Closing the mortality gap

Opportunities in sustainability and transformation planning

April 2016

Transforming London's health and care together

Closing the mortality gap for people living with serious mental Illness (SMI)

Opportunities in sustainability and transformation planning

This guide has been designed to support colleagues involved in developing London's Sustainability and Transformation Plans (STPs). Clinical leaders have prioritised domains for action for those seeking to improve the physical health outcomes for those living with SMI. It identifies levers to support system change. It is grounded in the recommendations of the Mental Health Taskforce.

The London Health Commission ambition is to reduce the gap in life expectancy between adults living with SMI and the rest of the population by 10%. Clinical Leaders have identified activities and outcomes by care settings that will contribute to delivering that ambition. It is envisaged that new Models of Care will erode demarcations between settings.

Healthy London Partnership will develop this guide further to provide detailed information by healthcare setting to support colleagues with the implementation of their Sustainability and Transformation plans.

Poor quality care contributes to worse health outcomes for people with SMI

There is clear evidence that illuminates the very stark health inequalities between the physical health of people living with SMI, and those of the general population.

- There is a health and well-being gap reflected in the 10-20 year mortality gap for those with SMI. This is related to a *care and quality gap* in provision of physical health care.
- Individuals with SMI have a higher rate of physical co-morbidity across many physical illnesses resulting in part from inadequate primary prevention and exclusion from many public health interventions.
- This risk of co-morbidity is heightened and associated particularly with smoking, other health behaviours such as diet and activity levels and psychotropic medication use.
- Individuals with mental health problems from marginalised groups including Black and Minority Ethnic (BME) communities, homeless people, older adults, those in contact with the criminal justice system and people with learning disabilities have a further elevated risk of poor health outcomes.

The disparity in health outcomes is in part due to inadequacies in current health and care systems. The inaccessibility of physical healthcare services to people living with SMI produce wider system costs. These costs indicate the opportunity to produce more value through new models of care that help close *'the cost and efficiency gap'*.

Public Health England's (PHE) fingertips tool can be used to explore local data relating to these issues: http://fingertips.phe.org.uk/profile-group/mental-health/profile/severe-mental-illness

Delivering the Five Year Forward View

NHS England policy requires parity of esteem between mental and physical health. The gap in life expectancy and associated significant health inequalities for those living with SMI, are central to this.

The NHS Mandate

NHS England's performance will be measured against the following objective:
'To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole'.

Delivering the Five Year Forward View; NHS Planning guidance 2016/17 – 2020/21

The guidance states that the STPs include the new Early Intervention in Psychosis (EIP) access standards and repeats the need to deliver the NHS Mandate objective to close the health gap.

- Must do - Achieve and maintain the two new mental health access standards.
- Overall 2020 goal - To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce).

The Five Year Forward View for Mental Health (Mental Health Taskforce)

- By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health.
- Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group.
- Mental health inpatient services should be smoke free by 2018.
- Mental and physical health support will be integrated. People with SMI at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care.
- Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.
- In future, new models of care will support people's mental health alongside their other needs, including physical health, employment, housing and social care. They will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors. Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with SMI will have been fully trialed.

Specific recommendations from the independent Mental Health Taskforce include:

Recommendation19: NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

Recommendation 20: PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

It is recognised that a wide range of partners will be required to help develop STPs and realise these recommendations. Partners including CCGs, providers, local authorities, public health and the voluntary sector will need to support and promote each other's work to achieve these goals and recommendations. Co-production with experts-by-experience should be a standard approach to commissioning and service design.

Parity of esteem

There is an expectation that each CCG's spending on mental health services will increase in real terms and grow by at least as much as each CCGs allocation increase.

The Five Year Forward View for Mental Health recommends that payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public.

Area of care	Outcome for people with SMI	Activities to achieve outcomes		
		Short term activities	Medium term activities	Long term activities
Prevention	1. Increased coverage and benefit from drug and alcohol services for people with SMI. 2. Reduction in smoking rates for people with SMI. 3. Reduction in incidence and prevalence of obesity for people with SMI 4. Increased uptake of national screening programmes for people with SMI	Analysis of unmet need, referral and provision gap of drug and alcohol and smoking cessation services (e.g. health equity audits). Strategy to increase uptake of MECC (Making every contact count) amongst all health and care professionals in contact with people with SMI. Strategy to increase evidence based tailored and targeted provision of smoking cessation to individuals with SMI. Strategy to increase access to interventions for obesity prevention and weight reduction including lifestyle interventions and other NICE approved treatments for obesity. Strategy to increase access to vaccinations and national screening programmes e.g. through Health Checks.	Strengthen tailored and targeted provision of drug and alcohol services to SMI population. Work with providers and voluntary sector to support care coordination and enhanced support to access drug and alcohol services. Ensure current smoking cessation services include targeted treatment for people with SMI including harm reduction approaches. Commission, and seek assurance of smoke free mental health services by 2018. Deliver screening and lifestyle interventions across sectors and care environments to support a reduction in sedentary behaviour, improve healthy eating and increase exercise. Increase coverage of targeted and tailored screening programmes working with and across care sectors to increase uptake in people with SMI.	Integrate dual diagnosis services within mental health trusts and streamline commissioning arrangements. Evaluate smoking cessation coverage and quit rates and adjust treatment delivery models as appropriate. Deliver interventions across all care settings. Evaluate coverage and impact of obesity strategy to include specific needs of SMI population and adjust models for delivery as appropriate. Evaluate change in SMI population uptake of screening programmes.

Area of care	Outcome for people with SMI	Activities to achieve outcomes		
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Primary care	5. Increased early detection and access to evidence-based physical care assessment and intervention.	Local data cleansing and analysis of SMI register to establish benchmarks, gaps, unmet need and priorities. Support primary care through QoF and local incentives to record and treat: • BMI • Blood pressure • Glucose • Lipids • Drug and alcohol misuse • Smoking Deliver core mental health training to increase mental health literacy for primary care staff.	Deliver care pathways optimising local incentives to increase coverage of screening (including QoF targets) and interventions. Implement standardised screening tools for SMI population (e.g. Bradford Tool) across primary care IT system. Commission reasonable adjustments within primary care for SMI population - e.g. increased appointment times. Deliver interventions to support self-management of physical health and medication optimising care, family and peer support roles.	Evaluation of screening coverage, diagnosis and treatment rates. Deliver and evaluate the impact of enhanced SMI services within primary care utilising alternative outreach or in-reach models on physical health parameters. Develop cross sector staffing models to deliver screening, monitoring and evidence based treatments.

Secondary mental health services	6. Increased physical health risk and needs assessment to support primary care treatment plans and uptake of screening	Deliver a training plan and standardised, compatible screening tools and protocols to support co-working and uptake of primary care assessments and shared treatment plans. Support the delivery of national physical health CQUINs across mental health trusts. Ensure physical health risk assessment and treatment plans are embedded in EIP services. Support the delivery of optimised prescribing guidelines and side effect management that utilise lifestyle interventions and strategies to support self-management, informed choice and involve family and carers.	Increase uptake of screening and implementation of physical health risk assessment. Implement standardised screening tools (e.g. Bradford Tool) to embed CQUIN requirements in sustainable systems and routine clinical practice. Support delivery of risk assessment tools within mental health trusts to stratify and trigger pathways for extra support or integrated mental and physical health outreach/ in-reach services. Support scale up of workforce physical health literacy and core skills particularly risk assessment, signposting and/ or delivery of structured lifestyle interventions through education, training and dissemination programmes.	Develop and deliver with primary care shared care pathways and models to support transitions between sectors that support recovery, deliver improved physical health outcomes and embed patient reported outcome measures (PROMs) in evaluation. Evaluate uptake and impact of workforce training and optimised prescribing standards on physical health outcomes and PROMs. Evaluate coverage of lifestyle interventions for physical health and the degree to which they are integrated and accessible across care sectors and environments.

Area of care	Outcome for people with SMI	Activities to achieve outcomes		
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Acute physical health services	7. Reduced unplanned physical health admissions to acute hospitals for people with SMI	Data analysis to identify priority areas and at risk population. Provide 24/7 core liaison psychiatry service at acute hospitals which support acute physical health care pathways.	Support the development of flexible service models that target unmet physical health needs and management of long-term conditions in partnership with mental health services. Support the development of care pathways and protocols for frequent attendees with physical health deterioration. Offer with these a case conference management approach and ensure named clinical ownership.	Evaluation of service models and refine/ roll out to other priority areas. Support delivery of risk and needs assessment tools to stratify risk and trigger pathways for physical health outreach services to mental health trusts.
Integration of care	8. Shared physical health records and treatment plans of people with SMI between primary, secondary and social care	Agree local standards for data sharing. Support the development of reciprocal arrangements with primary and secondary care providers regarding advice and review requests both in and out of hours. Implement information sharing tool for SMI population (e.g. Bradford Tool) across primary care and secondary care IT system.	Implement systems for roll out of shared care records addressing the current limitations of the Summary Care Record. Deliver systems which support sharing of primary care physical health screening and treatment plans with other health care professionals across tiers and sectors.	Evaluate, and refine systems for information transfer, communication and implementation of shared care plans across sectors.