The Islington SMI Service

Delivered by Islington GP Federation in conjunction with Camden and Islington Mental Health Trust

HSJ Health Inequalities Forum
16th May 2023

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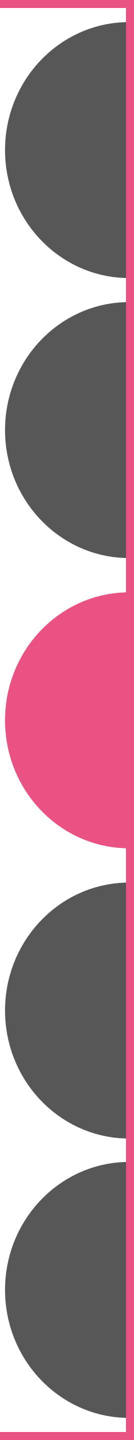


Service Summary

The SMI team works within general practice to address the physical health concerns of patients on the SMI (severe mental illness) register.
They complete 6 physical health checks (alcohol, blood glucose, BMI, BP, cholesterol and smoking status) as well as offering ECGs.
The team also complete a mental health review and care plan with the patient where necessary.

The team is made up of:

- 1 senior nurse (supervisor) – Susan Cummins
- 2 nurses – Peter Dwyer and Caroline Collins
- 1 HCA – Reah Mendoza
- 1 Administrator -Yolanda Kenyi
- 1 Ops lead – Ruta Habtom

Service Summary

- Locally not offered appropriate or timely assessments/checks
- Nature of severe mental illness, hard to engage, social factors
- NHS England – 6 Cardio Metabolic Checks now aligned with GP Quality & Outcomes Framework [QoF]
- Integrated- joint partnership with Camden & Islington and Islington GP Federation
- Nurse Led one stop shop in GP practices and home visits

Current Islington landscape

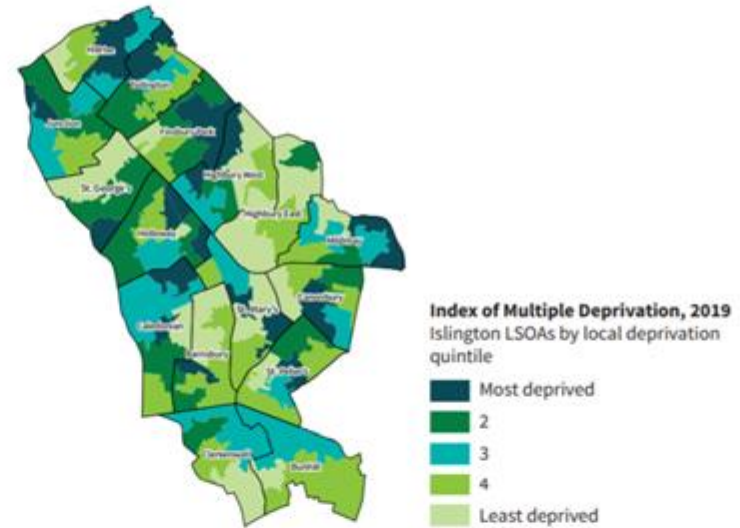
About Islington – socioeconomic profile

Islington is one of the most deprived boroughs in England. 27.5% of Islington residents are facing income deprivation, compared with 21.3% in London. 21.7% of people live in income deprived households with 47.5% of our children growing up in poverty.

Poverty is an issue in every part of the borough: almost every ward includes one of the most deprived Local Super Output Areas (LSOA) in Islington. As of 2019, the 5 most deprived wards in the borough were (in order of most deprived-least deprived): Finsbury Park, Junction, Tollington, Caledonian, and Hillrise.

Within Islington, variations in life expectancy can be observed between wards. For example, a boy born and living in Highbury East can expect to live for 6 years longer than a boy in Junction ward. A girl born and growing up in St. Peter's ward can expect to live for 10 years less than a girl from St George's ward.

Spread of deprivation among Islington by Local Super Output Area, 2019.



Source: English indices of deprivation 2019

10.4% of Islington households experience fuel poverty, compared to 11.8% in London and 10.9% in England. More than 8% of households with people aged 60+ are living in fuel poverty.

Islington has the 4th highest levels of income deprivation affecting older people in London. 34% of residents over the age of 60 were facing income deprivation, compared to a London average of 22%.

Dashboard created by the IGPF data analyst to track outcomes with a year on year comparison

Commentary

2017 - No service to improve physical health checks in patients with SMI

2018 - Pilot began in January in 7 practices in the SW CHIN

2019 - Scale up of nurse-led service across the borough

2020 - Service redesigned (to launch in April) to include HCA and nurses delivering health checks
Delays in launch with COVID-19 pandemic, service temporarily withdrawn during late March-July

Latest Percentage Achieved

58.5%

0.0% 100.0%

Run Chart of the Affected Measure

Year 2017 2018 2019 2020 2021 2022 2023

% Achieved: 20% 30% 40% 50% 60%

Month: January February March April May June July August September October November December

Physical health checks for SMI population – 2022/2

Measure	% Physical health checks 17/18 Q4	% Physical health checks 18/19 Q4	% Physical health checks 19/20 Q4	% Physical health checks 20/21 Q4	% Physical health checks 21/22 Q4	% Physical health checks 22/23 Q4
Assessment of smoking status	72.6%	75.3%	77.7%	60.8%	74.6%	**78.2%**
Measurement of weight	51.9%	56.6%	76.3%	60.5%	74.9%	**77%**
Blood pressure & pulse check	80.8%	83%	81.5%	58.4%	75%	**78.3%**
Assessment of alcohol consumption	79.5%	80.7%	64%	46.6%	71.9%	**76.4%**
Blood lipid incl cholesterol test	52.9%	56%	62.7%	52.4%	67.9%	**72.1**
Blood glucose test	52.1%	53.8%	60.5%	49.8%	67.6%	**71.4%**
All 6 physical health checks	**29.4%**	**33.3%**	**42.3%**	**32.3%**	**57%**	**60.1%**

Progressing equality through physical health checks

Ward	% Patients with all 6 Physical health checks 22/23 Q4 – average across GP practices within ward area	PCN area	% Patients with all 6 Physical health checks 22/23 Q4 - by PCN area
Tollington	56.3%	North 2	57.8%
Finsbury Park	65%	North 1	57.1%
Junction	58.6%	North 2	57.8%
Caledonian	76.7%	South	59.6%
Hillrise	69.1%	North 1 and 2	57.1% and 57.8%

- Access to physical health checks for those on SMI register across most deprived wards in Islington, shown above (largely within PCNs N1 and N2).
- PCN areas with higher deprivation generally performed higher, with majority of GP practices in those areas reaching above 60% target for patients receiving all six physical health checks.

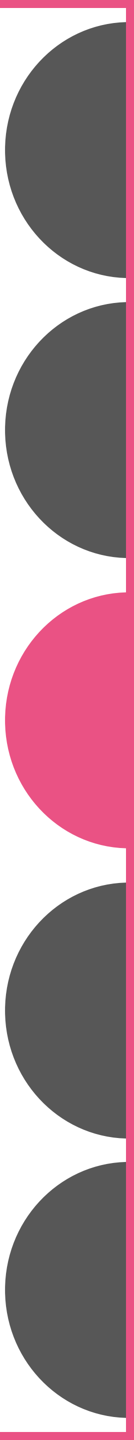
Activity Data

In 22/23, there were 723 instances of referral/signposting. Some examples of the referral areas are:

- 249 were to the community mental health team
- 126 were to podiatry
- 66 were to exercise and weight management
- 47 were to social services
- 27 were to smoking cessation services
- 6 were to safeguarding adults

Average DNA rates per annum is 36%

Average DNA rates for last month is 27%



Diversity/patient inclusion

- For any patients that can't attend a clinic (be it a physical health concern or to do with their SMI), we will visit them in their homes.
- We utilise language line for anyone that requires a translator – this can be both face to face or over the telephone.
- We recently had our first deaf patient attend an appointment and we were able to provide an in person translator for the consultation.
- We understand that some patients may have concerns about being examined by a clinician of the opposite gender, so will offer an alternative clinician if that is raised.

Case Study- Mary

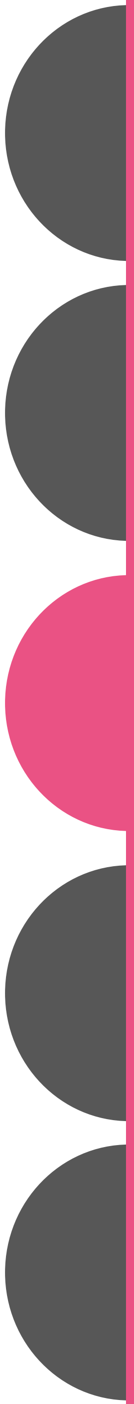
- 72-year-old patient with schizophrenia
- not seen by any medical professional since a hospital admission in 2014
- uncontactable by phone
- SMI nurse undertook home visit and conducted a full review physical, mental & social
- HbA1c out of control– nurse encouraged patient to attend GP for review so referred to Intermediate Diabetes Team
- Social & functional issues addressed by occupational therapy, physio and peer coach
- presented & discussed at Integrated Network Meeting
- Changed GP practice so all under the same surgery
- Now under the Memory Clinic
- Annual review booked with GP for home visit as now due

The Future

- The ICB have confirmed that they will be introducing block 3+2 contracts for the SMI work happening across NCL. This means we will receive a three year contract with the option of 2 more. This is a welcome departure from our annual contract renewal process.

- There has been additional funding provided from NHSE for 23/24, to provide more capacity for outreach. The funding must be spent within the 23/24 financial year so we are unfortunately not allowed any carry over.

- We will be launching a pilot with one PCN supporting practices with patient reengagement. This will involve:
  - Working closely with wellbeing coaches and care co-ordinators
  - Inviting them to join clinics and home visits as needed.
  - Co-ordinating patient outreach with those roles to make sure the patients social needs are met as well as their physical needs.



Thank You

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