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

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

Manchester Mental Health and Social Care Trust Pilot Project Evaluation Report

Manchester Academic Health Science Centre

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Contents

The **NIHR CLAHRC for Greater Manchester** is a collaboration of **Greater Manchester NHS Trusts** and the **University of Manchester** and is part of the **National Institute for Health Research**

1 Summary

- The aim of this project was to develop and implement a sustainable integrated service user pathway that supports the prevention and early diagnosis, treatment and management of physical health problems as part of the overall treatment and care of people with severe mental illness (SMI), who are cared for by the North West Community Mental Health Team (NW CMHT) of Manchester Mental Health and Social Care Trust (MMHSCT). This report provides details of the project and its evaluation, including both qualitative and quantitative data.
- The evaluation findings highlight the importance of project enablers and specific implementation ingredients. Project enablers have a co-ordinating role, involving knowledge integration, standardisation and a supportive organisational structure. Each enabler is supported by a number of specific implementation 'ingredients' which have contributed to the success of the project.
- Interviews conducted during the exploratory stage with primary care professionals and MMHSCT staff led to the identification of five improvement areas that would address the project objectives:
  1. Development of a Community Physical Health Co-ordinator (CPHC) role.
  2. Establishing regular multi-disciplinary team (MDT) meetings in a primary care setting, aimed at improving the co-ordination of physical health care between the Community Mental Health Team (CMHT) and primary care.
  3. Identifying physical health training needs amongst CMHT staff and delivering appropriate training to improve their capacity to address the physical health needs of service users.
  4. Establishing regular physical health assessments delivered in a community setting to ensure there was more focus on physical health beyond that which may be received in primary care.
  5. Increasing the utilisation of the existing physical health resources available within MMHSCT by service users and ensuring that they are supported in any lifestyle changes identified.
- The evaluation showed that the CPHC role and MDT meetings have enabled information to be shared between primary care and the NW CMHT, such that primary care and NW CMHT staff believe that care is now more co-ordinated and there is a shared responsibility for the (physical health) management of service users. Communication between primary care and the NW CMHT, which was previously reported to be poor, was also reported to have improved.
- A number of issues were frequently discussed during the MDT meetings, with disease reviews (n=43; 26%) being the largest area for discussion, closely followed by actions relating to physical health checks in both primary care (n=32; 20%) and in the community (via Rethink community physical health assessment (CPHA)[1] n=5; 3%). Medication reviews, changes and discussions around adherence levels were also prominent in MDT meetings (n=15; 9%). The focus on disease reviews, physical health checks and medication is an important finding for this project, particulaly considering the introduction of the NHS Health Check Programme.[2]

- Data showing the breakdown of responsibility for MDT actions illustrated that there was an equal division of actions between the GP practice (GP n=34; 21%, Practice Nurse n=19; 12% and combined n=53; 33%) and the NW CMHT (Care Co-ordinator n=58; 36%), with a number of these actions requiring joint responsibility (n=47; 29%). This is a key finding for the project as it shows that the GP practice and the NW CMHT have taken a co-ordinated approach to the care of their service users, to ensure that service users receive improved physical health management.
- Reframing the Assistant Practitioner (AP) role has been an important addition to delivering Rethink CPHAs; this has involved a change in the focus of the AP role; the AP is now delivering around one CPHA per day.
- To address the physical health training needs of NW CMHT Care Co-ordinators, mandatory physical health training has been agreed for all CMHT staff by MMHSCT as an output of this project. A collaborative training day with NW CMHT staff and community lifestyle services[3] staff was delivered to improve knowledge of lifestyle services available; 81% (n=9) of Care Co-ordinators felt that the training day had achieved this and 67% (n=8) believed that referral to lifestyle services had increased since the start of the project.
- Overall, the post project evaluation showed that the project has (a) been successful in establishing a model that improves communication between primary care and the CMHT to co-ordinate the physical health care of service users, (b) made inroads into developing and testing a model for delivering Rethink CPHAs, although there is more work to be done to refine this, and (c) improved the use of existing community lifestyle services by CMHT staff. Further work will be carried out by MMHSCT to refine parts of this work before the models are spread across the Trust in 2013/14.

1.1 Acronym glossary

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

2 Project overview

2.1 Introduction and background

Premature mortality rates have been reported for people with SMI for many years, leading to a reduced life expectancy of up to 25 years compared to the general population.[4] This is largely due to physical inactivity, an unhealthy diet, and a high smoking prevalence, in combination with medication induced weight gain which in return can lead to metabolic disorders (e.g. type 2 diabetes).[5,6,7]

Despite the fact that many of the physical health issues experienced by this group, e.g. cardiovascular diseases or diabetes, are preventable or controllable by chronic disease management, and many of the outlined lifestyle issues can be addressed by timely and patient-centred access to health promotion, people with SMI continue to experience health inequalities, particularly in relation to the provision of physical health services. In its current mental health strategy, the UK Government sets out the objective that '*more people with mental health problems will have good physical health*';[8] however, there remain several questions over the provision of good physical health care.

To address this health inequality, a joint 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 the Trust's service users with SMI.

Following an exploratory phase, conducted by the GM CLAHRC in March and April 2012, it was evident that physical health inequalities of service users within the Trust were partly caused by:

- a lack of focus of CMHTs on physical health; and
- a lack of integration between primary care and CMHTs to provide shared care for people with SMI.

This was reinforced by a lack of agreement over roles/responsibilities and insufficient/non-standardised levels of communication between different care providers responsible for service users' mental and physical health care. In addition, despite the wealth of health promotion resources available within MMHSCT, there was a lack of awareness among health care providers and service users about what services exist, resulting in many services being under-utilised.

To address these barriers, the GM CLAHRC identified a number of key areas of focus and supported MMHSCT in implementing changes from June 2012 to March 2013. The following report outlines the key project elements and their outcomes as analysed in the project evaluation, along with highlighting the key enablers and ingredients required for the successful implementation of this work.

2.2 Project aim and objectives

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.

The following three project objectives were defined:

Objective 1

To develop a system that demonstrates improved continuity of care achieved through strengthened coordination and collaboration between primary care and CMHTs, 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.

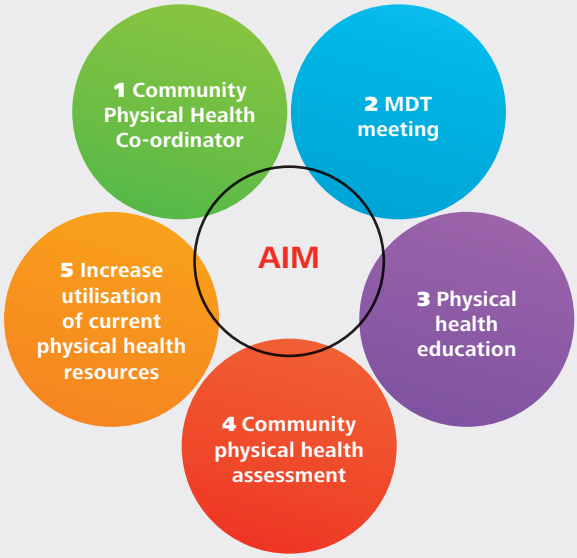
Objective 3

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.

2.3 Project outline

To achieve the objectives the project focussed on five improvement areas:

Figure 1: Project improvement areas



1. Develop a Community Physical Health Co-ordinator (CPHC) role.
2. Establish regular multi-disciplinary team (MDT) meetings between the CPHC and GP practices to establish shared care 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 utilisation of existing physical health resources.

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2.4 Project approach

This project focused on SMI service users under the care of a CMHT; it did not involve service users under the care of other MMHSCT teams or those only under the out-patient psychiatry clinic. The project was delivered with the NW CMHT and focused on improving the physical health of their service users.

Two MMHSCT staff, seconded on a part time basis (2 x 0.4 WTE), worked with GM CLAHRC to develop, test, implement, facilitate and evaluate physical health orientated interventions. Both secondees worked as Care Co-ordinators within the NW CMHT and acted as the main liaison for the five GP surgeries from North Manchester Clinical Commissioning Group (CCG) that took part in the project.

2.5 Selecting GP practices

This project was advertised to GP practices in Patch[9] 1 and Patch 2 of North Manchester CCG, via their internal monthly CCG newsletter. Seven GP practices expressed an interest and based on a) location, b) patient demographic, and c) practice size, five GP practices were selected. These practices accounted for 42% (n=163) of service users under the care of the NW CMHT and provided a cross-section of different practice based contexts, ranging from:

- Smaller practices (2 GPs) to larger practices (9 GPs).
- Smaller practice list sizes (approximately 4,000 patients) to larger practice list sizes (approximately 13,000).
- Smaller number of people under the CMHT (approximately 20) to larger number of people under the CMHT (approximately 50).

2.6 Evaluation design

An exploratory stage assessment was conducted to inform the development and improvement of the project.

This included:

- 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.

In addition, anonymised cardiovascular risk data (based on the indicators required for QRISK2[10]) for each service user under the care of the NW CMHT and the pilot practices was collected. This data focussed on the QRISK2 key measurement criteria, i.e. weight/body mass index (BMI), blood pressure, cholesterol, and recorded smoking status, for the previous 12 months.

A process evaluation (described as post project in this report) was performed at the end of the project to explore how the project components had been implemented and their impact on the provision of care. The post project evaluation adopted a triangulated approach to data collection, 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.

3 Project outcomes

This section provides an overview of the exploratory stage and post project evaluation information collected. Each of the three project objectives and specific project components will be discussed using the following structure: a) overview of the exploratory stage findings,
b) introduction of changes to practice, and
c) post project evaluation findings with key recommendations.

The following quote describes the culture shift that took place as a result of the project. How this culture shift was achieved is described in more detail throughout this section.

'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, NW CMHT

3.1 Objective 1

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

Project components

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3.1.1 Exploratory stage

The interviews with primary care professionals and the focus group with NW CMHT staff demonstrated that communication between the two services was poor. The general consensus was that there was a lack of integrated and co-ordinated care across primary care and the CMHT. Primary care staff were unsure who to contact in the NW CMHT if they had queries or concerns about a service user. Practice staff felt that they did not have a working relationship with the NW CMHT unless they initiated it. NW CMHT staff felt that there was infrequent contact with primary care and they were unaware of the particular specialist interests of practice staff and who to contact.

'It once took me six phone calls and three faxes to get a response from a GP.'
Care Co-ordinator, CMHT

'I think it's [the relationship with CMHT] quite poor, I think it's [communication with the CMHT] very disjointed. I think it was very fractioned and patient care, as a result, was quite poor.' **GP**

'It [communication] was patchy and sporadic; there was no routine and methodicalness to it. If you had a problem, you would have to then track down that person's Care Co-ordinator and that might not always be easy, and you didn't know who you were talking to, so it wasn't good.' **GP**

'There wasn't a relationship.' **GP**

'I didn't even know who they were; I mean you know that they exist but never really knew their role.' **GP**

Interviews with Care Co-ordinators highlighted the variations in their professional training and backgrounds, whilst highlighting that accessing a GP for information about their service user wasn't always particularly easy, timely or efficient.

'We're supposed to look at people holistically, as social workers we're not medically trained in any way and we're reliant on the client to tell us of any physical health problems, it's so difficult. I mean you can ring the GP and they do generally ring you back and you can discuss it. But if you just want a basic understanding of what the physical health needs are it's really difficult. I understand it's data protection and it needs to stay in place but something needs to support us looking at it holistically.'
Care Co-ordinator, NW CMHT

When interviewing services users, only 39% (n=7) felt that they addressed their own physical health, with just 33% (n=6) of service users saying that they talked to their Care Co-ordinator about their physical health. However, 84% (n=15) said that they talked to their GP about their physical health. When asked if they would access their GP practice for physical health issues, 84% (n=15) affirmed they would do so as necessary, however service users referred to problems and barriers they experienced in attending GP appointments, some of these involved: a) contacting the practice and making appointments, b) transport to the practice, c) fear of attending appointments, d) stigma attached to mental health issues and e) lack of awareness in primary care about mental health.

'Sometimes I think being really, really ill, there's a stigma attached to it, so I don't think that I get fairly treated by the receptionist at the GP [practice], who are aware I have a mental illness, even though they pretend that they don't recognise you, but you know they do, they have an expression on their face 'Not you again'.'
Service user

'Seeing you (Care Co-ordinator) and the consultant is different to going to see my GP, because he doesn't seem to understand the way that you understand.' **Service user**

'I am scared of going to the doctors in case it's something major, the paranoia kicks in.' **Service user**

'It's easy to see the GP, but normally you have to queue outside for an hour or so.' **Service user**

'I normally just phone on the day (…) if you want an appointment you have to ring up on the same morning.' **Service user**

To supplement the qualitative information from the service user and health care professional interviews, cardiovascular risk data (relying on QRISK2 indicators) was collected from the GP practice systems. In line with the literature, it was envisaged the cardiovascular risk of the service users would be high. However, the results showed that in the majority of cases (62%; n=115) it was impossible to accurately calculate a QRISK2 score due to the lack of at least one clinical indicator (within the previous 12 months) required. This included 43% (n=79) of service users having missing HDL/cholesterol data; 23% (n=43) missing smoking data; 23% (n=42) missing a recorded BMI; and 25% (n=47) missing blood pressure data. This data would seem to suggest that GP practices find it difficult to engage with people with SMI, this is due to several factors relating to the GP practice and service users.

Overall, the exploratory stage work demonstrated that issues exist with regard to the effective co-ordination, integration, management and access of physical health care that service users receive.

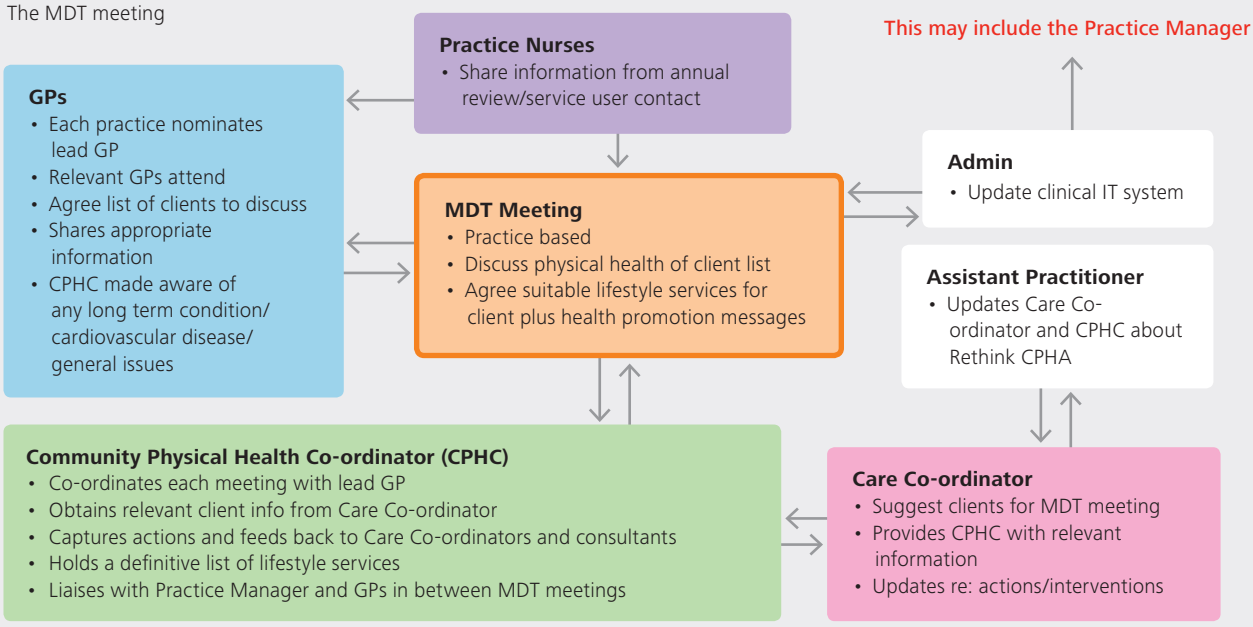
3.1.2 Changes to practice

To address the lack of integrated care and knowledge in physical health highlighted in the exploratory stage, looking at the literature[11] and local context, two key changes to practice were implemented:

- The appointment of two CPHCs (0.4 WTE each)
- Bi-monthly/monthly MDT meetings with GP practices.

The CPHC role was designed to be the hub of information sharing between the NW CMHT and the GP practices. The MDT meeting was established to be the vehicle for CMHTs and primary care to share responsibility and develop joint management plans for the physical health needs of SMI service users under the care of a CMHT. Figure 2 illustrates how these two key changes have worked.

Figure 2: The MDT meeting



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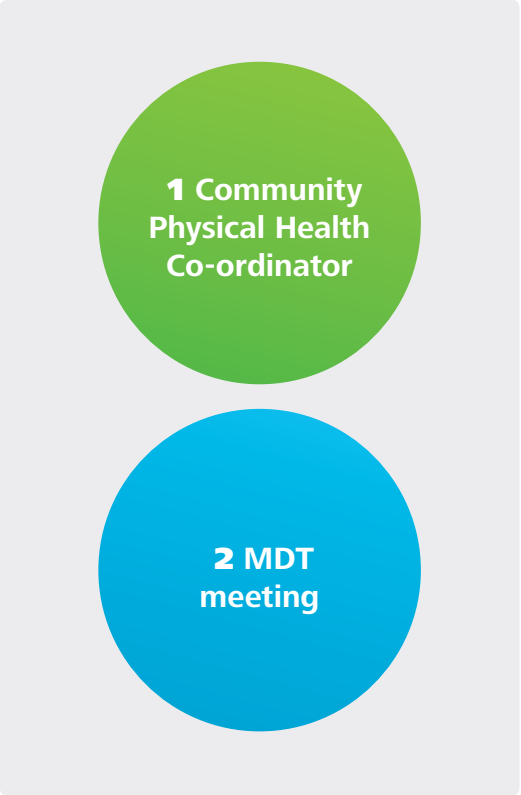
3.1.3 Post project evaluation – what has been achieved and how?



The CPHC role and the MDT meetings are inextricably linked and it is very difficult to evaluate one without the other, so for the purposes of this report they are presented together.

The relationships established by the CPHC with GP practice staff have enabled Care Co-ordinators to develop an increased awareness around a) the extent to which their service users see their GP, b) which GPs their service users see, and c) which GPs know their service users the best. Care Co-ordinators now ask questions about GP practices and ask CPHCs to raise specific issues regarding their service users' physical health.

> *'Some people [Care Co-coordinators] absolutely love it and come to us frequently, saying please will you discuss this person, could we discuss this person, and just think it's fantastic. Other people, we have to approach them more, so either it's just a lower priority for them or they've not quite got used to the role (…) but even the people who initially were pretty sceptical come to us now and say is this one of your practices, can we talk about it.'* **CPHC, NW CMHT**

To supplement the interviews and to gain a better understanding of the impact of the project on NW CMHT staff, a post project Care Co-ordinator survey (n=13) was done. The survey demonstrated that 92% (n=12) believed that the CPHC role had a positive impact on patient care with 62% (n=8) believing that that CPHC role had improved access to the GP for them and their service users.

> *'I did not have the time to check with all my clients' GPs with regard to their physical health, the CPHC has saved a lot of GP time for Care Co-ordinators. They flag up concerns which I may not have been aware of.'* **Care Co-ordinator, NW CMHT**

The close contact and working relationship developed between the CPHC and the GP practice has enabled a greater understanding and respect of each other's roles i.e. CMHT and the GP practice staff. All (100%; n=10) GPs and Practice Nurses interviewed believed that their relationship with the NW CMHT had improved. Previously, many GPs were unaware of the amount of contact and the level of care that was provided by CMHT staff and Care Co-ordinators in particular. The CPHCs have developed an effective working relationship with the practice staff to ensure there is on-going, effective and efficient communication regarding service users to facilitate improvements in patient care. All (100%; n=10) of GPs and Practice Nurses interviewed were keen to continue to liaise and work with the CPHC, with a number of GPs stressing that having contact with the

CPHC provided them access to the CMHT that they had previously never experienced.

'I think the GPs understand who people are and I think they understand the roles of people better. I think there was almost a light bulb switched on in one meeting when they realised the breadth of the CMHT, and also the individuals who look after it.' **Practice Manager**

The general consensus (100%, n=10) from the post project interviews with GPs, Practice Nurses, Care Co-ordinators and CPHCs is that physical health care is becoming more co-ordinated between primary care and the NW CMHT.

'It is more coordinated, yes (…) I suppose the other thing that it does is because there are more doctors here, it's made us all aware of all the patients more, whereas previously maybe one doctor knew about one patient, but didn't know about another.' **GP**

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

'Yes care is co-ordinated (…) there is now a shared responsibility.' **GP**

'Yes I do think care is more co-ordinated, just through attending the meetings, we're now aware what patients are being seen, what care is being given to those patients, and we're more aware of those patients ourselves.' **Practice Manager**

'Liaison with the [community physical health] co-ordinator is time saving for Care Co-ordinators and enables a better package of care for the client.'
Care Co-ordinator, NW CMHT

The improved communication was achieved through information sharing, particularly through the MDT meetings. Primary care and the NW CMHT have an improved understanding of the physical health needs of their mental health service users. Sharing information enabled the teams to provide a co-ordinated approach to the care of patients.

'Definitely communication's improved and I think the GPs have said they like having a particular person to link with.' **CPHC, NW CMHT**

'I think it's actually much better.' **GP**

'From the CPHC attending the meetings and the feedback you've given about patients (…) I think we all have a better understanding of what you're doing with the patients.' **Practice Manager**

Over two thirds 69% (n=9) of Care Co-ordinators stated that the MDT meetings had a positive impact on patient care with 92% (n=12) of them having carried out actions (detailed on Table 1) generated from MDT meetings.

'It has made it easier to liaise with GP surgeries and to work together to support patients.' **Care Co-ordinators, NW CMHT**

Throughout the project an MDT actions database was populated by the CPHCs. This provided detailed information about the different types of actions resulting from the MDT meeting, their status and the person responsible for carrying them out. The evaluation data relates to 24 MDT meetings (September 2012 to March 2013), where 101 service users were discussed, and a total of 163 actions were agreed.

Table 1: Breakdown of MDT meeting actions

Key actions	Total actions
Community; lifestyle service referral (inc. health trainers, expert patient programme, smoking cessation etc)	18
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)	16
Non clinical information (inc. requested and provided to either GP practice/CMHT or Consultant)	7
Other	7
GP practice based lifestyle service referral (inc. weight management, smoking cessation etc)	9
Primary care physical health assessment (in accordance with the requirements of the Quality Outcomes Framework)	32
Rethink community physical health assessment (performed by the CMHT)	5
Specialist referral	4
Test/investigation (inc. smear, bloods etc)	7
	166

Table 1 (above) illustrates the breadth and frequency of issues discussed during MDT meetings, with disease reviews (n=43; 26%) being the largest area for discussion, closely followed by actions relating to physical health checks in both primary care (n=32; 20%) and in the community (via Rethink community physical health assessment (CPHA) n=5; 3%). Medication reviews, changes and discussions around adherence levels were also prominant in MDT meetings (n=15; 9%).

The focus on disease reviews, physical health checks and medication is an important finding for this project, as these are key to improving the continued co-ordinated physical health management of service users.

Ensuring that service users receive the correct management and the early diagnosis (tests/ investigation n=7; 4%) of diseases such as hypertension, coronary heart disease, diabetes and cancer is essential to address the current 25 year early mortality gap for people with SMI.

Table 2: Breakdown of responsibility for MDT actions

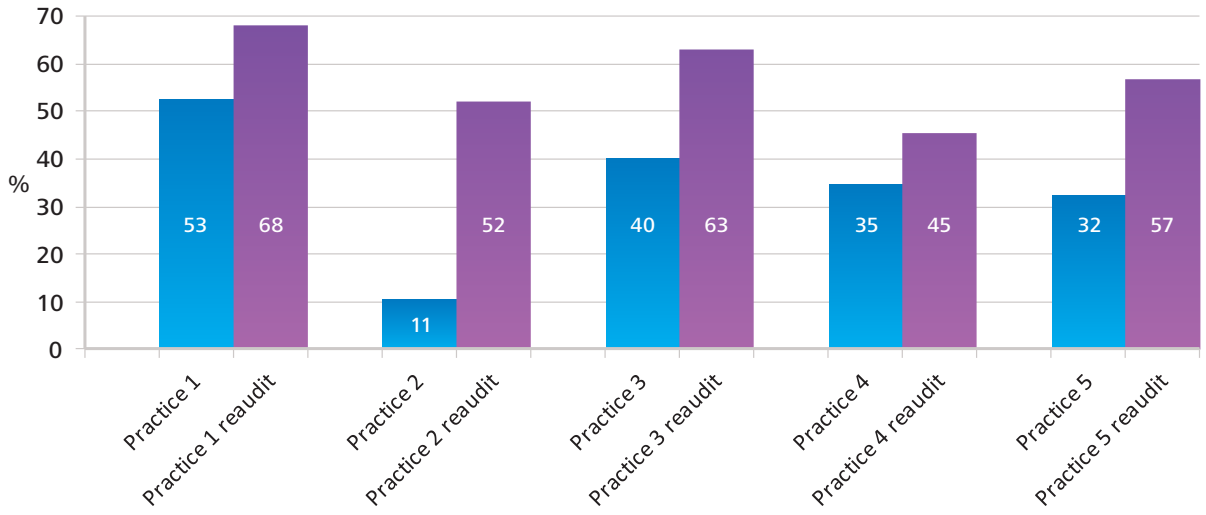
Person responsible	Total actions
GP	34
Practice Nurse	21
Active Case Manager	1
Care Co-ordinator	59
Consultant	3
Joint action (GP & Care Co-ordinator)	47
Blank	1
	166

Table 2 (above) displays information relating to who was responsible for carrying out the actions from Table 1. Interestingly, there appears to be an equal division of where the responsibility for the actions lies between the GP practice (GP n=34; 21%, Practice Nurse n=19; 12% and combined n=53; 33%) and the NW CMHT (Care Co-ordinator n=58; 36%), with a number of these actions requiring joint responsibility (n=47; 29%). This is a key finding

for the project as it shows that the GP practice and the NW CMHT have taken a co-ordinated approach to the care of their service users to ensure that service users receive improved physical health management.

As part of the post project evaluation the GP practice clinical systems were re-audited to investigate if there had been an improvement in the amount of cardiovascular risk (using QRISK2 indicators) clinical information that was recorded. The data illustrated that on average there was a marked improvement of 25.7% in the amount of information that is now recorded; during the exploratory stage there was missing data for 62% (n=115) of service users, post project this had improved with data missing for only 42% (n=79) of service users. At the point of data collection not all of the service users had been discussed at an MDT meeting, as the project progresses we expect that the number of service users discussed will increase and in turn there will be an increase in the follow up QRISK2 data. Figure 3 illustrates a practice breakdown of the increase in the amount of service users that now have no QRISK2 data missing.

Figure 3: Practice breakdown of complete QRISK2 data (no information missing)



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3.1.4 Service user case study

MDT meeting helped to facilitate a service user to attend a GP practice for a cervical smear.

A Care Co-ordinator asked for one of his/her service users to be discussed at an MDT meeting due to the service user's high BMI and an expression of interest in losing weight. At the MDT meeting it was agreed that the Practice Nurse would see the service user with a view to referring into the appropriate weight management service. During the MDT meeting it became apparent that her smear test was overdue. Due to the service user's reluctance to having a smear in the past, it was suggested that the Care Co-ordinator accompanied her to the appointment.

As a result, the Care Co-ordinator accompanied the service user to the appointment and a referral to the 'Choose to Change' weight management service was made. The service user agreed to have their smear test, however it was not possible to get a sample and the appointment was subsequently rearranged. Shortly afterwards the service user became anxious about re-attending for another appointment and following a discussion at another MDT meeting, it was agreed that the GP would issue a one-off prescription for diazepam for use at the next appointment for a smear test.

3.1.5 Key findings

- The introduction of a CPHC and the use of MDT meetings to discuss the physical health needs of service users under the NW CMHT has improved a) the relationship between the NW CMHT and the GP practices, b) the communication, c) the co-ordination of physical health management, and d) started to develop a clear shared responsibility for the physical health management of service users.
- Each practice has established and delivered MDT meetings differently to meet their local requirements, highlighting that a 'one size fits all' approach is not suited for the development of MDT meetings. However, there have been some general themes across all MDT meetings which have been consistently important, for example holding MDT meetings at least every two months, GP, Practice Managers, CPHCs and Practice Nurses attending MDT meetings.
- The breadth and frequency of issues discussed during MDT meetings shows that there is a focus on disease reviews, physical health checks and medication. This is an important finding as these are key to improving the continued co-ordinated physical health management of service users. The focus on physical health checks and medication is particularly important considering the introduction of the NHS Health Check Programme.
- The breakdown of responsibility for MDT actions shows that there appears to have been an even division of responsibility between the GP practice and the NW CMHT. This is a key finding for the project as it shows that the GP practice and the NW CMHT have taken a co-ordinated approach to the care of their service users to ensure that service users receive improved physical health management.

3.2 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.

Project components

3.2.1 Exploratory stage

Findings from the exploratory stage focus group with NW CMHT Care Co-ordinators showed that the majority believed that physical health was an element of their role; however, they saw their role as co-ordinating physical health management, rather than carrying out any specific physical health assessment. This was largely due to a) Care Co-ordinators being from different professional backgrounds with Social Workers and Occupational Therapists lacking clinical nursing training, b) Care Co-ordinators from nursing backgrounds didn't feel confident as many of them had not had an opportunity to practice these skills in a long time, and c) a lack of time available to carry out physical health assessments.

> *'Yes. We can't do blood pressure and things like that because we're not trained to do it. And that's, you know, we're social workers. Fair enough, we take that care coordination role, but we're not trained to do it.'* **Care Co-ordinator, NW CMHT**

MMHSCT had recently introduced the Rethink CPHA, which needed to be carried out on all service users under the care of the CMHT for a year or more (CQUIN[12] 2012/2013). There was limited knowledge and understanding of the Rethink CPHA amongst Care Co-ordinators. The general consensus was that the assessment would need to be completed by a member of staff with a nursing background; Care Co-ordinators questioned who would be delivering the assessments.

> *'I looked at the Rethink assessment form which yeah, I could still do some of it, but some of it we wouldn't understand or know where to go from. I suppose our knowledge is limited, being mental health workers we are not that involved with physical health or what's out there. Although I have been doing a wellbeing group[12] for seven weeks, so I am probably more aware than lots of other people.'*
> **Care Co-ordinator, NW CMHT**

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All (n=11) Care Co-ordinators in the focus group felt that they needed training around physical health, particularly with regards to a) diabetes, b) cardiovascular diseases, and c) weight gain. It was recognised that diabetes and excessive weight gain was a major problem for many service users. Care Co-ordinators requested assistance in relation to what to look for, simple disease management and vitamin deficiencies. It was felt that the Trust's Physical Health Nurses[13] could deliver training and education regarding these areas.

'You're conscious that you could miss things and obviously even with the side effects of medication, you're constantly (…) even with antipsychotics you're constantly going back to either nurses or the consultants regarding that. Again, you pick things up along the way, but that's not part of your training.'
Care Co-ordinator, NW CMHT

The service user interviews (n=19) highlighted that the majority 78% (n=14) believed that their physical health was either as important, or more important than their mental health.

'They're [physical and mental health] both equally as important.' **Service user**

'Well, the physical health is primary, because without it, there's no survival. The mental health is secondary but hopefully I know how to keep that in check.' **Service user**

'You can't really choose between the two of them really (…) because they are linked with each other.' **Service user**

They were generally positive about the idea of having a regular health check, only one was sceptical about the assessment. In fact 78% (n=14) of service users suggested that they had received a recent (within the last 12 months) physical health check at their GP surgery, however the collected QRISK2 data portrays a different picture with 62% (n=115) having missing (within the last 12 months) cardiovascular risk data. One of the service users queried the medical training of CMHT staff and whether the GP practice staff should do the assessment instead. However, service users were generally happy with Care Co-ordinators or a CMHT colleague performing the assessment; there were no objections about their Care Co-ordinator weighing them and measuring their waist circumference. When asked about locations for completing the assessment the following were mentioned: a) GP practice, b) service user's home or c) depot clinic. Service users felt that the assessment should be conducted every 6-12 months.

'Oh I was pleased to have it done, to know that somebody is paying attention to my physical health and trying to take a holistic view of me, both my mind and my body together.' **Service user**

Overall, the exploratory stage findings demonstrate that issues exist with regards to (a) Care Co-ordinators attitude towards physical health, and (b) Rethink CPHAs being performed. Whilst there appeared to be a clear acceptance from service users that their physical health was important and that in the majority of cases they were happy for this to be assessed by either their GP practice or by a member of the NW CMHT team.

3.2.2 Changes to practice

To develop clear pathways and guidance on delivering physical health checks in a community setting and ensure that the physical health of service users are assessed on a more regular basis, it is essential to address the issues of knowledge and confidence related to physical health in general and the Rethink CPHA, to ensure that staff feel that they are able to carry out physical health checks correctly. As part of this project, Care Co-ordinators received regular training, delivered by the Trust's Physical Health Nurses, this was an important step forward as it helped to equip staff with the necessary training and skills. This physical health training was already mandatory for inpatient staff and as a result of this project it is now also mandatory for community staff. This ensures that all staff have a standard level of training in order to help them feel more confident in completing the Rethink CPHAs. In addition, the Assistant Practitioner's (AP) role was re-focused on physical health, with their main focus of work being on completing Rethink CPHAs for each service user and feeding back any unmet needs to the GP practice, the Care Co-ordinator and the CPHC. The change of the AP role and the subsequent concentration on assessments has assisted the Care Co-ordinators in completing Rethink CPHAs for service users in the community.

3.2.3 Post project evaluation – what has been achieved and how?

To address the physical health training requirements of NW CMHT, physical health mandatory training has been agreed for all CMHT staff by MMHSCT, as an output of this project. It is believed that mandatory training will be key to ensuring the better physical health management of service users, and ensuring that Care Co-ordinators from different backgrounds are well placed to carry out Rethink CPHAs.

> *'What we're looking at initially is mandatory training (…) I think sometimes that's the key with it, because it's mandatory, people have to go.'*
> **Management, NW CMHT**

> *'Physical health training as part of mandatory training and I think that means, you know, mandatory obviously means it's necessary and you have to do it whatever their background is it's really irrelevant.'* **Management, NW CMHT**

In the interim, physical health training was arranged for NW CMHT staff. This was delivered by the Trust's Physical Health Nurses in smaller disease specific sessions which were designed to fit around Care Co-ordinators' case loads. However, the feedback from the focus group was that they were often difficult to attend as they were scheduled following the team meeting and Care Co-ordinators often faced problems balancing their case load. Those who attended felt the sessions were worthwhile and that management should encourage staff to attend sessions.

> *'People have lacked a lot of confidence in that because mental health trained professionals and some aren't from a nursing background, so I think that training has really, really supported people.'* **Management, NW CMHT**

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Well, I just think that's [training] been a bit hit and miss really. I think now that it's mandatory for the CMHT staff to attend the training, on physical health that will kind of have the biggest impact as opposed to the training sessions that we've tried to organise, because they've not been that well attended unfortunately.' **CPHC, NW CMHT**

4 Community physical health assessment

The post project Care Co-ordinator survey illustrated that 100% (n=13) of Care Co-ordinators agreed that physical health was important to their role and all 100% (n=13) of them stressed that Rethink CPHAs were important for their service users. However, resistance to completing the assessments remained with only 20% (n=2) admitting to have completed one or more assessment, of which 50% (n=4) stated a 'lack of time' as the reason why they haven't performed an assessment.

'I think it's a slight fear of it [the Rethink CPHA] creating more work for themselves [Care Co-ordinators], rather than not knowing what to do with them [Rethink CPHAs].' **CPHC, NW CMHT**

'It [the Rethink CPHA) hasn't become part of their [Care Co-ordinators] routine, doing them is the exception rather than the norm. Although some people have really got into the swing of asking the Assistant Practitioner to do them.
CPHC, NW CMHT

I [Care Co-ordinator] have done one Rethink [CPHA] with one of the nurses [physical health nurse] and I filled that one in, but that's all I've actually done because the Assistant Practitioner does the Rethink (…) I refer to the Senior Practitioner [within the CMHT] and the Assistant Practitioner and they get it done.' **Care Co-ordinator, NW CMHT**

The post project focus group with NW CMHT Care Co-ordinators demonstrated that there is still limited use of the Rethink CPHA amongst Care Co-ordinators; however the focus group showed that the attitudes of Care Co-ordinators towards physical health and the need for assessments are shifting. There is a greater acknowledgment that physical health is important to their service users and it should be part of routine care. Resistance towards the Rethink CPHA was generally attributed to a limited knowledge of physical health, particularly for those who did not have a nursing background. This was related to the importance of implementing a clinical governance system to ensure that Care Co-ordinators are appropriately trained and protected when completing the Rethink CPHA. However, the CPHCs have a differing view to the completion of the Rethink CPHA.

'I found it pretty straightforward to do and I had no problems getting information from the clients. I think Care Co-ordinators are well placed to do it because it can just be a continuation of their normal chats with people, but I can see that people feel like it's another piece of paperwork to do.'
CPHC, NW CMHT

From the focus group it was clear that the AP within the NW CMHT had started to take the lead for Rethink CPHAs and it was the main focus of the role. The AP was said to be carrying out about one assessment per day, this is a key shift as prior to the project the AP was not involved with Rethink CPHAs. This was also acknowledged in the interviews with managerial staff from the NW CMHT.

'The other bit is that we've got our Assistant Practitioner, and he/she is also very much with the programme really in terms of carrying out Rethink assessments.' **Management, NW CMHT**

The feedback from the focus group was that once the GP had been informed about the outcome of the Rethink CPHA, then it was the GP's responsibility to follow that information up. This opinion was also acknowledged in the interviews with managerial staff from the NW CMHT.

'I think some people see it as being a dual physical health check (…) they see Rethink as perhaps more of a screening tool and then the follow up, is a more in-depth physical health check. So, I think there's still that idea about people going to their GP and having that contact with their GP.' **Management, NW CMHT**

3.2.4 Service user case study

CPHA results prompted discussion about the service user at an MDT meeting, subsequent physical health reviews were conducted.

This service user was identified for discussion in the next MDT meeting as he/she was new to the CMHT. A Rethink assessment was completed prior to the MDT meeting showing that the service user was obese with a BMI of 45, had a poor diet, did no exercise, but he/she was motivated to change. The service user also had type 2 diabetes, hypertension, polycystic ovary disease, and was a heavy smoker.

The service user was non-compliant with all morning medications because he/she was confused about the order in which to take them. His/her morning medications were predominately for physical conditions. This was discussed in an MDT meeting and the GP gave assurance that the medications could be taken in any order. This was fed back by the CPHC and the Care Co-ordinator then relayed this to service user. The service user now sets reminders on his/her phone and has agreed to start taking his/her morning medications again.

Following discussion in the MDT meeting it was also identified that they had not been attending appointments and required a diabetic review and a physical health check. The Care Co-ordinator supported the service user to make an appointment for bloods and for his/her diabetic review. The service user will be discussed again in the next MDT meeting for an update and to agree a plan for future support with healthy eating and exercise.

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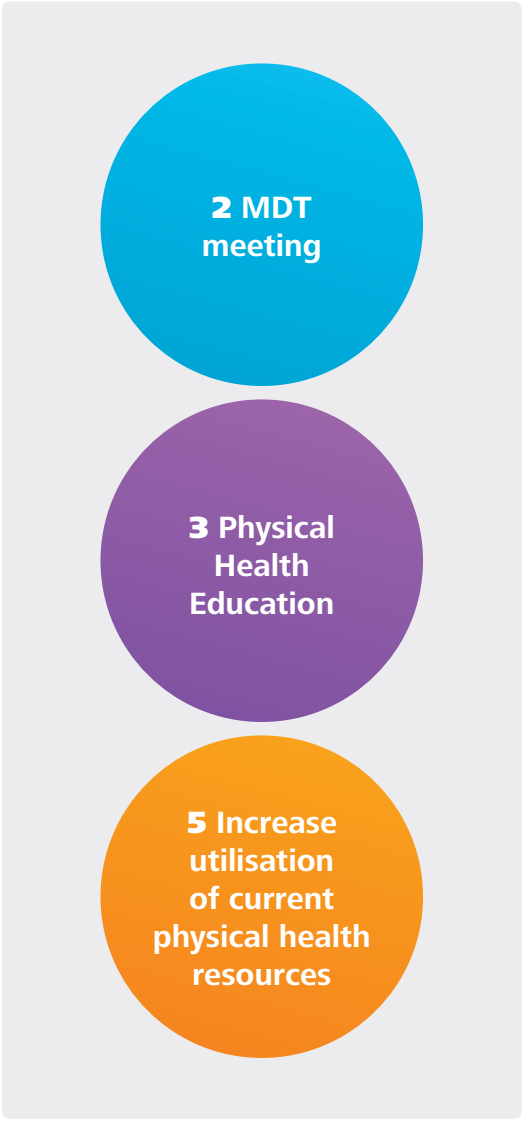
3.2.5 Key findings

- To address the issues of knowledge and confidence related to physical health in general and the Rethink CPHA training, the physical health training is now mandatory for community staff. This training will assist Care Co-ordinators in completing the Rethink CPHAs as they will have received appropriate training on physical health and physical health assessments, the hope is that this will improve the knowledge and confidence of Care Co-ordinators in assessing and managing the physical health needs of service users.
- The attitudes of Care Co-ordinators towards physical health and the need for assessments are shifting, there is a greater acknowledgment that physical health is important to their service users and as such should be part of routine care. Resistance towards the Rethink CPHA was generally attributed to a limited knowledge of physical health, particularly for those who did not have a nursing background.
- The reframing of the AP role within the NW CMHT to focus on Rethink CPHAs and the Trust's commitment to mandatory physical health training for CMHT staff have been key outputs. It was hoped that a greater impact would have been made on the number of Rethink CPHAs being carried out by Care Co-ordinators, but this has proved increasingly difficult due to a number of contextual factors. In order to sustain progress on the completion of the Rethink CPHAs, it is essential that Care Co-ordinators continue to become more involved in this process. The Trust will need to do work to align this priority with strategic objectives and the link between Rethink CPHAs, MDT meetings, supervision, clinical governance and shared protocols.

3.3 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.

Project components



3.3.1 Exploratory stage

From the exploratory stage focus group with NW CMHT Care Co-ordinators it was evident that varying levels of knowledge existed regarding (a) what community lifestyle services were available,[14] (b) what the services provided, and (c) how to refer into them. From the Care Co-ordinators who had used various community lifestyle services there was a mixed response about their effectiveness.

'You don't get a response from PARS (Physical Activity on Referral Scheme).'
Care Co-ordinator, NW CMHT

'[Health Trainers] it's not worked out very well when I've used it.'
Care Co-ordinator, NW CMHT

'You ring them [Health Trainers], they go who are you and it's like they forgot they met them, then you think what is the point.' **Care Co-ordinator, NW CMHT**

'You are only supposed to use PARS, but PARS is just not working, so you are in a catch 22.' Care Co-ordinator, NW CMHT

'What is PARS?' **Care Co-ordinator, NW CMHT**

The service user interviews demonstrated that only 16% (n=3) of service users said that they either previously accessed or were presently accessing community lifestyle services; however, 74% (n=14) stated that they would consider attending services in the future. The low numbers of service users attending community lifestyle services could be related to the lack of knowledge by their Care Co-ordinators and because it didn't appear to be routine for service users to discuss physical health with their Care Co-ordinators. Only 39% (n=7) of the interviewed service users stated that they discussed physical health with their Care Co-ordinator, 56% (n=10) said that they didn't, with 6% (n=1) being unsure. However, in an interview with a Care Co-ordinator, he/she appeared open to using the community lifestyle services when appropriate.

'I would think always if it's relevant. If I had a client that's got some issues, so smoking or their diet or they're not exercising, I would address it. So I would say always, when appropriate.'
Care Co-ordinator, NW CMHT

The service user interview responses indicated that service users understood that their physical health was important, with 78% (n=14) stating that their physical health was either as important, or more important than their mental health. However, this belief didn't always transcend into good physical health, as 33% (n=6) didn't take any care to address their physical health, 28% (n=5) taking little care and only 39% (n=7) believing they addressed it.

'I would say my own physical health is appalling and I should know better… I do know the information already but I choose to eat convenience food out of laziness and because it's nice but it puts the weight on and it fattens you up.'
Service user

'I go for walks sometimes, take the dog out (…) I try and eat healthy, but it is hard.' **Service user**

'Well I walk Oscar for 3 long walks a day, I go to the gym with the Assistant Practitioner and I've been going walking up Manchester as well (...) I've been known to do 10 miles a day.' **Service user**

'I don't go out very much; before I used to go jogging, I don't do that anymore (...) probably because of my medication and the inability to go to situations that I am not used to...' **Service user**

Primary care staff appeared to have a more co-ordinated relationship with lifestyle services, which is perhaps understandable considering their generalist role. However, there were still issues around the communication of information.

> *'Yeah they let us know how many sessions they have been for and if they've discontinued. It's probably not as robust as it could be.'* **GP**

> *'Unless their mental health is unstable there's no reason why they shouldn't go [to community lifestyle services].'*
> **Practice Nurse**

> *'From PARS we get stuff back; we don't get anything back from Health Trainers.'*
> **Practice Nurse**

Overall, the exploratory stage highlighted that a lack of knowledge and understanding about the community lifestyle services was a barrier to the services being utilised in an effective and productive way. Care Co-ordinators reported a number of negative experiences when working with lifestyle services, such as poor communication and co-ordination, this negative experience was felt to be a barrier to utilising these services.

3.3.2 Changes to practice

A collaborative training day for the NW CMHT and community lifestyle service staff was provided which focused on a) what lifestyle services were available, b) what they provided, c) how to refer into them, d) barriers to referrals, e) how to improve the current system, f) how to improve the uptake, and g) experiences of working with SMI service users.

A full day training session was delivered in two separate sessions, a morning and afternoon. Each session was held twice to ensure adequate cover for the NW CMHT. The training days included the following sections:

- Morning session:
  - Introductions, what people hoped to gain from the training, rationale for doing physical health and health promotion work and introduction to health promotion.
  - Group work on a case study to explore the support needs of a service user with SMI, in respect to improving their physical health and how this could be managed within the team and in collaboration with others.
  - Nutrition services and improving collaborative working.
- Afternoon session:
  - Information about the NW CMHT for the healthy living services.
  - Information from various healthy living services about their service.
  - Group work to improve collaborative working between the NW CMHT and three of the healthy living services, Manchester Community Health Trainers, Physical Activity Referral Service and Expert Patients Programme.

3.3.3 Post project evaluation – what has been achieved and how?

The role of the CPHCs and the discussions with GPs and Care Co-ordinators as part of the MDT meetings (see objective 1 for more information) has resulted in a more dedicated focus on physical health promotion and appropriate referral to community lifestyle services. Table 1 (page 13) outlines that 10% (n=16) were actions involving referring service users to lifestyle services, with a further 5% (n=8) being referred to lifestyle services delivered by the GP practices.[15]

'The client had raised cholesterol, I identified that the literature that had been provided to the client regarding healthy eating had not helped. Following discussion in MDT it was agreed that he would be appropriate for one to one healthy eating advice from the Practice Nurse. Appointments made and client attended.' **Care Co-ordinator, NW CMHT**

CPHCs reported that lifestyle service referrals was an area that required further discussion in the MDT meetings and, while there had been an increase in the number of referrals that had been made to services, there needed to be a more focused discussion about the potential of lifestyle services during MDT meetings.

There have been quite a lot of examples of referrals that we've made but I'm not sure it's always necessarily the first thing we think of in meetings (…) Perhaps that's something for us to think about going forward. **CPHC, NW CMHT**

The interviews with service users demonstrated that Care Co-ordinators were starting to discuss physical health with their service users more frequently, with 100% (n=8) of service users stating that they now discuss physical health with their Care Co-ordinators. There also seems to have been an improvement in the number of Care Co-ordinators promoting and suggesting suitable lifestyle services as 87% (n=7) of service users had discussed suitable community lifestyle services with their Care Co-ordinator.

'[What do you discuss around physical health with your Care co-ordinator] Well to help me eat a healthier diet, and to lose weight.' **Service user**

'Yeah, my Care Co-ordinator always reviews what exercise I'm getting and what my ambitions are to improve on my exercise plan.' **Service user**

'Well she's sent me some healthy eating things (…) she said, you know, you should change your habits and eat healthily and go for walks and things like that.' **Service user**

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'I think you've got to have the willpower to go through with that, and in the position I find myself in at the moment, I haven't got the willpower to do it.'
Service user

See Objective 2 for more information about physical health education.

5 Increase utilisation of current physical health resources

During the post project Care Co-ordinator focus group, Care Co-ordinators endorsed the information from the survey suggesting that there had been an increase in their referral to lifestyle services as a result of the collaborative lifestyle days, specifically referrals to the Health Trainer service and the Expert Patient Programme. There was also a belief that the referrals were beginning to be more successful as service users were attending the services they had been referred to. However, as it is still relatively early in the process it is difficult to ascertain the level of impact from a service user perspective.

'She [Smoking Cessation Nurse] has been twice.' **Service user**

'Yeah, I've actually got an appointment tomorrow.' **Service user**

In an interview with one of the CPHCs, they reflected on how knowledge about lifestyle services across the NW CMHT had improved throughout the project.

'Yeah, I mean, some were pretty good anyway but others definitely have [improved]. We had those training days last year (…) about general awareness of physical health and making it a high priority, and having a better understanding of the services that we can refer on to for a healthy lifestyle. So that was great (…) and the feedback for that was very good.' **CPHC, NW CMHT**

As part of the post project survey Care Co-ordinators were asked to reflect on their experience of the lifestyle service training and information. As Figure 4 illustrates, 82% (n=9) of Care Co-ordinators felt that the collaborative lifestyle training had improved their understanding of the services available, with 18% (n=2) being undecided. Figure 5 shows that 67% (n=8) of Care Co-ordinators believed that their referrals to lifestyle services had increased since the start of the project.

Figure 4: Lifestyle training has imporved my understanding of the lifestyle services available

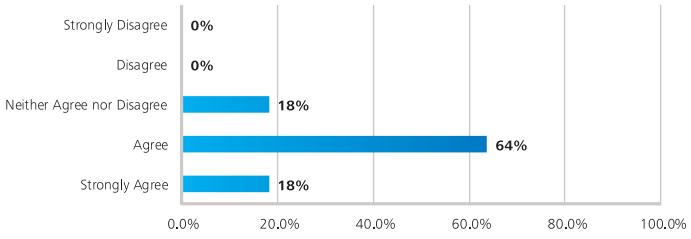
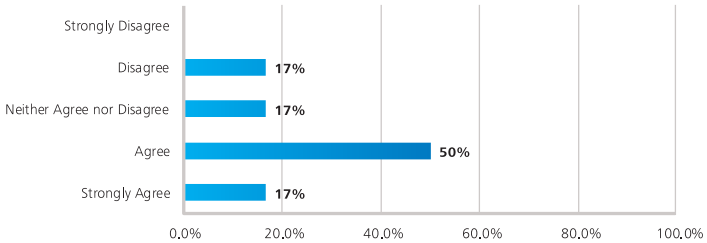


Figure 5: My service user referrals to the lifestyle services have increased since the start of the project



3.3.4 Service user case study

CPHC improved co-ordination of services which resulted in an improved approach to care provision, specifically diabetic review and smoking cessation.

I heard that my Care Co-ordinator, who is also the new CPHC, had a meeting at my surgery with my GP, District Nurses and Practice Nurses. I have many physical health problems including epilepsy, diabetes and heart disease and chronic mental health problems. I was absolutely flabbergasted by the results of the CPHCs meeting. 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 by diabetes more closely and I have had someone from the surgery here today to discuss stopping smoking. The CPHC 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 arise. My District Nurses now turn up daily and on time, my diabetes is getting treated by an expertly trained nurse, which then allows CPHC the time to fulfill 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.

3.3.5 Key findings

- Care Co-ordinators appear much more aware of (a) what community lifestyle services exist, (b) what they offer, and (c) how to refer into them.
- This improved knowledge of existing community lifestyle services has resulted in Care Co-ordinators feeling more confident about relaying this information to their service users, and as a result their referrals to lifestyle services have increased over the course of the programme.
- The lifestyle service collaborative training day has clearly been a key success of this programme and has led to improved awareness and an increase in appropriate referrals.
- This knowledge will be further developed with the planned introduction of a dedicated physical health intranet page displaying information and referral criteria for all community lifestyle services.

4 Recreating the model

Data indicates that 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. Based on the findings from the process evaluation, we have devised a framework to illustrate the key programme 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 figure 6). The key enablers are described as being (a) a boundary spanning role, (b) knowledge integration, (c) standardisation, and (d) a supportive organisational culture. The key enablers and implementation ingredients are based on the lessons that we have learnt from implementing the project, i.e. reflections on what has worked and how we could improve the project in the future. To supplement the information displayed in this section, a practical 'Community Physical Health Co-ordinator and Multi-Discplinary Team Meeting' guidance document has been produced. We recommended that this document is also consulted when trying to recreate the model.

Figure 6. 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 PHLW. Integrated working between Assistant Practitioners and Care Co-ordinators.
	Physical health education	Education 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.
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 the Rethink physical health assessment. Distributing a physical health check bag (including 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 Rethink physical health assessment. Support and guidance for completing the Rethink physical health assessment.

4.1 A boundary spanning role

What does the theory tell us?

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[16] and have the potential to promote and support integration. The boundary spanning role involves activities that occur at the internal or external boundaries of each service. It is imperative that individuals who span boundaries are well connected internally and are recognised externally as competent in their role and have appropriate personal characteristics to enable them to link across services.[17] Individuals who provide a boundary spanning role have been described as organisational liaisons and key nodes in information networks.[18,19,20]

How does this apply to practice?

Effective, quality and safe care for SMI service users relies on effective communication flows between differing professional groups within MMHSCT and primary care. A boundary spanning role based within the CMHT has provided a bridge between primary care and the CMHT to aid the integration and co-ordination of care. The CPHC provided the boundary spanning role and facilitated information sharing between the NW CMHT and the GP practices. The close contact and working relationship which developed between the CPHC and the GP practice has enabled a greater understanding and respect. Utilising the CPHC role as a 'conduit' of information has resulted in improved integration of care and has been integral to the holistic management of CMHT service users. The boundary spanning CPHC role has also provided consistency and continuity of care, as CMHT and primary care staff have one particular individual who co-ordinates the process.

'We have a CPHC who comes in and obviously she's not the Care Co-ordinator for everybody, but she'll find out what is going on, she finds out what we want to know. She either knows what is going on or is the conduit for finding that out, it's super.' **GP**

Implementation ingredients

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

this was essential for the success of the project. Training for the CPHCs was also a critical ingredient for success; CPHCs received training in conflict management, facilitation, negotiation and physical health management. This training helped to develop skills which were important to the CPHC role and will also help them in their future careers.

4.2 Knowledge integration

What does the theory tell us?

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.[21] Integrating diverse knowledge from multiple sources across organisational boundaries is challenging, but imperative for delivering integrated care. Knowledge integration can be defined as integration in terms of mechanisms for co-ordinating knowledge between individuals, which can be summarised as, communication systems, documents and routine procedures for co-ordinating explicit information, and group problem-solving for co-ordinating the personal know-how and experience of individuals.[22]

How does this apply to practice?

Knowledge integration was an important part of the implementation of the project and was organised through the MDT meetings, which provided a space for professionals to articulate and share knowledge about service users' physical health and mental health in a supportive environment.

The MDT meetings provided CMHT and primary care staff with a space to learn by (a) thinking, (b) reflecting and discussing, (c) identifying current knowledge and areas which require further improvement, and (d) developing a common language with respect to the physical health of service users. Knowledge integration is focused on combining knowledge from multiple perspectives around a key objective, rather than simply focused on combining, sharing and making information and data available. Sharing information enabled the teams to provide a co-ordinated approach, ensuring collective accountability, facilitating quality care for service users. Knowledge integration was also achieved through the lifestyle training sessions, which were developed to provide an opportunity for Care Co-ordinators to share their knowledge regarding their clients and the available lifestyle services.

'The MDT meetings have improved my knowledge of my own client's physical health needs and relevant recommended actions.' **Care Co-ordinator, NW CMHT**

Implementation ingredients

MDT meetings were conducted in a variety of ways across the teams; however, the general consensus was to involve at least a GP, Practice Manager/Administrator, Practice Nurse/Health Care Assistant and the CPHC and to hold the meetings monthly or bi monthly. The MDT meetings were delivered in two distinct ways, either as a standalone meeting, or as part of a wider integrated care meeting, for example, integrated into existing palliative care or long term conditions meetings. The success of each MDT meeting was that it was developed and delivered

according to local preferences, needs and requirements. A key finding for the project is the joint approach to MDT actions; GP practices and the NW CMHT have taken a co-ordinated approach to the actions generated from MDT meetings, to ensure that service users receive improved physical health management.

Knowledge integration within the CMHT was also an important ingredient for success, as it was imperative for CPHCs, Care Co-ordinators and Assistant Practitioners to work collaboratively to ensure quality physical health care for all SMI service users. CPHCs were based in the same location as Care Co-ordinators which helped to facilitate collaborative working.

To address the physical health training needs of NW CMHT Care Co-ordinators, mandatory physical health training has been agreed for all CMHT staff by MMHSCT, as an output of this project. Taster hour sessions were provided by the Physical Health Nurses, on a monthly basis as part of team meetings. Although the taster sessions were not as successful as hoped in relation to the implementation of this project, Care Co-ordinators suggested that a protected full day session would be more suitable to the delivery of such training. A full day session would enable staff to take protected time away from the office to dedicate to their physical health training. This has resource implications, but the general consensus was that this would be an improved way of delivering such important training.

A collaborative training day with NW CMHT staff and community lifestyle services staff was delivered to improve knowledge of a) lifestyle services available, b) what they provided, c) how to refer into them, d) barriers to referrals, e) how to improve the current system, and f) how to improve the uptake and experiences of working with SMI service users. Evaluation results showed that 81% (n=9) of Care Co-ordinators felt that the training day had achieved this and 67% (n=8) believed that referral to lifestyle services had increased since the start of the project. In addition, a collaborative training day for CMHT and lifestyle service staff provided the following information a) what lifestyle services are available, b) what they provide, c) how to refer into them, d) barriers to referrals, e) how to improve system, f) how to improve the uptake, and g) what it's like to work with people with SMI.

4.3 Standardisation

What does the theory tell us?

Standardisation 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 process standardisation is to specify transparent and uniform process activities across the organisation or service boundaries.[23] Standardising processes of communication to help improve the flow and quality is imperative for ensuring that knowledge is visible, accessible, and usable for decision making. When patterns and processes of care are widely divergent and produce significant variation, clinical outcomes may suffer and safety may be compromised.[24] Standardising procedures provide direction, improve communication, improve efficiency, improve safety, improve quality and can improve capacity.

How does this apply to practice?

Evaluation findings suggest that the CPHC developed systems which helped to improve the flow of communication and information within and between services. Developing a standardised approach for information sharing ensured consistency and continuity of communication both pre and post MDT meeting. This process was refined through a framework of continuous improvement, designed and led by frontline staff.

'The feedback from the surgeries is fantastic. They really like the form that we've come up with in the last month or two, with the colour coding about whether actions have been completed or not, with all the clients that we've discussed.' **CPHC, NW CMHT**

Implementation ingredients

Standardising certain processes has been essential for delivering reliable improvements. Standardising processes allows for individuals to make changes, based on continuous improvement cycles, but provides a basic template/format for primary care and CMHT staff to work from. As part of the project a number of documents and guides were produced to aid improvement, such as:

- A CPHC job description and a flowchart of responsibilities.
- A clinical guidance document to assist Care Co-ordinators carrying out the Rethink CPHA.
- An MDT Proforma Sheet (see Appendix 1 of the 'Community Physical Health Co-ordinator and Multi-Disciplinary Team Meeting' guidance document), to be used by CPHCs to document the appropriate information for any new service users to be discussed at MDT meetings.
- An MDT Traffic Light Action Feedback Form (see Appendix 2 of the 'Community Physical Health Co-ordinator and Multi-Disciplinary Team Meeting' guidance document), for CPHCs to document the actions discussed during the MDT meeting and the person responsible for carrying the action out.
- A process for identifying service users for discussion at the MDT meetings and for following up actions from the MDT meetings (more information about this process is available via the 'Community Physical Health Co-ordinator and Multi-Disciplinary Team' guidance document).
- The project evaluation findings have also resulted in a physical health check bag being available to all staff expected to complete a Rethink CPHA. This is a key piece of equipment which assists staff in completing the assessment.[25]
- The development, maintenance and utilisation of a lifestyle service directory easily accessible to all Trust staff, via the intranet.
- Adapted referral forms/pathways to be more engaging for people with SMI.

Primary care and CMHT staff now design joint action plans for the physical health management of service users and these can be discussed and appraised at MDT meetings.

The project has also led to the introduction of an optional joint initial introductory session with the Health Trainer service and the service user's CMHT worker.

4.4 A supportive organisational culture

What does the theory tell us?

To ensure that improvement is not dependent on individuals or transitory leaders, improvement needs to be institutionalised into the culture of the organisation.[26] Providing staff with the time, resources and support to test ideas and make changes to practice is viewed as a key facilitator for the success of this programme.

How does this apply to practice?

Evaluation findings suggest that commitment and support throughout the organisational hierarchy, providing appropriate case supervision and training for CPHCs and Care Co-ordinators is imperative for successful implementation. Care Co-ordinators also stressed the importance of a clinical governance system to ensure that they are appropriately trained and protected when completing the Rethink CPHAs. For staff to feel confident in completing Rethink CPHAs it is important that they receive relevant training and feel supported, improvements in the system need to be made to accommodate this. Developing an organisational culture which 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.

'We need to make sure that the supervision structure means that there is a proper discussion taking place with the manager around the care plan and then I suppose that's the safety check.'
CMHT Manager, NW CMHT

Implementation ingredients

Unsurprisingly, organisational culture is an important enabler for the delivery of co-ordinated care across primary care and mental health services. The evaluation findings highlighted a number of key ingredients which were important for developing a supportive culture for delivering improvement for the physical health care of SMI service users.

The evaluation found that co-ordinating physical health management requires leadership at all levels of the organisation and particularly support and guidance at a 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 role and appropriate leadership and support. Supervision of Care Co-ordinators is essential for ensuring there is effective management and guidance regarding MDT actions, this supervision will help to provide an assurance process that MDT actions are being completed appropriately and highlight any areas which require improvement.

Providing appropriate leadership and support for all CMHT staff in relation to completing the Rethink CPHAs is imperative, without this support completion of the assessments will be left up to the discretion of staff and will not be delivered and managed in a structured way. Changes need to be managed all levels of the system and CPHCs should be supported throughout the change process. This will help

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to ensure that the success of future work is not dependent on specific individuals, but is part of a change in organisational focus.

To ensure that Care Co-ordinators and CPHCs are appropriately trained in physical health issues, the Trust now provides physical health mandatory training, similar to that provided in acute settings. This is a crucial outcome of this project, as it ensures that leaders within the organisation are displaying commitment to the role of physical health in the management of SMI service users and provides Care Co-ordinators with the relevant knowledge and skills to care for the physical health of their service users.

The development of a spread and sustainability strategy is crucial for co-ordinating care between services. A spread and sustainability strategy ensures that best practice is adopted across organisations and that improvements are sustained in the future. A spread and sustainability strategy also allows leadership to articulate their commitment to the physical health of service users and provides a framework for improvements to practice and a direction for staff to work towards.

References

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

[2] The NHS Health Check programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or have certain risk factors, will be invited (once every five years) to have a check to assess their risk of heart disease, stroke, kidney disease and diabetes and will be given support and advice to help them reduce or manage that risk http://www.healthcheck.nhs.uk.

[3] These include services such as (a) Community Health Trainers, (b) Physical Activity on Referral, (c) Manchester Stop Smoking, (d) Sexual Health and Harm etc.

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[9] There are 3 'patch' working groups in North Manchester. They each include about 10 GP practices, grouped on their geographic location. They meet regularly to look at how improvements can be made to patient services in their local area.

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

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[12] The commissioning for quality and innovation (CQUIN) payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.

[13] There are two Physical Health Nurses employed within the Trust.

[14] Manchester Mental Health and Social Care NHS Trust recently became the provider of a number community lifestyle services, such as (a) Community Health Trainers, (b) Stop Smoking Manchester, (c) Physical Activity on Referral. However, they are not the sole provider of community lifestyle services across Manchester with services such as

Expert Patient Programme being provided by other organisations.

[15] These largely involve practice level smoking cessation and counterweight management courses.

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Contact details: **clahrc@srft.nhs.uk**