Domain 1: Commissioned or Provided Services	
Service: Physical Health and Wellbeing	
Owner / Dept Lead: Fiona Cooke (Physical Health Lead Nurse); Abi Larvin (EDI)	
Outcome 1A: Patients (service users) have required levels of access to the service	**Score: 2**

Evidence:
The Physical Health and Wellbeing team, established in 2014, aims to improve access to physical health checks and lifestyle advice for those who experience severe mental illness and learning disabilities, with an overarching goal of reducing health inequalities for these groups. At its inception, the team was highlighted as a national case study of best practice (NHS England) and is aligned to CORE20PLUS5 – NHS England's approach to tackling health inequalities – which includes increasing physical health checks for those with severe mental illness.

The service provides Physical Health Wellbeing clinics and Clozapine clinics with most referrals made via internal referral within the trust, typically from Community Mental Health Teams. There is clear guidance provided for GPs for shared care as part of the Physical Health and Wellbeing clinics. As of November 2024, there were 1718 service users on the Physical Health and Wellbeing caseload, with clinics collectively hosting 110 appointments on average per month. 273 (16%) of the case load were service users within the Clozapine clinic, with the remainder spread across the 5 Physical Health Wellbeing clinics across Airedale, City, Craven, North and South & West. The service discharges approximately 40 service users per month, when treatment is complete or no further treatment is required. The team work with patients care coordinators to understand their individual needs and, while they generally see patients in one of the clinics, spread geographically over Bradford and Craven, the service is flexible in where they offer appointments and will travel to patients' homes to enable access when required. Recognising that the internal referral process could be more streamlined, the team have rolled out a new referral system which seeks to improve access. Previously, the team haven't been able to screen and triage patients, whereas the new system provides more information about patients ensuring they are seen in the appropriate clinics.

More females (57.2%) are referred into the service than males (42.7%), however, for successful appointments, 58.1% are male service users, with 41.8% are female.

9.2% of referrals had no ethnicity known, compared with 4.4% of appointments. The number of ethnically diverse service users is broadly representative of the local population, but Asian groups are underrepresented. 14.5% of referrals are Asian or Asian British, compared with 29% of the Bradford and Craven population. This underrepresentation is predominantly from the Pakistani community. However, looking at successful appointments, there is no underrepresentation of the Asian community with 28.8% of appointments for patients from an Asian ethnicity. This infers that while referrals are lower, once within the service this group of patients generally engage with the service. Analysis of other ethnic groups, including Black and Mixed groups, indicated that these were all in line with census data for Bradford & Craven.

73.7% of service users experience high levels of deprivation (level 1-3). When service users addresses are mapped onto domains of deprivation, the majority of service users live in areas with high levels of crime, unemployment, disability and long term conditions and low levels of education and income.

35% of service users had no religion recorded which makes access for this group difficult to assess. 31.2% of appointments were with service users identifying as a Christian religion, with a further 22.6% with Muslim service users.

58% of service users had no sexual orientation recorded which similar results in assessing access for this group difficult. 1.7% of appointments were with patients who identified as Lesbian, Gay or Bisexual.

Healthy Minds have produced guidance and a video for service users about what happens at health checks to support access; this will particularly support neurodiverse patients with what to expect, why it's important to attend with guidance on how to access physical health checks, which is also advertised via Mind in Bradford.

The new referral system mentioned previously will free up staff time, which the service wants to use for additional direct telephone contact with service users that do not attend their appointments. The team are doing work to review DNAs holistically and developing an understanding of the reasons behind non-attendance and what could be done differently to enable people to attend. Recognising that letter-based appointment systems can be a barrier; they are planning to roll out SMS communications. The team work in collaborative with VCSE organisations, particularly the Healthy Living Advisors via Mind, to proactively engage individuals who may not otherwise access services.

70% of those who are on GP SMI registers and therefore eligible for a health check attend. The registers are maintained by the GPs, and sometimes the information is outdated with patients no longer suffering from an SMI and the team are unable to access

the register for all practices. As part of the ULCP-Primrose study, the team have been able to access SMI registers from across 4 GP practices, reviewing which patients have not accessed physical health checks and then conducting outreach with this group to explain what the physical health check involves and why it's important. The service plan to continue with this approach of proactive health promotion and engagement, depending on the recruitment of additional GP practices.

Outcome 1B: Individual patients (service users) health needs are met	**Score: 3**

Evidence:
Most patients on the caseload experience or have experienced psychosis (65%), with a further 35% having severe non-psychotic disorders. People living with SMI have increased risk of respiratory disease, liver disease, cardiovascular disease and cancer. Research suggests rates of preventative screening such as physical health checks, are lower among people with a severe mental illness. While antipsychotics and mood stabilisers increase life expectancy, medication can also have side effects that impact on people's physical health. If identified, these can be mitigated and treated so monitoring physical health and addressing problems is vital to improve health outcomes and quality of life.

The PH&W service enables thorough check of physical health and wellbeing. A physical health check includes screening for cardiovascular health (ECG, lipid profile, BMI and waist circumference), diabetes (HbA1c and blood glucose), and blood tests will also screen for potential kidney, liver, haematological issues. People on antipsychotic medication can experience weight gain and are at a higher risk of cholesterol and diabetes. Bradford District and Craven also has one of the highest rates of diabetes in the UK and ethnically diverse populations are 2-4 times more likely to develop Type 2 diabetes. Many more may be pre-diabetic or undiagnosed, so the service enables detection and earlier intervention. Practitioners will also discuss smoking habits, healthy eating, physical activity and illicit drug use and tailor advice to the individual. GPs are notified of any results outside of the normal ranges and actions are taken in collaboration with PH&W clinics and care coordinators. These tests are repeated after 3 months and then annually. Service users can decide whether to have their annual health checks through their General Practitioners or the PH&W clinic. Patients are more likely to attend the PH&W clinics than when they were previously referred back to their GPs (Physical Health Checks For People With Severe Mental Illness). This is having a direct impact on the risk oh physical health inequalities for people with SMI.

The team document investigations within SystmOne on the Bradford Mental Health Physical Review template for standardisation, ensuring patients receive high quality checks including the appropriate tests and highlighting particular health risks and also aims to prevent duplication across the system. In discussions with Mind Healthy Living Advisors, the team identified that GPs may

record information separately, leading to potential duplication of tests for patients. To address this, the team has agreed to add an alert or note to patient records, ensuring GPs are aware of their involvement with the Physical Health and Wellbeing service. This supports consistency and improves communication between primary and secondary care.

Alongside lifestyle advice, the service actively signposts and refers individuals to other services to support with risk factors identified within clinics, including VCSE organisations. This includes working closely with Healthy Living Advisors, who support individuals to access Living Well services, such as smoking cessation and Bradford Encouraging Exercise in People (BEEP). The team also engages with a network of other Physical Health for SMI groups nationally to share best practice, learning and to identify additional improvements.

Approximately 16.4% of appointments were with service users whose first language is not English. The service books interpreting provision where appropriate, with Polish, Urdu, Slovak and Punjabi interpreters provided over the past 3 months, with 42% of interpreting provision being provided face to face, and 57% via telephone. While this hasn't been an issue to date, the service identified that some of their drop-clinics may limit access to face-to-face interpreting provision.

The team are actively involved in research relating to Physical Health and SMI. People with mental health conditions are disproportionately affected by smoking and may find it more difficult to quit and the team have worked in partnership with Yorkshire Cancer Research as part of the ESCAPE study to provide vaping starter kits to service users to support smoking cessation, with the Lead Nurse as the Principal Investigator for the study.

As mentioned in 1A, the service have also been involved in development of the UCLP-Primrose Pathway which combines risk stratification, behavioural support, and enhanced clinical practices to better manage cardiovascular disease risk for patients experiencing SMI. In Bradford, the intervention was piloted within 4 GP practices, with the PH&W team working collaboratively with primary care. This resulted in referrals to social prescribers, additional engagement and outreach, and new statin prescriptions offered to those at the highest risk of cardiovascular disease. The service plans to continue this approach, refine it based on learning from the pilot, and implement it more broadly.

People with SMI are also 3 times more likely to lose their natural teeth. While the PH&W team focus on physical health services, the BDCFT dental academic clinical fellow has also contributed to research on psychiatric presentations in dentistry. The team have discussed that the lack of access to dental care can further compound the health inequalities experienced by people with an SMI, with clear links between cardiovascular disease and oral disease, and the negative potential impact of tooth loss on mental

health. Therefore, the team would like to develop additional links with community dental services and ensuring the physical health check is used as an opportunity to identify whether patients require any support to access dental care, potentially working in partnership with Health Living Advisors to enable assertive outreach.

Outcome 1C: When patients (service users) use the service, they are free from harm	Score: 2

Evidence:
The team have daily huddles and review any incidents, which are also shared by the Risk team monthly. There has been 1 patient safety incident in the last year. The team have panic alarms situated within clinics to support both staff and patients' safety.

Recognising the previous referral system meant the team lacked key information about individuals, the updated process allows for the disclosure of risks and provides the team with essential information. This ensures appropriate safeguards are in place to support safer and more informed care, and evidences a learning and improvement culture within the service.

There are documented processes developed in partnership across the system for shared care between GP and secondary care, with the SystmOne module developed specifically for SMI Physical Health checks supporting safety. The guidance includes what should be monitored as part of physical health checks which should be completed as a baseline, after 3 months and then annually. This provides practitioners with reference ranges, guidance and escalation criteria to ensure consistency in approach across the system. Those with SMI who are prescribed antipsychotic medication can also be at risk of complications and side effects, and there is documented guidance on shared care between the GP and PH&W team to manage risks associated with medications. There is regional work ongoing to review the shared care policy.

Regular blood tests for patients on Clozapine offered via the Clozapine clinics ensures consistency in care and supports patient safety by monitoring for risks associated with Clozapine use. The physical health check clinics also provide additional assessments, such as ECGs, which may not be available in primary care. These are vital for monitoring cardiac risks associated with antipsychotic medications, enhancing both safety and the quality of care.

Outcome 1D: Patients (service users) report positive experiences of the service	Score: 1

Evidence:

There were no complaints or FFT responses between March and September 2024. While the FFT system is undergoing procurement, paper responses are being used which is likely contributing to low uptake. Service users are generally on the caseload within other teams within mental health services so there are some concerns that feedback goes to other services, rather than directly to the PH&W service.

Following the closure of business of the previous FFT provider, there is work ongoing in the trust to procure and implement digital FFT collection via a new provider which will enable teams across the organisation to collect feedback via QR codes. Data will be available by demographic groups, to identify feedback themes specific to protected characteristics with a launch planned for mid December 2024.

Domain 1 – PH&W Overall	**Score: 8**