment in "areas of new or innovative practice focused on key elements of the care pathway and specific population groups".

Performance Management and Delivery

The examples listed in the section on *Practice Examples* provide suggestions for review and improved local practice. A number of support mechanisms and means of information gathering can be used to help benchmark existing provision and measure progress including:

- ISD Quality and Outcomes Framework data for Scotland (<http://www.isdscotland.org/isd/3305.html>); and the
- Joint NHS Board/Local Authority Delivering Mental Health Implementation Indicator returns to assess progress with meeting and monitoring the commitment to improve physical health.

Practices should consider the exclusion and exception data to review their practice performance as well as to ensure that appropriate high quality care is being delivered.

The 2007 NHS Quality Improvement Scotland published standards for Integrated Care Pathways for mental health include the recording of "A general physical health assessment and management of the findings" on an annual basis. It is anticipated these health reviews will include or resemble those carried out in Primary Care under the Quality and Outcomes Framework.

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Establishing clearly articulated responsibilities and the appropriate sharing of information within confidentiality limits will:

- focus attention on health needs requiring action;
- prevent loss of follow up; and
- prevent needless duplication.

The Scottish Government will also monitor responses through the regular Mental Health Implementation Review arrangements and visits that it has with NHS Boards and partners. NHS Boards will be expected to demonstrate:

- The priority given to health improvement initiatives for *hard to reach* care populations, particularly those with mental health problems;
- Ongoing collaboration between primary and secondary care for appropriate coverage for this care population;
- Ongoing liaison with local health improvement practitioners to facilitate and/or design evidence based health improvement interventions for this care population;
- Evidence in secondary care, of a physical health assessment as outlined in the standards for ICPs or confirmation that a review in primary care under QOF is adequate for individual needs; and
- Evidence in inpatient care that at least the same standards are met for those in hospital for more than 12 months.

Equity of access for delivery of care

Among people with severe mental health problems there are those for whom special considerations may apply. Specific examples are set below:

Age - Younger

Services delivering early intervention for psychosis must be particularly vigilant when recommending drug treatments with the potential for “metabolic” side effects such as weight gain and glucose irregularities. Frequent monitoring from the outset, coupled with appropriate action if side effects emerge are necessary to prevent an insidious slide into obesity and poor physical health at a young age and for the longer term.

Age - Older

Those in the over 65 population are more prone to falls, confusion regarding medication regimes, nutritional neglect and co-morbid physical

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health problems. In addition, they may have fewer (or older) carers and they may experience physical or sensory barriers to health care.

Social care services may need to contribute more to the enabling of older people with mental health problems such as schizophrenia and bipolar disorder to access regular health and well being input.

Learning Disabilities

For people with a learning disability, having a mental illness can add to the health inequalities gap. Factors include lack of self-reporting of symptoms and barriers to access such as physical, cognitive and overt discrimination. People with learning disabilities have a different pattern of health need and a different pattern of leading causes of death.

Targeted work should take account of the specific needs of this group and the individuals within it. This is best done in consultation with specialist learning disabilities services or in keeping with arrangements in place under the GMS Local Enhanced Services, (see section on *GMS Contract for Primary Medical Services*).

Black and minority ethnic groups

For some in this population there is an even higher risk of diabetes and related physical problems. There is a need therefore to ensure that the delivery of care reflects particular considerations. These considerations will include cultural, gender and other relevant aspects.

There may also be stigma issues for some associated with mental ill health, culturally different distinctions between mental and physical health, language barriers and evidence bases and monitoring systems not accounting for race.

Disability

Where an individual has a suspected or established physical or sensory disability, steps must be taken to ensure that their needs are clarified and responded to appropriately.

Inpatients

Individuals in psychiatric inpatient care for more than a year should be offered an appropriate annual review of their health promotion, prevention and physical care needs by suitably trained practitioners. This in addition to any specific requirements associated with their treatment or co-morbid illnesses.

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Medication Treatment

Extra monitoring is required for those whose treatment includes medication at high dosage or with special monitoring requirements (e.g. Clozapine). This may involve extra contacts with general practice or acute services when ECGs (electrocardiograms) or extra blood tests are required.

Sexual Health

In addition to contraceptive needs consideration must be given to education about the risks of sexually transmitted diseases. Sexual dysfunction can be directly attributed to some medications and when problematic can lead to some deciding to stop their treatment with associated risks to their mental health.

Anyone recommending or prescribing drug treatments with the potential for causing sexual dysfunction should ask about the presence of this or other side effects and consider the need to organise a check of an individual's prolactin levels with appropriate follow up.

Linked initiatives

Other initiatives support the overall objective of improved physical and mental health including attention to the potential for depression and anxiety arising among those with a new diagnosis of CHD or diabetes.

Reducing co-morbid depression and anxiety in CHD and diabetes

In keeping with the Commitment published in 2006, to improve assessment and treatment models for those with depression and anxiety, work is underway in partnership with the Royal College of General Practitioners, and others to evaluate the effectiveness of local stepped care pathways (such as training; skills development; service improvements; partnership working etc) in reducing co-morbid depression and anxiety in CHD and diabetes.

Substance misuse

National policy on the treatment of those with substance misuse problems is firmly directed towards addressing not only the immediate needs of addiction but also the underlying difficulties, which are often present, including physical and mental health. There is a close link in the work identified within this guidance and the publication of 'substance misuse and co-morbidity mental health' (published December 2008).

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The National Quality Standards for Substance Misuse (2006) are clear that clients need to be involved at all stages of assessment and care planning and that Services should work with a wide range of partners, including other services, to ensure that client needs are met.

As at 2007 Drug-related deaths continue to rise in Scotland. A minority (10% over the preceding five years) are attributed to intentional self-poisoning. To reduce this needless loss of life the (then) Scottish Executive published *'Taking Action to Reduce Scotland's Drug-related Deaths'* (2005) which reinforces the need for good practice, better information, better engagement, rapid intervention, improved treatment and better integration. The Scottish Government guidance (2007) **Closing the Gaps - Making a Difference** also refers.

Food and health

The policy framework for food and health is well established through the *Scottish Diet Action Plan* and through *Eating for Health - Meeting the Challenge* which set the context of wider health improvement policy. There are particular issues for low-income areas and vulnerable groups including those with mental health issues. Good nutrition can influence good mental health.

Health improvement - key policies and evidence

The National Institute for Health and Clinical Excellence (NICE) in England produces two types of guidance on public health topics: Public Health Interventions Guidance and Public Health Programmes. In Scotland, such Guidance has no formal status but attracts interest and provides a useful source of reviewed evidence and NHS Health Scotland (HS) produces Commentaries on NICE Public Health Guidance. The full Commentaries are available at www.healthscotland.com

This following references and information are presented for discrete topics, but carry clear implications for co-morbidity.

Physical activity

Let's make Scotland more active: A strategy for physical activity. (Former) Scottish Executive Physical Activity Task Force (February 2003).

<http://www.scotland.gov.uk/Publications/2003/02/16324/17895>

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Key source of evidence for this public health message was updated in 2004 in *Department of Health: At Least five times a week: evidence on the impact of physical activity and its relationship to health* - Department of Health/Chief Medical Officer England 2004

NICE Public Health Intervention Guidance no. 2: Four commonly used methods to increase physical activity: brief interventions in primary care, exercise referral schemes, pedometers and community-based exercise programmes for walking and cycling. (March 2006).

http://www.nice.org.uk/nicemedia/pdf/PHYSICAL-ALS2_FINAL.pdf

Weight management

Scotland does not have a specific policy on obesity - in line with the World Health Organisation Strategy for Obesity, the overall approach has been to tackle through comprehensive strategies for food and physical activity.

Public health aspects of NICE Clinical Guideline 43: *Obesity: guidance on the prevention, identification, assessment and management of obesity in adults and children* (December 2006).

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11000>

Health Scotland has replaced Recommendation 2.13 with the following;

Consideration should be given to possible roles for health professionals in working with local partners to promote healthy eating choices, consistent with existing good practice guidance, and to provide supporting information - taking account of relevant national and local schemes.

However, any such involvement should be considered in the wider context of how health professionals can best contribute to the overall picture of local multi-component efforts and partnerships.

Alcohol

Plan for action on alcohol problems, - updated Scottish Government (2007).

Scottish Intercollegiate Guidelines Network 74. *The management of harmful drinking and alcohol dependence in primary care: a national clinical guideline. Updated.* September 2003. Edinburgh: SIGN.¹

<http://www.sign.ac.uk/pdf/sign74.pdf>

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Slatterly, J. et al. *Health Technology Assessment Report 3: Prevention of relapse in alcohol dependence. Updated.* December 2005. Glasgow: NHS Quality Improvement Scotland.

www.nhshealthquality.org/mentalhealth/uploads/get_attachment.php?

Smoking

'Smoking Kills' is the UK wide white paper on tobacco. Published in 1999, it sets out a comprehensive tobacco control programme. The Scottish Government responded by driving implementation in a Scottish context through '*A Breath of Fresh Air for Scotland*'² the tobacco control action plan. <http://www.scotland.gov.uk/News/Releases/2004/01/4883>

Taken from NICE Public Health Intervention Guidance 1 on Brief intervention and referral for smoking cessation in primary care and other settings. (March 2006)

<http://www.nice.org.uk/guidance/index.jsp?action=byID&o=11375>

Health Scotland Note: Specific Scottish contextual points

Consistent with the Smoking Cessation Guidelines for Scotland 2004 Update, nurses in primary and community care should be encouraged to access accredited training in brief intervention.

Consistent with the Smoking Cessation Guidelines for Scotland 2004 Update, all relevant health professionals should be encouraged to access accredited training in brief intervention.

Specialist pharmacy based cessation services are in place, and are seen as having an important part to play, in some areas. The effectiveness of such services should be further assessed.

Consistent with the Smoking Cessation Guidelines for Scotland 2004 Update, relevant workers in the local government, community and voluntary sectors, should be encouraged to access accredited training in brief intervention.

Specific Scottish contextual points - Relevant to NHS Boards, Community Health Partnerships (CHPs), community pharmacies, local authorities, and community and voluntary sector groups and organisations; the introduction, on 26 March 2006, of smoke-free legislation has already prompted further investment in smoking cessation services in Scotland to enable NHS boards to increase the capacity and reach of services; any further review of

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smoking cessation services policy/provision in Scotland should take account of this Commentary and Smoking Cessation Guidelines for Scotland 2004 Update.

The 2007 NICE Public Health Intervention Guidance on workplace smoking cessation, on which Health Scotland will produce a commentary, will also be of relevance.

Specific targets for adults and pregnant women in deprived communities have been set for Scotland.

Allocations of smoking cessation funding to NHS boards reflect the Scottish Government's stated aim of closing the inequalities gap, and include specific funding for smoking cessation for the Keep Well anticipatory care pilots, which are aimed at reducing inequalities in health.

Local tobacco alliances, supported by ASH Scotland, are being developed across Scotland with a focus on areas of social deprivation and amongst specific target groups.

The PATH Tobacco & Inequalities Project funds activity in Scotland.

HS, ISD and ASH Scotland's planned An Atlas of Tobacco Smoking in Scotland publication will assist with targeting at CHP level.

Consistent with the Smoking Cessation Guidelines for Scotland 2004 Update, smoking status information should be recorded in the patient's case notes and smoking cessation services data should be entered into the NHS Smoking Cessation Minimum Database.

General Medical Services Contract for Primary Medical Services

Since 2004 additional resources have been provided to deliver high quality and consistency of primary care healthcare services.

These have been made through the General Medical Services (GMS) contract by setting standards to address the management of illness, undertake health promotion and health protection, ill health prevention and improvement of health and public health. The expectation is that individuals' health is managed in the social context of their families/carers and the community in which they live.

The impact is monitored through the Quality and Outcomes Framework (QOF), which is published annually.

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The contract includes; the provision of essential services; additional services; QOF and enhanced services. The first two are largely compulsory. The QOF and some enhanced services are optional. Enhanced services are commissioned at the discretion of NHS Boards and depend on local prioritisation. The Directed Enhanced Services are compulsory but are for NHS Boards to commission.

Encouragingly participation in the directed enhanced services and the QOF, which have to be offered by the NHS Boards, has been very high among the GMS Practices in Scotland. Practices not on the GMS contract have also attempted to deliver services to at least the level of the GMS contract.

GP Practices are resourced to provide primary health care to all individuals registered with the practice, as appropriate, whether they have mental ill health, physical ill health or are generally in good health. Therefore anyone with a mental health condition should receive similar attention and monitoring to those with physical ill health, and for co-existing physical conditions identified through the appropriate registers.

The following synopsis, gives some indication of the way in which GP Practices are supported to provide care to people They include:

Essential Services

These require the management of patients who are ill or believe themselves to be ill, including health promotion advice and referral as appropriate, reflecting patient choice wherever possible. Health promotion advice includes advice regarding life style issues such as weight management diet, smoking cessation, regular physical activity and moderation in alcohol intake.

Impact on Mental Health

Although the titles or the content may not specifically mention “mental health”, the activities undertaken will have an impact on mental health e.g. improving access, a focus on people with learning disabilities; supporting carers’ mental and physical wellbeing; increasing confidence, independence and well being by preventing falls in older people; and using brief interventions for hazardous and harmful intake of alcohol.

Services designed to manage patients with chronic lung disease (COPD) and diabetes are likely to improve their well being, while those addressing childhood obesity may impact on self esteem. Also, a review of referral processes for a presumed diagnosis of cancer may help people and their carers with the associated depression and anxiety.

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Additional services

These include: *Cervical screening, Child Health Surveillance, Maternity services; and Contraceptive services*

Quality and Outcomes Framework of the General Medical Services contract,

www.gpcontract.co.uk

Indicators include the development of a register and specified clinical management of patients with the following conditions:

- *Secondary prevention of Coronary Heart Disease (CHD)*
- *Heart Failure.*
- *Stroke and TIA.*
- *Hypertension*
- *Diabetes Mellitus*
- *Epilepsy*
- *Hypothyroid*
- *Cancer*
- *Palliative care*
- *Asthma*
- *Chronic Kidney Disease*
- *Atrial Fibrillation*

The following QOF indicators are particularly relevant to the published commitment on physical and mental health.

- ***Mental health*** – register of people with schizophrenia, bipolar disorder and other psychoses; annual review to include routine health promotion and prevention advice appropriate to their age, gender and health status; monitoring lithium therapy; comprehensive care plan agreed with patients and their family/carers recorded; active follow up by the practice team, within 14 days, of people who fail to attend.
- ***Dementia*** – register of people with dementia; annual review of care.
- ***Depression*** – annual review of patients with diabetes and and/or CHD to check for depression; patients with a new diagnosis of depression have an assessment of severity using a tool validated for use in primary care.
- ***Learning Disabilities*** – register of patients with learning disabilities.
- ***Obesity*** – register only of patients 16 years and over with a BMI equal to or over 30 in the previous year.
- ***Smoking*** – smoking cessation in patients with coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, asthma.

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There are additional service related indicators in the following areas:

- *Records and information* -e.g.; an indication for a drug on repeat medication recorded in the notes; record of ethnic origin; record of the smoking status of people over 15 years of age.
- *Information for patients*
- *Education and training* -including significant event analysis e.g.; of suicides, medication errors, admissions under the Mental Health Act and others.
- *Practice Management* -e.g.; protocol for identification of carers for social services assessment
- *Medicines management* -e.g.; availability of repeat prescription within 72 hours; annual medication review of patients on repeat medication.
- *Patient Experience* e.g.; annual patient survey and reflection on the results.

Enhanced Services

These are essential and additional services delivered to a higher specified standard or those services not provided through essential and additional services.

- *Directed Enhanced Services* - minor surgery; childhood and influenza immunisations.
- *National Enhanced Services* - specialised drug and alcohol misuse services; specialised depression services; specialised services for sexual health; minor injury services; enhanced care of the homeless; contraceptive fitting (IUCD); specialised services of multiple sclerosis; and others.
- *Scottish Enhanced Services Programme* - local and accessible health care (Adults with Learning Disabilities; Care for Adults with Diabetes; COPD rehabilitation; Flexible appointment sessions); improving public health (alcohol screening and brief interventions in harmful and hazardous drinking, falls prevention and bone health, cancer and urgent referral, carers and childhood obesity). NHS Boards can choose the areas, with a minimum of three services.

PRACTICE EXAMPLES

The following good practice examples offer insights to approaches for better outcomes for this care group and their families.

NHS Grampian

Additional developments have arisen including a walking group and smoking cessation interventions. Clinic staff also suggests local opportunities for men and women looking to take part in organised sport.

Community Mental Health Teams (CMHTs) in Fraserburgh and Peterhead have introduced annual Lifestyle Clinics for patients known to be suffering from Schizophrenia or Bipolar Affective Disorder. The clinics have been running for over three years and have been well attended.

Fraserburgh and Peterhead CMHTs created registers of patients with the relevant diagnoses. Following a team “away day” and wide consultation a protocol for screening measurements was developed.

Blood pressure measurement, urinalysis, ECG, BMI calculation, side effects screening and a series of blood tests are performed at an annual clinic to which every patient on the register is invited.

Clinics are run jointly by CMHT staff and practice nurses. All clinics are held in the GP surgeries. CMHT members facilitate attendance for their outpatients.

Where lifestyle screening highlights a risk factor further input is arranged (community dietician, exercise groups or smoking cessation advice etc). CMHT members also help with follow up appointments with GPs if abnormal results are shown from tests.

Outcomes to date:

- Attendance rate over 70% in year one in one centre indicated the feasibility of the initiative;
- Joint working between general practice and CMHT staff has consolidated shared care for this vulnerable patient group;
- Many treatable physical illnesses have been highlighted and brought to the attention of the primary care team; and
- Introduction of health screening to a group of patients who traditionally do not attend for such opportunities.

More details available from:

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Greater Glasgow and Clyde

Glasgow and Clyde experience - GMS contract/Mental Health interface

In Glasgow, GPs from the GMS contract group helped determine what can be most usefully achieved for patients under the current Mental Health Indicators. Evidence based guidance notes for GPs around the mental health indicators have been produced.

This guidance was circulated to all GPs in Glasgow and Clyde in January 2007, following the approval of the GMS contract group, the Mental Health Partnership and the CHCP Clinical Directors group.

Relevance to Mental Health Services Staff

Glasgow and Clyde recognises the importance of Mental Health Services staff sharing relevant clinical information with primary care colleagues.

This includes:

- Details and results of any physical reviews carried out on patients with severe and enduring mental illness;
- Care Plans, including those completed as part of the Integrated Care Pathway (ICP) and Care Programming (CPA);
- Other clinical information relevant to patients' care plans - which may include outpatient arrangements, Key worker details etc, as is standard for Community Mental Health Team contacts; and
- Collaboration in maintaining the accuracy of mental health registers in general practice under QOF.

Benefits

More focussed sharing of information regarding patients' care plans;
Improved communications between primary and secondary care;
Reduced likelihood of patients missing out on follow up;
Reduced likelihood of inaccurate information; and
Patients receiving improved health assessments in Primary Care.

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Next Steps

Ongoing work with colleagues in General Practice to ensure application of the QOF Mental Health Indicators helps to improve the health and well-being of patients with severe and enduring mental health problems.

Reviewing related practice in mental health care to ensure there is good accordance with the evidence based approach adopted in primary care. (E.g. ICP reviews, health and wellbeing clinics).

Consideration of training and I.T. needs.

More details available from:

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NHS Lothian

NHS Lothian has published a series of " Don't Panic" guides (currently on issue 7) keeping GPs and others up to date with changes to the QOF indicators and related issues.

The latest guide is available at:
<http://www.rcgp.org.uk/pdf/Lothian%20Dont%20Panic%20Guide%207.PDF>

Further details from:

GMS.contract@lpct.scot.nhs.uk (with "Don't panic!" in the title line)

NHS Lanarkshire

GUIDANCE HAS BEEN PREPARED TO SUPPORT THE DEVELOPMENT OF PRO-ACTIVE PRIMARY MENTAL HEALTH CARE AND ASSIST PRACTICES TO MEET THE REQUIREMENTS OF GMS (NGMS). THE GUIDANCE FOLLOWED LOCAL DISCUSSION WITH PRIMARY AND SECONDARY CARE PRACTITIONERS AND IS DESIGNED TO FACILITATE A CO-ORDINATED APPROACH TO DELIVERING THE INDICATORS IN A CONSISTENT, EFFICIENT AND EFFECTIVE WAY, IN LINE WITH APPROPRIATE GUIDELINES.

THE GUIDANCE FOCUSES ON THE MENTAL HEALTH, DEPRESSION AND DEMENTIA INDICATORS.

Separate guidance will be prepared for the learning disability indicators.

The clear systematic guidance offered includes relevant flow charts, read codes and a range of appendices. Links to further information are also included.

The guidance focuses on approaches to improve the health of people with severe/ enduring mental health mental care needs, depression and dementia living in Lanarkshire while also addressing the needs of their carers.

Liaison

Liaison is offered from secondary care services to support practices to implement the Mental Health indicators where the practice has identified a named person within the practice to lead on the mental health indicators.

The liaison focuses on the development of accurate mental health and dementia registers, which the practice can then use to meet the various indicators. The level of liaison will vary but includes:

Each Practice will have a named mental health professional from the community mental health team (CMHT) as liaison to the practice;

The CMHT will provide a list to each practice, of clients known to them who meet the criteria for inclusion on the mental health register;

The named mental health professional will offer to meet with the practice a minimum of twice a year to update the registers and share information with the practice;

The named mental health professional will also liaise with the practice to advise that they should also request patient lists from older people services, forensic services; and Psychiatric outpatients, resettlement teams and rehabilitation services, amongst others, to identify people for inclusion on the register.

Patient Reviews

Face-to-face reviews focus on support needs of the patient and their carer. In particular the reviews address:

- An appropriate physical and mental health review for the patient;
- The carer's needs for information commensurate with the stage of the illness and his or her and the patient's health and social care needs (if applicable);
- The impact of caring on the care giver and co-ordination arrangements with secondary care (if applicable); and
- Communication and co-ordination arrangements with secondary care (if applicable).

Available Documentation

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1. Guidance on putting the primary care registers together
2. Example patient review letter
3. Example annual review questionnaire.
4. Example summary care plan
5. Patient Health Questionnaire – PHQ9 for depression
6. Secondary Care List pro-forma

More details available from:

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NHS Lanarkshire
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NHS Western Isles

The concept of Psychiatric Annual Review Clinics (PARC) for patients with a severe and enduring mental illness was introduced in response, initially, to the targets and outcomes required from the NHS QIS *Standards for Schizophrenia*.

The diagnostic criteria was extended to include patients with either bi-polar or schizo-affective disorders.

These arrangements have been introduced for Lewis and Harris with a view to wider roll out soon to the Uists and Barra.

Procedure

Three weeks prior to the clinic, pro-forma letters are sent to both the patient and their GP. The patient letter explains the format of the clinic, asks the patient to make an appointment with their GP and encourages them to bring their principal carer to the clinic.

The GP letter and a form inviting a written up-date of their contacts with the patient, and current opinion covering any concerns around the patient's physical, mental or psychosocial needs and includes a list of tests that the GP is invited to perform (e.g. Prolactin, U & E's, Blood Lipids, LFT's, TFT's, FBC, B.P and ECGs).

This information is to be returned to the administrator with an up-to-date list of the patient's medication.

At the clinic, the patient has three consecutive appointments, in sequence, with

- A Community Psychiatric Nurse;
- A Specialist Social Work Practitioner in Mental Health; and finally with
- A Consultant Psychiatrist.

The CPN will have the returned pro-forma from the GP and will complete their section to include any outstanding concerns of the patient and/or their carer together with any presenting problems or areas of unmet need.

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The CPN will carry out a global rating using the Health of the Nation Outcome Scales (HoNOS), will assess side-effects using the Autonomic Involuntary Movement Scale (AIMS) and measure weight.

The patient and their carer will then have an assessment by the Specialist Social Worker, again recorded on the same pro-forma.

Finally, the patient will be seen by the Consultant who will have the completed reports from the other professionals. The consultant will be able to access all of the results of the blood tests that were performed electronically from SCI store

At the end of the clinic the Consultant, CPN and Specialist Social Worker will meet to discuss findings. The completed pro-forma will form the main outcome record for the clinic.

Outcomes

To date, following 6 of these quarterly clinics, a number of positive results are shown.

- 3 patients have had under-active thyroids detected;
- 2 patients have had elective admissions for major changes in medication prompted by side-effects;
- A number of others have had changes made in the community and onward referrals to Social Work, Dietetics and the Mental Health Occupational Therapy Service; and
- Feedback from patients and carers has been very positive with carers, in particular, expressing satisfaction with what they describe as their "MOT Clinic".

Challenges

The main challenge has been securing sign up by all practitioners. Many are now more responsive and we are hopeful for comprehensive engagement soon.

More details available from:

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Team Leader CPNs,

Lewis & Harris

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EXAMPLE GUIDANCE FOR QUALITY AND OUTCOMES FRAMEWORK MENTAL HEALTH INDICATORS (FOR GPs IN NHS GREATER GLASGOW AND CLYDE 2007)

Key

- In Keep Well Health Check (KWHC) & Delivering for Mental Health
- In KWHC only
- No Highlight - not included in KWHC

Suggested Actions	Potential Responses
SUGGESTED HEALTH PROMOTION and PREVENTION ADVICE (MH9)	
1. Note CVD medical history, family history and systems enquiry (Chronic Disease Register Status)	1. Pursue any suspicious symptoms identified on systems enquiry
2. Health related behaviours <ul style="list-style-type: none"> Smoking; record if current smoker (quantity), ex-smoker or never smoked Diet; record if problematic Physical activity; ask if thinking about becoming more active COMPLETE HEART HEALTH RISK SCORE	2. Health related behaviours-intervention advice <ul style="list-style-type: none"> If wishes to discontinue offer referral, e.g.; local groups, community pharmacies Offer general dietary advice Aim to accumulate 30mins or more of moderate intensity physical activity over the course of most days per week. Can offer referral to Live Active or GCVS if appropriate
3. Risk behaviours <ul style="list-style-type: none"> Alcohol; record details and pattern of consumption Illicit drugs 	3. Risk behaviours <ul style="list-style-type: none"> If suspect hazardous drinking offer advice/referral If suspect hazardous illicit drug use discuss liaising with CMHT or CAT
4. Check if additional health promotion activity required <ul style="list-style-type: none"> flu /pneumococcal vac, sexual health including cervical smear and contraception, eye screening, dental check, etc 	4. Additional health promotion <ul style="list-style-type: none"> Discuss arrangements where indicated
5. Height/Weight/BMI <ul style="list-style-type: none"> Record details Plus waist circumference 	5. Height/Weight/BMI <ul style="list-style-type: none"> If BMI is 25-30 (overweight) - offer advice If BMI > 30 (obese) - discuss referral to local weight management services
6. Pulse and blood pressure <ul style="list-style-type: none"> Record rate and regularity of pulse Record blood pressure 	6. Pulse and blood pressure <ul style="list-style-type: none"> If irregularly irregular refer to <u>AF Guidelines</u> If systolic >140 or diastolic >90 refer to <u>hypertension guidelines</u> and consider adding to the <u>hypertension register</u>
7. Investigations <ul style="list-style-type: none"> Glucose - it is good practice to check if; diagnosis in schizophrenia spectrum, or on any antipsychotic medication (cross check prescription with BNF), and no measurement recorded in the past 12 	7. Investigations <ul style="list-style-type: none"> Repeat and/or refer to diabetes diagnostic criteria and <u>diabetes MCN referral guidelines</u> if abnormal result obtained Repeat and/or refer to <u>cholesterol guidelines</u> for management if abnormal result obtained and set cholesterol

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<p>months (fasting lab sample preferred) CVD medication assessed Lipids – It is good practice to check if; on any antipsychotic medication (check BNF) and no measurement recorded in past 24 months. Total Cholesterol, High Density Lipids and Low Density Lipids.</p>	<p>screening interval to annually.</p>
<p>MEDICATION MANAGEMENT (MH9, MH4, MH5)</p>	
<p>8. Prescribing accuracy</p> <ul style="list-style-type: none"> ▪ Check if prescribed and taken medication matches recent CMHT communication ▪ Note any significant side effects ▪ Note willingness to continue on prescribed medication <p>9. If on Lithium;</p> <ul style="list-style-type: none"> ▪ Check level if no record of level in therapeutic range in past 6 months ▪ Check serum creatinine and TSH if no result recorded in past 15 months 	<p>8. Prescribing accuracy</p> <ul style="list-style-type: none"> ▪ Liaise with CMHT if significant problems identified <p>9. Action if levels/creatinine/TSH result unsatisfactory when on Lithium</p>
<p>CARE PLANNING AND CO-ORDINATION WITH SECONDARY CARE (MH6, MH7) (refer to CPA and ICP documentation if in existence)</p>	
<p>10. Determine current social care and occupational needs</p> <p>11. Review CMHT/voluntary sector/family input and co- ordination arrangements</p> <p>12. Discuss early warning signs (relapse signature) and action to be taken in the event of relapse</p> <p>Signposting and Referral Information Recorded</p>	<p>10. Discuss liaison with CMHT if significant problems identified</p> <p>11. Discuss liaison with CMHT/voluntary sector/family if significant problems identified</p> <p>12. Discuss liaison with CMHT/voluntary sector/family if significant problems identified</p>
<p>PROACTIVE FOLLOW UP (MH7)</p>	
<p>13. Recall within 14 days if fail to attend review appt.</p>	<p>13. If fail to attend three appts liaise with CMHT (if under their care) or send a fourth invite.</p>
<p>14. Additional Keep Well Questions –</p> <p>Literacy Benefits Employability</p>	

Abbreviations

CMHT*	=	Community Mental Health Team
CAT	=	Community Addictions Team
CPA	=	Care Programming Team
ICP	=	Integrated Care Pathway
SW	=	Social Worker
AF	=	Atrial Fibrillation
BNF	=	British National Formulary
MCN	=	Managed Clinical Network
GCVS	=	Glasgow Council for Voluntary Services

* Some CMHTs may not have an integrated Social Work team. In these circumstances liaison with Social Work colleagues may have to be done separately.

EVIDENCE BASE

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6. Role of antipsychotic medication in physical morbidity

The potential impact of antipsychotics on lipids in schizophrenia: is there enough evidence to confirm a link? Bush C., & Paton C. (2005). Journal of Psychopharmacology

Metabolic disturbances associated with antipsychotic use. Newcomer J.W., Haupt D.W., Fucetola, et al. (2001). Journal of Clinical Psychiatry (supplement)

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B. USA

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