Addressing physical health inequalities in people with severe mental illness

Professor Daniel Smith, Institute of Health and Wellbeing
Dr Moira Connolly, NHS Greater Glasgow and Clyde
Outline:

1. Physical health problems in severe mental illness: scale of the problem
2. Recent research in Glasgow
3. NHS and policy perspective (Dr Moira Connolly)
4. Discussion
"We care for our 34-year-old son who lives in a flat. He is overweight due to medication side effects and a poor diet. He is self-medicating on drugs and alcohol and his physical health is getting worse. There is an attitude of “if it is not a problem to us, leave well alone”.

There is no attempt to look at alternative medications and support is minimal. His physical health is not checked. If we did not keep on chasing this and other issues up nothing would be done. This would not be tolerated if it was a physical ailment."
### Reduced life expectancy of people with severe mental illness:

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Life Expectancy (95% CI, number of deaths)</td>
<td>Difference from male UK population*</td>
</tr>
<tr>
<td>Any Serious Mental Illness(^\wedge)</td>
<td>64.5 (63.3-65.6, n = 243)</td>
<td>-12.9</td>
</tr>
<tr>
<td>Schizophrenia (F20)(^\wedge)</td>
<td>62.8 (61.6-64.10, n = 196)</td>
<td>-14.6</td>
</tr>
<tr>
<td>Schizoaffective disorder (F25)(^\wedge)</td>
<td>69.4 (68.3-70.5, n = 16)</td>
<td>-8.0</td>
</tr>
<tr>
<td>Bipolar affective disorder (F31)(^\wedge)</td>
<td>67.3 (66.1-68.5, n = 43)</td>
<td>-10.1</td>
</tr>
<tr>
<td>Substance use disorders (F10-F19)(^\wedge)</td>
<td>63.9 (62.7-65.0, n = 254)</td>
<td>-13.6</td>
</tr>
<tr>
<td>Depressive episode and recurrent depressive disorder (F32-F33)(^\wedge)</td>
<td>66.8 (65.6-67.9, n = 284)</td>
<td>-10.6</td>
</tr>
</tbody>
</table>

*Life expectancy at birth 2006-08 in UK: Male = 77.4 years; Female = 81.6 years [27].
*Significant difference between genders.

doi:10.1371/journal.pone.0019590
http://www.plosone.org/article/info:doi/10.1371/journal.pone.0019590
Increasing mortality gap for patients diagnosed with schizophrenia over the last three decades — A Danish nationwide study from 1980 to 2010

René Ernst Nielsen a,b,c, Anne Sofie Uggerby a, Signe Olrik Wallenstein Jensen a, John Joseph McGrath c,d
Increasing mortality gap for patients diagnosed with schizophrenia over the last three decades — A Danish nationwide study from 1980 to 2010

René Ernst Nielsen, Anne Sofie Uggerby, Signe Olrik Wallenstein Jensen, John Joseph McGrath

Excluding suicide as cause of death
“A failure of social policy and health promotion, illness prevention and care provision.”
Editorial

Multimorbidity and mental health: can psychiatry rise to the challenge?
Julie Langan, Stewart W. Mercer and Daniel J. Smith

Summary
Multimorbidity – the co-occurrence of two or more long-term conditions in an individual – is highly relevant to psychiatry. Changes to training and a more integrated model of psychiatric and physical healthcare are needed in the future if we are to improve the long-term health of our patients.

Declaration of interest
None.

Physical health indicators in major mental illness: analysis of QOF data across UK general practice

BACKGROUND
The Quality and Outcomes Framework (QOF) has specific targets for body mass index (BMI) and blood pressure (BP) recording in major mental illness (MMI), diabetes, and chronic kidney disease (CKD). Although aspects of MMI (schizophrenia, bipolar disorder, and related psychoses) are incentivised, barriers to care may occur. Given the high rates of obesity, poor cardiometabolic health and the increasing gap in life expectancy between significantly higher for BMI recording in MMI than for diabetes for the UK combined (7.4% versus 2.3%, P<0.001) and for each country (Table 1). Indicator payment and population achievement rates for BP recording in MMI were also significantly lower than for BP recording in CKD for the UK combined (payment: 94.1% versus 97.8%, P<0.001; population achievement: 87.0% versus 97.1%, P<0.001) and for each country (Table 1). As with BMI, the exception rate for BP recording was significantly higher in patients.
Multimorbidity in bipolar disorder and undertreatment of cardiovascular disease: a cross sectional study

Daniel J Smith¹, Daniel Martin¹, Gary McLean², Julie Langan¹, Bruce Guthrie³ and Stewart W Mercer²
### Odds ratios for individual conditions: Bipolar patients (n=2,582) vs non Bipolar (1,421,796)

<table>
<thead>
<tr>
<th>Condition</th>
<th>95%</th>
<th>CI</th>
<th>ORs</th>
<th>Bipolar (%)</th>
<th>No Bipolar (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viral Hepatitis</td>
<td>3.22</td>
<td>10.01</td>
<td>5.69</td>
<td>0.4</td>
<td>0.1</td>
</tr>
<tr>
<td>Constipation</td>
<td>2.93</td>
<td>3.88</td>
<td>3.05</td>
<td>9.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Parkinson's</td>
<td>1.83</td>
<td>5.09</td>
<td>3.05</td>
<td>0.7</td>
<td>0.2</td>
</tr>
<tr>
<td>CKD</td>
<td>2.04</td>
<td>2.86</td>
<td>2.42</td>
<td>7.3</td>
<td>2.4</td>
</tr>
<tr>
<td>Thyroid Disorders</td>
<td>2.11</td>
<td>2.78</td>
<td>2.39</td>
<td>14.6</td>
<td>6.0</td>
</tr>
<tr>
<td>Crohns</td>
<td>1.42</td>
<td>2.66</td>
<td>1.99</td>
<td>1.1</td>
<td>0.7</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1.69</td>
<td>2.09</td>
<td>1.88</td>
<td>17.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Pain</td>
<td>1.28</td>
<td>2.29</td>
<td>1.71</td>
<td>1.8</td>
<td>1.1</td>
</tr>
<tr>
<td>Prostrate</td>
<td>1.42</td>
<td>1.87</td>
<td>1.63</td>
<td>9.2</td>
<td>5.6</td>
</tr>
<tr>
<td>Dyspepsia</td>
<td>1.06</td>
<td>2.37</td>
<td>1.58</td>
<td>1.2</td>
<td>0.6</td>
</tr>
<tr>
<td>Blindness</td>
<td>0.87</td>
<td>2.86</td>
<td>1.58</td>
<td>0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>MS</td>
<td>0.98</td>
<td>2.1</td>
<td>1.44</td>
<td>1.2</td>
<td>0.7</td>
</tr>
<tr>
<td>Psor. Eczema</td>
<td>1.17</td>
<td>1.86</td>
<td>1.39</td>
<td>6.6</td>
<td>3.7</td>
</tr>
<tr>
<td>COPD</td>
<td>1.14</td>
<td>1.64</td>
<td>1.37</td>
<td>5.7</td>
<td>3.7</td>
</tr>
<tr>
<td>IBS</td>
<td>1.13</td>
<td>1.63</td>
<td>1.31</td>
<td>8.4</td>
<td>5.3</td>
</tr>
<tr>
<td>Diabetes</td>
<td>1.26</td>
<td>2.82</td>
<td>1.26</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Liver Disease</td>
<td>1.0</td>
<td>1.54</td>
<td>1.23</td>
<td>4.6</td>
<td>3.1</td>
</tr>
<tr>
<td>Cancer</td>
<td>0.98</td>
<td>1.43</td>
<td>1.18</td>
<td>5.2</td>
<td>3.8</td>
</tr>
<tr>
<td>Hearing Loss</td>
<td>0.93</td>
<td>1.56</td>
<td>1.18</td>
<td>6.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Asthma</td>
<td>0.99</td>
<td>1.35</td>
<td>1.16</td>
<td>6.9</td>
<td>1.6</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0.8</td>
<td>1.53</td>
<td>1.11</td>
<td>1.8</td>
<td>1.3</td>
</tr>
<tr>
<td>Diverticular</td>
<td>0.87</td>
<td>1.41</td>
<td>1.11</td>
<td>3.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Stroke TIA</td>
<td>0.84</td>
<td>1.34</td>
<td>1.06</td>
<td>3.6</td>
<td>2.6</td>
</tr>
<tr>
<td>Arthritis</td>
<td>0.78</td>
<td>1.17</td>
<td>0.96</td>
<td>4.6</td>
<td>4.1</td>
</tr>
<tr>
<td>CHD</td>
<td>0.79</td>
<td>1.12</td>
<td>0.94</td>
<td>6.9</td>
<td>5.7</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>0.54</td>
<td>1.49</td>
<td>0.94</td>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Migraine</td>
<td>0.54</td>
<td>1.49</td>
<td>0.94</td>
<td>0.7</td>
<td>0.6</td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td>0.29</td>
<td>2.09</td>
<td>0.78</td>
<td>0.2</td>
<td>0.2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>0.73</td>
<td>0.92</td>
<td>0.82</td>
<td>17.9</td>
<td>16.5</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>0.65</td>
<td>1.24</td>
<td>0.82</td>
<td>1.1</td>
<td>1.2</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>0.46</td>
<td>0.94</td>
<td>0.68</td>
<td>1.4</td>
<td>1.7</td>
</tr>
</tbody>
</table>
• Very high rates of “pro-atherosclerotic” conditions:
  – Smoking (32.3% vs. 20.6% p=0.01)
  – Diabetes (8.4% vs. 5.3% p=0.001)

• But:
  – Coronary Heart Disease, Heart Failure, Peripheral Vascular Disease, Stroke and TIA not more commonly recorded in the bipolar group
  – Where cardiovascular diseases were recorded, there was evidence of less intensive treatment

• Substantial treatment inequalities for those bipolar patients known to have coronary heart disease and hypertension.
Modifiable risk factors for cardiovascular disease in individuals with features of depression and bipolar disorder

• Aims:
  – To quantify the relationship between health-related lifestyle behaviours, such as smoking, alcohol use, physical activity, and dietary energy intake, and features of MDD and BD

• Methods:
  – Cross-sectional study of 145,991 UK Biobank participants
  – Multinominal logistic regressions of associations between smoking, alcohol use, physical activity, and dietary energy intake, and features of MDD and BD
  – Adjusting for age, sex, ethnicity, socioeconomic deprivation and psychotropic medication use.

Martin et al, in submission
Modifiable risk factors for cardiovascular disease in individuals with features of depression and bipolar disorder

- Current smoking:
  - MDD OR=1.52; BD OR=2.32

- Alcohol on a daily basis:
  - MDD OR=1.10

- No regular physical activity:
  - MDD OR=1.19; BD OR=1.50

- High total energy intake:
  - MDD OR=1.13; BD OR=1.68

Martin et al, in submission
Cardiometabolic disease and features of depression and bipolar disorder: population-based, cross-sectional study

Daniel J. Martin, Zia Ul-Haq, Barbara I. Nicholl, Breda Cullen, Jonathan Evans, Jason M. R. Gill, Beverly Roberts, John Gallacher, Daniel Mackay, Andrew McIntosh, Matthew Hotopf, Nick Craddock, Ian J. Deary, Jill P. Pell and Daniel J. Smith
Adverse cardiovascular outcomes:

- In fully adjusted models, increased risk for:
  - Hypertension: BD > MDD > controls
  - Myocardial infarction: BD > MDD > controls
  - Angina: MDD > controls
  - Stroke: MDD > controls
  - Diabetes: MDD > controls
  - Any of the above: BD > MDD > controls
Impact of psychotropic medication:

Psychotropic medication increases the risk of cardiometabolic disease in MDD, BD and in controls
Improving patient care and clinical governance through the utilisation of a clinical information system

John Park, Catherine McAlaney and Moira Connolly

Greater Glasgow & Clyde NHS, Glasgow, UK
Glasgow “PsyCIS” cohort:

• Started 2005 - maintained by full-time research nurse and administration team
• Almost 10,000 individuals with psychosis (schizophrenia, bipolar disorder)
• Baseline (and annual) assessments:
  – ICD-10 diagnosis, Community Health Index (CHI) number, ethnicity, marital status, accommodation status and postcode, employment status, educational attainment, family history of psychosis, psychiatric admissions data, current illness severity (including Clinical Global Impression (CGI) and Health of the Nation Outcome Scale (HoNOS) scores), use of the mental health act, current and previous medications, adverse drug effects, psychosocial interventions received and psychiatric comorbidities.
About the Safe Haven

The four Safe Havens in Scotland were established as part of a national need for delivering research excellence and the need for rapid access to high quality health data for research purposes. They were developed in line with the SHIP blueprint which outlined a programme for a Scotland-wide research platform for the collation, management, dissemination and analysis of anonymised Electronic Patient Records (EPRs).
Datasets in Safe Haven:

- SMR00 - Outpatient Attendance
- SMR01 – Acute inpatient & Day Care
- SMR02 – Maternity
- SMR04 – Mental Health
- CHI – GG&C patient population (1.3 million)
- GRO – Births and deaths date for GG&C
- ePrescribing – encashed prescriptions for Glasgow
- Heart Failure – locally held national Heart Failure database
- Rheumatology – local clinical database
- SCI DC – National Diabetic database
- SCI Store results for GGC
- Hypertension clinic
- Parkinson – local clinical database for Movement disorders
- LES/Keep Well data
- Weight Management
- PsyCIS
- Clozapine cohort
- Lithium cohort
- EDIS (North Glasgow A&E)
- Lung Cancer
- SERPR – GGC element of Regional Renal application
- Pain Management
- Homecare Database
**Research question, eg:**
Do antihypertensive therapy impact on mood disorder outcomes?

**Research question, eg:**
Do patients with bipolar disorder and diabetes receive treatment with anti-diabetic medication?
Death Rate in Severe Mental Illness relative to Glasgow and Scotland by Deprivation Quintile

Deaths per 10,000 per 5 years (2006-2010)

Most affluent 2 3 4 Most deprived

SMI

SMI excluding suicide

Glasgow

Scotland

A Health Informatics Approach To Improving Long-Term Physical Health Outcomes In Major Mental Illness:

*Using routine data linkage:*

1. How complete is routine blood monitoring for patients with bipolar disorder?

2. For patients with evidence of raised HbA1C and/or lipid levels, what proportion are receiving appropriate medication treatment?
No record of routine blood testing within last 2 years:

- Bipolar Disorder (N=1988)
- Schizophrenia (N=3299)
**No record of routine blood testing within last 2 years:**

- No differences by socioeconomic deprivation status
- Younger patients were more likely to have no record of blood monitoring than older patients
- Low rates of using HbA1c to diagnose and treat diabetes
Proportion with clinically raised levels:

- Glucose $>11.1$ mmol/l
- HbA1C $>48.0$ mmol/l
- Cholesterol $>5$ mmol/l

- Bipolar Disorder (N=1988)
- Schizophrenia (N=3299)
Proportion with diabetes or raised cholesterol who are on medication treatment:

- Diabetes and on anti-diabetic medication: 70%
- High cholesterol and on a statin: 30%
The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.

Plato *circa* 370 BC
Three questions:

1. Is any of this relevant to mental health policy?

2. What would you be advising policy makers within NHS GG&C?

3. What would you be advising policy makers within Scottish Government?
Research Policy Practice

A clinician’s view

Dr Moira Connolly
Comment

Time for mental health to come out of the shadows

Arthur Kleinman, Georgia Lockwood Estrin, Shamaila Usmani, Dan Chisholm, Patricio V Marquez, Tim G Evans, Shekhar Saxena

Mental disorders, such as depression, anxiety, and substance use disorders, impose an enormous global disease burden that leads to premature mortality and affects functioning and quality of life. If left untreated, mental disorders can result in worse treatment adherence and outcomes for commonly co-occurring diseases, such as tuberculosis, diabetes, cardiovascular disease, and cancer. Yet parity between mental and physical health conditions remains a distant ideal. Poor mental health also impacts on economic development through lost production and consumption opportunities at both the individual and societal level. Unfolding tragedies, such as the conflict in Syria, displaced populations in Colombia, the burgeoning refugee crisis in the Middle East and Europe, and reconstruction efforts after natural disasters in Japan and Nepal or disease outbreaks such as Ebola virus in west Africa, compound mental health needs of affected populations. But the mental health aspect of these crises is often overlooked.
Developments in healthcare – a systematic approach

1. RESEARCH/EVIDENCE
2. Audit/improvement methodology
3. Strategy
4. Practice
5. Policy
The role of an NHS Secondee in Government

• Reshaping Care and Mental Health Division
• Bring NHS based clinical and managerial experience to strategic thinking and policy development
• Translate ideas and drivers into workable propositions
• Help problem solve
• Professional representation
This is what we want to deliver

**Good Clinical Outcomes**
- Effective assessments
- Effective and evidence-based treatments

**Patient Centred Services**
- Fast access to services
- Local access to services
- Quality clinical services

We can do this by ensuring:

- Comply with best practice guidance (assessments and treatments)
- Create integrated care pathways
- Provide a comprehensive range of effective CAMH services
- Promote and publicise services

So this is what we need to do:

- The gathering and use of evidence
- Effective planning and management
- The right people with the right skills
- Multi-agency engagement in capacity building
- Adequate resourcing
- User and carer involvement
- Value for money services

We can do this if we have:
The conversation asked three key questions:

1. “What help do we need in Scotland to live healthier lives?”
2. “What areas of health and social care matter most to you?”
3. “Thinking about the future of health and social care services, where should our focus be?”
Why Mental Health Matters to Scotland’s Future

A Scottish Mental Health Partnership Special Briefing Paper

Why mental health matters to Scotland’s future

We aim to:

Increase awareness of the prevalence and consequences of poor mental health in Scotland and influence public attitudes towards people experiencing mental health issues.

Improve the provision, accessibility and quality of mental health services and supports in Scotland, which are person centred, rights based and empowering.

Take a positive approach to considering the potential for systems level and transformational change in support of improved mental health.

Promote parity of esteem between mental and physical health provision and ensure that mental health is considered across policies.
Research - the story in 2005

Lifestyle and physical health in schizophrenia
Moira Connolly & Ciara Kelly

Abstract: People with schizophrenia have a higher risk of mortality from cardiovascular disease, including coronary heart disease and cerebrovascular disease, than does the general population. This increased risk may be related to the presence of comorbid conditions, such as obesity, diabetes, and hypertension, which are common in this population. The risk of premature death in people with schizophrenia is also influenced by lifestyle factors, including smoking, physical inactivity, and poor dietary habits. These lifestyle factors are modifiable and can be targeted in the prevention and management of schizophrenia.

Risk factors
Mortality in schizophrenia is influenced by a variety of factors, including age, sex, and comorbid conditions. Smoking, physical inactivity, and poor dietary habits are common in people with schizophrenia and can contribute to premature mortality. These lifestyle factors are modifiable and can be targeted in the prevention and management of schizophrenia.

Lifestyle
Our lifestyle choices are influenced by a variety of factors, including genetics, environment, and social and cultural factors. In schizophrenia, the illness itself also plays a role. A shift in the social scale associated with unemployment and poverty financial...
Reduced life expectancy in mental illness

(CMO England report 2013 chapter 13)

- People with SMI have life expectancies closer to low/middle income countries
- Substance abuse disorder, schizophrenia and schizoaffective disorder are among the worst
- Excess mortality may be worse in countries without universal healthcare
- Non-help-seeking individuals with depression have 1.5-2 fold increase in mortality rates

**Box 13.1 Candidate causes of excess mortality in people with mental illness**

- Health behaviours e.g. smoking, diet, exercise, alcohol and drugs
- Altered help seeking e.g. delayed presentation, reduced treatment adherence, poor uptake of health screening, impaired mental capacity leading to treatment refusal
- ‘Diagnostic overshadowing’ e.g. failure by health professionals to recognise physical health problems in people with mental disorders
- Discriminatory policies
- Iatrogenic factors e.g. obesity caused by antipsychotic medication
- Social conditions e.g. homelessness, unemployment, poverty
- Suicide and violent victimisation
- Direct physical impacts of mental disorders e.g. changes to immune function
Policy 2014

- BMA
- CMO England
Figure 13.1 Overlap between long-term conditions and mental illness

Long-term conditions: 30% of population of England (approximately 15.4 million people)

Mental illness: 20% of population of England (approximately 10.2 million people)

30% of people with a long-term condition have a mental illness (approximately 4.6 million people)

46% of people with a mental illness have a long-term condition (approximately 4.6 million people)

Health promoting hospitals

The Knowledge Network
Knowledge into Action for Health and Care

HPHS Mental Health Services

In support of CEL (1) 2012 delivery within Mental Health Services, NHS Health Scotland and the Scottish Government are coordinating support for local delivery colleagues to implement health improvement actions within mental health settings.

There are significant health inequality outcomes for those experiencing mental ill health; being more likely to develop type 2 diabetes, coronary heart disease, stroke, respiratory disease and specific cancers (Equal treatment; closing the gap, DRC 2006). The CEL (1) 2012 actions, offering a range of behaviour-change support and setting interventions, can promote and enable patients to improve their physical health through evidence-based support.

For further information, please contact the NHS Health Scotland HPHS Team at: nhs.HeathScotland-HPHSadmin@nhs.net.

Physical Health in Mental Health Services Project

Initial steps to embed CEL (1) 2012 into mental health settings have included the creation of a Physical Health in Mental Health Services (PHIMHS) Project. This project comprises of 3 test of change pilots in NHS Ayrshire & Arran, NHS Forth Valley and NHS Greater Glasgow & Clyde.

The context behind this project was outlined at the inaugural group meeting by Dr Moira Connolly in her presentation “Improving physical health for people with mental illness” (external link). Supported by the Scottish Government’s Leading Improvement Team with quality improvement methodologies, the group are implementing.

Resources
Well Scotland (external link) is intended for professionals who currently work in, or have an interest in the mental health improvement field. It includes:

- Background and current policies
- Mental health for various life stages
- Mental health and inequalities
- Resources and signposting to training and events

Steps for Stress (external link) is intended for the public and covers practical ways to start dealing with stress. It includes:

- 
- 
- 

Key Links
• “In simple terms, this policy aims to support best practice in securing better health outcomes for our patients and enabling them to live longer and healthier lives”

• “We welcome feedback and we want to learn from practice”

• “We want to keep the focus on achieving better outcomes for our patients – it is a duty we all share”
Improving physical health of people with mental illness in NHS GG&C

Physical Health Care - Scaling Up Driver Diagram

- Align key pathway stages with organisational strategy and goals
- Build on management support at all levels
- Engage clinicians including local “Leads”
- Build culture of proactivity for physical healthcare in mental health services
- Embed “don’t just screen – intervene” as a principle and act on it
- Develop competent confident workforce
- Develop strategic links between primary care services and mental health
- Ensure national guidelines and policies are reflected in local guidelines

- Deliver care that meets national standards
- Standardise care at key pathway stages: first episode, admissions and community
- Develop GG&C tools and processes to support pathway development
- Improve processes using Aim tools, PDSA cycles, & other improvement methodologies
- Consider the “harder to reach” and work with primary care to support engagement with health screening and interventions
- Up-skill staff in the application of the physical health care pathway

100% of first episode psychosis patients will have a fully documented first physical health screen and HoLA standards implemented

- Arrest the increase in SMR for people with psychosis in GG&C
- Increase recording of physical health screens on PsyCIS reviews by 50%
- Improve confidence of staff in NH services in knowledge and delivery of physical healthcare by 50%
- Increase the % uptake of CDM services in primary care by people with Psychosis

- Leadership
- Reliable pathway design and implementation
- Maximise efficiencies using electronic means
- Respectful Patient Partnership

- Design processes to assist patients to better manage their physical health
- Design pathway improvement based on information gained about patient experience (questionnaires, focus groups etc.) of the physical health pathway
- Include patients and representatives on local improvement teams
- Involve the patients and representatives in shaping the evaluation

- Improve recording of consultant-based diagnosis to improve PsyCIS capture within mental health services
- Establish sharing of clinical information across primary and secondary care to maximise efforts to implement pathway [permissions required]
- Establish a set of automated reports from registers at optimal frequency with optimal detail for both primary and secondary care
- Utilise electronic media to communicate and receive feedback on ‘scaling up’ learning
We need...

• An ‘overwhelming level of interest’ and strong lobbyists
• A commitment from NHS management to support audit and improvement approaches by clinicians
• The support of academics to lead research in the area of co-morbidities which goes beyond describing the problem
• Those who create evidence need to publicise it in accessible ways
Meeting the physical health challenge across mental health services - by addressing Physical health using Quality improvement, Reliably and Systematically every Time.

Welcome to our fifth bulletin - and thank you for your feedback on the previous issues. We hope you find something relevant to your clinical practice in this issue and as ever we would love to hear your thoughts on the bulletin. To send your feedback simply click ‘Reply’ to this email.

The Editorial Group led by Dr Moira Connolly, Physical Health Lead for NHSGG&C Mental Health Services.

Click to subscribe

Practice Points

Lester tool: Don’t just screen, intervene.

Patients with psychosis or schizophrenia in receipt of antipsychotic medications are at greater risk of morbidity and mortality. The Lester tool is aimed at guiding physical health screening and management in those with psychosis or schizophrenia who are prescribed antipsychotic medication. This accessible assessment and intervention tool based on national guidance can be used by members of the MDT to improve patient’s physical health.
Three questions:

1. Is any of this relevant to mental health policy?

2. What would you be advising policy makers within NHS GG&C?

3. What would you be advising policy makers within Scottish Government?
Addressing physical health inequalities in people with severe mental illness

Professor Daniel Smith: daniel.smith@glasgow.ac.uk
Dr Moira Connolly: moira.connolly@ggc.scot.nhs.uk