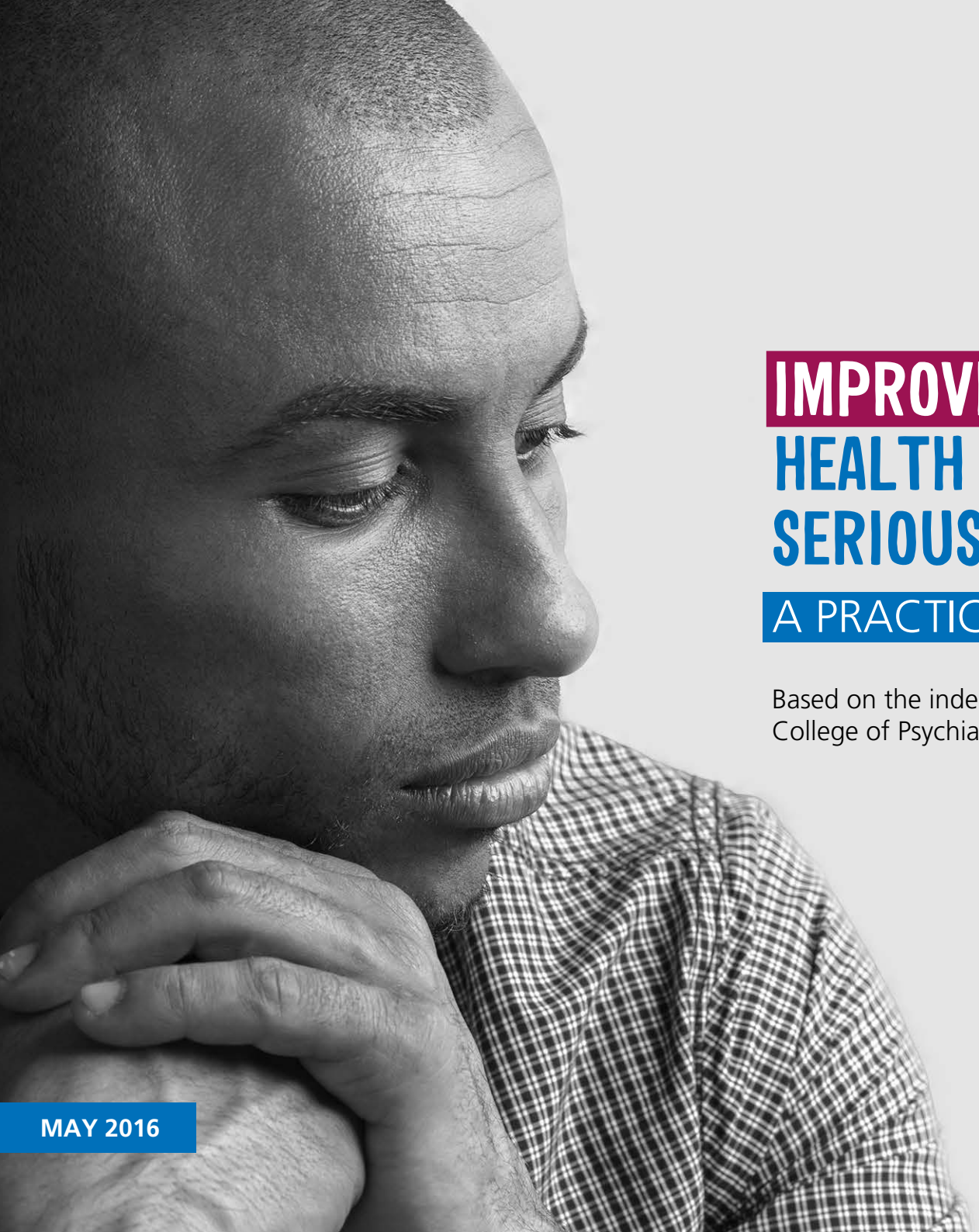

NHS England

IMPROVING THE PHYSICAL HEALTH OF PEOPLE WITH SERIOUS MENTAL ILLNESS

A PRACTICAL TOOLKIT

Based on the independent evaluation by the Royal College of Psychiatrists of four NHS England pilot sites

MAY 2016

Gateway Reference Information

Gateway reference number: 04999

Date of publication: 24 May 2016

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www.england.nhs.uk

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ACKNOWLEDGEMENTS

NHS England is extremely grateful to the many stakeholders who contributed their expertise, experience and time to this project.

Our particular thanks go to patients and staff at our pilot sites:

- **2Gether NHS Foundation Trust**
- **Northumberland, Tyne and Wear NHS Foundation Trust**
- **Tees, Esk and Wear Valleys NHS Foundation Trust**
- **Mersey Care NHS Trust**

We wish to express our gratitude to other members of the project steering group:

Sheila Hardy
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We also wish to thank the following for their advice and continued support of our work:

Geraldine Strathdee, National Clinical Director for Mental Health, NHS England
Huon Gray, National Clinical Director for Cardiac Care, NHS England
Jonathan Valabhji, National Clinical Director for Obesity and Diabetes, NHS England
The evaluation team at the Royal College of Psychiatrists' Centre for Quality Improvement
Kate Dale, Physical and Mental Health Lead, Bradford District Care Foundation Trust
Ben Thomas, Mental Health, Learning Disability and Dementia Care Professional Officer, Strategy and External Relations Directorate, Department of Health

IMPROVING THE PHYSICAL HEALTH OF PEOPLE WITH SERIOUS MENTAL ILLNESS: A PRACTICAL TOOLKIT

FOREWORD

When treating patients with serious mental illness (SMI), it's natural to think foremost about their mental health. But this group of patients are also at some of the greatest risk of poor overall health and premature mortality. Striking figures show that SMI patients die on average 20 years earlier than the general population due to preventable physical health problems – a life expectancy similar to the 1950's[1].

Estimates suggest there would be up to 12,000 fewer deaths from cardiovascular disease (CVD) if people with SMI had the same outcomes as the general population. A combination of factors, including the side effects of anti-psychotic medication, lifestyle and difficulty accessing mainstream health services can all contribute to this decreased life expectancy. The Five Year Forward View for Mental Health[2] recognises the need to address this.

But trusts and commissioners, with support from national bodies, are working in new and imaginative ways to change this. By working closely with four trusts, NHS England's pilot project has explored ways to implement the Lester (2014) tool, which helps identify SMI patients at risk of cardiovascular disease, and recommends the best option for intervention or treatment.

By providing a prompt for clinical teams to screen and intervene for cardiovascular conditions such as diabetes and high blood pressure, the Lester 2014 tool can be a valuable resource as we work towards parity of esteem for physical and mental health. In addition, the Lester tool has been aligned as part of this project with the Bradford tool, an IT template system which supports physical health screening.

While each pilot site has explored a different approach, in each location the project has helped make physical health a real priority for their SMI patients. Be it ensuring that staff have the right skills and the confidence to use them, that the right systems and pathways are in place or making sure that patients are engaged with their physical health, we hope this toolkit provides both inspiration and practical support for others.

We can no longer see patients with serious mental illness only through the prism of their mental health; we must ensure all their health needs are monitored and catered for equally.

Geraldine Strathdee,
National Clinical Director for Mental Health 2012-April 2016 and Consultant Psychiatrist Oxleas NHS Foundation Trust

Huon Gray,
National Clinical Director for Cardiac Care

[1] Chin-Kuo Chang et al (2011), Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental Health Case Register in London. PLoS One. 2011; 6(5): e19590
[2] The Independent Mental Health Taskforce (2016), The Five Year Forward View for Mental Health
https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

ABOUT THIS TOOLKIT

In February 2016, NHS England published the Five Year Forward View for Mental Health. Produced by the Mental Health Taskforce it sets out the start of a ten year journey for transformation of mental health services, with the experience of people with mental health problems at the heart of it.

Physical health is a key part of that vision. The report recommends that:

'NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.'

Between 2014 and 2016, NHS England worked with staff and patients in four mental health trusts to improve the cardiovascular (CVD) health outcomes and reduce premature mortality in people with serious mental illness. CVD is the biggest cause of premature death in this patient group.

Cardiovascular disease: The four conditions defined as cardiovascular disease are heart disease, type 2 diabetes, kidney disease and stroke.

The four trusts took different approaches to the problem, taking into account local priorities and ways of working, but each one involved implementing the Lester (2014) screening tool. NHS England's Sustainable Improvement Team (working as NHS Improving Quality for much of the project) provided the sites with specialist quality improvement advice. The trusts were:

- 2gether NHS Foundation Trust (2Gether)
- Northumberland, Tyne and Wear NHS Foundation Trust (NTW)
- Mersey Care NHS Trust (Mersey Care)
- Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV)

This toolkit is designed to help other mental health trusts implement the Lester tool, using a combination of detailed case studies, short examples and supporting documents provided by each pilot site. By sharing the pilot sites' own material (such as physical health policies, example job descriptions and lists of equipment), we hope that other trusts will be able to use these as the basis for their own materials – without needing to start from scratch.

The materials included in this toolkit are all practical, local resources and some may still be work in progress. Readers are encouraged to consider, adopt or adapt the content as locally appropriate, and to acknowledge and reference the relevant trust accordingly. These sites own the intellectual property rights for their materials and are provided on an 'as is' basis.

IMPROVING THE PHYSICAL HEALTH OF PEOPLE WITH SERIOUS MENTAL ILLNESS: A PRACTICAL TOOLKIT

What can trusts do to improve the physical health of people with serious mental illness?
The Royal College of Psychiatrists were commissioned to carry out an independent evaluation, which looked at how the Lester tool had been implemented in each of the four trusts. This identified a number of 'causal mechanisms' which based on the pilot sites' experience are the key to bringing about change:

1. Motivating and engaging staff
2. Roles and responsibilities
3. Skills and confidence
4. Equipment
5. Recording information
6. Communicating with service users
7. Interfaces with other services

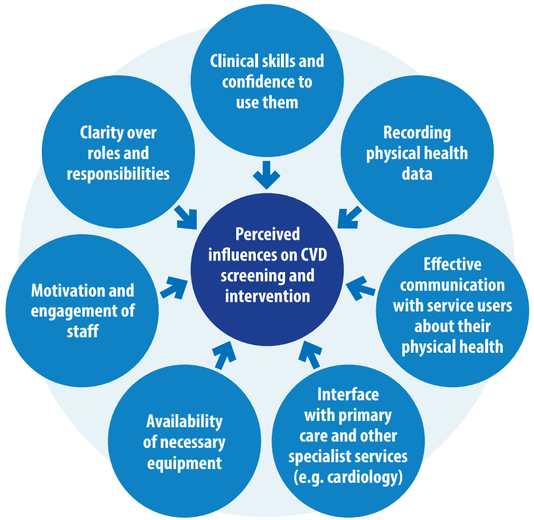
This toolkit deals with each causal mechanism in turn, providing guidance, supporting documents and case studies to illustrate how trusts can address each factor when implementing the Lester tool.

Supporting resources

- An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings, Royal College of Psychiatrists

[3] Royal College of Psychiatrists, An evaluation of the implementation of the Lester tool 2014 in psychiatric inpatient settings, p88

Perceived influences on the amount and quality of CVD screening and intervention in psychiatric inpatient settings[3]



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Headline results

Implementing the Lester tool had a positive impact on the way physical health was delivered in the four trusts.

- Inpatients receiving all five recommended CVD screens increased from 46% across all sites at baseline to 83% at follow up.
- Interventions delivered to those who needed them as a result of appropriate screening increased from 79% to 94%.
- 89% of service users surveyed reported wanting one or more tests or support when in mental health hospital.
- A cause for concern is that at follow up 41% of patients who needed an intervention for abnormal blood pressure and 33% of patients who needed an intervention for abnormal blood glucose did not receive one.

In addition, staff in all four trusts perceived that the project had bought about a significant cultural change with physical health now seen as a core part of each service users' treatment, and a core responsibility of all clinical staff – helping bring about parity of esteem for physical and mental health care.

While it is too early to report on the long term impact on morbidity and mortality, it is hoped that improving the physical health of patients with serious mental illness will have long-term positive outcomes.

What is the Lester tool?

The Lester (2014) tool (also known as the Lester Cardio-metabolic Health Resource) helps clinicians to assess the cardiovascular health of patients with SMI and recommends the best course of intervention and treatment – including thresholds for intervention. It brings together advice from a number of NICE guidelines and is also designed to take into account the impact of anti-psychotic medication on an increased risk of CVD in people with SMI.

The tool, (originally adapted by the Royal College of Psychiatrists and the Royal College of GPs for use in the UK), was modified to fit the NHS context by a partnership between the Royal College of Psychiatrists, NHS England and Public Health England, resulting in the Lester (2014) version – referred to as 'the Lester tool' in this report.

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The Lester Tool

Lester UK Adaptation | **2014 update**

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**

Smoking	Lifestyle and Life Skills	Body Mass Index (BMI) Weight	Blood Pressure	Glucose Regulation Assess by fasting blood glucose (FPG); random blood glucose (RBG); HbA_{1c}	Blood Lipids	
Current smoker	Poor diet **AND/OR** Sedentary lifestyle	BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) **AND/OR** Weight gain >5kg over 3 month period	>140 mm Hg systolic **AND/OR** >90 mm Hg diastolic	HbA_{1c} or Glucose threshold: HbA_{1c} ≥42 mmol/mol (≥6%) **AND/OR** FPG ≥5.5 mmol/l **OR** RPG ≥ 11.1 mmol/l	Total chol/HDL ratio to detect high (>10%) risk of CVD based on QRISK-2 Tool http://qrisk.org/ *Note: CVD risk scores can underestimate risk in those with psychosis*	RED ZONE
Medication review and lifestyle advice to include diet and physical activity ***NB Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.***						
			Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.			
Brief intervention Combined NRT and/or varenicline Individual/group behavioral support or specialist support if high dependency Referral to Smoking Cessation service		Follow NICE guidelines for obesity http://www.nice.org.uk/CG43	Follow NICE hypertension guidelines http://publications.nice.org.uk/hypertension-cg127 Consider anti-hypertensive therapy Limit salt intake in diet	**At High Risk of Diabetes** HbA_{1c} 42-47 mmol/mol (6.0% - 6.4%) FPG 5.5 - 6.9 mmol/l i) Offer intensive structured lifestyle education programme ii) If ineffective consider metformin	**Diabetes** HbA_{1c} ≥48 mmol/mol (≥6.5%) FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l Endocrine review Follow NICE diabetes guidelines http://www.nice.org.uk/CG87	Follow NICE guidelines for lipid modification **AND** Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l) **AND** Consider lipid modification for those with CVD or Diabetes	INTERVENTIONS
Stop smoking	Improve quality of diet Contain calorie intake Daily exercise of 30 mins/day	BMI 18.5-24.9 kg/m² (18.5-22.9 kg/m² if South Asian or Chinese)	<140/90 mm Hg (<130/80 mm Hg for those with CVD or diabetes)	Prevent or delay onset of diabetes HbA_{1c} <42 mmol/mol (<6%) FPG <5.5 mmol/l	HbA_{1c} 47-58 mmol/mol (6.5-7.5%)	Primary Prevention: consider statin treatment if ≥10% risk based on QRISK2 **OR** Secondary Prevention: aim to reduce non-HDL chol by 40% and review in 3 months	TARGET

FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

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CONTEXT

People with serious mental illness are at some of the greatest risk of poor health and premature mortality, dying on average 20 years earlier than the general population due to preventable physical problems. This is due to a combination of factors including the side effects of anti-psychotic medication, lifestyle and difficulty in accessing mainstream health services. Estimates suggest there would be up to 12,000 fewer deaths from cardiovascular disease (CVD) each year if people with SMI had the same outcomes as the general population. The reduction in CVD related mortality in the general population is attributed primarily to improvements in diagnosis and treatment.

To improve physical healthcare and reduce premature mortality in people with severe mental illness, the mental health CQUIN[4] was introduced in 2014/15 and continues to be one of the CQUIN goals for 2015/16. It aims to support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with severe mental illness and improve their safety through improved assessment, treatment and communication between clinicians.

Alongside the mental health CQUIN and the recommendations made in the Five Year Forward View for Mental Health produced by the Mental Health Taskforce, the Department of Health have produced 'Improving the physical health of people with mental health problems: Actions for mental health nurses' which focuses on the clinical skills mental health nurses and students need to tackle some of the key risk factors for physical health problems in people with an SMI.

[4] Commissioning for Quality and Innovation payment

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1. MOTIVATING AND ENGAGING STAFF

Overview

One barrier identified by the project was that some staff felt it was not appropriate to deliver physical health care in a mental health setting. It was essential to motivate and engage staff to tackle a prevailing culture focussing solely on mental health.

The Royal College of Psychiatrists' evaluation reported that the pilot sites also expressed concern about whether it was appropriate to carry out screening and interventions in units that provide short term care for patients who are in acute mental distress. Sites reported that staff in acute inpatient wards did not have enough capacity and needed to prioritise managing patients' mental health. Smoking and weight were particularly identified as being better dealt with in long stay wards as these did not take priority when trying to stabilise someone's mental state.

Recovery and rehabilitation wards were seen to give greater opportunity for screening and intervention. Service users on these wards were thought more likely to pay attention to their physical health. This is in part due to a greater stability of mental state and because staff felt better able to support and monitor lifestyle changes on these wards.

The evaluation report highlighted three main ways of engaging staff with physical health care:

- Senior level support for of the work
- Employing a dedicated physical healthcare facilitator or project manager
- Organising large scale health engagement events for staff and service users

All four pilot sites were able to use their pilot funding to employ a dedicated physical healthcare facilitator or project manager to deliver the work. The short examples below show how two of the pilot sites used all three of these change mechanisms:

Senior support

2gether NHS Foundation Trust

2Gether has a Physical Health Clinical Expert Reference Group, chaired by a consultant psychiatrist and made up of senior staff from a range of disciplines who give oversight to physical health issues affecting the trust such as CQUIN activities.

The reference group gave the project top-level support by developing the pilot proposal and application for pilot funding. Senior frontline staff were already familiar with the Lester tool, in part due to its overlap with the National Early Warning Score (NEWS)[5] tool which was implemented in the trust in 2012.

Northumberland Tyne and Wear NHS Foundation Trust

NTW's Physical Health and Wellbeing Group gave senior support to the importance of physical health, and discussed the mental health CQUIN at every meeting.

[5] https://www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news

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Dedicated physical health resource:
2gether NHS Foundation Trust
2gether employed a health facilitator who worked closely with the expert reference group and senior staff to engage frontline clinicians in practice improvement. They integrated the Lester tool with the trust IT system, provided training and support and developed policies explaining the responsibilities of different clinicians. Staff said that these activities gave them structure for screening and intervention and helped them understand the reasons behind the emphasis on physical health.

Read more about training at 2gether in chapter 3 – **Skills and Confidence**.

Northumberland Tyne and Wear NHS Foundation Trust
NTW employed a project manager who coordinated a trust-wide training programme which both enhanced mental health and community nurses' physical health skills and helped to embed importance of physical healthcare into the trust's culture.

Read more about the NTW training programme in chapter 3 – **Skills and Confidence**.

Health engagement events:
2gether NHS Foundation Trust
2Gether ran a physical health day to make service users and staff aware of health issues for people with SMI. 120 delegates heard about the easy steps people can take to improve physical health and which services are available. There were stalls showcasing sexual health, dental access, breast awareness, the learning disability health facilitation team, Slimming World, diabetes awareness, balanced diet, hydration, and substance misuse and practical sessions on foot care, pelvic floor classes, brief stress tolerance and relaxation sessions, mindfulness colouring and smoothie making.

Northumberland Tyne and Wear NHS Foundation Trust
To engage staff, the Physical Health and Wellbeing Group at NTW held two conferences called 'Improving Health and Wellbeing – Everybody's Business' to help launch the Lester tool across the trust and into clinical practice. Staff were also able to find out more about:

- the mental health CQUIN and what it means for them
- healthy lifestyles and physical health interventions
- shared care & anti-psychotic medication
- the Physical Health Link Worker/Champions role

Supporting resources

- **Job description** – Band 6 health facilitator, 2gether NHS Foundation Trust
- **Job description** – Band 7 project manager, Northumberland, Tyne and Wear NHS Foundation Trust
- **Job description** – Band 5 project support manager, Tees, Esk and Wear Valleys NHS Foundation Trust

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2. CLARITY OF ROLES AND RESPONSIBILITIES

Overview
To make the Lester tool an effective resource for reducing CVD associated morbidity and mortality in patients with SMI, it is vital that all staff are clear about their roles and responsibilities for physical healthcare. This could be in the form of a written policy or a clear induction programme for new clinical staff. A written physical health policy can demonstrate senior commitment for and endorsement of physical healthcare, while also making it clear which physical health screenings and interventions staff are expected to carry out, within which timeframes.

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Case study
2gether NHS Foundation Trust
Developing a trust-wide physical health policy for service users with serious mental illness

Key learning
- Strong support from senior staff, along with national drives such as the CQUIN, made a joined up approach to physical health possible.
- The trust created a dedicated physical health facilitator role, with the time and knowledge to pull disparate policies together.
- Roles and responsibilities for physical health care were clearly assigned.

Introduction
2gether NHS Foundation Trust in Gloucestershire used funding from the pilot site project to appoint an Agenda for Change band 6 'physical health facilitator' to join up the trust's approach to physical health care for service users with serious mental illness (SMI). A key element of this work was to create a standardised, trust-wide physical health policy that pulled together all existing policies in a clear and comprehensive format and set out the roles and responsibilities of clinical staff when admitting and caring for a patient.

Background
Before the pilot project began, 2gether had a number of physical health policies. These included brief guidance on which medical checks should take place when a patient was admitted, guidance on completing National Early Warning Score (NEWS) charts and an Essence of Care (EoC) screening tool[6]. However, these policies were disjointed and in need of tying up into one easy to use document. The trust's infection control lead nurse had already produced a policy based on one used by the Royal Maudsley hospital, but this had received little support from the trust's Physical Health Group (later to become the Clinical Expert Reference Group, CERG) and at the time there were few local and national drivers in existence to support a joined-up approach to physical health care for SMI patients.

The solution
National initiatives such as the CQUIN (introduced in 2014/15) and the National Audit of Schizophrenia highlighted the importance of a joined-up approach to physical health care for SMI patients. This, along with strong support from the trust's director of nursing and CERG and the recruitment of a dedicated physical health facilitator, made it possible to begin pulling together the different physical health policies that the trust were using. The physical health facilitator worked with the lead nurse to scope out all the policies in existence across the trust and pull them into one clear and concise document that covered both inpatient and community services.

[6] https://www.gov.uk/government/publications/essence-of-care-2010

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It took around a year to finalise the policy. Throughout the drafting process, feedback was sought from the trust's matrons and medics to ensure the policy was clear and easy to use. The final document was approved by the CERG and then the deputy director of nursing.

The policy is available on the trust's intranet and was cascaded by the matrons to their teams. The team behind the policy are very conscious that it will not be a rigid resource and update it in response to changes in physical health guidance or the physical health needs of the trust's patients.

2Gether's physical health policy allows all members of staff to access a clear, concise, document that sets out their responsibilities and can be used to hold them to account if necessary.

Next steps
The physical health policy has been available to the trust's staff since November 2015 and is already recognised as a valuable document to assist staff in their everyday duties. An open access version of the RiO system which allows users to make changes to the system will soon be available to the trust and a link to the document will be included in every patient's physical health record.

What 2Gether's physical health policy included:
- A breakdown of responsibility for physical health by team, including timeframes for completing screening when patients are admitted and reviewed.
- Guidance for recording scores on the clinical IT system (RiO) and descriptions of the physical health screens to be completed, including:
  - physical examination
  - admission bloods
  - electrocardiogram
  - EoC screening tool
  - Lester tool care plan
  - NEWS
  - SBARD (communication tool for facilitating handover to the medical team in a medical emergency)
  - Malnutrition Universal Screening tool
  - venous thromboembolism assessment
  - falls assessment
  - substance and alcohol dependence
  - acute kidney injury
  - sepsis
- Links to supporting documentation.

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Supporting resources

- **Physical health policy, 2Gether NHS Foundation Trust**

Physical health policy appendices:

- Appendix 1 – **Essence of Care (Eoc) screening tool**
- Appendix 2 – **National Early Warning Scoring (NEWS) chart**
- Appendix 3 – **General practice sepsis screening and action tool**
- Appendix 4 – **Lester update June 2014**

Tees, Esk and Wear Valley NHS Foundation trust - Models of care

The TEWV experience is a good example of how different models of care were used depending on the characteristics of the unit and its patients. The TEWV pilot project was rolled out on two wards – Farnham ward acute inpatient unit and Primrose Lodge rehabilitation unit.

Farnham Ward

Farnham ward is a 20-bedded male acute inpatient unit and physical health care for inpatients is considered to be the responsibility of all members of clinical staff. Physical health observations for all inpatients are recorded on an electronic physical health monitoring tool (see chapter 5: Recording, monitoring and communicating information for more). Information from the tool is used to assign duties and tasks relating to physical health care of inpatients to ward staff during daily report out each morning. This ensures that staff know exactly what their responsibility is each day, and the process has made a huge impact on integrating physical and mental health care on the ward.

Primrose Lodge

Primrose Lodge is a 15-bedded rehabilitation unit providing rehabilitation and recovery services to men and women with mental health problems in a community setting. Responsibility for physical health care is assigned to the visiting GP who is contracted to work one day a week on the ward. Physical health care tasks are assigned to the GP during weekly report out, and these are picked up by the GP. The GP also reviews every person on the ward once a week and makes any necessary referrals for further physical health tests or interventions.

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3. SKILLS AND CONFIDENCE

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Overview

One problem consistently highlighted by the pilot sites was a lack of training in physical health skills among mental health nurses. The pilot sites all reported that mental health nurses received inconsistent training in physical health skills. Some mental health nurses had received a good grounding in physical health skills while others reported that their training had missed this out completely.

Giving mental health nurses training in physical health skills and, crucially, the confidence to use them appropriately, ensures that staff are better able to carry out the screenings and interventions prompted by the Lester tool.

The NTW and TEWV pilot sites carried out a learning needs and confidence assessment during the early stages of their pilots, which highlighted the key development and training needs of staff, in particular mental health nurses.

At TEWV, 64% of staff who completed the assessment were mental health nurses. The results showed that clinical staff felt least confident in phlebotomy, calculating BMI, and performing an ECG. Most people reported that they felt confident identifying a physical health problem related to a change in smoking status, alcohol intake and side effects of medication.

Case study
Northumberland, Tyne and Wear NHS Foundation Trust
Designing a trust-wide physical health training programme - Use of link nurses and a 'train the trainer' approach

Key learning
- A trust-wide physical health training programme increased staff confidence.
- Existing management support and a trust-wide focus on physical health helped to embed a culture of good physical healthcare.
- A Physical Health Passport ensured all staff had the same level of physical health skills.

Introduction
Northumberland Tyne and Wear (NTW) NHS Foundation Trust trained and supported 96 physical health link nurses across the trust to lead implementation of the Lester (2014) tool into clinical practice. The trust designed and implemented a new physical health training programme to improve existing physical health skills among mental health nurses and increase their confidence in using them.

Background
NTW is one of the largest mental health, learning disability and neuro-disability organisations in England, providing services through 60 sites. The trust has been actively working to improve the physical health of service users for many years and already had a dedicated physical health policy, stating that every patient should have a regular assessment of their physical health and be offered appropriate interventions. 'link workers' – staff with a specific interest and skills in physical health – had been nominated in most inpatient areas to support their team to improve service users' physical health and wellbeing. Physical health champions were performing the same role in the community.

It was apparent that staff members' physical health skills varied across the trust, with some nurses reporting that they had received little physical health training during their mental health nurse training or feeling their competence and confidence had waned if they had trained some years ago.

The solution
The trust used the pilot funding to employ a project manager (Agenda for Change band 7) to coordinate and support the development of the existing 96 physical health link nurses (band 6) using a 'train the trainer' cascade approach. By developing physical health care in a coherent manner, the aim was that every qualified member of staff had the same basic level of physical health skills.

Nurses working at Watergate Park neuro-sciences unit already had a very high level of physical health skills and were used to help shape a foundation skills training programme.
They checked the training was suitable for roll-out and their feedback was used to amend the training. The programme incorporated using the Lester tool and QRISK2 cardiovascular risk calculator and carrying out baseline physical health observations. Once agreed, the training programme was rolled out to link nurses across the trust who in turn transferred these skills to the nurses in their area.

The training was delivered in a classroom over one day. This proved to be a good way to refresh existing skills and upskill those who felt they had not received enough physical health training. The classroom environment encouraged people to share their knowledge and experience with one another and helped establish the context for putting the theory into practice.

The initial Foundation Skills training sessions were evaluated and the comments were used to amend the training further. For example, attendees felt that too much training time was being spent on head injuries and requested more 'hands-on' experience with the equipment, such as blood pressure monitors, thermometers and urine sticks. Regular evaluation ensures the training continues to evolve, with the project manager responding to feedback, and requests for further topics.

A Physical Health Passport was developed to ensure staff completed all necessary training and were fully competent in their physical health skills. The passport clearly set out the rationale behind the training programme and provided a checklist for line managers to assess the competence of their staff.

Impact
The role of link nurses has expanded across the trust. The original nurses are now aided by assistant practitioners (band 4) and support workers (band 3) to support their team members in identifying, monitoring and coordinating appropriate physical health interventions, and the foundation skills training is being prioritised for new link workers. 344 staff have now completed the foundation skills training.

The training has helped to raise the importance of physical health and wellbeing among all nursing staff and the project manager has noted an increase in calls from people asking for support and advice, where before staff may have simply made a note on the electronic patient record (RiO). The training has been rolled out to all areas of the trust, and areas that may have been initially hesitant about the programme are now running with excellent practice in physical health.

Next steps
The number of link workers has increased to 120 across all inpatient units, with numbers expected to continue to rise further as roll-out continues. As new community teams are also developed, the number of the community physical health champions is also increasing.

Advanced physical health skills training is also being rolled out to qualified link workers and health champions (in the first instance), using a 'SIM mannequin' in a dedicated skills lab, to simulate various physical health scenarios. Sample topics include QTc interval changes, sepsis, congestive heart failure, head injury and hypoglycaemia although the system can be programmed to accommodate any scenario a team may come across. The advanced skills course supports staff to identify and respond to a patient whose health is deteriorating.

Supporting resources
- Physical skills passport for nursing staff, Northumberland, Tyne and Wear NHS Foundation Trust
- User guide: Physical skills passport for nursing staff, Northumberland, Tyne and *Wear NHS F*oundation Trust

2gether NHS Foundation Trust

2gether used a 'train the trainer' approach. The project's health facilitator designed a training programme which both promoted and supported the Lester tool processes. The training was delivered in every inpatient unit by a health facilitator, with a link worker or 'champion' nominated to coordinate and promote screening and intervention.

Coaching was provided to individual staff members to build confidence and skills in screening and intervention, and training in blood tests was incorporated into the induction provided to junior doctors.

Tees, Esk and Wear Valleys NHS Foundation Trust

At TEWV, the team carried out a training needs assessment survey of all clinical staff. The training was designed to target the needs and responsibilities of different clinical staff groups and was focussed on the different domains highlighted by the Lester tool, such as smoking cessation. The team also used the training needs assessment to focus on areas of low confidence for clinical staff, such as phlebotomy and ECGs.

Mersey Care NHS Trust

Mersey Care carried out a basic survey of nursing staff knowledge, skills and confidence and used this to provide a 'back to basics' training in physical health screening for staff.

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National training programmes

Health Education Yorkshire and the Humber

Recognising and assessing medical problems in psychiatric settings: using clinical simulation to improve physical healthcare for mental health patients – the RAMPPS course.

Key learning

- A simulation-based training course helped mental health clinical staff feel more confident in dealing with their patients' physical health conditions.

> **"The training is a really advanced approach for mental health nurses across the trust. It helps us develop the skills to recognise when a patient under the care of mental health services is deteriorating due to physical health problems."**
>
> **Kate Dale**, Mental and Physical Health Lead, Bradford District Care Foundation Trust

Background

People with severe mental illnesses (SMIs) have more comorbid physical health conditions than the general population and this group die, on average, 20 years earlier than the general population. A proportion of these deaths are due to preventable physical conditions. There is strong evidence for a close association between SMIs and cardiovascular diseases, diabetes, chronic obstructive pulmonary disease (COPD) and musculoskeletal disorders.

Health Education Yorkshire and the Humber (HEYH) became aware that whilst training and interventions were being developed for community settings - recognising the importance of physical healthcare as part of an overall plan - there was a need to improve awareness and training in inpatient settings.

This was particularly true in relation to recognising when a patient on a psychiatric ward might be medically deteriorating. In medical and surgical inpatient settings a systematic approach to this is well embedded, but in psychiatric settings the approach has been much less well developed.

The team at HEYH recognised that mental health staff may lack confidence in managing physical health problems, as they may lack training or experience. A working group was set up

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to explore how mental health staff in these settings could be given training and education to provide better physical healthcare.

The solution

In relation to other clinical areas, training programmes which use simulation techniques have been underused in mental health contexts. Simulation techniques involve re-creating clinical situations using actors (simulated patients) and/or manikins in scenarios that allow staff to complete practical training in a risk-free environment.

The working group from HEYH decided that simulation would lend itself well to a mental health setting and developed a training course to promote inter-professional team-working focused around a medically deteriorating patient.
This team of consultant psychiatrists, higher trainees, nurses, simulation leads and trainers attended a development day where they wrote and refined a series of clinical simulation scenarios. An inter-professional faculty was trained to run these standardised scenarios and debrief delegates.

The Recognising and Assessing Medical Problems in Psychiatric Settings (RAMPPS) course was tested by junior doctors in psychiatry and mental health nurses on a pilot day. 30 delegates took turns to take part in 10-15 minute clinical scenarios and 30 minute debriefing session for reflection and learning.

Participants gave extremely positive feedback, reporting that they had enjoyed the pilot day despite initial nervousness about what to expect. Delegates were asked to complete a pre- and post-training questionnaire, mapped to the three different clinical staff groups and their specific training curriculum.

The analysis showed that all clinicians had increased their knowledge and felt significantly more confident following the RAMPPS course.

The result

Following the successful pilot course in 2012 a number of mental health organisations across the Yorkshire and the Humber region have have introduced the RAMPPS course, with over 200 doctors, nurses and healthcare assistants taking part.

Staff say that they have improved their knowledge, skills and confidence for dealing with deteriorating physical health in mental health patients, alongside better team working and improved communication.

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Mental health staff can now receive simulation training from ten scenarios which can be adapted to each individual organisation:

- brain tumour
- chest infection
- hypoglycaemia
- substance abuse
- respiratory depression
- complications of rapid tranquilisation
- neuroleptic malignant syndrome
- Wernicke's encephalopathy
- venous thrombosis
- ligature strangulation
- Clozapine-induced bowel obstruction

All the scenarios, debriefing tools and pre and post questionnaires have been published in the Health Education England RAMPPS handbook.

Next steps

The team currently have a full-time leadership fellow and a part time regional clinical skills advisor who continue to develop new scenarios, including children and young people and older adults, and evaluate the impact of the RAMPPS programme on patient safety.

The team have also developed a RAMPPS e-learning package to support the simulation training. The ten minute module provides pre-learning for all course attendees and includes a structured approach to the deteriorating patient using the ABCDE approach, the SBARD tool , the AVPU scale and National Early Warning Scores . This has now been integrated into the Electronic Staff Record systems of a number of trusts in the region and is now available on the national system too. The module is being added to the eLFH (e Learning For Health).

The HEYH team are now actively involved in spreading the course more widely across the region and to all local offices of Health Education England. Academic articles have been published in Mental Health Practice and Health Informatics.

- You can watch a film explaining the course at: https://youtu.be/OWQDyzep9RU

Supporting resources

- RAMPPS Handbook

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"Not only did I really enjoy the experience, I also took away several important learning points which I had to put into action surprisingly quickly. The final station of the day was a patient with neuroleptic malignant syndrome and I was the junior doctor in the team. Afterwards, we spoke as a group about the scenario, and I mentioned that I'd never had to treat it before so it was a good exercise to practice rare and unusual presentations. Later that evening, I was on call, covering the wards in Sheffield. I had a job handed over to chase the blood test results of a patient who hadn't been well that day. On seeing a creatinine kinase result of over 1000, I immediately thought NMS and transferred the patient to A&E. Had I not had the experience given to me by the RAMPPS course earlier that day, maybe I wouldn't have seen the significance of that result, or maybe the course gave me the confidence to say, 'this is NMS, he needs to go to hospital as soon as possible."

Dr Victoria Lattimer, Junior Psychiatrist, RAMPPS delegate

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4. EQUIPMENT

Overview

While the pilot site project evaluation does not specifically focus on what equipment is needed, each pilot site acknowledged that to carry out the physical health checks recommended by the Lester tool it was essential to have access to the correct equipment. It is also essential to have private space available for physical health checks to take place.

Equipment will vary depending on setting.

Supporting resources

- Recommended medical devices from South London and Maudsley NHS Foundation Trust

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5. RECORDING, MONITORING AND COMMUNICATING INFORMATION

Overview

Physical health monitoring and intervention is complex and may involve many different professional groups, including psychiatric nurses, psychiatrists, health instructors, physiotherapists, dieticians, GPs, practice nurses and specialists in secondary care, who are all likely to be collecting physical health data for the same service user.

Because of the complexity of this shared responsibility for service users' physical health, it is vital to have an effective method of recording and sharing information. This can ensure all aspects of physical health are covered, avoid duplication and enable safe and effective clinical decision making.

Most mental health trusts now use electronic patient record systems to record both mental and physical health information for their service users. The systems used vary widely by trust and include PARIS, RIO, EPEX, Mental Health CareNotes and Lorenzo/IPM. The ideal solution would be a shared record across all care sectors with access for all relevant professionals and service users themselves. But given this range of systems in use in mental health, coupled with the range of systems in primary care and acute care, it is unlikely that this will be achieved in the foreseeable future. Therefore, many trusts have begun to look at different ways of providing an effective system whilst working within the boundaries of the existing technology.

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Case study

Tees, Esk and Wear Valleys NHS Foundation Trust

Developing an electronic physical health monitoring tool (working with PARIS)

Key learning

- Developing an electronic physical health monitoring tool increased staff awareness of the importance of physical health monitoring for SMI patients.
- Existing culture and physical health processes on pilot wards changed as a result.
- Demonstrating the effectiveness of and need for the tool helped bring about changes to existing PARIS system.

Introduction

Tees, Esk and Wear Valley NHS Foundation Trust (TEWV) were awarded funding by NHS England to support implementation of an electronic physical health monitoring tool. Piloting the tool helped standardise physical health-related work processes on two wards, enabled timely and accurate recording of physical health information, and overcome limitations in the existing electronic patient record (PARIS).

Background

Following a quality improvement event using the Kaizen method[7], the Durham and Darlington Adult Mental Health locality (D&D AMH locality) agreed to implement an electronic physical health monitoring system and standardise related work processes.

[7] The 'Kaizen method', also known as continuous improvement, is a long-term approach to work that systematically seeks to achieve small, incremental changes in processes in order to improve efficiency and quality.

The PARIS system had been expanded to incorporate a 'physical heath' entry in the 'casenotes' section, but this was limited in function and meant that physical health data was still difficult to retrieve and review. The locality identified that PARIS lacked a specific location to record and review physical health parameters, especially trends.

Electronic access to blood test results from local pathology labs was limited to a specific number of login 'licences', meaning not all clinical staff could view the results quickly and easily. By developing and testing the tool in practice, the NHS England-funded pilot project helped demonstrate that physical health monitoring needed a specific area for all results to be collated for reviewing trends. Added to the CQUIN recommendations that all trusts develop an electronic monitoring tool for physical health, this has resulted in changes to the trust's PARIS system.

The solution

The new electronic monitoring tool was developed by the trust's pharmacy team to combat recording issues in medicines management for use in the Clozapine clinic. The tool never reached the piloting stage, so the D&D AMH directorate clinical pharmacist seized the opportunity to modify the tool for the physical health project. Although the existing tool already included some elements of physical health monitoring, more were added to provide a complete picture of a service users' physical health.

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Based in an excel spreadsheet, the physical health monitoring tool included fields for:

- Patient details
- Blood pressure
- Pulse
- Temperature
- Weight
- Waist measurement
- BMI
- Smoking status
- Alcohol consumption
- Side effects of medication
- Constipation
- Date of blood tests

The tool also included graphs to show trends in a patient's physical health perimeters, and a link to the Lester tool.

The tool was piloted on the Farnham acute inpatient ward (20 beds) and Primrose Lodge rehabilitation ward (15 beds). The clinical pharmacist and project manager visited the chosen wards to explain the purpose of the tool and proposed changes to existing work processes. Staff received training in how and why to use the tool and an online survey asked staff about their further training needs.

The tool was placed on the trust's shared drive, with full access limited to the ward clerks and other ward staff given read-only access so they could check a patient's measurements. A paper-based physical health recording sheet was developed for ward staff to use during physical health assessments of patients, with the ward clerks taking responsibility for transferring data to the electronic tool. While this process did mean additional work for the ward clerks, some of the funding from the project was used to remunerate them for their work.

Impact

Introducing the tool has had an enormous impact in several key areas and within a matter of months staff perceived that it had contributed to a change in culture and attitudes towards physical health on both pilot wards.

- **Report Out:** involving all key ward staff, Report Out takes place every weekday morning on Farnham ward and once a week at Primrose Lodge. The ward clerk uses data from the tool to inform discussion about each patient and assign tasks to the multi-disciplinary team for that day or week. This ensures that every patient's physical health needs are accurately recorded, and a focus on physical health is embedded continually into ward culture. The whole team is also clear which physical health tasks have been completed so that only necessary tasks are allocated.
- **Blood tests:** introduction of the tool means it should now be easier for clinical staff to check if and when a patient has had a certain blood test, and chase the results if necessary.
- **Changes to PARIS:** piloting and testing the tool in practice provided the trust with evidence that changes to the existing system were needed. Changes are being made to bring physical health data together and allow staff to record and access physical health data more quickly and easily

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Next steps

Changes and additions to the PARIS system are currently in the testing stage and will soon be available for trust-wide use.

These will include:

- a more comprehensive physical case notes section
- the ability to print graphs to show trends and improve monitoring of a patient's physical health. This will allow staff to see at a glance when something is unusual for a particular service user and pick up any problems immediately.
- links to the QRISK CVD risk assessment and Lester tools
- health and lifestyle information and interventions

The trust has a separate project to improve communication with GPs and physical health care in general (including on wards), which is hoped to improve physical health interventions within the trust rather than relying on action by patients' GPs.

Supporting resources

- Electronic physical health monitoring tool, Tees, Esk and Wear Valleys NHS Foundation Trust
- Standard process description 1: Registration onto T:drive, Tees, Esk and Wear Valleys NHS Foundation Trust
- Standard process description 2: Completion of physical health monitoring of patients electronic tool for patients included in NHSIQ pilot, Tees, Esk and Wear Valleys NHS Foundation Trust
- Physical health monitoring recording sheet, Tees, Esk and Wear Valleys NHS Foundation Trust

The Bradford template

The Bradford template is a specially designed screen developed for the SystmOne, EMIS Web and Rio IT systems which collects all the physical health data required for each service user in one place and links to relevant guidance on treatment and intervention. The template now includes all the data recommended by the Lester tool but has a few additional sections designed to meet the specific requirements of Bradford District Care Foundation Trust.

Supporting resources

- Bradford physical health template, screenshots SystmOne version

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2Gether NHS Foundation Trust – working with RiO
2Gether NHS Foundation Trust use the 'open RIO' system as their electronic patient record which means that they have the freedom to make changes to the system, but cannot pick up national changes such as the roll out of the Bradford Template. The trust decided to make it easier to record physical health data by pulling together all of the data recording fields for the Lester tool into one place. They did this by developing a care plan specifically aligned to the Lester tool. The way this care plan is used is set out in the trust's physical health policy.

The Lester care plan is linked to the trust's 'Essence of Care' (EOC) screening tool which is completed for every patient within 72 hours of admission. If the patient is 'high risk' in any cardiovascular risk factor area, the EoC will signpost the individual to then open the Lester tool care plan, which provides guidance for interventions available to the patient. This care plan travels with the patient through community services once they are discharged.

Supporting resources
- Screenshots of RiO template, 2Gether NHS Foundation Trust
- 2Gether Physical health policy
- Essence of Care (EOC) Screening Tool

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Mersey Care NHS Trust working with EPEX Mersey Care currently uses EPEX as their electronic patient record system. However, they discovered this was not compatible with the recently developed Bradford template and did not bring together physical health data in a way which would facilitate use of the Lester tool. Doctors and nurses had access to different screens, which did not encourage joined up working across multi-disciplinary teams. This led the trust to develop a dedicated physical health screen, which they incorporated into the existing IT system.

A working group made up of nurses, junior doctors, dieticians, senior clinicians and IT support made recommendations which resulted in a new IT screen that allows all clinical staff to record physical health data in one place. This has now been rolled out across the whole trust.

Initially, the new screen did not make a significant impact on recording of physical health data, despite inclusion in staff training and inductions, and use of the screen remained inconsistent. To combat this, each department, ward and community team introduced a weekly report on completion of the screen for each patient. This made a huge impact on reporting of physical health data as it highlighted the importance of physical health care to each team, enabled them to view their performance and facilitated discussions on physical health data.

Supporting resources
- Screenshots of physical health observations screen for EPEX, Mersey Care NHS Trust

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Using IT to join up physical healthcare across primary and secondary care

The Bradford Template (working across multiple systems)

- A physical health recording template was created for use on SystmOne and EMIS Web in primary care and RIO in secondary care.
- The template prompts clinicians to carry out all aspects of the physical health check, prevents duplication and makes recording physical health data easier by collecting it in one place.
- A mechanism has been put in place to allow data sharing between primary and secondary care providing continuity of care and reducing duplication.
- The Bradford physical healthcare template is aligned with the Lester 2014 tool.

This project to improve the physical healthcare of people in Bradford with serious mental illness was initiated as a partnership between Bradford District Care Foundation Trust (BDCFT), Leeds and York Partnership NHS Foundation Trust and the West and South Yorkshire and Bassetlaw Commissioning Support Unit. The work has been built upon with internal initiatives within BDCFT.

Bradford's story of improving physical healthcare for people with SMI began in primary care with a template incorporated into the SystmOne IT system which was used by 80 GP practices in the Bradford area (it was later translated into EMIS web). The new template was designed to prompt GPs to carry out comprehensive health checks for people with SMI which included cardiovascular risk calculations and had the added benefit of helping to generate QOF payments more easily. Training was provided for practices on the benefits and use of the template to help embed it in practice.

The initial evaluation results were positive, showing an increase in adherence to the NICE standards of calculating CVD risk through using the template and using the template more than doubled the detection rate for at risk patients (patients with a QRISK2 score of >20%) than health-checks without it (from 1.5% to 3.9%).

Following the success of the template in primary care the team set their sights on spreading the template, both geographically into other areas in England and also into secondary care. The template was translated for the RIO patient record system for use across BDCFT and implemented as part of a drive to improve physical healthcare which also included the introduction of health and wellbeing clinics across community mental health teams. As part of this project, the team worked in partnership with NHS England to ensure that the Bradford template was aligned to the Lester 2014 tool, therefore aligning work in Bradford with NHS England's work to implement the Lester 2014 tool and with the national CQUIN for physical health. Following a successful roll-out in BDCFT, the team have now rolled-out the Bradford template further by negotiating with RIO to allow access to the template to all trusts that use the standard RIO system across the country.

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The team felt that a vital step was to link up the primary and secondary care records to avoid duplication and provide continuity of physical healthcare between BDCFT and primary care. A number of mechanisms make this possible: E-Discharge has been implemented for patients moving back to the care of their GP from BDCFT, BDCFT has read-only access for SystmOne to avoid duplication of tests and the trust is currently posting paper copies of physical health check outcomes to patients' GPs whilst an electronic solution is being developed.

Physical healthcare for people in Bradford with serious mental illness is now much improved, with increased numbers of comprehensive physical health checks, more patients receiving cardiovascular risk assessments and improved communication between primary and secondary care. Next steps for the team include continued spread by incorporation into the PARIS patient record system to make the template available for even greater numbers of patients.

Supporting resources

- Screenshots of Bradford physical health template, SystmOne version

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6. COMMUNICATING WITH SERVICE USERS TO INSPIRE ACTION

Overview

There is often a perception that people with serious mental illness are not concerned about their physical health and therefore will not want to engage with physical healthcare, particularly when on an acute ward in a crisis situation. To enable them to design a service based around the needs of patients, Mersey Care NHS trust believed it was vital to challenge this assumption and ask service users for their views on physical healthcare in psychiatric settings.

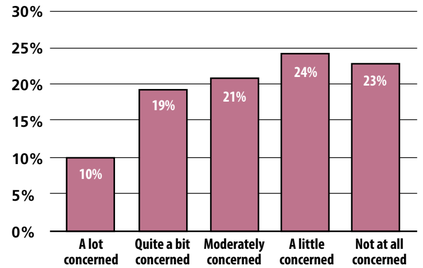
A questionnaire was designed and tested with service users before being sent out widely across the four pilot sites and was completed by 195 service users who were inpatients or recently discharged.

Royal College of Psychiatrists' evaluation findings

The graph (Figure 1) on the right shows the responses of service users when asked how concerned they were about their physical health.

Whilst almost a quarter of service users were not concerned about their physical health a large proportion were worried. Although the service user questionnaire did not address the issue directly, it is possible that those who are not concerned about their physical health may not be aware of their increased risk of cardiovascular conditions and premature death.

Figure 1: Service users' level of concern about their physical health[8]



> **"Not all of them but some of them are taking a little bit more interest, and they'll say: "My blood pressure all right? Is it all right today?" And they're asking about it and actually taking an interest in it."**
>
> **Staff member, mental health trust**

[8] An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings, RCPsych, p23, table 4.

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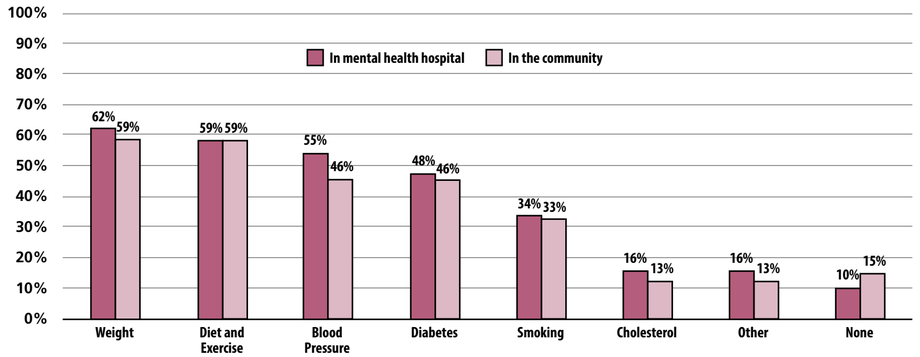
The graph below (Figure 2) shows the tests that service users reported that they would like to have when in hospital and in the community. This suggests that a large proportion of people are willing to engage with their physical health in both settings. The full results of the service user questionnaire can be found in the evaluation report.

Figure 2: Proportion of respondents wanting assessment of physical health problems in hospital and in the community*



*Caution should be exercised in relation to these figures, particularly in relation to support with smoking, exercise and diet because need was not assessed. The survey did not ask respondents if they were current smokers or were motivated to improve diet and exercise.

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There are many factors which might play a role in a service user's reported health status and level of concern, for example, a lack of knowledge about the risks of taking antipsychotic medication or their lifestyle choices, and of the consequences of the resulting poor physical health, diagnostic overshadowing when attending non-mental healthcare settings or the failure of clinicians to screen for cardiovascular conditions and explain the implications of the results. This makes it very important to communicate with service users about their physical health, but this communication can often be challenging. Some staff interviewed as part of the evaluation thought that the Lester tool helped them to communicate with patients.

"We could see if there's something wrong, we could ask them if there's something wrong. And they would turn round and say, I'm fine, I'm fine, I'm fine, when we know there's something wrong. But actually using this tool, for all they say, I'm fine, I'm fine, I'm fine, this is a way of saying, it shows that you're not fine, something's wrong."

Staff member, mental health trust

[9] An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings, RCPsych, p27, figure 1.

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The Lester Postcard Prompt

There is also a Lester Postcard Prompt which can be used in one-to-one communication with patients. Using the postcard, the Lester tool can be presented as an authoritative tool and be used to encourage discussion about a range of health issues. The postcard was developed by the National Audit of Schizophrenia service user reference group to empower service users to approach their GP or mental health team to ask how the Lester tool could help improve their physical health.

Supporting resources

- Service user questionnaire, Royal College of Psychiatrists
- Results of service user survey, Tees, Esk and Wear Valleys NHS Foundation Trust
- The Lester postcard prompt

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7. INTERFACES WITH OTHER SERVICES

Overview

Once a service user has been identified as at risk of developing CVD, it is important to make sure they actually receive the interventions that they need. Yet, this may not always happen if clear mechanisms for cardiovascular interventions have not been put in place across the whole of a trust's patch.

Lack of skills and confidence amongst mental health staff can make in-house intervention for inpatients difficult, whilst ineffective links with primary care may mean that opportunities for intervention are missed once the service user is back under the care of their GP. Where service users are found to have a pre-existing cardiovascular condition which needs specialist intervention, access to services can be patchy and may rely on the connections of individual psychiatrists or on 'gentleman's agreements' between physicians.

For Lester 2014 to be successful in reducing CVD associated morbidity and mortality in patients with SMI, it must be part of a joined-up system of interventions that prevent and treat CVD conditions. Where it is not possible to provide risk assessment or intervention in-house (see chapter 3 on training), mechanisms should be put in place to ensure efficient communication and delivery of services across organisational boundaries.

Case studies

2Gether NHS Foundation Trust

Improved letters for communication with primary care

2Gether recognised that better communication with primary care was vital to make sure that physical health monitoring and interventions for people with SMI takes place. This also avoids duplication and provides continuity of care as service users move between primary and secondary care. In the absence of a shared IT system, the trust decided to adapt the letters which were already sent between the trust and primary care to make sure they contained relevant information such as date of last annual health check and current physical health diagnosis. The trust also standardised the clinical letters used by consultant psychiatrists. Initially the trust used the new clinical letter template to write to GP practices about SMI patients who had been on Care Programme Approach (CPA) for more than 100 days as they may not have received the necessary physical health screening. This allowed the trust to focus on the most vulnerable patients before rolling it out to all service users.

Supporting resources

- Consultant psychiatrist clinical letter template, 2Gether NHS Foundation Trust

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Northumberland, Tyne & Wear NHS Foundation Trust

Procurement of specialist services

NTW have begun to map pathways for a range of specialist services to ensure that all of their service users have the same access to high quality services. The first of the pathways they looked at was the one with the greatest number of referrals – cardiology – and more specifically, the pathway for specialist interpretation of ECGs. Because ECG interpretation is a fairly simple service in terms of referral and delivery, the trust decided to carry out a procurement exercise.

NTW used a trust-wide questionnaire to ask clinical staff about existing cardiology services, which confirmed that current arrangements were not generally sustainable. Whilst most areas were satisfied with their access to ECG facilities clinicians were almost unanimous in their lack of confidence when it came to interpreting ECG results. 70% of the 125 responses claimed to have an access route to a specialist cardiology opinion, of which only 9% were 'formal agreements'.

One consultant psychiatrist explained: "I am very strongly in favour of having formal arrangements for cardiology review of ECGs. We are now carrying out regular ECGs on our patients. If an ECG looks abnormal, I currently contact the on-call cardiology registrar, faxing through the ECG and asking for an opinion. This is very unsatisfactory as I am relying on the goodwill of the person at the end of the phone to interpret the ECG for me…If there is truly to be parity for patients with mental health, we need reliable access to experts to read ECGs."

A scoping exercise predicted demand for up to 2000 ECGs each year, of which the trust estimated that between 52% and 100% of ECGs would be reported as abnormal. An options appraisal concluded that it would not be cost effective to train NTW staff to provide the service internally, and the trust's procurement team are currently exploring options to outsource ECG interpretation.

A business case was developed to procure ECGs through a national telemedicine service which will be able to give equal coverage to the whole of NTW's large geographical area. The trust has considered the business case and given approval for the service to be introduced across the trust on a trial basis.

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MOTIVATING AND ENGAGING STAFF
CLARITY OF ROLES AND RESPONSIBILITIES
SKILLS AND CONFIDENCE
EQUIPMENT
RECORDING, MONITORING AND COMMUNICATING INFORMATION
COMMUNICATING WITH SERVICE USERS TO INSPIRE ACTION
INTERFACES WITH OTHER SERVICES
EQUALITY AND HEALTH INEQUALITIES
SUPPORTING DOCUMENTS
USEFUL LINKS AND RESOURCES

Service improvement techniques – process mapping

To make sure patients have equal access to all physical health interventions, Northumberland, Tyne & Wear NHS Foundation Trust are starting to address the provision of some much more complex, patient facing, services such as diabetic care and COPD. Many trusts use a mix of internal and external provision for this kind of service and they may find process mapping useful to understand the current and future provision of these services.

The NHS Institute's Introduction to Process Mapping

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EQUALITY AND HEALTH INEQUALITIES

Equality and Health Inequalities

The Lester tool was designed for use in all patients with psychosis on antipsychotic medication and this project has focussed on a smaller group again by working with service users in inpatient care. Although the toolkit shares resources which are relevant for use for everyone, there are some specific issues related to equality and health inequalities which staff should bear in mind when conducting physical health checks using the Lester tool.

Age

The evaluation highlighted two issues related to age. Firstly, some staff expressed concern that using QRISK2 for service users under the age of 40 can sometimes result in lower levels of intervention for elevated blood lipids than for their older counterparts due to the way in which the QRISK2 algorithm considers age as a risk. Secondly, other staff suggested that some of the interventions recommended by the Lester tool might be less appropriate for older adults who are coming to the end of their lives or affected by other conditions such as dementia. Staff should use their clinical judgement to ensure that patients receive equitable treatment regardless of age as directed by the Equality Act 2010.

Ethnicity and disability

Although the evaluation conducted for this project did not collect data on ethnicity or disability, it is important to remember that the NHS has a duty to collate and monitor this data and make services accessible for all 'protected characteristics' as defined in the Equality Act 2010.
The resources highlighted in this toolkit are generic versions created by our pilot trusts for use with their own staff and local populations but other trusts are reminded that local adaptations may be needed to ensure that physical health checks using the Lester tool are accessible to diverse service users[10].

[10]For more information: Guidance for NHS Commissioners on Equality and Health Inequalities Duties https://www.england.nhs.uk/about/gov/equality-hub/legal-duties/

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SUPPORTING DOCUMENTS

1. Job description: Band 6 health facilitator, 2Gether NHS Foundation Trust
2. Job description: Band 7 health facilitator, Northumberland, Tyne and Wear NHS Foundation Trust
3. Job description: Band 5 project support manager, Tees, Esk and Wear Valleys NHS Foundation Trust
4. Physical Health Policy, 2Gether NHS Foundation Trust
5. Appendix one: Essence of Care (EoC) screening tool
6. Appendix two: National Early Warning Scoring (NEWS) chart
7. Appendix three: General practice sepsis screening and action tool
8. Appendix four: Lester update June 2014
9. Physical skills passport for nursing staff, Northumberland,Tyne and Wear NHS Foundation Trust
10. User guide: Physical skills passport for nursing staff, Northumberland, Tyne and Wear NHS Foundation Trust
11. RAMPPS handbook, Health Education, Yorkshire and the Humber
12. Recommended medical devices, South London and Maudsley NHS Foundation Trust
13. Electronic physical health monitoring tool, Tees, Esk and Wear Valleys NHS Foundation Trust
14. Standard process description 1: Registration onto T:drive, Tees, Esk and Wear Valleys NHS Foundation Trust
15. Standard process description 2: Completion of physical health monitoring of patients electronic tool for patients included in NHSIQ pilot, Tees, Esk and Wear Valleys NHS Foundation Trust
16. Physical health monitoring recording sheet, Tees, Esk and Wear Valleys NHS Foundation Trust
17. Screenshots of RiO template, 2Gether NHS Foundation Trust
18. Screenshots of physical health observations screen for EPEX, Mersey Care NHS Trust
19. Screenshots of Bradford physical health template, SystmOne version
20. Service user questionnaire, Royal College of Psychiatrists
21. Results of service user survey, Tees, Esk and Wear Valleys NHS Foundation Trust
22. Consultant psychiatrist clinical letter template, 2Gether NHS Foundation Trust

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USEFUL LINKS AND RESOURCES

An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings – The Evaluation Team at the Royal College of Psychiatrists' Centre for Quality Improvement.

Bringing together mental and physical health – a new frontier for integrated care – The King's Fund

The Code – Professional standards of practice and behaviour for nurses and midwives, Nursing and Midwifery Council

The Five Year Forward View for Mental Health - A report from the independent Mental Health Taskforce to the NHS in England

Health Education England

Lester tool 2014 – NHS IQ's screening tool to improve CVD outcomes for people with SMI 2gether NHS Foundation Trust film

NHS Improving Quality case studies on improving the physical health of people with serious mental illness

Right from the Start: Keeping Your Body in Mind, A guide for people experiencing psychosis for the first time and those who care for them, Greater Manchester West Mental Health NHS Foundation Trust.

Skills for health

Equalities Act 2010

Equal Treatment: Closing the GAP (A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems)

No health without mental health: A cross government mental health outcomes strategy for people of all ages

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NHS England

www.england.nhs.uk/mentalhealth

www.england.nhs.uk/futurenhs

Twitter: @NHSEngland