Evaluation of the physical health checks programme for people with severe mental illness in South East London

June 2025

Health Innovation Network South London

Contents

About the Health Innovation Network South London 4

Acknowledgements 5

Glossary 6

Abbreviations 6

Key terms 6

Executive summary 7

1. Introduction 9

1.1 Bridging the health gap 9

1.2 The physical health checks programme in South East London 10

1.3 This report 11

2. Evaluation approach 12

2.1 Evaluation objectives 12

2.2 Evaluation design 12

3. Programme overview 15

3.1 Programme timelines 15

3.2 Programme approach 18

3.3 Oxleas activities 20

3.4 SLaM activities 24

3.5 VSCE engagement: Mind activities 27

4. Intervention implementation insights 32

4.1 Key challenges to implementation 32

4.2 Key factors supporting implementation 35

5. Programme impact and learnings 38

5.1 Patient impact 38

5.2 System impact 39

5.3 Programme sustainability 40

6. Limitations 44

7. Conclusion and recommendations 45

7.1 Conclusion 45

7.2 Recommendations 45

8. Appendices 49

8.1 Programme delivery data template (Group B) 49

8.2 Service user case studies 50

8.3 Example programme GP communications 51

8.4 Data analysis overview 52

8.5 Oxleas and SLaM data by demographics 52

8.6 SLaM activity in Lewisham 53

About the Health Innovation Network South London

This evaluation was led by the Health Innovation Network South London (HIN) Insights team on behalf of the South East London Integrated Care System. The HIN is the Health Innovation Network for south London, one of 15 across England. We are the bodies uniquely established to connect NHS and academic organisations, local authorities, the third sector and industry, in order to increase the spread and adoption of innovation across large populations, at pace and scale.

The HIN is embedded within and understands south London's health and care system. We bring a wealth of experience delivering real-world evaluations of health and care programmes in south London (and beyond) that provide insights and actionable recommendations.

Acknowledgements

The evaluation would not have been possible without the extensive contributions from programme partners. We thank all participants who took part in this evaluation who generously shared their insights and experiences.

Special thanks go to:

- Nursing teams at Oxleas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust
- Primary care stakeholders that engaged and supported the programme in South East London
- South East London Mind and Mind in Bexley voluntary sector partners

We would like to extend our gratitude to the HIN mental health team for their leadership and project management, as well as the HIN's lived experience partner for their advice and support.

Finally, we would like to thank South East London Integrated Care System for funding the programme and evaluation.

Glossary

Abbreviations

CMHT	Community Mental Health Team
ICB	Integrated Care Board
ICS	Intgrated Care System
IG	Information Governance
LUCI	Locating Useful Clinical Information
MH	Mental Health
Oxleas	Oxleas NHS Foundation Trust
PCN	Primary Care Network
PHC	Physical Health Check
POCT	Point of Care Testing
QOF	Quality and Outcomes Framework
RAG	Red-Amber-Green
SEL ICS	South East London Integrated Care System
SLaM	South London and Maudsley NHS Foundation Trust
SLP	South London Partnership
SMI	Severe Mental Illness

Key terms

- A mental health practitioner is a relatively new role (2021) often jointly funded by the mental health trust and primary care, these roles have the ability to work across both organisations. Their main duties include:
    - Providing support to people with severe mental illness or complex mental health needs
    - Serving as a 'link' between primary care and specialist mental health services
    - Offering timely support and advice to GPs and other primary care staff
    - Helping to ease workload pressures
    - Fostering stronger collaboration and building relationships with mental health services

  Please note that not all GP practices currently have a mental health practitioner

- A mental health trust care coordinator acts as a central point of contact and support for individuals with mental health needs, helping them navigate the healthcare system and access necessary services. They work to ensure a person's care plan is effective and that all aspects of their support are coordinated, often connecting them with various professionals and resources.

- OneLondon is connecting health and care staff to the London Care Record so they have up to date patient details. It joins up data across London in a secure way to drive health and care improvements.

Executive summary

Background

In England, people with severe mental illness (SMI) have a life expectancy 15-20 years shorter relative to the general population, largely due to preventable physical illnesses[1]. The NHS has a national target for at least 60% of people with SMI to receive a full annual physical health check (PHC) by March 2025[2].

In 2022/23, South London Partnership secured Core20PLUS5 innovation funding from South East London (SEL) Integrated Care System (ICS) for a collaborative approach to increase PHCs for people with SMI in SEL.

The programme aimed to enable joined up data sharing and completion of individual PHCs to support PHC achievement for SMI registered patients by mobilising mental health nurses from Oxleas NHS Foundation Trust (Oxleas) and South London and Maudsley NHS Foundation Trust (SLaM) into primary care. This aimed to improve patient care and achieve PHC targets for people with SMI in SEL. In the final year, the programme was extended to: (1) increase awareness of PHCs for people with SMI amongst health care professionals and patients by partnering with the voluntary sector to deliver targeted activities; and (2) identify digital solutions through conducting a horizon scan and market review of tools that could address operational challenges.

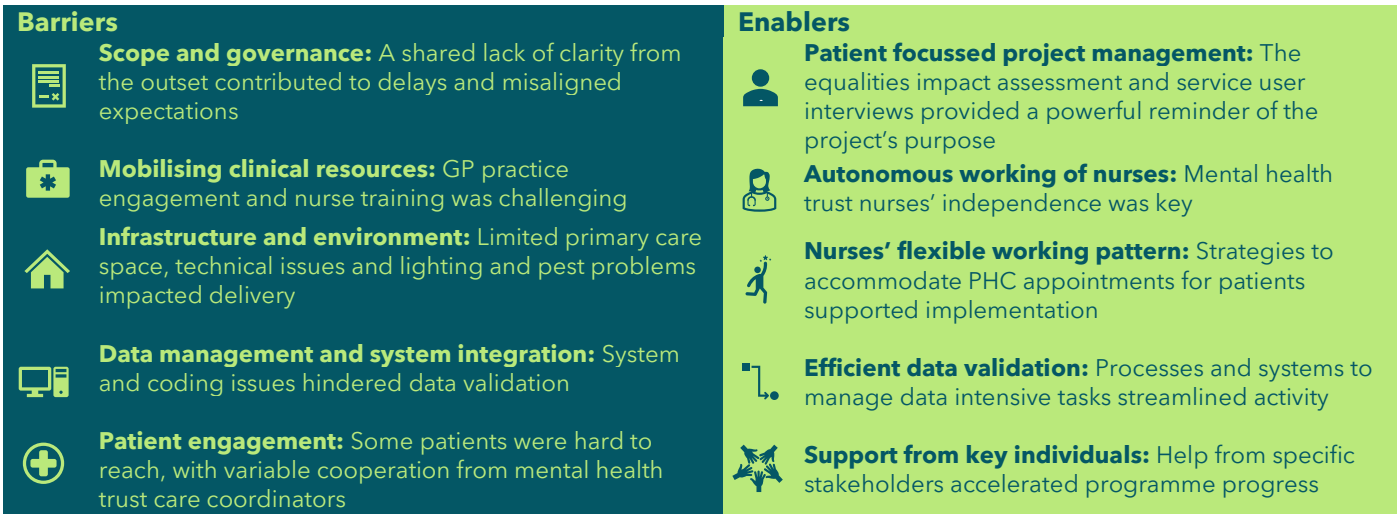
The Health Innovation Network South London (HIN) was commissioned to deliver an independent, mixed-methods evaluation of the programme.

Findings

Reach: Across SEL, 31 GP practices and 1 Primary Care Network (PCN) were engaged in the programme, during which 2684 patient care records were reviewed. Among the 1540 patients with available programme data, there was an average increase of 0.5 to 1.2 in the number of PHC elements completed.

Implementation: The programme faced significant initial delays due to information governance and nurse recruitment challenges. It experienced further disruptions due to staff sickness, turnover, ongoing recruitment and major external events (such as a GP collective action campaign and a cyberattack on Synnovis pathology services). Figure 1 summaries the key PHC model implementation insights.

Figure 1 Key factors affecting the implementation of the PHC delivery model in primary care



[1] Severe mental ill ness (SMI) and physical health inequalities: briefing - GOV.UK
[2] NHS England » 2024/25 priorities and operational planning guidance

Impact and wider learnings: Despite the challenges delivering the programme, it had direct and system-wide benefits:

- While primary care stakeholders found it difficult to assess the programme's impact, nurses highlighted the added value for patients – particularly those disengaged from GP or community mental health services – by enabling holistic care and intervention.
- System-wide, the collaborative model fostered stronger partnerships across primary, secondary, and voluntary sectors. It also supported the upskilling and professional development of mental health trust nurses and a deepened understanding of operating context and system barriers.
- The programme identified strategies to promote sustainable practices for improving PHCs in people with SMI across SEL, such as primary care led strategies to reach disengaged patients and support robust monitoring, as well as potential role expansion of the primary care mental health practitioner to encompass PHCs.

Key recommendations

1. **Learning from programme delivery**
   - **Engage primary care early and meaningfully:** Early involvement of primary care stakeholders is critical to address the engagement barriers.
   - **Coordinate and streamline information governance:** A coordinated approach should be established, involving key stakeholders to address obstacles and ensure sign off before delivery.
   - **Prioritise patients:** Since a large number of patients reviewed had checks already completed by practices, resources could focus on targeting significantly disengaged patients.

2. **Increasing targeting and uptake of PHCs**
   - **Expand the use Point of Care Testing (POCT) for lipids:** Multiple appointments were a consistent barrier to PHC completion, with lipid checks among the least completed elements. Wider rollout of POCT could streamline this process, reduce patient burden and improve completion rates.
   - **Advance primary care strategies:** Strengthening PHC delivery within primary care requires robust oversight of SMI registers and new and transformed approaches to annual monitoring.
     - Appoint named leads at practice, PCN, and system level to promote accountability and support system collaboration
     - Identify opportunities to integrate and improve PHC data entry into existing workflows to reduce duplication and the need for a data validation
     - Implement targeted strategies (e.g. RAG rating patients) and coordinate with secondary, community services and integrated neighbourhood teams to reach the most disengaged
     - Expand the remit of existing roles (e.g. mental health practitioners, care coordinators, and/or clinical pharmacists) to support PHCs, promoting a shared commitment
   - **Extended outreach through system collaboration:** There needs to be a continued movement towards integrating physical health in mental health. System-wide effort should focus on:
     - Develop a collaborative framework with mental health voluntary sector organisations to promote and raise awareness of the PHCs for people with SMI
     - Implement a multi-faceted community education strategy that goes beyond basic awareness of the PHC itself, emphasising the increased physical health risks faced by people with SMI
     - Conduct targeted PHC outreach in communities, leveraging voluntary sector networks to engage disengaged groups
     - Continue to promote PHC awareness amongst health professionals to ensure physical health in mental health is prioritised and barriers to attendance are addressed

3. **Supporting system development**
   - **Invest in data infrastructure and scale innovative tools:** Key specific opportunities include:
     - Promote use of the London Care Record across all stakeholders to reduce duplication, improve data accuracy, and enhance patient experience
     - Prioritise the integration of primary and secondary care systems through platforms like OneLondon to enable comprehensive, real-time access to patient information

1. Introduction

A severe mental illness (SMI) is referred to an enduring mental illness that often impairs a person's ability to engage in functional and occupational activities. Common diagnoses associated with SMI include schizophrenia and bipolar disorder1.

1.1 Bridging the health gap

In England, people with SMI experience one of the most pronounced health inequality gaps, with a life expectancy 15-20 years shorter relative to the general population. Chronic physical medical conditions (such as cardiovascular disease, respiratory disease, diabetes and hypertension) are leading causes of death for people with SMI. It is estimated that two thirds of deaths are from preventable physical illnesses, with the mortality gap continuing to widen[1].

Tackling this disparity is a key focus of NHS England's Core20PLUS5 initiative[3], community mental health transformation commitments[4] and the national planning guidance. The 2024/25 objectives aimed for at least 60% of people with SMI to receive a full annual physical health check (PHC) by March 2025, working towards a 75% target[2].

Box 1 Annual PHCs

The annual PHC includes six core elements:

1. Alcohol consumption status
2. Blood glucose or HbA1c test (as clinically appropriate)
3. Blood pressure
4. Body mass index
5. Lipid profile
6. Smoking status

A more comprehensive check also includes additional components covering prior history, lifestyle aspects, disease screening and medication[7].

Annual PHCs significantly reduce A&E visits and unplanned hospital admissions for individuals with SMI[10]. However, only about half of those eligible currently received a full PHC[11]. To improve outcomes for this vulnerable population, a more comprehensive and integrated care approach is crucial – aligning with NHS England's 10 key actions for improving physical health in this population[12].

Looking ahead, the 2025/26 priorities and operational planning guidance has introduced a more streamlined set of indicators to increase local autonomy and thus specific PHC targets for this group has been removed[5]. Nonetheless, PHCs remain part of the quality and outcomes framework (QOF)[6] for 2025/26, and the national guidance continues to recommend annual physical health monitoring for people with SMI[7], alongside NICE clinical guidelines[8]. In South East London (SEL), the draft 2025/26 joint forward plan highlights a continued focus in some boroughs such as Bexley[9].

[3] NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities
[4] Community-mental-health-framework-for-adults-and-older-adults.pdf
[5] NHS England » 2025/26 priorities and operational planning guidance
[6] The Quality and Outcomes Framework (QOF) in the UK incentivises GP practices to improve the quality of care, including specific indicators for the physical health of people with SMI, which require annual health checks
[7] NHS England » Improving the physical health of people living with severe mental illness
[8] NICE clinical guidelines such as CG178 and CG185.
[9] South East London 2025/26 Joint Forward Plan Executive Summary
[10] Supporting the physical health of people with severe mental illness
[11] Physical Health Checks for People with Severe Mental Illness, Q3 2024-25 - NHS England Digital
[12] NHS England » 10 key actions: Improving the physical health of people living with severe mental illness

1.2 The physical health checks programme in South East London

In 2022/23, SEL Integrated Care System (ICS) received Core20PLUS5 innovation funding to increase the number of PHCs in SEL. The programme proposed was a collaborative model, delivered in partnership with:

- Health Innovation Network South London (HIN) - programme management and evaluation
- Oxleas NHS Foundation Trust (Oxleas) - clinical delivery partner
- South London and Maudsley NHS Foundation Trust (SLaM) - clinical delivery partner
- South London Partnership (SLP) - senior responsible owner

1.2.1 Background to the programme

The programme was built on a successful **health check liaison pilot project** led by SLaM:

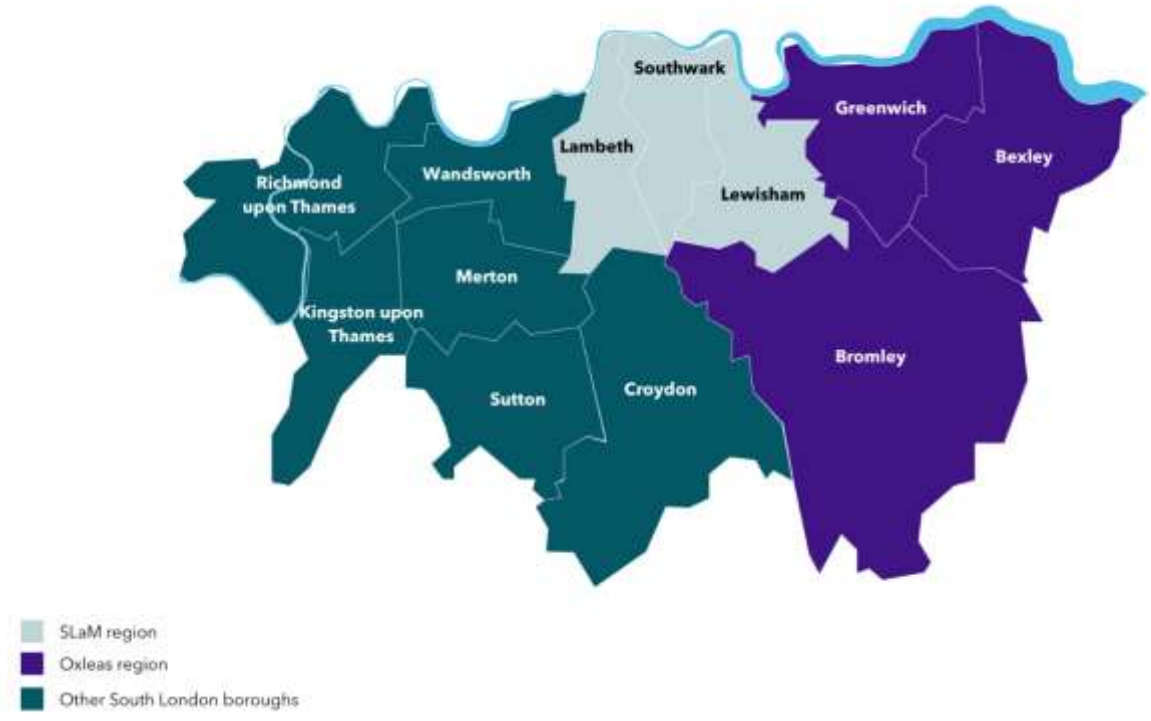
- The pilot comprised of seven Band 4 assistant practitioners, a team administrator and one Band 8a health care liaison project lead
- They supported local teams in completing PHCs by 'loaning' assistant practitioners to assist with physical health clinics and outreach
- Additionally, the team also facilitated **sharing** of secondary mental health services data to primary care to support QOF compliance
- The SLaM model **did not** include access to GP systems

This model represented a novel approach to **integrating primary and community care,** supporting the broader transformation of community mental health for adults and older adults.

1.2.2 Aims of the programme

The vision for the SEL programme was to build on and scale up the SLaM model of care to reduce inequalities in access and health outcomes for people with SMI across the six SEL boroughs: Bromley, Bexley, Greenwich, Lambeth, Lewisham, and Southwark (Figure 2).

Figure 2 Map of South London (highlighting Oxleas and SLaM regions)



The programme aimed to **enable joined up data sharing across systems to support PHC completion for SMI registered patients**. Mental health trust nurses were expected to work with primary care teams (within primary care settings) to check and update the completeness of PHC data for people with SMI, through both data validation and patient outreach:

- Oxleas were engaged and funded directly through the programme.
- SLaM received additional funding in 2024/25, as their initial SEL ICS baseline funding and business as usual model did not include working with primary care.

Box 2 The purpose of the data validation

The data sharing and data validation process was identified as a key mechanism for supporting annual PHC compliance for people with SMI. It aimed to reduce duplication for patients and help GP practices in meeting the relevant QOF indicators.

Its primary goal was to ensure an accurate SMI patient register, through verifying and correctly coding PHC elements, and through supporting the appropriate use of personalised care adjustments.

This process was intended to function as a quality control mechanism, enabling more tailored and individualised care for patients with SMI—for example, through the provision of home visits.

In the final year of the programme, the programme extended to:

- **Increase PHC awareness** by partnering with the voluntary sector to deliver targeted activities
- **Identify digital solutions** through conducting a horizon scan and market review of tools that could address operational challenges

The HIN Mental Health team project managed the programme and the HIN Insights team was commissioned to lead a mixed-methods evaluation of the programme.

1.3 This report

This report details the evaluation of the PHCs programme for people with SMI in SEL, highlighting implementation insights, its impacts, key learnings and resulting recommendations. Insights from this evaluation aim to inform the shape and scope of any future programme activity.

2. Evaluation approach

The evaluation aimed to explore the implementation of the physical health check (PHC) programme for people with severe mental illness (SMI) in South East London (SEL). It further sought to understand programme impact and identify learnings and recommendations. This section outlines the evaluation's aims and design.

2.1 Evaluation objectives

The evaluation aimed to address the following objectives:

Describe the programme to understand how and why it is – or isn't – working:

- Understand how the programme was implemented overall (and what adaptions were made)
- Identify the key enablers and challenges faced by the local areas in delivering the programme

Assess outcomes to see if the programme had the desired impact:

- Understand the impact of the programme on PHC uptake among people with SMI in SEL
- Explore the profile of patients with SMI undertaking PHCs
- Determine outcomes of PHCs on patients with SMI
- Assess patient acceptability and experience of PHCs

Identify lessons and learnings to support sustainability and inform improvements

2.2 Evaluation design

The evaluation employed a mixed-method approach to comprehensively evaluate the programme. It primarily adopted a formative approach due to limitations in the available data, as described further in Section 6.

2.2.1 Data collection methods

The data collection used qualitative primary data collection methods and quantitative secondary data collection methods.

Qualitative primary data collection methods

Table 1 summarises the primary data collection methods. The qualitative fieldwork involved obtaining informed consent from participants, following semi-structured topic guides and recording and transcription via Microsoft Teams. The HIN Lived Experience Partner also contributed to shaping the approach and design of the topic guides.

Table 1 Overview of primary data collection methods

Method	Timeframe	Description and sample size
HIN programme management focus group	October 2024	HIN staff involved in the set-up and programme management participated in focus group to discuss programme oversight and implementation. • 5x staff participated, with three holding prior project management or insight roles
Oxleas NHS Foundation Trust (Oxleas) and South London and Maudsley NHS Foundation Trust (SLaM) nursing team focus group and interviews	February 2025 – April 2025	Oxleas and SLaM nurses involved in project delivery were interviewed to capture their involvement in the programme, understand day to day implementation and gather insights on programme outcomes and learnings. • 3x Oxleas staff participated in a focus group • 1x Oxleas staff participated in a follow up interview • 3x SLaM staff participated in interviews
Primary care stakeholder focus group and interviews	February 2025 – June 2025	Primary care-based stakeholders shared their views on the programme's delivery and outcomes through focus groups and interviews. Staff were recruited by nursing teams and HIN project management staff. Interviewees ranged from practice managers, an advanced mental health practitioner, a lead practice nurse, a GP, primary care network programme managers / service improvement facilitators, and SEL Integrated Care Board staff. • 6x staff supporting Oxleas delivery participated in four interviews and one focus group • 4x staff supporting SLaM delivery participated in two focus groups
Voluntary sector interviews	February 2025 – April 2025	Mind staff were interviewed to understand intervention development and impact, partnership learnings and opportunities for SMI patients. • 2x Mind in Bexley staff participated • 2x SEL Mind staff participated

Quantitative secondary data collection methods

The secondary data collection methods are described in Table 2.

Table 2 Overview of secondary data collection methods

Programme delivery data	NHSE data	SEL ICS dashboard
Oxleas and SLaM teams collected anonymised programme delivery data. This included patient demographic, mental health diagnosis, physical health check completeness for each element and programme implementation data (such as patient centred follow up actions and data entry details). An example data template is provided in the Appendices (Section 8.1). **This dataset is the primary dataset used in the evaluation as it provided the most granular information.**	Annual Quality Outcomes Framework (QOF) data was accessed. This data is submitted by GP practices following an annual validation and cleansing exercise. Further standardisation is applied by NHSE. This was primarily used at project inception and to provide wider historic benchmarking and context. The data is made publicly available, however annual data for 2024/25 has not yet been published to further assess and compare progress against targets.	The SEL ICS data dashboard provides monthly insights on achievement of the QOF targets. This data is not subject to any cleaning or validation processes and as such does not fully align with annual published data. This dataset supported comparison of QOF targets across boroughs from nursing and voluntary sector activities. The HIN team had limited access to the dashboard and data outputs made available to other stakeholders, which restricted our ability to further investigate QOF achievement.

2.2.2 Data analysis

Data were analysed across the data sources using:

- **Qualitative data analysis** in Excel using descriptive statistics
- **Qualitative analysis** of interview and focus group data adopting a framework analysis approach, with themes deductively coded against the evaluation objectives and topic guides, followed by an inductive approach to identify emerging themes
- **Formulation of emerging insights and recommendations** with programme stakeholders across the HIN mental health team, Oxleas and SLaM nursing leads and Mind partners

3. Programme overview

This section details how the physical health check (PHC) programme for people with severe mental illness (SMI) operated in South East London (SEL). It describes the broad programme timelines, outlines the delivery model and explores activities and outputs delivered by Oxleas NHS Foundation Trust (Oxleas), South London and Maudsley NHS Foundation Trust (SLaM) and Mind voluntary sector partners.

3.1 Programme timelines

The programme was delivered from November 2022 to March 2025. Each of the programme actors played a distinct role:

- The Health Innovation Network South London (HIN)'s Mental Health team provided project management and oversight of the overall programme, as well as delivering some key activities such as service user engagement and the horizon scan of digital tools
- Oxleas and SLaM worked in primary care to check and update the PHC data for people with SMI, through data validation and outreach activities
- Mind in Bexley and SEL Mind delivered targeted activities such as training sessions and animations to increase PHC awareness amongst healthcare professionals and people with SMI

Figure 3 (on page 17) highlights the different strands of activity delivered by the respective partners, as well as key milestones and external events that occurred throughout the lifecycle of the programme.

The delivery of the programme and the timelines are best understood within the following context:

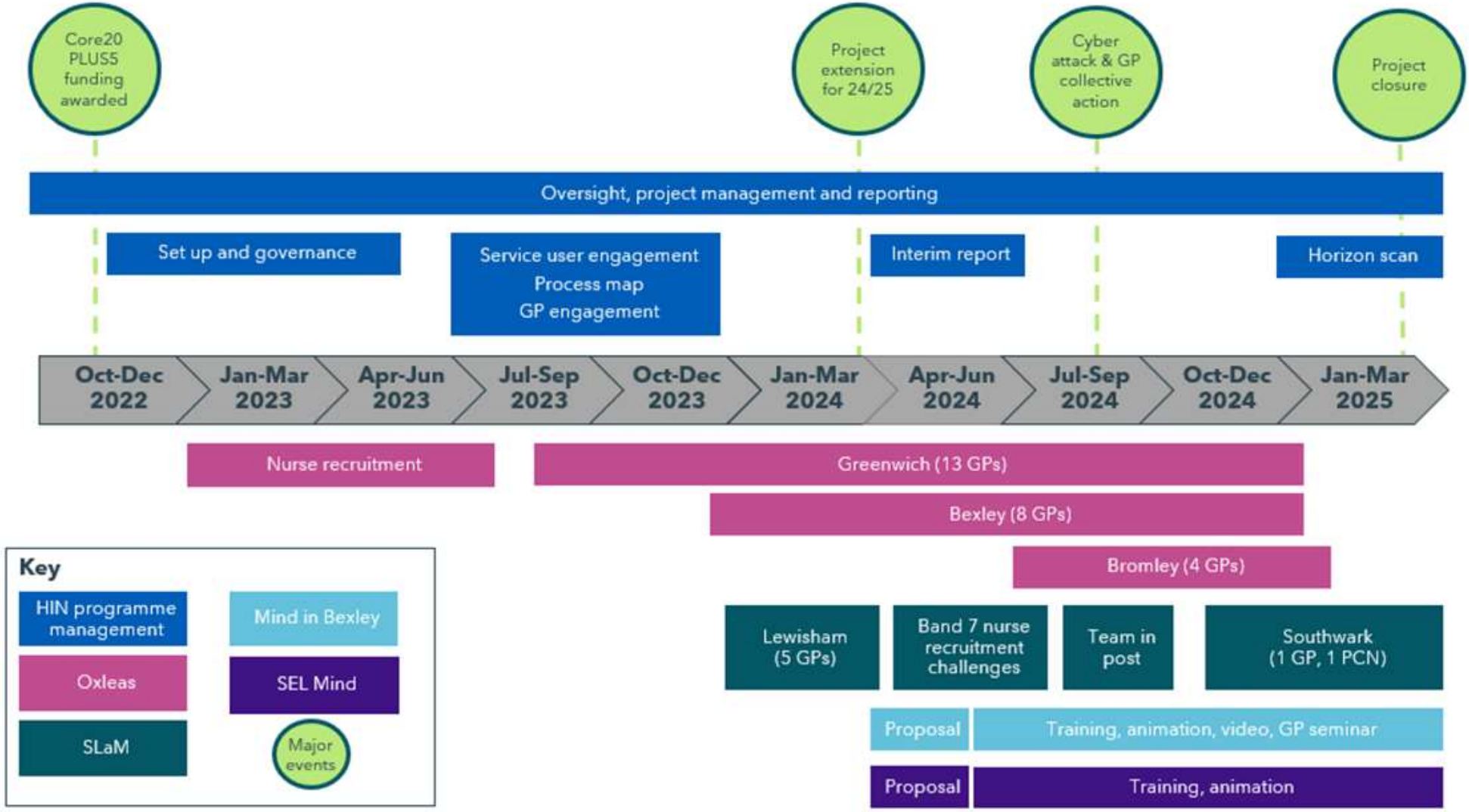
- **Governance:** The HIN managed various forums to maintain progress and accountability, including fortnightly operational meetings and monthly programme meetings with programme partners. South London Partnership, as the senior responsible oversight, were also engaged throughout with initially fortnightly meetings, followed by quarterly reporting.
- **Service user engagement:** This phase informed programme design and delivery and comprised of five in-depth interviews with people with SMI to explore their lived experience and perceptions accessing and undergoing PHCs. Key themes from the interviews centred around communication challenges, elements often missed as part of the PHC, the perceived value of the PHCs (and lack of in some cases), and common barriers to completing PHCs. Case studies from each interview are presented in the Appendices (Section 8.2).
- **Cyber-attack:** Programme delivery was disrupted in June 2024 due to a cyberattack on Synnovis (a pathology service). Whilst impacting phlebotomy services, this accelerated the use of point of care testing (POCT) for cholesterol amongst Oxleas teams. SLaM was advised against carrying out routine blood tests, which were required to complete PHCs.
- **GP collective action:** As part of the collective action campaign led by the British Medical Association, GPs were advised against signing up to new initiatives and data sharing agreements[13]. This impacted GP recruitment for the programme in summer 2024.
- **The mobilisation of mental health clinical resources:** From the outset, Oxleas and SLaM delivery was significantly delayed due to information governance and recruitment issues.
    - In Oxleas, the recruitment of band 6 nurses was challenging (in line with nation-wide shortages), with the team formally starting from August 2023. In addition, long-term sickness and leave impacted delivery.
    - In SLaM, there were significant challenges due to staff turnover, ongoing issues with recruitment and the further releasing of budget to start delivery. This meant that the programme did not commence operational delivery until January 2024, with the majority of delivery in 2024/25, when additional funds were provided to enable the nurses to work

[13] GP-collective-action-20240801.1.pptx

directly with GP patient data.

- **Project extension:** A proposal was accepted by SEL Integrated Care Board (ICB) to extend the programme into 2024/25, which included:
    - **Voluntary sector engagement:** Proposals were submitted by Mind in Bexley and SEL Mind to increase PHC awareness and their activity was primarily delivered between October 2024 – March 2025.
    - **Horizon scan:** In recognition that there was an opportunity to address the need to offer people with SMI a choice of intervention to support their physical health, the HIN team carried out a horizon scan of digital technologies to support the physical wellbeing of people with serious mental illness. Twelve digital health interventions were identified, that offered support with smoking cessation, physical fitness and nutrition.

Figure 3 Overview of programme timelines



3.2 Programme approach

This section describes and compares the specific elements of the approach and model implemented by Oxleas and SLaM teams.

3.2.1 Staffing model

The programme was delivered using two distinct workforce models for Oxleas and SLaM staff (Table 3), with a key difference between trusts being in nurse banding.

Table 3 Staffing model

Insights	Oxleas	SLaM
Team	Agile physical health intervention team	Health check liaison team
Project funded	Three part-time Band 6 nurses	Two full-time Band 4 assistant practitioners
Trust contributed	Practice development nurse (Band 8a) to oversee implementation	Clinical service lead (Band 8a) to oversee implementation
Context	Due to long-term sickness, the two Band 6's operational delivery was covered by the Band 8a and a Band 4 (assistant practitioner)	Three clinical service leads were involved throughout the course of the programme

Oxleas and SLaM staff reflected on the staffing model that:

- **The band six operating model in Oxleas contributed to good clinical judgement, decision-making and interpretation of physical and mental health data.** This staffing level also facilitated cooperation with teams (e.g. for blood results) and strengthened risk assessment and management capabilities, particularly for home visits.

  "It needed people that were qualified to have a look through the details (…) and making sure that that's accurate and making decisions about information (…) and (…) how to respond to it because there's an element of risk assessment and risk management that also needs to go on." (Mental health trust nurse)

- **The band four operating model in SLaM relied on support from the clinical service lead for both communication and management**. Although this model functioned effectively due to the skills of Band 4 nurse in post, the potential benefits of involving a Band 7 nurse were noted. Nonetheless, a decision was made to proceed with delivery to finalise the project, as opposed to continuing Band 7 recruitment.

  "Protecting some time, (…) but actually somebody (…) kind of having (…) oversight over it and being able to feedback to leadership." (Mental health trust nurse)

3.2.2 Delivery model

Figure 4 provides an overview of how Oxleas and SLaM nursing teams' work. This involved four main phases.

Figure 4 Overview of delivery model

[14] Electronic patient record systems included EMIS (GP), RiO (Oxleas), ePJS (SLaM) and the London Care Record.
[15] The red-amber-green (RAG) rating system encompassed patients with a complete PHC (green), patients with a partial PHC (amber) and with patients no PHC within the last 12 months (red).

3.3 Oxleas activities

The Oxleas team worked across the London boroughs of Bexley, Bromley and Greenwich.

The analysis divides Oxleas-supported GP practices and patients into two separate groups (A and B) due to a mid-project change in the team's data collection approach:

- Group A represents the earlier practices Oxleas worked with, with fewer data points available (while there was information on whether each PHC element had been completed, it did not specify whether this was attributable to the GP practice, prior involvement from the mental health team, or the project team itself).
- Group B represents the later practices, which have fuller data points on Oxleas activity.

An overview of the practices and patients included in the analysis is provided in the Appendices (Section 8.4).

This section provides insights on GP practice coverage, patient profile[16], and PHCs completed in Oxleas (including individual elements of PHCs, average number of PHC elements by patient, full PHCs, and all checks completed by community mental health team (CHMT) status[17]).

3.3.1 Primary care coverage

The team at Oxleas worked across 25 GP practices between August 2023 and December 2024. Time spent within each practice varied between one day and seven months.

Most practices were in Greenwich, which included some large practices e.g. one with an SMI patient list of over 400. Progress in Greenwich was likely accelerated due to senior staff commitment and in particular supporting establishment of a data protection impact assessment.

There were a total of 2,365 patients on the SMI register within the 25 GP practices, corresponding to approximately 30% of SMI patients within Bexley, Bromley and Greenwich (Table 4).

Table 4 Practice profile in Oxleas

Borough	Total SMI patients[18]	No. of practices in project	No. of SMI patients in project practices	% of SMI patients in project within total population
Bexley	1959	8	492	25%
Bromley	2587	4	339	13%
Greenwich	3388	13	1534	45%
TOTAL	**7934**	**25**	**2365**	**30%**

[16] Further in-depth analysis on demographics and equality within the SMI population, specifically in relation to completion of PHCs in SEL can be found here.
[17] CMHT status typically refers to a person's involvement with a community mental health team (CMHT). It indicates whether an individual is currently receiving support, treatment, and care from this type of multidisciplinary mental health service.
[18] Total SMI patient figures are from SEL data dashboard at the beginning of delivery in each respective borough. Please note that these figures are unlikely to mirror Quality and Outcomes Framework (QOF) 2024/25 published figures.

3.3.2 Patient profile

Table 5 provides a detailed breakdown on the demographic profile of the patients within the Oxleas practices included in the project. This includes information on the total number of patients and the specific number who received support from a CMHT[19].

Overall, data shows that:

- 40% of patients from the Oxleas practices included in the project were under a CMHT
- The demographic profile of each group (all patients and those under CMHT) was broadly similar
- A slightly higher proportion of Black or Black British patients were under a CMHT

Table 5 Demographic profile of primary care patients supported by Oxleas teams (group A & B)

	Total		Under CMHT	
	Number	%	Number	%
Total	**2365**	**-**	**948**	**40%**
Sex				
Female	1187	50%	460	49%
Male	1174	50%	487	51%
Unknown	4	0%	1	0%
Age band				
18-24	105	4%	40	4%
25-34	392	17%	173	18%
35-44	518	22%	201	21%
45-54	488	21%	184	19%
55-64	479	20%	194	20%
65-74	245	10%	92	10%
75-84	98	4%	49	5%
85+	24	1%	8	1%
Unknown	16	1%	7	1%
Ethnicity				
Asian or Asian British	265	11%	93	10%
Black or Black British	459	19%	230	24%
Mixed	205	9%	80	8%
Other	167	7%	62	7%
White (incl. White Other)	1220	52%	467	49%
Not stated/Unknown	49	2%	16	2%

3.3.3 Completion of physical health checks

Analysis of the number of completed PHCs has been carried out by:

- Examining individual checks or elements of the PHC (e.g., alcohol consumption status, blood glucose or HbA1c test, blood lipid profile, blood pressure, body mass index, and smoking status)
- Assessing the completion rate of full PHCs, encompassing all six of these elements (as improving the completeness of these checks is a key objective of this project)

When reviewing the data below, the impact of the Synnovis cyber-attack should be noted, which likely disrupted the delivery of checks requiring blood tests – specifically, blood glucose and lipid profiles. Therefore, the average number of individual checks has been analysed to provide further context.

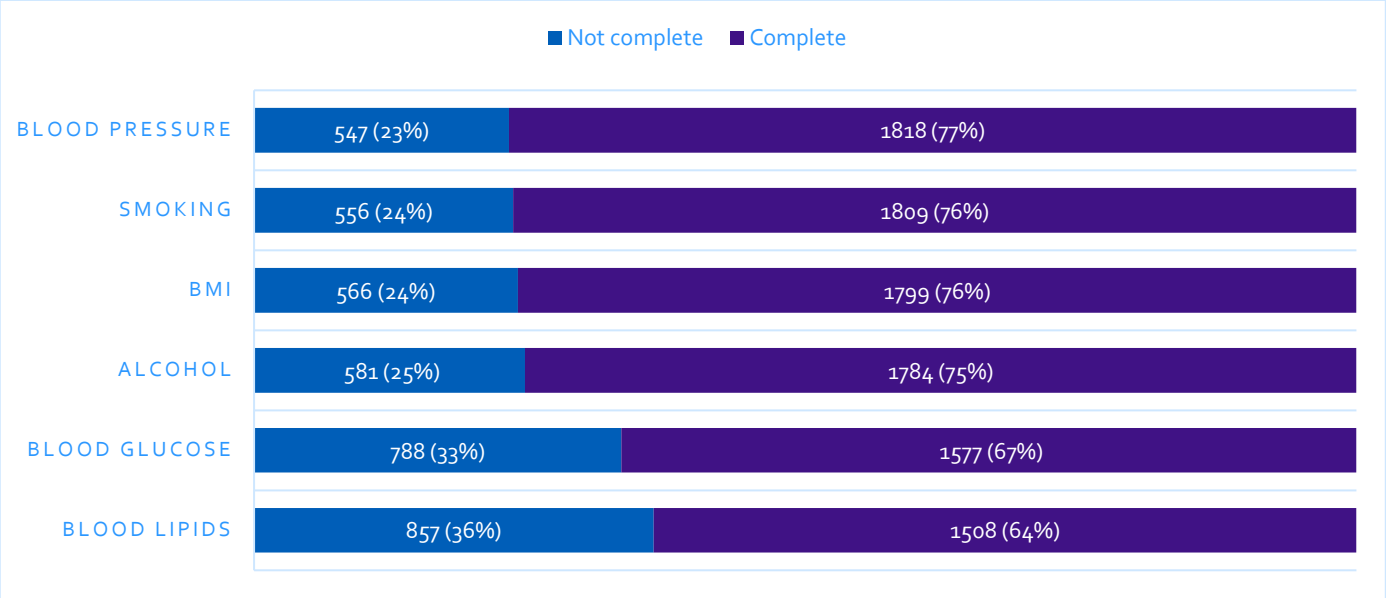
[19] It means the individual has been referred to and accepted by a CMHT, which usually comprises professionals like psychiatrists, psychologists, mental health nurses, social workers, and occupational therapists. The aim of CMHTs is to help individuals manage their mental health conditions and live as independently as possible in their own homes.

Individual elements of checks

Overall, 73% of the total PHC elements were completed. This is based on 2,365 patients on the SMI register across the GP practices supported by the Oxleas team (Table 4) having 10,295 of a total of 14,190 expected individual checks (i.e. 2,365 patients × 6 checks each).

Blood lipids and blood glucose had the lowest completion rates, 64% and 67% respectively (Figure 5). This was expected, due to the impact of the laboratory cyber-attack and historically lower uptake of these tests on a national level. Nursing staff also report that patient difficulties with blood draws and needle phobias could play a role. **All other individual check elements achieved completion rates above 75%.**

Figure 5 Types of checks and completion status for Oxleas (groups A & B)

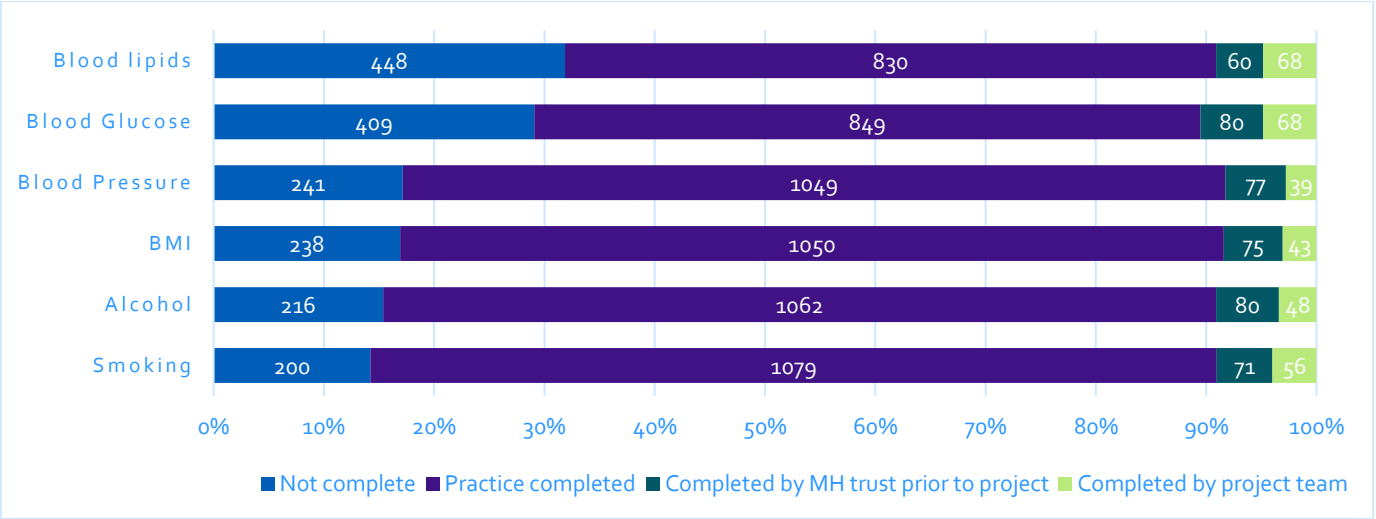


For group B practices, further analysis was conducted to understand how (i.e. by whom) PHCs were completed:

- **GP practices:** The majority of individual PHC elements – 5,919 (**70%**) – were completed by GP practices prior to the start of the project.
- **Oxleas mental health trust:** 443 individual PHC elements (**5%**) were completed by the mental health trust before the project began, with the data later reconciled and updated in EMIS. This highlights the potential benefits of improving data sharing between CMHTs and GP practices. It must also be noted that that as well as data being inputted to EMIS from Oxleas mental health trust team, key data from EMIS will also have been transferred to the mental health trust system (RiO), which is not captured here.
- **Oxleas project nursing team**: 322 individual PHC elements (**4%**) were carried out directly by the project team. Among these, the nursing team successfully completed 68 blood lipid checks and 68 blood glucose checks, both of which are typically among the least frequently completed checks.

Figure 6 shows the distribution of completion/method for each individual PHC element.

Figure 6 Completion of individual PHC elements for Oxleas (group B)



There was an **increase from 4.2 to 4.7 (0.5) in the average number of individual PHC elements completed** before and after the programme for group B Oxleas practices. The most notable increase (0.8) was observed among Black or Black British patients. This is likely attributable to a higher proportion of Black patients being under the care of CMHTs (see Appendices Section 8.5, Table 15).

Table 6 Average number of individual PHC elements (Oxleas group B)

Total patients	Average # checks pre project	Average # of checks post project
1406	**4.2**	**4.7**

Full PHC (all six individual PHC elements)

A key aim of the project was to ensure patients had the full PHC (all six individual PHC elements) within the previous 12-month period. Where this had not been achieved, the nursing team aimed to complete the outstanding checks themselves or by coordinating with the GP practice.

As shown in Table 7, within the group B practices supported by the Oxleas team:

- **833** out of 1406 patients (**59%**) had the full set of checks
- The majority of these (**626**) were completed by the GP practice
- **207** of these patients had a full set of checks completed due the programme.

Table 7 Full PHCs achieved by Oxleas (group B)

	Total patients	All 6 checks completed	All 6 done by Practice prior	All 6 done via project
Total (group B)	**1406**	**833**	**626**	**207**

As shown in Table 8, of these:

- **96 patients** had their records completed through the data reconciliation exercise
- **86 patients** had their PHCs directly completed by the project team
- **25 patients** had their PHCs completed through a combination of the project team efforts and data reconciliation

Table 8 Method of full PHC achievement (Oxleas group B)

Full PHC completion method	#	%
Data and project checks GP activity, MH trust data reconciliation, project nurse activity	25	3%
Data reconciliation GP activity, MH trust data reconciliation	96	12%
Project team checks GP activity, project nurse activity	86	10%
Practice completed GP activity	626	75%
Grand total	**833**	**100%**

Practice completed checks were most prominent. Interestingly, further investigation of the data shows that several patients achieved a full PHC solely through reconciliation of mental health trust data sources or direct nursing activity.

- **Data reconciliation:** 14/96 patients had all 6 elements updated exclusively through mental health trust data sources, the remainder were a combination of practice and mental health data
- **Project team checks:** 16/86 patients had all 6 elements done exclusively by the nursing project team, the remainder were as a result of partial intervention (i.e. prior completed practice checks and direct nursing activity)

3.3.4 Completion of physical health checks by CMHT

The majority of patients involved in the programme (61%) were not under a CMHT (Table 5). Whilst the Oxleas nursing team supported all patients with SMI regardless of CMHT status, those under CMHT care patients may have had data on preexisting systems or opportunities to have PHCs completed via additional routes, which could explain the higher completion rates.

As shown in Table 9, the impact of the programme varied between these patient groups:

- For patients under CMHT care, the average number of **completed checks increased from 4.2 to 5.4**. Among those, a total of **181 patients** received all six individual PHC elements as a direct result of the intervention – either through data reconciliation or checks performed by the project team.
- For those not under CMHT care, the average rose more modestly, from **4.2 to 4.3.**

Table 9 Physical health checks (full and individual elements) by CMHT status (Oxleas group B)

Under CMHT	#	%	Average # checks pre project	Average # of checks post project	All 6 checks completed	All 6 done by Practice prior	All 6 done via project	% patients with all 6 by project
Yes	547	39%	4.2	5.4	422	241	181	33%
No	859	61%	4.2	4.3	411	385	26	3%

3.4 SLaM activities

The SLaM nursing team worked across the London boroughs of Lewisham and Southwark in the final year of the programme. This section provides insights on GP practice profile, patient profile, and PHCs completed across SLaM (including individual PHC elements, average number of PHC elements by patient, full PHCs, and all checks completed by CHMT status).

Due to the incompleteness of data from SLaM's work in Lewisham, this section primarily focusses on activity in Southwark. Section 8.4 in the Appendices captures the practices and patients included and excluded in the analysis.

3.4.1 GP practice and primary care coverage

The SLaM nursing team supported patients with open referrals to SLaM, across two sites, during the project period in Southwark.

- **Camberwell Green GP practice** (in South Southwark) from January to February 2025. The team worked with the entire patient list that had active SLaM referrals.
- **North Southwark Primary Care Network** (PCN) in March 2025. Due to the programme nearing its end, the team focused on two specific patient cohorts:
    - Those missing only one individual PHC element
    - Those with completed blood tests but outstanding non-blood elements

Due to the **targeted and selective nature** of the SLaM intervention, direct comparisons with Oxleas data or national benchmarks are not appropriate.

In March 2024, a project intervention in 5 Lewisham practices took place with a limited and aggregate data set provided. This Lewisham activity is summarised in the Appendices (Section 8.6).

3.4.2 Patient profile

The SLaM nursing team supported **134 patients** through the intervention in Southwark (Table 10). Due to the targeted nature of the activity (where only one practice was seen as a 'whole population' and patients at the PCN were specific cohorts), the demographic profile differs largely to that at Oxleas and national profiles.

Table 10 Patient demographic profile (SLaM)

	Number	%
Total	**134**	
Sex		
Female	51	38%
Male	83	62%
Age band		
18-24	6	4%
25-34	19	14%
35-44	29	22%
45-54	38	28%
55-64	35	26%
65-74	5	4%
75-84	2	1%
Ethnicity		
Asian or Asian British	8	6%
Black or black British	54	40%
Mixed	8	6%
Other	14	10%
White (incl. white other)	46	34%
Not stated/Unknown	4	3%

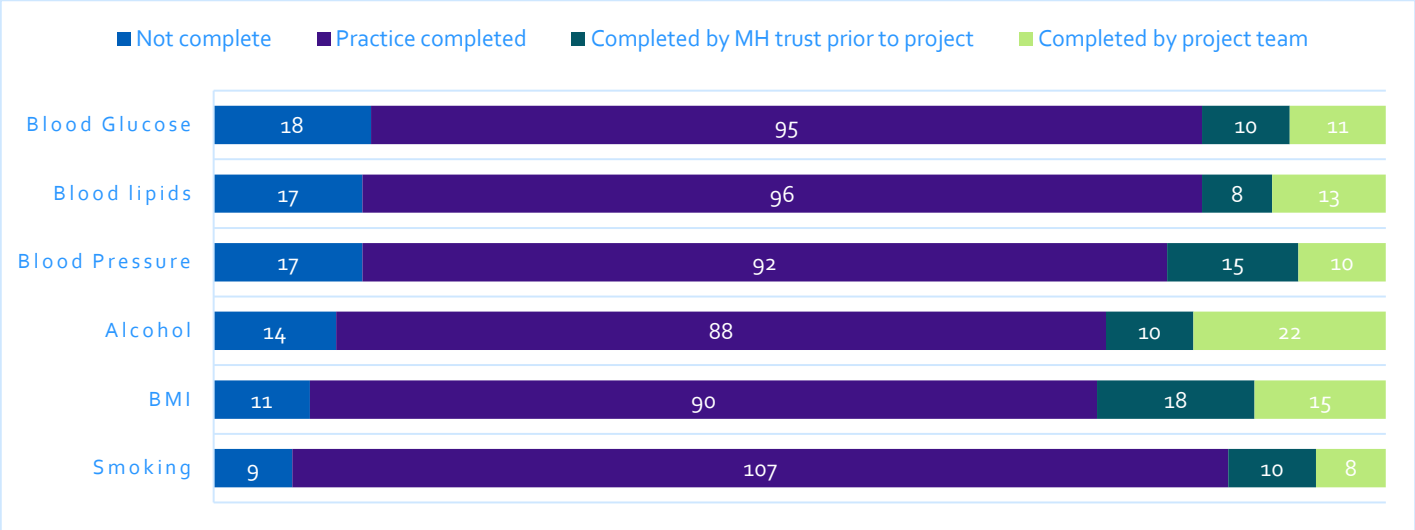
3.4.3 Completion of physical health checks

Individual PHC elements

The SLaM nursing project team completed **79 individual PHC elements** during the project in Southwark. An additional **71 individual PHC elements** prior to the project by the CMHT and the data added to EMIS through the data reconciliation exercise.

Alcohol reviews (22) were the most frequently completed individual PHC element by the project team and the most common individual PHC elements added through the data reconciliation were **BMI** (18) and **blood pressure** (15) (Figure 7).

Figure 7 Individual check element completion (SLaM)



Focusing on the SLaM patient group at Camberwell Green (to look at the 'whole population'), the **least frequently completed individual PHC elements** by the end of the intervention were:

- **Blood glucose**: 28% of patients did not have this check completed
- **Blood lipids**: 25% of patients did not have this check completed

The average number of individual PHC elements increased from 4.2 to 5.4 (i.e. by 1.2) during the programme was delivered at Southwark. Both settings showed an identical increase (Table 11). Table 16 in the Appendices (Section 8.5) provides a detailed breakdown by demographic status.

Table 11 Average number of individual check elements (SLaM)

Average # check elements	Pre	Post
Camberwell Green	3.9	5.0
South Southwark PCN	4.5	5.6
Total	**4.2**	**5.4**

Full PHC (all six individual PHC elements)

In Southwark, **97 (72%)** of the 134 patients reviewed by the SLaM team had received the full set of checks by the end of the programme (Table 12).

Table 12 Full physical health check achievement (SLaM)

All 6 completed by end	Total	By programme intervention
Camberwell Green	39	18
South Southwark PCN	58	51
Total	**97**	**69**

As shown in Table 13, of these 97 patients:

- **30 patients** had their records completed through the data reconciliation exercise
- **35 patients** had their PHCs directly completed by the project team
- **4 patients** had their PHCs completed through a combination of the project team efforts and data reconciliation

Table 13 Method of achievement of full physical health check (SLaM)

6 checks achieved by	#	%
Data and project checks GP activity, MH trust data reconciliation, project nurse activity	4	4%
Data reconciliation GP activity, MH trust data reconciliation	30	31%
Project team checks GP activity, project nurse activity	35	36%
Practice completed GP activity	28	29%
Grand Total	**97**	**100%**

3.5 VSCE engagement: Mind activities

To maximise GP engagement, enhance patient awareness, and further support the programme's objectives, the HIN Mental Health team used project funds to engage the voluntary sector in the financial year 2024-2025. This strategic outreach in South East London aimed to leverage the sector's community links and expertise to promote PHCs for individuals with SMI. In response, Mind in Bexley and SEL Mind submitted proposals outlining their respective approaches, the delivered activities of which are detailed in the following sections.

3.5.1 Mind in Bexley

Mind in Bexley[20] delivered a range of activities[21] that focused on leveraging existing resources rather than creating new materials. This work was supported by a task and finish group with GPs from local primary care networks (PCNs) and available on the Bexley Mind website (Figure 8):

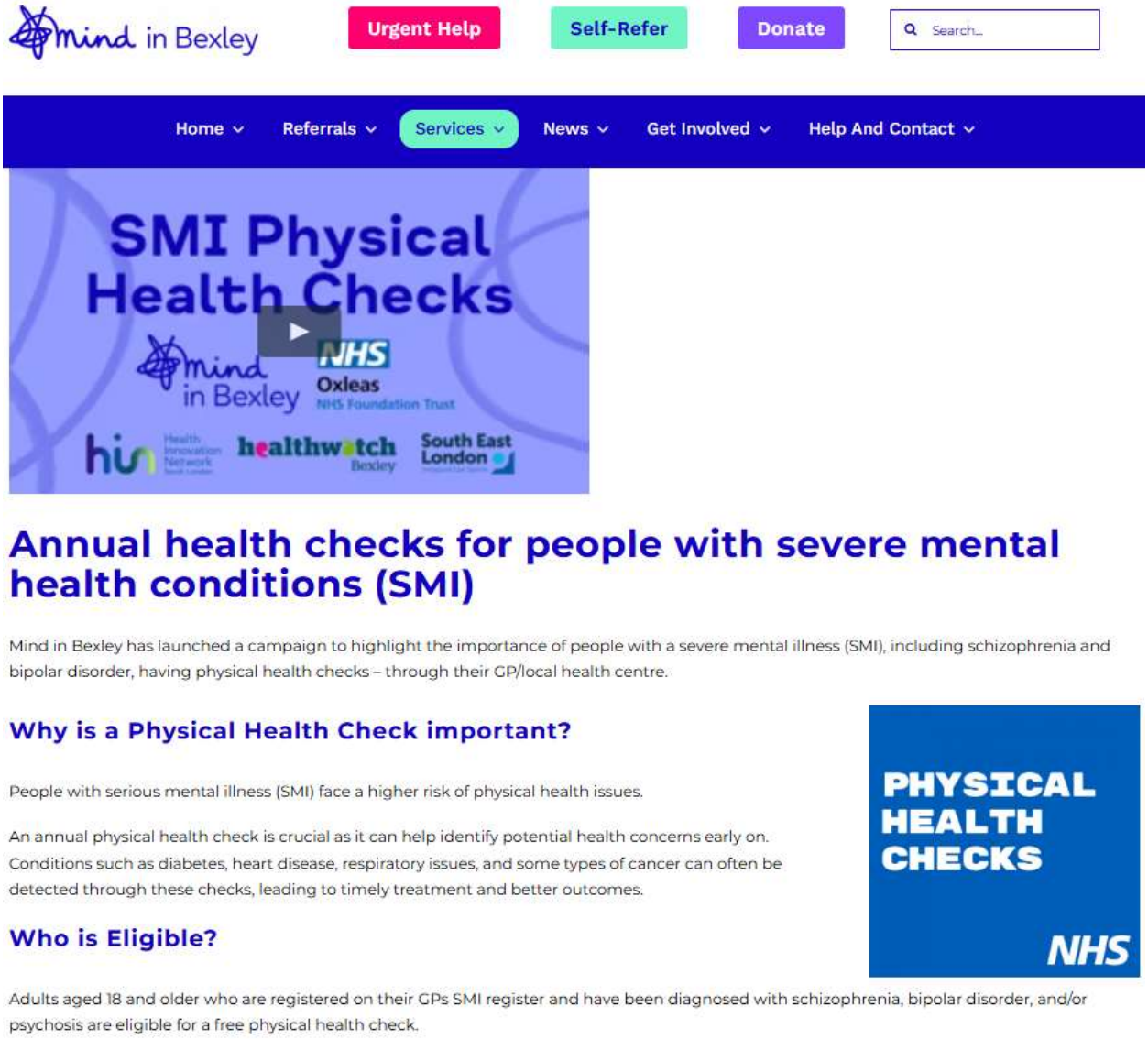
- **Video:** They produced a video, using footage from a previous PHC project, supplemented by interviews featuring Mind in Bexley clients and local health practitioners. The video was aimed at medical professionals to help them understand the barriers patients face in accessing their PHCs.

- **Animation:** The Mind in Bexley team adapted and re-branded an animation originally developed by Birmingham NHS, which they had permission to use. They also translated the animation subtitles into five languages (Polish, Urdu, Bangla, Punjabi and Pahari). The animation was promoted via Mind in Bexley's social media and through closed Facebook groups. However,

[20] HOME - Mind in Bexley
[21] The resourced used by Bexley are available to view at: https://mindinbexley.org.uk/physical-health-checks/

reliable data is not available on the level of engagement due to limitations with social media.

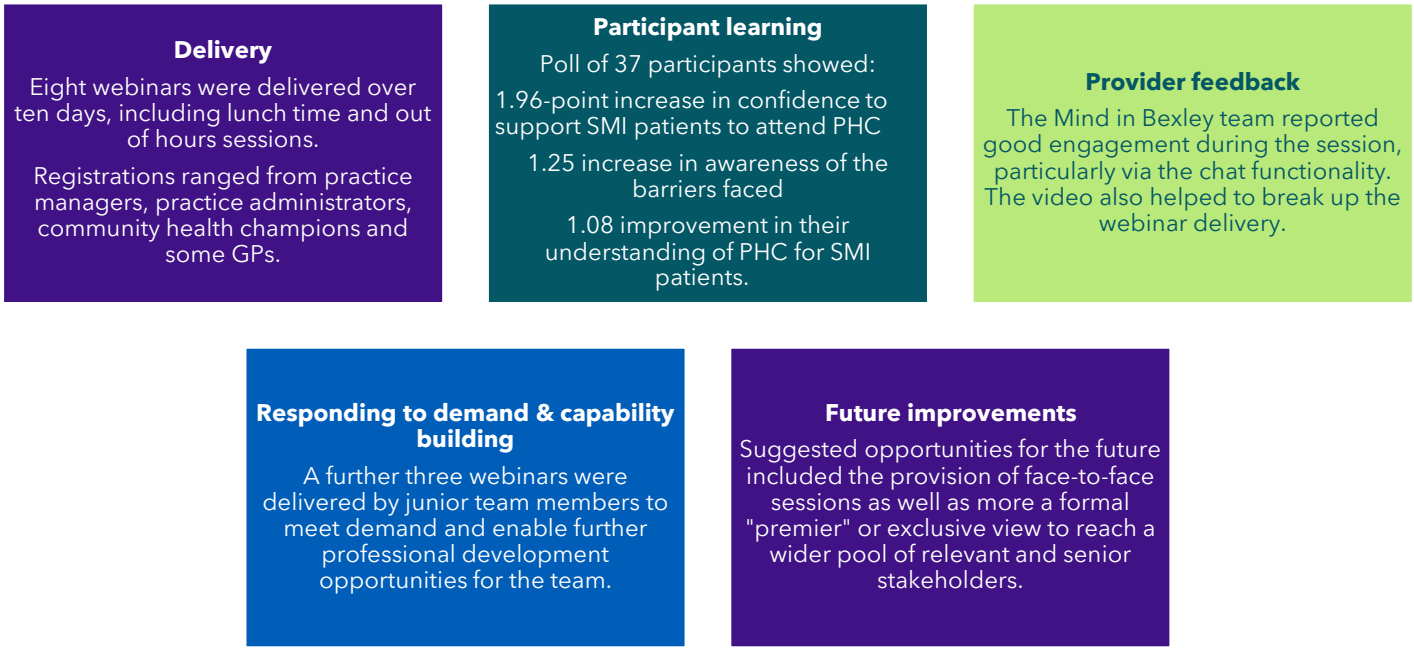
Figure 8 Mind in Bexley website with resources (source Mind in Bexley[22])



- **Webinars:** A series of webinars were delivered to health professionals providing foundational knowledge about PHCs for people with SMI and its overall importance with the aim to increase awareness among this group. The content was adapted from the SEL Mind-designed programme and included both a video and accompanying animation. The series was promoted via closed Facebook groups, through personalised messages and as part of a targeted exclusive access approach. Through this approach, Mind in Bexley aimed to foster engagement and interaction with their produced content. A pre- and post- webinar poll was also conducted to measure knowledge and confidence (on a five-point scale), and capture feedback. Figure 9 summarises the key webinar activities and feedback.

[22] https://mindinbexley.org.uk/physical-health-checks/

Figure 9 Summary of webinar activities and feedback



- **GP round table:** This event was part of a broader session aimed to engaging GPs across Bexley to discuss the challenges of engaging with SMI patients. Mind in Bexley delivered content similar to that used their webinar series, but showcased an alternative version of their video, which incorporated additional perspectives from NHS leaders. This adaptation was designed to better resonate with the target audience.
    - There were 26 GPs that participated and feedback from 12 participants showed a change in their confidence to support SMI patients to attend health checks (1.2 points out of five).
    - There were limited gains in GPs understanding (0.2) and awareness (0.9).
    - The engagement levels were reported as mixed, with some GPs heavily invested and interested, and others appearing less interested in the topic.

Thematic analysis of participants' comments, conducted by the Mind in Bexley team, highlighted:

- The value of the work for participants, including increased knowledge and awareness, empowerment and improved confidence
- The importance of personal narratives from people with lived experience
- A desire for continued outreach and engagement with health professionals

Box 2 Feedback collected by Mind in Bexley from webinar and GP round table participants

"I clearly understood the purpose and need for the session. The information was clear, the information given was very useful and practical. I now have a much better knowledge and can help more people."

"Excellent webinar presentation. Clear and easy to understand. Video of healthcare professionals made it more real."

"All practice nurses from each surgery should be encouraged to attend as it was really useful."

3.5.2 South East London Mind

As part of their engagement in the programme, South East London (SEL) Mind[23] delivered a webinar series[24] and animation[25], that placed strong emphasis on co-production with people with lived experience.

1. Webinar

- **Design:** The webinar aimed to target health professions and the training content was co-produced with people with SMI. This involved two focus groups, including one with SEL Mind lived experience consultants and another via a SLaM service user and carer advisory group.

  "I met with these two different focus groups and actually a really nice part of it is (…) I'm setting up meetings, (…) to debrief with them because I think one of the most important things (…) I'm looking forward to kind of closing that loop and (…) telling them how it went." (Mind staff member)

  The webinar design balanced the project scope, duration and the needs of a diverse audience. It focussed on three main components:
  - Why do we need to increase take up of physical health checks for patients with SMI?
  - What are some of the barriers patients with SMI may face in attending a PHC?
  - How can we take a personalised approach to overcome these barriers and increase take-up?

- **Dissemination:** Events were arranged through Eventbrite and promoted via:
  - Direct email invitations to 68 primary care and voluntary and community sector contacts
  - Newsletter channels such as Community Southwark SEL GP bulletin and the SEL Mind newsletter (1527 subscribers)
  - SEL Mind social media, such as LinkedIn (1k+ followers), Facebook (1k+ followers), Instagram (4k+ followers) and Threads (900+ followers)

  From September to November 2024, a range of video and static content was posted on SEL Mind's social media to highlight the inequality gap and encourage webinar participation. The majority of content was also posted on LinkedIn, targeting healthcare professionals. This campaign resulted in a total of 3,485 impressions and 78 engagements (excluding Threads content due to the platform's lack of analytical capabilities)[26].

- **Delivery:** 12 online webinars were delivered, with a total of 214 registrations and 118 attendees. Participants were mostly from the statutory sector (57%), followed by the voluntary sector (39%).

- **Outcomes:** Based on pre-post webinar poll provided by SEL Mind (measured on a five-point scale), there was a:
  - 1.5-point increase individuals' confidence to support people with SMI to attend a PHC
  - 1-point increase in awareness of the barriers people with SMI face in attendance a PHC
  - 0.5-point increase in understanding of why increasing uptake of PHCs for people with SMI is important

  Qualitative feedback from webinar participants indicated that:
  - Key takeaways included the importance of identifying and overcoming barriers, supporting underrepresented groups, using sensitive and positive approaches and

[23] South East London Mind | mental health and dementia services
[24] SEL Mind and Body: Bitesize training | South East London Mind
[25] Why are physical health checks so important?
[26] . Examples of top reaching content across the three different platforms included the following posts: Instagram, LinkedIn and Facebook.

collaborating across agencies.
    - Next steps involved working on gentle positive conversations, promoting and supporting PHCs more widely, addressing barriers, collaboration, and sharing learnings to improve access.

- **Reflections on webinar delivery:** Engagement was challenging, particularly due to participants keeping their cameras off, making it difficult to develop rapport and foster interaction. The short duration for a complex topic also limited opportunities for in-depth discussion and the use of break out rooms. However, the format supported higher attendance. Additionally, the team identified opportunities to enhance the Eventbrite registration process in future sessions, which included sharing training materials with those registered but did not attend and collecting participants' role or job title during sign-up to better tailor content and follow-up.

2. Animation

- **Design:** The animation was created to be accessible, inclusive and locally relevant, with the aim to support the uptake of PHCs among people with SMI. Its design was co-produced with lived experience partners, supported by a dedicated working group. The animation was developed by an external production company and the overall design included characters that reflecting the diversity of the local population, accessible brand guidelines (based on National Mind Federation well researched form), and translation into additional languages (Polish, Portuguese, Spanish, Somali).

- **Promotion:** The animation was shared via social media channels, internal and external newsletters, primary care network contacts.

- **Learning:** Several key enablers were identified, including the involvement of people with lived experience, prior collaboration with the production company, and engagement from the training lead to share health professional insights from the webinars. Conversely, area for improvement identified included the need for more targeted dissemination strategies, stronger partnerships with healthcare providers (e.g., addressing email bounce-backs and identifying appropriate right contacts), and greater investment in community engagement events, some of which were limited due to capacity and resource constraints.

  "It was really important to involve people with lived experience from the beginning, because very often, (…) they're kind of brought in at the end and (…) it was good to have their involvement from start to finish." (Mind staff member)

4. Intervention implementation insights

This section explores the key factors affecting the delivery of the programme by Oxleas NHS Foundation Trust (Oxleas) and South London and Maudsley NHS Foundation Trust (SLaM) within primary care settings. It is based on insights gathered from the nursing teams and key stakeholders involved in the implementation, delivery or oversight of the programme.

4.1 Key challenges to implementation

In reflecting on the programme's implementation and delivery across both trusts, participants identified several key challenges encountered throughout the four core stages of the model. These challenges primarily related to:

- Scope and governance
- Clinical resource mobilisation
- Data management and system integration
- Patient engagement and transfer of results

4.1.1 Scope and governance

Among programme management, mental health trust, and primary care stakeholders, there was a shared perception that the delivery model lacked clarity from the outset. This contributed to project delays and misaligned expectations around roles, responsibilities and intended outcomes, which led more specifically to the following challenges.

- **Governance challenges:** As the Mental Health team at the HIN took on the programme management, they assumed that SEL ICS had an existing data sharing agreement between primary care and secondary care mental health trusts. However, this agreement was not put in place prior to project commencement, which added significant delays. Additionally, while many valued the fortnightly operational and monthly stakeholder meetings to drive accountability, some staff identified a need for greater GP and integrated care board involvement. The development of a task and finish group from the outset could have also addressed project set up issues and facilitated shared learning across boroughs and with senior stakeholders.

  "They're probably doing a really good job. I have no idea. (…) I think that it would have been really good to have the key stakeholders come together for sharing good practice. (…) It would have been nice to learn something from others as well." (Primary care stakeholder)

- **Information governance (IG) complexities:** Staff unanimously agreed that IG requirements were a significant barrier to implementation. This was exacerbated by unclear requirements and limited understanding of the operating model, as well as challenges identifying and accessing the right stakeholders for sign off. Changes in IG staff due to staff turnover further complicated the process. Some stakeholders believed these issues could have been mitigated with proactive planning and stronger ownership from the outset.

  "I wish that (…) we'd completed that [data protection impact assessment] or done something before the project officially kicked off, because it really did delay the project delivery." (Programme management team)

- **Loss of momentum:** Some stakeholders felt that the project's prolonged set-up and initial lack clear roles and responsibilities hindered project mobilisation, led to loss of momentum and, in some cases, cause deflated motivation amongst staff. This was further compounded by staff turnover and IG.

  "The teams are coming on board and (…) just as you developed relationship with them, they left (…). So it was kind of a lot of HR changes." (Primary care stakeholder)

- **Shift from outreach to data management:** All stakeholders initially expected the nursing teams would deliver a greater number of home visits and outreach activities. However, the nurses' workload became heavily dominated by data validation and migration. Nurses also recognised that the majority of PHCs in the GP practices they visited were already completed, or incorrectly coded, effectively turning their role into a data checking and cleaning function.

  "I think we anticipated (…) that there would be a lot more outreach (…) and that we'd be [doing] a lot more hands on work, whereas what we found is, (…) it's a vast quantity of (…) data validation and migrating that data, which isn't really any of our expertise as much as we do it." (Mental health trust nurse)

  ''The practitioners were great and it was lovely to have them in practice and get to know them (…). I think a lot more if it ended up being on just data sharing rather than kind of actively going out to engage patients and (…) I think that [it] probably is just learning going forward and then if that's what's going to happen, perhaps it doesn't need to happen within a practice." (Primary care stakeholder)

4.1.2 Clinical resource mobilisation

The project faced significant hurdles in mobilising clinical resources. Those included difficulties engaging with GP practices, perceived inadequacies in nurse training for the data validation aspects of the of role, and challenges linked to suitable working environments.

- **Issues with GP practice engagement:** Participants reported an initial challenge partnering with GP practices. The original vision was to deploy and to identify and target GP practices based on indicators of greatest need (such as volume of patients on the SMI register). However, in practice engagement became reliant on the willingness of individual practices to participate in the programme. It was suggested that certain practices might have been wary of external scrutiny. Additionally, some believed the multi-layered sign-up process to the data protection impact assessment, involving primary care networks (PCNs) and GP practices, further hindered engagement efforts.

- **Inconsistent training:** There was not a consistent approach to training the mental health trust nurses for the data validation components of the role. In practice, the team were required to navigate GP systems, the London Care Record and data collection spreadsheets. The training needs varied depending on nurse experience and knowledge of IT systems and data. In some cases, this lack of training led to staff feeling overwhelmed with the data heavy aspects of the role.

  "I couldn't understand what (…) was going on (…) it's like you're thrown in but you're not been able to swim. And then just as about you're (…) about to get there, (…) you're (…) at the top already. So it's like I didn't understand any of this." (Mental health trust nurse)

- **Infrastructure and environmental issues:** Several infrastructure-related challenges were reported; they hindered both data validation and the delivery of PHCs in primary care settings. These reported issues were:

- Limited space in GP practices for the nursing teams
- Technical issues such as poor Wi-Fi and frequent password resets which disrupted daily working
- Physically unsuitable primary care environments, lacking natural light, heating and safety features (e.g. panic alarms), and in some instances with pest issues

Those conditions contributed to a sense of isolation among nursing teams and were further compounded by the need for constant travel between primary care and secondary case sites. Some primary care staff felt that the space requirements were not clearly defined from the outset, noting this challenge also affects their own clinical teams.

"Getting a room was (…) hard work. (…) If you said to me let's do it again, I'd say well, yeah, we could do it again but it would need to be done on a laptop in, in a space that I could use." (Mental health trust nurse)

4.1.3 Data management and system integration

Participants highlighted challenges related to the data validation process, data quality and the overall burden placed on nursing teams.

- **Skills set and data burden on mental health trust nurses:** The project placed a significant data management burden on nursing teams, requiring them to manage multi-screen interfaces, lengthy NHS digit entries and to demonstrate digital and IT literacy. This not only increased the risk of error but also diverted focus from their core clinical responsibilities, making their involvement in the programme stressful for some.

  "It just opened my eyes in terms of what I do already and there is a slight difference because this is more data migration and more data validation. (…) I miss my area because I'm used to seeing patients every single day." (Mental health trust nurse)

- **Data storage and coding challenges:** Variation in the configuration of EMIS[27] across PCNs and GP practices created additional challenges for nursing teams navigating the patient database. Additionally, identifying their details was often difficult as information was stored inconsistently, sometimes 'hidden' under events, or incorrectly coded. This inconsistency complicated efforts to identify and validate patient details. Furthermore, some primary care stakeholders noted that letters from mental health trusts frequently lacked key clinical results.

  Such issues underscored the need for improved interoperability between primary and secondary care systems. The lack of data flows between these systems resulted in significant administrative burdens and inefficiencies, as experienced by the mental health trust nurses.

  "I think one of the key learnings was around how like we know that the systems in mental health and primary care are not interoperable. None of the data flows through. But I guess what we couldn't have anticipated was how much admin time would be taken." (Programme management team)

  Over the final 18 months of the programme, the HIN Mental Health team raised these issues with OneLondon and facilitated meetings between mental health trust nurses and the OneLondon team. These discussions helped ensure that OneLondon was aware of the teams' needs and could take them into account in shaping their work.

[27] EMIS Health supplies electronic patient record systems and software used in primary care, acute care and community pharmacy in the United Kingdom.

4.1.4 Patient engagement and transfer of results

Project obstacles also included elements of patient engagement and project closure (which are described further below).

- **Variable cooperation from mental health trust care coordinators:** Several challenges were reported, including some care coordinators refusing to cooperate, difficulties identifying appropriate team email addresses, and varied response times from the trust care coordinators. The project nurse lead had to escalate these issues to care coordinator team leads and ultimately the nursing team relied on pre-existing relationships within settings to drive engagement. Primary care stakeholders also noted that they were unaware of this extra step (of involving care coordinators) in the process and would have raised concerns if informed from the beginning.

- **Reaching SMI patients:** Mental health trust nurses reported difficulties reaching some patients. Issues included missed clinic appointments, concerns about data privacy and a lack of interest from some patients.

- **Discrepancies between 'core' and 'comprehensive' PHCs:** Both a mental health trust nurse and primary care stakeholder recognised differences in the number of PHC elements intended to be completed as part of the programme, compared to the others' expectation. In this case, the programme focussed on the six 'core' checks, whereas others were expecting other aspects of a 'comprehensive' PHC to be completed. The latter includes aspects such as prior history, lifestyle aspects, disease screening and medication.

  "I suppose there's something about some communication at the (…) outset, because of course you can imagine this (…) practice nurse (…) was rather disappointed because what she thought would be almost a one stop for that patient (…) actually didn't reduce the amount of work for her because she still had to make sure that medications were reconciled and that there was a care plan in place and (…) do some other lifestyle questions around nutrition." (Mental health trust nurse)

- **Data transfer and closure communication:** Nurses encountered challenges transferring completed PHC data back to GP systems and discussing delivery findings with primary care staff. Often primary care staff were unaware of teams' return, leading to unresponsiveness to emails or inability to provide available times for data transfer. Nurses had to continuously follow-up with primary care teams.

4.2 Key factors supporting implementation

In response to the multi-faceted challenges faced by the nursing and programme teams, participants highlighted the creative approaches employed to address these issues. These strategies and the broader factors that facilitated successful implementation are outlined below and grouped into three main themes:

- Patient focused project management
- Proactive nursing teams and flexible and practical strategies
- Key individuals instrumental to programme delivery

4.2.1 Patient focussed project management

The programme management team particularly valued the patient focussed elements introduced during the set-up phase, nothing that they significantly grounded their approach and enhanced their knowledge and understanding of patient experience.

- **Importance of the equalities impact assessment and service user interviews:** The HIN mental health team conducted an equalities impact assessment as part of the project set-up phase and interviewed service users to understand their experience and barriers. These elements specifically highlighted the challenges faced by people with SMI, bringing their experiences to the forefront. For the programme management team, this served as a powerful reminder of the project's purpose, its impact on individuals and the overacting the goals and ambitions they were collectively working towards.

  "The Trusts you're working with (…) they've been fantastic, giving us the access to the service users and having (…) the interviews have really helped shape the project and make sure [that] we're (…) targeting the right thing and (…) bring the project back to life as to why we're doing this, not just for data validation." (Programme management team)

- **Late-stage project momentum facilitated primary care interest:** Despite the initial challenges reaching GP practices, interest from primary care increased noticeably towards the end of the programme. Although project closure prevented further exploration of these new leads, one site granted a three-month extension to SLaM project team. Key factors contributing to this late-stage momentum included presentations at GP conferences by mental health trust and project management staff, growing word-of-mouth awareness, voluntary sector involvement and visibility of the project gained over time.

4.2.2 Proactive nursing teams and flexible and practical strategies

Nursing teams played a pivotal role in enhancing the programme's delivery and efficiency by adopting proactive strategies to support programme delivery.

- **Autonomous working:** Primary care stakeholders noted the independence and autonomous working approach of the mental health nurses. This, however, sometimes limited primary care's ability to provide feedback or input on the nurses' activities.

  "They used my office. There were three of them. They obviously worked together (…) my input as I recall is making sure that they were all set up correctly because they had their own searches (…) So they were working off their own system as well as ours. And obviously they shared information with us once they've done what they needed to do. But yeah, I wouldn't have said that I had a huge amount of input." (Primary care stakeholder)

- **Flexible working patterns** to accommodate PHC appointments supported implementation.

  "For example, if we go on a Monday morning to do the data validation in the morning, sometimes we book [visits] in the afternoon (…)and some of them we have to meet them in another clinic (…) even though you (…) you've done like 5 hours of data which is can be you know very challenging sometimes you (…) end up with headaches and dehydration sometimes (…), it's consuming lot of energy. You (…) have to (…) try and accommodate them [patient] in that time." (Mental health trust nurse)

- **Efficient data validation processes:** Mental health nursing teams introduced several strategies to manage data-intensive tasks more efficiently and streamline the data validation process, significantly reducing the time spent per patient from 10 minutes to 3 minutes in one team. This improvement was driven:
  - Use of multiple screens, allowing quicker navigation between systems
  - Effective collaboration, reducing workflows and duplication.
  - Time-saving tools like 'Locating Useful Clinical Information' (LUCI) and advance running of reports

"I think for me, and I find it really helpful when two or three people, especially when three people are doing the (…) job because one on EMIS, one on the spreadsheet, and one on RiO and that sort of flow." (Mental health trust nurse)

- **Testing population level approaches:** The SLaM team adopted a PCN wide, more population-level, delivery model towards the end of the programme, which enabled additional learning and reflection. As part of this approach, the team prioritised and focussed on the patients where the greatest impact could be achieved. While the benefits and drawbacks are still being assessed, the team noted that this approach improves operational efficiency with the opportunity to work across multiple GP practices, with a dedicated space for data validation and an available management team for support. This approach, however, did not foster direct GP relationships, which are crucial for shifting practice culture, addressing safeguarding concerns and providing patient feedback.

4.2.3 Key individuals instrumental to programme delivery

The programme was significantly shaped by individuals who played a key role in driving progress and facilitating patient engagement. Insights from interviews are below.

- **Support from key stakeholders:** All participants identified specific stakeholders that were crucial in escalating and accelerating programme progress. These included IG support and Integrated Care Board (ICB) staff involved in implementation and training, and SMI working groups that facilitated primary care recruitment, and the hard work and dedication from programme partners.

  "They've [primary care stakeholder] been able to make things happen, but they've also been incredibly approachable and amenable and have been great teachers in amongst it all as well (…) and incredibly supportive. (…) I just think (…) they've got the knowledge and they sit in a position where they've been able to make things happen a lot quicker." (Mental health trust nurse)

  "I would join the two weekly nurse meeting (…) and I would then say, "OK, you're having a challenge or you're having lack of engagement". I would e-mail them and then start the ball rolling, somehow, they would respond to me and not with them. Maybe it's a familiar name, or a clinician. I don't know. Whatever the reasons were, (…) [we] went on recruiting more and more practices as their capacity was available, but sadly (…) [the] project has ended." (Primary care stakeholder)

  "Despite all the challenges in this project, the commitment and enthusiasm to make a difference for people with SMI continually impressed us both form the mental health trusts and the voluntary sector partners." (Programme management team)

- **Value of care coordinators:** Despite the challenges working with care coordinators, the mental health trust teams indicated that they played a key role in building patient trust, addressing safeguarding concerns, and fostering partnerships.

  "That's a real learning opportunity there with the care coordinators. So if they didn't know, then we could help them (…) in understanding what our annual physical health screen consists of, how we do it, and to work collaboratively (…). (…) As a mental health practitioner, (…) I'm never familiar face to that patient, so often they can be a real kind of way of getting (…) the patient to engage (…) linking in with the care coordinator can often alleviate some of that." (Mental health trust nurse)

5. Programme impact and learnings

This section described the patient and system-wide impacts, as well opportunities to embed further learning and sustainment of the programme.

5.1 Patient impact

Many primary care stakeholders found it difficult to comment on the programme's impact—both on people with severe mental illness (SMI) and on their own GP practices. Some were less familiar with the programme's activities or felt they were already effectively managing their SMI registers, though they still appreciated the additional support. However, others recognised and valued the mental health expertise that the nurses brought into their practices.

> *"It is not entirely clear what they think the outcomes were. Thirty-one people with SMI had the physical health checks? Also, there seemed to be a suggestion that some or all of them would have been seen anyway and so the added value of the project is questioned." (Primary care stakeholder)*

> *"Our GP said that for years she's done the SMIs and she's never been able to get hold of these difficult, (…) hard to engage patients. She doesn't understand why. (…) It was (…) really helpful to (…) have her team (…) go in (..) Our GP couldn't believe it. She was like, 'wow', she goes, 'she just went in with their team, did all the checks and came back and said it's done'. " (Primary care stakeholder)*

Nonetheless, mental health trust nurses identified direct impacts of their activity.

- **Bridging the gap for vulnerable patients:** Nurses highlighted the project's value in enabling physical health checks (PHCs) for patients who would not normally engage with their GP or community mental health team. They recognised the importance of prioritising this cohort, noting that the project enabled them to specifically reach this population.

- **Providing holistic patient care and intervention:** Beyond the data validation, nurses reported that the programme provided opportunities to intervene with patients and offer direct feedback to GPs. They were able to identify vulnerable patients, raise safeguarding concerns and ensure appropriate support and care were put in place.

  "I think for me, (…) it's been very rewarding to know that you were able to make positive impacts into a patient's life. Where there have been gaps and they have disengaged and you've been able to get through to them, carry out these checks. (…) It's been really a good journey." (Mental health trust nurse)

- **Delivering creative approaches to patient care:** Some nurses went above and beyond to reach and support patients, employing creative methods to complete health checks. For example, one mental health nurse described a situation where they conducted their own blood pressure check with a patient, creating new avenues to build trust and engage with patients.

- **Looking forward, stakeholders noted the importance of aftercare for patients**. While the project focused heavily on data validation and raising awareness via voluntary sector initiatives,

there were concerns about its ability to demonstrate an impact on improved physical health for patients. The removal of national PHC targets also raised questions, with some partners expressing concerns about patients falling through the cracks.

"There's no guarantee that increasing the number of people who attend is going to improve their physical health." (Voluntary sector partner)

5.2 System impact

The programme was perceived as delivering wider system benefits, fostering greater collaboration, personal development, and a deeper understanding of the current operating landscape.

- **Strengthened partnerships:** There was evidence to suggest some improved partnership working across primary and secondary services. Some commented on previous fragmented relationships, noting the programme offered opportunities to build connections and enhance information sharing. This included relationship building between GP staff and nurses (with some settings requesting further engagement), as well as collaboration within mental health trust teams. The latter involved promoting physical health awareness amongst care coordinators, and sharing established processes and tools within nurses' existing teams to improve patient care and physical health interventions.

  "In (…) [borough] especially, initially, it was a very strained relationship between primary care and (…) [mental health trust], but (…) having this joint programmes, working and enhancing that care, I think we are getting [on] much better than we were before (…) There is no capacity for any one organisation to do it all." (Primary care stakeholder)

  "It might be better if they came in a bit more frequently, even like quarterly (…) As I say, (…) we are (…) quite keen to (…) have a more joined up approach with the other agencies." (Primary care stakeholder)

  In contrast, voluntary sector partners had mixed views on whether the relationships established would lead to sustained collaboration with primary and secondary care beyond the programme. Some felt that there were no direct opportunities within their own roles, however, the programme might offer continued partnership working for the wider organisation or more senior stakeholders. Others highlighted that this initiative opened doors for more sustainable, ongoing, collaborations.

  "I was very pleased with (…) that element of engagement, (…) and to get the animations on top and (…) the GP round table and just the engagement within our own organisation about the importance of physical health checks, (…) it's (…) elevated its importance within us. We now have a physical health checks lead. (…) we're (…) going to be doing more with it we think." (Voluntary sector partner)

- **Upskilling of nurses:** Nurses reported improved skills (such as communication, partnership working) and increased insight into working with and alongside primary care. The data management aspects of the role also enabled one staff member to transition into a similar data-based position.

  "I've learnt patience, improved communication skills and even at the face of someone even telling you things you don't like to hear but still maintaining, keeping me professional to say, OK, fine, let's just focus and get this done." (Mental health trust nurse)

- **Increased awareness of importance of PHCs in South East London (SEL):** The programme worked towards raising awareness of the importance of PHCs through its multi-dimensional

activities. This included the education sessions delivered by nurses, the targeted patient-level insights shared with GPs, the collaboration with care coordinators and the activities delivered by Mind in Bexley and SEL Mind. Despite the lack of sufficient data, participants acknowledged the value of these learning opportunities for health care professionals.

"One thing I've learned from (…) [mental health trust] team is that (…) all you have to do is just say to them that 'this is just (…) a yearly assessment, just to check on your well-being to see how you're getting on and (…) and if there's any concerns that you have' and that way it just makes it feel normal. (…) I've kind of changed the way in which I approach the patients (…), I've found it's easier for me to engage them better." (Primary care stakeholder)

- **System barriers:** As part of the programme, programme delivery partners identified various practices that could be improved. This ranged from SMI register oversight, London Care Record use, duplication of patient activities, as well as the need for interoperability between systems and an improved understanding of physical health in mental health. Programme activity also directly worked towards accelerating progress in these domains though partnership working with OneLondon and the horizon scan of digital technologies to support the physical wellbeing of people with SMI.

  "One practice (…), it's their practice manager that has oversight. It's not a huge caseload (…) but nevertheless, there's (…) an implicit stigma to that. That this cohort doesn't even require a practice nurse to have oversight or a mental health practitioner. The practise manager can do it (…) [they were] doing a pretty good job (…) managed to establish a rapport with a lot of these patients, but nevertheless there's something about (..) how they're viewed as a as a cohort." (Mental health trust nurse)

  "We've got a big job on our hands as mental health trusts, I think to get people on board with what we call our movement (…) of looking at holistic care of those patients, and how we manage physical health in a mental health setting." (Mental health trust nurse)

5.3 Programme sustainability

The programme primarily addressed the immediate need for validating SMI data, while also embedding sustainability through voluntary sector activities and specific nursing efforts. Some concerns were raised about the duplication of the voluntary sector initiatives and the need for more centralised and collaborative efforts. However, some nursing activities aimed to move beyond this temporary solution through the educational sessions, and post meetings, where vulnerable patients were discussed, and sustainable practices were explored.

"Another part of it was establishing some relationship and having post meetings after we've done all the data validation to (…) think about sustainability, how would they do it next year and the year after (…) and different practices have different ideas." (Mental health trust nurse)

Stakeholders emphasised the importance of, more generally, continued investment initiatives to address the inequality gap for SMI patients. Participants from different stakeholder groups offered a range of perspectives, highlighting the need for ongoing efforts to engage patients and improve outcomes. This is highlighted in Table 14.

Table 14 Opportunities to sustain efforts to improve PHCs in people with SMI

Principles for engaging patients with SMI

- Make every contact count for people with SMI
- Avoid separate appointments for individual checks
- Deliver community outreach activities
- Collaborate with mental health trust nurses and conduct joint primary and secondary care visits, drawing on shared expertise
- Recognise engaging patients with SMI and completing PHCs is a collaborative effort

"For (…) both primary care and secondary care to come together and see how they can get this done because (…) the (…) patient is telling you "I was seen last week" (…) and you'll have expected that healthcare professional to have done all the checks while the patient was with them and they haven't done it and it doesn't make any sense. But then you have to (…) spend your time to explain why this particular one is necessary for them to be carried out. I think we've been trying to encourage our (…) professionals to do all (…) check[s] at the point of contact with patients." (Mental health trust nurse)

Primary care strategies

- RAG rate[28] all patients with SMI and proactively work with disengaged patients, prioritising the most vulnerable and ensuring the right escalation pathways are in place
- Set up alert systems and develop mechanisms to ensure patients don't get missed e.g. conducting PHCs during the month SMI patients were born

"When you RAG rate these people, it's about 10% of all of the caseload. (…) those greens, you don't need to worry about (…) because they come in. (…) Then there are the ones that amber, and inevitably, they're the ones where somebody's forgot to ask whether they drink, smoke or they haven't had their blood test done (…). Then you've got your red (…) and these are the ones that are disengaged at secondary care, they're disengaged at primary care and in some cases, for as long as four years (..._ And when you go out to see them, they may not be very well. They may be safeguarding issues (…) and those are the ones that actually we need to jointly work together in a collaborative way. But somebody needs to know who those people are and to my mind, I go this needs to sit between the mental health practitioner and us." (Mental health trust nurse)

Extend the remit of existing roles to include PHCs

- Explore good practice cases such as a Bexley setting whereby home visits for PHCs were part of a paramedic's role
- Adapt the care coordinator role to drive PHC completion, additional teaching and training could be delivered alongside
- Enable mental health trust practitioners within GP practices to play a greater role, which would need to involve a shared understanding of the role amongst GPs and ensuing that insurance arrangements adequately cover home visits
- Support clinical pharmacists to deliver PHCs, as every GP practice has one

"We need to continue this funding (…) [Be] a healthcare assistant, be a clinical pharmacist, be a mental health practitioner, (…) be a registrar, (…) be a trainee pharmacy technician. (…) As long as they're (…) trained (…), and as long as they know (…) [at a] certain point there's a referral to the GP. We haven't quite got there yet." (Primary care stakeholder)

[28] As described earlier, the red-amber-green (RAG) rating system encompassed patients with a complete PHC (green), patients with a partial PHC (amber) and with patients no PHC within the last 12 months (red).

System level opportunities

- Develop a collaborative framework with key voluntary sector organisations specialising in mental health to promote and raise awareness of the PHCs for people with SMI among patients and primary care staff
- Work towards bridging primary and secondary care with integrated digital records for shared insights and holistic care
- Develop a multi-faceted community education strategy that goes beyond basic awareness of the PHC itself, emphasising the increased physical health (and cancer) risks faced by people with SMI
- Deliver more physical health awareness presentations to health professionals to ensure that physical health is prioritised within mental health care, while also addressing barriers that may prevent patient attendance

Despite a number of challenges and project delays, the programme has built momentum and established a strong foundation that evaluation participants across services were eager to build upon. It has shown that with dedicated effort, information can be effectively reconciled, and patients can receive the care they need. Moving forward, several concrete steps are in train to support the development of the programme in SEL:

- An additional three months of funding from a primary care network to support ongoing nursing activities within primary care
- Review of the mental health practitioner role in primary care to build on the project's success and enhance targeted outreach with primary care
- Potential adaptation of the care coordinator role to mirror similar activities

"If you don't physically see them, you don't physically close the loop, you're not improving the health outcomes, and ultimately they also die 20 years earlier. (…) How can we sustain it? We have to be pushing the boundaries." (Primary care stakeholder)

"I think what this project has allowed us to do is (…) what we're currently doing and that's facing inward a little bit more at secondary services and really raising the profile. (….) I feel a bit despondent because I feel like I've been doing this for a decade. (…) Why is it so difficult for us to do six core checks? (…) And yet between secondary and primary care, we cannot achieve it. (…) But on the other hand, (…) it just motivates me to keep going. Because I know that we can do it. It's just making sure that those processes are in place to make it happen efficiently and effectively." (Mental health trust nurse)

"We've got momentum, but we're not going to stop. We're either going to find some funding or we're going to do it off our own back because (…) that will then create a multiplier effect for other services." (Voluntary sector partner)

5.3.1 Primary care case study

During the programme, an existing primary care model in Lambeth was identified that has similarly aim for improving data quality and increasing PHC completion rates. This case study is useful to highlight because the approach addresses some of the challenges experienced in SEL programme, by drawing on staff with data expertise and building sustainable practice in primary care.

Box 3 Primary care case study

The existing model focuses on improving data quality in primary care. It is led by staff with a data background and prior GP practice experience and is overseen by a clinical staff member.

This model assesses GP practice data a population level across a federation and broadly involves:

- Monitoring a dashboard of key metrics and indictors
- Conducting an in-depth investigation of key trends (e.g. an outstanding PHC element)
- Intervening, through highlighting gaps and supporting (mostly primary care) staff to address data quality issues

The team also delivers a training and educational component, which includes developing and implementing templates and tools and promoting and showcasing good practice. They also help to embed culture change through:

- Partnering with secondary care to ensure data is shared correctly by secondary mental health trusts
- Supporting admin staff and practice managers to ensure data is coded and inputted correctly into primary care systems

Overall, the model aims to reduce overall duplication for patients and has led to notable increase in PHC completion rates.

6. Limitations

Despite valuable insights from evaluation participants and data, the evaluation's scope shifted towards a formative approach. This was due to data constraints that influenced the initial impact assessment framework, and thus understanding the impact on physical health outcomes and onward treatment for patients.

The key limitations for the evaluation were:

- **Absence of patient perspectives:** Identifying and interviewing patients proved difficult due to:
    - The limited scale of delivery (i.e. the number of patients who had their physical health check (PHC) completed by the mental health trust nursing teams as part of this programme).
    - Low patient engagement (i.e. engaging individuals with SMI in evaluation or research present unique challenges and factors such the nature of their mental health condition can contribute to low participation rates)
    - Evaluation timelines (with some of the project delivery occurring prior to evaluation activities).

  Although feedback and insights from programme partners supplemented these insights, the lack of independent patient data limits our ability to robustly assess patient acceptability and experience of PHCs.

- **Limited quantitative data:** The evaluation's capacity to comprehensively assess the programme's impact on PHC uptake and patient outcomes was constrained by limitations in the quantitative data collected. Specifically, issues with the data collection template and inconsistencies with data entry significantly impacted the reliability and completeness of this information:
    - **Inability to disaggregate PHC data:** 12/25 Oxleas delivery data collection templates did not enable distinction between PHC data completed by the local programme team, and PHC data inputted from mental health trust records. This lack of distinction prevents the evaluation from accurately quantifying the programme's specific contribution to PHC delivery in Oxleas.
    - **Inconsistent capture of PHC outcomes:** The free text fields in the data collection template did not allow for consistent and clear recording of PHC outcomes, such as out of range results, follow-up actions taken and wider lifestyle issues supported. This inability to consistently capture key PHC outcomes meant it was not possible to quantitatively assess the programme's effectiveness in improving patient health.
    - **Limited access to South East London (SEL) dashboard and outputs:** Although regular data packs are distributed with various stakeholders, the HIN evaluation team could not get access to these during the project period. Widened access to the data packs and SEL dashboard access to the programme and evaluation team could have enhanced usage and analytics.

7. Conclusion and recommendations

7.1 Conclusion

The physical health check (PHC) programme for people with severe mental illness (SMI) in South East London (SEL) faced a number of significant challenges throughout its implementation. This ranged from major external disruptions such as the pathology cyber-attack and GP collective action, to programme specific issues related to lack of clear scope, information governance hurdles and staff turnover and sickness. Collectively, these factors contributed to disrupted and delayed delivery.

The programme placed a significant administrative burden on mental health trust nurses, albeit supported the completion of checks for patients across 31 practices and one PCN. Despite the quantitative data limitations, the nurses reviewed 2684 patient records[29]. Many cases were already completed by GPs, with **an average increase of 0.5 to 1.2 PHC elements completed through the programme** (based on the data available for 1540 patients[30]).

The evaluation findings highlighted the dedication of nurses from both mental health trusts. Faced with a substantial data migration task (beyond their usual roles and responsibilities) they demonstrated persistence, collaboration, and creativity in finding efficient and effective ways to support implementation and deliver care. Their commitment to patient wellbeing was evident and acknowledged by primary care stakeholders.

Additionally, the programme promoted sustainability and longevity through its training, communication and engagement activities, led by Mind in Bexley and SEL Mind. These efforts, alongside the work of the nursing team, helped raise awareness and build commitment to improve the uptake of PHCs for people with SMI, bridging the gap between mental health and physical health.

Overall, the model had significant limitations and, therefore, wider scaling should be carefully considered. National targets have since shifted, yet addressing the inequality gap for people with SMI and improving physical health outcomes remains a priority in SEL. The momentum generated through this programme has facilitated a renewed focus and supported the development of further action.

7.2 Recommendations

This evaluation presents a set of recommendations based on key insights gathered throughout the programme. These have been developed in collaboration with key programme partners and are organised under three core themes:

1. **Learning from programme delivery:** Highlighting lessons learnt from this programme to direct and improve future initiatives.
2. **Increasing targeting and uptake of PHCs:** Identifying strategies to improve the reach and completion of PHCs for people with SMI.
3. **Supporting system development:** Providing broader insights and learnings to improve structural and systemic barriers, promoting more integrated and sustainable care.

[29] Based on Oxleas Group A and B (2365 patients) and SLaM delivery (Southwark 134; and Lewisham 185)
[30] Based on available data from Oxleas Group B (1406 patients) and SLaM delivery in Southwark (134 patients)

7.2.1 Learning from programme delivery

Sections 3 and 4 of the report highlights the nursing team's contributions and pinpoint key areas for improvement. While the data validation exercise helped to reduce PHC duplication for a small but high-priority SMI population, it also placed a significant burden on already overstretched nursing staff. Findings from this evaluation suggest that this model, in its current form, has notable limitations and therefore any plans for wider scaling should be carefully considered. The following recommendations outline the critical elements that would be needed to enhance impact and efficiency of such model, offering guidance for future system-wide initiatives.

Strategic programme set-up

A more planned and structured approach to programme set-up would be essential. Key recommendations include:

- **Clarify and map the vision:** Implementation challenges revealed the need for a clearly defined scope. Future programmes and models should develop a logic model or theory of change from the outset to provide a shared direction and measurable goals.
- **Reconsider workforce model:** There were inefficiencies with the nursing-led model, particularly for data verification and administrative duties. Further thought should be given to leveraging management, analytical, or administrative staff to support data related functions. This shift would enable nurses to concentrate on patient care, such as outreach, home visits and innovative patient engagement strategies. Staffing structures should also be evaluated, including the potential need for Band 7 oversight to support day-to-day operations.
- **Engage primary care early and meaningfully:** Early involvement of primary care stakeholders is critical to address the engagement barriers experienced throughout the programme. In practice, this necessitates: a) establishing a dedicated set up of and finish group; b) forming senior-level steering group to support shared learning across boroughs; c) conducting roadshows or wider engagement activities to promote awareness of the initiative; d) securing explicit commitment and dedication from primary care and ICB leaders; and e) targeting practices based on need to ensure efficient resource use.
- **Coordinate and streamline information governance (IG):** Delays due to IG must be addressed upfront to avoid disruption and loss of momentum experienced throughout. A coordinated approach should be established, involving key stakeholders to address obstacles and ensure sign-off before delivery.

Practical day-to-day implementation

Building on programme learnings and pending strategic resourcing decisions, the following practical elements would need to be prioritised to support effective delivery:

- **Provide appropriate training:** Staff involved require a consistent and comprehensive training programme that covers both:
    - **System access and interface use** (e.g. improved accesses and integration of electronic patient record systems, OneLondon care record, Excel for data entry and reporting)
    - **Clinical understanding** to support informed decisions on reconciling SMI and PHC data
- **Strengthen primary care communication:** Collaboration could be improved through structured set-up meetings using a clear checklist outlining space requirements, planned activities and roles and responsibilities. To support programme closure, end of project meetings are key to transfer results, share findings and discuss future SMI monitoring procedures.
- **Ensure fit for purpose working environments:** Linked to the above, ideally staff would have individualised access to EMIS allowing remote log-in via laptops. Where this is not possible, secure internet, dedicated, safe and appropriate working spaces must be arranged to enable data and clinical work.
- **Streamline operational tasks:** In line with prior suggestions to employ management and

analytical staff, future activities should consider the automatic upload and download of patient data and reports to reduce manual data entry and investigation to improve overall efficiency.
- **Prioritise patients:** Since a large number of patients reviewed had checks already completed by practices, resources could focus on targeting significantly disengaged patients. This could be achieved through data analysis of existing reports or via targeted lists provided by primary care, avoiding full SMI register review.

Extending sustainability and learnings

Initiatives should build in practices to sustain good practice and act on learnings. In practice, this should consider the following recommendations:

- **Develop a comprehensive Standard Operating Procedure or manual:** Throughout delivery, the nurses developed effective techniques and systems that significantly accelerated data validation and enhanced patient care. To promote team consistency and improve efficiency in any future implementation, a practical guide should be created. This should document workflows, tips for efficient data validation, patient prioritisation strategies, and approaches to managing patient engagement and appointment scheduling.
- **Optimise evaluation and feedback:** This evaluation had a number of limitations that prevented a full understanding of programme activities and patient outcomes. Future evaluations should refine the data collection tools to ensure they are user-friendly and capable of capturing all relevant activities. Additionally, incorporating patient feedback should be prioritised to inform continuous improvements and ensure services remain patient centred.

7.2.2 Increasing targeting and uptake of PHCs

Beyond the day-to-day delivery, the programme and its key stakeholders identified key barriers and opportunities to meaningfully increase PHC uptake and addressing physical health inequalities for people with SMI. While some quick wins were identified, it's clear that sustained impact requires integrated working, cultural change and innovative approaches. Building on the momentum and commitment generated, wider efforts should focus on the following:

- **Expand the use Point of Care Testing (POCT) for lipids:** Multiple appointments were a consistent barrier to PHC completion, with lipid checks among the least completed elements. Wider rollout of POCT could streamline this process, reduce patient burden and improve completion rates.
- **Advance primary care strategies:** Strengthening PHC delivery within primary care requires robust oversight of SMI registers and new and transformed approaches to annual monitoring. The following should be considered:
    - Appoint named leads at practice, PCN, and system level to promote accountability and support system collaboration
    - Identify opportunities to integrate and improve PHC data entry into existing workflows to reduce duplication and the need for a data validation exercise as a whole (such as the service improvement model described in Section 5.3.1)
    - Implement targeted strategies (e.g. RAG rating patients) and coordinate with secondary, community services and integrated neighbourhood teams to reach the most disengaged
    - Expand the remit of existing roles (e.g. mental health practitioners, care coordinators, and/or clinical pharmacists) to support PHCs, promoting a shared commitment to increasing the number of checks completed
- **Extended outreach through system collaboration:** There needs to be a continued movement towards integrating physical health in mental health. System-wide effort should focus on:
    - **Develop a collaborative framework with mental health voluntary sector organisations** to promote and raise awareness of the PHCs for people with SMI among patients and primary care staff

- **Implement a multi-faceted community education strategy** that goes beyond basic awareness of the PHC itself, emphasising the increased physical health risks faced by people with SMI
- **Conduct targeted PHC outreach in communities**, leveraging voluntary sector networks to engage disengaged groups
- **Continue to promote PHC awareness amongst health professionals** to ensure physical health in mental health is prioritised and barriers to attendance are addressed

7.2.3 Supporting system development

The current landscape presents a timely opportunity to strengthen integration between physical and mental health care – particularly with the rollout of OneLondon, which aims to connect health and care staff to the London Care Record. Similarly, with changes to national PHC targets for people with SMI there is a more than ever need to maintain a strong focus. To support this, the broader system should prioritise the following:

- **Invest in data infrastructure and scale innovative tools:** The Health Innovation Network South London programme team has already created formal opportunities for nursing teams to contribute to OneLondon development and use innovative tools like LUCI. Building on the programme's progress, continued investment in flexible, interoperable tools is critical to improving care coordination and outcomes. Key specific opportunities include:
  - Increase awareness and widening access to the SEL ICS data dashboard. This dashboard offers monthly, real-time insights into QOF target achievement, drawn directly from the 'discovery' data warehouse. This would empower GP practices, nursing teams and the voluntary sector to more effectively target their efforts in increasing PHC uptake for people with SMI, potentially encouraging improved data quality, coding and completion earlier in the QOF cycle. Broader and more consistent usage could inform ongoing developments to the dashboard, ensuring the data can be viewed and analysed in ways that are most meaningful and accessible to users.
  - Scale tools like LUCI, which support clinicians in managing caseloads and tracking patient outcomes more efficiently
  - Promote use of the London Care Record across all stakeholders to reduce duplication, improve data accuracy, and enhance patient experience
  - Prioritise the integration of primary and secondary care systems through platforms like OneLondon to enable comprehensive, real-time access to patient information
- **Sustain focus and accountability:** With the removal of national PHC performance targets, it is vital to maintain local oversight and leadership. This should include:
  - Ensure that appointed leads prioritise addressing broader issues related to the SMI register, including inconsistent clinical coding and the need for a clear, standardised process for adding and removing patients
  - Continue monitoring and reporting of PHC delivery at the ICB level, with a real focus on reducing the morbidity gap
  - Leverage locally commissioned services to further incentivise GPs to prioritise care for this population and achieve PHC goals

8. Appendices

8.1 Programme delivery data template (Group B)

Practice	Practice name
Ethnicity	Asian or Asian British Black or black British Mixed Other White (incl. white other) Not stated/Unknown
Age Band	18-24 / 25-34 / 35-44 / 45-54 / 55-64 / 65-74 / 75-84 / 85+ Unknown
Sex	Female/Male
On SMI register as per the QOF stipulated criteria	For patient management (not analysis)
Psychotropic medicines patient is on:	
Are they under the care of the community mental health team?	Yes/No
If patient is under the care of the CMHT which team is responsible for the patients care?	Free text
Were all checks completed before this project (this could include by the practice or the CMHT)?	Yes/No
Check 1 completed: **Blood Pressure**	No - not complete Yes - completed as a result of checks done by project team Yes - completed by MH trust prior to project Yes - completed by primary care prior to project
Check 2 completed: **Height and Weight**	
Check 3 completed: **Blood glucose**	
Check 4 completed: **Blood lipid**	
Check 5 completed: **Smoking**	
Check 6 completed: **Alcohol**	
If applicable, reason for an incomplete physical health check	Not consistently captured
Other reason for an incomplete physical health check	Freetext
Were any out of range results identified (e.g. high blood pressure, BMI overweight or obese etc)?	Not consistently captured
Where out of range results were identified, what follow up actions were taken? *(you can select more than one action per patient here)*	Not consistently captured
Were any lifestyle issues identified (e.g. smoking or excessive alcohol consumption)?	Not consistently captured
Where lifestyle issues were identified, what follow up actions were taken? (you can select more than one action per patient here)	Not consistently captured
Where an 'other' follow up action was taken please describe it here	Not consistently captured
Have the results from the checks been uploaded to EMIS?	Not consistently captured
Additional comments	Free text

8.2 Service user case studies

Case study: Service User A

Service User A has been a mental health service user for over 30 years and takes anti-psychotic medications. Their GP sends them a text reminder to make an appointment for their PHC – which they attend.

All tests are usually done in the same appointment, except for the blood test where a separate appointment is required. On one occasion, they requested a referral to see a dietician to support their weight management efforts, which was necessary because of the side effects of anti-psychotic medications, but they were advised this service was not available in the GP practice.

> "It's important that the GP reinforces the significance (of the test), for example by saying *'high cholesterol is damaging, so it's important to get it tested.'*"

Case study: Service User B

Service User B has previously undergone several PHCs through both their GP and mental health trusts. This service user does not routinely receive reminders from their GP practice to attend their PHC appointment and instead has reminded the practice that they are due to attend a PHC. The last PHC was completed during an appointment for a COVID booster injection. Following the check, Service User B was referred for a blood test, which could be booked online or via telephone at a different location to the GP practice.

The value of the PHC test was not explained to them by the GP Practice, because this service user is medically informed they knew it was important to attend and complete the PHC. Service User B had no follow up by the GP practice to ensure they had undertaken a blood test and reported limited co-ordination between their GP practice and mental health trust.

> "Patients (living with SMI) can be sent on a goose chase to access the service they need..."

Case study: Service User C

Service User C was contacted by their GP to attend a PHC, however, the purpose of the PHC was not explained by either the GP or the practice staff.

During the PHC, Service User C underwent BMI and BP checks but was not asked about lifestyle factors such as smoking or alcohol habits. Despite the PHC including a BMI check, they have not previously engaged in discussions about BMI with their GP, even when they were overweight.

Service User C did not ever receive any results of the PHC or follow up but felt that any abnormalities would have been followed up by their GP and appropriate referrals made.

This service user also had negative experience from poor co-ordination between their GP and MH trust, involving a lack of communication over a medication change recommended by their psychiatrist. As a result, there was a period where this service user did not take their medication and their mental health subsequently deteriorated.

> "My GP knew what they were doing, but they should have explained why they were doing the physical health check – I genuinely didn't know what it was for!"

Case study: Service User D

Service User D has a professional career background and is university educated. This service user lives with bipolar, insomnia, paranoia and anxiety. They have also previously been sectioned.

They have self-researched their condition and feel this knowledge is helpful in informing their clinicians during appointments. They visit their GP practice every six months and undergo blood tests.

Service User D reports that 95% of the time the service they receive is brilliant. However, there were some problems following being sectioned where the service user did not see the same psychiatrist.

The co-ordination between services had been good, letters were circulated, and Patient D was able to access these letters on request. Service User D reports being referred for specialist support by their GP, and the GP phoning to check this had been followed up, which was helpful. Another time Service User D contacted their GP because of insomnia and was called back immediately and offered helpful advice.

For the PHC, no-one explained why it was needed but Service User D did their own research and was able to understand why the PHC is important.

> "If a person was already anxious, paranoid, did not trust in their GP and did not know the reason for the physical health check, it would be unlikely that they would attend these appointments!"

Case study: Service User E

Service User E has a complex mental health history, including a personality disorder and complex PTSD and has been a MH service user for 25 years. They have experienced musculoskeletal and cardiac physical health problems in the past and have lived experience of homelessness and domestic violence. No one has ever explained why it's important to have a PHC instead, Service User E has educated themselves through Google or speaking to peers.

In lockdown Service User E was required to undergo a physical examination and was advised they were unable to bring anyone with them, which can be a barrier to women accessing physical health services, especially if they have gone through previous trauma such as sexual assault.

Patient E reflected on a previous negative experience undergoing an intimate physical examination in which they felt the clinician was too rough, they complained and were subsequently signposted to a specialist service that offered additional support and reflected they had to "go through a bad experience before being offered additional support."

> "There could be a lot of women not attending appointments as there is not enough understanding as to what support is required."

8.3 Example programme GP communications

Health Innovation Network
Floor 10, Becket House
1 Lambeth Palace Road
London
SE1 7EU

25 June 2024

Dear Practice Manager,

Project: Reducing inequalities in physical health care for people with SMI through increasing the uptake of physical health checks (PHC)

South London Partnership, South London and Maudsley NHS Foundation Trust, Oxleas NHS Foundation Trust and the Health Innovation Network are working in partnership and are writing to invite your practice to participate in a SEL ICS funded project aimed at reducing inequalities by increasing the number of physical health checks for patients with severe mental illness (SMI). As you may know, individuals with an SMI diagnosis face stark health inequalities, are at a higher risk of physical health problems and often face barriers to accessing appropriate care. Compared to the general population, patients with SMI face a shorter life expectancy, by an average of 15-20 years.

The project aims to address this issue by offering the expertise of Oxleas NHS FT Community Mental Health Team to support the physical health checks to patients with SMI in primary care settings.

The project involves:

- Your practice agreeing to a data sharing agreement with Oxleas to help with identifying patients with SMI who have not received a physical health check in the last 12 months.
- Oxleas checking your SMI patient population data to see if they have already received a physical health check through the Trust in the last 12 months and informing your practice with the results of the health check.
- Your practice offering these patients a physical health check including assessments of blood pressure, blood sugar, blood lipid, BMI, smoking status and alcohol consumption.
- Providing feedback to the patient and their GP regarding any health concerns identified during the check.
- Referring patients for further assessments or treatment as indicated.
- Your practice updating EMIS following the outcome from the physical health checks.
- Your practice offering a space/room (exact arrangement to be agreed between the practice and the Oxleas nursing team).
- Contributing to continual improvement of the physical health check offer through collating information onto a QI spreadsheet (the content of which will be agreed with your practice)

Health Innovation Network

We understand your practice may have already consented to participate in this project. Shortly you will receive an email from the Data Controller Console to sign a data processing agreement (DPA) to enable data sharing between primary and secondary care.

Your involvement is greatly appreciated and will make a significant contribution to improving the physical health outcomes for patients with SMI in south east London.

Kind regards,

8.4 Data analysis overview

Group	Practices engaged	Patients reviewed	Commentary
Oxleas – Group A	12	959	Data not included in analysis (1 practice excluded from patient analysis due to late submission)
Oxleas – Group B	13	1406	Data included in analysis
SLaM - Lewisham	5	185	Data not included in analysis
SLaM - Southwark	1 + 1 PCN	134	Data included in analysis
Oxleas - Total	25	2365	
SLaM – Total	6 + 1 PCN	319	
Analysed - Total	14 + 1 PCN	1540	

8.5 Oxleas and SLaM data by demographics

Table 15 Average check elements and full PHC achievement by demographic status (Oxleas group B)

	Total patients	Average # checks pre project	Average # of checks post project	All 6 checks completed	All 6 done by Practice prior	All 6 done via project
TOTAL	**1406**	**4.2**	**4.7**	**833**	**626**	**207**
Sex						
Female	720	4.4	4.9	439	339	100
Male	686	4.0	4.6	394	287	107
Age band						
18-24	54	3.1	3.8	23	14	9
25-34	244	4.0	4.6	138	100	38
35-44	296	3.9	4.5	148	110	38
45-54	306	4.3	4.8	174	128	46
55-64	290	4.4	5.0	201	157	44
65-74	142	4.6	5.0	93	74	19
75-84	55	4.8	5.2	41	33	8
85+	14	5.0	5.7	12	7	5
Unknown	5	4.4	4.4	3	3	
Ethnicity						
Asian or Asian British	143	4.1	4.6	80	61	19
Black or black British	263	4.2	5.0	171	109	62
Mixed	153	4.1	4.4	74	59	15
Other	98	4.2	4.7	58	46	12
White (incl. white other)	736	4.3	4.8	446	348	98
Not stated/Unknown	13	3.2	3.8	4	3	1

Table 16 Average check elements and full PHC achievement by demographic status (SLaM)

	SLaM Patients		Average # checks		All 6 completed by end	
	Number	%	Pre	Post	Total	By project intervention
TOTAL	**134**		**4.2**	**5.4**	**97**	**69**
Sex						
Female	51	38%	4.5	5.3	33	22
Male	83	62%	4.1	5.4	64	47
Age band						
18-24	*	*	4.0	4.2	*	
25-34	19	14%	4.3	5.1	12	9
35-44	29	22%	4.4	5.5	23	18
45-54	38	28%	4.1	5.4	25	20
55-64	35	26%	4.1	5.6	30	21
65-74	*	*	4.6	4.6	*	
75-84	*	*	5.5	6.0	*	*
Ethnicity						
Asian or Asian British	8	6%	4.1	5.4	6	4
Black or black British	54	40%	3.8	5.0	35	25
Mixed	8	6%	5.1	5.9	7	6
Other	14	10%	4.3	5.7	11	7
White (incl. white other)	46	34%	4.6	5.6	35	25
Not stated/Unknown	4	3%	4.5	5.5	3	2

8.6 SLaM activity in Lewisham

- 185 patients open to SLaM were sent to a project team. By the end of the intervention period, **107 (58%)** had had a full PHC.
- Of this 107, 28 (26%) had the full check by the GP practice, 52 (49%) had the checks done by the Mental Health Trust teams and through data reconciliation their records were completed, and 27 (25%) were seen by the project team. Therefore **79 patients had their full health checks completed in EMIS as a result of the project intervention**.
- 21 patients declined the service and 11 were discharged.