Living well with severe mental ill-health

12th February 2025

Chair: Professor Emily J. Oliver

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Setting the context

- People living with SMIH die on average 15-20 years earlier than the general population; national policy focus
- Physical and mental health services are often siloed; wider transformation programmes
- Service provision and accessibility is variable and challenging.
- A need for more holistic approaches; strong buy-in from both healthcare professionals and communities.
- However, implementing change is challenging in a healthcare system that is finite in resource.

UCLP-PRIMROSE

Dr Philippa Shaw

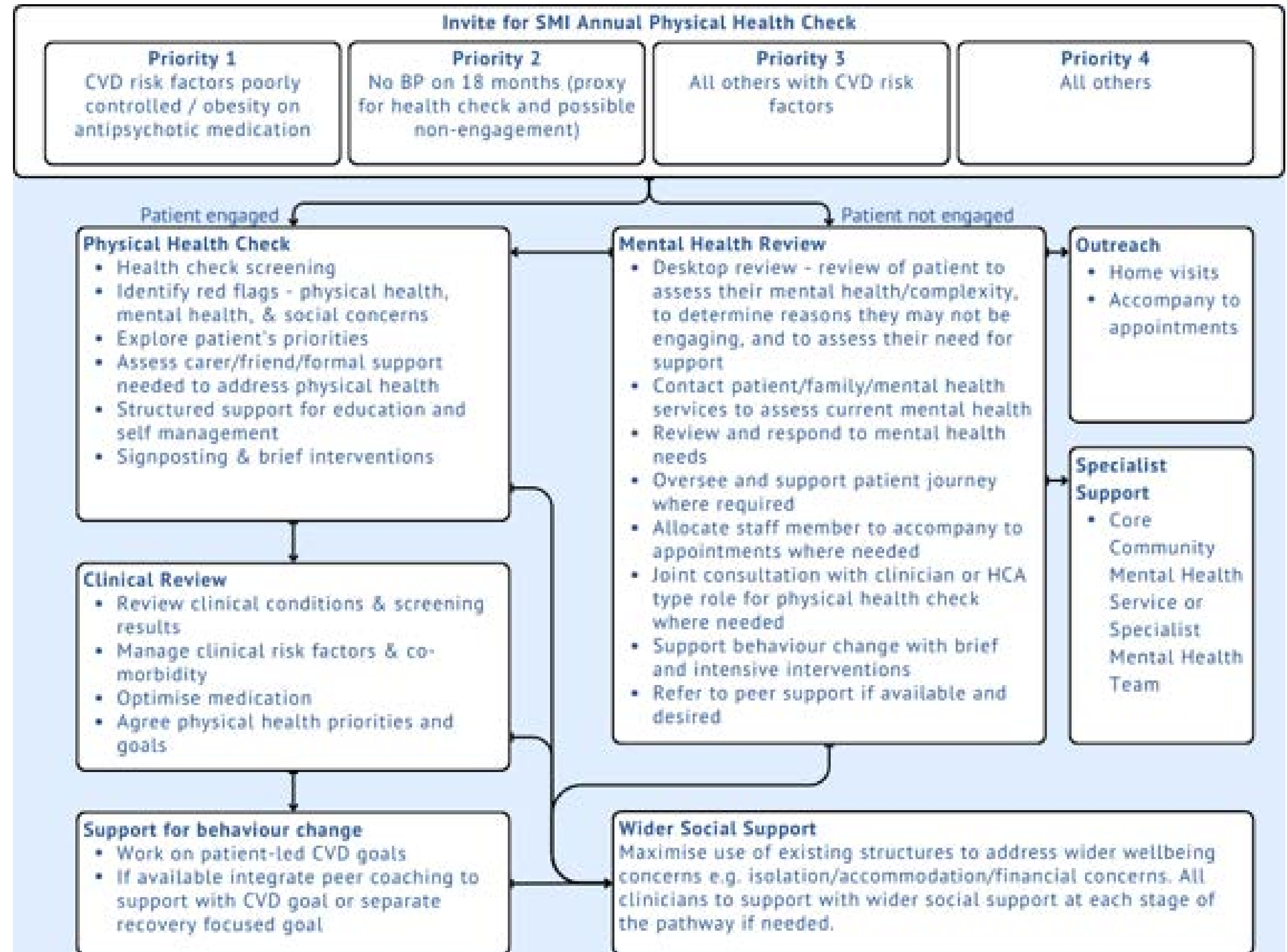
- People with Severe Mental Illness (SMI) have a higher risk of dying from cardiovascular disease.
- To close this health inequality: developed & tested better risk prediction tools & new management strategies.
- NIHR funded national trial of PRIMROSE - a care model involving structured behaviour change support. Good acceptability & decreased hospital admissions, increasing efficiency.
- Adapted PRIMROSE (PRIMROSE-A & UCLP-PRIMROSE).
- Being implemented in Yorkshire & North and East London, with plans to roll out further.

&

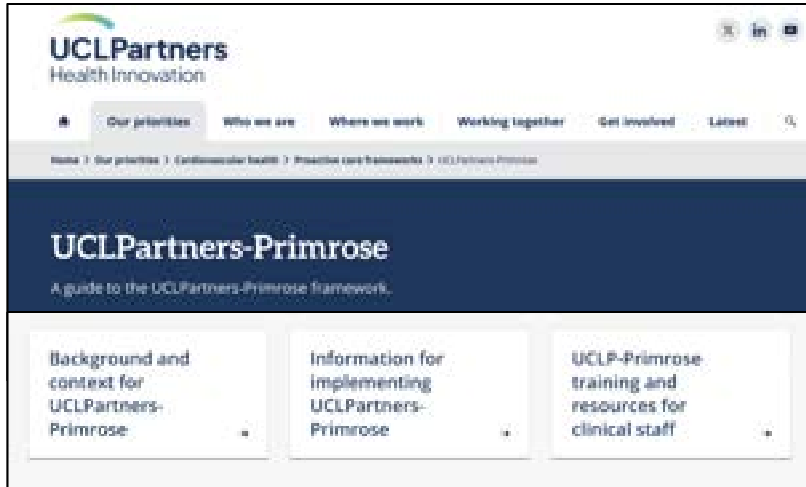
UCLP-PRIMROSE

5 core elements:

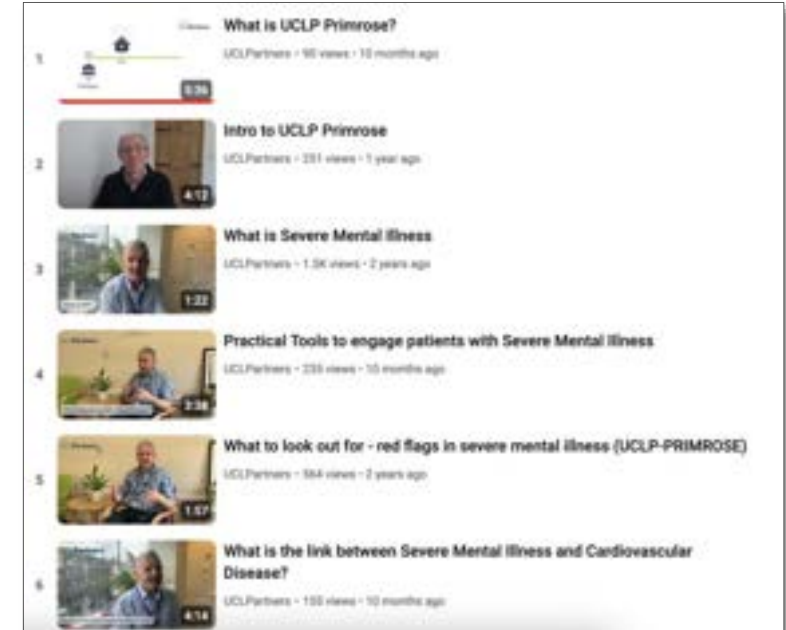
1. Patient list stratification
2. Health check
3. Clinical Review
4. Care plan delivery (support for behaviour change / peer support / wider support)
5. Non-engagement (desktop review / outreach)



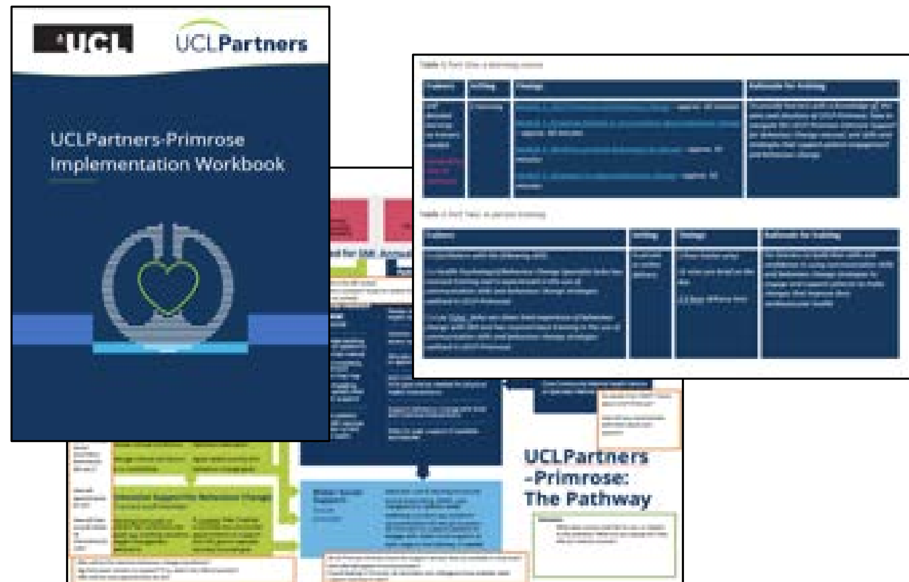
Suite of materials & guidance available online



Online training course



Information / training videos



Implementation manual & training plans

Delivery manuals

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"Avoiding what we've done for generations in the NHS, just believing that all we have to do is articulate the guidance just that bit more clearly ... The magic doesn't happen because the real world doesn't allow it to."

Research

Mixed methods to explore if and how UCLP-PRIMROSE could be set up in the real-world:

- Could sites set-up and deliver UCLP-Primrose?
- What were the challenges / what helped with implementation?

Implementation in Yorkshire (1 primary care network) & London (3 boroughs).

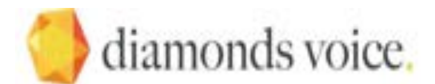
Multi-methods:

- Qualitative: process data, site visits and interviews,
- Quantitative: pathway uptake / actions

- Reflexive thematic analysis,
- Consolidated Framework for Implementation Research,
- Normalisation Process Theory,
- Stanford Lightning Reports,
- Frequency / Proportion

Public and patient involvement:

- Diamonds Voice
- Quality & Safety Patient Panel (Improvement Academy)



Implementation of core elements

24 GP practices delivered to some extent.

Differences in who delivered & element connection / consistency:

- More consistent = Health checks (24), clinical reviews (24), & some of care plan delivery (behaviour change & wider support; 19).
- More variable = non-engagement support (6), patient list stratification (12) & peer coach element (1) of care plan delivery.

Findings

Transforming care in the current context is difficult, but possible.

System level challenges with data sharing and unconnected electronic patient records need to be resolved to ease integrated care.

Centrally mandated incentivised QOF targets have unintended consequences of deprioritising time and resource for intervention and prevention.

Supportive learning environments with breathing room for reflection and problem solving enables staff involvement and iterative quality improvement.

Adapting UCLP-PRIMROSE to current resource and ways of working is key to better chances of success and felt ownership.

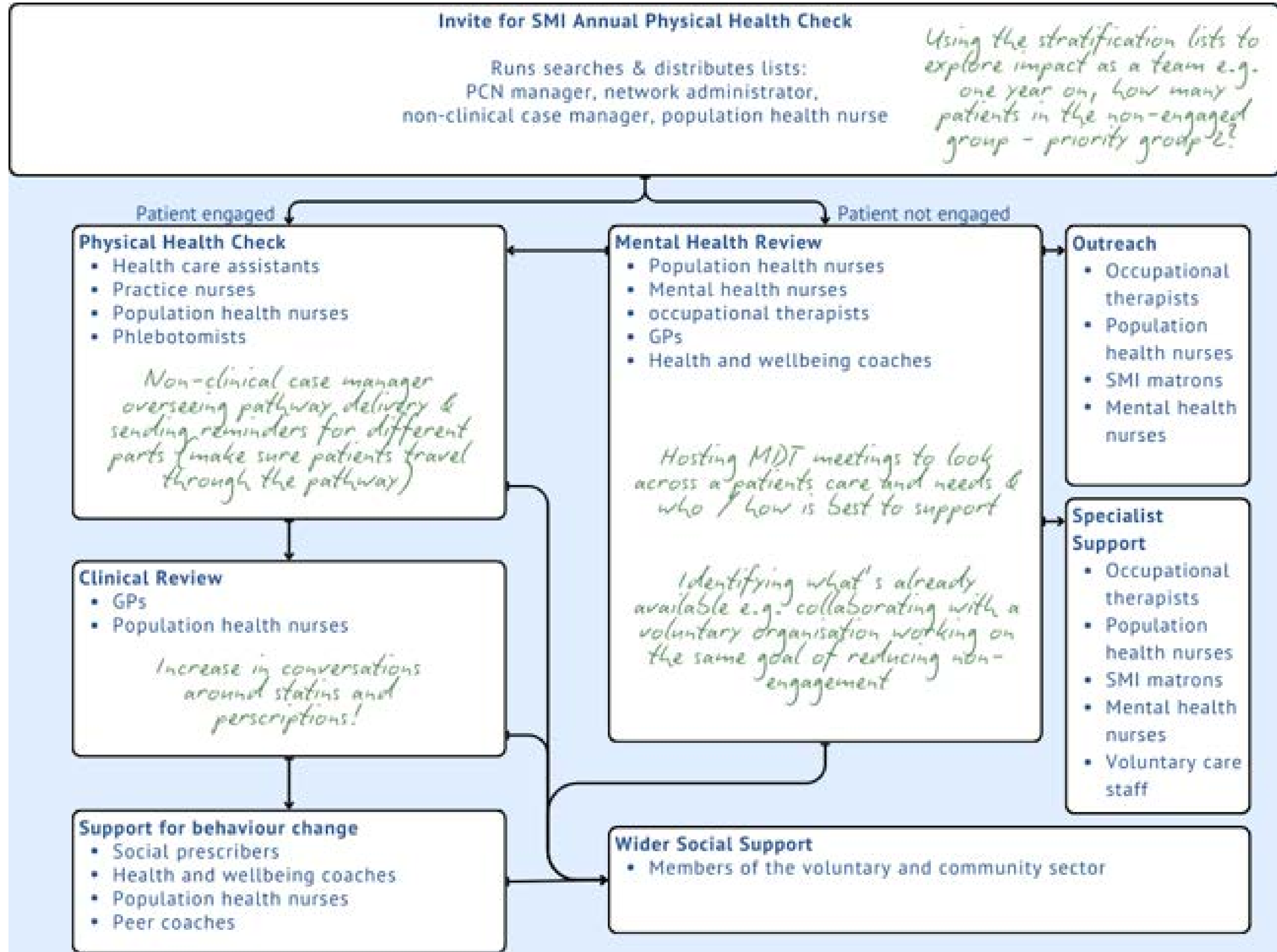
Resources (time and staff) are needed when setting up UCLP-PRIMROSE- including scoping staff and projects for collaboration and laying the groundwork for staff receptiveness.

Involvement of leadership, GPs and champions, and establishing a central implementation team are essential to create momentum with implementation.

Holding people accountable for actions through reporting and examining outcomes helps teams learn what is going well and what is not.

Local adaptation and best practice

"I can't get hold of this patient. Let's ignore him and just do the ones that we can. You're actually trying to figure out a way to get those patients that are not interacting [in] and it feels less like a tick box and more like patient care."



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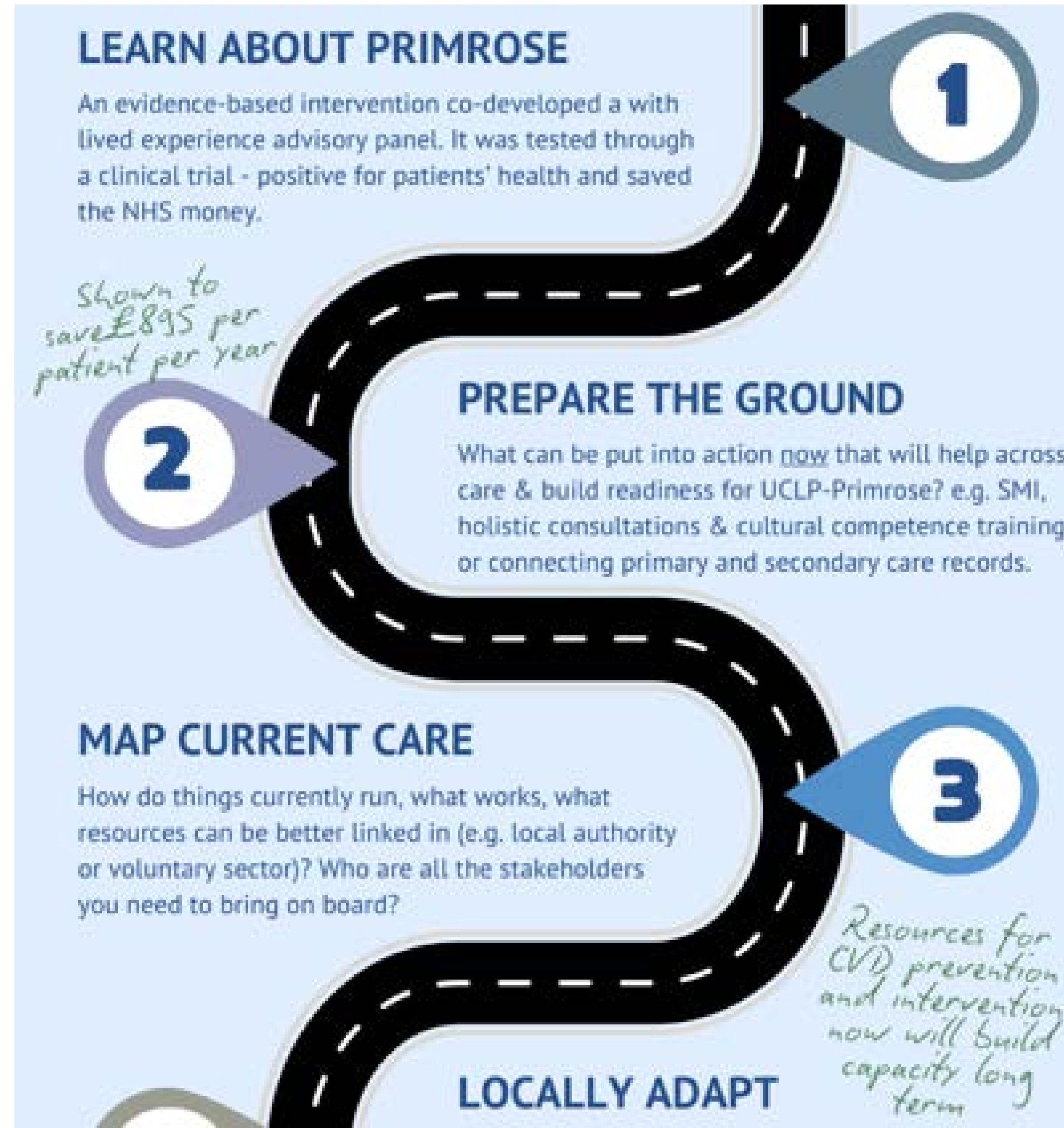
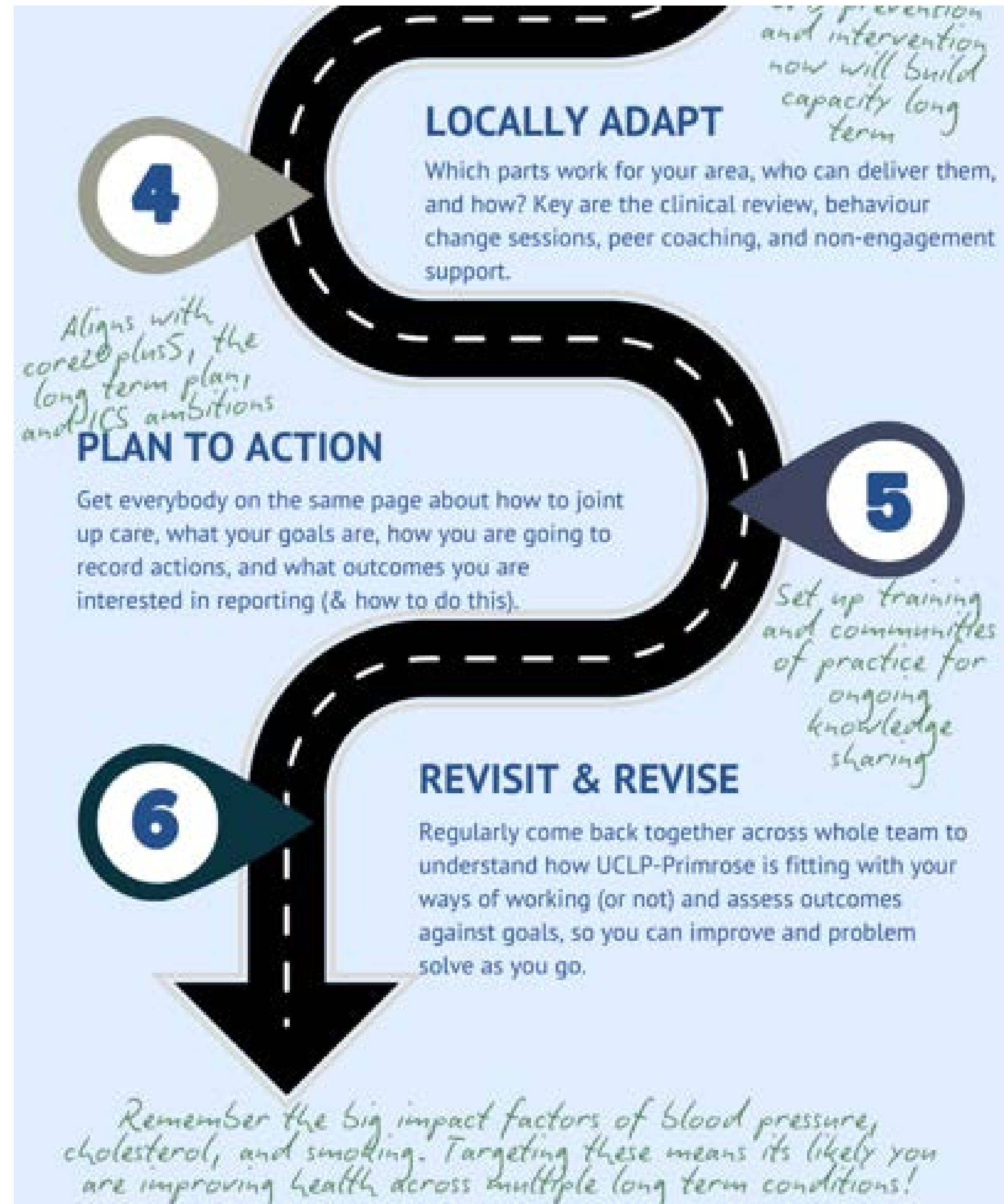
Steps of implementation



> “It’s about kind of getting going with our first few patients and just kind of, I think we will learn a lot from our first few patients in terms of the process and what we need to do and then continually optimising that process.”



Implementation of UCLP-PRIMROSE in practice- the Bradford Experience

Dr Gregor Russell

- R&D Director/Consultant Psychiatrist, Bradford District Care NHS Foundation Trust
- Visiting Senior Lecturer, Mental Health and Addictions Research Group, University of York

Bradford Implementation Team

- Primary care (1 Primary Care Network - PCN)
- Bradford District Care Trust (BDCT)
- Voluntary Care (Mind in Bradford)
- West Yorkshire Integrated Care Board
- Yorkshire and Humber Improvement Academy
- University of York

"I agree that that's one of the selling points of [UCLP-]PRIMROSE, the knitting together [of different care being delivered for patients with SMI], and in fact that these [physical health] checks are happening in two different places [primary and secondary care] without regard to each other."

Pre-existing situation

- BDCT has physical health team- this carried out checks on people receiving services from secondary care
- People with SMI not open to secondary care got health checks from GP surgery
- No coordination- so duplication, or missed checks, unclear ownership and accountability
- Community Mental Health Teams Transformation Programme- UCLP-PRIMROSE seen as fitting with aims of Physical health in SMI component of this
- UCLP-PRIMROSE introduced in 1 PCN in April 2023, superseding previous system of annual health

Implementation- what went well

- Enthusiasm from staff- widespread sense this was important, and strong sense of goodwill about it
- Training- required in person, but attendance still good, and thought to be relevant, informative and engaging
- Identified cohort of staff to deliver Intensive Behaviour Change- and sense that those that engaged with this made significant changes to lifestyle
- Collaboration with colleagues in MIND in Bradford District and Craven to bring their Health Engagement Officer project together with PRIMROSE to deliver the 'outreach' function
- Statin prescribing in target population showed 20% increase

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Implementation- snags and challenges

- Outreach worker post- funding planned from Transformation budget- delays in this becoming available, and in posts being approved by HR; then staff appointed to secondments were not released- so posts unfilled- ‘backup plan’ implemented, a nurse from BDCT physical health team allocated to this late in year to get some data on impact of outreach to improve uptake- showed good potential
- Communication issues between Primary and Secondary care were not solved- issues with record sharing and tasking on SystmOne
- Variable understanding of UCLP-PRIMROSE model and its purpose between Primary care sites and across staff groups- some practices more engaged that others- 50% of new statin prescribing and most intensive behaviour change referrals came from one of the four practices
- Stratification tool perceived as burdensome and unnecessary

Implementation- the current situation and next steps in Bradford

- UCLP-PRIMROSE still going! Continues as 'usual care' in patients with SMI registered with practices in the PCN- but with variability over how faithfully it is being implemented
- Problems to solve: Informatics issues; sustainability of training; stratification; uptake of behaviour change; outreach; leadership
- Meeting of Health and Care Partnership stakeholders took place in December- proposal to roll out across district rejected, insufficient evidence of impact, more evidence of how to implement successfully required
- Discussions over how to do this- effectiveness of implementation appears dependent on having 'champion' present at the site- so plan is to have an implementation support worker spend time at sites to engage with staff and embed understanding of the PRIMROSE purpose and processes

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Research in collaboration with:

WHOLE-SMI: Adapting, enhancing and implementing services in the North East and North Cumbria.

12th February 2025

Dr. Ilaria Pina & Dan Steward

WHOLE-SMI

Wellbeing and HOListic health promotion for people with Severe Mental Ill-health

WHOLE-ME

WHOLE-SMI

Phase 1

Mapping the service delivery landscape and community needs.

Phase 2

Mapping pre-implementation processes.

HOLISTIC HEALTH & SEVERE MENTAL ILLNESS

PEOPLE WITH SEVERE MENTAL ILLNESS, DIE EARLIER...

because of poorer physical health & healthcare

The scandal of PREMATURE MORTALITY

LONG WAITS for treatment/ only contact when in crisis

NOT THE MEDICATION MODEL ONLY — medications have side-effects

LACK OF COMMUNICATION between treatment teams & support providers

DISJOINTED, meditation lead & crisis focused

A HOLISTIC APPROACH:

in community spaces, easily accessible

THE GOAL IS TO STOP THIS!

ANNUAL HEALTH CHECKS in the community

NOT JUST SURVIVING, BUT THRIVING,

as a person, not just as a patient

LIFE ENHANCING (proactive prevention,

LIVING WELL with self, others & the community

FULL RECOVERY cope with triggers & get on with daily life

PARTNERSHIPS WITH THIRD SECTOR (NHS need to be more open to working with third sector)

Not ONE SIZE fits all

INCLUSIVE ACCESS even when people are not in crisis

Routes to being active in the community (in groups, outdoors, etc)

HOW?

SOCIALISING with those with LIVED EXPERIENCE & WITHOUT

PEER SUPPORT WORKERS lived experience & shared understanding

SMARTER SIGNPOSTING

VIEW THE PATIENT & not just the complaint

Being able to be THE REAL ME

Newcastle University · Durham University · Northumbria University Newcastle · McPin Foundation · UCL · NIHR | National Institute for Health and Care Research

Quotes highlighting community needs

“…a service should be **proactive**. It should be quicker. It should **tailor** itself **to the individual**. You should have **more time** with people.“

“… how people experience it and their perception of the world ... can be hugely different… if medicine and support were to be **personalised**, or tweaked more towards the individual and their needs, I think that would be ideal.“

"...there needs to be more access to **preventative support**, ... which there isn’t, and whatever there is just makes things worse."

“What matters to me?“

“…the problem is how [it’s] recorded on a system... that she wasn't prepared to engage, whereas actually, that's the complete opposite… **massively keen to engage, but restricted by the actual process**."

WHOLE-ME

WE ARE MORE THAN OUR DIAGNOSIS!

We need to look at the BIGGER picture!

More resources and holistic approaches to tackle mental health

It's not a health service if you only see us when we're ill.

Prevention is BETTER THAN CURE.

LESS TIME ON PAPERWORK, MORE TIME ON THE PERSON

What should happen now

Strategic & Policy-Level Actions

Leadership & Partnerships

Referral pathways

Language shift

Targeting missing people

What should happen now

Strategic & Policy-Level Actions

Move beyond reactive models

Ensure implementation of national policies at local levels

Stable, long-term funding to commissioning and service delivery staff

Technology & data sharing

What should happen now

Service delivery and Public actions

Thank you

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WHOLE-ME WHOLE-SMI

McPin Foundation