Improving physical health

Developing integrated care pathways to support mental and physical wellbeing

A joint project between

Manchester Mental Health and Social Care Trust and NIHR Collaboration for Leadership in Applied Health Research and Care for Greater Manchester

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The University of Manchester
MANCHESTER CITY COUNCIL
Manchester Mental Health and Social Care Trust
National Institute for Health Research

What is a CLAHRC ?

Collaboration for **L**eadership in **A**pplied **H**ealth **R**esearch and **C**are

- **Greater Manchester**
- Birmingham and the Black Country
- Cambridge
- Leeds, York and Bradford
- Leicester, Northamptonshire and Rutland
- NW London
- Nottinghamshire, Derbyshire and Lincolnshire
- South Yorkshire
- Peninsula

Collaboration between a university and its local NHS trusts that will…

↓

Conduct high quality health services research

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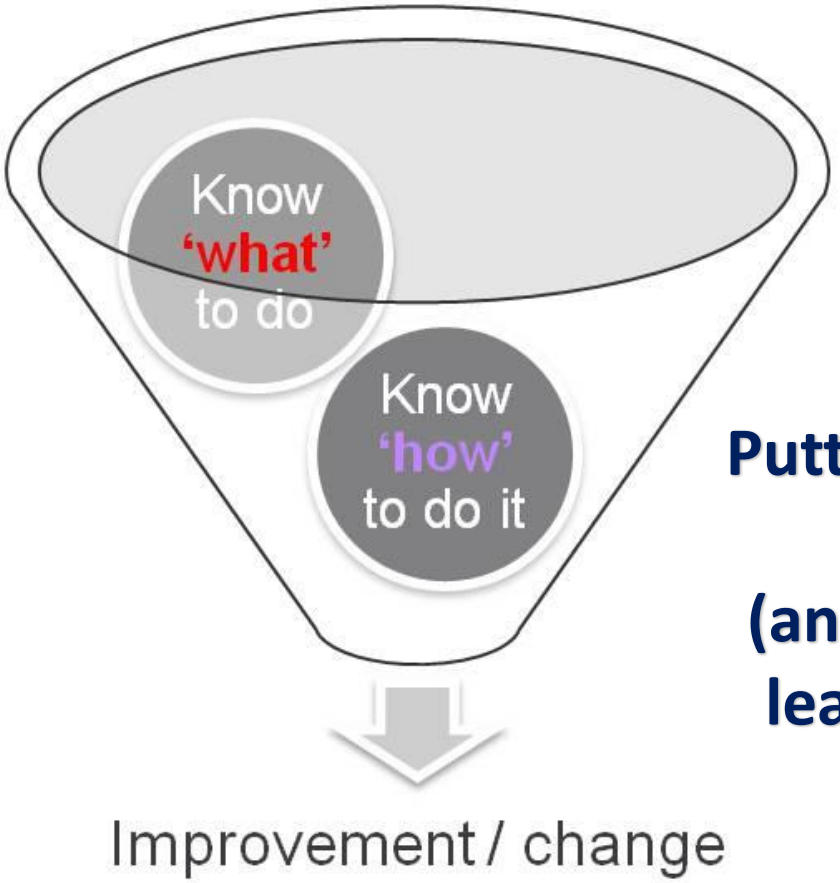
Ensure knowledge gained from the research is translated into improved health care in the NHS

patient and public involvement

CLAHRC: The know 'What' and know 'How'…

Innovating through research



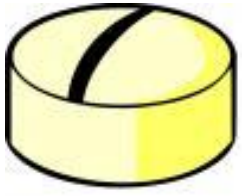
Putting evidence into practice (and evaluating and learning from this)

Manchester Mental Health and Social Care Trust (MMHSCT)

- Provides a wide spectrum of mental health, physical health and wellbeing services
- Is one of only five combined mental health and social care Trusts in England and Wales
- Serves an estimated population of 503,000 people, operating with the Manchester City Council boundaries
- Has two inpatient units offering acute care, as well as a number of Community Mental Health Teams
- Is one of the most research active mental health trusts in the country and hosts a number of national leaders in their field, including National Clinical Director for Dementia Professor Alistair Burns, Professor Nav Kapur, who heads suicide research at the University of Manchester and Professor Louis Appleby, National Director for Health and Criminal Justice.

Life expectancy is reduced by up to 15-25 years in people with SMI: Why?

Lifestyle factors:



Antipsychotic medication-induced weight gain

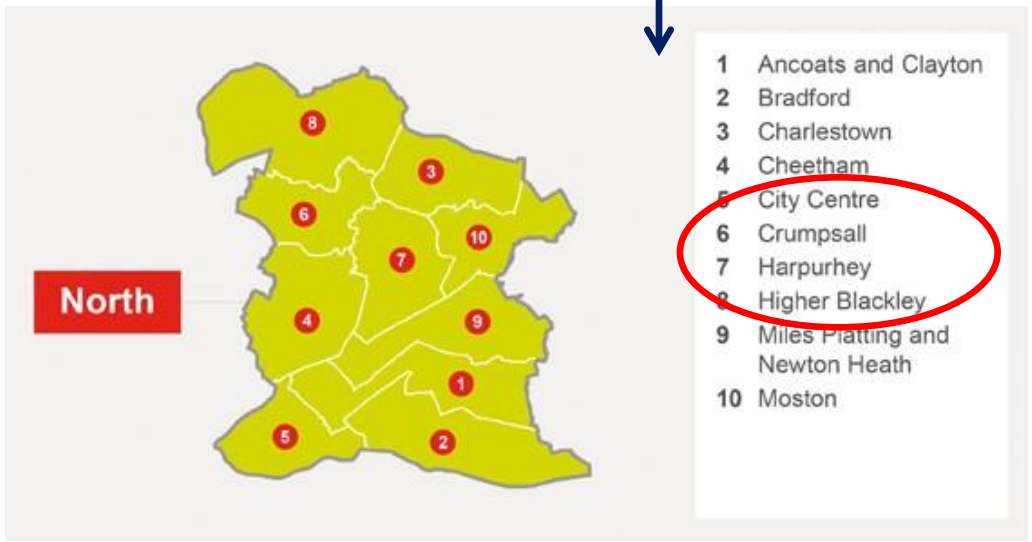
Service users' attitudes towards physical health

Background information

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

Anya Telford **Liz King**

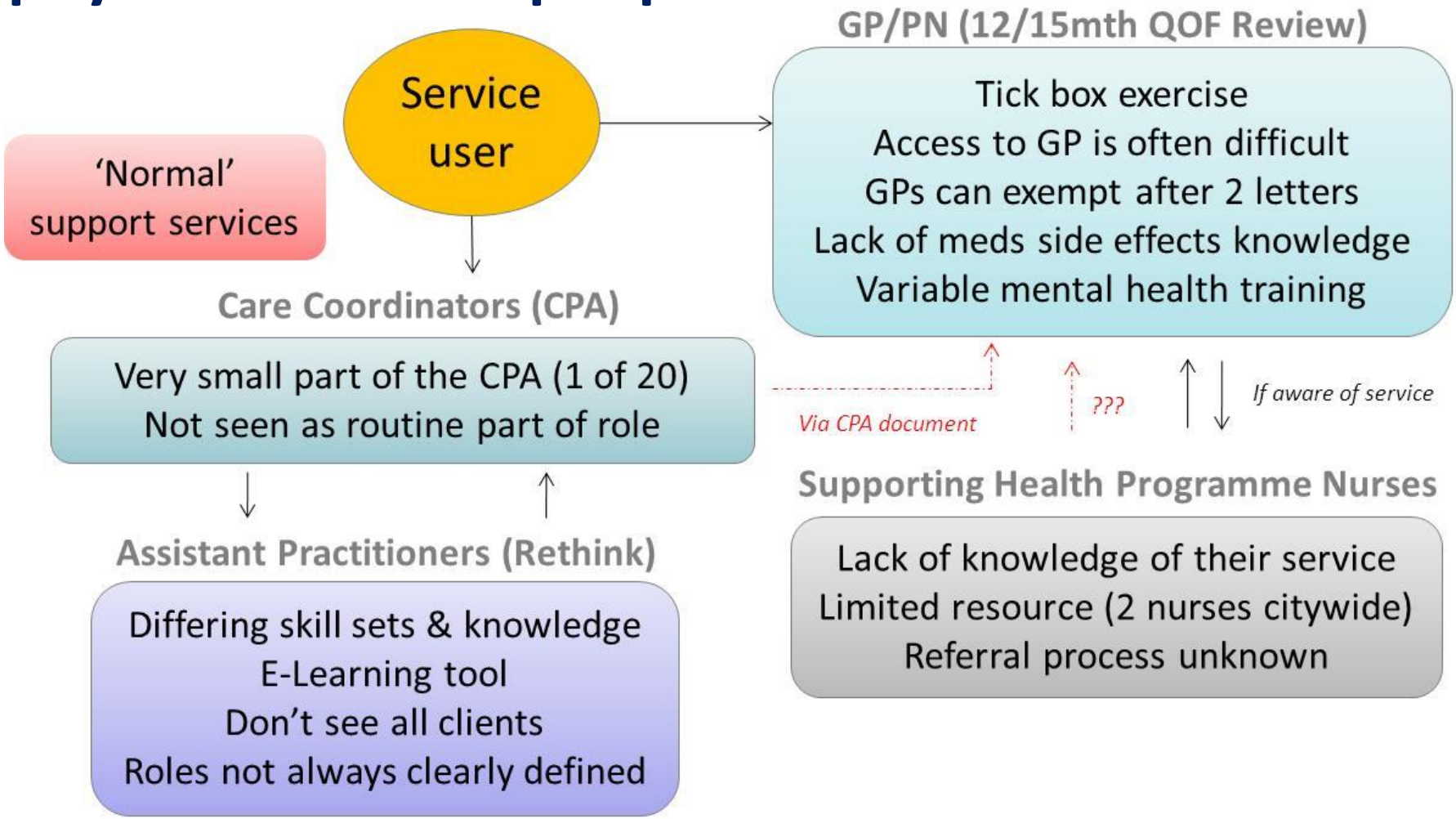
(Care coordinators)



5 GP surgeries involved

These vary in size, culture & mental health knowledge

Situation at project start: the management of physical health in people with SMI



The GOLD standard for MMHSCT

To develop and implement a sustainable integrated service user pathway that supports prevention and the early diagnosis, treatment and management of physical health problems as part of the overall treatment and care of people with SMI

Joint approach

Needs to be a **joint** approach to improving physical health, involving community mental health teams **and** GPs

Shared responsibility

Needs to be an integrated physical health assessment and plan with **shared** responsibility for action/management

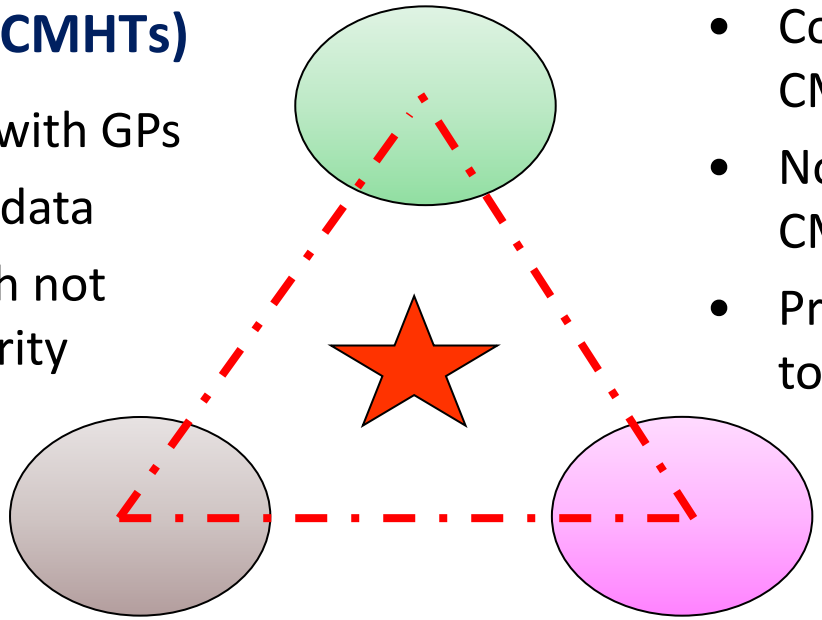
The improvement challenges

Community Mental Health Teams (CMHTs)

- Little contact with GPs
- No sharing of data
- Physical health not seen as a priority

Primary care

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



Service users

- Lack of trust in GPs
- Difficulty accessing GP surgery
- Avoidance strategy
- Lack of motivation

Improving physical health: The service user's perspective

Attitude towards physical health:

- "I would say if you feel bad physically then you feel bad mentally … I think it goes hand in hand."
- "I have a mental problem you know (…) when someone says physical to me I don't know what you mean. All I know about is mental health. (…) although I don't really understand it. I do think it is critical more than mental."

Barriers:

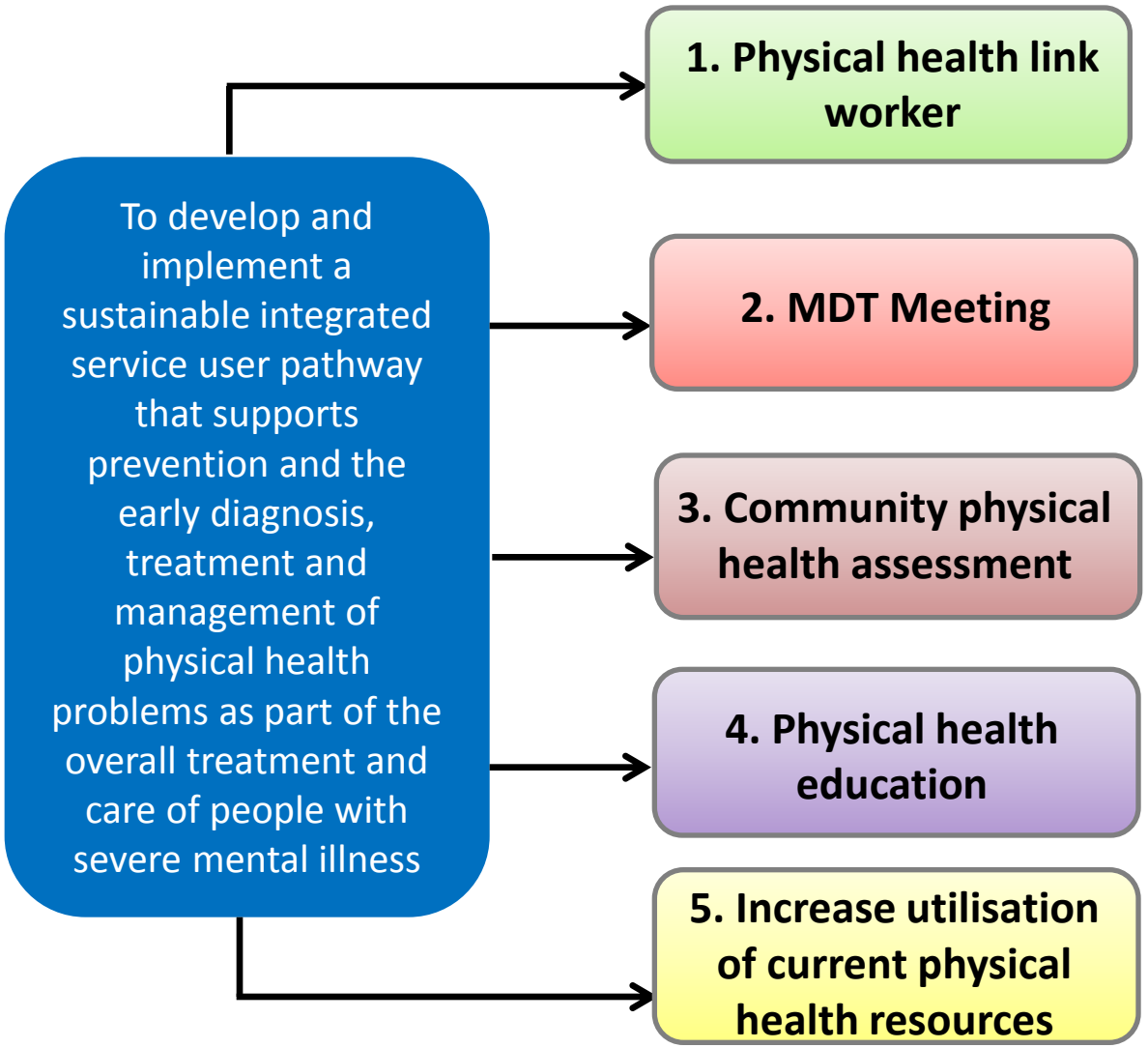
- **Lack of trust:** "Seeing you and the consultant (…) is different to going to see my GP, because he doesn't seem to understand (…). I'd rather not speak to my GP, she is not very sympathetic."
- **Avoidance strategy:** "I wouldn't want to know if there was anything wrong."
- **Lack of motivation; importance of social support:** "If (…) I had to catch the bus, I might not bother so much. I might think that I will wait for someone to take me (…) I know that seems lazy but sometimes I don't have the motivation."
- **Access to GP surgeries:** "It's easy to see the GP, normally you have to queue outside for an hour or so." – "(…) there is a stigma attached to it, so I don't think I get fairly treated by the receptionists (…), who are aware I have a mental illness (…) they have an expression on the face 'not you again' (…) so I get someone else to phone up for me."

Critical success factors for developing a sustainable model of shared care

Developing the model…

- **Improving communication** between CMHTs and primary care; instilling a mutual respect for each others' roles
- A **mutually agreed, clearly defined pathway** for managing mental health and physical health across community, acute and primary care teams
- **Up-skilling existing staff** to take on new responsibilities and new roles
- **Utilising existing resources** – no reinvention of the wheel

How do we achieve the gold standard?



Link to Trust CQUINs

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

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

Physical health link worker role

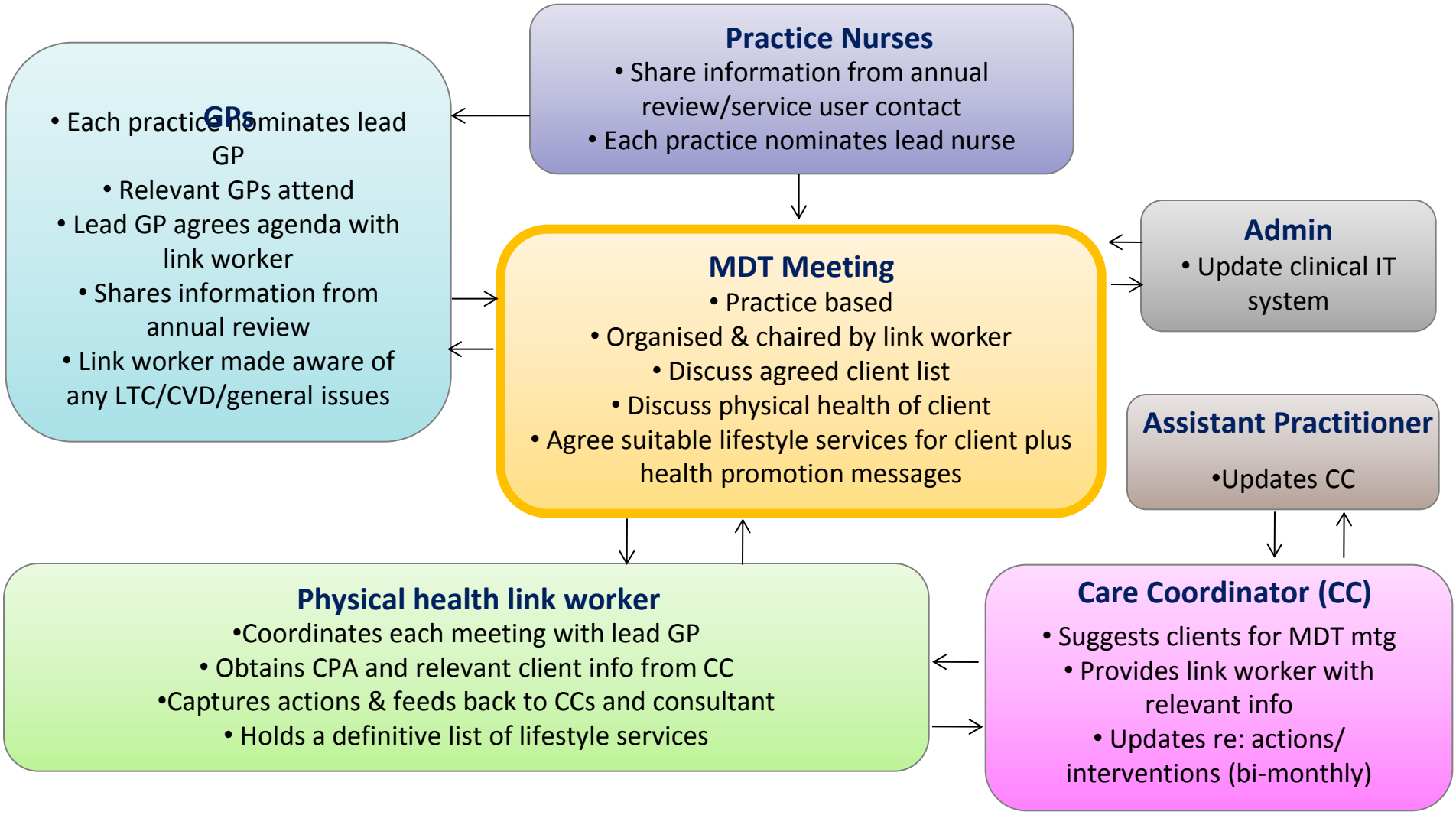
- Physical health link worker (PHLW) is based within the community mental health team, and provides a bridge between primary care surgeries and the community mental health team

- This is a split role; it is seen to be essential to continue as a care co-ordinator to
    a) retain clinical skills
    b) have the respect from peers
    c) understand the complexities of care co-ordination
    d) have access to the appropriate information, meetings and discussions

- Attends MDT meetings with GP surgeries

- A job description and a flowchart of responsibilities have been developed, this includes information regarding
    a) preparation for MDT meetings
    b) managing MDT meetings
    c) following up MDT meeting actions

MDT & physical health link worker role



MDT & physical health link worker role

- To address unmet needs in mental and physical care
- Should involve at least a GP, practice manager/administrator, practice nurse/health care assistant and the PHLW
- Important to have a lead liaison point in the surgery
- Hold monthly or bi-monthly; some have been stand alone, others have been integrated into
    a) existing palliative care
    b) long term conditions
    c) integrated care meetings

MDT & physical health link worker role

- The list of service users should be shared before each MDT via NHS.net
- Joint action plans for the physical health management are developed and shared with the primary care team and consultant
- Specific actions and information are recorded ideally on the GP clinical system and CMHT database
- Actions from previous meetings are reviewed and followed up at each MDT meeting

MDT & physical health link worker role

MDT Meetings

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

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

To both CCs/APs/Consultant and GP surgery

Improved liaison between consultant and GP surgery

MDT & physical health link worker role

Sandra has a BMI of 45, poor diet, Type II diabetes, hypertension, Polycystic Ovary Disease, is a heavy smoker, and does not exercise, but she is motivated to change.

Sandra is not compliant with all of her morning medication because she gets confused about the order in which to take them. This was discussed in the MDT meeting, and the doctor gave assurance that the medications could be taken in any order. Sandra's Care Co-ordinator relayed this information to Sandra who then set reminders on her phone and agreed to start taking her medication again. Following discussion in the MDT meeting it was identified that Sandra had also not been attending appointments and required diabetic review and a physical health review. Sandra's Care Co-ordinator supported her to make an appointment for bloods and for diabetes review."

Progress: MDT & physical health link worker role

January 2013

Key Actions	Total Actions
Community Lifestyle Service Referral	9
Disease Review (inc. repeat bloods; CHD; Diabetes etc)	23
Medication Review	8
Other	31
Practice Lifestyle Service Referral	6
Primary Care Physical Health Assessment	21
Rethink Assessment	3
Blank	1
Total	102

Progress: MDT & physical health link worker role

Service User Story

It started with me answering some questions on tape. I didn't really have much hope of this project working because I am sure lots of projects of this kind have been tried before. So the question stage was completed and the rest was left to Liz **and I admit I thought I would hear no more!**

Then I heard that Liz had 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 Liz's 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 my diabetes more closely and I have had someone from the surgery here today to discuss stopping smoking. **Liz 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 Liz the time to fulfil her role. **These people have never looked like coming together before and in truth it make 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!

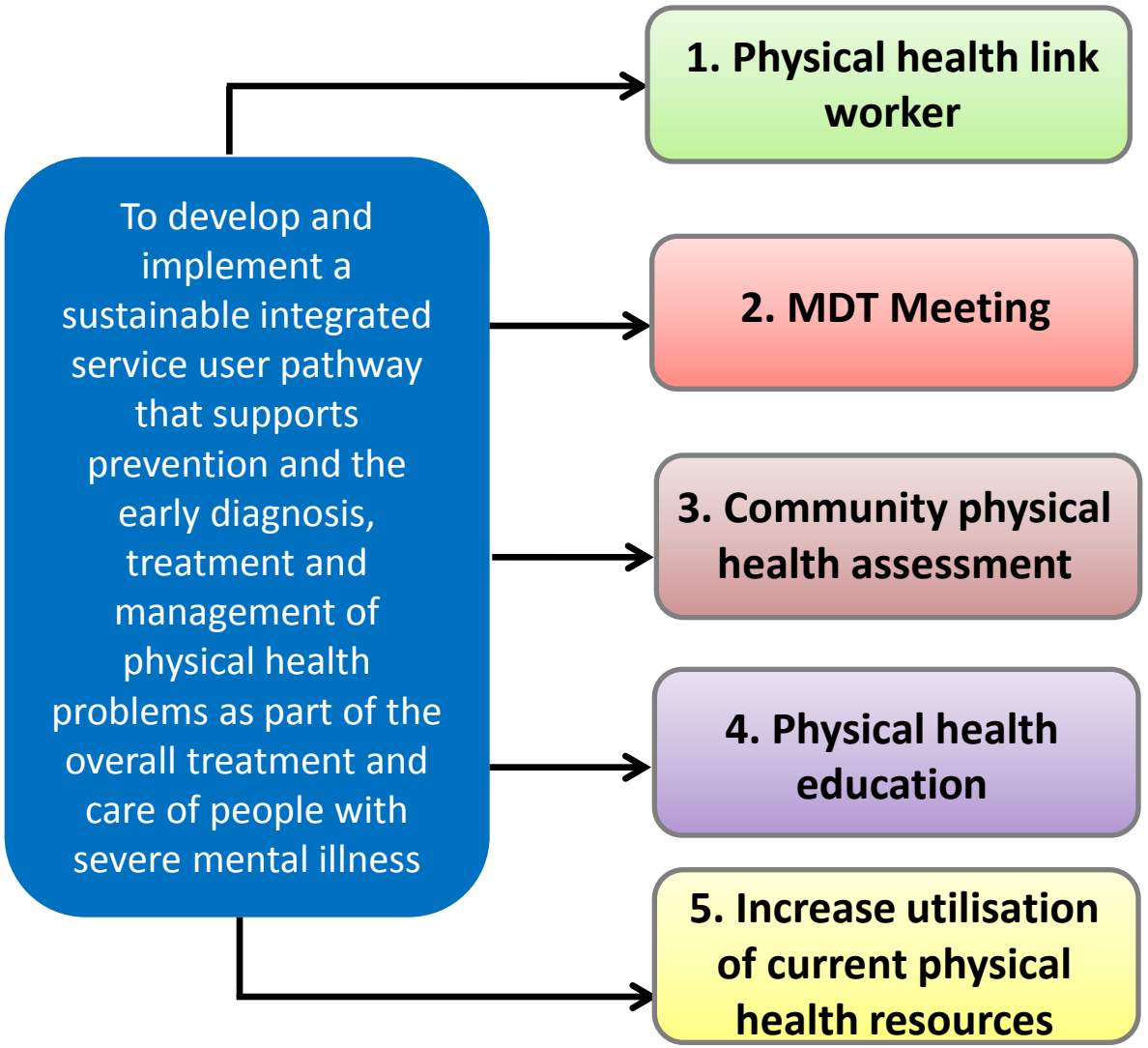
MDT & physical health link worker role

Care Coordinator Feedback

My client is a 46 year old woman of South Asian origin. She has been under the Community Mental Health Team twice but **has a history of poor engagement and non-compliance with medication**. **She is significantly overweight and has diabetes which is poorly controlled. It appears she has a limited understanding of her health needs** and tends to prioritise looking after her family over herself. Our work has mainly focused on providing information about her illness to allow her to manage it appropriately. I have **tried to focus on my client's physical health i.e. compliance with treatment for diabetes, healthy eating, weight management and attending appointments**.

I have liaised with our PHLW Anya who in turn has liaised with staff at the GP Practice which has allowed me to better co-ordinate my client's physical health care. Anya sent regular emails asking whether I had concerns I wanted to raise at the regular MDT. She subsequently provided feedback and action points via follow-up email and face-to-face conversation. If I had any queries Anya was able to liaise with the GP/nurse on my behalf which was helpful and saved time. **Overall Anya's support allowed me to increase my awareness of her physical health needs and I feel I was able to provide better support as a result. Specifically I have been able to monitor her GP/practice nurse appointments, and support her to attend as GP staff highlighted her poor attendance. This allowed the practice nurse to carry out several tests including blood tests, BMI, etc and her diabetic medication has been changed as a result. My client has also been referred to the dietician as a result of these appointments.**

How do we achieve the gold standard?



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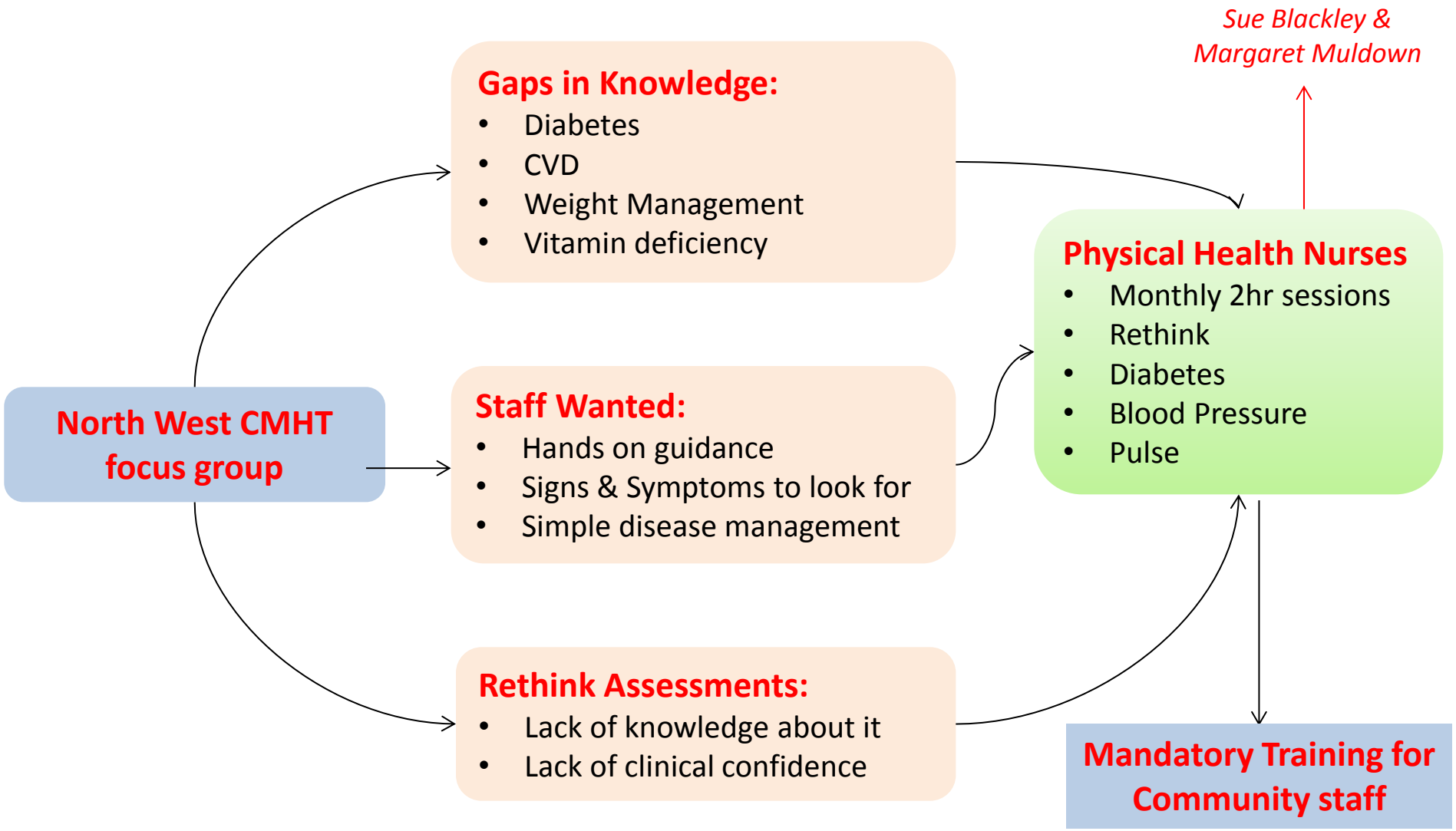
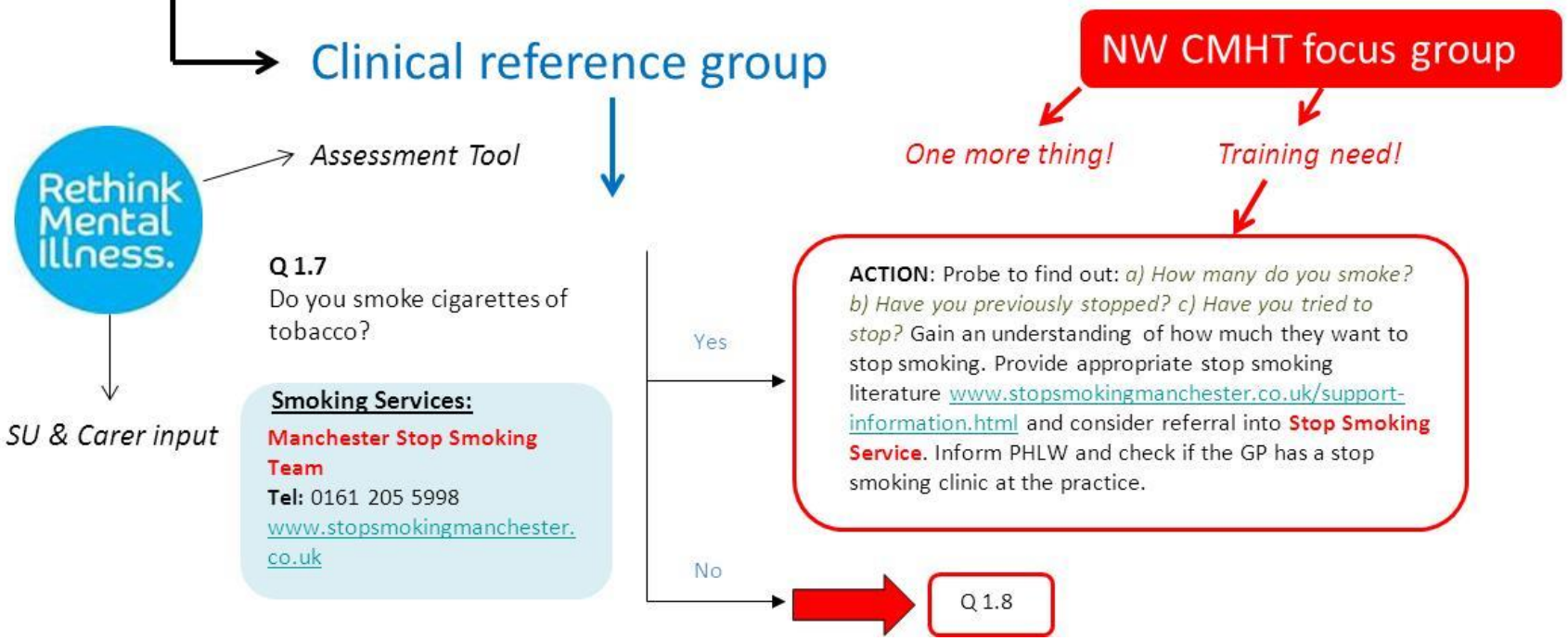
Physical health education



Community physical health assessment

"To make matters worse White et al (2009) and Citrome & Yeomans (2005) warn that important issues such as the appropriate frequency of physical health screening… are not known yet" (Collins, Tranter & Irvine, 2012)



Increase appropriate utilisation of lifestyle services

Key Issues

- Lack of time
- Lack of physical health knowledge
- Indifferent knowledge of community lifestyle services

Criteria
Referral forms
What they offer

North West CMHT focus group

Manchester Public Health Development Service

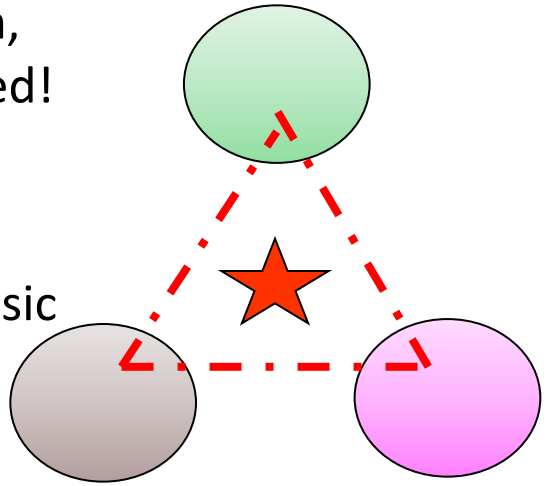
- 2 Collaborative Learning Days
- 30 NW CMHT staff attended
- 15 people from various lifestyle services
- 1 Service User from Rethink

Lifestyle Service Directory

Feedback so far

CMHTs:

- Improved communication, ongoing efforts are needed!
- Positive about the link worker role
- Uncertain about doing basic physical health assessments
- Increased knowledge re lifestyle services available



Service users:

- Initial impressions are positive
- Currently gathering this information

Primary care:

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

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

What next?

- Complete evaluation of current project
- Prepare for integrating this work into core Trust business
  - Ensure all structural components required for spread are identified and implemented
  - Gather all outputs for spread from current project
  - Prepare the teams – plan spread and communicate well!

Questions?

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