

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

Community Physical Health Co-ordinator
and Multi-Disciplinary Team Meeting
Guidance Document



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1 Purpose of this guide

1.1 Background information

This guidance describes how to implement a physical health liaison role between community mental health teams (CMHT) and primary care. The information within this document was gathered by the Collaboration for Leadership in Applied Health Research and Care for Greater Manchester (GM CLAHRC) during a project run in conjunction with Manchester Mental Health and Social Care Trust (MMHSCT) and the Manchester Academic Health Science Centre (MAHSC) in 2012/2013.

The project aimed 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 treatment and care of people with severe and enduring mental illness (SEMI). As part of this project a boundary spanning Community Physical Health Co-ordinator (CPHC) role, was successfully implemented to improve the physical health management of people with SEMI who are jointly under the care of the community mental health team (CMHT) and primary care.

The evaluation of the project with MMHSCT highlighted that adopting a 'flexible' approach to engaging primary care was a key factor in the success of the CPHC role. CPHCs developed and agreed their working arrangements and the structure of multi-disciplinary team (MDT) meetings with individual GP practices, tailoring various elements, which are described in this guide.

In line with the extensive literature around the spread of improvements and innovations, it is important to note that it may be necessary for other organisations to adapt the model described in this document to suit the local context or to apply only the broad principles or the guiding framework of this improvement model.

1.2 Guidance content

This document provides a detailed description of the CPHC role and will guide organisations wishing to implement this, or a similar role in:

- Selecting the right person for the job
- Providing the CPHCs with relevant training
- Effectively liaising with primary care e.g. in building effective relationships with primary care staff and preparing for and running physical health MDT meetings
- Communicating with CMHT staff e.g. Care Co-ordinators and Assistant Practitioners
- Improving MDT meetings.

2 Roles of the CPHC

The CPHC should liaise with, co-ordinate and communicate the physical health management of service users to and from primary care and the CMHT. Developing and maintaining a link with GP practices in primary care and Care Co-ordinators within the CMHT, to discuss the physical health of service users and develop joint action plans for managing service users' physical health, should be the key focus of the CPHC role.

The CPHC will be the hub of information sharing to and from CMHTs and primary care. Information on each service user should be gathered by the CPHC, via Care Co-ordinators, Assistant Practitioners, Consultant Psychiatrists and the GP practice team. This information is shared and discussed with the GP practice team via an MDT meeting or a similar means. Using the MDT meeting format enables joint action planning to take place and service user management plans to be developed. The CPHC is responsible for communicating and disseminating physical health-related actions to the relevant members of the CMHT concerned with implementing them.

The CPHC is not simply a hub to convey physical health information; they provide professional guidance and co-ordination for the care of people with SMI.

2.1 The main elements of the CPHC role

There are a number of essential elements to the CPHC role:

- Building relationships with Care Co-ordinators within the CMHT and raising awareness of the need to care for the physical health of service users alongside their mental health needs.
- To collaboratively develop and facilitate the implementation of physical health management plans for service users with GP practices.
- Developing a close working relationship with any physical health-focused roles that exist within the Trust/CMHT e.g. Assistant Practitioners or Physical Health Nurses, to discuss physical health interventions e.g. weight management services, and community-based physical health assessments such as use of the Rethink community physical health assessment (CPHA)¹.
- Obtaining an excellent understanding of ALL Trust services - although detailed discussions will focus on service users attached to the CMHT, an extensive knowledge of other services will help to build a positive working relationship with primary care and the 'credence' of the CPHC. Invariably questions will be asked that involve other services within the mental health trust. This will be particularly useful if no other strong link exists between primary care and the mental health trust.
- A good working knowledge of the local community and voluntary sector lifestyle resources available to people with SMI is essential. This includes knowledge about a) the provision of the service, b) referral criteria, c) possible service user benefit, and d) timetables. This is useful for suggesting physical health interventions during MDT meetings and in discussions with CMHT colleagues.

¹ This tool is designed to improve the monitoring of physical health for people with severe mental illness. It provides a structured way of assessing physical health concerns. A key part of the check is the action plan, drawn up collaboratively by health professionals and people using mental health services.

- Developing a close working relationship with practices associated with the CMHT in which the CPHC works. Specifically:
 - The development of an agreed process with the GP practice for discussing the physical health of service users e.g. the implementation of MDT meetings and communication requirements between meetings.
 - To provide timely and accurate follow up information for all of the actions developed during the MDT meeting – it is essential that actions generated at MDT meetings are followed up by the appropriate health care professional, providing an update of actions generated from preceding MDT meetings ensures that everybody knows the current situation and if necessary a different action can be taken.
 - To provide key support and advice for GP practices (and Care Co-ordinators) for service users who frequently do not attend GP appointments.
 - To provide GP practices with guidance on systems of recall and the development of any shared care agreements.
 - The CPHC may also provide educational support to the GP practice team (and Care Co-ordinators) re: medication side effects, general physical or mental health issues.

2.2 The core ingredients of a good CPHC

The evaluation of ‘the improving the physical health of people with SMI’ project with MMHSCT highlighted a number of core ingredients of a good CPHC. When developing the boundary spanning CPHC role it is essential that these ingredients are recognised.

Personality

It is important that the CPHC has an interest in physical health and that they are able to perform all aspects of the role.

The CPHC role should not be assigned to a Care Co-ordinator unless they are interested in taking this forward, as assigning to somebody uninterested can result in a lack of motivation and due to the complex nature of the role it can become ineffective. They need to be effective communicators and we would suggest they are a relatively senior Care Co-ordinator who is well respected within the CMHT. The interactions the CPHC has with GP practices may be the only point of contact that the Trust has with individual practices. The CPHC will represent the face of the mental health trust.

The CPHC role involves liaising with and co-ordinating between primary care and the CMHT; this means that the CPHC should have excellent organisational and time management skills. Being able to balance the complexities of a split role, requires forward planning and good diary management.

CPHC should be a split role

Two CPHCs at 0.4 WTE each, were utilised as part of the project, for the remainder of their time they continued in their Care Co-ordinator role. It was essential for the CPHCs to retain their Care Co-ordinator skills as this allowed them to keep up to date with the Care Co-ordinator role and to continue to have contact with service users and colleagues. Maintaining a care co-ordination role also allowed them access to relevant meetings and discussions with other CMHT staff. CPHCs felt that it was important that colleagues knew them and respected them before commencing their new role. Maintaining a Care Co-ordinator role also helped to continue this respect as colleagues felt that they understood the complexities of care co-ordination. Respect was a key facilitator for gaining the trust and support of other Care Co-ordinators.

2.3 Training the new CPHC

Table 1: Mandatory Physical Health Training

Topics covered
1. The severity of the physical health problem for people with SMI
2. The side effects of medication
3. Chronic obstructive pulmonary disease (COPD)
4. Obesity and weight management
5. Type 2 diabetes
6. Measuring blood pressure and pulse
7. Preventing venous thromboembolism
8. The Rethink CPHA (physical health assessment adopted by MMHSCT)
9. Physical health-related case study examples from the Trust's serious untoward incidents (SUIs) record.

Training around physical health is essential for CPHCs; developing a basic level of understanding about the detection of cardiometabolic diseases and their management is advantageous. It allows CPHCs to assist Care Co-ordinators and Assistant Practitioners with physical health management support.

As part of the 'improving the physical health of people with SMI' project, the CPHCs attended MMHSCTs mandatory physical health training for inpatient staff. Table 1 shows the topics which this training involved.

To supplement their physical health training, CPHCs also received training focussed on a) developing a better knowledge of the GP practice context and the way which primary care operates, b) understanding what lifestyle support services exist within the local community setting, and c) running effective meetings. This is outlined in table 2.

Table 2: Primary Care and Community Lifestyle Training

Type of Training	Specific Elements
Primary care (none of the CPHCs had previously worked with primary care)	<ol style="list-style-type: none"> 1. The GP practice environment 2. Primary care commissioning and clinical commissioning groups (CCGs) 3. The Quality Outcomes Framework (QOF) and how it relates to the physical health care of people with SMI 4. Knowledge about primary care clinical IT systems and Read Coding² 5. The use of cardiovascular risk screening tools (e.g. QRISK2).³
Community and volunteer lifestyle services (delivered by Manchester Public Health Development Service)	<ol style="list-style-type: none"> 1. What services exist 2. Their suitability for people with SMI 3. How to refer into them.
Running effective meetings	<ol style="list-style-type: none"> 1. Facilitation 2. Conflict management 3. Negotiation

2.4 Estimation of CPHC resource requirements across a CMHT and primary care

Ensuring protected time for the CPHC role is essential, as it requires dedicated time to prepare for, organise and attend MDT meetings, along with time to ensure that actions generated from MDT meetings are followed up by CMHT colleagues. The demands on a Care Co-ordinator mean that unless protected time is agreed, it is not possible to carry out the CPHC role in an effective way.

Table 3 illustrates the time requirement that CPHCs believed they required, per practice, during the early stages of developing a relationship with a practice and holding MDT meetings. Table 3 is based on the CPHC attending MDT meetings on a monthly basis with practices. However, it is expected that the time requirement per practice will decrease over time (move to bi-monthly meetings), once a good relationship has been established with the practice and CMHT colleagues become familiar with the process.

² Read Codes are a coded thesaurus of clinical terms they are the basic means by which clinicians record patient findings and procedures in health and social care IT systems across primary care.

³ QRISK cardiovascular disease risk algorithm (QRISK2) provides an accurate estimate of cardiovascular risk in patients from different ethnic groups in England and Wales. It relies on the following clinical indicators: (a) age, (b) gender, (c) ethnicity, (d) smoking status, (e) diabetes status, (f) family history of angina or myocardial infarction, (g) chronic kidney disease, (h) atrial fibrillation, (i) blood pressure treatment, (j) rheumatoid arthritis, (k) cholesterol/HDL ration, (l) systolic blood pressure, and (m) body mass index.

Table 3. Time Requirement for Early MDT Meetings (per practice, per month)

Action	Descriptor	Time
General practice liaison and planning time per MDT	<ul style="list-style-type: none"> Establishing relationships/contacts Maintaining relationship with practice contacts. Preparing service user list and emailing Care Co-ordinators, Consultants and GP practice. Discussion with Care Co-ordinator. Looking at entries on the clinical system and completing the proforma. (see appendix 1) 	General liaison = 1.5 hours MDT meeting = 0.5 hours per service user, average 6 services per MDT = 3 hours
MDT meeting time	<ul style="list-style-type: none"> Travel Meeting time 	2 hours
Feedback from MDT	<ul style="list-style-type: none"> Filling in the traffic light MDT action feedback form. (see appendix 2) Sending emails about the actions to the appropriate members of the CMHT. 	1 hour
Follow up from MDT re: action completed by CC and GP practice	<ul style="list-style-type: none"> Following up on actions recommended to Care Co-ordinators. Speaking to Care Co-ordinators about their service users and feeding back to the practice. Answering queries from practices about service users - whether they are under the team, who their Consultant is, when they are due to be seen etc. 	2.5 hours
		Total time per practice per month = 10.5 hours

2.5 Information governance considerations for the CPHC

As sharing service user data between the CMHT and GP practices is a necessity, it is important to take guidance from the Trust's Caldicott Guardian. Please be aware of the following:

- Exchanging service user information with GP practices from a Trust email address e.g. joe.bloggs10@mhsc.nhs.uk account is NOT secure; please liaise with the Trust's IT department to set up an nhs.net account; nhs.net is widely used in primary care and it is the only secure way to exchange service user information. Please ensure an nhs.net account is used when exchanging service user information with GP practice staff.
- Never send service user information to a GP practice's generic email address as no named individual has responsibility for that account. Always send the documentation directly to practice staff (e.g. Practice Manager, GP, Practice Nurse, etc.) and as above ensure this is an nhs.net account.
- Consider the use of the service user's initials when sending documents electronically, rather than using their full name.
- Consider password protecting documents containing service user information (speak to the Trust's IT department to discuss how to do this) that are shared with the GP practice. This could involve one simple password for each GP practice.
- A simple but informative configuration management system should be adopted when saving documents. All data should be saved with the practice's name in the heading of the file name to avoid sending data to the wrong surgery e.g. Joe Bloggs Medical Practice – dd_mm_yy.

2.6 Engaging with CMHTs

CMHT colleagues must be made aware of the role and remit of the CPHC. The role should be broadly communicated in team meetings and described to the whole CMHT. It is imperative that Care Co-ordinators are made aware of how the CPHC can assist them in caring for the physical health of service users under their care.

Continuous engagement with CMHT colleagues is necessary to ensure that actions generated from MDT meetings are followed up, along with ensuring that appropriate service users are being raised for discussion during MDT meetings. Using internal CMHT team meetings to update, feedback, and discuss the physical health of service users could be useful. The liaison nature of the CPHC role will mean that working with CMHT colleagues on a continuous basis will be necessary. Over time, the dynamic between Care Co-ordinators and their CPHC should change, such that the CPHC does not need to proactively raise service user concerns with the Care Co-ordinator, rather the Care Co-ordinator proactively raises physical health concerns of their service users with the CPHC.

The CPHC should also work closely with the physical health professionals present in the Trust. In the project with MMHSCT the CPHCs developed a very good working relationship with the Assistant Practitioner attached to their CMHT, as the Assistant Practitioner was increasingly becoming more involved with performing Rethink CPHAs. The CPHC also formed a close link with the Physical Health Nurses within the Trust, as they provided information and assistance for any complex physical health issues.

It is essential that CMHT Area Managers and/or Assistant Area Managers understand the scope and remit of the CPHC role. Their managerial support, through clinical accountability and quality performance, is key to ensuring that Care Co-ordinators follow up and complete physical health-related actions developed from MDT meetings. If the Care Co-ordinator job description currently does not mention caring for the physical health of service users, the CMHT managers will need to ensure that this element of the Care Co-ordinator role is acknowledged by all staff. They will need to work with the CPHC in the early weeks to establish the CPHC role within the team.

3 Engaging with primary care

3.1 Initial engagement with primary care practices

It is important to note that not every GP practice will want to develop a link with the CMHT via the CPHC. Even though the initial contact may be to discuss the role and its benefits, this discussion may come to nothing and the GP practice may think that this commitment is not for them at that particular time. Senior members of the mental health trust will probably have met with senior CCG leads, to open practice doors for the CPHC ahead of any practice engagement.

Once a positive link has been established with a practice, we recommend meeting with the Practice Manager and lead GP in the first instance. It is important to develop a strong relationship with both a clinical (GP and Practice Nurse) and an administrative lead (Practice Manager) within in the GP Practice.

When initially engaging with practices it is important to discuss the following:

- The purpose and focus of the CPHC and how physical health will be discussed within that practice e.g. using an MDT meeting format. Having a dedicated physical health focus, frames and leads the discussion; at times the general mental health care of service users will need to be discussed, but the primary focus should be physical health.
- How the GP practice would like to run the MDT meetings, should they be a) stand-alone meetings, or b) part of existing MDT meetings (this will affect who attends the MDT meetings, if it is part of a bigger MDT then District Nurses are often present).

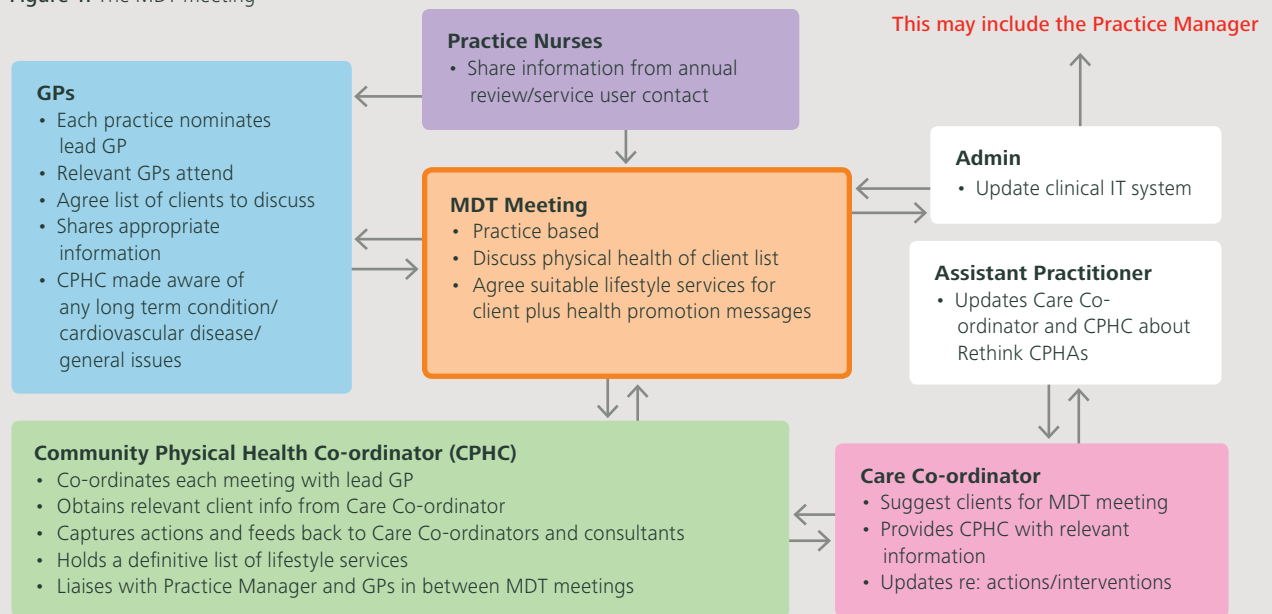
- The frequency of the MDT meetings e.g. monthly or bi-monthly. We would recommend that initially meetings are held on a monthly basis until a positive relationship with the practice has been developed and many of the priority service users have been discussed.
- Who should attend the MDT meetings (as a minimum we would expect there to be 1 GP or Practice Nurse and 1 Practice Manager or Administrator).
- How to select service users to discuss (see section 3.2.2).
- What the CPHC will not deliver (discussions about inappropriate referrals to mental health services, the care of service users attached to primary care mental health services etc).
- Who should be the main contact point and receive the majority of the communications from the CPHC. The lead contact within practice can disseminate information to the appropriate member of the practice team (in some practices this has been the Practice Manager in others it has been a lead GP).

3.2 Delivering or participating in MDT meetings with primary care

An MDT meeting is an ideal vehicle for CMHTs and primary care to share responsibility and develop joint management plans to address the physical health needs of service users under the care of a CMHT.

The MMHSCT project evaluation showed that the CPHC role and MDT meetings enabled information to be shared between primary care and the CMHT, such that primary care and CMHT staff believed that care became more co-ordinated and a shared responsibility for the physical health management of service users was developed.

Figure 1: The MDT meeting



Communication between primary care and the CMHT, which was previously reported to be poor, was also reported to have improved.

Figure 1 illustrates how the CPHC role and MDT meetings worked in the ‘improving the physical health of people with SMI’ project.

Each practice will establish and deliver MDT meetings differently to meet their local requirements, highlighting that a ‘one size fits all’ approach is not suitable. However, there have been some general themes across all MDT meetings which have been consistently important, these are highlighted in the following sections of this document.

3.2.1 When and how should the MDT meetings be held?

In the initial stages of setting up the MDT meetings, it is recommended that meetings are scheduled once a month. This provides sufficient time between meetings to ensure appropriate actions are completed or followed up and ensures that there is a relatively

short time between meetings to maintain momentum. This is particularly important in the initial stages of developing a co-ordinated approach to care.

Once the meetings and attendees are established (after approximately three meetings) the MDT meetings can be moved to a bi-monthly basis if this is preferred by the attendees. Meeting monthly or bi-monthly is a decision that should be made by all members of the MDT meeting.

Some practices have established MDT meetings as a stand-alone meeting which is specifically focused on discussing physical health issues of SMI service users. Other practices have integrated their MDT meetings into a) existing palliative care, b) long term conditions, and c) integrated care meetings. Table 4 shows the positive and negatives of different types of meetings.

Table 4. Positive and Negatives of Different Meeting Types

Stand-alone MDT meetings		Integrating into existing meetings	
Positives	Negatives	Positives	Negatives
1. Very focussed and all those who attend are active contributors for the full duration of the meeting.	1. It can be seen as being 'another meeting' by clinicians, which can lead to reluctance due to GPs busy schedules.	1. It means that clinicians only have to attend one meeting (which may increase the number who attend).	1. Can lead to the CPHC sitting through discussions that aren't always relevant e.g. non mental health patients.
2. There is more flexibility as fewer people usually attend; this means that it is easier to find suitable dates and facilities to accommodate the group.	2. It doesn't allow for discussions about the care of service users with other health professionals e.g. District Nurses.	2. Other allied health professionals usually attend e.g. District Nurses; this allows co-ordinated working across a variety of services, where appropriate.	2. Having a 'slot' on the agenda often involves a time limit; sometimes it isn't possible to have detailed in-depth discussions.
3. There is usually more time to discuss service users; as is this the sole focus of meeting, rather than it being one of many discussions.			

3.2.2 How to identify service users to discuss at MDT meetings

It is important to identify service users to discuss collaboratively with the GP practice. Up to 10 service users may be discussed at any one MDT meeting. If service users are not proactively suggested by the GP practice or Care Co-ordinators, the CPHC can use the criteria detailed in table 5 to identify service users for discussion.

The following questions may encourage Care Co-ordinators to suggest service users for discussion at an MDT:

- Have any of your service users recently missed or had physical health/GP appointments?
- Have any of your service users got overdue tests or examinations?
- Are you (Care Co-ordinators) waiting for any information from any GPs/Practice Nurses about the physical health of any of your service users?

- Are there issues regarding collecting prescriptions or booking appointments with the GP practice for your service users?

Table 5. Prioritising Service Users

Who to Prioritise	Responsibility
1. Service users that have recently had a community physical health assessment completed and follow-up is required	CMHT
2. Poor attenders at the GP practice	Practice staff
3. Service users with missing physical health data/information on the practice system and/or overdue a GP physical health check	Practice staff
4. Service users newly referred to the CMHT	Joint
5. Service users with concerning physical health symptoms that need further investigation	CMHT
6. Service users previously discussed that need clarification of actions or further discussion	Joint

3.2.3 Administrative preparation for MDT meetings

The list of service users to discuss should be suggested to the practice at least one week before the MDT date to provide them with the opportunity to add more names. It may be that the practice does not suggest further service users.

Complete an MDT Proforma Sheet (see Appendix 1 for an example) or similar document for any new service users to be discussed and thoroughly discuss the service user with their Care Co-ordinator. It is important to get the wider picture of the service user to be able to share a good understanding of the service user's history with the practice. These discussions need to begin at least one week prior to the MDT to enable the preparation sheets to contain meaningful information. The Care Co-ordinator might also want to inform the service user that she/he will be discussed at the next MDT meeting.

For subsequent MDT meetings, use the MDT Traffic Light Action Feedback Form (see Appendix 2 for an example) or similar document to see which previous actions from service users previously discussed need to be followed up and take this document with you to the MDT meeting. Discuss the follow up of the actions with Care Co-ordinators to ensure they have been completed and take any necessary information to the MDT meeting.

As a general rule, allow 30-40 mins preparation time for any new service user to be discussed and about 10 minutes per service user for each follow up action.

3.2.4 The CPHC's role in the MDT meeting

It is unlikely that the CPHC will chair the MDT meeting; this is usually done by a member of the practice team. The CPHC's role will be to lead the discussion around the physical health

of mental health trust service users, whether this is a stand-alone or integrated MDT meeting. Questions will often be answered immediately if there is access to the practice system during the meeting. The best model is where a member of the practice team has access to the computer and checks service user records during the meeting.

The CPHC should push to get answers on the day of the MDT meeting and get access to the practice's records immediately to answer queries. Take feedback from the last meeting and update the practice with the actions of the appropriate CMHT professional and ask for an update from the GP practice regarding their actions; note any outstanding actions to be added/followed-up. Probe to find out what has actually happened i.e. diabetes review – what was the outcome? Is there anything to note? What are the follow up actions?

Bring and discuss all Rethink CPHAs carried out by the CMHT. Discuss if there are any service users which require an urgent assessment. Collect information for upcoming service users that may need to have an assessment.

Importantly, the CPHC should check the date and time of the next MDT meeting and ensure it is in their diary.

3.2.5 Follow-up from each MDT meeting

Once the MDT meeting is finished, the MDT Traffic Light Action Feedback Form should be completed (see Appendix 2) for the relevant practice and sent to the GP practice using an nhs.net account.

This form, or specifically tailored emails, (on internal mail) should be sent to the CMHT Area Manager, relevant Care Co-ordinators and Psychiatrists. Tailored emails to a Care Co-ordinator can assist in ensuring actions are followed through. Stating that the Care Co-ordinator is receiving the email because there is an action for them increases the likelihood of a response.

Make sure the CPHC is proactive in ensuring actions are followed up by Care Co-ordinators before the next scheduled MDT meeting and they should work with the Team Leader to follow up actions with Care Co-ordinators in caseload supervision.

Prior to the next meeting, the above preparation steps including printing off the last meeting's MDT Traffic Light Action Feedback Form (see Appendix 2) and chasing up actions with the relevant Care Co-ordinators, should be repeated. It is important for the CPHC to check the clinical system for outstanding information.

The CPHC should encourage Care Co-ordinators to feed back to service users as good practice. Consider adding this to feedback emails to Care Co-ordinators e.g. 'It would be helpful if you could feed this back to the service user at your next opportunity.'

3.2.6 Preparation for subsequent MDT meetings

The CPHC should liaise with the GP practice ahead of the date to confirm the time and date of next MDT meeting.

Review follow up actions from the previous meeting through discussion with the relevant CMHT professionals.

An up-to-date service user list should be sent to the GP practice and the relevant CMHT professionals, allowing one to two weeks for GPs and Care Co-ordinators to suggest service users to be discussed.

The GP practice should be sent a confirmed list of names for discussion a week prior to the meeting.

The MDT Proforma Sheet (see Appendix 1) should be completed for any new service users to be discussed, as mentioned above.

Remember that preparation is key – make sure there is enough time to discuss service users with the Care Co-ordinators, and gather as

much information as possible before the next MDT meeting.

3.3 Guidance for improving the CPHC role with primary care

Some GP practices are more difficult to work with than others and there is no doubt that each CPHC will have to work with some challenging practices. The following aspects have been identified to foster the relationship with the GP practice and to improve how the MDT meetings are run.

3.3.1 Relationship building

CPHCs should be proactive in providing information to the GP practice, e.g. blood results they don't have access to, contact details of the service users Care Co-ordinator, or updated mobile number of the service user and Care Co-ordinator.⁴

Liaise with the main contact, probably the Practice Manager, on a regular basis; this could help if actions are not being followed up by the practice team.

Make sure the CPHC goes to each MDT meeting well equipped with the appropriate service user information.

Ensure the CPHC has a good knowledge of all the Trust's services so that the practice can rely on the CPHC to be knowledgeable of all aspects of the Trust.

If the relationship doesn't feel right, the CPHC should raise this with the main contact and ask whether the relationship is beneficial to the practice and if not, what can be done to improve that, or improve the running of the MDT meetings.

Finally, if there are other CPHCs in the Trust, consider meeting on a monthly basis to discuss the role and to share ideas around best practice.

⁴ It is imperative that consent is gained from service users prior to the sharing of such information. Consent should also be gained from Care Co-ordinators to share their mobile phone numbers.

3.3.2 MDT meetings

The CPHC should be explicit regarding who is responsible for carrying out each agreed action.

They should encourage a wide range of practice staff to attend, i.e. not only a GP but also the Practice Nurse and the Practice Manager. The Practice Manager should be copied into the 'actions' email sent to the practice after the MDT meeting.

Having access to the service user's data is key; the CPHC should suggest meeting in a room where practice staff have access to the GP clinical database.

Supporting practices in gathering missing data, which could enhance their annual QOF payments, can really help. Encouraging the Practice Manager to suggest those service users who have data/measurements missing, could be a way to get practices more interested.

Service users not attending appointments can be very frustrating for practices. Why not encourage the Practice Manager to provide a list of upcoming appointments for those service users under the care of the CMHT and ask Care Co-ordinators, Support Workers or Assistant Practitioners to support the service user to attend the appointment, where appropriate.

Appendix 1

MDT Proforma Sheet

Information MDT meeting	
Surgery name:	
Date of MDT meeting:	
Time / duration:	
Attending:	<i>Names, roles</i>
Client information	
Surname:	
First name:	
Gender:	Female / Male (<i>Delete accordingly</i>)
D.O.B. / age:	
Address:	
Database ID:	
Client informed re: MDT meeting:	Yes / No (<i>Delete accordingly</i>)
Responsible health care professional	
Care Co-ordinator:	<i>Name, contact details</i>
Consultant:	<i>Name, contact details</i>
Last appointment with consultant and outcomes:	<i>Date/outcomes (e.g. ...)</i>
GP:	<i>Name, contact details</i>
Current medication	
Mental health medication:	
Physical health medication:	
Current physical health and well-being	
QRisk (score / date):	
Medication adherence:	<i>To be deleted accordingly:</i> 1) Doesn't take medication 2) Takes meds when they experience symptoms 3) Compliant with meds
Date of last health check in primary care:	
Rethink completed and any outcomes:	Yes / No (<i>Delete accordingly</i>) Actions agreed:
Current physical health issues:	
Current efforts to improve physical health	<i>E.g. recently started attending smoking cessation clinic on a Saturday or started working with Health Trainer</i>
What would the client like to address?	<i>E.g. Mentioned stop smoking service</i>
What would the Care Co-ordinator like to address/discuss?	<i>E.g. Identifying suitable services for supporting client to improve diabetes control</i>
What would the GP practice team like to address?	<i>E.g. How to improve diabetes control</i>

Appendix 2

MDT Traffic Light Action Feedback Form

Client's initials	Client's DOB	Date	Actions agreed	
			GP surgery	CMHT

Green = indicates that an action is complete
Amber = indicates that an action has been performed i.e. referral, but this needs following up
Red = indicates a new or a previous action that hasn't been performed

The Collaboration for Leadership in Applied Health
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