# Closing the Gap Improvement Collaborative

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## Background

In 2018 community mental health teams from Oxford Health joined a national collaborative run by NHS Improvement to improve the quality of physical healthcare provision for patients with schizophrenia and psychosis. These patients have increased rates of mortality, due to poor physical health, reduced quality of life and function and decreasing life expectancy. Many patients receive treatment in the form of antipsychotics which increase risk of cardiometabolic symptoms.

The quality improvement projects would use the Lester Tool to support the application of NICE (2009) guidance of annual physical health monitoring. Key areas of focus were smoking, lifestyle and life skills, BMI (weight), blood pressure, glucose regulation and blood lipids.

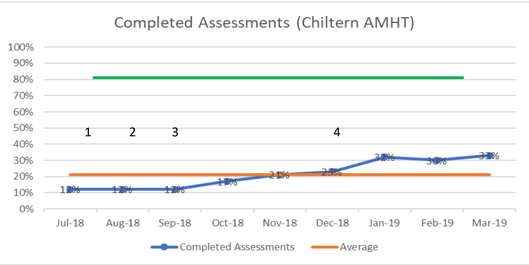
## Tests of Change

***Oxford Teams***

- Physical health clinics ran across Witney and Banbury
- Physical health leads in both bases
- Physical health training including smoking cessation
- 'Food and Moo' group at Day Hospital
- British Heart information booklets
- Team management talking about physical health in supervision and at team meetings

***Chiltern Teams***

- June 2017 - Physical health leaflets ordered
- January 2018 - A new physical health clinic set up in Amersham
- July 2018 - Training for all staff for Drug and Alcohol and Smoking, physical health monitoring equipment ordered for each consultant room
- August 2018 - Mobile physical health kits ordered, ADH staff to carry out physical health checks on all their patients
- December 2018 - Physical health added to business meeting and MDT agenda
- February 2019 - Blood card forms posted to patients/given to care coordinators (CCs), Individual emails to CCs asking for patient's physical health information
- April 2019 - Physical health lead nurse appointed
- May 2019 - Phlebotomy training for nurses, extra clinic dates added (twice weekly), staff attended carers forum to promote physical health
- July 2019 - Nurses Forum
- Ongoing interventions - Access to blood results for more staff, access granted to GP records, referring patients to 'Live Well Stay Well' for support with physical health, team managers are attending physical health training




1 **July 2018-Amersham PH Lead left**

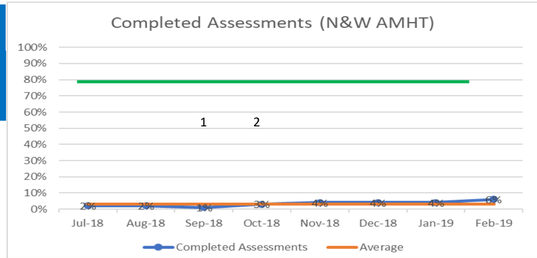
2 **August 2018- Day Hospital staff started to record PH**

3 **September 2018- Reports issued**

4 **Dec/Jan 2018- Extra staff help to record all BMI/BP**

1 **September 2018- Staff engagement started**

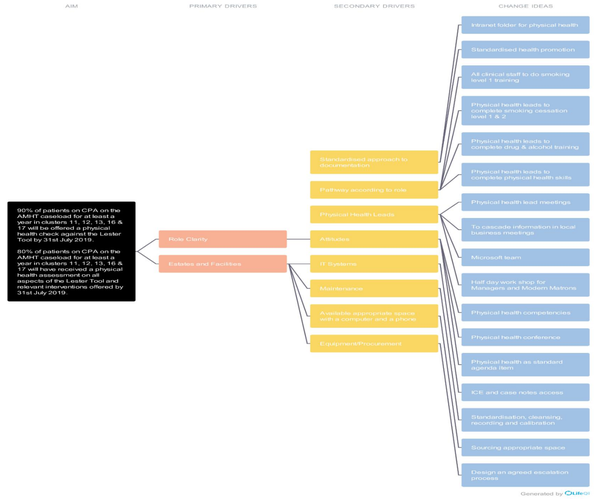
2 **October 2018- Contact with local GPs about health promotion offered**




**AIMS:**

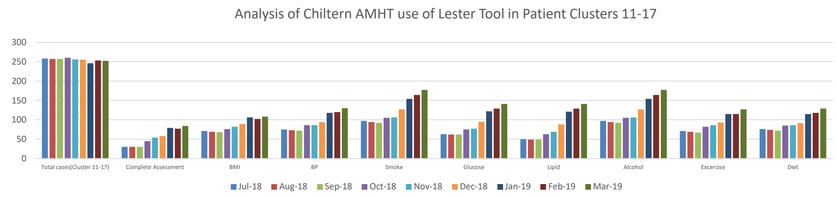
90% of patients on CPA on the AMHT caseload for at least a year in clusters 11, 12, 13, 16 & 17 will be offered a physical health check against the Lester Tool by 31st July 2019

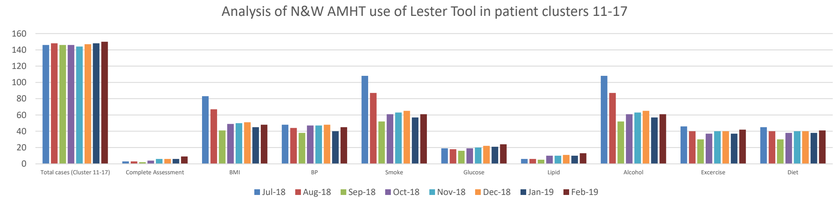
80% of patients on CPA and on the AMHT caseload for at least a year in clusters 11,12,13,16 & 17 will have received a physical health assessment on all aspects of the Lester Tool and relevant interventions offered by 31st July 2019




## Measures

Outcomes were measured by reports pulled from Carenotes each month for both teams. Completed individual items of the Lester tool for each patient were counted as well as an overall outcome measure of all 8 items complete for each patient.



## Understanding the problem

Together the teams set the aims for their projects and created a Driver Diagram to identify key areas that needed to be addressed.

Mental health team doctors routinely asked GP's to carry out the physical health checks, but many patients are reluctant to visit their GP or encounter barriers to accessing appointments.

Physical health clinics were set up by the mental health teams, ran by nurses who had completed relevant training, however the clinic often had patients that would not attend so appointments were then made on a referral basis from patients' CCs or doctors to prevent this.

Physical health equipment was identified as a being needed to achieve the project aim.

Culture was identified as a barrier of staff feeling that they were either not trained in physical health or did not see it as part of their role. As with any change the perception of extra burden was recognised as a potential barrier to be handed sensitively.

## Next steps

***Chiltern Teams***

- Using monthly reports to identify uncompleted forms
- Increase clinics
- Introduce home visits using mobile kits
- Work closer with GP surgeries – potentially have clinics in GP surgeries
- Initiate drop in sessions, with 'Live Well Stay Well', looking at diet, exercise, smoking, drugs and alcohol
- Improve intervention data and follow up process
- Improve staff engagement further through regular training sessions
- Work with 'Sports in Mind'
- Staff wellbeing day
- Encourage CCs to take the lead in PH checks with their own patients

***Oxford Teams***

- Dedicated space in Witney for the physical health clinic
- Blood results and staff having access to these
- Stabile team base, less changes to the physical health leads within the teams
- On-going work to improve clinic attendance and outreach work
- On-going work to improve care coordinators and medical staff levels of completing the physical health check and completing the form on Carenotes
- Newly qualified band 5 in Witney to focus on physical health alone
- Links to community cooking groups for patients to access
- Staff at Day Hospital to complete a food hygiene course so they can offer "soup groups", using leftover vegetables and fruit from the weekly delivery by local supermarkets.
- Moving forward, we continue to meet with other physical health leads and the QI team to ensure physical health is not forgotten. Managers will continue to encourage care coordinators to monitor their patients physical health and to complete checks, recording them as appropriate and informing the GP.

## Reflections

**Working with the Quality Improvement team helped us to identify gaps and where we could help "close the gap".**
**CCs were not used to offering physical health as a routine part of care, this took more time than anticipated to bring to the forefront of staff minds when working with people. Staff culture is changing towards physical health checks and staff are now aware that physical health is everybody's business, as new staff start there is hope that this will be considered part of routine care.**

**Some specific challenges have been:**

**BMI is not always recorded within GP records, and not always done during physical health checks | Blood results are not always requested by a patient's GP, and sometimes patients are given blood cards but do not go to hospital to have their bloods taken | Blood pressure, as staff have not always felt confident to take this manually, sometimes the patient's GP has not taken a blood pressure reading within the year | Diet and exercise, having to email to CCs to obtain information**