

Improving physical health for people with severe mental illness, learning disabilities, and autistic spectrum condition

A Strategy for Sheffield 2019 - 2022



Introduction

People living with severe mental illness (SMI), learning disabilities (LD) and autistic spectrum condition (ASC) have for many years faced some of the greatest health inequality gaps in England, resulting in significant (and in most cases avoidable) mortality and morbidity gaps.

To join up mental and physical health care, organisations need to address wider issues of stigma and diagnostic overshadowing (the failure to see a physical problem because the symptoms are attributed to someone's mental health, learning disability, or autistic spectrum condition). We need to put in place the necessary initiatives and adjustments to ensure people get the care they need. Involving people with lived experience (and their carers) in making these improvements is an important part of this work.

In Sheffield, key stakeholders are working together (through the Physical Health Implementation Group - PHIG) to look creatively at how we can support people living with these conditions to have the best possible physical health.

This strategy outlines our shared commitments (and the high level action plan that underpins it) that will help the city to achieve these outcomes. The strategy will not be prescriptive or seek to capture all activity in Sheffield; rather it will indicate our ambitions for the city and priority areas.

Why do we need a strategy?

The average life expectancy for someone with a long-term mental health illness is at least 15-20 years shorter than for someone without and it is estimated that for people with SMI, 2 in 3 deaths are from physical illnesses that can be prevented¹. On average men with LD die 23 years earlier than men without a LD and for women it's 27 years earlier². People living with ASC die on average 16 years earlier than the general population³.

¹ <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>

² <https://www.nursingtimes.net/news/learning-disability/talk-to-people-with-learning-disabilities-about-death-professor-urges-06-08-2019/>

This disparity in health outcomes is partly due to physical health needs being overlooked. For too many people this means living for many years with a long-term physical health condition and with reduced quality of life. Reduced life expectancy (for the majority of people) is due to a preventable illness – linked to factors such as smoking, obesity, alcohol misuse and both illegal and prescribed drugs.

Poorer physical health is for the majority of people due to preventable illnesses, linked to factors such as:

- The impact of certain types of prescribed medication (for example on weight gain leading to obesity and from increased likelihood of diabetes⁴ and cardiovascular disease⁵), and over-prescribing of some medications (for example, antipsychotic medication for people with learning disabilities)
- Higher rates of respiratory disease linked to increased smoking rates particularly for people living with severe mental illness⁶ and due to eating and swallowing problems for people with learning disabilities⁷.
- Lifestyle factors around physical activity, obesity, and higher rates of alcohol/illegal drug misuse for some people.

Due to the higher prevalence of significant comorbidities, people living with these conditions are also more at risk from contracting Covid19 and experiencing severe symptoms if they do contract it. People living with these conditions are also likely to have more difficulty in monitoring their own physical health needs and in following social distancing and infection control guidance.

In Sheffield, there are approximately 3400 people aged 18+ on the LD case register; 6000 people living with ASC, and approx. 5665 adults in Sheffield recorded by GPs as living with SMI. There is some cross-over between the three registers, for example for people with both learning disability and autism.

³ <https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf>

⁴ https://www.diabetes.org.uk/about_us/news/half-of-people-with-Type-2-diabetes-and-severe-mental-illness-can't-access-support

⁵ <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>

⁶ <https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>

⁷ <https://www.nursingtimes.net/roles/learning-disability-nurses/improving-equality-of-healthcare-for-people-with-learning-disabilities-18-03-2019/>

What is our vision for Sheffield?

Our vision for Sheffield is that people living with severe mental illness, learning disabilities and autistic spectrum condition will live longer and healthier lives, because of improvements in their physical health and reduction (or early identification) of avoidable physical illness.

These are three very different groups of people, but they share challenges in terms of physical health and disparity in health outcomes which are partly due to physical health needs being overlooked. For too many people this means living for many years with a long-term physical health condition and with reduced quality of life, as well as on average a dramatically reduced life expectancy.

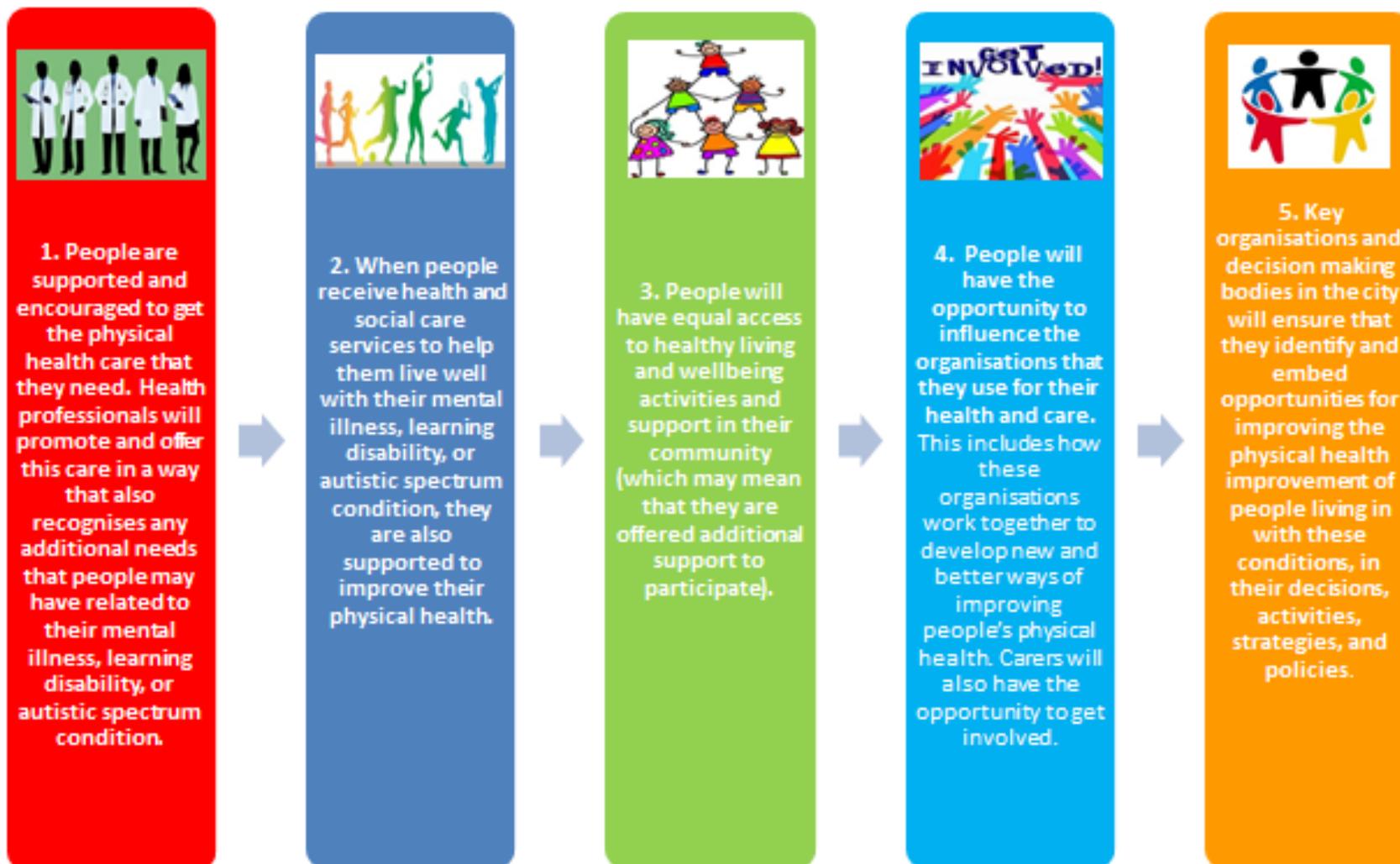
The 5 commitments for the Strategy are listed on the next page. These are underpinned by high level actions agreed by the PHIG to help organisations to achieve the commitments (See Appendix 1). These will be enacted through organisations and decision making bodies in the city identifying and embedding opportunities for improving the physical health of people living with these conditions, in their decisions, activities, strategies, and policies.

There is a range of national research about the differential (and often negative) experiences of people living with SMI, LD, and ASC from different communities – such as some Black, Asian, Minority Ethnic (BAME) communities; lesbian, gay, bisexual, transgender (LGBT) communities, and some faith communities. The PHIG Strategy provides us with an opportunity to work towards some of the recommendations within the *Beyond the data: Understanding the impact of COVID-19 on BAME groups* PHE Report⁸, in particular recommendation 6 relating to accelerating efforts to target culturally competent health promotion and disease prevention programmes. PHIG also needs to ensure that engagement is inclusive to ensure a representative voice.

⁸https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/892376/COVID_stakeholder_engagement_synthesis_beyond_the_data.pdf (see page 11 for recommendation 6).

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The 5 key Commitments for the Strategy:



Our approach

The Strategy is included within the projects/priorities in the Sheffield Mental Health Transformation Plan (with governance through the PHIG and reporting to the Mental Health, Learning Disabilities, Dementia and ASC Delivery Board).

It is based upon national plans, research and good practice, as well as local engagement with a range of stakeholders. Sheffield NHS Clinical Commissioning Group (CCG), working with Sheffield City Council, is taking the lead for the strategy. Sheffield Health and Social Care Foundation Trust and Sheffield Teaching Hospitals Foundation Trust are also lead partners in this work.

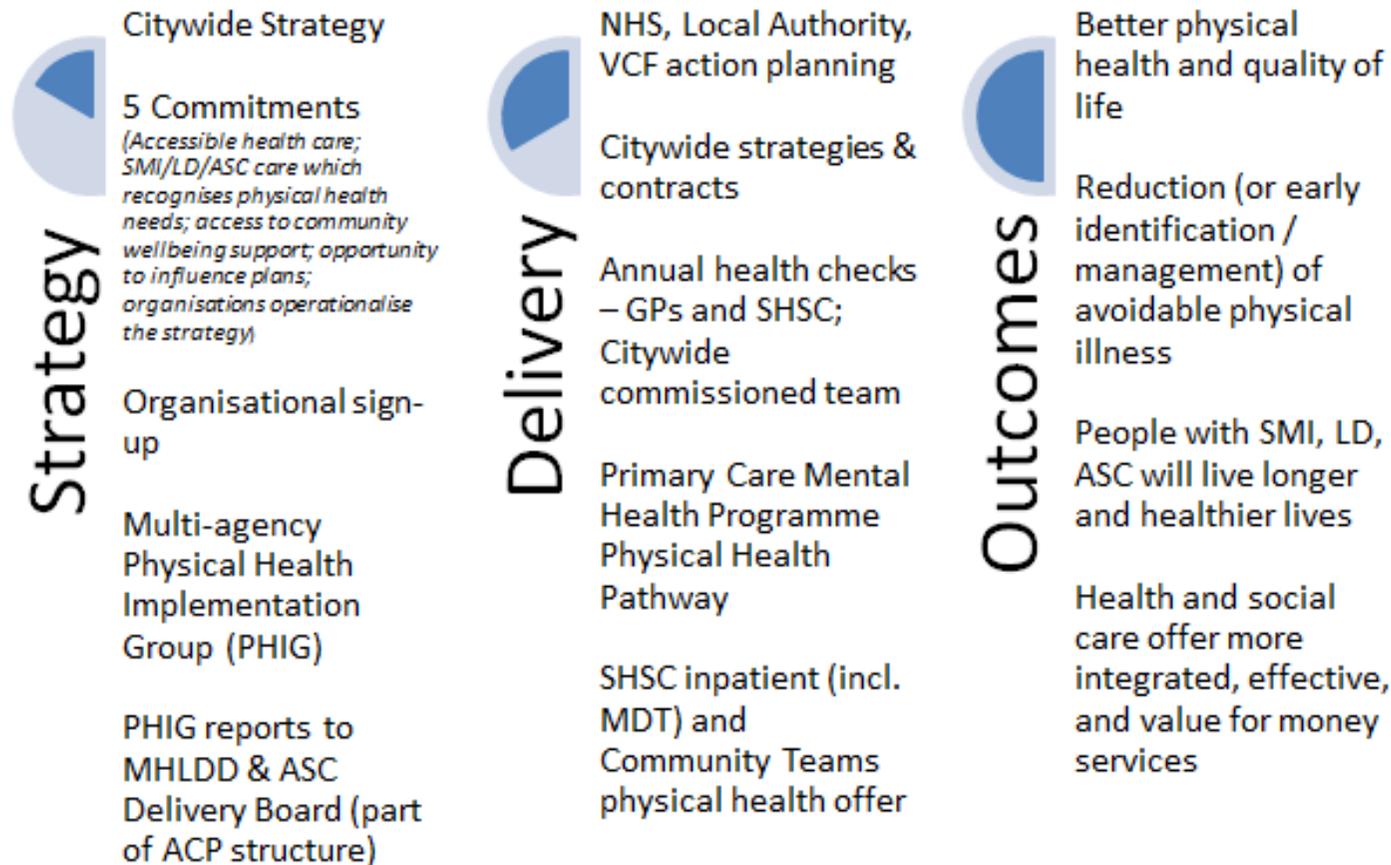
One of the key commitments in the strategy is for people living with these conditions (and family/informal carers) to have the opportunity to influence how organisations work together to develop new and better ways of improving people's physical health in Sheffield. Engagement has been an important part of progressing the priority actions and refining the cross organisational strategy and the PHIG will continue to engage with people with lived experience, their families and stakeholder/advocacy organisations. There is also an ongoing commitment to build feedback mechanisms into improvement, commissioning and monitoring activity.

PHIG continued to meet during Covid, focusing on responding to the commitments in relation to the pandemic.

During the first phase of the strategy, PHIG initially had more of a focus on innovation and development, looking creatively at how to improve current system and organisational approaches to physical health for people living with these conditions. As the strategy moves further into its implementation phase, the PHIG will refocus with a quality assurance and monitoring role.

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The Strategy is starting to translate into Delivery (actions and outputs), which are in turn beginning to improve Outcomes for individuals.

There is still a long way to go but progress is starting to be made.

The Strategy will help to drive, prioritise and embed the work that is already underway.

The diagram opposite provides a summary which highlights the key components of the strategy and the structures which support it.

Through the PHIG and its supporting workstream activity, there has already been an increase in organisational awareness of the important of improving the physical health of people living with SMI, LD, and ASC, and in commitment to achieving this.

Through the development of the Strategy (and 5 commitments), underpinned by the high-level citywide action plan, organisations are now much clearer about what the practical steps are to making improvements.

The table opposite provides some examples of progress to date.

SMI Annual Physical Health Checks	• Completion rate has increased to 27.3% in quarter 3 2019/20 (up from 18.5% in 2018/19)
SMI physical health training	• Approx. 200 staff (cross-system) trained in Feb/March (with excellent feedback and many 'pledges' for action)
LD Annual Physical Health Checks	• Completions increased since last year to 1,026 by quarter 3 2019/20 (up from 930 completions by quarter 2018/19)
Detailed Commissioning Plans	• For a citywide SMI/LD/ASC Health Check Team have been developed, led by SCCG
SCC Mental Recovery Health Framework contract amendment	• To ensure people attend annual health checks and national screening and that physical activity is included in support plans
Primary Care Mental Health Programme	• The principles of the Strategy are embedded, including a physical health pathway, and 2 'health check' staff roles.
Sheffield Tobacco Strategy	• Refresh specifically targets people living with SMI and LD
SHSC has now accelerated its physical health work, incl. during Covid	• There has also been a cross-organisational response to supporting physical health of people within inpatient wards
STOMP/STAMP	• Ongoing work across the system to ensure effective medicines management

Appendix 1 – High Level Action Plan

Commitments (Milestones)	Key Tasks	Key measures of success
<p>1. People are supported and encouraged to get the physical health care and interventions that they need. Health professionals will promote and offer this care in a way that also recognises any additional needs that people may have related to their mental illness, learning disability, or autistic spectrum condition</p>	<p>1. Prevent, treat or manage physical health problems, by increasing the number of people accessing Annual Physical Health Checks (with follow up interventions where needed).</p> <p><i>Key to this is increasing awareness and understanding about the importance of health checks and developing innovative ways to achieve this (e.g. through the pharmacists project and commissioned models).</i></p>	<p><i>Increase uptake of health checks (GP registers, all settings):</i></p> <ul style="list-style-type: none"> * People living with SMI from 26% to 60% * People living with learning disabilities from 56% to 75%. <p><i>Increase rate of follow up intervention (where this is required):</i></p> <ul style="list-style-type: none"> * People living with SMI from 37.4% [check this stat] * People with learning disabilities [check if we have this data] <p><i>Commissioning for Citywide team completed</i></p> <p><i>Local response to Health Checks during Covid established/delivered</i></p>
	<p>2. Improve system wide approaches to reasonable adjustments and promoting uptake of health care support / interventions* (including through innovative use of digital technology – e.g. <i>increased use of technology and support to use technology during Covid</i>)</p>	<p>Targets based on current access / improvement required from baseline; implementation of reasonable adjustments; feedback from people using services</p>
	<p>3. Establish an autistic spectrum condition register and a local approach to physical health checks.</p>	<p>Register is in line with NICE recommendations. Increase in people living with ASC accessing annual health checks and screening, and follow up interventions (including people with ASC, and people with SSC/LD or ASC/SMI). Engagement of people living with ASC.</p>

Commitments (Milestones)	Key Tasks	Key measures of success
<p>2. When people receive health and social care services to help them live well with their mental illness, learning disability, or autistic spectrum condition, they are also supported to improve their physical health</p>	<p>1. Health and Social Care planners and commissioners will require and/or support care providers to consider physical health more holistically as part of the care they provide (for example in relation to health checks, support at appointments, or being more physically active). This will be supported by awareness raising, resources, contractual arrangements / monitoring etc as appropriate.</p> <p>2. Staff working in health and social care (and VCF partners where appropriate) will receive the training and awareness raising that they need to provide holistic care.</p>	<p>Changes made to existing contractual arrangements/monitoring arrangements</p> <p>Audit of contractual arrangements completed.</p> <p>Training and awareness raising plan delivered (primary/secondary care; adult social care; VCF). Feedback from staff on impact of this. This will include training in relation to the Covid response.</p>
<p>3. People will have equal access to healthy living and wellbeing activities and support in their community. This may mean that people are offered additional support (reasonable adjustments) to participate.</p>	<p>1. Determine to what extent people living with these conditions already access healthy living and wellbeing activities and support (e.g. getting more active, cutting down on alcohol, eating more healthily).</p> <p>2. Identify/implement ways to improve the accessibility of activities and support and to further promote participation, leading to more 'open doors'/innovative ways for people to access support and advice.</p> <p>This will include improving the information and advice that is available about healthy living and accessible health and wellbeing activities.</p>	<p>Targets based on current access / improvement required from baseline; implementation of reasonable adjustments; feedback from people using services.</p> <p>Information and advice resources are updated and available.</p> <p>This will include providing and updating information to support people during Covid.</p>

Commitments (Milestones)	Key Tasks	Key measures of success
<p>4. People will have the opportunity to influence the organisations that they use for their health and care. This includes how these organisations work together to develop new and better ways of improving people's physical health. Carers will also have the opportunity to get involved.</p>	<ol style="list-style-type: none"> 1. Working with Co:Create¹, produce a clear map of stakeholders and assets, which will be the basis of co-production work for activity going forward 2. Ensure that people with lived experience are involved in developing physical health improvement priorities and activity (including opportunities for positive peer influence and to participate in local research projects). 3. Ensure that organisations/projects capture (and learn from) feedback and experience data 	<p>Clear evidence of the difference that involving people with lived experience has had in decision making and plans for improvements (case studies etc).</p> <p>Systems in place to capture/learn from the experiences of people accessing services/support.</p>
<p>5. Key organisations and decision making bodies in the city will ensure that they identify and embed opportunities for improving the physical health of people living in with these conditions, in their decisions, activities, strategies, and policies.</p>	<ol style="list-style-type: none"> 1. Embed physical health in key health and wellbeing strategies / action plans / initiatives and frameworks 2. Partner organisations to develop their own physical health action plans that will fulfil the commitments. 3. Health and social care services will work more closely together to improve physical health outcomes for people. 4. There will be a cross-organisational approach to cross-cutting themes such as: <ol style="list-style-type: none"> a) Communications about the 5 commitments b) Meeting the needs of diverse communities, incl. supporting adherence to the Accessible Information 	<p>Evidence of how key strategies/action plans have incorporated the physical health commitments.</p> <p>Plans in place and monitored through internal governance for:</p> <ul style="list-style-type: none"> • Sheffield CCG • Sheffield City Council • Sheffield Health and Social Care Trust • Sheffield Teaching Hospitals • Key public health strategies <p>Information on physical health assessments carried out in secondary care will be routinely shared with primary care.</p> <p>Cross-organisational communications plan</p>

Commitments (Milestones)	Key Tasks	Key measures of success
	<p>Standard; and accelerating efforts to target culturally competent health promotion and disease prevention programmes.</p> <p>c) Increasing and developing local research opportunities</p> <p>d) System wide recommendations from PHIG, for example regarding IT systems and interoperability.</p> <p>e) Ensuring effective medicines management for people living with these conditions.</p> <p>f) Ensuring that larger organisations support smaller organisations to achieve the commitments.</p> <p>g) Identifying opportunities for employing people with lived experience to support the work and training that is needed</p>	<p>developed/delivered/tested.</p> <p>Local research projects delivered.</p> <p>Evidence that people from BAME and other diverse communities have equitable uptake of health services (e.g. health checks).</p> <p>STOMP programme delivered.</p> <p><u>Covid response runs through all these measures as required.</u></p>

For more information, please contact Sheffield CCG, Mental Health Transformation Team at SHECCG.mhldportfolio@nhs.net.

ⁱ <https://www.wearecreate.com/>