British Heart Foundation

Left Behind

A Policy Response to Cardiovascular Inequalities in Severe Mental Illness

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Forewords

It's a clear injustice that people living with mental illness can expect to die up to two decades before the rest of the population. It's one of the starkest health inequalities that exists in Britain today. But it is not inevitable.
This report sets out the links between severe mental illness and cardiovascular disease. It shows the mechanisms by which a person with a mental illness may face a far higher risk of cardiovascular disease, and crucially what policies and practices could help to close the gap.

All too often, many of the risk factors for cardiovascular disease, including diet, physical activity, and smoking are perceived as individual characteristics or choices. For people with a mental illness, and indeed many others, it's much more than that. It's about living in poverty, in unsafe homes and neighbourhoods, with the traumas and stresses that place unbearable pressures on people's mental and physical health.

This report is also clear that discrimination and disadvantage don't only affect the risk factors for cardiovascular disease amongst people with a mental illness. They also stop people getting the right help early on, or the necessary treatment when they become unwell.
The inequities described in this report are systemic and deeply entrenched. But there are solutions, at every level of the healthcare system. Through Equally Well UK, we are supporting system change to close the health gap. From the day-to-day practice of health care to national government policies - change is possible.

This report sets out some of the solutions that can break the link between severe mental illness and cardiovascular disease. They include taking action to increase access to healthy food amongst people with a mental illness, putting in place evidence-based help to stop smoking, and making better and more consistent use of the annual health check to address cardiovascular disease risk factors early on.

There is no better time to act. A national Mental Health Strategy is on the way, for the first time in 15 years, and a Modern Service Framework will set out new ambitions and standards for mental health services.
We can't leave this to chance. It needs bold ambition, effective implementation, and reliable data to track progress. But the alternative is to accept the current inequities as inevitable.



Andy Bell
Chief Executive, Centre for Mental Health

People living with severe mental illness face some of the starkest health inequalities in our society. Despite significant advances in our understanding and treatment of mental illness, too many people with severe mental illness continue to die years, often decades, earlier than the general population. These premature deaths are overwhelmingly driven by preventable physical health conditions, in particular, cardiovascular disease.

We know that people with severe mental illness are more likely to be exposed to many of the risk factors associated with cardiovascular disease, including smoking, obesity, and deprivation. We also know that they are more likely to encounter barriers when seeking help, experience fragmented care, and face stigma and diagnostic overshadowing when their physical health concerns are raised. The result is a health gap that has persisted for decades despite repeated warnings and growing evidence.

Reducing these inequalities requires us to recognise the complex realities of people's lives, and that mental illness does not occur in isolation from financial insecurity, discrimination, or deprivation. These wider determinants shape both mental and physical health and are particularly important for people living with severe mental illness.

Whilst the issues highlighted in this report are not new, what makes this report particularly valuable is that it moves beyond describing the problem. The evidence is clear, but so too are many of the solutions. From embedding better physical health monitoring in routine practice, to strengthening tailored smoking cessation support, and improving access to a healthy diet, there are practical actions that national government, the NHS and local systems can adopt today.

Importantly, these recommendations come at a critical moment. The development of a new Mental Health Strategy for England and the Modern Service Framework for Severe Mental Illness provide important opportunities to embed physical health firmly within the future of mental healthcare.



Dr Lade Smith CBE
Immediate Past President,
The Royal College of Psychiatrists



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Executive summary

Cardiovascular disease (CVD) is one of the leading causes of morbidity and mortality in the UK, with over 7 million people living with CVD in England alone. People living with severe mental illness (SMI) have a life expectancy 15-20 years younger than the general population, and this is largely accounted for by physical health conditions, including CVD. Indeed, people living with SMI are around four times more likely to die early from CVD than the general population. This report demonstrates how policies that target the disproportionate CVD burden amongst people living with SMI could help to reduce these inequalities in life expectancy.

This report draws on a review of available evidence, led by British Heart Foundation, discussions with three adults living with SMI and CVD, and engagement with a group of academic and clinical experts. Through this mixed-methods approach, we demonstrate to policymakers and healthcare system leaders how practical policy action can improve prevention, diagnosis and treatment for people living with SMI and CVD. It does not seek to present these inequalities as a new issue. Rather, it highlights that, despite longstanding recognition of the problem, progress has been too slow, and urgent action is still needed across the healthcare system and wider health environment.

Owing to the devolved nature of health systems across the UK, this report focuses specifically on England. The nature of devolved health means that healthcare systems within each UK nation operate within a distinct policy context, and attempting to reflect these distinctions within a single report may limit our ability to provide detailed, actionable recommendations. We have therefore focused on the NHS in England, whilst recognising that many of the challenges described throughout this report are relevant across the UK.

7m+
people live with CVD in England alone

The drivers of CVD inequalities amongst people living with SMI are complex and interconnected. People living with SMI are more likely to be exposed to environmental and clinical risk factors for CVD, including smoking and obesity, as well as the cardiometabolic effects of some psychotropic medication. In England, rates of obesity among people with SMI are 1.8 times higher than in the general population, and more than 40% of people with SMI smoke. However, tailored support can make a difference.



Evidence suggests that sustained behavioural interventions can reduce excess weight amongst people living with SMI, and tailored smoking cessation support that combines pharmacological and behavioural interventions can increase quit rates. However, services are not consistently designed, commissioned or delivered in ways that meet the needs of people living with SMI.

These risks are compounded by structural inequalities. Living in deprivation is associated with higher rates of SMI and worse physical health outcomes, including higher CVD prevalence and premature mortality (dying before the age of 75). For some, these inequalities intersect with ethnicity, culture, sex and gender, and geography, affecting both the likelihood of developing CVD and SMI, and the ability to access adequate and timely care.

66%
of patients with SMI have undetected CVD prior to cardiovascular death

People living with SMI often face significant barriers to CVD diagnosis and treatment. Research cited in this report indicates that patients with SMI have a 47% lower likelihood of undergoing cardiac interventions, are 15% less likely to have a recent prescription for statins, and up to 66% have undetected CVD prior to cardiovascular death.

Fragmentation between mental and physical healthcare services is a major barrier. Historically, these services have operated separately, leaving patients to navigate disconnected pathways and, in some cases, act as their own care coordinator.

Patients also report stigma and diagnostic overshadowing, where physical health symptoms are dismissed as a consequence of mental illness or medication, contributing to inadequate treatment and worse outcomes.

There is a clear need for a renewed national focus on cardiovascular prevention, diagnosis and treatment for people living with SMI.

Summary of policy recommendations

- The UK Government should set a ten-year target to reduce smoking prevalence amongst people with SMI in England.
- The UK Government must implement a comprehensive approach to increasing the accessibility, affordability and appeal of healthier food and drink products.
- Commissioners should ensure consistent and accessible provision of effective weight management support for people with SMI.
- The Department of Health and Social Care and the NHS in England must incentivise healthcare systems to improve the monitoring, quality of delivery, and follow-up of the Annual Health Check (AHC) for people with SMI.
- Integrated Care Services (ICSs) should be supported to commission liaison psychiatrists to provide input into specialist cardiology services to improve the physical health management of people with SMI in secondary care settings.
- All NHS psychiatric and primary care services in England should be adequately trained and supported to adopt the Lester Tool as a minimum standard to monitor and improve the physical health outcomes of people living with SMI.
- Together, these recommendations would help shift the dial from care that is often reactive and fragmented, towards proactive, integrated cardiovascular prevention and support for people living with SMI, so that every person living with SMI can live a longer life in good heart health.

Whilst this report focuses on much-needed policy changes to support those living with SMI and CVD, we hope it will also raise awareness of these significant inequalities more broadly, and the need for urgent action at all levels of the healthcare system and wider health environment. We are grateful to Centre for Mental Health, Equally Well UK, and the Royal College of Psychiatrists for their collaboration and endorsement of this report.



Introduction

The association between cardiovascular disease and severe mental illness

Cardiovascular disease (CVD) is one of the leading causes of morbidity and mortality in the UK. In England alone, over 7 million people are living with CVD, and around 140,000 die from it each year.[1] CVD places enormous burden on individuals, the healthcare system and the economy. For those living with CVD, it can significantly impact their quality of life, reducing their ability to maintain employment or engage in meaningful activities outside of work.

Heart disease is one of the leading causes of economic inactivity, with nearly one-third of people who are economically inactive reporting a heart or circulatory condition.[2] However, the costs of CVD go far beyond the individual. CVD costs the healthcare system in England an estimated £10 billion each year, with the total costs to society estimated at £24 billion.[1]

Beyond its wider impact, the burden of CVD is not spread evenly across all of society. Some groups are disproportionately impacted by many cardiovascular conditions, both in terms of prevalence of risk factors, and access to adequate and timely healthcare.[3] One such group are those living with severe mental illness (SMI).

In England, just over 1% of the population are estimated to be living with schizophrenia, bipolar disorder and other psychotic illnesses.[4] SMI is associated with dying 15-20 years younger than the general population,[5] largely due to physical health conditions.[6] Indeed, adults living with SMI are around four times more likely to die prematurely (before the age of 75) from CVD than the general UK population.[7]

Evidence from the UK Government estimates that 2 in 3 deaths of people living with SMI are due to physical illnesses, including CVD, which are often preventable.[8]

This suggests that one way to reduce the disproportionate burden of CVD amongst people living with SMI may be through preventative policies and practice such as smoking cessation support, weight management services, and treatments to lower high blood pressure and cholesterol.

Adults living with SMI are

4 times

more likely to die prematurely from CVD

The disproportionate burden of many major cardiovascular conditions amongst people with SMI likely reflects the cumulation of increased prevalence of risk factors, the cardiometabolic effects of some psychotropic medication (though their use is associated with lower overall cardiovascular mortality), and barriers to accessing timely diagnosis and treatment.[9] [10] The following sections of this report explore these factors in detail, alongside policy levers within the UK Government and healthcare system, to improve cardiovascular prevention and integrated physical health care for people with SMI.

A note on terminology

Severe mental illness

Definitions of severe mental illness (SMI) vary and, even within the NHS in England, definitions are not consistent across all clinical guidance and policy documents. For the purposes of this report, SMI is defined as diagnosable mental, behavioural, or emotional disorders that cause serious functional impairment that substantially interferes with, or limits, one or more major life activities. An SMI can include substance use disorders, severe depression, eating disorders, psychosis, post-traumatic stress disorder (PTSD), schizophrenia and bipolar disorder.[11] [12]

Cardiovascular disease

Cardiovascular disease (CVD) is an umbrella term for a range of heart and circulatory conditions including heart attack, stroke and vascular dementia.

Obesity

Throughout this report, we refer to people living with excess weight or obesity. As with other health conditions, we use person-first language, meaning we refer to a person 'living with obesity' rather than 'an obese person'. This approach is guided by engagement with the Obesity Health Alliance (OHA), clinicians and our own lived experience experts, with the aim of reducing weight stigma. We recognise that obesity is a complex health condition that is driven by many factors outside of a person's control - it is not simply a matter of personal choice. We use this term sensitively and in line with clinical definitions.[13] BHF is committed to reducing weight stigma and advocating for policy changes to our food environment to improve everyone's access to a healthy diet.



Risk factors

There are a number of risk factors which increase the likelihood of CVD, and which are more prevalent amongst individuals living with SMI.

Smoking

Higher smoking prevalence is also a leading cause of increased CVD burden amongst people living with SMI. The most recent available data suggests that over 40% of people with SMI in the UK smoke,[14] compared to 11% of adults in the general population.[15] Smoking is a known risk factor for CVD, associated with as many as 18,000 CVD deaths each year in the UK.[1 8] While the NHS in England has not published data on smoking prevalence amongst people with SMI since 2014-15, it is estimated that around half of deaths amongst people with SMI can be attributed to smoking, highlighting the potential impact of adequate preventative interventions and smoking cessation support amongst this patient group.[5]

One study investigating all-cause mortality risk amongst patients with diagnosed schizophrenia, found that participants who were current smokers had an 86% higher 20-year cardiovascular mortality risk, relative to their non-smoking counterparts. The authors conclude that smoking cessation interventions may be one of the single most impactful interventions for reducing CVD inequalities amongst people with SMI.[16]

Evidence suggests that tailored smoking cessation support for people with SMI is effective. Approaches which combine pharmacological and behavioural interventions with tailored adaptations such as, support from a qualified mental health nurse, home visits and additional face-face support, have been shown to increase quit rates amongst people with SMI.[17]

NHS tobacco dependence treatment and smokefree policies

The NHS Long Term Plan (2019) committed NHS systems in England to offer NHS-funded tobacco dependence treatment services to long-term users of specialist mental health services, and to ensure these services are available to people with SMI living in the community.[18] The 10 Year Health Plan for England (2025) reaffirmed the commitment to embed opt-out smoking cessation interventions in all routine care within hospitals, though it made no specific commitment to SMI and did not renew the commitment to implement community-based tobacco dependence treatment services.[36] Nevertheless, it is promising that the Modern Service Framework for CVD (2026), highlights smoking cessation as a priority, requiring Integrated Care Boards (ICBs) to proactively and systematically identify people who smoke and offer evidence based smoking cessation and tobacco dependency services for all smokers in their local population.[19]

Despite evidence demonstrating the efficacy of tailored tobacco dependency services for people with SMI,[20], a survey conducted by Action on Smoking and Health (ASH) in 2024 concluded that over half of surveyed NHS Mental Health Trusts in England could not provide smoking cessation services to all patients with tobacco dependency.

They also found that whilst capacity to deliver these services has increased across inpatient settings since 2019, this capacity has not been matched in community settings meaning that many patients risk losing access to support at the point of discharge.[21] Further evidence suggests that staff uncertainty about long-term funding is a key barrier to sustained implementation of community-based tobacco dependency treatment services for people with SMI, hindering the establishment of long-term protocols, staff recruitment and subsequent retention.[22]

To support action to reduce rates of smoking and improve the consistency of NHS-funded tobacco dependency services across all inpatient and community mental health settings, the UK Government should set a ten-year target to reduce smoking prevalence amongst people with SMI, alongside a roadmap setting out how this target will be achieved, and a commitment to fund evidence-backed interventions to achieve year-on-year reductions in prevalence.



Case study

The Tobacco Dependency Service at Berkshire Healthcare NHS Foundation Trust provides personalised support to patients who smoke whilst admitted to acute adult mental health inpatient wards. Tobacco dependency treatment is integrated into wider recovery planning and includes assessment, tailored nicotine replacement therapy (NRT), hospital-issued e-cigarettes (vapes) where appropriate, behavioural support, relapse prevention, and coordination with community stop smoking services to support continuity of care after discharge.

Between April and July 2026, 94% of patients who smoked and were admitted to mental health inpatient wards were assessed by the Tobacco Dependence Advisor. During this period, 29% committed to quitting smoking completely and a further 17% undertook a temporary quit attempt. Overall, 46% of patients made a commitment towards smoking cessation, while an additional 10% aimed to reduce their smoking. At 28-day follow-up, 22% remained smoke-free. When compared with non-tailored interventions, these results demonstrate strong engagement with smoking harm reduction and behaviour change support, highlighting the value of integrating tobacco dependence treatment into acute mental health inpatient care.

Excess weight and dietary health

Living with excess weight, including obesity, is a key risk factor for CVD, and population data show that rates of obesity amongst people with SMI are 1.8 times higher in England than rates across the population as a whole.[8 23] Higher rates of obesity amongst people with SMI are likely driven by a combination of factors including barriers to consuming a healthy diet, the cardiometabolic side effects of some psychotropic medication, and barriers to engaging in physical activity.

Effectively addressing the increased rates of obesity amongst people with SMI requires a comprehensive, coordinated approach across national, regional and local governments and services. Obesity is a complex condition shaped by multiple drivers including social, economic and environmental factors, and no single solution will ever be sufficient on its own.

Dietary health

International research suggests that people with SMI typically have higher energy and sodium dietary intake than those without.[24] Poor dietary health may be a key driver of higher rates of obesity amongst people living with SMI, as overconsumption of food and drinks high in fat, salt and sugar (HFSS) is known to increase the risk of overweight and obesity.[25] In turn, living with obesity is a key risk factor for the development of CVD including heart attack and stroke, alongside the cardiovascular risk associated with a high sodium intake, through its effect on raising blood pressure.[26]

There are several reasons why people with SMI may have higher consumption of HFSS products. There is some evidence that people living with SMI may experience lower motivation or ability to purchase and prepare nutritious foods which may, at least in some cases, be due to the metabolic side effects of some psychotropic medication.[27 28] Evidence also suggests that people with SMI are more likely to experience food insecurity (when a person is living without reliable access to sufficient affordable, nutritious, or healthy food),[29] a factor known to decrease access to healthy foods, such as fresh fruit and vegetables.[30 31]

One study exploring food insecurity amongst people with SMI living in the North of England found rates of food insecurity to be 50.4%, with variation according to region and severity of SMI.[32] This is significantly higher than the regional averages in the North East and North West of England (23% and 26% of households, respectively).[33]



To help improve access to a healthy diet for people with SMI, policymakers must prioritise effective, evidence-based policies that enhance the accessibility, affordability and appeal of healthier products at the population level. Healthier foods are nearly twice as expensive per calorie as less healthy foods, and this gap is widening. Less healthy foods are also more widely available and more heavily marketed, with 40% of food and non-alcoholic drink promotions devoted to HFSS products. Fast-food outlets make up 1 in 4 places to buy food in England, and this rises to over 1 in 3 in the most deprived areas.[31] Existing policies, such as the Soft Drinks Industry Levy (SDIL) have demonstrated that mandatory incentives can improve the healthiness of the products on supermarket shelves.

The SDIL was associated with an average 47% reduction in the amount of sugar sold in soft drinks between 2018-9 and 2022-3, and £2.2bn raised in revenue.[34] [35] Expansion of the SDIL, or a similar fiscal lever applied to HFSS foods, could have a similar impact on the availability of healthier products.



As part of its 10 Year Health Plan for England (2025), the UK Government committed to launch a moonshot to end obesity.[36] This includes implementing restrictions on junk food advertising and strengthening the SDIL, as well as a commitment to introduce mandatory healthy food sales reporting and targets for all large food companies. A comprehensive approach such as this could reap significant benefits for improving the accessibility and affordability of healthier food and drinks across the population, including for people living with SMI.

It is important to note, that the conditions which are often associated with less healthy food environments often coincide with other drivers of SMI, including deprivation. More research is needed to explore how targeted action can provide specialised support for people with SMI to help them access a healthy diet.

40%
of food and non-alcoholic drink promotions are devoted to HFSS products



Case study

One pilot led by Teesside University, and Tees, Esk and Wear Valleys NHS Foundation Trust, co-designed a novel solution to improving access to healthy foods with three individuals with lived experience of SMI and socioeconomic disadvantage living in the North East of England. The pilot achieved small reductions in participants' food insecurity levels through co-developing healthy ready meals which were distributed to local community larders.[37] Co-produced initiatives such as this may help to address both the accessibility and affordability of healthier foods for people with SMI at a local level, if implemented alongside broader, population-level measures.

Weight management services in the NHS

Ensuring consistent and effective delivery of weight management services is a key opportunity to support the cardiovascular health of people living with SMI. NHS guidance states that tailored weight management is an important intervention for people living with SMI, especially following initiation of antipsychotic medication.[5]

In line with this guidance, an evidence review conducted by Equally Well UK concluded that lifestyle interventions, such as exercise and dietary advice, can help reduce levels of excess weight for people living with SMI, but such interventions must be sustained beyond six months and must be delivered by qualified health professionals, such as dietitians.[38]

However, qualitative research conducted by Centre for Mental Health suggests that patients, practitioners and clinical commissioners face several barriers to both engaging with available services and in providing them.

For patients, these barriers include difficulties in remaining motivated during fluctuations in mental health, complexities in the relationship between emotions and food, and a lack of long-term support. For practitioners and commissioners, barriers include competing priorities, which often favour psychiatric care, as well as a lack of clarity around responsibilities for coordinating the physical health care of patients with SMI, possibly reflecting system-level issues with the integration of mental and physical health services.[39]

"I've lost eight stone in the last year…that was partly down to having a new GP who was very on the ball, very focused, very driven, had my back and listened to me, and understood the mental health side, and the correlation between the two [mental and physical health]. And, you know, that is where there's a big gap - where the systems aren't working together."

– Male, 57, living with post-traumatic stress disorder (PTSD), major depressive disorder, and stroke



Case study

The PEGASUS programme, led by East London NHS Foundation Trust and City St George's, University of London, aims to develop a tailored approach to reducing CVD risk amongst people with SMI. The study, which is due for completion in 2028, is co-developing group clinics across four mental health Trusts, with mental health service users and mental and physical health professionals. The clinics offer personalised, goal-oriented exercise and diet advice, alongside monitoring and review of psychiatric medication, and peer support. The programme also has a dedicated workstream working with communities to address health inequalities, particularly those experienced by ethnic minority communities. Though no evaluation is available yet, the programme demonstrates how tailored approaches to weight management support can be co-developed with lived experience experts to improve cardiovascular health outcomes.[40]

Pharmacological interventions

Alongside behavioural support, some pharmacological interventions are showing promise as effective weight management treatments for people living with SMI. Metformin, for example, which is typically prescribed for the management of Type 2 diabetes, has been shown in clinical trials to be effective at reducing weight gain associated with antipsychotic medications.[41] Weight loss medications, such as GLP-1s, can be prescribed by healthcare professionals to support weight loss in eligible people living with obesity. Emerging evidence is showing promise for the use of weight loss medications for patients living with SMI and obesity or pre-diabetes.[42] [43] However, issues in accessing weight loss medications are already well-established, as fewer than half of all ICBs had rolled out GP-led Mounjaro prescribing by January 2026.[44] In addition, analysis of inequalities in access to GLP-1 treatments found people in the most deprived areas of England were accessing 32% fewer GLP-1 prescriptions than those in the least deprived, where rates of SMI are higher.[45] Whilst these medications may show early promise for their use in managing weight amongst people with SMI, further evidence is needed to fully understand the policy implications.

Living with SMI poses an additional challenge to maintaining a healthy weight, as symptoms of mental illness can impact significantly on a person's ability to care for themselves, to engage in healthier behaviours, or to access weight management services. Taken together, the above evidence strongly suggests that a comprehensive approach is needed to improve the delivery of weight management support for people with SMI. Firstly, tailored services, provided over a period of at least six months, are likely to be most beneficial for people living with SMI and excess weight. Addressing system-level barriers to provision of these services such as, a lack of clear responsibility and ownership amongst clinical staff, is also necessary. The UK Government and the NHS in England should support local services to embed tailored weight management services so that these can be delivered as part of a broader package of measures to address increased rates of excess weight amongst people living with SMI.

Physical activity and movement

Ensuring people with SMI have opportunities to participate in regular physical activity and movement is also important for both physical and mental health. Evidence supports the efficacy of physical activity for helping to prevent CVD and supporting good mental health, including for people with SMI.[46] [47] However, research by Centre for Mental Health and Rethink Mental Illness demonstrates that people with SMI face numerous systemic barriers to engaging in regular physical activity. These include financial constraints, accessibility concerns, and inadequate transport links, alongside compounding psychosocial factors including, stigma, anxiety and social isolation.[48]

Centre for Mental Health and Rethink Mental Illness recommend that mental health service providers and sports, leisure and fitness services should work together to address both the practical and psychological barriers to engaging in regular physical activity. In addition, local and combined authorities should seek to remove financial and geographical barriers to participation through, for example, offering concessionary fares on public transport for people with SMI and their carers to travel to sport and leisure facilities.[48]

This research suggests that a combination of regional and targeted interventions, co-designed with lived experience experts, is needed to overcome the systemic and structural barriers to engaging in regular physical activity and movement faced by people living with SMI.

Deprivation

Alongside risk factors such as smoking and obesity, which place individuals with SMI at an increased risk of CVD, structural risk factors exacerbate this risk further. Living in deprivation, for example, is strongly associated with increased rates of SMI, and worse physical health outcomes, including higher prevalence and mortality rates for CVD. [49] [50]

2 times

Premature mortality rates from CVD are twice as high in the most deprived areas in England



The age-standardised prevalence rate for CVD is 61% higher in the most deprived areas in England compared to the least deprived, whilst premature mortality rates associated with CVD are twice as high.[a] [51] [52] Similarly, the prevalence of SMI is over twice as high in the most deprived areas of England, compared to the least deprived.[53]

Broadly, the association between deprivation and worse physical and mental health outcomes is driven by the cumulation of increased exposure to:

- Key risk factors such as smoking, obesity and air pollution, all of which are more prevalent in more deprived areas.
- Inadequate and uneven provision of healthcare services, as increased demand on services in more deprived areas is not always met with increased capacity or funding.
- Wider environmental factors, often referred to as the wider determinants of health, such as access to green spaces, stable employment and safe, affordable housing.[3] [54]

Whilst the above factors may drive rates of CVD and SMI in more deprived areas, living with these conditions may also present a barrier out of poverty, as three-quarters of people with SMI report being economically inactive.[55] Indeed, there is a large body of evidence to show that mental illness is a significant barrier to employment, both in terms of entering into new employment or remaining in current employment.[56] Similarly, analysis by the Institute for Public Policy Research (IPPR) suggests CVD is the leading factor behind people leaving the workforce prematurely due to ill-health.[2]

Tailored training programmes, such as IPS (Individual Placement and Support), have been shown to be effective in supporting people living with SMI to re-enter the workforce. IPS involves intensive one-to-one support, alongside a rapid job search, followed by placement in paid employment.

3 quarters

of people with SMI report being economically inactive.



Employees and employers are also offered time unlimited support to help sustain employment for as long as possible. One evaluation found IPS clients were twice as likely to gain employment (55% compared with 28%) and remained in employment for significantly longer.[57]

The association between deprivation, CVD and SMI is exacerbated for some individuals by intersecting factors such as ethnicity and structural racism. For example, national data shows that estimated prevalence of SMI is highest amongst Black ethnic groups in England (1.95%), and is more than double prevalence estimates for Asian (0.82%) and Other ethnic groups (0.84%). Amongst White ethnic groups, prevalence estimates sit at 1.19%. Similarly, there is a large body of evidence showing higher rates of cardiovascular risk factors or CVD amongst some ethnic minority groups in the UK, compared to White ethnic groups.[3]

[a] CVDPREVENT analysis of key cardiovascular conditions (not inclusive grouping). Area pertains to quintile for CVD prevalence and decile for CVD mortality rates.

However, healthcare services are not always equipped to respond adequately to the mental and physical health care needs of patients from ethnic minority backgrounds. Qualitative research from the mental health charity Mind suggests patients from ethnic minority backgrounds often experience prejudice when approaching the healthcare system for support with their mental health.[58] These findings are supported by insights gathered from lived experience experts to inform this report, who highlighted the significant barriers, including language and communication barriers, that patients from ethnic and cultural minority backgrounds face in advocating for their mental and physical health care.[59]

Living with SMI may also intersect with sex and gender based, and regional, inequalities. Analysis by Health Equity North found that rates of SMI amongst women of all ethnic, socioeconomic and age groups are higher in the North West and North East of England, where rates of regional deprivation are also higher. [60] [61]

This analysis also revealed that women living in these regions with a diagnosis of a mental illness were less likely to be receiving treatment for their condition, suggesting that, not only is prevalence higher, but access to care is worse.[60] For CVD, BHF analysis has shown that entrenched regional inequalities in CVD outcomes in England have resulted in rates of premature mortality from CVD that are around 50% higher in the North West of England than in the South East.[3]

We also know that women's access to cardiovascular diagnosis and care is often inadequate and can lead to poorer health outcomes. Research funded by BHF shows that between 2003 and 2013, over 8,200 women's lives were lost to heart attack in England and Wales because they did not receive the same standard of care as men.[62] Women with SMI may face a double disadvantage. They can face sex-specific risk factors, such as menopause, and barriers to care due to clinical bias and lower awareness of cardiovascular risk.

At the same time, they may be at increased risk of developing CVD, as a result of risk factors including side effects of medication, deprivation. and diagnostic overshadowing*. [63]



* Diagnostic overshadowing describes a process by which physical health symptoms are dismissed as a consequence of a person's mental illness, or a side effect of their medication. Diagnostic overshadowing is commonly reported by people living with SMI and is associated with inadequate access to treatment for physical health conditions, worse treatment outcomes, and increased mortality.[64]

Barriers to effective and timely diagnosis and care

Alongside an increased risk of developing CVD, research suggests that people living with SMI are less likely to receive a diagnosis of a cardiovascular condition or receive effective and timely treatment. Research shows that patients with SMI have a 47% lower likelihood of undergoing cardiac interventions, are 15% less likely to have a recent prescription for statins, and up to 66% of patients with SMI have undetected CVD prior to cardiovascular death.[9] [65] To understand why these inequities exist, we must look within the healthcare system and at the barriers which place individuals with SMI at an increased risk of living with undiagnosed CVD or receiving inadequate care post-diagnosis.

The following sections of this report were developed against a backdrop of unprecedented uncertainty across the healthcare system in England, following the planned abolition of NHS England and restructuring of some ICBs. We therefore acknowledge that whilst healthcare services must deliver for all patients, they must also be supported to do this through appropriate resource, guidance and clarification of where responsibility sits.

Continuity of care and disconnected services

Despite the disproportionate prevalence of CVD, and many of its risk factors, amongst people living with SMI, physical and mental health services in the NHS have historically operated independently of one another, addressing physical and mental health conditions in isolation. There is good evidence to show that this operating model works against the best interests of patients with SMI.[66]

A critical review of the barriers faced by patients with SMI in accessing NHS support for their physical health concluded that high staff turnover, a lack of physical health training amongst mental health providers, and inflexible appointment times and settings are key barriers that often prevent patients with SMI from accessing effective, joined-up care for their physical health.[67] In line with these findings, the King's Fund states that whilst examples of effective, integrated care for both mental and physical health exist, these instances are the exception, rather than the rule. Fragmented care that relies upon the patient to act as their own healthcare coordinator is a common experience.[66] In 2016, a progress report for the NHS Five Year Forward View for Mental Health recommended building stronger links between secondary mental health providers and primary care to improve the physical health of people with severe and enduring mental illness, as one of three key strategic priorities.[68] After a decade, these issues persist.

> **"If I have symptoms of bipolar, these seem to take precedence over any physical illness. There is an urgency to treat that and get me into hospital and keep that stabilised, which inevitably means symptoms of physical illness can be missed, and I have missed scans and appointments for physical health issues when I have been hospitalised for bipolar."**
>
> – Carina, 42, living with bipolar disorder and family history of CVD

There are numerous resources to support the integration of physical and mental healthcare services:

- The Lester Tool provides guidance on how healthcare professionals should monitor the cardiometabolic health of adult and adolescent patients with SMI, and what interventions should be taken in the presence of behavioural and clinical risk factors. The universal adoption of this guidance across all NHS psychiatric services in England would provide a first step towards more joined-up care and proactive monitoring of SMI patients' cardiovascular health across primary and secondary care.[69]
- The UCLP-PRIMROSE pathway is an evidence-based primary care pathway designed to support individuals with SMI to improve their cardiovascular health. It brings together data stratification to identify patients with SMI who need priority management for their physical health, alongside structured behavioural support and self-management, and holistic support for wider health and social needs.[70]
- NHS England and Diabetes UK have developed an integrated care model, with recommendations to guide commissioning and provision of mental health care in diabetes pathways, and diabetes care in mental health pathways, which could be applied to other long-term conditions, including CVD.[71]
- The Psychosis Metabolic Risk Calculator (PsyMetRiC) is a digital tool designed for clinicians to predict cardiometabolic risk in young people with early psychosis.[72] The web-based tool, which is registered as a software medical device with the Medicines & Healthcare products Regulatory Agency (MHRA), uses routinely recorded healthcare information to estimate risk. It was designed with lived experience experts to prompt meaningful discussions and encourage shared decision-making between young people with SMI and healthcare professionals about preventative measures, interventions, and behavioural change. Following its release in 2026, PsyMetRiC is now being implemented and evaluated locally across NHS Trusts.

Alongside the structural fragmentation between mental and physical health services, many people with SMI report experiencing stigma when approaching healthcare services for a physical health complaint.[73]

> **"I feel there's a clear element of stigma in both hospital and general practice settings. It starts immediately at the reception desk and then continues throughout the whole experience."**
>
> – Robert, 62, living with bipolar disorder and cardiometabolic risk factors, including hypertension and high cholesterol

Existing models of care

There are a number of existing and emerging models of care, which show promise for bridging many of the divides between mental and physical care highlighted in this chapter.

Liaison psychiatry

One example of existing integrated care practices comes from the sub-speciality of liaison psychiatry, in which psychiatrists provide specialist mental health support and treatment for patients in physical healthcare settings, such as general hospitals.[74] The Royal College of Psychiatrists has collated examples of liaison psychiatry services in the NHS which are shown to enable the delivery of more integrated and patient-centred care.[75] For example, Oxford Integrated Psychological Medicine (OIPM), which is part of Oxford University Hospital NHS Foundation Trust, employs and manages psychologists and psychiatrists directly into the Trust across a wide range of clinical specialties.[76]

It is important to note that liaison psychiatry models are generally restricted to secondary care settings, meaning a broader package of integrated care is needed to ensure all patients with SMI are able to access the care they need right across the cardiovascular pathway. It is



also important to recognise that in addition to liaison psychiatrists, other sub-specialties within psychiatry spend a significant amount of time considering a patient's physical health. For example, smoking cessation may be addressed by addiction psychiatrists. The biopsychosocial model within psychiatry emphasises the importance of considering a patient's past experiences, family, culture, surroundings and work as well as medical features.[77]

To improve the physical health management of people living with SMI in secondary care settings, national government and the NHS in England should ensure liaison psychiatry services are commissioned to provide input into specialist cardiology services. This should include a full evaluation of patient outcomes where such services are in place. Where they are not, local systems should be supported to improve communication, information sharing and person-centred care across mental and physical health services.

Neighbourhood models of care

As part of its 10 Year Health Plan for England, the UK Government made a commitment to expand neighbourhood-based mental health services through the rollout of 24/7 neighbourhood mental health centres. These centres are equipped to support people living with SMI and could represent an important opportunity to improve links between mental health services, primary care, and social and community services. Though this model is still being piloted, these centres may provide a vehicle for delivering more integrated physical health support for people living with SMI, such as Annual Health Checks, cardiovascular risk assessment and cardiac rehabilitation, smoking cessation and weight management support, as well as ongoing follow-up.[78] However, it is important these services are built into centre protocols, to ensure staff have clear responsibilities to monitor and follow-up on physical health checks.

NHS Annual Health Check

The NHS Annual Health Check (AHC) for people with SMI is available to all patients aged 18 and over with diagnosed schizophrenia, bipolar disorder or psychosis.[79] This check provides an important point of contact for those who may be living with undiagnosed risk factors for CVD such as hypertension, which is associated with around half of all heart attacks and strokes.

AHCs are typically delivered at GP surgeries, which can create barriers for patients who may not wish to, or are unable to, visit their GP surgery.

To help address this, the NHS RightCare Toolkit, developed with BHF, recommends health commissioners ensure AHCs are also offered through community pharmacies, medication clinics and other routine appointments, to expand patients' access to this important service.[80]

Since 2004, primary care services in England have been financially incentivised to review and monitor the physical health of their patients with SMI through the Quality Outcomes Framework (QOF).[81] However, NHS England's 2025/6 GP Contract retired the QOF indicator linked to delivery of the full AHC (MH021), as well as the indicator which incentivised practices to maintain a register of patients with SMI (MH001).[82] Whilst some QOF indicators for measures within the full AHC have been retained,[83] [84] the retirement of MH021 and MH001 holds significance for SMI patients' cardiovascular outcomes.



[b] This process of removing patients from AHC registers, known as exception reporting or personal care adjustments, is deemed necessary and, in some cases, may reflect personal choice to opt-out of screening. However, there is also concern that patients who face barriers to accessing services are not accounted for in AHC completion rates and research suggests some groups including, men, patients from Asian or Black ethnic backgrounds, and younger patients, are more likely to be exception reported.

Evidence shows that removal of QOF indicators can lead to subsequent declines in uptake of physical health checks, as well as reductions in the quality of relevant service delivery.[85] [86]

This is a concern, particularly as uptake for the AHC when these indicators were still in place was only moderate. In 2022/23 it was estimated that just under two-thirds of eligible patients received the full AHC. Even then, this figure may mask patients removed from GP practices' AHC registers due to ineligibility or repeated non-attendance.[87] [b]



Alongside concerns relating to consistent delivery of the AHC, there is limited data on what happens after an AHC. Reviews of the wider NHS Health Check, which is available to all adults aged 40-74 in England without a pre-existing health condition, points to patchy and inadequate provision of follow-up support. One study concluded that funding and capacity constraints mean services are often under pressure to deliver as many health checks as possible, which has a knock-on effect on the resources left to deliver ongoing support. These pressures may be compounded by reduced funding to local public health services, limited staff training in delivering behaviour change interventions, and confusion over who is responsible for delivering follow-up care.[88] Consistent provision of the AHC is an important lever for improving the management of CVD risk and outcomes amongst people with SMI.

However, the NHS in England must incentivise local practices to go beyond simply delivering the check to all patients with SMI, and incorporate scalable targets for the consistent, long-term management of their cardiovascular health. Such targets should be developed in consultation with ICBs to understand how local primary and community practices can be supported to deliver these services effectively.

Case study

North West London ICS and Hillingdon Mind have developed an innovative approach to increasing engagement with the AHC. Since 2021, outreach funding from the ICS has been used to commission Hillingdon Mind to run a support service for eligible patients who have not responded to an invitation to attend their AHC.

GP surgeries in Hillingdon can refer those patients to the charity, who then follow-up with a letter and resources explaining what the AHC involves and the support that Hillingdon Mind can provide. Mind staff offer to book the appointment on the patient's behalf, liaise with primary care providers, and attend the appointment with the patient.

The programme has gained a number of important learnings in how to design services to better meet the needs of people living with SMI. For example, patients reportedly favour longer, afternoon appointments, which reduce the need for patients to return for a follow-up. Hillingdon Mind staff also encourage patients to complete a Wellbeing Action Plan, to help set realistic goals for general health and wellbeing.

In 2022-3, 65% of patients who had engaged with Hillingdon Mind went on to attend their AHC, demonstrating the value of this intervention. [89] [90]



Policy recommendations



The evidence presented in this report makes a clear case for change in how cardiovascular health is prioritised for people living with SMI. Policymakers and healthcare leaders must prioritise the following actions to improve the prevention, diagnosis and treatment of CVD amongst patients living with SMI, with particular attention paid to those who experience multiple forms of disadvantage including, people living with SMI from ethnic minority backgrounds, and those living in areas of high deprivation.

These actions should feed directly into the design and implementation of Government's Modern Service Framework for SMI, and the forthcoming Mental Health Strategy for England.

1. **The UK Government should set a ten-year target to reduce smoking prevalence amongst people with SMI in England.**
This should be published alongside a roadmap setting out how this target will be achieved, including a commitment to fund evidence-backed smoking cessation interventions to achieve year-on-year reductions in prevalence.

2. **The UK Government must implement a comprehensive approach to increasing the accessibility, affordability and appeal of healthier food and drink products.**
This must be done at the population level, as well as co-developing tailored approaches with people living with SMI to improve their access to a healthy diet.

3. **Commissioners of weight management services must ensure consistent and accessible provision of effective weight management support for people with SMI.**
This should be holistic and person-centred and include measures to address the specific barriers to engaging in regular movement and physical activity faced by people with SMI.

4. **The Department of Health and Social Care and the NHS in England must incentivise healthcare systems to improve the monitoring, quality of delivery, and follow-up of the Annual Health Check (AHC) for people with SMI.**
This may be achieved through the reinstatement of relevant QOF indicators, and should include a scalable target for healthcare systems to deliver the AHC and proactively follow-up with patients regarding subsequent treatment and support, with the expectation these activities increase over time. Consultation with ICBs should be undertaken to better understand how local services can be better supported to deliver these checks.

“This report makes a clear case for change in how cardiovascular health is prioritised for people living with SMI.”

5 **ICSs should be supported to commission liaison psychiatrists to provide input into specialist cardiology services to improve the physical health management of people with SMI in secondary care settings.**
This should begin with a full evaluation of patient outcomes where such services are in place. Beyond secondary care settings, all local NHS systems should be supported to improve communication, information sharing and person-centred care across mental and physical health services.

6 **All NHS psychiatric and primary care services in England should be adequately trained and supported to adopt the Lester Tool as a minimum standard to monitor and improve the physical health outcomes of people living with SMI.**
This should support monitoring of physical health outcomes at regular intervals throughout the year, and must include services for adolescents using the 2025 Lester Tool update.



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References

1 British Heart Foundation. England Cardiovascular Disease Factsheet. 2026.
2 Institute for Public Policy Research. Revealed: Heart disease is the single largest factor behind people leaving the workforce due to ill health [Press release]. 2024.
3 British Heart Foundation. Bridging Hearts: Addressing inequalities in cardiovascular health and care. 2025.
4 Department for Health & Social Care. Public health profiles: Adult mental health and wellbeing data for England. 2026.
5 NHS England. Improving the physical health of people living with severe mental illness: Guidance for integrated care systems. 2025.
6 Clark A et al. Severe mental illness in the UK: Public perceptions and healthcare priorities. The Policy Institute, King's College London. 2025.
7 Department of Health & Social Care. Fingertips: Public health profiles - Adult mental health and wellbeing. [Accessed 17 July 2026].
8 BHF. UK Cardiovascular disease factsheet. 2025.
9 Polcwiartek C et al. Severe mental illness: cardiovascular risk assessment and management. European Heart Journal, 2024;45(12): 987–997.
10 Bratten K et al. Mental health and heart disease: A review of behavioural and structural risk factors [unpublished]. BHF. 2024.
11 British Heart Foundation. Symptoms of depression linked to increased risk of heart disease and stroke [Press release]. 2020.
12 Das-Munshi J. Expert Report for the UK Covid-19 Public Inquiry Module 10 - Impact on Society: Impacts on people living with severe mental health conditions. 2025.
13 NHS. Overweight and obesity in adults. 2026.
14 Action on Smoking & Health. Smoking and Mental Health. 2019.
15 Office for National Statistics. Smoking habits in the UK and its constituent countries. 2025.
16 Stolz PA et al. Effects of Cigarette Smoking and Clozapine Treatment on 20-Year All-Cause & Cardiovascular Mortality in Schizophrenia. Psychiatric Quarterly, 2019;90: 351-359.
17 Gilbody S, Pekham E, Bailey D, Arundel C, Heron P & Crosland S. Smoking cessation for people with severe mental illness (SCIMITAR+): a pragmatic randomised controlled trial. The Lancet Psychiatry, 2019;6(5): 379-390.
18 NHS England. Tobacco dependency programme. 2019.
19 Department of Health & Social Care. Cardiovascular disease (CVD) modern service framework (MSF): a cardiovascular-kidney-metabolic approach. 2026.
20 Phillips W, Dawney J, Spitters S, & Newbould J. Tobacco dependency treatment services for people with severe mental illness: A mixed methods rapid evaluation. NIHR Open Research,2025;5(99):1-26.
21 Action on Smoking and Health. Findings from a survey of smokefree policies and tobacco dependence treatment services in NHS mental health trusts in England, 2024. 2025.
22 National Collaborating Centre for Mental Health. Tobacco dependency community-based services for people with severe mental illness: An evaluation of NHS early implementer sites. London: National Collaborating Centre for Mental Health. 2024.
23 Public Health England. Severe mental illness (SMI) and physical health inequalities: briefing. 2018.
24 Teasdale SB et al. Dietary intake of people with severe mental illness: systematic review and meta-analysis. BJPsych, 2019;214(5): 251-259.
25 Dimbleby H. National Food Strategy – The Plan. 2021.
26 British Heart Foundation. High blood pressure - causes and symptoms. 2023.
27 Van Der Pols JC. Nutrition and mental health: Bidirectional associations and multidimensional measures. Public Health Nutrition, 2018;21(5), 829–830.
28 Holmes K, Heaney S, Smith A, Skinner J & Burrows T. Dietary E□Health Interventions for Adults with Severe Mental Illness: A Systematic Review. J Hum Nutr Diet, 2025;38(4): e70112.
29 British Red Cross. Food insecurity: how food shortages can cause a humanitarian crisis. 2026.
30 Smith J et al. Food insecurity in adults with severe mental illness living in Northern England: A co-produced cross-sectional study. Nutrition & Dietetics, 2024;81(4): 411-424.
31 The Food Foundation. The Broken Plate 2026. 2026.
32 Smith J et al. Food insecurity in adults with severe mental illness living in Northern England: A co-produced cross-sectional study. Nutrition & Dietetics, 2024;81(4): 411-424.
33 Trussell. Hunger in the UK. 2025.
34 Office for Health Improvement & Disparities. Sugar reduction in drinks: 2015 to 2024. 2025.
35 HM Revenue & Customs. Soft Drinks Industry Levy statistics commentary 2026. 2026.
36 Department of Health and Social Care. 10 Year Health Plan for England: fit for the future. 2025.
37 Smith J, Dunne J, & Lake A. Increasing accessibility of affordable healthy food to adults living with Severe Mental Illness in Middlesbrough: Programme Development Grant (PDG) public partnerships learning review case study. 2026.
38 Equally Well UK. Healthy Weight Management in People with a Severe Mental Illness: a review of the literature to identify effective weight management interventions. 2020.
39 Wilton J. More than a number: Experiences of weight management among people with severe mental illness. VCSE health & wellbeing alliance, 2020.
40 City St George's. The PEGASUS Project. [Accessed 18 August 2026].
41 de Silva VA, Suraweera C, Ratnatunga SS, Dayabandara M, Wanniarachchi N & Hanwella R. Metformin in prevention and treatment of antipsychotic induced weight gain: a systematic review and meta-analysis. BMC Psychiatry, 2016;16(341):1-10.
42 Zierhut M., Weiser, M., Thanarajah SE. & Opel N. GLP-1 Receptor Agonists for Pharmacologically Induced Weight Gain. JAMA Psychiatry, 2025;82(11):1063-1064.
43 Breit S. & Hubl D. The effect of GLP-1RAs on mental health and psychotropics-induced metabolic disorders: A systematic review. Psychoneuroendocrinology, 2025;176:107415.
44 Healthwatch. People struggle to access weight loss drugs on the NHS. 2026.
45 The Health Foundation. New data reveal inequalities in access to private GLP-1 weight loss drugs as demand surges. 2026.
46 British Heart Foundation. Staying active. 2025.

47 Dauwan M, Begemann MJH, Heringa SM, & Sommer IE. Exercise Improves Clinical Symptoms, Quality of Life, Global Functioning, and Depression in Schizophrenia: A Systematic Review and Meta-analysis. Schizophrenia Bulletin, 2015;42(3): 588-599.
48 Doyle J, McHayle Z, Yau K, Bell A, & Woodhead D. Exercising our rights: Improving access to physical activity for people living with severe mental illness. Centre for Mental Health & Rethink Mental Illness. 2025.
49 Centre for Mental Health. Poverty, economic inequality and mental health. 2022.
50 King's College London. Social and economic deprivation associated with more severe symptoms of PTSD [Press release]. 2025.
51 BHF Analysis. CVDPREVENT 2025 outcomes data. 2026.
52 British Heart Foundation. Cardiovascular inequalities in England: an analysis. 2025.
53 Office for Health Improvement & Disparities. Estimated prevalence of severe mental illness in England: report. 2026.
54 Health Equals. Building blocks of health. [Accessed 3 July 2026].
55 Cybulski L et al. Health, Disability, and Economic Inactivity Following a Diagnosis of a Severe Mental Illness: Cohort Study of Electronic Health Records Linked at the Individual-Level, to Census from England. Schizophrenia Bulletin, 2025;51(5):1367-1379.
56 Illingworth J et al. Working well: Improving mental health in the workplace. Imperial College London. 2025.
57 Centre for Mental Health. What is IPS?. [Accessed 30 July 2026].
58 2CV. Mind: Fighting for the MH of people living in poverty. 2021.
59 British Heart Foundation and Equally Well UK. Analysis of qualitative insights with lived experience experts [unpublished]. 2026.
60 Health Equity North. Woman of the North: Inequality, health and work. 2024.
61 Ministry of Housing, Communities & Local Government. English indices of deprivation 2025: statistical release. 2025.
62 Wilkinson C, Bebb O, Dondo TB, Munyombwe T, Cadadei B, Clarke S et al. Sex differences in quality indicator attainment for myocardial infarction: a nationwide cohort study. Heart, 2019;105(7): 516-523.
63 Royal College Psychiatrists. Menopause and mental health: Implications for clinical practice, services and policy. 2026.
64 Equally Well UK. Physical health checks for people living with severe mental illness. 2021.
65 Hippisley-Cox J et al. Inequalities in the primary care of patients with coronary heart disease and serious mental health problems: a cross-sectional study. Heart, 2007;93:1256-1262.
66 The King's Fund. Bringing together physical and mental health A new frontier for integrated care. 2016.
67 Sheridan E et al. Breaking Barriers Transforming Primary Care to Serve the Physical Health Needs of Individuals With SMI in the NHS. International Journal of Mental Health Nursing, 2024;34(1): e13480.
68 NHS. Five year forward view mental health: One year on. 2016.
69 Royal College of Psychiatrists. Lester UK Adaptation: Positive Cardiometabolic Health Resource. 2025.
70 Shaw P, Khurshid Z, Lamb D, Stevenson FA, Russell G, Hudson K. et al. Bridging the gap in the UK's National Health Service integrated care systems: insights from a mixed methods implementation evaluation of UCLP-PRIMROSE, a care innovation to reduce physical health inequalities for people with severe mental illness. BMJ Open,2026;16:e105511:1-13.
71 Sachar A et al. An integrated care model for mental health in diabetes: Recommendations for local implementation by the Diabetes and Mental Health Expert Working Group in England. Diabet Med., 2023;40(4): e15029.
72 Perry BI, Osimo EF, Si S, Hitchins KVB, Lewis C & Laws B et al. Cardiometabolic prediction models for young people with psychosis spectrum disorders in the UK (PsyMetRiC 2.0): a retrospective, multicohort clinical prediction model study. The Lancet Psychiatry, 2026;13(4): 291-303.
73 Oswald TK, Papoulias S, Williams, J & Das-Munshi J. 'It Is Like a Cross□Stitch … All Joined Together But Not Making a Very Nice Pattern': A Qualitative Study of Patient Perspectives on Physical Health Inequalities in Severe Mental Illness. Health Expectations, 2025;28(4):1-11.
74 Royal College of Psychiatrists. Liaison psychiatrist. 2026.
75 Royal College of Psychiatrists. The role of liaison psychiatry in integrated physical and mental healthcare. 2019.
76 NHS Oxford University Hospitals NHS Foundation Trust. Psychological Medicine. 2024.
77 The Royal College of Psychiatrists. The Competence Framework for Physician Associates in Mental Health. [Accessed 28 August 2026].
78 The NHS Alliance. Delivering the left shift: the 24/7 neighbourhood mental health pilot sites. 2026.
79 NHS. Annual health check for people with severe mental health conditions. 2025.
80 Public Health England & NHS RightCare. NHS RightCare Toolkit: Physical ill-health and CVD prevention in people with severe mental illness (SMI). 2019.
81 Launders N., Jackson CA., Fayes, JF., John A., Stewart, R., Iveson MH., et al. Prevalence and patient characteristics associated with cardiovascular disease risk factor screening in UK primary care for people with severe mental illness: an electronic healthcare record study. BMJ Ment Health, 2025;28:1-8.
82 NHS England. Changes to the GP Contract in 2025/26. 2025.
83 NHS England. NHS Oversight Framework 2026/27. 2026.
84 NHS England. Quality and Outcomes Framework guidance for 2026/27. 2026.
85 Matias MA., Jacobs R., Aragón MJ., Fernandes L., Gutacker N., Siddiqi N. et al. Assessing the uptake of incentivised physical health checks for people with serious mental illness: a cohort study in primary care. Br J Gen Pract, 2024;74(744): e449-e455.
86 Morales DR et al. Estimated impact from the withdrawal of primary care financial incentives on selected indicators of quality of care in Scotland: controlled interrupted time series analysis. BMJ, 2023;380: e072098:
87 Lynch H et al. What works – Health checks for patients with severe mental illness. Health Equity Evidence Centre. 2024.
88 Duddy C, Gadsby E, Hibberd V, Krska J & Wong G. What happens after an NHS Health Check? A survey and realist review. Health Soc Care Deliv Res, 2023;11(12):1-133.
89 Hutchinson J. Reaching out: Improving the physical health of people with severe mental illness. Equally Well & Centre for Mental Health. 2024.
90 NHS England. VCSE outreach supporting person-centred SMI physical health checks. 2024.



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