NHS
Avon and Wiltshire
Mental Health Partnership
NHS Trust

Reducing Health Inequalities: Physical Health Delivery Plan 2017-2020

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1. Reducing health inequalities together

In the UK, the first guiding principle for the NHS is to 'provide a comprehensive service, available to all [… and] to promote equality through the services it provides' (Department of Health, 2015; p3).

With our partners, which include GPs, acute and community providers, local authorities and the third sector we will work towards a common purpose to reduce the health inequalities and preventable disease burden in people with enduring mental health needs. Physical health is a core component of trust services.

This delivery plan sets out how we focus on and discharge our responsibility to our service users to ensure that they will have their health risks supported and acted upon by the most appropriate agency. This should achieve:

- Improved life style risk detection and sign posting and/or brief advice
- Improved health and mental well-being through implementing a smoke free trust across all sites and services
- Improved information sharing to reduce duplication and improve baseline understanding of our service users health risks at the earliest opportunity.
- Improved supported access to GP care to ensure a patient's risks to their health are well managed.
- Mutual support and collaboration to put patients first.
- Accessible information for service users and carers to help them make informed choices around what screening and interventions are available for them to access
- Improved screening for frailty and falls vulnerability, and care planning to prevent falls risks from materialising.
- An awareness of Venous Thrombo Embolism (VTE) and ensure that our staff have knowledge of screening and care planning to manage the risks.
- Improved tissue viability management and pressure ulcer prevention with timely access to specialist tissue viability services for our inpatients
- Reduction of urinary tract infections for those with an indwelling catheter
- Improved nutrition and hydration management and screening for those who are at risk.
- Improved surveillance and monitoring of HbA1c and blood glucose monitoring in our inpatient and community patients to prevent the risks associated with diabetes mellitus.
- Improve physical health monitoring for those prescribed psychotropic medication, for example, lithium, depots, clozapine, rapid tranquilisation, showing particular care for those at high risk, for example, those with co-morbidities and / or subject to restrictive practices

2. Why should we do this?

The physical health of people with severe mental illness (SMI) is significantly worse than the health of the general population.

People with SMI:

- have a life expectancy that is shortened by 10–20 years (Davies, 2013)
- have higher rates of physical ill-health than the general population
- have higher rates of health-risk behaviours, including obesity and tobacco smoking (approximately twice as high than the general population) (Davies, 2013)

- are likely to have a long-term physical condition (Naylor et al, 2012).

The NHS *five year forward view* makes the case for what has been called 'triple integration' (Stevens 2015) – integration of health and social care, primary and specialist care, and physical and mental health care. The importance of the third of these components has been further emphasised in the report of the independent Mental Health Taskforce to the NHS in England, which called for the development of integrated care spanning people's physical, mental and social needs (Mental Health Taskforce 2016).

In the Kings Fund *Bringing together physical and mental health* (2016), they cite "increasing prevalence of multi-morbidity is a central part of the rationale for integrated care. The number of people living with two or more conditions is rising rapidly, meaning that multi-morbidity and the challenges it brings for co-ordination of care are increasingly becoming the norm (Barnett et al 2012). As previous research has shown, the existence of co-morbid mental health problems alongside long-term physical health conditions is a particularly common and pernicious form of multi-morbidity (Naylor et al 2012). The Kings Fund (2016) refers to earlier analysis they had undertaken which indicated that between 12 per cent and 18 per cent of all NHS expenditure on long-term conditions is linked to poor mental health – most commonly in the form of depression or anxiety disorders, which if left untreated can significantly exacerbate physical illness and drive up the costs of care (Naylor et al 2012)."

The Kings Fund goes on to argue that the other side of "the multi-morbidity challenge is that people with mental health problems – particularly the most severe mental illnesses – are at much higher risk of a range of physical health conditions. The clearest and most alarming illustration of this is the finding that life expectancy for people with bipolar disorder or schizophrenia is 15 to 20 years below that of the general population, largely as a result of raised rates of cardiovascular disease and other physical health conditions (Laursen et al 2014; Miller and Bauer 2014). Physical health issues are also highly prevalent among people with eating disorders, personality disorders, drug or alcohol use disorders, or untreated depression or anxiety. These striking and persistent inequalities serve as a powerful reminder that the case for integrated care for mental and physical health is an ethical one as much as an economic one."

3. How can we do this?

3.1 Integrated care from a service user perspective

> *If I go to see someone about my eyes, my eyes are what I am and the rest of me doesn't matter. It's the same with mental health. If I go to see someone for a mental health problem, I am a mental health problem.*

This is a quote from a focus group participant in The Kings Fund (2016) research emphasising the need for clinicians and health professionals to see the fundamental purpose of their role as being to support improvements in both the mental and physical health of the people they work with.

We expect all clinical staff across AWP to practice in accordance with The Kings Fund recommendation that they should hold,

- a foundation of basic common competencies in mental and physical health
- an openness to explore what a person's wider needs might be beyond the boundaries of their own specialism
- an understanding of other forms of support that are available and how to make a referral to relevant services

We expect all senior clinicians should,

- Promote an holistic multi-disciplinary approach to physical health that encourages the role of allied health professionals both internally and externally in the provision of physical health.

- Support staff development through competency based learning and the provision of clear, accessible policies, procedures, guidance and assessment tools.

3.2 Clinical Executive / Corporate Services

The Medical Director will be the trust board member with responsibility for the implementation of this physical health delivery plan and the development of clear measurable outcomes (in accordance with the recommendation from the working group on *Improving the physical health of adults with severe mental illness: essential actions (2016).*

A quarterly Trust Physical Health meeting will oversee the implementation of the delivery plan, provide direction and support to all clinical services in local implementation. This will be chaired by a senior clinician from the Clinical Executive demonstrating strong visible clinical leadership for physical health.

Appropriate levels of serious incident analysis will be undertaken for each patient whose physical health deteriorates significantly.

The Lester Tool (Shiers et al, 2014) is the intervention framework to support staff and remind them of the circumstances in which to act.

The National Early Warning Score (NEWS) system is that which is to be used to enable the early recognition of deterioration and appropriate action to be taken in a timely way.

Implementation of the 'Think Sepsis' agenda if a service user triggers a NEWS, looks ill and or has signs of infection to ensure prompt screening and early intervention.

The SBAR (Situation, Background, Assessment and Recommendation) system is that which is to be used as a communication system for handover and medical emergencies.

Patient clinical record systems will have dedicated physical health pages to support the accurate recording of comprehensive physical health assessments. These will be based upon the Lester Tool and designed to support the collation of data to delivery against annual CQUIN indicators.

A comprehensive clinic list will be available to recommend medical devices for inpatient and community teams clinics. A trust asset register (f2) will enable teams to maintain their medical devices lists and support the annual programme of maintenance.

3.3 Clinical services

All patients will receive a comprehensive Standard Physical Health Assessment within 28 days of their acceptance into a community service or within 24 hours of admission to an inpatient setting.

All patients with identified physical health needs requiring intervention must have individualised care plans in place that seek to incorporate the contribution of allied health professionals.

Shared planning to ensure that communication with GPs maximises information flow, this should include details of;

a. Core health indicator measures

b. Underlying cardiovascular or systemic conditions

c. Any conditions which impact on access, mobility or health.

In the event of inpatient transfer to acute hospital beds, information needs to go with the patient that is relevant, clear and in a format which is readily integrated into the receiving organisations care record. This information should also be routinely requested on transfer back to AWP.

All teams should have agreed pathways which ensure interventions by trust staff where appropriate and sign posting to the most appropriate agency to address the health risks identified.

All community teams should have access to or participate in the provision of weekly “health clinics” for their service users that will provide a range of physical health assessments and interventions as well as offering appointments for those prescribed depots, lithium or clozapine management.

An identified Lead Nurse/Link for Physical Health will be in place in every ward or community team. They will be responsible for the coordination of or access to trust provided health clinics, ensuring that clinic standards are met and monitoring the training/competency of the staff team

The Lead Nurse/Link for Physical Health will support the Team/Ward Manager in monitoring the training and competency of staff in the team and facilitating local training provision as required.

Provide and promote supported self-management courses for long-term mental and physical conditions for service users and carers.

Ensure service users are offered NHS screening for sexual and reproductive health, eye, dental and oral health, cervical, breast / testicle screening where challenges exist for service users to access these from primary care within their local community

Ensure there is equality in access to physical health across all inpatient services, especially in relation to End of Life care and tissue viability provision

Ensure prescription and access to assistive equipment and referral/ prescription for larger adaptations, in conjunction with local authorities that promote and support independence for service users with co-existing physical health problems.

4. Measures of success

- Improved service user and carer satisfaction / reduction in complaints
- Improved staff confidence in undertaking physical health screening and timely referral when required
- New physical health pages in RiO during 2017/18
- Implementation of smoke free trust status during 2017/18 and achievement against associated measures of impact
- Completion of physical health assessments for all patients accessing services (sliding scale over 3 years)
- Multi-agency coordination of physical healthcare demonstrated through individualised care plans and information sharing with GPs (sliding scale over 3 years)
- 90% training compliance with L1 smoking cessation e-learning and alcohol screening e-learning by all clinical staff
- Maintenance of achievement of 95% for the Safety Thermometer
- Progress in achievement of CQUINs 3a and 9 during 2017/18 and 2018/19
- Improvements in flu vaccination programme with increases in inpatient numbers in later years of the delivery plan.
- Organisational learning from RCA and Mortality Reviews.
- Improvement in compliance for all physical health related Trust wide Clinical Audits.

Version History

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1.0	21/11/2017	Approved by Quality and Standards Committee	Associate Director for Nursing - Community	Approved