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

Improving the physical health care of people with serious mental illness: Programme Report

June 2015

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

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Acronym glossary

AP	Assistant Practitioner
BMI	Body Mass Index
CCG	Clinical Commissioning Group
CMHT	Community Mental Health Team
CC	Care Co-ordinator
CPHA	Community Physical Health Assessment
CPHC	Community Physical Health Co-ordinator
CQUIN	Commissioning for Quality and Innovation
CLAHRC GM	NIHR Collaboration for Leadership in Applied Health Research and Care Greater Manchester
MAHSC	Manchester Academic Health Science Centre
MDT	Multi-Disciplinary Team
MMHSCT	Manchester Mental Health and Social Care Trust
SMI	Serious Mental Illness
PN	Practice Nurse
PM	Practice Manager

Quotation coding

North East CMHT:

North West CMHT:

Central East CMHT:

Central West CMHT:

South Mersey CMHT:

Executive Summary

- Building on the initial *'Improving the physical health of people with severe and enduring mental illness'* pilot evaluation (Jan 2012 – May 2013) this programme report details how these elements have been spread and sustained as the programme has rolled out across Manchester Mental Health and Social Care Trust (MMHSCT) during phases three and four (June 2013 – April 2015). The aim of the programme was to develop and implement a sustained integrated service user (SU) 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 serious mental illness (SMI).

- The report utilises the four key enablers identified in phases one and two to structure the findings: a) boundary spanning, b) knowledge integration, c) systemisation, and d) supportive organisational culture.

- The programme faced a number of challenges during phases three and four, including a) resourcing of the move from a pilot project to everyday working, b) service reorganisation, c) service capacity, and d) changing financial incentives. These have influenced the implementation of aspects of the programme.

- The ***boundary spanning*** nature of the Community Physical Health Co-ordinator (CPHC) role was key in a) sharing information, b) ensuring a better understanding of roles, and c) service user engagement with primary care. It was also recognised that sharing learning, education and training were essential in providing CPHCs with skills to be effective boundary spanners. The key challenges that CPHCs faced largely concerned their location and proximity to the Community Mental Health Team (CMHT) that they were working with, and the time required to perform the role.

- Multi-disciplinary team (MDT) meetings held within GP practices were effective vehicles for ***knowledge integration***. During phases three and four, 84 MDT meetings were held with over 293 related actions developed; the two most discussed topics being '*clinical information'* sharing (n=115; 35%) and *'non-clinical information'* sharing (n=82; 28%). The biggest challenges to knowledge integration involved the time to attend MDT meetings, and the recruitment of GP practices to work in this way.

- The ***systemisation*** of working processes related to physical health and SMI were also seen to be important, with a number of CPHCs relying on the 'traffic light' action feedback form, whilst they also developed systems related to SU physical health assessments. However, CPHCs found it challenging to identify close links with community lifestyle services, largely due to contextual challenges, and they found that completing templates and forms was quite time consuming, which limited their use.

- Having a ***supportive organisational culture*** is important for embedding the CPHC role. CPHCs found that where they received protected time, or a caseload reduction, it was advantageous; as the CPHC role requires time to prepare, plan and follow up the physical health management of SUs. The key challenges involved the lack of time CPHCs received to perform the role because it was often seen as an add on to their day-to-day full time role, along with there being limited mandatory physical health training in place.

- Overall, the programme has helped to improve the physical health management of people with SMI who are under the care of CMHTs. The aim has been partly achieved: to develop and implement a sustained integrated service user (SU) 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 serious mental illness (SMI). The CPHC role has been spread to five out of the six CMHTs within MMHSCT, with 8 CPHCs working with 20 GP practices. However, to fully embed this model of care there needs to be increased organisational support, adequate resourcing and dedicated training.

1. Introduction

This programme report builds on the existing *'Improving the physical health of people with severe and enduring mental illness'* pilot report (available from http://clahrc-gm.nihr.ac.uk/evaluation-reports/), which details the approach and the outcomes of the exploratory and pilot phases (one and two) of the programme which ran from Jan 2012 – May 2013 (see table 1). This report does not describe the key improvement areas (see figure 2) as these are detailed in the pilot report, with practical advice and guidance about implementing the Community Physical Health Co-ordinator (CPHC) role relying on multi-disciplinary team (MDT) meetings in the *'community physical health co-ordinator and multi-disciplinary team meeting guidance document'* (also available from http://clahrc-gm.nihr.ac.uk/).

This report focuses on the evaluation of the *'managed'* and *'supervised'* phases (three and four) of the programme, with specific focus on whether the successes of the initial pilot have been sustained and developed, as the model has been spread across the Community Mental Health Teams (CMHTs) within Manchester Mental Health and Social Care Trust (MMHSCT). Data is presented using the four key enablers identified in the pilot evaluation report (see figure 3), to describe the key elements associated with the roll out of the full programme. This is in line with the initial programme aim to develop and implement a sustained integrated service user (SU) 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 serious mental illness (SMI).

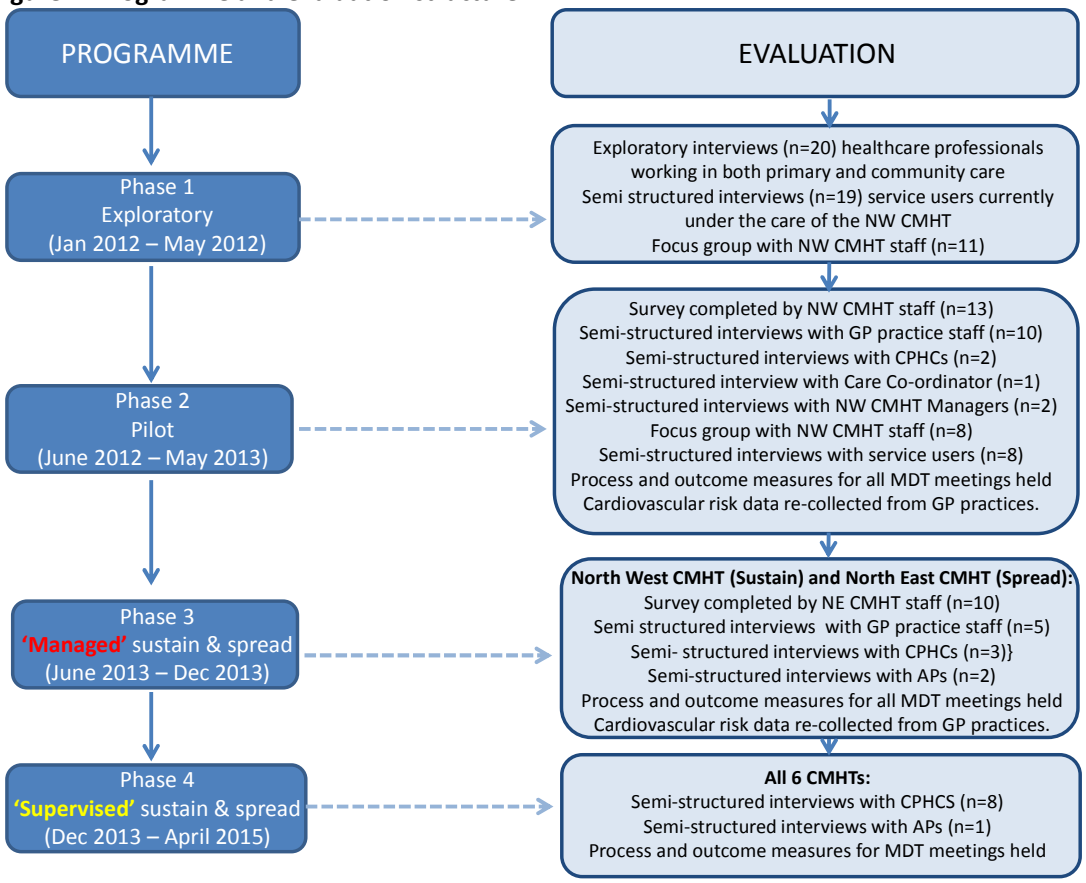
Table 1: Phases of the programme

Phase	Title	Timing
One	**Exploratory** *initial phase to scope out the current practices, challenges, systems and context; to develop a programme of work*	Jan – May 2012
Two	**Pilot** *involved the implementation and evaluation of the five improvement areas (2.1.3) with five general practices and one CMHT*	June 2012 – May 2013
Three	**'Managed' sustain and spread** *The work continued within the initial CMHT, with less (no financial backfill) CLAHRC GM support, whilst being spread to one other CMHT via CLARHC support.*	June – Dec 2013
Four	**'Supervised' sustain and spread** *Full roll out of the CPHC and MDT model of working, with the endorsement of MMHSCT, across all six CMHTs in MMHSCT, with no financial backfill support for any of the CPHCs.*	Jan 2014 – Mar 2015

2. Phases and Structure of the Overall Programme

Figure 1 describes the key phases of the programme and the corresponding methods of evaluation. The main method of data collection for evaluation involved semi-structured interviews with a purposive sample of key people. Cardiovascular risk data was collected at phase two and phase three. We were unable to collect this data during phase four as the programme moved to a more supervised design and the CLAHRC GM team had less day to day contact with the GP practices and CPHCs.

Figure 1: Programme and evaluation structure



2.1 Phases one and two

It is useful to recap on the aims (2.1.1), objectives (2.1.2), the five improvement areas (2.1.3) and the key implementation ingredients (figure 3), from the pilot report here, to put the findings in context. For detailed information about phases one and two please refer to the *'Improving the physical health of people with severe and enduring mental illness'* pilot report.

2.1.1 Aim of phases one and two:

The initial project aim was to develop and implement a sustainable integrated service user pathway that supports prevention, early diagnosis, treatment and management of physical health problems as part of the overall treatment and care of people with SMI.

2.1.2 Objectives of phases one and two:

The following project objectives were defined for phases one and two:

Objective 1:
To develop a system that demonstrates improved continuity of care achieved through strengthened coordination and collaboration between primary care and community mental health teams, such that there is a clear shared responsibility for the physical health of people with SMI.

Objective 2:
To develop clear pathways and guidance on delivering physical health checks in a community setting to ensure that the physical health of people with SMI is assessed on a more regular basis and access to appropriate care is timely, resulting in better health outcomes for the service user.

Objective 3:
To ensure that people with SMI are provided with improved access to lifestyle services currently available within MMHSCT, whilst improving the provision of targeted health information that will empower service users to take care of their own physical health needs.

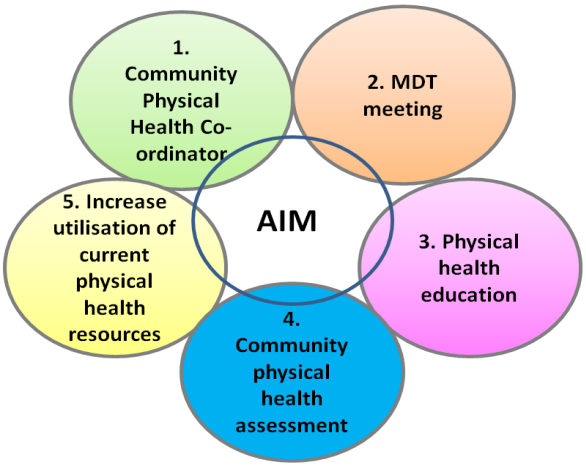
2.1.3 Improvement areas focused on the objectives:

To achieve the objectives the project focused on five improvement areas (see figure 2):

(1) Develop a CPHC role.
(2) Establish regular MDT meetings between CPHCs and GP surgeries to establish shared care with the North West (NW) CMHT.
(3) Identify the training needs amongst NW CMHT staff and deliver appropriate training to improve capacity to address physical health needs and support lifestyle change.
(4) Establish regular community physical health assessments (CPHAs).
(5) Increase the current utilisation of the existing physical health resources.

The project focused on SMI SUs under the care of a CMHT; it did not involve SUs under the care of other MMHSCT teams or those only under the out-patient psychiatry clinic. The project was initially delivered (pilot - phase two) with the NW CMHT and focused on improving the physical health of their SUs.

Figure 2: Initial project – Five improvement areas



2.1.4 Phase one and two findings:

The key aspects of this programme evaluation concern the four key enablers for improving the physical health care management of SMI service users identified (see figure 3). The four enablers were linked to individual project components and described key implementation ingredients

Figure 3: Project components and implementation ingredients from phase one and two

Enabler	Project Component	Implementation Ingredients
Boundary spanning role	**Community Physical Health Co-ordinator**	Split role; it is seen to be essential to continue as a Care Co-ordinator.
	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 PHLW. Integrated working between Assistant Practitioners and Care Co-ordinators.
	Physical Health Education	Taster hour sessions provided by the Physical Health Nurses. Mandatory physical health training for all CMHT staff.
	Increased Utilisation of Lifestyle Services	Collaborative training day for CMHT and lifestyle service staff.
Systemisation	**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 the Rethink physical health assessment. Distributing a physical health check bag to CMHT staff.
	Increased Utilisation of Lifestyle Services	Lifestyle services directory made available and distributed to CMHTs.
Supportive organisational culture	**Community Physical Health Co-ordinator**	Commitment to CPHC role, protected time and resources. Spread and sustainability strategy.
	MDT meeting	Supervision of Care Co-ordinators to reflect 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 Rethink physical health assessment. Support and guidance for completing the Rethink physical health assessment.

It is also useful to identify the outcomes associated with the objectives of phases one and two:

Objective 1:
The introduction of a CPHC and the use of MDT meetings did improve a) the relationship between the NW CMHT and GP practices, b) the communication, c) the co-ordination of physical health management, and d) the establishment of shared responsibility for the physical health management of SUs.

Objective 2:
Physical health training for all CMHT had been introduced to improve the skills and knowledge of staff towards Rethink CPHAs, with their being a greater acknowledgement from CMHT staff that physical health was important to SUs routine care. The Assistant Practitioner's (AP) role within the NW CMHT was also reframed to focus specifically on physical health and Rethink CPHAs.

Objective 3
As a result of the training days, Care Co-ordinators (CCs) from the NW CMHT appeared much more aware of a) what community lifestyle services existed, b) what they offered, and c) how to refer to them. This increased knowledge resulted in more CCs being confident in referring SUs to lifestyle services.

2.2 Phases three and four

This programme report focuses on the evaluation of phases three and four, with reference to the successes realised from the work in phases 1 and 2.

2.2.1 Aim of phases three and four:

The aim of phase three and four was to examine the sustainability and spread of the project components and implementation ingredients across all of the CMHTs within MMHSCT.

2.2.2 Objectives of phases three and four:

The objective for phases three and four has a wider focus than the objectives established for phases one and two, due to the changing nature of CLAHRC GM involvement throughout phases three and four from a *'managed'* to *'supervised'* role. The objective was, to investigate the implementation of the project components and to understand the critical ingredients for success, across the sustainability and spread phases of the programme.

2.3 Key changes to the operating context throughout the programme

There have been a number of organisational and process changes since the pilot phases, and during the roll out across MMHSCT that include:

a) Resourcing of the move from pilot to everyday working:

- As part of the initial agreement with MMHSCT, CLAHRC GM backfilled two CPHCs attached to the NW CMHT (pilot phase); during phase three the funding was removed for the CPHCs at NW CMHT but CLAHRC GM backfilled the time of a CPHC from the North East (NE) CMHT as a means of testing '*spread'* to a different CMHT; during phase four there was no financial backfill from CLARHC GM for any of the CPHCs. Backfill was removed via agreement from MMHSCTs Transformation Board in Nov 2013, to integrate this model of working with 30 GP practices across all 6 CMHTs as part of *'core'* CMHT working.

b) Service reorganisation:

- The programme commenced during the implementation of a Community Services Review (CSR). Following a number of delays to the CSR and as the programme started to gain momentum during phase three, the effects of the CSR became increasingly apparent. As part of the CSR process there were a number of changes to staffing which hindered the spread and sustainability of the programme. For example, both of the initial CPHCs from the NW CMHT were transferred to different teams, one to a different CMHT, and one to the Review team which had limited connections to the NW CMHT.

- The CSR process also resulted in the partial integration of Assertive Outreach Teams (AOTs) into CMHTs during phases three and four, which caused a number of disruptions to the culture and working relationships within the CMHTs. During phase four there then appeared to be a move towards dis-integrating AOT from CMHTs. These structural and staff changes resulted in a challenging operating context.

c) Service capacity:

- Capacity issues within the CMHTs, due to staff illness, waiting lists and high use of agency staff within some CMHTs, also made the operating context difficult and this affected the uptake and participation of certain CMHTs.

d) Changing financial incentives:

- The associated physical health related CQUIN targets altered throughout the phases of the programme. The initial CQUIN during the pilot phase involved the use of the Rethink tool as a form of community physical health assessment (CPHA) on all SUs under the care of the CMHT for one year of more. This was altered during phase three with the CQUIN target changing to simply require that a CPHA was carried out by the CMHT only on SUs who had not received a physical health assessment by their GP, which is a subtly different operating model to the previous phase.

2.4 Spread and roll out of programme components

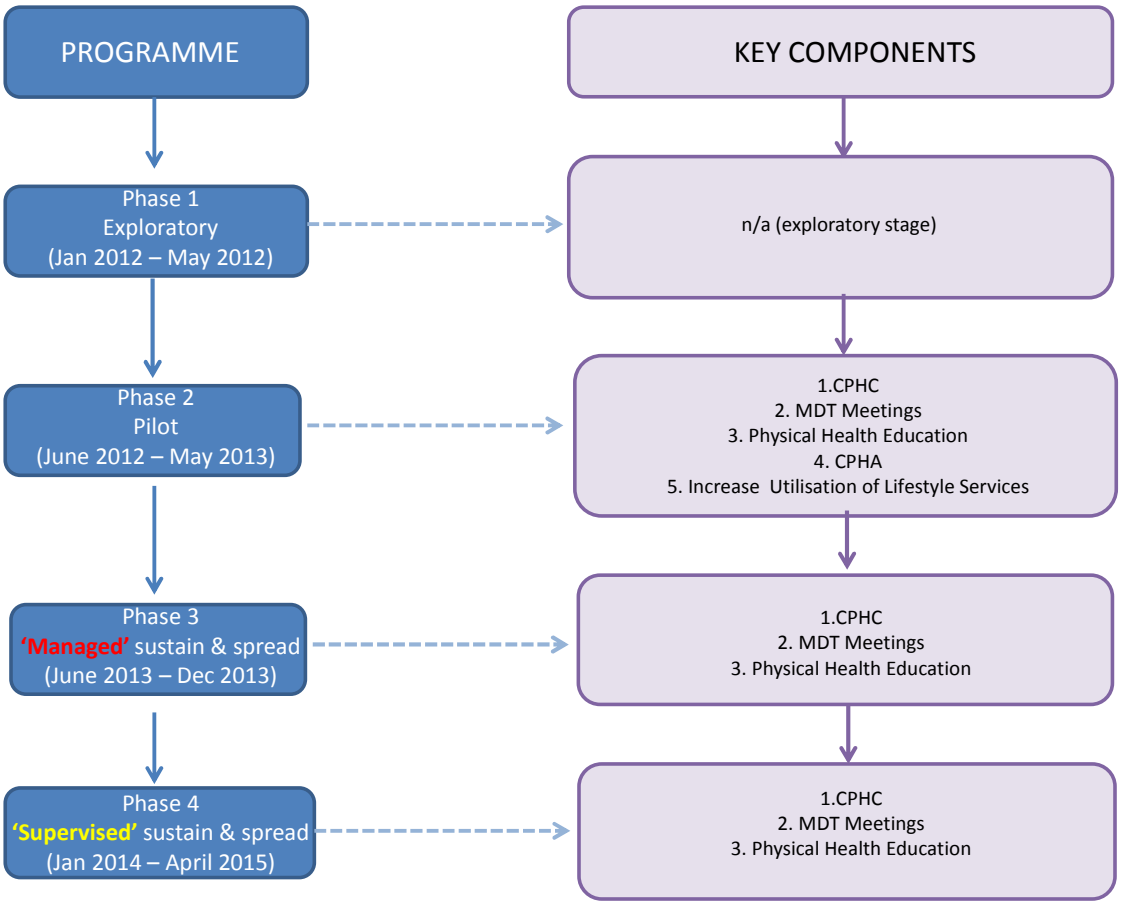
As stated in 2.2.1, the aim of phase three and four was to examine the sustainability and spread of the project components which were facilitated in different ways, phase three was a *'managed'* process and phase four was referred to as a *'supervised'* process. Because of the difference in stages of the programme, it was not possible to spread all of the project components that were initially tested in phase two.

As highlighted in the *'key changes to operating context'* section 2.3, the changing nature of the physical health associated CQUIN, resulted in less active promotion of the use of Rethink CPHAs by CMHT staff during phases three and four of the programme. CPHCs were encouraged to promote the use of Rethink CPHAs with their colleagues, however it was difficult to implement due to the nature of the new CQUIN target. The specific components of the programme that were delivered throughout all of the phases of the programme are shown in figure 4.

As figure 4 displays, during the pilot phase two, all NW CMHT staff received a dedicated training session facilitated by Manchester Public Health Development Service (MPHDS), focused on improving the knowledge of CMT staff about the local lifestyle services that were available for SUs. Due to the changing nature of MPHDS's service delivery model and the service reorganisation (see section 2.3) it was not possible to repeat this during phase three and phase four with the other

CMHTs. CPHCs were encouraged to promote the lifestyles on offer, within their CMHTs; however there were no formal education or knowledge sharing sessions delivered.

Figure 4: Key components at the different phases of the programme



2.5 Structure of the evaluation of phases three and four

Unlike the pilot report, which evaluated each of the objectives of phases one and two individually, this evaluation utilises the four key enablers outlined in figure 3, to ascertain a) the extent to which these have been implemented, b) the aspects which have worked well, and c) the challenges faced, when the work has been rolled out across all six CMHTs in MMHSCT during phases three and four. The enablers are

a) Boundary spanning
b) Knowledge integration
c) Systemisation
d) Supportive organisational culture.

3.0 Boundary Spanning Role

3.1 Description

Boundary spanning is the activity whereby individuals within an organisation provide information and communication, acting as information brokers and as conduits for resources, information and influence. Boundary spanners facilitate the communication and sharing of expertise by linking groups who are separated by location, division, or function[1]

Core elements of the CPHC role included:

- Building relationships with CCs within the CMHT and to raise the awareness of the need for CPHAs.
- Spanning the boundaries of primary care and the CMHT.
- Developing a close working relationship with GP surgeries and to facilitate the implementation of physical health management plans.
- Developing a close working relationship with other physical health focused roles, in particular Assistant Practitioners (APs) within CMHTs
- Developing a good working knowledge of the local community and voluntary sector lifestyle services.

The role of the CPHC was to act as a co-ordinator, spanning the boundaries of primary and community care, focused on improving the relationship and facilitating the co-ordination of care. For CPHCs to act as *'boundary spanners'* they needed physical health related training.

During both the pilot phase two and the *'managed'* phase three of the programme, CPHCs were provided with core training around physical health. This was predominantly delivered by the CLARHC GM team and the two Physical Health Supporting Health Nurses from MMHSCT; figure 5 provides an overview of the topics and key elements of this training. One of the biggest successes of the pilot project was MMHSCT establishing that physical health training for all CMHT staff would be mandatory, on a rolling three year cycle.

However, with the service reconfigurations (see section 2.3) and the changing role of the Supporting Health Nurses, the uptake and implementation of mandatory training was difficult. Consequently, during phase 4, the CLAHRC GM team adopted a different training model; the team established monthly CPHC meetings, similar to action learning sets, and as part of these monthly meetings *'expert'* sessions were delivered by a range of local clinicians. These sessions included education on: a) stroke, b) diabetes management and detection, c) weight management, d) COPD, e) Amigos training around the recording of physical health information, f) antipsychotic medication and the physical health related side-affects, and g) smoking cessation.

[1] Gittell, J.H., (2009). *High Performance Healthcare: Using the power of relationships to achieve quality, efficiency and resilience.* McGraw-Hill: New York.

Figure 5: Pilot phase training for CPHCs:

Core training	Elements
Physical Health	1. The severity of the physical health problem 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 the MMHSCT) 9. Physical health related case study examples from the Trust's serious untoward incidents (SUIs) record)
Primary Care	1. The GP practice environment 2. Primary 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 Clinical IT systems and READ Coding 5. The use of cardiovascular risk screening tools (e.g. QRISK2)
Community and volunteer lifestyle services	1. What services exist 2. Their suitability for people with SMI 3. How to refer into them
Running effective meetings	1. Facilitation 2. Conflict management 3. Negotiation

3.2 Has the initial work from the pilot phase been sustained or developed?

There are a number of elements of a boundary spanning role that have been sustained by the CPHCs during phases three and four of the programme. Despite this, CPHCs have faced a number of challenges, particularly in relation to organisational changes.

3.2.1 What worked well?

a) Sharing information:

Collaboration and co-ordination between primary and community care is pivotal for providing effective health care. The role of the CPHC was to act as a co-ordinator, spanning the boundaries between community and primary care, with the aim of improving co-ordination of physical health care for SMI SUs. The CPHCs facilitated the sharing of information across and between services, which helped to improve relationships and promote a greater understanding and respect for professional roles.

"I guess that I've got an increased understanding of what goes on in GP practices, and their agendas, and the way they view things, which is quite interesting… The CPHC role is to enhance the relationship between us, the mental health team, the GPs, and to increase the communication backwards and forwards between the two." (CPHC1 – phase 4)

"We didn't have an understanding of the role of each [GP Practice and the CMHT] and there have maybe been some strains in relationships and not having information passed, so I think to have that

person to link between [is good] and the GPs know that even outside the meeting, they can e-mail me if there's something urgent." (CPHC2 – phase 4)

"What's really enhancing [the care] and improved things is the CPHC coming in and coming to the MDT meetings, it is really helpful speaking the CPHC before and afterwards, having a list of patients who we both understand, where we talk about the same people and have the opportunity to raise other people/ patients who should be included in both of caret... So I've seen it [good practice] not only at MDT meetings, but also as a result of carers or professionals coming in with patients to help facilitate their [service users] health and engagement with health services" (GP – Phase 3)

On the whole, CPHCs were viewed as a conduit for information sharing and provided a link and liaison role between services, with the primary aim of gathering information between teams and co-ordinating physical health related SU actions. CPHCs were responsible for communication and engagement, with a focus on mobilising a shared willingness to collaborate to improve the physical health care of SMI SUs. A core component of the role was to act as a bridge between professionals and services and to ensure the effective flow of communication.

CPHCs were expected to liaise with CCs regarding specific SU actions and ensure that they are followed up. The CPHC role helps to provide some accountability in terms of facilitating engagement.

b) Understanding of roles:

The CPHC role helped to develop an understanding of roles and trust between the two services.

"Yeah, so it's liaising with GP practices and sort of gathering information from CCs and from the GPs around the SUs typical health." (CPHC - phase 4),

"They [CPHCs] acted as a conduit to their team and relayed information from the GP regarding individual clients." (CC – phase 3)

"The main advantage was increased communication with GP surgeries [in particular the more difficult ones to work with], and we have one particular client, he/she had a serious case manager because he/she had COPD and lots of other physical health conditions going on. It was quite good to hear their [GP surgery] side of the argument, whilst I was supervising the Care Co-ordinator who was involved in his/her care, because the client was a very tricky customer, and could be very aggressive. But, the advocacy did work, and it possibly improved his/her outcome." (CPHC1 – phase 4)

"I think it [CPHC role] made the GPs, certainly the clinicians, consider contacting the service more readily than they had done previously. I think they felt they had a contact person in the CPHC to be able to channel things through." (PN – phase 3)

"I had a good relationship with the GP there. We had one another's email addresses, the NHS.net address, so that enabled us to stay in contact, in between meetings, if necessary. So yeah it was a good relationship." (CPHC2 – phase 4)

c) Engagement with SUs:

The CPHC role also helped to improve engagement with SUs, helping to encourage attendance at GP appointments, specifically disease reviews and blood tests. Often the CC had relevant information regarding a SUs mental health condition and/or lifestyle, which may act as a barrier to attending the surgery. Ensuring that CCs were aware of the importance of attending a physical health care

appointment helped to facilitate SUs engaging with primary care and as the following quote states, provide a *'seamless'* service for SUs.

"The role is to act as that sort of link person with the GP surgery… bridging that gap between the mental health and the physical health…having that seamless service, so it improves the SUs' experience…The GPs might be exasperated by sending out letters, trying to get people to come for their health checks, and then I might come along and say, "well they never leave the house. So maybe you need to come to them." And that might have been going on for ages and no-one's got anywhere and no-one's thought to do anything about it, so just having that liaison means that things might actually improve." (CPHC1 – phase 4)

"Definitely a lot more people are being seen and it's made it easier to mainly get prescriptions done" (CPHC – phase 4)

d) Sharing skills, training and learning:

Shadowing was seen as a useful way to gain experience of the CPHC role and to understand the role requirements and the necessary skillset. Shadowing also provided an opportunity for CPHCs to attend MDT meetings and to observe how colleagues facilitated MDT meetings and provided a level of peer support and guidance, as the following quote illustrates;

"When I first started, giving me a good script and run down of what the role has entailed in the past. I went and shadowed someone else…so that was helpful, just to go and see how it runs." (CPHC2 – phase 4)

CASE STUDY:

Philip has schizophrenia and was notorious for missing his health checks and GP appointments. Before the introduction of a CPHC, he was only semi-compliant in attending his blood, cholesterol and ECG tests.

Information passed on by John (CPHC) through his discussions and liaison with the GP practice, led Philip's Care Co-ordinator from the CMHT to prompt Philip to attend his appointments. Phillip is now aware that he has to have regular blood, cholesterol and ECG tests to make sure that his physical health, as well as his mental health, is accounted for. Since the introduction of the CPHC Philip has only missed one appointment so far, but as part of the liaison and co-ordination with the GP practice this was picked up and Philip has attended an extra appointment in place of the one he missed.*

As previously described, during phase four all of the CPHCs were invited to attend monthly meetings organised by the CLARHC GM team. Attendance at these meetings provided support for their development and an opportunity to share experiential learning and knowledge. The meetings were scheduled for two hours, the first half dedicated to providing updates and shared learning, with the second half focused on developing knowledge in a particular physical health related areas. This was well received by the CPHCs, with this being dedicated time and space for them to come together as a *'team'* of CPHCs.

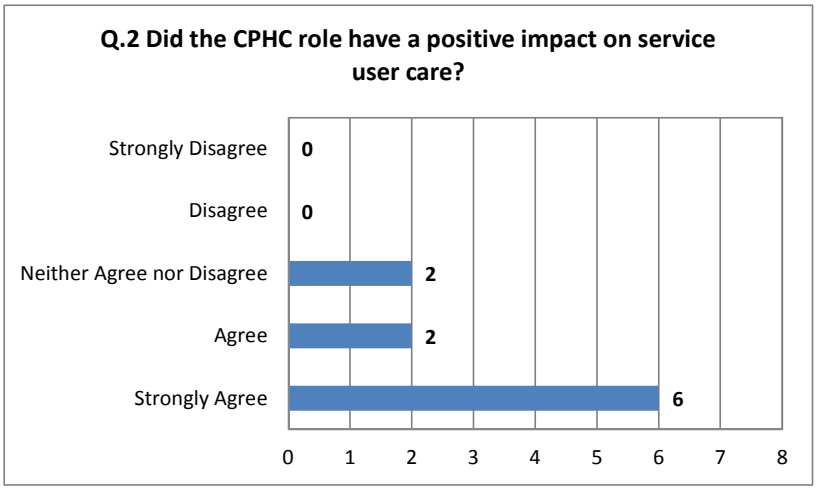
"Yeah I found it really useful, really interesting, I thought I was quiet knowledgeable in some of the topics, but the expert sessions made me realise that I wasn't. They were really insightful."
(CPHC2 – Phase 4)

"Those [education sessions] have been very, very useful, I've learned a lot from them, diabetes and it was Dr X that did the thing about Lithium, and then there was the one about stroke, that was very good, that's been very useful" (CPHC – Phase 4)

"Yes, they were very useful. The ones that did the diabetes I thought were really, really good, it really cements the knowledge that you have and, kind of, reframes things. The one on, was it, smoking and clozapine, that was very useful. Yes, they were very good."
(CPHC1 – Phase 4)

Overall, where CPHCs had links with GP practices, they were able to fulfil their boundary spanning role between primary care practices and the CMHT. It is also clear that this has improved relationships and communication flows between the two services; this is perhaps best typified by the positive opinions (figure 6) that the CCs surveyed from the NE CMHT had about the role of the CPHC during phase three of the programme, with n=8 (80%) believing the role to have a positive impact on SU care:

Figure 6: NE CMHT survey results on the impact of the CPHC role



3.2.2 What were the challenges?

a) Location of CPHCs:

During phases three and four a number of challenges to the boundary spanning nature of the CPHC role were experienced. One of these being that CPHCs found that working in a different locality to CCs had a negative impact on the flow of communication as it made it difficult to communicate face-to-face with CMHT staff. This was highlighted during phase three, when one of the original CPHCs from the pilot phase, moved to a different service situated in a different office, as part of the structural changes of the CSR. Location had a negative impact on access to information, CPHCs felt that they had a reduced awareness of organisational and team issues when they were based at a different location to CCs.

"It's been more difficult to keep up with what's happening with the CMHT with the client groups and just not being in the office on a daily basis means that I don't hear what's happening with service users, I don't get the opportunity to chat informally with care coordinators and I have to make a special trip to meet with them or take special time to check Amigos more thoroughly. I haven't got the regular contact with the GPs surgeries for my own clients, so again it feels like a slightly forced relationship." (CPHC – phase 3)

"I think I used to get a lot of verbal responses before, which is harder for people to give me now because I'm not in the office. I'm getting fewer emails as well because I'm not visible in the office I think to remind people." (CPHC - phase 3)

Locality was also an obstacle for two CPHCs during phase four, as they were based in a different office to the CCs in their team. This was a particular problem when new members of staff joined the CMHT, as there was less opportunity to discuss the role and the MDT meetings and an increased reliance on communication via email.

"In my last team I was with the team, I got less work done, but then I knew of all the dynamics that materialised. Here it does feel a bit distant." (CPHC – phase 4)

For the CPHCs based in different locations to their associated CMHT, it was noted by some GP practice staff that this affected a) the relationship, b) information sharing, and c) boundary spanning ability of the CPHC. This was more evident during phase three, where the CPHC moved to a new team having previously been based within the CMHT and having established relationships with GP practice staff as part of the pilot phase 2 of the programme.

"it has tailed off in that I don't think we've had the same level of input from the CPHC, or anyone else, into the project, and as a result of that I also think that internally in the practice that has meant that we have not necessarily considered patients with mental health problems and their health care." (PM – phase 3)

b) Time to carry out the CPHC role:

The lack of time that CPHCs had for the boundary spanning role was also a key challenge to the programme. This lack of time was a challenge to all aspects of the four enablers, and it will be discussed in more detail within the '*knowledge integration'* section 4.2.2 and the *'supportive organisational culture'* section 6.2.2 of this report.

3.3 Skill set of CPHCs

The CPHC role required a specific skillset:

- They need to be effective communicators and this appears to more common in relatively senior CCs who are 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 represents the face of MMHSCT to the general practices.

- As the data illustrate, the CPHC role involves large amounts of liaison with co-ordination between primary care and the CMHT; this means that the CPHC should have excellent organisational and time management skills.

- All of the CPHCs involved in the programme had a split role, they were CCs or Assistant CMHT Managers and the CPHC role was an add on to their role in the CMHT. Being able to balance the complexities of a split role, requires forward planning and organisational skills.

Therefore, it is inappropriate to view the role as *'interchangeable'*, whereby any CC can simply step into the post. Training regarding core role components will help to equip CPHCs with the required skills.

3.4 Implications for sustainability

- Protected time for the CPHC role is crucial for sustaining improvement.
- The CPHCs play a key role in facilitating the flow of communication to encourage SUs to attend surgery appointments.
- The importance of locality, CPHCs and CCs working in the same office/location.
- CPHCs need appropriate training and guidance, particularly if they have limited IT expertise.
- The seniority and experience of the CPHC is crucial in the success of the role

4.0 Knowledge Integration

4.1 Description

Knowledge integration is 'a process for co-ordinating the specialised knowledge of individuals'. It is a multidisciplinary process that involves three related components: knowledge management, knowledge synthesis, and knowledge translation[2].

The main vehicles for knowledge integration were MDT meetings situated within the primary care general practice setting. The MDT meetings functioned as a structured platform for supporting and sustaining the communication and co-ordination between primary care and the CMHT. They were used as the medium to exchange information about SUs; helping to fill in the gaps where knowledge was lacking.

Throughout phases two, three and four, the CLAHRC GM team in collaboration with the associated CMHT approached general practices. A member of the CLAHRC GM team largely facilitated the initial approach with introductory meetings attended by CLAHRC GM facilitators, GPs and assigned CPHCs. As part of the introduction meeting, a proposed *'working'* plan and structure for future meetings and discussions was developed. The evaluation of the pilot project illustrated that a *'one-size fits all'* approach to working with GP practices was not productive, so the frequency, vehicle and types of interactions differed from practice to practice. For some GP practices, CPHCs attended existing MDT meetings to discuss physical health and SMI as part of a wider discussion, for others it was a dedicated MDT solely focusing on physical health and SMI; some CPHCs visited the GP practice monthly, others it was bi-monthly; there was one instance where the majority of communication was via NHS.net and then a phone call to discuss further.

During phases three and four, the differences in the interactions and structures of MDT meetings was not evaluated, as it was clear from the pilot evaluation that MDT meetings should be locally designed and there was no one *'best'* approach.

4.2 Has the initial work from the pilot phase been sustained or developed?

By the end of phase four (March 2015), there were 20 (out of a target 30) GP practices and 8 CPHCs, across 5 (out of 6) CMHTs working collaboratively to improve the management of physical health and SMI management, who were engaged in the programme. Practices were recruited over time through a process of *'snowballing'* and active recruitment by the CLAHRC GM team. A total number of 84 MDT meetings were held between January 2014 and March 2015; this is illustrated in figure 7, which details the number of MDT meetings per month and the estimated number of SUs discussed, during phase four of the programme.

To supplement figure 7, all CPHCs were encouraged to collect action logs to detail the discussions and decisions that were made during MDT meetings. Not all of the CPHCs were able provide action data, but for those that could, figure 8 outlines that there were 293 associated actions.

As figure 8 displays, the majority of discussions and actions (n=115; 35%) involved *'clinical information',* this groups a number or related actions, such as the sharing of blood results, mental

[2] Grant, R. M. (1996a). "Toward a Knowledge-Based Theory of the Firm." Strategic Management Journal **17**(Winter Special Issue): 109-122.

health information updates and physical health related information exchanges. '*Non-clinical information'* MDT sharing actions were the second largest number (n=82; 28%), this groups together actions relating to social work and the associated lifestyles of SUs. Interestingly, figure 8 also demonstrates who was responsible for the actions generated from the MDT meetings, with the majority of actions being related to the CPHC and CCs from the CMHT (n=113; n=81, combined =194), rather than the GP (n=55). This is a marked shift from the pilot phase two evaluation, which suggested a relatively equal distribution of the actions between the CMHT and the GP practice time.

Figure 7: Number of MDT meetings per month

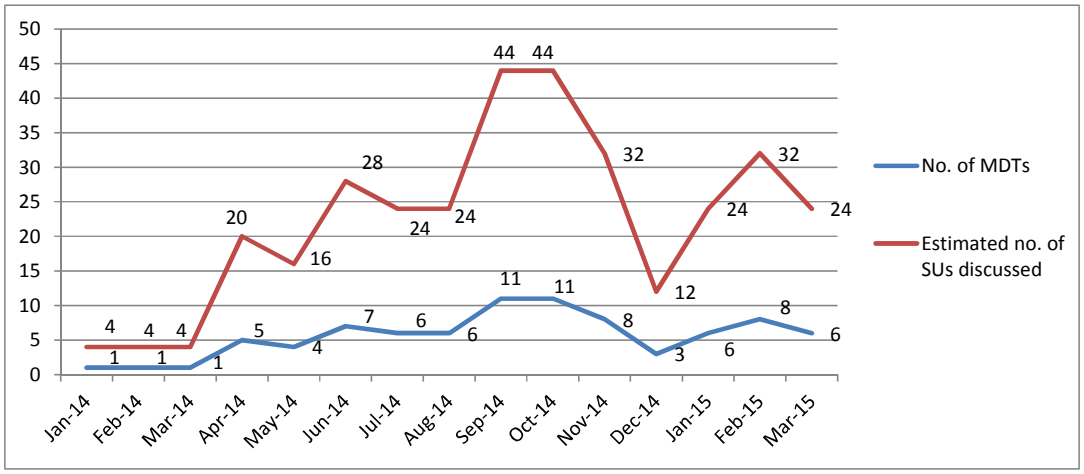


Figure 8: Number and type of MDT actions

	Lifestyle service referral	Clinical information	Disease reviews	Medication review	Non-clinical information	Primary Care physical health assessment	Specialist referral	Test/ Investigation	Totals
CPHC	5	55	1	2	48	1	1	0	113
CC	5	37	1	0	26	4	2	6	81
GP	10	10	2	4	4	7	9	6	52
AP	7	6	1	0	1	4	0	3	22
CC+GP	0	2	1	1	0	3	1	1	9
CPHC+CC	1	4	0	1	2	0	0	0	8
CPHC+GP	2	0	1	0	1	0	1	0	5
CPHC+AP	1	1	0	0	0	0	0	0	2
PN	1	0	0	0	0	0	0	0	1
Total	**32**	**115**	**7**	**8**	**82**	**19**	**14**	**16**	**293**
%	**11**	**39**	**2**	**3**	**28**	**6**	**5**	**5**	

It was not possible to fully embed the CPHC role within all of the CMHTs across MMHSCT; there was one CMHT that did not engage despite a range of attempts using a variety of approaches. Some of the challenges (see section 4.2.2) resulted in problems recruiting further GP practices even within CMHTs that were engaged.

4.2.1 What worked well?

a) MDT meetings:

The MDT meetings provided an opportunity for health care professionals to come together and discuss SUs physical health needs and requirements and provided a way of gathering more in-depth information about SUs conditions.

"I think it [the MDT meeting] was really good, because it was quite focused and prepared. The GP would bring up his/her computer for each client and we would ask questions, like 'have they been collecting their prescription?'… So yes [it was good], it was quite specific areas that you could focus on" (AP – Phase 4)

The range of staff attending the MDT meetings ensured that the discussions were productive and promoted collaborative decision-making. On a number of occasions, CMHT staff attended MDT meetings alongside their CPHCs; this was particularly useful for providing information and feedback regarding a specific SU. This multidisciplinary approach facilitated joint working and helped to build relationships across and between services. Primary care staff were able to meet a range of individuals from the CMHT and CMHT staff had a greater awareness and understanding of the MDT meetings and the CPHC role. Sharing information enabled the teams to provide a co-ordinated approach to the care of SUs.

"When you need a bit more of a discussion about care planning and more ambiguous stuff, that open dialogue, then you definitely need the meetings… and the meetings will very much become more of that discursive-based type, which is needed. Hence why, you know one of the CPNs is coming to the GP meeting, 'cause there's no point him sending 50 e-mails back and forth for the GP, when they can have a meaningful discussion, debate and agree and action plan in that meeting." (CPHC – phase 4)

"Sometimes you get a little bit more knowledge about other conditions that you didn't really know about properly." (CPHC – phase 4)

"Greater understanding of the clients overall condition, enabling me to positively add to the care package" (CC – phase 3)

"It [MDT meetings] has also highlighted compliance issues with one of my clients for both physical and psychotropic medication which I have then addressed via CPHC's work" (CC – phase 3)

CPHCs commented on the importance of clarifying roles and objectives either in a pre-meeting or at the initial MDT meeting. The first MDT meeting was crucial for building relationships and developing trust. It was important for GPs to feel confident in the CPHC and this could be an important facilitator for future collaboration. Clarifying roles proved effective for developing a clear understanding of the objective of the meeting and the value that each professional could bring to the discussion, this may also save time in the future as individuals will be clear about what information they are expected to gather prior to the meeting and who is responsible for completing actions. MDT meetings also provided an opportunity for CPHCs to build relationships with other healthcare professionals involved in the care of SUs registered with the CMHT. This enabled further sharing of information and actions particularly when district nurses could also provide a physical health check in clients' homes.

"You've ironed out what the role is [CLAHRC GM] and they've [GPs] got a clear understanding of it." (CPHC – phase 4)

All CPHCs interviewed (100%) reported that they could discuss all clients identified at MDT meetings, although a client list could have been long (e.g. up to 40 clients) the MDT meetings allowed staff to identify and discuss those in urgent need of physical health assessments.

CASE STUDY:

Lewis had been suffering with recurrent ear infections, he is deaf in one ear and he has started to experience problems in the other. At first glance, it seemed that Lewis's problem was caused by a build-up of ear wax, however through regular contact with his Care Co-ordinator, Lewis continued to stress that he was struggling with his hearing. Lewis's Care Co-ordinator informed and worked with the CPHC, who in turn liaised with Lewis's GP. As a result of these discussions, Lewis's GP arranged for him to be referred to an audiologist to have his hearing checked, which resulted in Lewis' hearing aid being replaced. The involvement of the CPHC ensured that the Care Co-ordinator's concerns about Lewis were followed up in a timely and appropriate manner; this co-ordinated approach has allowed Lewis to have a better quality of life.

4.2.2 What were the challenges?

There were two key challenges to knowledge integration; the first involves the time to attend MDT meetings and the time to prepare appropriately, the second relates to the difficulties engaging with GP practices.

a) The time to attend MDTs:

The time required to fulfil the CPHC role is a challenge for all of the four enablers, and it will be discussed in more detail within the *'supportive organisational culture'* section 6.2.2. However, the preparation for, attendance at, and follow up from MDT meetings does require a substantial amount of CPHC time, which they often found difficult to manage, despite it being a part of their role.

"It was an additional task [preparing for meetings], and quite a time consuming one…" (CPHC – phase 3)

"The disadvantages to it [attending MDT meetings] are the time is takes really to do it… the actually meeting doesn't take particularly that long, but the follow up from it did take quite a lot of time." (CPHC – phase 4)

"It's the time and… because you've got so many different roles that you have to undertake and it's trying to fit everything in." (CPHC – phase 4)

b) Recruitment of GP practices:

In terms of engaging GP practices, largely due to the contextual challenges that many of the CMHTs faced, it was difficult to actively recruit GP practices, as it was often unknown if the CPHC resource would be available to fill the role.

4.3 Implications for sustainability

- The physical presence of CMHT staff at MDT meetings is crucial for on-going engagement and collaboration.

- Reduced attendance at MDT meetings was attributed to a lack of protected time to fulfil the CPHC role.

- Clarifying MDT meeting objectives and individual roles is important for establishing engagement and developing trust, which facilitates collaborative working.

- Changes in responsibility for MDT actions in phases three and four (an increase in the number of MDT actions assigned to CPHCs and less to GPs) suggests reduced collaborative working in phases three and four.

5. Systemisation

5.1 Description

Systemisation means creating processes across various divisions or locations, which can result in processes that consistently meet objectives and reduce the risk of failure. The objective of systemisation is to specify transparent and uniform process activities across the organisation or service boundaries[3].

Physical health needs and requirements change over time and services need to respond in a flexible approach through the co-ordination and integration of knowledge. Developing systems and processes, which are managed across services and not reliant on one team or individual, helps to ensure that a consistent approach to managing and sharing information is developed and sustained. Developing sustainable systems is a way of ensuring that changes are locally tailored and sustained.

Throughout phases two, three and four of the programme the systems and processes displayed in figure 9 were developed:

Figure 9: Systems and processes developed

Process/system	What	Area adopted
MDT proforma sheet	A document/questionnaire that gathers essential SU information. This should be filled in for all new SUs that have not yet been discussed at an MDT meeting.	Central East North East North West (partial) South Mersey
Traffic light action form	A form to document all actions agreed during MDT meetings. This defines what the action was, it's progress, and the person responsible for it. This should be taken to each MDT meeting to document new and review previous actions.	North East Central East Central West North West (partial) South Mersey
Rethink physical health assessment tool	This a comprehensive physical health assessment, primarily used by APs, for SUs who do not receive a physical health assessment at their GP practice,	Used sparingly by all teams (APs use rather than CCs)
CPHC guidance document	A document to provide information about the CPHC role, on how to choose and train a CPHC. The document also provides guidance on the process of preparing, attending and following up the MDT meetings, and how to select service users. The document contains the MDT proforma sheet and the traffic light action form in its appendix.	All CPHCs made aware of the document, unknown actually how many used it.
Health check bag	A bag containing equipment that is needed to carry out the Rethink Assessment Tool, which includes: a) Blood pressure monitor, b) scales, c) a measuring tape, d) urine test kit, e) urine sample pot, and f) BMI calculator.	All CMHTs

[3] Nielsen GA, Rutherford P, Taylor J. *How-to Guide: Creating an Ideal Transition Home*. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at http://www.ihi.org.

5.2 Has the initial work from the pilot phase been sustained or developed?

Due to the pilot nature of the work during phase two, a number of the documents and tools highlighted in figure 9, were generated as part of this phase. During phases three and four CPHCs looked to build on these processes, refining and developing them so that they were designed to meet local ways of working and develop their own systems of working.

5.2.1 What worked well?

a) Traffic light action feedback form:

To initiate and formalise joint working, CPHCs developed systems to improve communication between CCs and GPs, systems such as the MDT proforma and the traffic light action form which were developed during phase 2. These did help CPHCs to improve the flow of communication between services and provide accountability for actions.

"I will produce a spreadsheet of all the SUs we've got at that GP practice and I'll e-mail round all the CCs…they'll fill in the spreadsheet. There's a box for comments for them to bring things up, to say if everything's okay, anything they want me to discuss were on there and then I e-mail that across to the GP surgery and then I'll feedback and action things with care coordinators when I'm back, verbally or via e-mail." (CPHC - phase 4)

"Important to actually try and have an action plan…documenting on Amigos, so certain things were very much needed to be documented…it's all part of trying to improve the physical health of the clients" (CPHC – phase 4)

As displayed in figure 8, the majority of CPHCs collected MDT action data through the traffic light action feedback form, and it is clear that this helped to facilitate and capture physical health related working.

b) Identification of systems for physical health assessments:

In an attempt to develop a process for physical health assessments, during the pilot phase two, the CLARHC GM encouraged the use of the Rethink CPHA. There was an initial resistance from CCs within the NW CMHT towards completing the Rethink CPHA due to limited knowledge of physical health, particularly for those without a nursing background. To address this, physical health and Rethink training was made mandatory for all community staff, so that they had the appropriate knowledge and confidence to complete the assessment. The emphasis on physical health and physical health assessments had a positive impact on CC's attitudes regarding the importance of physical care and it is now acknowledged as an aspect that should be included in routine care provision.

During phases three and four, the responsibility for completing the assessments shifted from CCs to APs, which is partly due to the reframing of the AP role which occurred alongside the changes to the physical health assessments and training. APs also facilitated SUs attending the GP practice so that primary care staff can conduct the physical health assessments. This method of working has seen an increase in the number of physical health assessments completed and the importance of the assessment is being seen in earlier detection of diseases which would otherwise have gone unnoticed.

"I don't tend to do the Rethink assessments … I tend to take people for physical health checks [at the GP Practice], I encourage them to actually go and I will go with them. I think it's more important that they see the GP rather than me doing the Rethink assessment Tool." (AP – phase 3))

"Yes, they [CCs and CPHCs] will come to me if they want to a Rethink physical health assessment doing, for example, if the client has got a lot of physical health problems that the Care Co-ordinator is struggling to get the best input with, I can directly help with that." (AP – phase 4)

It is evident that the physical health assessments are valued by those health care professionals involved with the project, and they are seen as important for holistic care, despite this, there remains some disagreement regarding who should perform the assessments.

"Last year, I think it was 9 who had diabetes and didn't know they had it [as a direct result of Rethink CPHA]" (AP – phase 3)

"If the CC does do a rethink it would probably lead to a much deeper discussion- more likely to identify issues" (CPHC – phase 3)

It is often difficult to engage with SMI service users, particularly asking them to attend the GP practice for a physical health assessment. In a number of cases the AP completes the assessment when the SU attends a CC or GP appointment; this appears to be a more effective use of time, as the CCs are not required to assist the SUs in coming back to the surgery on a separate occasion.

"If somebody came in [to the GP] for an appointment, I will catch them after… I just say hang on a minute let me do this on you so I do a few of them that have just called here for an appointment and the Care Co-ordinator says do a Rethink after." (AP – phase 3)

Overall, setting up clear systems and processes for communication and co-ordination has enhanced the management of physical health care for SUs under the care of the CMHT.

CASE STUDY:
Beverley had been suffering with depression and following an overdose, the CPHC within the CMHT were able to improve the communication and co-ordination between Beverley, her Care Co-ordinator and her GP. The CPHC liaised with both the GP practice and Beverley's Care Co-ordinator to ensure that the GP practice was kept up to date with any developments. Beverley's Care Co-ordinator was able to speak to the CPHC, so that the CPHC could in turn speak on her behalf (as this made her feel supported) and thus speed up the process of Beverley's GP receiving the discharge plan following her overdose. From here, Beverley received the appropriate medication and follow up care.

5.2.2 What were the challenges?

a) Links with community lifestyle services:

Following the pilot phase two, CCs within the NW CMHT appeared to be more aware of what community lifestyle services were available, what they could offer and how to refer SUs, which resulted in improvements in the number of CCs promoting and suggesting lifestyle services to SUs.

However, findings from phase three and four show that this trend has not been continued, which is possibly because it was not possible to repeat the lifestyle service training sessions that were delivered to the NW team in phase two. This is compounded by the poor relationship between CMHTs and the lifestyle services, which appear to have arisen as a result of SUs and CMHT staff negative experiences.

"I [don't] think some of the services deliver what they say they deliver. I think we've had quite a few problems with some of the health trainers, some of the clients have said 'they've seen me for five minutes and then…" (AP – phase 3)

b) Lack of time to complete templates:

The lack of time which CPHCs report, was again a problem, as completing the templates and documents as part of creating a defined process takes time, especially the collation of information prior to and post MDT meetings.

"The amount of time for planning that is required [disadvantage of the work], yeah it is a lot of work doing the planning beforehand and writing it all up and passing it round" (CPHC – phase 4)

5.3 Implications for sustainability

- Developing systems and processes to facilitate joint working and information sharing ensured consistency and continuity of communication both pre and post MDT meeting and can provide an efficient way of working. These systems and processes need to be adapted to fit local requirements.

- Developing and maintaining systems can provide a centralised method of recording SU information and MDT actions.

- For CPHAs, CMHT staff need to be adequately trained to feel confident in performing these on SUs. There also needs to be a specific system for the recording and sharing of CPHAs with people involved in the care of SUs.

6. Supportive Organisational Culture

6.1 Description

To ensure that improvement is not dependent on individuals or transitory leaders, improvement needs to be institutionalised into the culture of the organisation[4].

Commitment and support throughout the organisational hierarchy is an essential ingredient for the successful implementation of the CPHC role and MDT meetings. Developing an organisational culture that supports the implementation of innovative practice and builds objectives for sustainability and spread into the organisational strategy is a key enabler for ensuring continuous improvement.

6.2 Has the initial work from the pilot phase been sustained or developed?

As highlighted in section 2.3, throughout the programme the team faced a number of challenges relating to the changing operating context of MMHSCT, and more specifically the individual CMHTs. The impact of the CSR and the re-organisation of staff and services cannot be underestimated, as CMHT managers appeared to be under increasing capacity and staffing pressures. The result was that although the programme had support from many people within MMHSCT, it was not always enough to achieve *'managerial buy in'* from all of the CMHT managers; some gave full support, and others gave none.

6.2.1 What worked well?

a) Protected time (where allocated):

Management support and active engagement were seen as critical elements to success in terms of understanding the CPHC role and MDT meeting commitments and providing support, guidance and supervision. It was important that management had an understanding of the amount of time that was required from the role and that they had the ability to make necessary changes to the individual's caseload.

"These are areas of good practice effectively, aren't they, and what happens is they fall by the wayside when caseloads are pushed, and that's the tricky business isn't it?" (CPHC1 - phase 4)

"Yes, the team manager was very positive, he/she was quite positive about this, and he allowed XX and I to do it. I mean, we're quite lucky in that he/she reduced our caseload slightly so that we were able to do all the administrative things, and all the safeguarding, and all the other stuff. So, you know, he/she was really positive about it." (CPHC2 – phase 4)

"With my direct manager, I've had lots of discussions. It's a supervision topic that I bring up on a monthly basis with him/her, so I feed back to him/her how the role's going, any issues and difficulties." (CPHC – phase 4)

[4] Øvretveit J (2005). 'Leading Improvement'. *Journal of Health Organization and Management*, vol 19, no 6, pp 413-430.

Where CPHCs were given the appropriate protected time to carry out the CPHC role, it is clear that effective working relationships with GP practice staff, CCs and APs (from within the CMHT), were established.

CASE STUDY:

I have many physical health problems including epilepsy, diabetes, heart disease and chronic mental health problems. I was absolutely flabbergasted by the results of the meeting. The district nurse took some bloods when he/she came to visit and because they were not quite right, the doctor then came to visit me at home. The practice nurse is coming to see me this week to monitor my diabetes more closely and I have had someone from the surgery here today to discuss stopping smoking. My mental health worker opened the process of bringing everyone together to discuss their roles and my needs. 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 my mental health worker the 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.

6.2.2 What were the challenges?

a) Time to perform CPHC role:

CPHCs required protected time to fulfil the role effectively, but the data suggests that in the majority of cases this was not provided and CPHCs managed their extra duties alongside their CC role. Capacity issues were highlighted throughout phases three and four and can be illustrated by the experience of the NW CMHT CPHC. Following the protected time in phase two they were provided with little, if any, protected time in phases three and four, and as a result found it difficult to attend MDT meetings due to time pressures and other work commitments. This change had a negative impact on the GP practices and CMHT. Protected time and having a reduced caseload were seen as important facilitators for success.

"Having the time, that would be an improvement, if you could manage your time and fit it in properly. I think, if they, sort of, you know…it depends where it is on their agenda, you know, on the team's agenda. Is it at the bottom or the top? How important is it? You know, and it should sort of tie in and think with the assistant practitioner, because I think on one of the other teams their assistant practitioner was always at our meetings. Ours wasn't." (CPHC – phase 4)

"It's [the relationship with the CMHT] fairly non-existent really. Whereas I felt, when [the initial CPHC] was here, we had a good relationship and if I did have a problem I could email [them] and [they'd] give us a ring." (PN – phase 3)

"No support… we were told we would have a reduced caseload and our caseload has just gone higher and higher so I guess that's just fallen off. We were supposed to work with 21; I have 27 at the moment." (CPHC – phase 4)

b) Lack of training:

The lack of dedicated physical health training offered by MMHSCT was also noted as an issue in phases three and four. As described earlier, one of the successes of the pilot phase 2 work was the development of mandatory face-to-face training package, delivered by the Supporting Health Nurses on physical health for all CMHT staff.

Despite this success, due to a number of issues, face-to-face physical health training did not become mandatory and an e-learning course was offered instead. The CPHCs did not rely on the e-learning training and they voiced concern about specific knowledge gaps, hence the CLAHRC GM provided *'expert'* sessions to increase their physical health knowledge. APs were also invited to attend these sessions to broaden their knowledge.

"E-learning is very good as long as you've got the time to do it, but it puts the onus of responsibility for learning back on the worker. What they should do is allot a space of time and ask them to attend, in that way they have an allotted space of time and they don't have other agendas coming in. (CPHC1 – phase 4)

"I think if we had maybe training once a year that covered a broad range of physical health needs. Especially like, diabetes, I don't think I've had any training on diabetes but everyone seems to have diabetes." (CPHC – phase 4)

6.3 Lessons learned and Implications for sustainability

- Co-ordinating physical health management requires leadership, support and guidance at all levels of the organisation, but particularly at the local level.

- It is essential that the organisation shows commitment to the CPHC role, from managerial, operational and executive level leadership, to ensure that CPHCs have protected time to fulfil their responsibilities.

- Organisational and leadership skills are essential to promote effective collaboration; leaders need to show active engagement to ensure sustainability.

- Staff need appropriate physical health training to ensure that they are equipped with the relevant knowledge to manage SUs physical health needs.

7.0 Concluding comments

- The evaluation data shows that it is possible to translate a previously tested integrated service user pathway into a different CMHT setting successfully. With the introduction of a CPHC, a CMHT and primary care relationship was established and communication improved. Regular MDT meetings further supported communication flow and encouraged CMHT staff and GP practices to collaborate.

- Due to the CPHC role and the MDT meetings, CCs' access to primary care GP practice staff improved, which enabled improvement in care for the physical health of SUs

- Physical health care became more co-ordinated as primary care teams and CMHTs collaborated, however, in order to achieve clear and shared responsibility for the physical health of SUs with SMI, further work is required.

- The North West CPHC was less positive about progress and sustainability of the model because of the change in their role from phase two, when they had protected time and a reduced caseload. During phase three they experienced an increase in their caseload and protected time was diminished, thus limiting the effectiveness of the programme.

- To further embed the CPHC role it is essential that the organisation shows commitment to the role, from managerial, operational and executive level leadership, to ensure that CPHCs have protected time to fulfil their responsibilities.

- The recent piloted introduction of portable tablet devices within the CMHTs, connected SU records, could significantly aid the development and enhancement of the CPHC role.