# Improving physical health for people with Severe and Enduring Mental Illness

## Developing integrated care pathways to support mental and physical wellbeing

A joint project between

Manchester Mental Health and Social Care Trust, Manchester Academic Health Science Centre and NIHR Collaboration for Leadership in Applied Health Research and Care for Greater Manchester


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# Quiz: How severe is the physical health problem?

Q. *On average how many years younger do people with schizophrenia/psychosis die than the general population?*

| | |
|---|---|
| A<br>3–5 years | B<br>5–10 years |
| C<br>15–20 years  | D<br>30–40 years |

# Quiz: How severe is the physical health problem?

Q. *What is the average weight gain of people after 6–8 weeks of taking Olanzapine?*

| | |
|---|---|
| A<br>1–2 kg | B<br>3–4 kg |
| C<br>5–6kg  | D<br>8–9kg |

# Quiz: How severe is the physical health problem?

Q. *Approximately what percentage of patients treated with anti-psychotics experience significant* weight gain?*

| | |
|---|---|
| A<br>20% | B<br>40% |
| C<br>60% | D<br>80%  |

** A weight increase of >5% is seen to be clinically significant (Institute of Medicine)*

# 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***

***Access***

***Education & training***

***Clarity of responsibility for management and monitoring***

***Assessments***

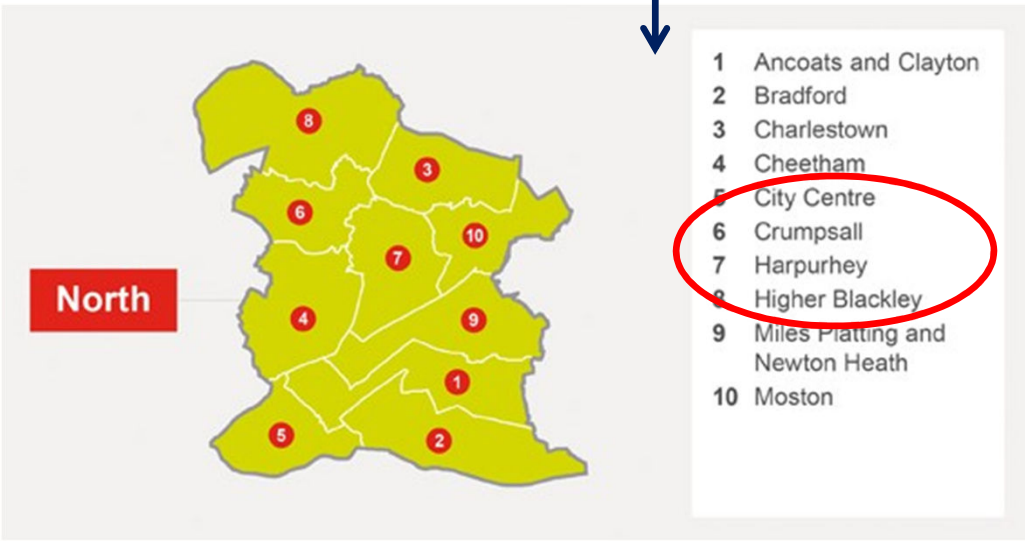
# Background information to the project


**Anya Telford** **Liz King**

(Care Co-ordinators)

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

5 GP surgeries involved




These vary in size, culture & mental health knowledge

Project ran from June 2012 to March 2013

# Data collection

**Discovery stage**

- Exploratory interviews with 20 healthcare professionals working in both primary and community care
- Semi-structured interviews with 19 service users currently under the care of the NW CMHT
- A focus group with 11 NW CMHT staff

**Process and outcome stage**

- Semi-structured interviews with 10 GP surgery staff
- Semi-structured interviews with 2 CPHCs
- A semi-structured interview with 1 Care Co-ordinator
- Semi-structured interviews with 2 NW CMHT Managers
- A focus group with 8 NW CMHT staff
- A survey completed by 13 NW CMHT staff
- Semi-structured interviews with 8 service users
- Process and outcome measures for all MDT meetings held
- Cardiovascular risk data recollected from GP practices

# Discovery stage findings – Context pre project

## Community Mental Health Teams (CMHTs)

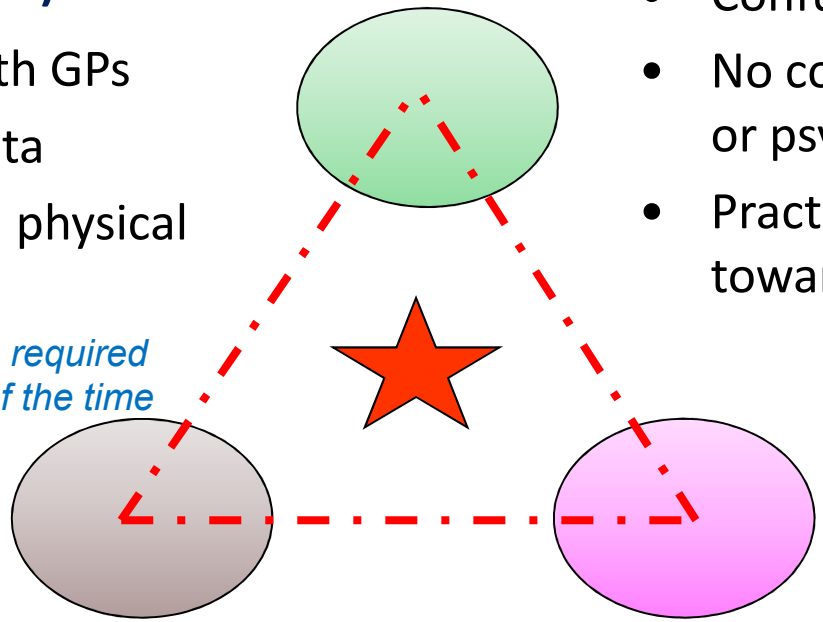
- Little contact with GPs
- No sharing of data
- Limited focus on physical health

*"It is often hard to gather the required information from GPs, a lot of the time you have to rely on the client." (Care Co-ordinator)*

## Primary care

- Confused over remit of CMHTs
- No communication with CMHTs or psychiatrists
- Practice staff negativity towards service users

*"I think it's quite poor. I think it's very disjointed. I think it was very fractioned and patient care, as a result, was quite poor." (GP)*



## Service users

- Lack of trust in GPs
- Difficulty accessing GP surgery
- Avoidance strategy
- Lack of motivation
- Majority felt that physical health was as important as mental health

*"There are big problems accessing the GP ".. feel uncomfortable going to the doctor, I just can't be bothered." (Service user)*

# The GOLD standard for MMHSCT

**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 SMI**

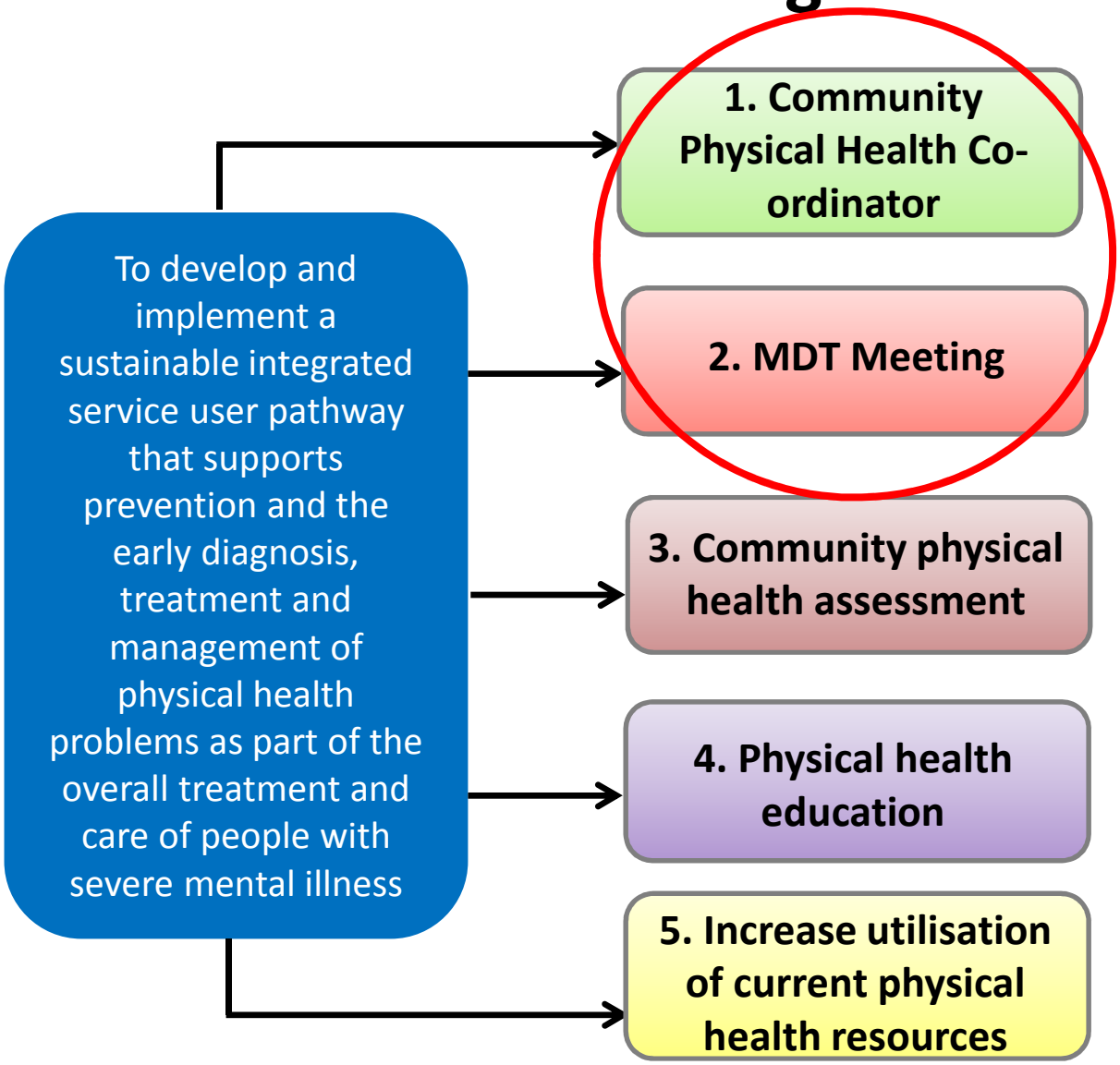
## Joint approach

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

# How do we achieve the gold standard?

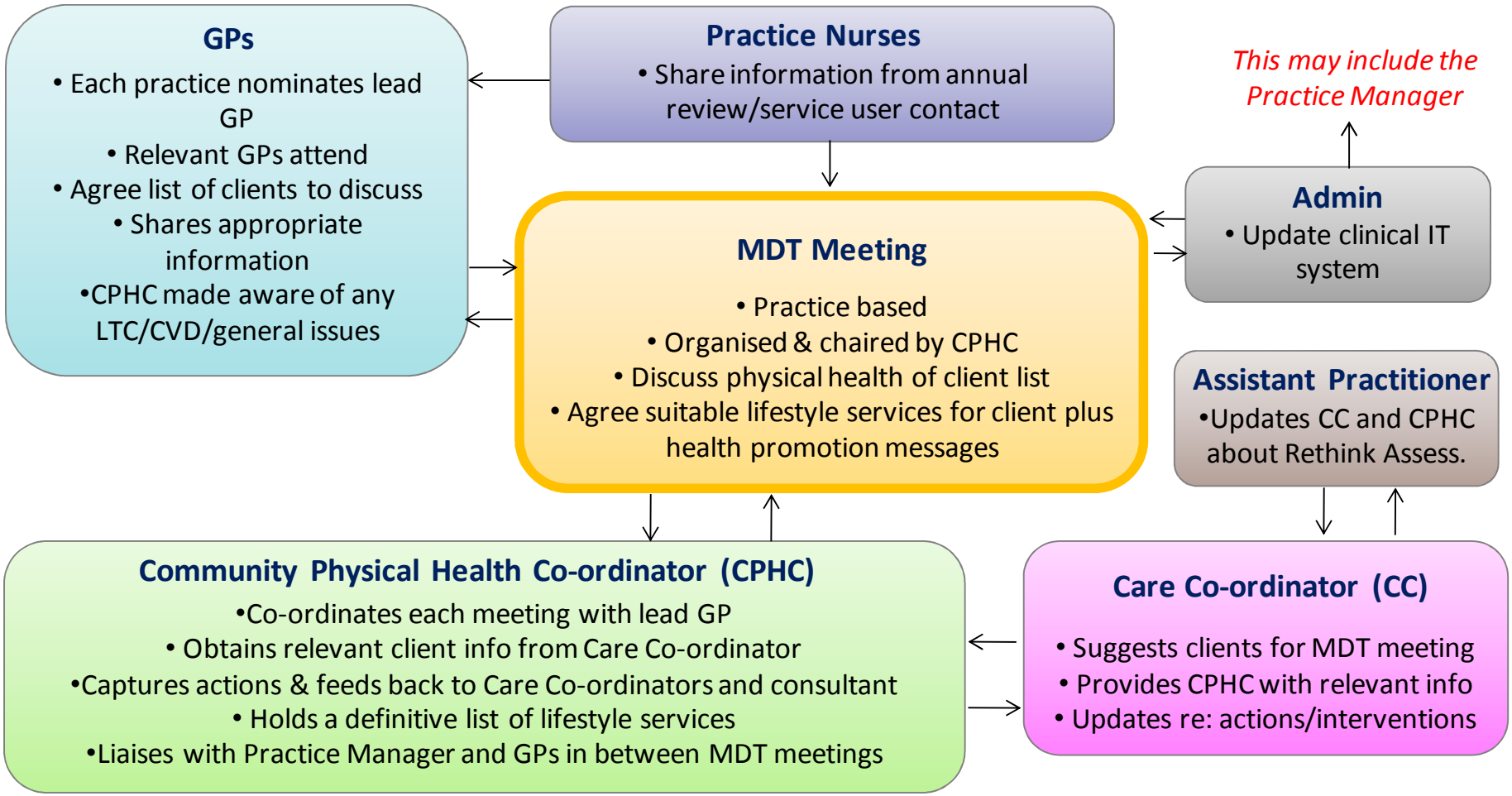



## Link to Trust CQUINs 2012/13

L4.2 *'To establish models of joint working between GP Practices and MMHSCT link staff'*

L5.2 *'% of adult and later life patients in CMHT for 12/15 months with Rethink tool completed in the last 12 months'*

# MDTs & Community Physical Health Co-ordinator



# MDTs & Community Physical Health Co-ordinator

## MDT Meetings

- 24 held over 8 month project period
- Either monthly or bi-monthly
- LTC QIPP or dedicated mental health
- Between 5–10 clients discussed
- Joint actions generated
- Communicated via NHS.net
- Case supervision to ensure actions followed through

- *GP concern /care co-ordinator concern*
- *Requires test/assessment*
- *Poor GP attenders / clients with missing data*
- *Rethink physical health assessment*
- *High CVD Risk*
- *BMI >30*
- *Heavy smokers*
- *Complex needs*

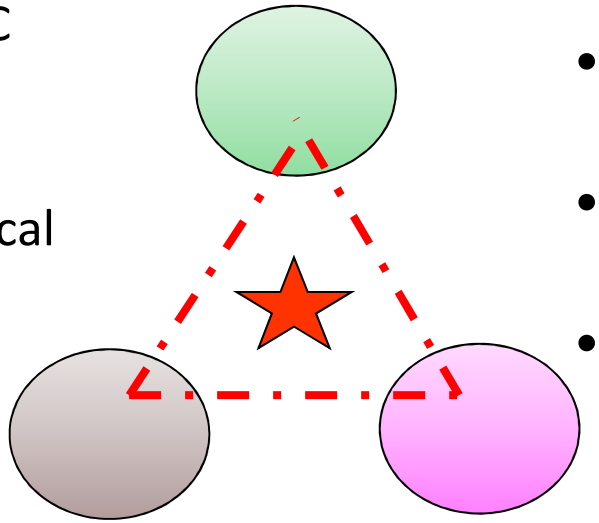
*To Care Co-ordinators /APs/Consultants and GP surgery*

**Improved liaison between consultant and GP surgery**

# Project findings – Summary of outcomes

## CMHTs:

- Improved communication
- Positive about the CPHC role
- However still uncertain about doing basic physical health assessments



## Primary care:

- Improved co-ordination of care
- Understand the role of the CMHT
- Identifying people requiring tests and investigations
- Appropriate referrals into lifestyle services

## Service users:

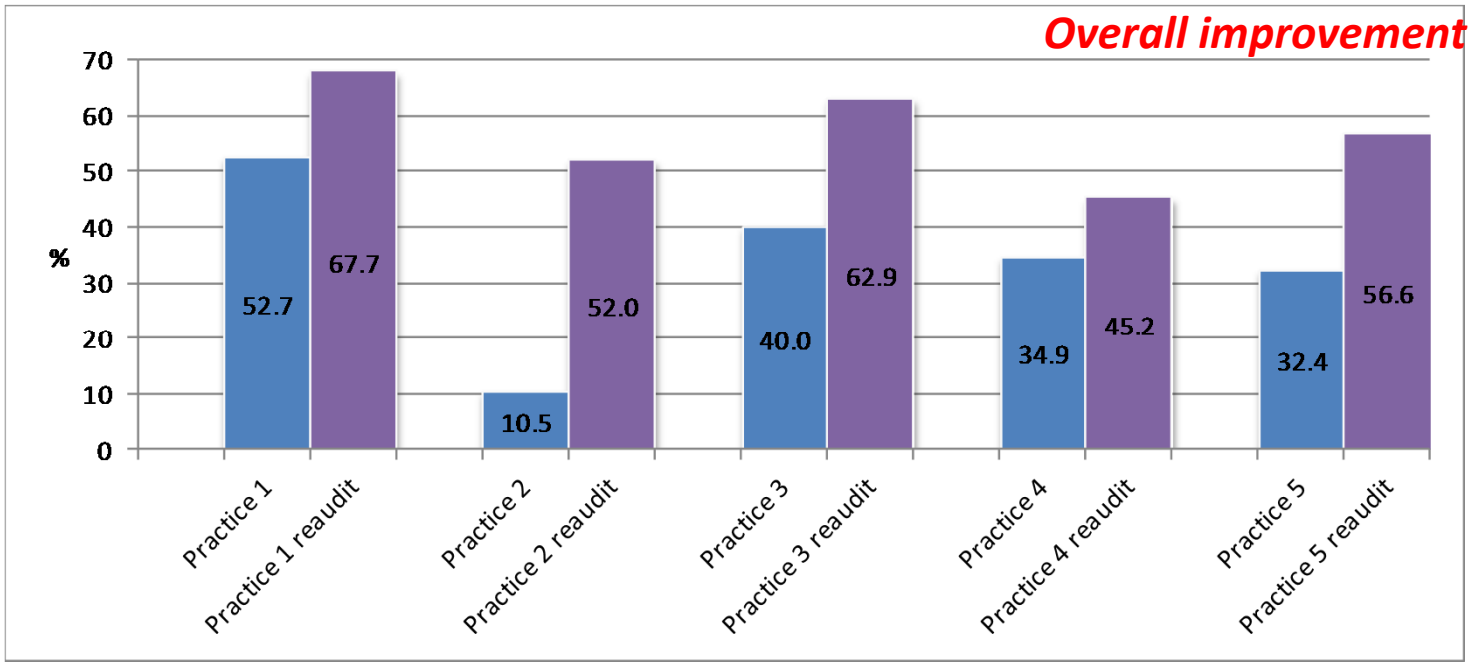
- 100% (n=8) felt that they discussed physical health with their Care Co-ordinator and 88% (n=7) discussed lifestyle services.
- An array of positive service user stories.

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

*(GP)*

# Outcome – Improved CVD data collection

***Practice Breakdown of NO missing QRISK data***




Discovery stage data showed that information was missing for **61.8% (n=115)** of service users, post project this had improved with data missing for only **41.5 (n=79)** of service users.

# Outcome – Improved integration of care

| **Key Actions** *(from 101 service users discussed during 24 MDT meetings)* | **Total Actions** |
|---|---|
| Community Lifestyle Service Referral | 16 |
| Clinical Information (inc. requested and provided to either GP Practice/CMHT or Consultant) | 18 |
| Disease Review (inc. repeat bloods; CHD; Diabetes etc) | 43 |
| Medication (inc. reviews, changes and adherence) | 15 |
| Non Clinical Information (inc. requested and provided to either GP Practice/CMHT or Consultant) | 7 |
| Other | 7 |
| GP Practice Based Lifestyle Service Referral | 8 |
| Primary Care Physical Health Assessment | 32 |
| Rethink Assessment | 5 |
| Specialist Referral | 4 |
| Test/Investigation | 7 |
| Blank | 1 |
| | **163** |

Approx. 1/3 of these were joint actions between the CMHT & the GP practice

# Outcome – Service user perspective

**Service user**

SU 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.

**Service user**

Identified that he had a **lump in his testicle**. He made an appointment but realised it was with a **female Dr** so **cancelled**. The Care Co-ordinator was aware that the appointment had been made, but **the service user didn't say he cancelled the appointment** because he was **too embarrassed,** the whole thing was **mortifying** for him. It was highlighted by the practice in the **MDT meeting** that he had cancelled the appointment. The Care Co-ordinator made a **further appt with a male doctor** and the **service user attended.**

# Outcome – Service user perspective

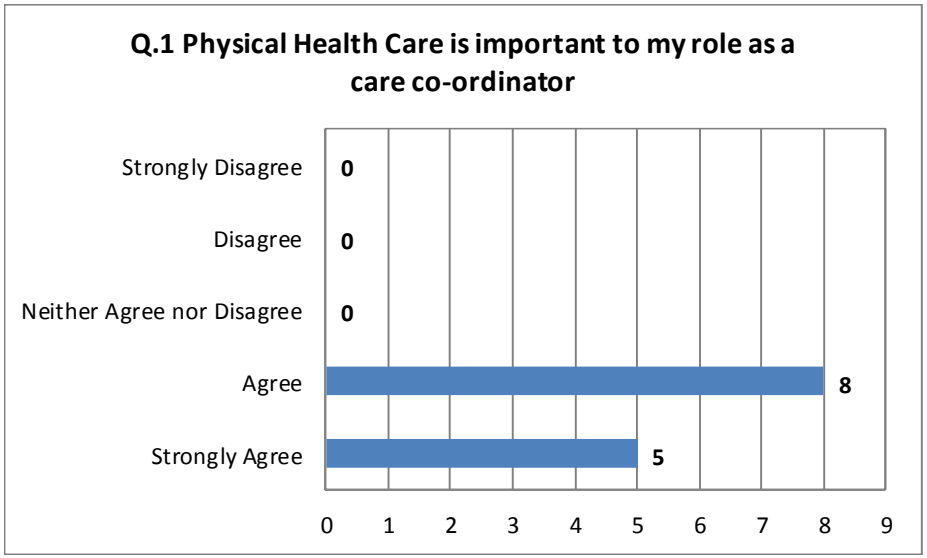
I have **many physical health problems** including epilepsy, diabetes and heart disease and chronic mental health problems.

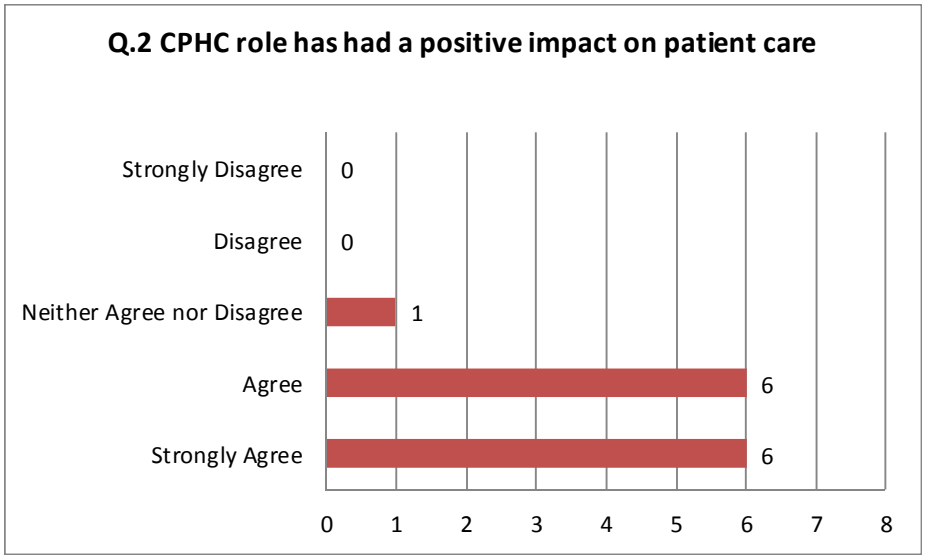
The **district nurses took some bloods** when they came to visit and because they were not quite right, this resulted in the **doctor coming to visit me at home**. The practice nurse is coming to see me this week to monitor my diabetes and I have had someone **from the surgery in today to discuss stopping smoking.**

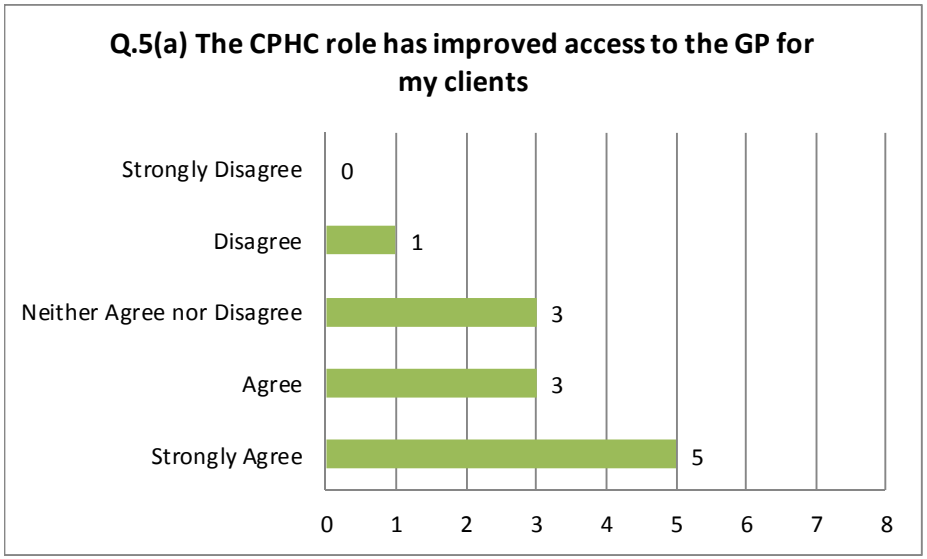
**The CPHC opened the process of bringing everyone together** to discuss their roles and my needs. I was listened to and help is beginning to be available. My district nurses now turns up daily and on time and my **diabetes is getting treated by an expertly trained nurse**, which then allows the CPHC time to fulfil her role.

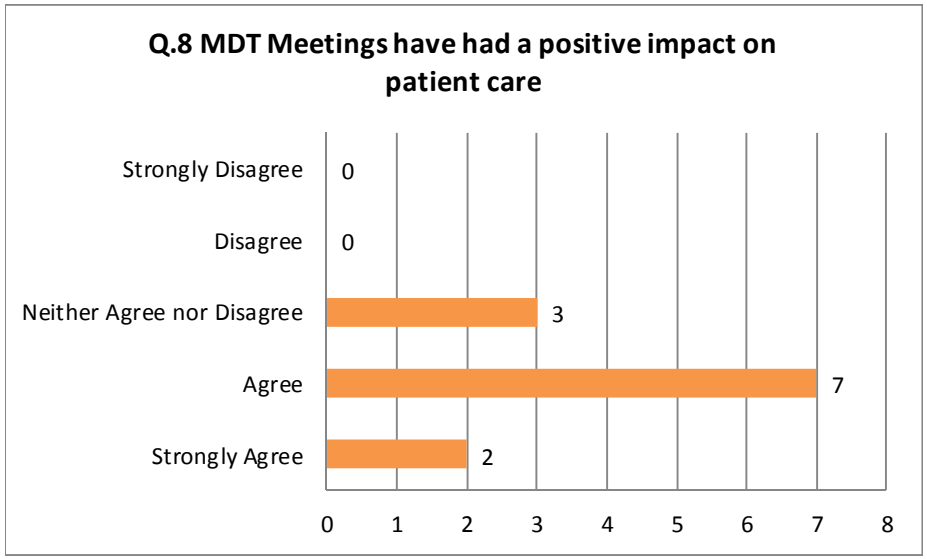
These people have never looked like coming together before and in truth **it makes me feel empowered and cared for** because I know there is somebody out there who can help me deal with my problems.

# Outcome – Staff perspective



# Outcome – Staff perspective

"Some Care Co-ordinators used to say **physical health isn't part of my role, they no longer say that.** I think it has definitely **improved** the **relationship with the GPs, better understanding and more respect**. I think historically, there could have been a bit of **tension**, GPs wanted us to do things and vice versa and it would end up with nobody doing anything."

**(CPHC, NW CMHT)**

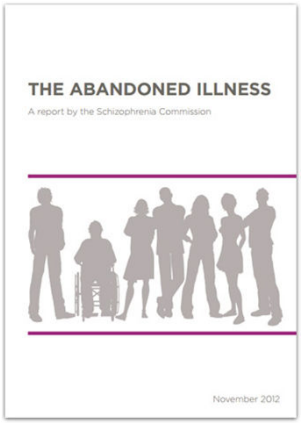
"It is **'holistic'** to use the jargon. We bring patients, she (CPHC) brings patients, she identifies what some of the problems are, we identify what some of the problems are and **we try and meet those needs**… "

**(GP, Primary Care)**

"the main thing is that we have **accurate clinical notes**."

**(Practice Manager, Primary Care)**

# Addressing The Schizophrenia Commission




1. Securing clarity of responsibility between primary care services for monitoring and managing mental health problems.

2. More training in physical health care and health promotion for all mental health practitioners.

3. A programme of physical health management integrated with the better prescribing and management of anti-psychotic medication.

4. Better training for GPs.

5. Smoking cessation advice should be offered as standard.

6. Finding a way to motivate people who access services to commit to healthier living as an essential priority and to maintain this in the long term.

7. Tailored health promotion programmes on exercise and healthy eating and helping people take more responsibility for their own health.

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# How could this approach work for you?

# Key enablers

Co-ordination

Knowledge Integration

Standardisation

Supportive organisational culture