

# Choosing Health: Supporting the physical health needs of people with severe mental illness

*Commissioning framework*

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**DH INFORMATION READER BOX**

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# Executive summary

People with diagnoses of severe and enduring mental illnesses (SMI) such as schizophrenia and bipolar disorder are at increased risk for a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity. They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease.

The White Paper, *Choosing Health: Making healthy choices easier*,<sup>1</sup> identified mental health as a priority area for health improvement in England. The Department of Health has stated that, 'We will use the lessons from a new approach being piloted in eight centres in England to extend the new models of physical healthcare for people with mental health problems across all PCTs. Further development of this model will be linked into plans for providing NHS health trainers.'

Additional revenue to assist delivery of physical health and well-being support programmes has been allocated to the 88 spearhead primary care trusts (PCTs) in the financial years 2006/07 and 2007/08. The value of the investment equates to approximately two nurses per spearhead PCT.

For non-spearhead PCTs, there are potential savings to be made on prescribing and acute care budgets through prevention or early detection of serious illness in these groups of service users.

This best practice document aims to help PCTs plan for, design and commission and monitor services that will deliver improved physical health and well-being for people living with SMI.

It describes the necessary leadership for a successful physical healthcare programme, suggests who might be best placed to deliver the programme, outlines the roles and responsibilities of those involved with the programme, provides case studies along with outcomes achieved and gives details of a range of promising practice that promotes physical healthcare and treatment and health promotion for people with SMI.

# 1. Introduction

- 1.1 One of the founding principles for the NHS in 1948 was that it should improve individual and population health and prevent disease. The needs of service users and carers lie at the heart of this fundamental mission and have served as drivers for the development of the *National Service Framework for Mental Health*<sup>2</sup> and also *Choosing Health: Making healthy choices easier*.<sup>1</sup>
- 1.2 Issues about waiting for treatment are being tackled and developments are in process to transform the NHS into a health, rather than a sickness, service. There is now a focus on bringing mental health and physical health together to provide holistic care and reduce inequality both in access to and provision of mental and physical healthcare for people with severe and enduring mental illnesses. There is also focus on supporting partnership working to help staff and organisations work together by ensuring patients and service users have greater choice and greater access to information and care.
- 1.3 The driver for this focus comes from the well-documented links between inequalities and poor health outcomes and the strong associations between higher incidence of mental health problems and social inequalities.
- 1.4 *Choosing Health*, the White Paper on improving the public's health, is the key policy driver underpinning programmes of work to improve the physical health of people with SMI. The White Paper identified people with mental health problems as a priority group and acknowledged that their physical health was worse than the rest of the population. There was also recognition that supporting these groups to lead healthier lifestyles would enhance their mental and psychological well-being as well as their physical health.
- 1.5 The ideas in *Choosing Health* on promoting and delivering physical health checks and interventions to people with SMI are not radical or complex. They are consistent with the modernisation of services currently under way in the NHS to improve access to treatment and care through the provision of early intervention, assertive outreach and crisis resolution teams. Improving the provision of physical health checks for people with SMI, and supporting them in lifestyle changes, provides an opportunity to make a major difference to the health and well-being of this vulnerable group.
- 1.6 *Choosing Health* also sets out a proposal that, from 2006, NHS health trainers will be giving support to people who want it in the areas with highest need, and from 2007 progressively across the country. Information on health trainer competencies is available on the Department of Health website.<sup>3</sup> These roles will also inform the successful delivery of physical health support for people with SMI.

- 1.7 This approach is supported in the White Paper on healthcare outside hospitals. *Our health, our care, our say*,<sup>4</sup> which places an emphasis on prevention and the provision of appropriate information to enable individuals to make healthy choices and lead healthy lives. There is also recognition of the need to support commissioners and strengthen commissioning to enhance health and well-being.
- 1.8 The mental health policy agenda focuses on the core themes of integration, recovery and social inclusion. The key policy documents are the *National Service Framework for Mental Health* (NSFMH)<sup>2</sup> and the *National Service Framework for Mental Health: Five Years On*.<sup>5</sup>
- Standard One of the NSFMH positions the promotion of mental health squarely within social inclusion activity and discusses the role for health and social services ‘to promote mental health and reduce the discrimination and social exclusion associated with mental health problems’.
  - Standards Two and Three of the NSFMH focus on primary care and access to services. People with SMI should be able to expect consistent advice and help, not only for mental health issues but also for all health concerns, including assessments and referrals on for specialist treatment if necessary. The five-year review of the NSFMH has described a vision of mental healthcare in primary care that reflects the concern of the NHS with chronic disease management (or long-term conditions) and health inequalities.
- 1.9 The Chief Nursing Officer’s review of mental health nursing, *From values to action*,<sup>6</sup> has recommended that mental health nurses (MHNs) attain the skills required to improve the physical well-being of people with mental health problems. Many MHNs, working with people of all ages, act as care co-ordinators and, as such, are in a particularly strong position to work between primary and secondary care to ensure that the whole range of health needs are assessed and responded to.
- 1.10 The desired physical health outcomes for these vulnerable groups of service users have been clearly articulated but the methods for delivering these outcomes have been left open to local discretion. This stance acknowledges the differences in configuration of local services as well as differing population needs and variations in service gaps.
- 1.11 In essence, the overarching priorities remain the same; all providers will need to take steps to ensure that the physical health of people with SMI is not overlooked and that provision is implemented and managed effectively. However, the roles and responsibilities for those delivering this care and treatment are best decided locally.
- 1.12 Some examples of the ways in which physical health checks and promotion for people with SMI have been delivered are included in Appendices A and B. For instance, lessons from a new approach being piloted in eight localities in England offer an insight into a structured model of physical health assessment and support which provides a systematic appraisal of lifestyle, health and medication side effects to support healthier choices and provide opportunities for exercise, weight loss and medication reviews.

- 1.13** These accounts of current practice should enable employers and service managers to think about how best to plan local services to meet the challenges of improving healthcare and health promotion effectively for these vulnerable groups. They demonstrate that much can be done simply and effectively to improve equality of access to services and treatments and to improve health.

## 2. Background

- 2.1 People who use mental health services, in particular those with a diagnosis of schizophrenia or bipolar disorder, are at increased risk for a range of physical illnesses and conditions, including coronary heart disease, diabetes, infections, respiratory disease and greater levels of obesity. In many cases, weight gain is a clear side effect of medication.<sup>7</sup> They are almost twice as likely to die from coronary heart disease as the general population and four times more likely to die from respiratory disease.<sup>8,9,10</sup>
- 2.2 New analysis of records of 1.7 million primary care patients found that people with a diagnosis of schizophrenia or bipolar disorder are more than twice as likely to have diabetes than other patients and also more likely to experience ischaemic heart disease, stroke, hypertension and epilepsy.<sup>11</sup>
- 2.3 The *National Service Framework for Coronary Heart Disease*<sup>12</sup> acknowledges the associations between inequalities across social class, ethnic groups and regions and prevalence of heart disease. There is a stated recognition that general health promotion programmes can sometimes act to widen inequalities because the better off make more effective use of prevention advice and services.
- 2.4 The NSFCHD singles out mentally ill people as part of a vulnerable group that requires special attention. Everyone deserves equal access to high-quality services and an equal opportunity to live their lives to the maximum of their potential. But not everyone has an equal opportunity to put forward their case or to make use of the services to which they should be entitled. Those who provide public services have a duty to make sure the needs of vulnerable groups are not forgotten.
- 2.5 The *National Service Framework for Diabetes*<sup>13</sup> has 12 standards designed to improve care and treatment of those with the condition. Neither people with a diagnosis of schizophrenia nor bipolar disorder are singled out as high-risk groups in need of particular care.
- 2.6 The interaction between diabetes and schizophrenia is complex. Many people with schizophrenia have multiple risk factors for type 2 diabetes such as a family history of diabetes, higher risk ethnic origin, obesity, sedentary lifestyle and smoking. It has also been suggested that the condition itself might be an additional risk factor for diabetes, as may anti-psychotic treatment. Consequently, people with schizophrenia may represent a high-risk group for diabetes.<sup>14</sup>
- 2.7 Previous research suggests the reasons for health inequalities among people with SMI are complex and likely to include poverty, lifestyle, access to health assessments and treatments and side effects of anti-psychotic and mood stabiliser medication.<sup>15</sup> The inequalities cannot be explained by the mental health problem alone.<sup>16,17</sup>

- 2.8** There is sufficient evidence to show that those with mental health problems are likely to have their physical health needs unrecognised, unnoticed or poorly managed. A number of studies suggest that people who use mental health services are much less likely than the general population to be offered blood pressure, cholesterol, urine or weight checks, or to receive opportunistic advice on smoking cessation, alcohol, exercise or diet.<sup>15</sup>
- 2.9** Reasons include being unaware of and/or late recognition of symptoms, low expectations of healthcare services, difficulties in attending a GP surgery and potentially long waiting times, communication problems with healthcare professionals, and stigma and discrimination on the part of healthcare professionals, as well as problems with GP registration.
- 2.10** Health promotion information rarely makes clear its importance and relevance to people with severe mental illness. There are very few resources that specifically address the physical health needs and concerns of service users.<sup>10,17</sup>
- 2.11** There is a perception gap between mental health service users and their professional and lay carers about physical health needs. Research has demonstrated that staff and carers think service users are uninterested in their physical health, but service users do not share this view.<sup>18,19</sup> Motivation to do something about physical health is further impaired by mental health problems and so service users need encouragement and support.
- 2.12** There is also a substantial body of evidence that demonstrates service users' experience of diagnostic overshadowing, ie practitioners interpret their physical health symptoms and concerns as a mental health issue.<sup>18</sup> However, attending to the physical health needs of people with SMI has been associated with improvements in both mental and physical health, particularly in terms of service users' improved self-esteem.<sup>10</sup> Such multiple outcomes provide strong reasons for targeting support to the care and treatment of these groups' overall health.
- 2.13** There is a general assumption that people with mental health problems do not attend appointments; however, this is not the case in practice. People do attend appointments, accept appropriate health promotion advice and act on it, leading to general and specific health improvement.<sup>20</sup>
- 2.14** The Healthcare Commission identified outcomes that mental health service users prioritised and were also affordable by local services. Physical health was in their top five along with social inclusion and quality of life, safety, satisfaction with services, and psychological health.
- 2.15** More than 500 people with mental health problems responded to the Disability Rights Commission's consultation questionnaire in 2005 as part of its formal investigation into health inequalities. A significant proportion of respondents said that they faced difficulties when trying to use the services provided by their health centre or doctor's surgery. These difficulties included attitudes of reception staff, a tendency of some clinical staff to neglect physical health problems focusing only on the person's psychiatric condition, problems with inflexible appointment systems and inaccessible information and communications.<sup>11</sup>

- 2.16** Health and social care services are the key to identifying and responding to the unmet physical health needs of people who use mental health services. Primary care occupies a central place both as provider and commissioner of services. For example, the GP consultation rate for people who use mental health services is much higher than average, 13–14 times per year compared with 3–4 times for the general population. Over 90% of patients with mental health problems are treated within primary care.<sup>10,15,21</sup>
- 2.17** Most mental health service users view primary care as the cornerstone of their healthcare but experience their illness and noisy or crowded waiting areas as barriers to accessing the services they require.<sup>22</sup>
- 2.18** There has been an array of efforts to remedy health inequalities by improving access to healthcare for those with severe mental health problems. A series of projects and recommendations has been introduced to identify and tackle the physical health needs of these groups with appropriate annual health checks and specialist health screening services.
- 2.19** Government policy has endorsed many of these initiatives, for example, in the NSFMH,<sup>2</sup> in the General Medical Services (GMS) contract for general practitioners (GPs) and with the introduction of the Quality and Outcomes Framework (QOF).<sup>23,24</sup>
- 2.20** The responsibilities of primary and also secondary care with regard to the mental and physical healthcare and treatment of people with mental health problems are outlined in the National Institute for Health and Clinical Excellence (NICE) guidelines on schizophrenia,<sup>25</sup> depression,<sup>26</sup> bipolar disorder<sup>27</sup> and depression in children and young people.<sup>28</sup>
- 2.21** More broadly, the national Public Service Agreement (PSA) sets targets for improving outcomes for people with long-term conditions by providing personalised care for those most at risk and focusing on health and well-being. This includes people with SMI.
- 2.22** Despite these efforts, there remains a pressing need to implement many of the current policy recommendations, and find practical solutions to improve access to healthcare, and thereby reduce existing health inequalities for people with mental health problems.
- 2.23** The Disability Rights Commission has recently completed a formal investigation into physical health inequalities experienced by people with mental health problems (and learning disabilities). Their investigation report<sup>29</sup> will be published mid-September and will be available on [www.drc-gb.org/healthinvestigation](http://www.drc-gb.org/healthinvestigation).
- 2.24** Under the Disability Discrimination Act 1995,<sup>30</sup> and the forthcoming Disability Equality Duty, people with mental health problems (and other disabled people) need to be able to access health services and treatments on equal terms with other citizens, and services need to work towards closing gaps of inequality in physical health.
- 2.25** Compliance with Part 3 of the Disability Discrimination Act is a driver for effective change in achieving health targets and in attempts to overcome discriminatory policies, procedures and practices.

# 3. Establishing physical health programmes

## Programme support

- 3.1 There is research to show that a more integrated approach to the provision of primary care services for people with SMI yields health benefits through more appropriate use of health services, improved access to services and increased take-up of preventative measures. There is also evidence that the relationship between professionals and service users has the greatest influence in making life changes.
- 3.2 There are examples across England of programmes established to support people with mental health problems to attain and maintain positive physical health.
- 3.3 These include improving primary care services for psychiatric inpatients through employing physical health leads on inpatient wards and through the development of in-reach services.
- 3.4 Investments have been made to increase physical health screening through enhancing links between primary and secondary care, through community mental health teams (CMHTs), assertive outreach teams and therapeutic intervention services. In some areas, the development of physical health link workers among care co-ordinators in appropriate teams has provided the appropriate route to care and treatment.
- 3.5 In other areas, there have been improvements in referral through secondary care to a wide range of health enhancement and health improvement programmes. For example, there have been initiatives in certain localities ensuring that each CMHT has a team member who can refer patients directly on to exercise programmes without GP referral.
- 3.6 There are also programmes that deliver individual or group interventions such as smoking cessation for people with specific diagnoses, schizophrenia being the most common; exercise referral programmes; walking groups; activity groups such as football, tennis or badminton; yoga and Pilates sessions; increased access to alternative therapies and treatments such as participation in arts, movement and dance; community and specific well-being/advice days; and signposting resources and publications. Some of these programmes are run specifically within secondary care, some specifically within primary care or others generically within primary care, such as programmes being delivered by health trainers.
- 3.7 However, in the past, programmes have tended to be limited either by resource or time constraints. Few programmes are sustainable and fewer still have been evaluated.

## Programme aims

- 3.8** It has been demonstrated that having a mental health problem is associated with both deterioration in physical health and poorer access to appropriate physical healthcare services. As a consequence, people with SMI require a holistic lifestyle management approach in order to combat the clear physical health inequalities that currently exist for them.
- 3.9** Dedicated services should aim to offer continuity of care for people with SMI, involving and motivating individuals to improve their health by:
- ensuring an accurate register of all people with SMI exists and systems are in place to record current practice, access and follow up, enabling professionals to review progress;
  - completing physical health checks for people with SMI;
  - providing consultations about healthcare and health improvement including:
    - reviewing current services and treatments being received;
    - providing information and access to appropriate health promotion information and services;
    - signposting people with SMI to other appropriate services;
  - supporting people to access appropriate healthcare and health promotion services through:
    - referral to appropriate health provision for issues identified through screening or for ongoing health concerns;
    - referral to appropriate health promotion services within the locality;
    - delivery of individual and group health improvement services such as one-to-one support on diet and food diary reviews and healthy activity and exercise groups.

## Programme establishment

- 3.10** Programmes benefit from local leadership. The Well-Being Support Programme pilots<sup>31</sup> identified some themes common to successful programme establishment, including:
- identification of a senior local person to act as a programme champion;
  - circulation of the programme aims and aspirations to ensure sign-up;
  - establishment of partnerships and joint working agreements;
  - full and effective implementation of the programme in community facilities;
  - robust documentation and procedures relating to information sharing and issues of confidentiality.
- 3.11** New approaches to the management of physical ill-health among people with mental illness are being piloted by Lilly. Specialist teams, working in partnership with primary and social care providers, help support people with severe mental illness who are vulnerable to physical ill-health. The teams offer health checks and blood tests; guidance on diet, smoking and exercise;

information for the patient, their GP and the care worker; as well as ongoing support and follow up. This approach has identified the early signs of disease, such as diabetes or coronary heart disease.

- 3.12** The pilot programmes employed a lead mental health nurse practitioner to deliver the health improvement programme for people with SMI (see Appendices C and D for example job description and specification). All nurses were RMNs and this was seen as preferable because they had already been trained in building relationships with mental health service users, they had the skills to recognise medication side effects more easily and to offer specific advice on medication, and they could more easily recognise signs of relapse and liaise with and refer to mental health services appropriately. One nurse was allocated per PCT and the number of patients for these pilot programmes was limited to between 125 and 150 people. The service was attached to an existing team, eg a primary care team or a CMHT, ensuring a smooth referral process and good communication. Joint working arrangements were created from the outset, which was vital to effectiveness and sustainability.

## Consultation with stakeholders

- 3.13** Local stakeholders need to be involved on a meaningful and long-term basis in the development, delivery and evaluation of health improvement programmes. This approach is coherent with the Department of Health's priority on increasing the influence of patient involvement. Key groups of local stakeholders should include people with mental health problems and the advocacy and voluntary sector groups that support them and their carers. Engaging carers in the programme in relation to implementation and monitoring outcomes has proven to be highly effective to date, particularly in relation to diet and physical activity.
- 3.14** Important stakeholders from among practitioners include a range of health professionals, such as directors of public health, health improvement teams and directors of mental health services. Managers, practitioners and colleagues working in primary care or generic health and social care roles are also crucial to the effective development and implementation of these programmes of work. It is beneficial for individual nurse leads to build on any relevant existing clinical networks, or to develop new ones, which will support them in delivering a successful and sustainable programme for their client group. In some areas, multidisciplinary forums have been established to support and encourage co-ordinated local practice, for example the Physical Health Forum in Cambridge.
- 3.15** A recent development which appears promising is funding for a voluntary sector provider to develop and deliver an advocacy service to improve access to healthcare and health promotion services. In some areas, advocacy services are already funded and support around physical healthcare could be an addition to a current contract. In other areas, services may need to be developed, such as the programme developed by Hammersmith and Fulham Mind. The service aims to build bridges and improve relationships between individuals and a range of primary care professionals such as GPs, podiatrists, dentists etc. The service will provide information and support, through attendance at appointments or follow up if required, as well as signposting to other services available. A service such as this could enhance the effectiveness and reach of a health improvement programme within a locality.

## Communication and structures

- 3.16** An open referral policy to programmes on health improvement has been shown to be most effective. However, time should ideally be spent increasing awareness about the programme's availability and offering access to a range of health and social care professionals within the locality, as well as local service user groups.
- 3.17** Appropriate consultation throughout the programme can ensure suitable referral to activities and services. Generally, individuals will require availability of a range of programmes – some instructed, some facilitated and some individual activities. In some areas, buddying programmes have been developed as part of the structure to increase attendance, particularly among hard-to-reach groups.
- 3.18** Frequent communication and review are important within a health improvement programme and modern technology has been used to deliver health messages. For example, the use of SMS text messaging, email or website alerts can increase client attendance. This approach serves the dual purpose of keeping in good contact with people with SMI and reducing costly non-attendances.

## Inter-agency and partnership working

- 3.19** The lead nurse practitioner should ideally work in partnership with a range of other individuals and agencies. Practitioners such as dieticians, pharmacists, dentists, podiatrists, occupational therapists, physiotherapists and substance misuse specialists can provide advice and expertise. Health promotion experts, for example those working in smoking cessation, will be particularly important given the high rates of smoking prevalence among people with SMI.

## Programme delivery

- 3.20** There are many ways that programmes improving the physical healthcare of people with mental health problems can be delivered. The deliverables outlined below are fundamental elements of the health improvement programme. It is imperative that all areas of these programmes are delivered sensitively in relation to the gender or ethnicity of individuals. There should be equal access also to those with additional needs or disabilities, such as learning difficulties or sensory impairments.
- 3.21** The central principle of the programme, however, is the provision of continuous support, rather than assessment or screening alone. Appropriate interventions and treatments as well as a process of follow up and review are key to efficacy. Recording and sharing information is a critical element to the success of these programmes. The collation of data will lead to an increased evidence base supporting proactive programmes for those with the greatest health needs, in terms both of improving the quality of individuals' lives and cost savings.

## Establishing a register

- 3.22** An accurate register of people with SMI is essential in terms of contacting and monitoring patients and is one of the quality indicators in the GMS contract. The leads can support

individual practices to develop their registers. This should be done in consultation with secondary services to ensure that all appropriate individuals access the programme.

**3.23** The physical health leads can also advise those working with individuals, from both the statutory and voluntary sector of the programme. In some areas, this has led to three out of four patients attending their physical health assessments.

## Completing physical health checks

**3.24** Once identified through the register, patients ought to be offered annual reviews that include:

- demographic details, patient history and family history information;
- current medication and medication history for all health problems, plus any side effects or contraindications;
- basic health checks including blood pressure, pulse, body mass index (weight and height);
- blood tests and urinalysis;
- lifestyle assessments should be completed to include a review of diet, physical activity, smoking, alcohol and intake of illicit substances.

## Physical health consultations

**3.25** Following the health checks and assessments, a more in-depth consultation should be carried out, led by the programme lead. This consultation provides an opportunity to review current services and treatments being received from both primary and secondary care services and to discuss and agree results with the individual.

**3.26** The consultation also provides an opportunity for the nurse lead to involve the individual in decisions relating to healthcare and health improvement, motivating them to make healthier choices. Within the consultation, the lead will provide relevant health and health promotion information, in a range of different formats, particularly relating to healthy lifestyles – diet, physical activity, smoking, alcohol (and potentially substance misuse) – the key risk factors for cardiovascular disease.

**3.27** The consultation also provides an opportunity for the nurse lead to signpost people to other health-promoting services such as healthy walking groups, cycle-together groups, types of dieting or weight-watchers programmes, and smoking cessation services. Improved access will support social inclusion and the participation of people with mental health problems in more mainstream services.

**3.28** Finally, the consultation allows for broader health-related issues to be explored, such as carers' assessments, employment or education issues, access to voluntary agencies and self-help support. A follow-up consultation at a jointly agreed time should be completed once action is under way.

## Supporting people with mental health problems

- 3.29** The nurse lead will also support individuals to access appropriate healthcare and health promotion services. Depending on the position of the practitioner, they may directly support individuals or provide their care co-ordinators with the relevant information to enable them to support their clients appropriately. There should be a multidisciplinary approach to identifying possible interventions in primary and secondary care settings.
- 3.30** The nurse lead will refer individuals to appropriate health provision for screening such as cervical smears, breast examinations, further blood tests such as thyroid functioning or tests for sexually transmitted diseases. Other screenings could include sensory function tests such as eye examinations or hearing tests.
- 3.31** The nurse lead will refer individuals to appropriate health promotion services, both generic and for people with specific health problems such as high blood pressure, obesity, or programmes specifically for people with mental health problems. Services can include nutritional programmes, physical activity groups – cycling, swimming, walking, line dancing, football, badminton, tennis etc – smoking cessation services and groups for addictions in general, or alcohol or substance misuse problems specifically.
- 3.32** The nurse lead should also establish specific programmes on healthy living, weight management and physical activity advice, as well as more general, ongoing support sessions for individuals and groups. These sessions should be delivered in a range of settings based on local need, including hospital sites and community mental health bases, GP practices or local leisure facilities. This support may be provided individually on a one-to-one basis or within groups. Advice about nutrition, physical activity, smoking and alcohol, sexual health and substance misuse are key issues for consideration. Sessions and groups are most effective when tailored to the specific target audiences.
- 3.33** Previous pilots have demonstrated that the most effective results were associated with nurse practitioners seeing 20 patients per week for checks, assessments, consultations and reviews, as well as running relevant health improvement groups. However, numbers of reviews and consultations will vary depending on the complexity of need and the outcomes sought, in consultation with individual service users.

# 4. Managerial considerations

## Management

- 4.1 Programmes should be needs-led within a locality. The nurse lead practitioner should be based within primary care but settings where the programme is delivered will vary. The programme may also need to deliver interventions in individual centres or provide home visits to improve attendance rates.
- 4.2 Successful programmes, such as the Well-Being Support Programme pilots, described in Appendix A, have engaged with local consultant psychiatrists. This collaborative approach has enabled access to services, authority to implement and oversee programmes and provided valuable connections within local services and communities. Individual nurses have benefited from access to a clinical lead and a lead manager.
- 4.3 Recruiting the right person to deliver these programmes is an important part of success. To aid recruitment, a sample job description and job specification are provided at Appendices C and D. These are advisory and should be used in the context of local need.

## Roles and responsibilities

- 4.4 The nurse lead practitioner will be responsible for programme delivery and outcomes relating to improved health, reduced risk factors for poor physical health, increased health literacy and service user satisfaction. Clear objectives should be set for an individual practitioner. It is recommended that these objectives relate to the number of enrolments, health checks, consultations, interventions and reviews completed, as well as the quality of the services provided and the outcomes achieved individually and collectively.
- 4.5 The boundaries separating the roles of the lead nurse, the individual's community psychiatric nurse and/or care co-ordinator, if applicable, need to be clearly defined and maintained. Effective communication is key to ensuring that relevant information is shared and that follow up is accessed and reviewed.
- 4.6 The nurse lead will need to make appropriate links with colleagues in primary care, CMHTs, assertive outreach teams, early intervention teams, crisis resolution teams, in-reach teams and drug and alcohol services. The nurse lead should provide effective liaison between primary care and secondary care services, where applicable. They should deliver effective interventions to ensure that unnecessary consultations, treatment schedules and reviews are avoided.

## Training, support and supervision

- 4.7 In previous successful programmes, training and supervision have been key to positive outcomes. Training should be provided to ensure the competence and confidence of the individual practitioner. Appropriate training, support and supervision are key to retaining skilled and motivated members of staff to provide a consistent service to people with mental health problems.
- 4.8 To this end, for those organisations that are committed to delivering a dedicated well-being support programme as outlined in *Choosing Health*,<sup>1</sup> Lilly will develop a partnership agreement with the organisation and provide training and mentoring free of charge. Details of this can be found at Appendix E along with a contact number.
- 4.9 Training will enable individuals to be competent in all aspects of their role but particularly the health checks and reviews, lifestyle checks and interventions, and ability to monitor, measure, review and reflect. It is fundamental for those from a mental health background to have an understanding of physical health and health improvement, and for those from physical healthcare backgrounds to have an understanding of mental health symptoms, side effects, care plans and pathways.
- 4.10 The nurse lead should have good, up-to-date knowledge of relevant local statutory, voluntary and community services. They should ensure that other practitioners also have access to this information and, in essence, act as a conduit to other services and practitioners and as an advocate for their clients with SMI. In order to play this role effectively, such information should be kept as current as possible and stored in accessible formats.
- 4.11 The nurse lead will require a range of personal and professional support in what is a pioneering role. Regular and monitored clinical supervision to review their progress as well as that of their clients is vital. They will also have personal training and support needs. For example, individual practitioners have benefited from mentoring, either from someone within the same role within a different team, or someone within the locality with complementary skills.
- 4.12 In some localities, the development of a physical health forum has worked positively to support leads or link workers with an interest in physical health gain. A forum can allow individuals to share expertise and practice, to network with service providers in the locality, to promote referral to community providers, to raise awareness about resources and to ensure that physical healthcare remains on the agenda.

## Evaluation and review

- 4.13 It is important that an audit tool is put in place to measure the effectiveness of the programme from the outset. Individual programmes should collate key patient programme data including patient reports of health checks and lifestyle assessments, improvements and actions, referral and follow-up procedures. Regular audits of the service should be undertaken to review DNAs and to look at service provision and service user satisfaction.

- 4.14 Outcomes of the programme can be monitored in a number of different ways such as through local implementation plans, GMS contract reviews, clinical governance arrangements or Local Area Agreements.

### **Programme outcomes**

- 4.15 Audits of current programmes have shown impressive results to date in relation to the take-up of service, increased health checks and assessments, referral rates, continuity of care and increases in reported improvements in physical health and, in some cases, mental health and well-being.
- 4.16 Research shows that physical healthcare checks have, in the past, been accessed by less than a third of individuals with severe mental health problems. Specific programmes can ensure blanket coverage for health checks. Further research shows that effective nurse-led programmes, which provide basic physical health checks, lifestyle advice and reviews, can significantly reduce the levels of risk factors for cardiovascular disease overall. Attendance can lead to increased understanding of health information and lifestyle changes, increased levels of activity, weight loss, improved confidence and self-esteem.
- 4.17 There is value in raising awareness across the health community about the importance of physical health for people with mental health problems. Delivering concrete results through targeted programmes of work achieves this goal among primary and secondary care staff. Consequently, in some areas, there are reported strengthened links between primary and secondary care services.
- 4.18 A supplementary but no less important outcome is the increased participation by people with mental health problems in their local community, for example continuing to access leisure and activity facilities. Most importantly, service user feedback on such programmes has been increasingly positive.

# Appendix A

## Case studies of pilot programmes

### Site One

This programme is a citywide service selecting clients from all sectors of the city. The key people involved in the setting up of this service were the lead consultant, community mental health managers and other psychiatric consultants. Consultations were undertaken almost exclusively as home visits, as patients were found to be reluctant to attend clinic settings. A G Grade nurse ran the programme.

Two healthy living groups were established and were attended weekly by an average of 15 patients each. A physical activity group was set up at the local sports centre which was attended on a weekly basis by 20 patients. Patients were encouraged to attend a walking group sponsored by the city council.

Outcomes included:

- a 57% reduction in alcohol intake;
- only a 1% did not attend (DNA) rate;
- a 32% reduction in smoking;
- 44% lost weight, with as many patients remaining weight neutral;
- a marked increase physical activity – in some cases of more than 50%;
- an improvement in self-esteem in 95% of patients;
- an improvement in the diet of the majority of patients.

### Site Two

The programme was delivered primarily through targeting patients from the assertive outreach service and the rehabilitation and recovery service in an urban location. The key people involved in establishing this service were the lead consultant and managers of appropriate services. A G Grade nurse ran the programme.

All consultations were carried out in home visits due to patients' reluctance to engage. Healthy living groups proved far more popular when based in the continuing care adult inpatient unit rather than the local leisure centre (assertive outreach referrals).

Outcomes included:

- a 3% DNA rate;
- an increase in the number of patients attending primary care practice (previous non-attenders);
- an increase in knowledge and skills relating to healthy living;
- detection and diagnosis of major physical complications such as type 2 diabetes, hyperprolactinaemia and thyrotoxicosis in patients;
- existing services, such as local tailored football groups and open-access community programmes have grown in popularity;
- weight loss in 62% of patients between the ages of 30 and 34;
- an increase in activity levels of nearly 60% on average.

### Site Three

This was a rural site where patients were enrolled from the community mental health team (CMHT) and the lead consultant. An F Grade nurse ran the programme. The key stakeholders involved in setting up the programme were the lead consultant for mental health, social services, non-statutory services, community psychiatric teams and social workers, as well as individual GP practices.

Initially the consultations were based in a community mental health clinic, and home visits were also offered during the life of the programme. These proved popular due to poor local transport systems.

Three healthy lifestyle groups were run in a mental health day unit, a social services day centre and a community rehabilitation home. The average weekly attendance was 35 patients. A physical activity group was also run in conjunction with the local sports centre which was also well attended.

Outcomes included:

- 41% of patients lost weight;
- 15% stopped smoking;
- 62% reduced their alcohol intake – some by more than 50%;
- physical activity increased by more than 40%;
- notable improvements in self-esteem.

### Site Four

The programme operated out of both an inner city setting and a rural base, led by a G Grade nurse. The patients were enrolled on the programme exclusively from a multi-agency centre, which included social services, the voluntary sector, links to education, employment advice, complementary therapies and befriending, as well as mental health services. The lead consultant also operated from this site.

The key stakeholders involved in setting up the service were the lead consultant for the programme and GPs, had signed up to joint working agreements. The trust's gym co-ordinator and diabetic services were also engaged. Approximately 40% of the patients were seen in a home environment and the rest in clinics and GP surgeries. The increase in home visits can be attributed to patients who had problems with transport, childcare or their physical health.

There are two healthy lifestyle groups run from a community mental health centre, which also acted as a day centre. Each group attracted up to 20 patients. There were also five activity groups, four of which were based in the community, including a leisure group, a gardening group, a walking group, a 'stepping out' group and a recovery group. One of the patients has since become joint convenor of the group. The other convenor is a nurse from the local team.

Outcomes included:

- Nearly half the clients cut down on their smoking.
- Reduction in the consumption of alcohol was more than 62%.
- The majority of clients showed robust improvement in their physical activity.
- Self-esteem was the most improved outcome for the programme.

For more information on the pilot sites please call the Lilly customer response centre 01256 315999.

# Appendix B

## Other promising practice

### Inpatient support

#### Programme One

A weekly primary care service is provided by a local GP to an acute inpatient unit. During a 10-month period, 36 clinics were held and 123 appointments were attended, amounting to 22% of all patients admitted to the unit in that period. Clinics involved three-hour sessions in three acute adult psychiatry wards and a more limited service to the older persons service. Referrals were accepted from staff and patients. Appointments were 30 minutes in length, to deal with complex needs and communication difficulties.

Presenting complaints included a wide range of acute and chronic conditions, affecting all body systems. New medication was prescribed in 66 consultations, and existing medication altered in a further 8 consultations; watchful waiting was relevant for 49 consultations, and 8 required follow-up appointments.

As well as treating specific complaints, the doctor undertook health promotion work directly with the patient in 97% of cases. The doctor also provided information and advice for staff on the wards about physical health assessment, care and maintenance. This programme could be usefully extended to involve practice nurses in the delivery of physical health assessments and provision of health promotion information and services, where appropriate.

#### Programme Two

A health screening pilot was run in an inpatient unit for those with a length of stay in excess of six months. The clinics were held three times a month over a three-hour period where four or five individuals were seen in each session. In total, 66 service users attended an appointment of those, 41 reported a current medical complaint. Patients were given the choice of seeing a male or female GP or a practice nurse. Professionals would also see people in their surgery or on the wards if individuals preferred.

Some 82% of patients were willing to take up the offer of health screening. Reported medical complaints included 59% of patients with a body mass index (BMI) over 25, 59% who smoked, 27% with ear problems, 17% with raised blood pressure and 11% with sight problems.

Fifty of the 66 patients had staff recommendations made and only 66% of those were followed through. Feedback was discussed in CPA meetings (62%), with medical staff (66%) and with patient themselves (69%).

Frontline staff valued the service for the impact on patients and for their increased knowledge. Again, in this programme further health promotion information and services could improve the health of those in inpatient care. The primary nurses on the ward could take a more proactive health promotion role with additional training and support. There is also a need to promote self-help further.

### Programme Three

An acute mental health trust has established a physical healthcare team for its acute inpatient wards, led by a mental and physical health dual-qualified practice nurse. For one year the nurse practitioner was available only one day a week, but the trust identified that there was a significant need. Since August 2005 the role has been full time, supported by two full-time assistant practitioners.

Over 90% of service users have received an initial physical healthcare screening. This is offered on admission. The screening includes tests for a range of common conditions such as asthma and diabetes, as well as blood pressure, weight, BMI, oxygen saturation levels and bloods. Service users are re-screened if they are readmitted to the unit – it is not a one-off service.

Well woman and well man clinics are run weekly in the unit, and some of the main issues for service users are cervical screening, testicular self-examination and sexually transmitted diseases. Service users are taught breast and testicular self-examination methods, as well as inhalation techniques if they are asthmatic and require inhalers.

The trust shares its site with a separate general medical acute trust, so service users can be referred to relevant physical health services on site including dieticians and occupational therapists as well as health promotion services.

There are five staff members trained in smoking cessation techniques and they oversee service users' reduction and quit attempts. The clinical pharmacist advises on necessary adjustments to medication that might be affected as nicotine levels reduce. The senior house officer (SHO) can write out prescriptions for nicotine replacement therapy (NRT) for would be non-smokers.

At discharge, a case conference reviews holistic health for service users, and relevant information is passed back into the community and primary care services. There is a weekly physical health clinic run by a community psychiatric nurse (CPN) in the community which provides advice, guidance and support on weight management, diet and a range of other issues. Referrals are made to an occupational therapist (OT) for support with appropriate physical exercise.

In the three months from November 2005 to January 2006:

- 66 people have attended well man clinics.
- 54 people have attended well woman clinics.
- 225 physical health assessments have been carried out.
- 38 referrals to the smoking cessation clinic have been made.
- 56 diabetic monitoring sessions and 37 diabetic training sessions have been completed.
- 117 asthmatic monitoring sessions have been undertaken.

## Community services

### Programme One

A joint venture between primary and secondary care services has been established in two pilot areas to improve the physical health of people with severe mental illness (SMI). The programme aims to promote collaborative working between primary and secondary healthcare professionals. This is being delivered through the completion of physical health checks and the monitoring of service users' physical health, particularly in relation to medication and side effect reviews.

Incidents identified in a pilot study found significant levels of individuals experiencing extra pyramidal side effects (15%), incidence of raised prolactin (35%), high glucose levels (20%), high levels of obesity or being overweight (55%), raised cholesterol levels (15%) and high rates of lipid abnormalities (43%). Recommendations from the pilot were that service users with SMI should receive physical health checks, that they are able to access general practice, that their access to screening and monitoring should be reviewed, that training should be delivered to primary and secondary care staff using the buddy system and that side effects of medication should be monitored within three months in secondary care. Through clinical governance these recommendations are being rolled out further.

Each locality is delivering the programme differently to meet local need. In one area the programme promotes checks, delivers training to those identified by locality managers for mental health and for primary care through the primary care trust's (PCT's) mental health lead and practices, provides support for service users to improve their health and well-being, promotes physical activity and provides details for further screening and treatment.

In a second area the programme promotes checks, delivers training to those key mental health nurses with an interest and those identified by their CMHT (for mental health) and those (for primary care) identified by the nursing director, provides support for service users to improve their health and well-being and delivers an innovative lifestyle and behavioural programme to manage service users' weight and improve health.

To date the programmes have improved communication between primary and secondary care, enhanced joint working and established appropriate training and buddying programmes. There has been a positive impact on the quality of life of service users and measurable impacts in areas such as blood pressure, weight, BMI, physical activity levels and participation levels.

In one of the localities healthcare practitioners have been trained in smoking cessation, which enables service users to be referred directly for support to clinics to reduce smoking. This issue was not previously addressed by the healthcare practitioner teams, but now there have been 12 people referred in the last year from the assertive outreach team alone. In primary care there has been a notable reduction in DNA rates for those attending the physical health clinics.

### Programme Two

In one area there are 17 GP practices. SMI registers have been established in all of the practices. The criteria for inclusion on the registers are those with psychotic disorders and bipolar disorder. Annual health checks are carried out.

The screening is conducted using an electronic template, agreed across the PCT after being piloted in one practice.

The template includes the recording of basic health data such as blood pressure, BMI, waist circumference, smoking status and alcohol consumption. Cholesterol, blood glucose, liver function, kidney and thyroid function blood tests are also recorded.

There is also a health promotion focus within the template with links to smoking cessation services, prescriptions for health services at the local health centre and sexual health services.

The appointments last 40 minutes on average and are conducted varyingly across surgeries by GPs and/or practice nurses. A series of prior education sessions have been provided for primary care staff, to explore their role in addressing the physical health needs of people with mental health problems.

Mental health nurses work across the primary care/secondary care interface, ensuring that the process of inviting service users in for screening is co-ordinated. They notify secondary care workers to maximise the opportunities for supporting service users to attend the appointments. Service users themselves report that the appointments are very beneficial and that they offer a real opportunity to discuss their health.

The use of the template has provided useful audit data, most replicating national data. Attendance levels for the appointments are generally similar to those for other chronic disease groups. A number of surgeries, however, have demonstrated 100% attendance. Those attending most often tend to be in the middle age groups: those aged 40–50 are most likely to attend, followed by those aged 51–60. This has led to a focus on attempting to persuade younger service users to attend. The audit data have also identified a group with multiple chronic conditions, the greatest number being those suffering from a SMI plus type 2 diabetes and hypertension.

### **Programme Three**

A mental health nurse was employed within a locality to support GP practices to develop a register for people with SMI and to carry out physical health assessments as outlined in the GMS contract.

There are about 350 mental health patients on the register. The role covered 8 surgeries with a patient list of over 100,000. The remit also covered other mental health prevention strategies such as depression workshops, anxiety management, GP clinics and teaching and training for mental health.

A mental health template was developed, taking into account the contract requirements and the evidence base for poor health.

### Physical health template

Weight	Glucose
Height	Cholesterol test
BMI	Framingham's risk assessment
Dietary advice	Alcohol consumption and advice
Exercise referral	Drug use and advice
Blood pressure	Smoking status and advice

All patients were offered three opportunities to attend a physical health review. Statutory and voluntary agencies concerned with the management of mental health patients were advised of appointments and reviews.

Initially the GPs and the practice nurses were resistant to carrying out the physical health checks. The mental health nurse accordingly offered joint clinics to enable the checks to get off the ground. These clinics also served to improve her physical health skills and the mental health skills of the primary care practitioners. The practice nurses are now very comfortable about doing the checks, and no resistance remains.

# Appendix C

## Example job description: nurse practitioner

**Title:** Well-Being Support Programme Nurse Adviser.

**Job purpose:** Provide a high-quality mental health nursing service for patients with SMI, to assess and advise on general health issues, including physical health, lifestyle and medication side effects.

Support the expansion of a holistic approach to health for these groups of service users through identification of key CMHT/NHS workers who are committed to service improvement.

**Reports to:** Case manager.

### Nurse responsibilities

1. Provide a high-quality mental health nursing service for patients with SMI to advise on physical healthcare including diet, weight gain, exercise, lifestyle, sexual health and side-effect monitoring.
2. Undertake the clinical audit programme, as agreed, by determining the patient group, obtaining all necessary clinical and health economic data, reporting back on activity versus objectives and quality of outcomes in accordance with laid down procedures. Any changes in medication which may result from the audit programme must be as a result of a decision by the relevant psychiatrist. Ensure an audit tool is completed and updated on a weekly basis.
3. Set up and run patient clinics, as agreed with lead clinician, in order to assess, provide support and give advice and clinical assistance to patients, where necessary, according to local guidelines.
4. Set up and run/facilitate weight management groups and physical activity groups.
5. Train other nursing staff in the counselling and optimisation of care for patients with SMI including physical health checks and advice.
6. Submit accurately all required reports to the lead clinician and case manager in the agreed format and to agreed deadlines.
7. The nurse will be expected to organise their own time in order to balance outpatient clinics with audit tool requirements and answering patient queries.
8. Regularly agree and review project objectives with the lead clinician and case manager.
9. Manage time and workload effectively in order to achieve identified and agreed objectives.
10. Keep abreast of all developments in clinical issues relating to the disease area, NHS changing structures and decision-making processes, and developments in disease treatment.

11. Be thoroughly familiar with the Nursing and Midwifery Council code of professional conduct and ensure that all clinical support activities and advice and information given comply with this code.
12. Attend appropriate training courses as required in order to be up to date in any knowledge/skill area or to address a particular development need.
13. Align all key local managers to support the programme and its implementation.
14. Communicate the programme and its outcomes to key healthcare professional colleagues, up-skilling of clinical teams and providing advice, guidance and educational/clinical support.
15. Train, facilitate and empower local nursing staff in the successful implementation and optimisation of this approach.
16. Provide reports to internal and external colleagues when required.

### **Person specification**

The jobholder must be a professionally qualified RMN who is well organised and has previous experience of CMHT working. Successful candidates will have effective communication skills and possess the ability to train and mentor others and be able to present to groups of people. They will have competent IT skills, audit experience being a distinct advantage. They will have a keen interest in physical well-being and will be self-starters with high personal motivation who enjoy working both alone and in a team environment.

# Appendix D

## Example job specification: nurse practitioner

<b>JOB SPECIFICATION</b>	<b>Nurse adviser</b>
<b>JOB TITLE</b>	Well-Being Support Programme Nurse Adviser
<b>REPORTS TO</b>	Case manager/lead clinician
<b>PURPOSE OF POST</b>	Deliver the objectives of the well-being support programme to patients with SMI
<b>HOURS</b>	Full or part-time
<b>LOCATION OF EMPLOYMENT</b>	Regional
<b>SALARY</b>	G Grade (but to be discussed with individual)
<b>CAR</b>	Travel allowance
<b>TELEPHONE</b>	Yes: private calls paid by individual
<b>HOLIDAYS</b>	25 days
<b>SPECIFIC QUALIFICATIONS</b>	Minimum top E Grade
<b>EXPERIENCE REQUIRED</b>	Three years in mental health arena
<b>START DATE</b>	January 2006

# Appendix E

## Well-being support programme and training opportunity

For those organisations that are committed to delivering a dedicated well-being support programme as outlined in *Choosing Health*,<sup>1</sup> Lilly will develop a partnership agreement with the organisation and provide a three-day training course so that NHS nurses can widen their skills to provide a holistic service for individuals with SMI free of charge:

Any travel and accommodation costs are not covered.

### Day 1: Service development

Introduction/welcome, outline course, physical health in mental health, developing the service

#### Outcomes

- Introduction to government guidelines for people with SMI.
- Understanding the physical health needs of SMI patients.
- Understanding the key components to achieve success in changing and implementing a service to fulfil patient and government requirements.

### Day 2: The components of the well-being support programme

**General health:** blood pressure, pulse rate, body mass index, thyroid function, serum prolactin levels, blood glucose levels, lipid and cholesterol levels.

**Lifestyle:** smoking rates, diet, physical activity levels, illicit substance use, alcohol use.

**Side-effect management:** regular LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) assessment.

**Interventions:** one-to-one nursing time to discuss overall health and well-being and agree lifestyle plan to suit the individual.

- Referral to other NHS agencies when health issues are identified requiring specialist intervention.
- Weight management advice – group participation or individual support.
- Physical activity support – group participation or individual support.
- Recommendations to healthcare team regarding side-effect management.

#### Outcomes

A developed skill set to provide better holistic care of SMI patients in line with government aspirations.

### Day 3: Skills acquisition

Audit tool training, mentorship arrangements, questions and answers

#### Outcomes

- Working knowledge of web-based audit tool.
- Organisation of individual 12-month mentorship support.
- Initial queries and questions answered.

#### Also provided

- A comprehensive, state-of-the-art **web-based audit tool** – each site will have its own webpage to measure programme progress, epidemiological data, key data on physical health and lifestyle indicators, measurement of interventions and reports that support the achievement of targets.
- **Full IT and helpdesk support** for the web-based audit tool – available by phone or email Monday to Friday 9am to 5pm.
- The Well-being Support Programme **Nurse Adviser Mentorship Scheme** – an experienced RMN who has established their own Well-being Support Programme will offer ongoing support to the NHS nurse over five days.
- **Nurse resource pack**, including group work packs, standardised administration pack.
- **Patient materials and education** – comprehensive patient resource pack, educational leaflets around diet and exercise, smoking cessation advice, group work participation.
- Attendance at an **annual conference**.

Please phone the Lilly customer response centre on 01256 315999 for further information.

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## Organisations

- Disability Rights Commission ([www.drc-gb.org.uk](http://www.drc-gb.org.uk))
- Mental Health Foundation ([www.mentalhealth.org.uk](http://www.mentalhealth.org.uk))
- MIND ([www.mind.org.uk](http://www.mind.org.uk))
- National Institute for Mental Health in England (<http://nimhe.csip.org.uk/home>)
- Rethink ([www.rethink.org](http://www.rethink.org))
- Sainsbury Centre for Mental Health ([www.scmh.org.uk](http://www.scmh.org.uk))
- SANE ([www.saneone.uk](http://www.saneone.uk))
- SHiFT ([www.shift.org.uk](http://www.shift.org.uk))



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