MANCHESTER CITY COUNCIL

Manchester Mental Health and Social Care Trust
A University Teaching Trust

# Improving Physical Health for people with severe mental illness

**Effectiveness Day : Focus on Schizophrenia**

Mike Edmondson
Astrid Born

10th October 2014

Proud to be a partner in
Manchester Academic Health Science Centre

MANCHESTER 1824
The University of Manchester

NHS National Institute for Health Research

*Where People Matter Most*

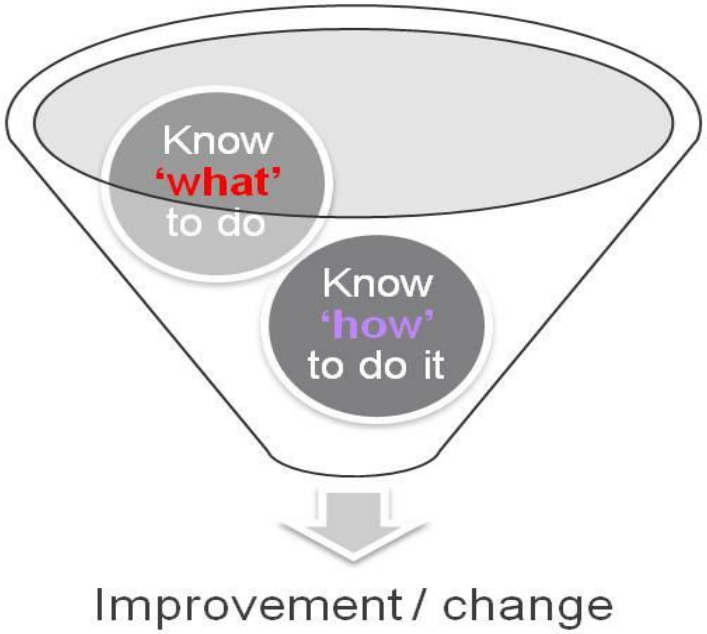
# What is the project about?

- Improving Physical Health for people with SMI is a joint project between our Trust, Manchester Academic Health Science Centre and the National Institute for Health Research for Greater Manchester which intended to integrate care pathways to support mental and physical well being.
- **GM CLAHRC** is the Collaboration for Leadership in Applied Health Research and Care for Greater Manchester

# CLAHRC: The know 'What' and know 'How'…

Integrated approach

Innovating Through Research




Putting evidence into practice and learning from this

**Bridging the Gap between Research and Clinical Practice**

## The facts (Schizophrenia Commission 2012)

Prevalence of diabetes is 2-3 times higher for people with schizophrenia

61 % of people with schizophrenia smoke, compared to 33% of the general population

People with SMI are twice as likely to die from heart disease than the general population

People with schizophrenia who develop cancer are 3 times more likely to die than those in the general population.

***The Commission believes that the neglect of people's physical health cannot be allowed to continue***

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NHS

# The GOLD standard for MMHSCT

**To develop and implement a sustainable co-ordinated service user pathway that supports prevention and the early diagnosis, treatment and management of physical health problems as part of the overall treatment and care of people with SMI**

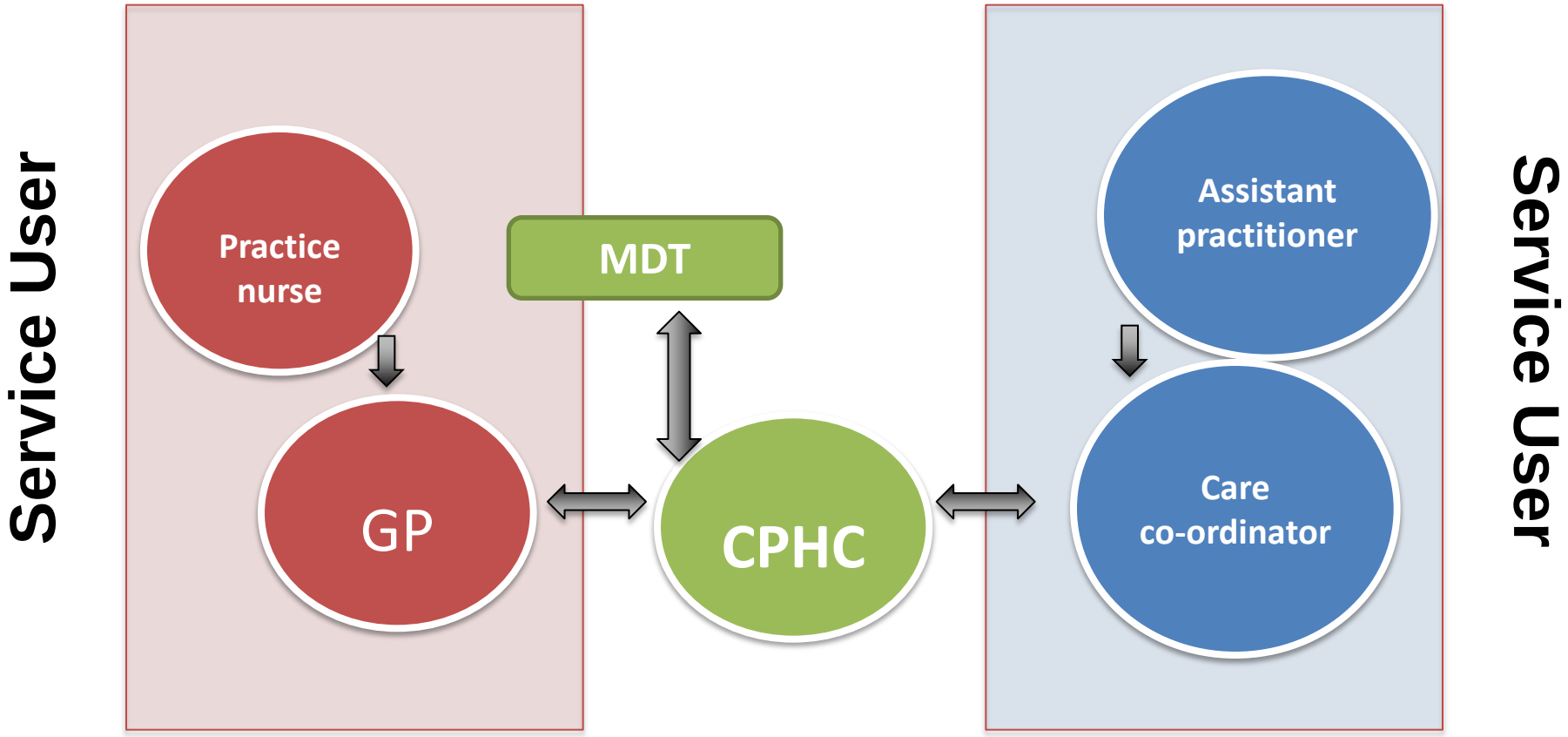
## Joint approach

Needs to be a **joint** approach to improving physical health, involving community mental health teams **and** GPs

## Shared responsibility

Needs to be an integrated physical health assessment and plan with **shared** responsibility for action/management

# Intervention Structure



## Project Timeline & Structure

### Pilot

**North West CMHT** June 2012 – March 2013

### Implementation

**North East CMHT & North West CMHT** June 2013- December 2013

### Spread & Sustainability

**All 6 CMHT in Manchester** December 2013 – Now

# Background information to the project - Pilot


Anya Telford Liz King
(Care Co-ordinators)

5 GP surgeries involved varying in size culture and mental health knowledge

**North West Community Mental Health Team**
**Around 500 service users**
**Approx 25-30 staff (mixed professions)**
**2 secondees (2 x 0.4 WTE)**


Project ran from June 2012 – March 2013

# Background information to the project – Spread & Sustain

Janine Jacobs
(Care Co-ordinator)

2 GP surgeries were involved initially, now increased to 5

**North East Community Mental Health Team**
**Around 400 service users**
**Approx 28 staff (mixed professions)**
**1 secondee (1 x 0.4 WTE)**


Project ran from June 2013 – December 2013

# Where we are now – Spread

**North West CMHT**
Sharon Hill
Mags Mays

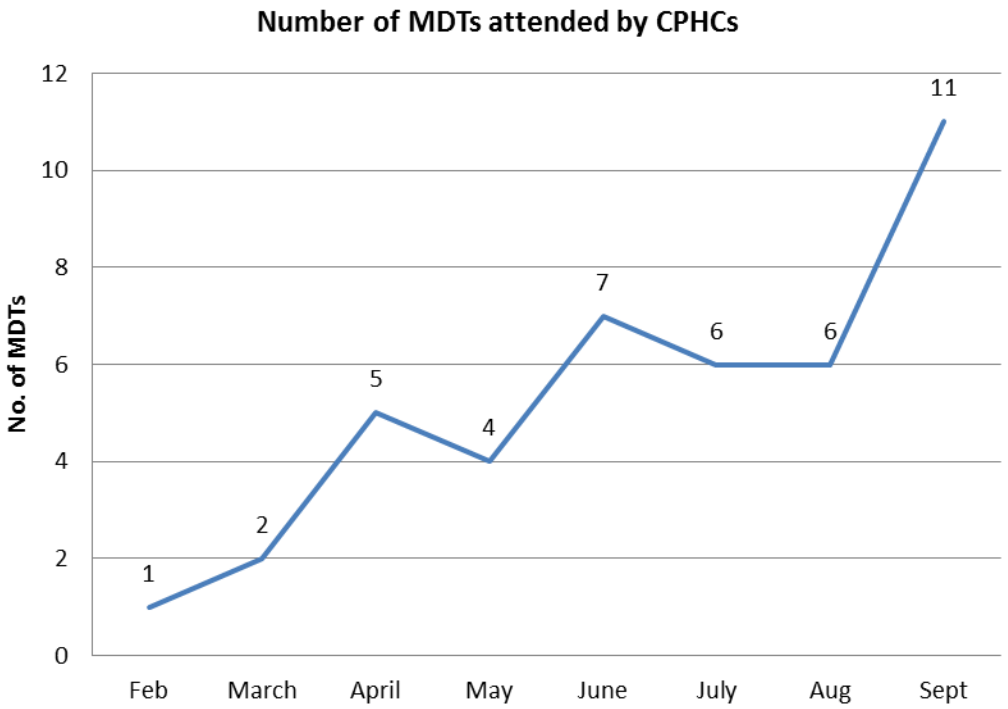
**Central East CMHT**
Natalie Figgins
Michael Bourne

**North East CMHT**
Janine Jacobs

**South Mersey CMHT**
Anya Telford

**Central West CMHT**
Gayle Burch
Claire Colley
Maria Houlihan

**North Mersey CMHT**
Jennifer Wilkin-Rowe
Sue Timmons




December 2013 – Now

# Outcome – Qualitative interviews with GPs & practice nurses

*"I think the GPs understand who people are and I think they understand the roles of people better. I think there was almost a light bulb switched on in one meeting when they realised the breadth of the CMHT, and also the individuals who look after it."*

***Practice Manager***

*"This sharing of information is enabling the surgery and the NW CMHT to work in a much more co-ordinated way."*

**GP**

*Yes, I do think care is more co-ordinated, just through attending the meetings, we're now aware what patients are being seen, what care is being given to those patients, and we're more aware of those patients ourselves."*

***Practice Manager***

# Outcome – Service user case study (CMHT view)

*I [Care Co-ordinator] have liaised with the CPHC, who in turn has liaised with staff at the GP Practice which has allowed me to better co-ordinate Neeha's* care in relation to her physical health. The CPHC sent regular emails asking whether I had concerns I wanted to raise at the regular MDT. She subsequently provided feedback and action points via follow-up email and face-to-face conversation. If I had any queries Anya was able to liaise with the GP/nurse on my behalf which was helpful and saved time.*

*Overall the CPHC's support allowed me to increase my awareness of physical health needs and I feel I was able to provide better support as a result. Specifically I have been able to monitor Neeha's appointments with the practice nurse, and support her to attend because GP staff highlighted her historical poor attendance. This allowed the practice nurse to carry out several tests including blood tests, BMI etc and Neeha's diabetic medication has been changed as a result.*

*Neeha has also been referred to the dietician as a result of these appointments as it was noted that her weight had increased over the past year.*

*It became apparent that even with support to attend GP appointments, Neeha lacks understanding of her physical health needs and their possible implications. She continued to miss appointments unless I supported her to attend which was not always possible. The CPHC co-ordinated a referral to the Supporting Health nurses who offer further support at home.*

**** Names have been changed to protect confidentiality***

# Outcome – Service user case studies

*It was identified that this service user had a lump in his testicle. He made an appointment at his GP surgery, but realised it was with a female Dr and subsequently cancelled the appointment. The Care Co-ordinator was aware that the appointment had been made, but they were unaware that the service user had cancelled the appointment, as he was too embarrassed. The whole thing was mortifying for him.*

*It was highlighted by the practice in the MDT meeting that the appointment had been cancelled. The Care Co-ordinator liaised and encouraged the service user to make a further appointment with a male Dr. This combined effort ensured that the service user attended the re-arranged appointment.*

*This service user had abnormal blood results showing from recent admissions to psychiatric ward that hadn't been reported to the GP.*

*Through the process of the CPHC reading their notes for an MDT meeting this was picked up, the bloods were re-tested and they were found to have a problem.*

*They've now been referred to the specialist kidney service. .. that wouldn't have happened, without the CPHC role.*

*Previously the Care Co-ordinator and GP were unaware of the problem.*

# Positives and Challenges

## Positives

"CPHC have made a big difference to the Practice" (GP)

"She provides information that she has access to that I may not have obtained myself" (Care Co-ordinator)

"Last year, I think it was 9 service users who has diabetes and didn't know they had it" (Assistant Practitioner)

"Having a named contact from the CMHT who works closely with the Practices improves relationship"(Nurse Practitioner)

## Challenges

" It can be challenging to manage and organise time effectively along everything else that is going on"

"Prioritising this work can be a real challenge along case loads"

"Communication/ interaction with GPs can be challenging due to existing misconceptions and misunderstandings about mental health services"

***CPHCs***

# What next?

**Continue to recruit practices to participate in the programme**

**Organise expert meetings to educate CPHCs further in specific topics/disease**

**Evaluate the implementation phase and initiate the spread and sustainability phase**

**Publish a monthly CHPC newsletter to keep everybody informed of progress and relevant national and local initiatives**