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NHS
National Institute for Health Research
Collaboration for Leadership in Applied Health Research and Care (CLAHRC) Greater Manchester

IMPROVING THE PHYSICAL HEALTH CARE OF PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS

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National Primary Care ACF Conference, Oxford
4th April 2014

The **CLAHRC Greater Manchester** is part of the National Institute for Health Research and is a partnership between providers and commissioners from the NHS, industry, the third sector and the University of Manchester **W:** clahrc-gm.nihr.ac.uk **E:** clahrc@srft.nhs.uk **T:** @CLAHRC_GM

Background

- Severe mental illness (SMI)
  - *Schizophrenia*
  - *Bipolar affective disorder*
  - *Other psychotic disorders*

  - PREVALENCE = 8.44/1,000 patients (QOF 2012/13)
  - Average practice = <u>55 patients</u>

Background

- 4x increased risk of premature death (<50)
  - Excess CVD, DM, respiratory conditions, osteoporosis…
- Prevalent risk factors:
  - Diet
  - Smoking
  - Exercise
  - Compliance
  - Psychotropic medication
  - Problems accessing care
  - Exception reporting?...

….a perfect storm

Background

	MALE		FEMALE	
	Life expectancy	**Average difference**	**Life expectancy**	**Average difference**
Schizophrenia	62.8	-14.6	71.9	-9.8
Schizoaffective disorder	69.4	-8.0	64.1	-17.5
Bipolar	67.3	-10.1	70.4	-11.2
COMBINED SMI	**64.5**	**-12.9**	**69.9**	**-11.8**
UK average	**77.4**		**81.6**	

"…one of the biggest health scandals of our time, yet it is very rarely talked about."

Professor Sue Bailey
President of the Royal College of Psychiatrists

Intervention: CLAHRC

- Collaborative Leadership in Applied Health Research and Care (**CLAHRC**), Greater Manchester
  - NIHR-funded
  - 5 year collaborations between research users and producers
  - SMI health identified as priority and **collaborative care** intervention designed
  - North West CMHT chosen as test site

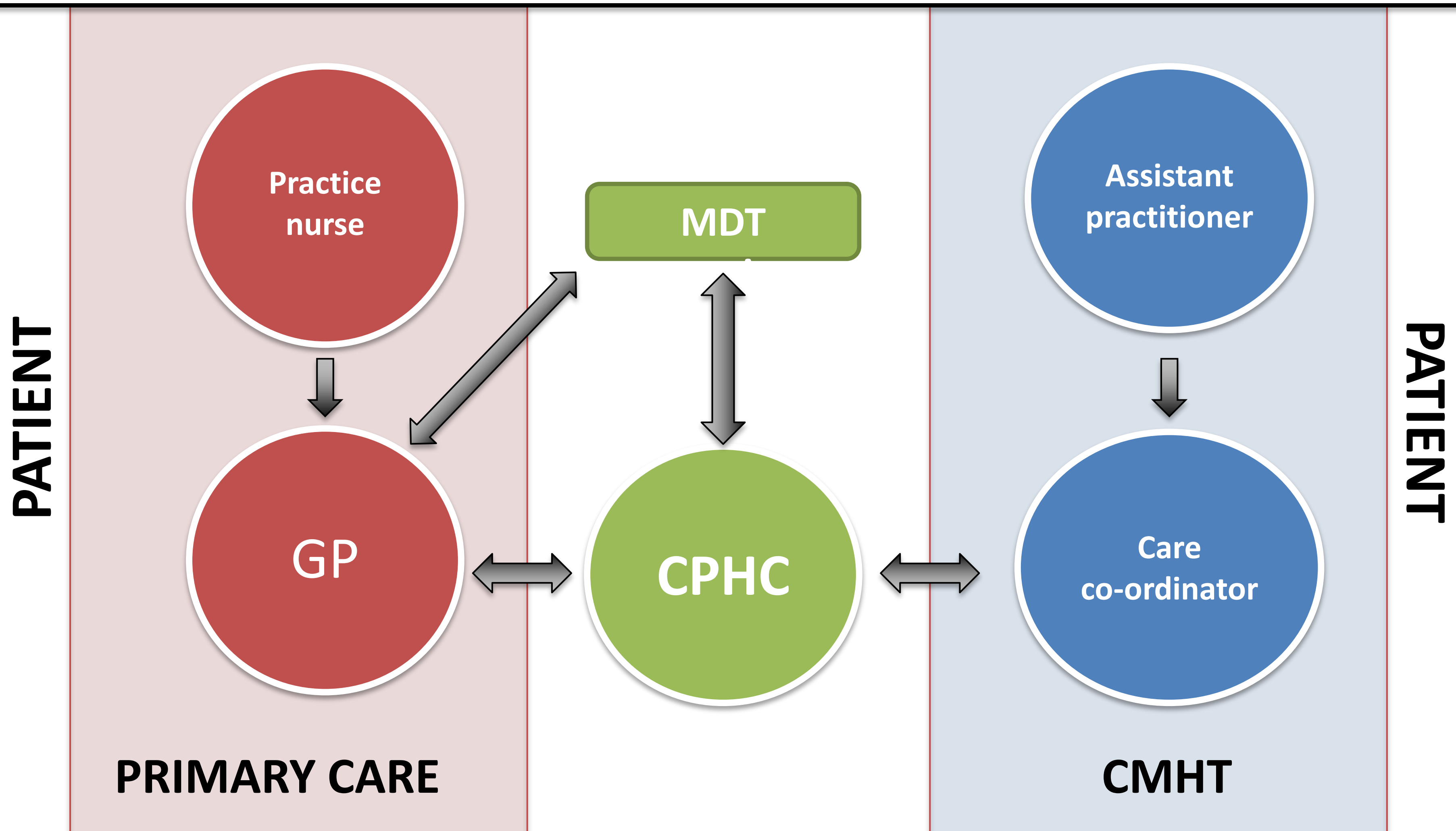
CLAHRC Greater Manchester work 2008-2013

- Blood pressure self monitoring
- Chronic kidney disease care
- GM-ELIAT and GM-ELIRT long-term conditions tools
- GM-HFIT Greater Manchester Heart Failure Investigation Tool
- GM-SAT Greater Manchester Stroke Assessment Tool
- Heart failure alert card
- Heart failure website
- Impaired glucose tolerance care call (diabetes prevention)
- Impaired glucose tolerance health trainer (diabetes prevention)
- Severe mental illness and physical health
- Research theme: Health information systems
- Research theme: Healthcare practitioners
- Research theme: People with long-term conditions

Complex intervention

COMPONENTS	DETAIL
COMMUNITY PHYSICAL HEALTH CO-ORDINATOR (CPHC)	• 'Hub' of information sharing between CMHT / GP • 2 seconded MMHSCT staff x0.4 WTE
MDT MEETING	• Bimonthly / monthly meetings at GP practice • 5-10 clients discussed
COMMUNITY PHYSICAL HEALTH ASSESSMENT (CPHA)	• 'Rethink' tool • Mainly completed by Assistant Practitioners
PHYSICAL HEALTH EDUCATION	• Care co-ordinators received physical health training • Training in lifestyle services

Intervention: structure



Intervention: Rethink tool

Symptoms checklist

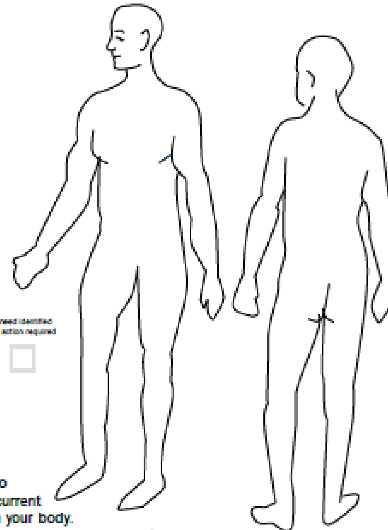
This section is for you to describe any current physical symptoms you are experiencing. Please give as much detail as possible in this section.

2.1 In Table A below, tick any of these symptoms experienced.

	Tick
Increased thirst	
Problems with urination	
Breathlessness	
Weight gain (unexpected)	
Weight loss (unexpected)	
Fits / blackouts	
Constipation	
Difficulties having sex	
Chest pain	

Please give details:

need identified and action required



2.2 On each body figure please use numbers to indicate any areas where you experience current or regular pain, discomfort or difficulties in your body. Please include issues such as skin, dental, ear problems or incontinence.

Place a number in each area of difficulty on the body and then use **Table B** to explain further details about it. For example, '1' placed over the chest area might indicate: **Problem** - chest pain, **Frequency** - when exercising, **Impact** - prevents me from exercising.

Table B
For other symptoms marked on body outline, note frequency and severity in the table below:

need identified and action required

Number	Problem	Frequency	Impact
Example: 1	Chest pain	When exercising	Prevents me from exercising

Screening checks

need identified and action required

This section should be used to highlight areas that may require investigation and alert you to the need for checks that may be overdue.

3.1 Are you registered with a GP? Yes / No

3.2 General health checks

	Date / timing	Any other details: e.g. reason for visit / results of test
When did you last visit your GP or practice nurse?		
When did you last visit your dentist?		
When did you last have your eyes tested?		
When did you last have a blood test?		
When did you last have a screening for bowel cancer? (aged 60+)		
When did you last have a chlamydia screening? (25 and under)		

3.3 Gender specific checks

A: Checks for women

	Date / timing	Any other details
When did you last have a cervical smear test?		
When did you last have a menstrual period?		
How often do you have your period?		
When did you last have a mammogram (for women aged 50+)?		

Do you check your breasts for lumps or other changes? Yes/No
If no, would you like more information on this? Yes/No

B: Checks for men

	Date / timing	Any other details
How often do you examine your testicles?		

Are you aware of the increased risk of prostate problems in men aged 50+? Yes/No
If no, would you like more information on this? Yes/No

3.4 Please record the following information if possible:

Height ________m/cm **Weight** ________kg **Calculate BMI** ________

Waist measurement ________cm **Blood Pressure** ________ **Urinalysis** ________

3.5 Any other issues
Are there any other issues we have not covered that you are concerned about? Yes / No

Methodology

PRE-INTERVENTION	EVALUATION
Exploratory interviews *20 healthcare professionals*	**Semi-structured interviews** *10 GP staff; 2 CPHCs; 1 care co-ordinator; 8 service users*
Semi-structured interviews *19 service users*	**Focus group** *8 NW CMHT staff*
Focus group *11 NW CMHT staff*	**Survey** *13 NW CMHT staff*
Anonymised QRISK2 data	**Anonymised QRISK2 data**
	MDT meeting processes / outcomes

Results: Exploratory phase

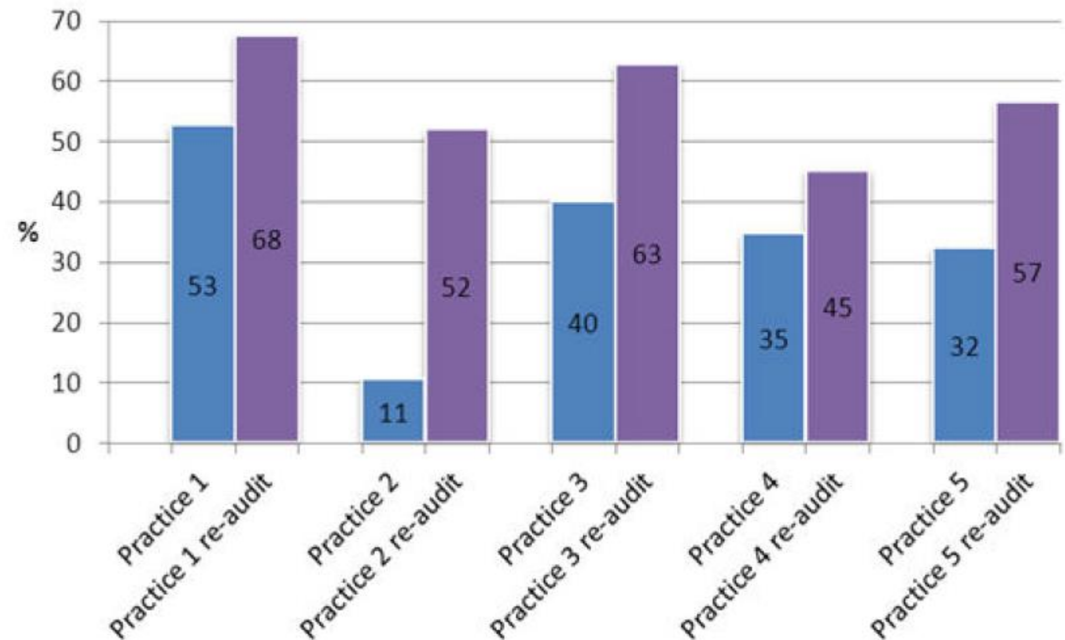
- Integrated care
  - *'It once took me six phone calls and three faxes to get a response from a GP.'* **[Care Co-ordinator, CMHT]**
  - *'I think it's [the relationship with CMHT] quite poor, I think it's [communication with the CMHT] very disjointed. I think it was very fractioned and patient care, as a result, was quite poor.'* **[GP]**
- Access
  - *'I don't think that I get fairly treated by the receptionist at the GP'* **[service user]**
  - *'Seeing you (Care Co-ordinator) and the consultant is different to going to see my GP, because he doesn't seem to understand the way that you understand.'* **[service user]**

Results: QRISK2 data

Missing indicators

INDICATOR	% MISSING (No.)
HDL/ cholesterol	43% (n=79)
Smoking data	23% (n=43)
BMI	23% (n=42)
BP	25% (n=47)
Any indicator	**62% (n=115)**

Missing QRISK2 data, practice level: before/after



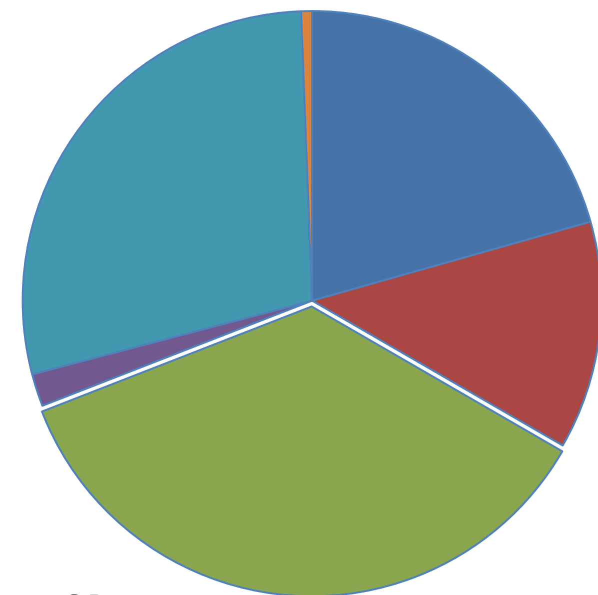
Overall, missing data fell from 62% (n=115) to 42% (n=79)

Results: MDT meetings

- 24 MDT meetings
- 166 actions for 101 service users

Action	Frequency
Disease review	**26% (n=43)**
Primary care physical health assessment	**19% (n=32)**
Lifestyle service referral	**16% (n=27)**
Request information	**15% (n=25)**
Medication review	**10% (n=16)**
Arrange tests/investigations	**4% (n=7)**
Specialist referral	**2% (n=4)**
Other	**7% (n=12)**

Outcome tasks



Results: MDT meetings

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.

Results: Evaluation

- **Integrated care**
  - *"For some Care Co-ordinators who just used to say physical health isn't part of my role, they no longer say that. There's nobody in the team who would say that physical health isn't part of their role at all."* **[CPHC]**
  - *'Yes care is co-ordinated (…) there is now a shared responsibility.'* **GP**
- **Access**
  - *"Yes it has had an impact in that it's brought patients in the door who wouldn't have come in normally."* **[Practice manager]**
- **User perspectives**
  - *"it makes me feel empowered and cared for, because I know there is somebody out there who can help me deal with my problems"*

Outcomes

- Physical health training mandatory for CMHT staff
- SMI priority for CLAHRC-2 (2014 onwards)
- Spread
  - North East Manchester initially
  - Now across MMHSCT (503,000 population)
- Sustainability issues
  - Staff retention
  - Preserving intervention characteristics
- Research or quality improvement?

Acknowledgements

- CLAHRC team
  - Michael Spence
  - Carrianne Hunt
  - Michelle Coleiro
  - Liz King
  - Anya Telford
- Partner organisations
  - MAHSC
  - MMHSCT