Service	Nottingham & Nottinghamshire ICB Physical Health Checks for Serious Mental Illness Local Enhanced Service
Commissioner Lead	XXXXXXXXXXXX
Provider Lead	GP Practices of Nottingham and Nottinghamshire ICB
Period	April 2026 to March 2027
Date of Review	Annually

1. Population Needs

1.1 National/local context and evidence base

Evidence shows there are stark levels of premature mortality for people with a Serious Mental Illness (SMI) whose life expectancy is 15-20 years shorter than that for the general population, largely due to preventable or treatable physical health problems. Compared with the general patient population, People living with SMI have:

- 6.6 times increased risk of respiratory disease
- 6.5 times increased risk of liver disease
- 4.1 times increased risk of cardiovascular disease
- 2.3 times increased risk of cancer
- are 3 times more likely to lose their natural teeth

People with a long-standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder.

Whilst medication for people with SMI, such as antipsychotics and mood stabilisers can increase life expectancy, they do have side effects that can impact on people's physical health, including weight gain, diabetes and increased lipids. However, these can be mitigated and treated if identified through monitoring and early intervention and through a process of shared decision making.

The NHS England Five Year Forward View for Mental Health (2016), NHS Long Term Plan (2019) and Mental Health Implementation Plan (2019) set a standard that by 2023/24, 390,000 people living with Severe Mental Illness will have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention each year.

For Nottingham and Nottinghamshire, the target for 2023/24 was 7029 people living with SMI will have a core annual physical health check, funded through the NHS Quality and Outcomes Framework (QOF). The Local Enhanced Service (LES) ensures consistency in approach by adopting the same criteria as the QOF (see appendix A) for the six core components of the annual physical health check but incentivised the five additional comprehensive components.

For 2026-27 the LES will continue to reflect QOF and relevant national guidance and continue to incentive practices to complete the additional components and follow ups including relevant cancer screenings in line with the Improving the Physical Health of People Living with Severe Mental Illness (2024) guidance:

	Core Components		Additional Comprehensive Components
1	Weight (BMI/ BMI and weight)	1	Assessed nutritional status, diet, physical activity
2	BP and pulse check	2	Assessed use of illicit substance, non-prescribed drugs
3	Blood lipid including cholesterol	3	Medicines review
4	Blood glucose	4	Access to relevant national screenings
5	Assessed alcohol consumption	5	Indicated follow-up interventions
6	Assessed smoking status		

Along with the above components, the guidance also recommends that an annual physical health check includes medical and family history, blood-borne virus and liver function screening, relevant national immunisation programmes, oral health advice and brief interventions, sexual and reproduction health assessment and advice (including contraception) and to consider asking if they have a carer who may want to apply for a carers assessment and/or access carer-focused education and support.

In addition to patients on the SMI Register, the guidance also recommends that annual physical health checks should be undertaken for those with a diagnosis of personality disorder, eating disorder, severe depression and people with mental health rehabilitation needs and all patients taking antipsychotics or mood stabilisers in line with summary of product characteristics (SmPC) and/or British National Formulary guidelines.

In Nottingham and Nottinghamshire (as at 1 January 2024) there were 8571 patients on the SMI register of whom; 720 (8.4%) SMI patients had not received a single health check against the 6 core components in the last 12 months and 5042 against a target of 7029 had had all 6 core components. Approximately 45% of patients have had one or more of the additional components, follow ups vary with 88% of smokers receiving a follow up intervention and 65% receiving diabetic interventions, but only 20% receiving other follow up interventions for lipids, diet and exercise and only 6% for substance misuse.

Nottingham and Nottinghamshire ICB	Number of components completed	Number of patients	Percentage
Core Physical Health Check Components Complete as at 1st January 2024 (12 rolling months)	0	720	8.4%
	1	412	4.8%
	2	417	4.9%
	3	407	4.7%
	4	690	8.1%
	5	833	10.3%
	6	5042	58.8%

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	Preventing people from dying prematurely	X
Domain 2	Enhancing quality of life for people with long-term conditions	X
Domain 3	Helping people to recover from episodes of ill-health or following injury	
Domain 4	Ensuring people have a positive experience of care	X
Domain 5	Treating and caring for people in safe environment and protecting them from avoidable harm	X

2.2 Local defined outcomes

It is expected that the provision of this service within Nottingham and Nottinghamshire ICB practices will lead to:

- High quality physical health care for SMI patients that enables early identification and intervention, providing care that advances equality and reduces premature mortality.
- Improved quality of life for SMI patients.
- At least 7030 (to be confirmed once 2024/25 NHSE Planning Guidance is received) SMI registered patients receive a comprehensive physical health check in 2024/25, in line with the national Long Term Plan ambition and NICE clinical guidelines.

3. Scope

3.1 Aims and Objectives of Service

The aim of the service is to improve the physical health of people with a Severe Mental Illness (SMI), in turn reducing the premature morality rate and health inequalities experienced by this cohort.

The service will support practices and the ICB to fulfil their responsibility and requirement to provide high quality physical health checks and follow up interventions to people with a SMI for at least 7029 (target to be confirmed once 2024/25 NHSE Planning Guidance is received) of the registered SMI population in 2024/25, excluding those patients recorded as in remission in line with QOF guidance[1].

The objective of the service is to:

- Provide high quality full physical health checks for SMI patients in primary care.
- Improve uptake of physical health checks for those eligible on the GP SMI register in line with national expectations.

[1] QOF guidance outlines that clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:
• no record of anti-psychotic medication;
• no mental health in-patient episodes; and
• no secondary or community care mental health follow-up for at least five years

- Measure and monitor the physical health of SMI patients, enabling early identification and intervention. Provide follow up health interventions and relevant advice, in line with NICE guidelines, that supports and educates patients with SMI to make informed, healthy choices and positive lifestyle changes.
- Initiate personalised care and support planning in partnership with the patient that encourages active participation and ownership.
- Provide care that supports Making Every Contact Count and Trauma Informed approaches.

3.2 Service Description/Care Pathway

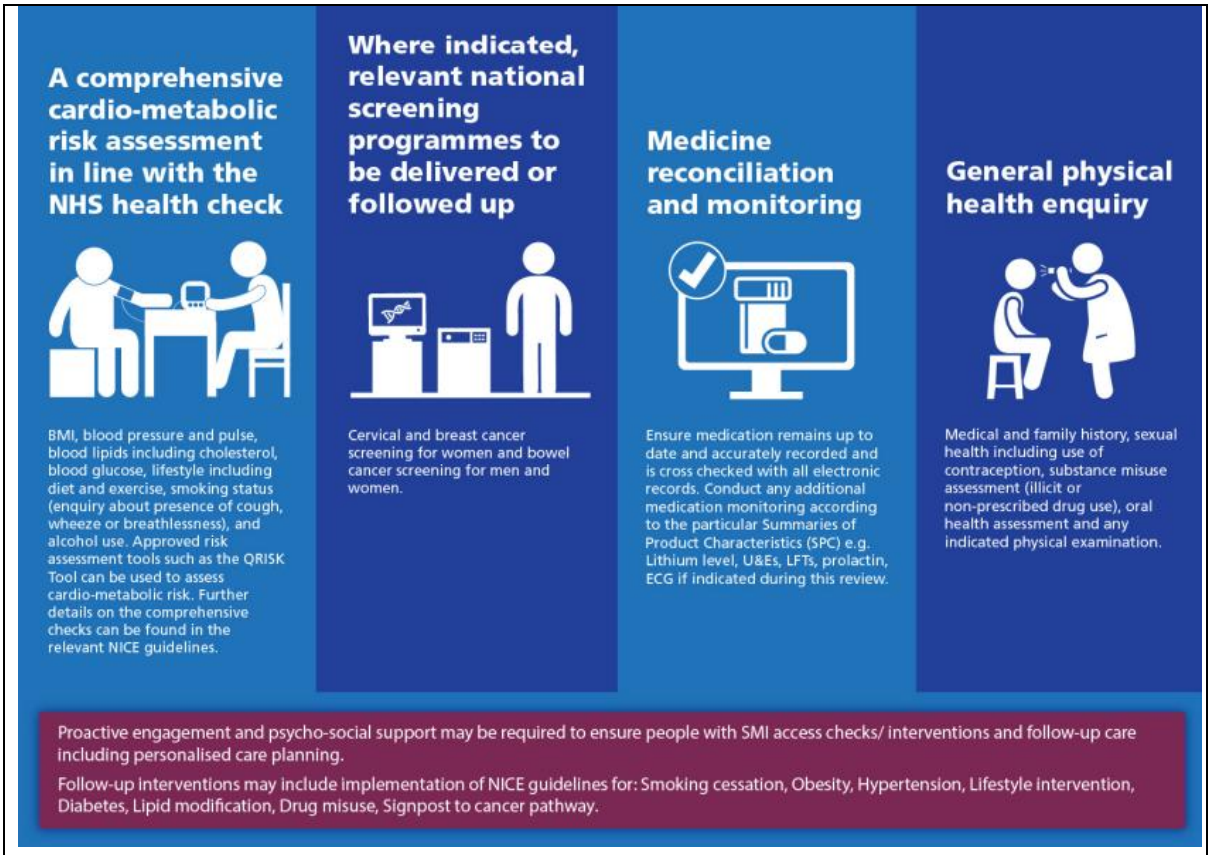
The service shall ensure high quality, complete annual physical health checks and follow up interventions are undertaken for their QOF registered SMI population in line with the six core components and five additional comprehensive components outlined above which builds on the Lester Positive Cardiometabolic Health Resource. The service shall also consider medical and family history, BBV and liver function screening, relevant immunisations, oral health advice, sexual and reproductive health assessment and advice

The service shall ensure all patients taking antipsychotics or mood stabilisers, regardless of whether they are on the SMI register or not, should have medication reviews and their physical health monitored in line with Summary of Product Characteristics (SmPC) and/or British National Formulary guidelines on antipsychotics, lithium and sodium valproate as appropriate.

A detailed breakdown of the core and additional comprehensive components has been included in Appendix B at the end of the specification and an overview is included in Figure 1 below.

It is recognised that the follow up interventions will be tailored to meet the needs of the individual, and therefore not all interventions may be appropriate to complete.

Figure 1: The recommended physical health assessments for people on the SMI register, taken from Improving physical healthcare for people living with SMI in primary care (2018)



The provider shall:

- Provide physical health checks for their QOF SMI registered population (excluding patients recorded as 'in remission') they are responsible for by a suitably qualified clinician (GP/Practice Nurse).
- Undertake the six core components and five additional comprehensive components (detailed above) as part of a complete physical health check, on an annual basis for their eligible SMI patients. The checks can be completed across a number of appointments within the 12 month period, linking in with existing reviews e.g. annual medication reviews, but it is recommended that they are completed in one appointment, reducing the number of visits the patient needs to make, thereby supporting the Making Every Contact Count approach. Appointments may need to be longer than a standard appointment, and further appointments may be required to discuss results and provide follow up interventions.
- Request any bloods or tests required as part of the health check.
- Undertake proactive follow up on results of all assessments.
- Provide lifestyle guidance, health education literature, or referral to appropriate health/lifestyle services as part of the indicated follow up interventions and personalised care planning.
- Record completed physical health checks in the patient's electronic record in line with QOF SMI indictors and the requirements of this service.
- Install the locally developed PH SMI templates for S1 and EMIS to capture recording and local reporting of activity as part of this service.
- Validate their SMI register on an annual basis to ensure it is accurate and up to date, in line with QOF indicator MH001.

- Build strong working relationships with the PCN-aligned Health Improvement Workers, ensuring they are embedded within the practice to support with engagement of and deliver of health checks for those hard to engage SMI patients.
- Work jointly with Secondary Care and the Health Improvement Workers (HIW) engage and develop relationships with those patients who previously disengaged or didn't engage with the practice and ensure HIW are supported to identify, engage and deliver health checks with the practice.
- Ensure all staff involved in providing the physical health checks has the necessary training and skills, and professional development is available.
- Take a Trauma Informed approach to checks and follow up support, considering how someone's mental health may impact on how they experience their physical health, the health check and the ability to make lifestyle changes.
- Make reasonable adjustments in line with the Equality Act as required e.g. consider different and proactive ways for inviting people in for checks, provide a longer appointment, offer choice in how to access an appointment, provide additional reassurance or support for those afraid of needles.
- Ensure physical health checks undertaken and communicated by inpatient wards and community mental health teams are input and coded appropriately.
- Utilise the Rethink Mental Illness – Physical Health Check tool with patients
- Ensure accurate SNOMED Coding
- Consider focusing on engaging patients for their annual physical health check at the beginning of the year to avoid undertaking this routine check during winter pressure periods.

Further guidance and support is outlined in the GP PHSMI Toolkit available on Team Net.

3.3 Population Covered

Eligibility for the service is in line with QOF guidance; therefore the service will cover those patients not 'in remission'[2] on the SMI registers in Nottingham and Nottinghamshire.

3.4 Any Acceptance and Exclusion Criteria and Thresholds

SMI registered patients under primary or secondary care will be eligible for this service, including those who are not in contact with secondary care and those who have been in contact with secondary care for more than 12 months and/or whose condition has stabilised.

In line with QOF, those patients on the SMI register who are 'in remission' will be excluded from this service.

3.5 Interdependence with other services/providers

- Health Improvement Workers (HIWs) within the Local Mental Health Teams (LMHTs) provided by Nottinghamshire Healthcare NHS Foundation Trust.

[2] QOF guidance outlines that clinicians should only consider using the remission codes if the patient has been in remission for at least five years, that is where there is:
• no record of anti-psychotic medication;
• no mental health in-patient episodes; and
• no secondary or community care mental health follow-up for at least five years

The HIWs within the LMHTs will provide outreach support and undertake physical health checks for those patients who have not engaged with their GP practice for their physical health checks. The HIWs will work with the patient to understand any potential barriers to attending their practice and engage with the practice to share learning and re-establish the relationship so the patient attends the practice for future physical health checks.

The HIW will prioritise health checks for patients identified under section 3.4 who are not engaging with primary care. They are not required to complete health checks for all the practices SMI register. They will enter checks into their standalone SystmOne unit.

- Community health and lifestyle services (i.e. smoking cessation services).
  Onward referrals for healthy lifestyle interventions identified as part of the physical health checks and individualised care plan.

- PCN Social Prescribers and Link Workers to support the practice and individuals with SMI by providing signposting to health and lifestyle services and raising awareness of the physical health checks.

4. Applicable Service Standards

4.1 Applicable national standards (e.g. NICE)

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards including adherence to the relevant NICE guidelines where applicable.

- NICE CG178 Psychosis and schizophrenia in adults
- NICE CG185 Bi-polar Disorder
- NICE NG181 Complex Psychosis

Appropriate evidence-based physical care interventions should be provided for all physical health risks or conditions identified during the assessment including:

- For alcohol NICE CG115 and illicit/non-prescribed drug use: follow guidance on co-occurring substance misuse and SMI NICE CG120.
- For Obesity prevention NICE CG43
- For Physical activity: brief advice for adults in primary care NICE PH44
- For Hypertension in adults: diagnosis and management NICECG136
- For Type 2 diabetes prevention and treatment NICE PH38, NICE NG28
- For Type 1 diabetes diagnosis and management NICE NG17, NG18 and NG19
- For Lipid modification NICE CG181
- For current smokers NICE NG209
- For Shared Decision Making NICE NG197

British National Formulary Guidance:

- Antipsychotics – BNF Psychoses and related disorders monitoring
- Lithium – BNF Lithium Carbonate monitoring
- Sodium Valproate – BNF Sodium Valproate monitoring and MHRA Drug Safety Update 2018

4.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)

The provider must ensure that they are aware of, compliant with, and can provide evidence if required, to demonstrate compliance with all relevant standards.
NHS England:

- The community mental health framework for adults and older adults
- Improving the physical health of people living with severe mental illness (SMI)

4.3 Applicable local standards

The provider must ensure that they are aware of, compliant with, and can provide evidence if required to demonstrate compliance with all local policies, procedures and guidance. CQC registration is completed, and the Regulations for Service Providers and Managers met (https://www.cqc.org.uk/guidance-providers/regulations). Staff involved in delivering this service should be adequately trained and supervised as determined by the provider and must have suitable indemnity.

Serious Incidents (SI's) and Patient Safety Incidents (PSI's)

It is a condition of participation in this service that providers will report all incidents where a patient has experienced harm to the ICB, in line with the Patient Safety Incident Response Framework (PSIRF). Providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. If deemed to be a Serious Incident the incident will be logged by the ICB on the current serious incident management system STEIS (the Strategic Executive Information System) or any other data base as directed by national guidance.

Safety Alerts

Providers must ensure that they are aware of and have a process in place for managing any safety alerts from the following sources that apply to any equipment or patient safety concerns associated with this enhanced service and that these are acted upon:

- Medicines and Healthcare products Regulatory Agency (MHRA) http://www.mhra.gov.uk/#page=DynamicListMedicines
- Local or national clinical guidance
- National and local formularies

Where requested details of action taken must be reported back to the ICB within the designated timescale.

Infection Prevention and Control

Good infection prevention and prudent antimicrobial use are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone (The Health Act 2008) Registered providers should meet the requirements of The Health and Social Care Act 2008. The provider should:

- Have systems in place to manage and monitor the prevention of infection, including regular audit and training. Infection prevention and control training for all staff every 2 years and hand hygiene yearly for all clinicians

- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections and meets national estates guidance and local IPC guidance
- Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
- Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely manner
- Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to others
- Systems to ensure that all care workers are aware of and discharge their responsibilities in the process of preventing and controlling infection
- Provide adequate isolation facilities
- Secure adequate access to laboratory support
- Have and adhere to infection prevention and control policies that are based on national and local guidance
- Have a system in place to manage the occupational health needs and obligations of staff in relation to infection and vaccination
- Have robust systems and processes in place to manage pandemics at a practice level including the management and reporting of staff outbreaks

Safeguarding
All staff working in this service area will be trained and competent in safeguarding children and adults as outlined in the Intercollegiate Guidance: -

Children: https://www.rcpch.ac.uk/resources/safeguarding-children-young-people-roles-competencies

Adults: https://www.rcn.org.uk/Professional-Development/publications/adult-safeguarding-roles-and-competencies-for-health-care-staff-uk-pub-007-069

Looked After children Looked After Children: Roles and Competencies of Healthcare Staff | Royal College of Nursing (rcn.org.uk)

All staff will comply with Nottingham and Nottinghamshire safeguarding children and adult procedures which can be accessed via these links: -

Safeguarding Children Procedures City & County:
https://nottinghamshirescb.proceduresonline.com/

Safeguarding Adult Procedures Nottinghamshire : -
https://nsab.nottinghamshire.gov.uk/procedures/

Safeguarding Adult Procedures Nottingham City: -
https://www.nottinghamcity.gov.uk/information-for-residents/health-and-social-care/adult-social-care/adult-safeguarding

On the request of the commissioner, the provider will provide evidence to give assurance of compliance with safeguarding standards.

5. Applicable Quality Requirements and CQUIN Goals

5.1 Applicable Quality Requirements (See Schedule 4 Parts A-D)

5.2 Applicable CQUIN Goals (See Schedule 4 Part E)

6. Location of Provider Premises

The Provider's Premises:
The Service will be provided within the boundaries of Nottingham and Nottinghamshire ICB. Providers must have adequate mechanisms and facilities including premises and equipment as are necessary to enable the proper provision of this service.

Location(s) of Service Delivery
The Provider is required to carry out the service within a recognised primary care setting registered for the purpose of healthcare.

Days/Hours of operation
As a minimum the service will operate Monday to Friday 8am to 6.30pm, GP core opening hours. The service will be expected to provide a variety of clinic times providing choice for the patient and will vary from provider to provider.

7. Contract

The contract will run from 1st April 2026 to 31 March 2027.

The notice period is three months for termination under General Condition 17.2 in writing to the Primary Care Commissioning Team nnicb-nn.primarycarenotts@nhs.net

Remuneration and Outcome Measures
Providers will be paid £XX per completed physical health check which includes all six core components and five additional comprehensive components (only one payment per SMI patient given a comprehensive physical health check). This payment reflects the additional follow up work to be undertaken following the six core components incentivised through the QOF SMI indicators.

SystmOne
For SystmOne practices, as part of F12 there is a report for SMI in the F12 Local Enhanced Services Claims folder which make it simple to find the numbers for claiming. These reports show patients coded as below.

Consider using the F12 LES templates for the service where green stars indicate the codes to add for claiming purposes.

EMIS
Unfortunately, EMIS reports cannot be shared centrally in the way we do as SystmOne; therefore practices will need to write these searches for themselves currently– the same codes and criteria should be used for reporting purposes, however.

Report Name	Criteria and requirements	F12 Template
SMI1	Any patient with applicable codes for achieving each indicator from the PHSMIXXX clusters e.g. PHSMIALC – PHSMI Alcohol consumption codes	F12 SMI Physical Health Check LES

If you have any queries on the searches or coding, please contact the F12 Team support@nottsf12.freshdesk.com

Claims

An automated claims process is currently being developed. Until this is in place, practices should claim using the LES claim form on a quarterly basis.

A claim can be made for each completed physical health check, including those completed by a HIW, which includes all six core components and five additional comprehensive components. Providers will receive quarterly payments in arrears based on submitted LES claim form.

Quarterly LES Claim Form Submission Deadlines

All practices should have processes and alerts in place to ensure LES requirements are met, and submissions made by the deadline date.

Practices are reminded that records relating to the completion and submission of the claim, including confirmation of date & time of submission, are kept within the practice to support the claim. These records may be examined by the ICB for verification purposes as part of an annual review or at any other notified time.

Completed claim forms to be submitted by the deadline date to the Primary Medical Services Commissioning Team nnicb-nn.primarycarenotts@nhs.net

LES Claim Forms will **not** be accepted after the deadline date (except in exceptional circumstances) which will lead to loss of practice income.

- Q1 deadline 31 July
- Q2 deadline 31 October
- Q3 deadline 31 January
- Q4 deadline 30 April

Providers will be required to:

- Comply with requests from Nottingham & Nottinghamshire ICB to provide information as it may reasonably request for the purposes of monitoring the providers' performance of its obligations under this service.
- Participate in an audit relating to this service as requested by Nottingham & Nottinghamshire ICB, if required.

Appendix A Mental Health Quality and Outcomes Framework

Clinical Area	Indicator ID	Indicator wording	Points	Thresholds
SMI	MH003	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood pressure in the preceding 12 months	4	50-90%
	MH006	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of BMI in the preceding 12 months	4	50-90%
	SMOK002	The percentage of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the preceding 12 months	25	50-90%
	MH007	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of alcohol consumption in the preceding 12m	4	50-90%
	MH011	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of lipid profile in the preceding 12 months (in those patients currently prescribed antipsychotics, and/or have pre-existing cardiovascular conditions, and/or smoke, and/or are overweight) or preceding 24 months for all other patients	8	50-90%
	MH012	The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a record of blood glucose/HbA1c in the preceding 12m	8	50-90%

Appendix B – Core Components and Additional Comprehensive Components for PH SMI

Part 1	Core Physical Health Check Components Complete
Part 2	A measurement of weight
	A blood pressure and pulse check
	A blood lipid including cholesterol check
	A blood glucose test
	An assessment of alcohol consumption
	An assessment of smoking status
Part 3	An assessment of nutritional status or diet and level of physical activity
	An assessment of use of illicit substance/non-prescribed drugs
	An assessment of Covid-19 vaccination status
	Medicine reconciliation and review
Part 4	Follow-up interventions - weight management
	Follow-up interventions - blood pressure - Part A (lifestyle interventions)
	Follow-up interventions - blood pressure - Part B (pharmacological intervention)
	Follow-up interventions - blood glucose - Part A (high-risk/prediabetic interventions)
	Follow-up interventions - blood glucose - Part B (diabetic interventions)
	Follow-up interventions - alcohol consumption
	Follow-up interventions - smoking
	Follow-up interventions - substance misuse intervention
	Follow-up interventions - Covid-19 vaccination status
	Other follow-up interventions related to blood lipid measurements and an assessment of nutritional status, diet and level of physical activity
	Other follow-up interventions related to blood lipid (including cholesterol)
Part 5	Access to national screening - cervical cancer screening
	Access to national screening - breast cancer screening
	Access to national screening - bowel cancer screening

Appendix C - Coding

In respect of SMI registers, all SNOMED codes under the SNOMED Cluster MH_COD have been used to define this cohort, minus all SNOMED codes under the SNOMED Cluster MH_REM (those in remission).

All relevant SNOMED codes under the MH_COD cluster can be found on the Primary Care Domain Reference Set Portal. The content of clusters is dynamic and can be updated several times throughout the year. Please refer to the portal/txt files for the most up to date content.