Improving the physical health care of people with severe and enduring mental illness

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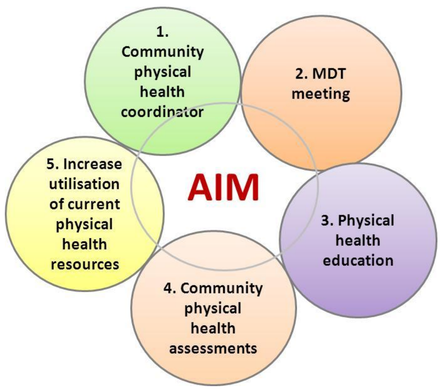
Background & project outline

People with severe and enduring mental illness (SMI) die on average 15-25 years prematurely, with poor physical health being a major precipitating factor. The aim of this project was to develop and test an integrated model of physical health care between a community mental health team (CMHT) in North Manchester and five participating primary care practices. The project lasted from September 2012 to March 2013.

The project was designed from the results of an extensive scoping exercise; involving GP surgeries cardiovascular (CV) risk data, 28 interviews with Manchester Mental Health and Social Care Trust staff, service users (SUs), primary, community and secondary health care professionals and a focus group with 17 CMHT staff. It was evident that physical health inequalities of service users within the Trust were partly caused by a lack of focus of community mental health teams on physical health, and a lack of integration between primary care and community services to provide shared care for people with SMI. As a result the following project aim was agreed: **To develop and implement a sustainable integrated service user pathway that supports prevention and the early diagnosis, treatment and management of physical health problems as part of the overall care of people with SMI.**

Project elements

Five key project elements were developed addressing the gaps highlighted above, (see Graph 1). The main focus of the project was to develop a Community Physical Health Coordinator (CPHC), based within the CMHT. The core focus of this role, which was performed by two seconded care coordinators, was to discuss service users' physical health needs in multi-disciplinary team (MDT) meetings held with GP surgeries. Actions agreed within these meetings, held either monthly or bi-monthly, were then communicated, performed or followed up by the, CPHC, care coordinators or GP surgery staff.



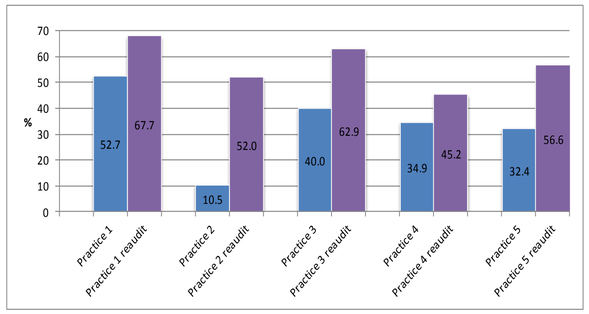
Graph 1: Five project elements

Evaluation outline

A summative evaluation was performed at the end of the project consisting of both qualitative and quantitative elements; process and outcome measures were collected for all MDT meetings held, CV risk data was re-collected, a CMHT staff questionnaire was developed and completed by 13 staff, 18 interviews were held with GP surgery staff, service users and CPHCs, and a focus group held with 8 CMHT staff.

Evaluation outcomes

- 24 MDT meetings were held between September and March, from which 163 actions arose for 101 service users which addressed missing disease reviews (26%), conducting physical health assessments (23%), referrals to lifestyle service (15%), overdue medication reviews/changes (10%), plus others
- As a result, fewer service users had incomplete CV risk data recorded in primary care (Graph 2)
- Qualitative data shows that the CPHC role and the MDT meetings have had a positive impact on integrated care, particularly through the sharing of information, identifying unmet needs, co-ordination of actions, and proactive delivery of care
- Care coordinators also stated that the MDT meetings and CPHC role have improved access to GP surgeries and have had a positive effect on service user care.



Graph 2: % of service users with no missing CV risk data before and after

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

"Also partly as a result of that first meeting at the surgery, we have had a meeting in my flat to discuss my care. I was listened to and help is beginning to be available. My district nurses now turn up daily and on time and my diabetes is getting treated by an expertly trained nurse, which then allows Liz the time to fulfil her role. These people have never looked like coming together before and in truth it make me feel empowered and cared for because I know there is somebody out there who can help me deal with my problems." (Service user)

"Liaison with the CPHC is time saving for care coordinators and enable a better package of care for the service user."

"Overall the CPHC's support allowed me to increase my awareness of [service users'] physical health needs and I feel I was able to provide better support as a result." (Care coordinators, CMHT)

Conclusion

The evaluation data indicates that the introduction of multi-faceted interventions has improved the communication and management of the physical health care for people with SMI jointly managed by the CMHT and GP surgeries.

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