The Physical Health Check

** prioritize CVD risk factors poorly controlled Obesity on antipsychotic medication

** prioritize No BP in 18 months (proxy for health check and possible indicator of non-engagement)

** prioritize All others with CVD risk factors

** prioritize All others

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** Invited for SMI Annual Health Check

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** The Physical Health Check:** HCA* (default pathway)
- Physical health check e.g. BP, weight, bloods, screening
- Identify physical health red flags
- Structured support for education and self-management
- Identify social concerns & mental health red flags
- Explore patient’s priorities
- Assess carer/friend/formal support needed to address physical health
- Brief interventions and signposting (e.g. smoking)

** Clinical Review:** Nurse/pharmacist/GP
- Review clinical conditions
- Optimise medication
- Manage clinical risk factors & co-morbidities
- Agree health priority and behaviour change goals

** Intensive Support for Behaviour Change:** Trained staff member
- Working intensively on patient-led cardiovascular goals e.g. smoking cessation, weight management, adherence
- If available, Peer Coaches to provide less structured appointments to support the CVD goal or separate recovery focused goal

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** Mental Health Review:** MH nurse
- Undertake desktop review of patient to assess their mental health/complexity, to determine reasons they may not be engaging, and to assess their need for support
- Contact patient/family/MH services to assess current mental health
- Review and respond to mental health needs
- Oversee and support patient journey where required
- Allocate staff member to accompany to appointments where needed
- Joint consultations with clinician or HCA type role as needed for physical health interventions
- Support behaviour change with brief and intensive interventions
- Refer for peer support if available and desired.

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** Wider Social Support:** Social provider
- Maximise use of existing structures (social prescribing, MIND, care navigators) to address wider wellbeing concerns e.g. isolation/accommodation/financial concerns.
- All clinicians to support patients to engage with wider social support at each stage in the Pathway, if needed.

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** Outreach**
- Home visits
- Accompany to appointments

** Specialist Support**
- Core Community Mental Health Service or Specialist Mental Health Team

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UCLPartners – Primrose: The Pathway

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*This may be a HCA or another member of the wider workforce, e.g. wellbeing coach, social prescriber.