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

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

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Premature mortality rates have been reported for people with severe and enduring mental illness (SMI) for many years, leading to a reduced life expectancy of up to 25 years compared to the general population. This is largely due to physical inactivity, an unhealthy diet, and a high smoking prevalence, in combination with medication induced weight gain, which in turn can lead to metabolic disorders (e.g. type 2 diabetes).

To address this health inequality, a joint improvement project was initiated between Manchester Mental Health and Social Care Trust (MMHSCT), the Manchester Academic Health Science Centre (MAHSC), and the NIHR Collaboration for Leadership in Applied Health Research and Care for Greater Manchester (GM CLAHRC) to develop ways to improve the physical health of people with SMI, who were under the care of a Community Mental Health Team (CMHT).

Aim

The project aim was 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.

Methods

This project involved the North West (NW) CMHT and five GP practices from North Manchester Clinical Commissioning Group (CCG). An exploratory stage assessment was conducted to inform the development and improvement of the project. This included:

- Discovery interviews with 20 healthcare professionals (HCPs) 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.

In addition, anonymised cardiovascular risk data (based on the indicators required for QRISK2 i.e. weight/body mass index (BMI), blood pressure, cholesterol, and recorded smoking status) for each service user under the care of the NW CMHT and the pilot practices was collected.

A process evaluation was performed to explore how the project components had been implemented and their impact on the provision of care. A triangulated approach to data collection was used, collecting both qualitative and quantitative data:

- A survey completed by 13 NW CMHT staff
- Semi-structured interviews with 10 GP practice 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
- Semi-structured interviews with 8 service users
- Process and outcome measures for all MDT meetings held
- Cardiovascular risk data re-collected from GP practices.

Interventions

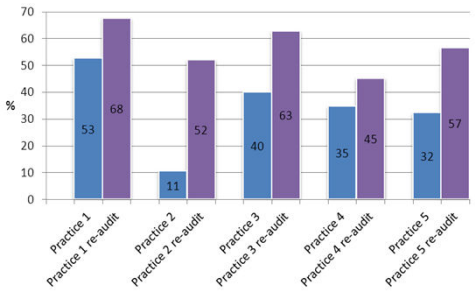
To achieve the objectives five service level interventions were developed:

1 Develop a boundary spanning Community Physical Health Co-ordinator (CPHC) role, to address the physical health needs of service users under the care of the NW CMHT and GP practices.
2 Establish regular multi-disciplinary team (MDT) meetings (held in GP practices) between the CPHC and GP practices, to develop joint management plans with the NW CMHT.
3 Identify the training needs amongst the NW CMHT staff and deliver appropriate training to improve capacity to address physical health needs and support lifestyle changes.
4 Establish regular physical health assessments delivered in a community setting.
5 Increase the use of existing physical health resources.

Results

- 24 MDT meetings were held between September 2012 and March 2013, from which 163 actions arose for 101 service users. The actions addressed missing disease reviews n=43 (26%), conducting physical health assessments n=37 (23%), referrals to lifestyle services n=27 (17%), overdue medication reviews/changes n=16 (10%), plus others.
- As a result, fewer service users had incomplete cardiovascular risk data recorded in primary care (graph 1)

Graph 1. The % of service users with complete QRISK2 risk data



- Qualitative data showed that the CPHC role and the MDT meetings have had a positive impact on co-ordinating care, particularly through the sharing of information, identifying unmet needs, co-ordination of actions, and proactive delivery of care. All n=10 (100%) interviewed HCPs stated that care was more co-ordinated.
- Care Co-ordinators stated that the MDT meetings and the CPHC role had improved access to GP practices and this had a positive effect on service user care.
- N=8 (67%) Care Co-ordinators also believed that referrals to lifestyle services had increased.

"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 Coordinator)

"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 my Care Co-ordinator the time to fulfil his/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. Thank you and well done! From a grateful service user." (service user)

"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. I think it has definitely improved the relationship with the GPs, with us having a better understanding of their role, them understanding our role better and more respect. I think historically, there could have been a bit of tension, GPs wanted us to do things, we wanted GPs to do it and it would end up nobody doing anything. I think in most surgeries we work with, that has gone. So that's really good." (CPHC)

Enablers and implementation ingredients

Based on the findings from the process evaluation, a framework has been devised to illustrate the key enablers for change and the specific implementation 'ingredients' which are fundamental to improving the integration of physical health care for service users with SMI (see table 1). The key enablers are described as being:

a) A boundary spanning role
b) Knowledge integration
c) Standardisation
d) A supportive organisational culture.

Table 1. Enablers and implementation ingredients

Enabler	Project Component	Implementation Ingredients
Boundary spanning role	Community Physical Health Co-ordinator	Split role; essential to continue as a Care Co-ordinator whilst carrying out the CPHC role.
	MDT meeting	Training in a) conflict management, b) facilitation, c) negotiation, and d) physical health management.
Knowledge integration	MDT meeting	MDT meetings involving at least a GP, Practice Manager/Administrator, Practice Nurse/Health Care Assistant and the CPHC. Integrated working between Assistant Practitioners and Care Co-ordinators.
	Physical health education	Education sessions provided by Physical Health Nurses. Mandatory physical health training for all CMHT staff.
	Increased utilisation of lifestyle services	Collaborative training day for CMHT and lifestyle services staff.
Standardisation	Community Physical Health Co-ordinator	A CPHC job description and a flowchart of responsibilities.
	MDT meeting	A process for identifying service users to raise for discussion at the MDT meetings. Joint action plans for the physical health management of service users.
	Community physical health assessment	Clinical guidance document to assist Care Co-ordinators carrying out physical health assessments. Distributing a physical health check bag (includes scales etc.) to CMHT staff.
	Increased utilisation of lifestyle services	Lifestyle services directory made available and distributed to all CMHT staff.
Supportive organisational culture	Community Physical Health Co-ordinator	Commitment to CPHC role from management, protected time and resources. Spread and sustainability strategy.
	MDT meeting	Supervision of Care Co-ordinators to include MDT actions. Spread and sustainability strategy.
	Physical health education	Implementation of physical health mandatory training for all CMHT staff. Spread and sustainability strategy.
	Community physical health assessment	Protected time to complete physical health assessments. Support and guidance for completing physical health assessments.

Conclusion

In conclusion, data indicates that within the confines of this project, the implementation of a multi-faceted intervention has improved the management of the physical health care of people with SMI, particularly through the sharing of information, co-ordination of actions, and proactive delivery of care.