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

A Strategy for Sheffield 2019 - 2022

NHS Sheffield Clinical Commissioning Group

NHS Sheffield Health and Social Care NHS Foundation Trust

Sheffield Teaching Hospitals NHS NHS Foundation Trust

Sheffield City Council

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 prevented[1]. On average men with LD die 23 years earlier than men without a LD and for women it's 27 years earlier[2]. People living with ASC die on average 16 years earlier than the general population[3]. 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.

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

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 diabetes[4] and cardiovascular disease[5]), and over-prescribing of some medications (for example, antipsychotic medication for people with learning disabilities).
- The learning from deaths of people with a learning disability (LeDeR) programme[6] highlights local learning.
- Higher rates of respiratory disease linked to due to eating and swallowing problems for people with learning disabilities[7] and increased smoking rates particularly for people living with severe mental illness[8]. Whilst smoking prevalence in Sheffield is at an all-time low of 12.5% (2018), smoking prevalence for people on the SMI register in primary care is 37.9% (2018) and for people admitted to secondary care mental health inpatient services around 60% (2019)[9].
- Most autistic adults are at a significantly increased risk of preventable chronic medical conditions such as heart disease, stroke, chronic respiratory disease (including asthma), and kidney disease[10].
- Health behaviours around smoking, physical activity, obesity, and higher rates of alcohol/illegal drug misuse.
- Some people living with these conditions may need assistance to access healthcare but many are socially isolated and lack support networks (particularly those living with SMI and/or ASC).
- Diagnostic overshadowing.

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

In Sheffield, there are approx. 3,400 people aged 14+ on the LD case register; approx. 4,866 adults recorded by GPs as living with SMI, and between 8,500 to as many as over 20,000 people (all ages) living with ASC[11] (however more is needed to understand the ASC population and the LD population). There is some cross-over between the three registers, for example for people with both learning disability and autism.

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[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.england.nhs.uk/learning-disabilities/improving-health/mortality-review/
[7] https://www.nursingtimes.net/roles/learning-disability-nurses/improving-equality-of-healthcare-for-people-with-learning-disabilities-18-03-2019/
[8] https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing
[9] http://ash.org.uk/information-and-resources/reports-submissions/reports/the-stolen-years/; https://sheffieldnewsroom.co.uk/news/stoptober19/
[10] https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=6bb44a4174274d7f8f19662592226731
[11] https://sheffieldcc.maps.arcgis.com/apps/Cascade/index.html?appid=6bb44a4174274d7f8f19662592226731

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.

This Strategy is primarily focused on adults, however it acknowledges the need for flexibility, for example, in relation to LD health checks being available for young people aged 14+ and that Sheffield Adult Autism and Neurodevelopmental Service (SAANS) supports people aged 16+. Age considerations will be kept under review.

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 Report [12], 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.

[12] https://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).

Improving physical health for people with severe mental illness, learning disabilities, and autistic spectrum condition – A Citywide Strategy for Sheffield 2019-2022

The 5 key Commitments for the Strategy:

1. People are supported and encouraged to get the physical health care 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.

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.

3. People will have equal access to healthy living and wellbeing activities and support in their community (which may mean that they are offered additional support to participate).

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.

5. Key organisations and decision making bodies in the city will ensure that they identify and embed opportunities for improving the physical health improvement of people living in with these conditions, in their decisions, activities, strategies, and policies.

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 (including inpatient and community services) and Sheffield Teaching Hospitals Foundation Trust (including hospital and community services) are also lead partners in this work. Sheffield Mental Health Network, Sheffield Mencap and Gateway, and other VCF organisations are key to the delivery of this strategy.

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.

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

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.

Some examples of engagement during 2020…

Survey summer 2020 – Headlines

- 68 people responded – good mix of respondents, incl. people with lived experience, carers, organisations, and people with expertise around SMI, LD, and ASC. We need more feedback from some BAME and LGBT communities.
- All 5 commitments were rated as important but commitment 1 was came out as a priority.
- COVID/social distancing has impacted negatively on people's physical health, e.g. exercise/diet
- Responses were in line with the 'working' strategy.
- Respondents shared lots of ideas for inclusion in the implementation plan about how to address barriers/make improvements.

Survey summer 2020 – Physical Health Strategy: What will success look like?

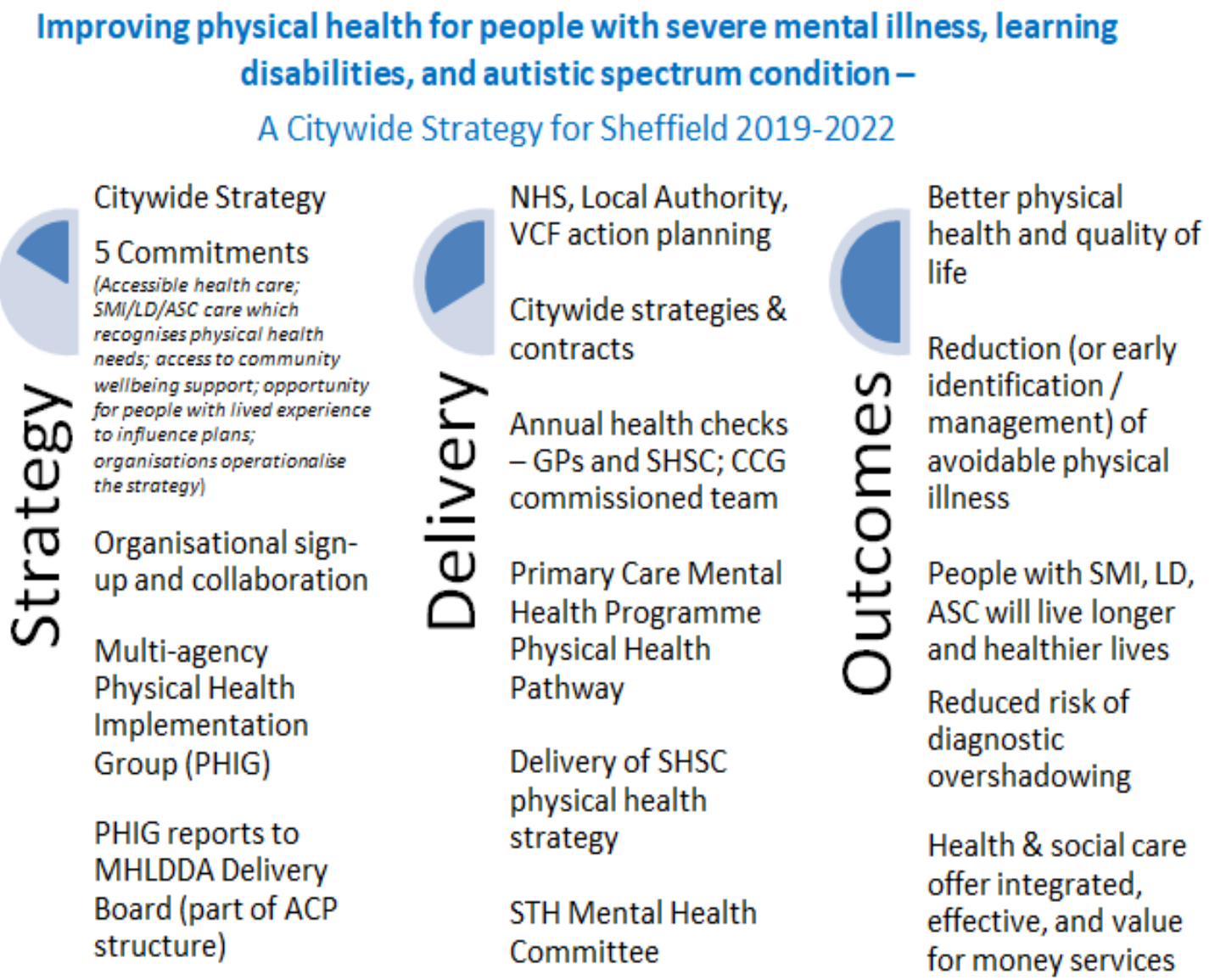
- "When the health of all of these people show improvement and they are not wary of approaching health or care organisations because of previous bad experiences."
- "Organisations do not give up on people who do not engage in that first step."
- "When we have equal opportunities and support to access things that would help this"
- "Leisure centres and health clinics aren't scared of working with people and they know how to make access easier"
- "Getting both the person and agencies to see this as a priority."

SMI/ASC workshop with people with lived experience, carers and advocates (Feb 2020): What support or advice could help you to be more healthy?

"Support and encouragement to attend my appointments"	"Encouragement from [social care] staff to keep up my personal hygiene, to help my with my skin problems"	"Exercise with support. E.g. someone to go with me at first"
"Access to nutritious food & cooking skills"	"Actually getting an appointment with a GP"	"Help with cost e.g. gym membership /physio"
"Information on being more healthy"	"Making manageable goals"	"Less judgemental doctors (injuries are injuries, doesn't matter how you got them)"

SMI/ASC workshop with people with lived experience, carers and advocates (Feb 2020): What would a good health check look like to me?

"My nurse or GP to inform of it coming up / letter sent out"	"I'll get a reminder letter or prompt"	"Suitable appointment time, with no long waiting times"
"Getting a good explanation of what will be done and what happens next"	"Help with communication / not being rushed"	"With a qualified professional. Doesn't have to be called 'doctor'"
"At the surgery, Day centre or at home"	"Availability of a support worker"	"Make sure you have support if you know the appointment will cause anxiety"



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
STOMP/STAMP	• Ongoing work across the system to ensure effective medicines management
Annual health checks during COVID	• Co-produced guidance pack/risk stratification/comms - for SMI/LD ASCs during the pandemic using a 'blended' model

Appendix 1 – High Level Action Plan

Commitments (Milestones)	Key Tasks	Key measures of success
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	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). *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).*	*Increase uptake of health checks (GP registers, all settings):* * People living with SMI from 27% to 60% * People living with learning disabilities from 56% to 75%. *Increase rate of follow up interventions and cancer screening (where this is required)* Information on physical health assessments carried out in secondary care will be routinely shared with primary care. *Commissioning for Citywide team completed* *Local response to Health Checks during Covid established/delivered* *Year on year reduction in smoking prevalence as recorded in SMI Register in primary care, and secondary care inpatient data, with target of 5% by 2035.*
	2. Improve system wide approaches to reasonable adjustments and promoting uptake of generic and targeted health care support and interventions. To include – • GP surgeries (including urgent treatment services/out of hours treatment) • Dental and optician services • Pharmacies • STH Hospital services • STH Community services	Targets based on current access / improvement required from baseline; implementation of reasonable adjustments; feedback from people using services. Staff providing physical health care will understand how they can offer this in the context of people's SMI, LD, ASC needs. Innovative use of digital technology – e.g. *increased use of technology, and support to use technology, during Covid.*

Commitments (Milestones)	Key Tasks	Key measures of success
		Health and social care services will recognise that for some individuals living with these conditions, they need to go beyond providing an accessible service when someone has already presented – and be much more actively proactive in encouraging and supporting people to even 'get through the door'.
	3. Establish an autistic spectrum condition register/better understanding of the ASC population and their support needs around physical health (including different needs for men/women, and younger/older adults). Define a local approach to physical health checks for people living with ASC.	Engagement of people living with ASC. Work closely with the Autism Partnership Board and Sheffield Autistic Society on these tasks. 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 ASC/LD or ASC/SMI).
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.	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.	Changes made to existing contractual arrangements/monitoring arrangements Audit of contractual arrangements/contract monitoring completed.
	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, that recognises the links between physical health risk and living with SMI/LD/ASC. To include – • SHSC secondary care services (e.g. CLDT, CMHTs, inpatient care)	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.

Commitments (Milestones)	Key Tasks	Key measures of success
	• Social care services (including residential and community based) • VCF providing support and care for people living with SMI, LD, ASC	
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.	1. Determine to what extent people living with these conditions already access healthy behaviours and wellbeing activities and support (e.g. getting more active, cutting down on alcohol, eating more healthily, weight loss, smoking cessation).	Targets based on current access / improvement required from baseline; implementation of reasonable adjustments; feedback from people using services. A range of local providers will be involved, e.g. leisure centres, diet clubs, exercise groups etc Information and advice resources are updated and available. This will include providing and updating information to support people during Covid. Increased awareness of staff/volunteers of needs of people living with SMI/LD/ASC and importance of supporting physical health improvements. Consider accessibility/approaches in terms of language, race, gender, age etc.
	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. This will include - Improving the information and advice that is available about healthy living and accessible health and wellbeing activities, as well as opportunities for more buddying/peer support and 'social prescribing'. - Explore opportunities to respond to VCF PHIG feedback regarding gaps and needing to: 1) educate organisations to be more accessible (first impression counts; how to provide extra support if needed for someone attending; referrals to more specialist/targeted services if needed etc) and 2) Identify resources/capacity to practically provide participants with additional support to take part, e.g. if someone needs one to one support initially or on an ongoing basis	

Commitments (Milestones)	Key Tasks	Key measures of success
	- Ensure commissioners offer grants that are supportive of disability – e.g. grants don't always include scope for additional capacity for people with greater support needs.	
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.	1. Working with Co:Create[i], 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	Clear evidence of the difference that involving people with lived experience has had in decision making and plans for improvements (case studies etc). Systems in place to capture/learn from the experiences of people accessing services/support.
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.	1. Embed physical health for people living with these conditions in key health and wellbeing strategies / action plans / initiatives and frameworks (including Tobacco Strategy; Move More; Food Strategy, flu vaccination campaigns etc.) 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 closely to improve physical health outcomes for people.	Evidence of how key strategies/action plans have incorporated the physical health commitments. Plans in place and monitored through internal governance for: • Sheffield CCG • Sheffield City Council • Sheffield Health and Social Care Trust • Sheffield Teaching Hospitals (incl. Sheffield Children's Hospitals e.g. regarding Transitions, STH Hospital services, STH Community services and STH Mental Health Committee) • Key public health strategies

Commitments (Milestones)	Key Tasks	Key measures of success
	4. There will be a cross-organisational approach to cross-cutting themes such as: a) **Communications** about the 5 commitments b) **Meeting the needs of diverse communities**, incl. supporting adherence to the Accessible Information Standard; and accelerating efforts to target culturally competent health promotion and disease prevention programmes. c) Increasing and developing local **research opportunities** d) System wide recommendations from PHIG, for example regarding **IT systems and interoperability**. e) Ensuring **effective medicines management** for people living with these conditions. f) Ensuring that larger organisations support smaller organisations to achieve the commitments. g) Identifying opportunities for employing people with lived experience to support the work and training that is needed	• Other health organisations e.g. dental/pharmacies as required Cross-organisational communications plan developed/delivered/tested. Local research projects delivered. Evidence that people from BAME and other diverse communities have equitable uptake of health services (e.g. health checks) and that services are accessibly to different communities. STOMP programme delivered. **Covid response and also meeting the local requirements of the Sheffield LeDeR[ii] programme runs through all these measures as required.**

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

[i] https://www.wearecocreate.com/

[ii] https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/