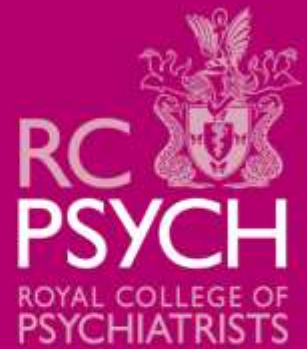


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An Evaluation of the Implementation of the Lester Tool 2014 in Psychiatric Inpatient Settings

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Executive Summary

This report summarises findings from an evaluation carried out by the College Centre for Quality Improvement (CCQI) at the Royal College of Psychiatrists of efforts made by four mental health trusts to improve the physical health of people with severe mental illness in psychiatric inpatient settings. Each trust used funding from NHS England's Sustainable Improvement team (formerly NHS Improving Quality) to support existing programmes aimed at ensuring that people with mental health conditions receive screening, intervention and treatment for physical health problems. Each trust used the Lester tool as a starting point for identifying risk factors for poor cardiovascular health among people with severe mental illness: smoking; lifestyle; weight; hypertension; glucose; and cholesterol.

Pilot sites were awarded between £33,000 and £75,000 to make improvements over one year. The trusts funded by NHS England were 2gether, Northumberland Tyne and Wear (NTW), Tees, Esk and Wear Valleys (TEWV) and Mersey Care. Over the course of 6-9 months, trusts used the funding on a variety of initiatives, including: staff training (all sites); development of new or improved information systems (all sites); networks of physical health link workers or champions (NTW, 2gether); and mapping and development of clinical pathways (NTW, Mersey Care).

Quantitative data collected from pilot sites before and after these initiatives demonstrated increased levels of screening overall, with the proportion of inpatients receiving all five screens increasing from 46% across all sites to 83% and interventions for those needing them increasing from 79% to 94%. Despite these positive findings, a significant minority of patients after the intervention period who had abnormal blood pressure and abnormal blood glucose did not have documented evidence of receiving an intervention.

Interviews with managers and frontline staff highlighted organisational culture, IT systems and enthusiasm of dedicated staff as helping drive the changes. Some concerns were raised that initiatives were doing more to improve the quality of documentation of physical health needs than to improve the quality of care that was delivered. However, most respondents felt that the work had contributed to changing culture in frontline teams to make physical health a much greater priority for staff.

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1. Introduction

In the UK and other high-income countries, life expectancy among people with severe mental illness (SMI) is 20% (13 to 32 years) lower than in the general population (Wahlbeck et al., 2011). Most of the increased mortality is the result of higher levels of physical health problems, particularly cardiovascular disease (CVD) (Saha, Chant, McGrath, 2007). Reasons for this increased vulnerability of people with SMI to CVD include a range of biopsychosocial factors. People with SMI are more likely than members of the general population to be physically inactive, overweight and to smoke tobacco (Compton et al., 2006). Treatment of mental illness is also implicated; antipsychotic medications can cause metabolic changes leading to weight gain and dyslipidaemia, increasing risk of CVD (Daumit et al., 2011; DeHert, Cohen et al., 2011). Critically, with reduction in CVD related mortality in the general population attributed primarily to improvements in diagnosis and treatment, disparity in health care for people with mental disorders is recognised as a public health priority (British Health Foundation, 2014; NHS England, 2015).

People with SMI commonly receive suboptimal care, including misdiagnosis and underdiagnosis of physical health problems (Coghlan et al., 2001). While diverse individual and system related factors shape access to and use of services, stigma and discrimination related to mental illness are repeatedly identified as determinants of care provided (Lawrence & Kisely, 2010). In the UK, premature mortality among people with SMI has been called a 'national scandal' (Thorncroft, 2011) and efforts to improve physical health care for people with SMI are a key component of current mental health strategy (DH, 2011).

The need to improve physical health care for people with severe mental illness was highlighted by findings of the first National Audit of Schizophrenia (NAS, 2014). The audit of the records of 5,091 patients diagnosed with schizophrenia treated in mental health hospitals across England and Wales showed that assessment and treatment of common physical health problems was falling well below acceptable standards. For example, weight or BMI had been recorded for less than half the patients and intervention was provided to just over half (54%) of those patients whose records showed they had high blood pressure. Key recommendations from

the audit were that trusts needed to 'screen and intervene' to improve the poor physical health care and outcomes among people with schizophrenia.

The results of the audit and other work in this area have prompted a number of important initiatives designed to improve the quality of services and reduce morbidity and premature mortality among people with severe mental illness (SMI). These include the development of simple guidance on cardiovascular health for users and providers of mental health services - the '*Lester Cardiometabolic Resource*' (Shiers et al., 2014) - and a national physical health CQUIN (NHSE, 2014), which aims to reward trusts that deliver high quality physical health care in accordance with this guidance.

The '*Lester Cardiometabolic Health Resource*' is based on screening the well-known determinants of cardiovascular disease, bringing together the advice in a number of NICE guidelines for the management of conditions such as diabetes and dyslipidaemia. The flow chart it presents is based on one developed by a team in Australia led by Jackie Curtis and colleagues (Curtis et al., 2012). In consultation with NHS England, NHS Improving Quality (now the NHS England Sustainable Improvement Team) and Public Health England, the team from the National Audit of Schizophrenia adapted the guidance to fit the NHS context. The adaptation, commonly known as the Lester tool, provides a framework of factors that indicate increased risk of poor cardiovascular health and thresholds at which interventions should be offered. As a combined algorithm of current NICE guidelines, it brings together information in a useful way, but the values and cut offs are no different than they are for the non-SMI population. The resource has been widely disseminated through trusts and frontline clinicians and services across England, and is being rolled out nationally by NHS England as part of its work on actions from the Cardiovascular Disease (CVD) Outcomes Strategy. Feedback collected informally by the team running the NAS is that frontline clinicians find the guidance helpful in supporting them to improve and standardise the care provided. However, in the absence of formal evaluation and outcomes studies, little is known about how the Lester tool can best be implemented and what impact it might have on practice related to physical health of people with SMI. This evaluation of the Lester tool implementation in selected pilot sites was commissioned to (a) find out whether the tool is suitable for further roll out and (b) learn lessons that can be

used to inform ongoing improvements in physical health screening and intervention for inpatients.

1.1.1. NHS IQ pilot projects and evaluation aims

NHS England funded four mental health trusts to pilot projects targeting improvement in the cardiovascular health of people with SMI. Detailed characteristics of these trusts, including the number of CCGs they serve, annual turnover, population served, and other information can be found in Appendix 1: Descriptive information for each pilot site.

By introducing the tool into pilot sites, the team hoped to:

- increase the number of patients with SMIs having physical health checks;
- increase the number of appropriate referrals for diabetes, heart disease, renal and stroke in patients with SMIs;
- increase patient satisfaction with care;
- increase staff confidence in dealing with physical health problems;
- encourage the development of more integrated models of delivery for mental and physical health;
- improve relationships and dialogue between mental health units and local primary and secondary care services.

Each of the four projects in trusts across England involve the use of the Lester tool but the contexts and approaches to implementation differ. NHS England provided specialist advice regarding quality improvement and funded a team at the CCQI within the Royal College of Psychiatrists to undertake an external evaluation of the Lester tool implementation in the four pilot sites.¹

¹ See more at: <http://www.nhsiq.nhs.uk/news-events/news/pilots-will-test-ways-to-improve-cardiovascular-health-of-people-with-serious-mental-illness.aspx#sthash.WkJH4ctB.dpuf>

The broad aims of the evaluation were to:

1. Describe the process and impact of implementation of the Lester tool in the pilot sites.
2. Assess the extent to which the Lester tool may be transferable to other groups of patients.

This report describes the methods and findings of the evaluation in relation to the first of these aims. The second aim will be reported on separately.

2. Methodology

2.1. Design

To achieve the aim of describing process and impact of the pilot projects, mixed methods were employed, informed by the tenets of Realistic Evaluation (Pawson & Tilley, 1997). A multiple case study approach was adopted (Yin, 2014) with each case study involving collection and analysis of data in two interlinked work packages:

Work Package 1: the 'outcome audit' was designed to quantitatively assess the impact of the implementation of the Lester tool on levels of screening and intervention.

Work Package 2: qualitative investigation of the process and impact of the pilot activities, was designed to shed light on how and why the outcomes observed in Work Package 1 were achieved.

The four case study sites were selected by NHS England following an application process. The sites were four mental health trusts in England. In each case the objectives of the evaluation were to:

- describe the context in which pilot activities took place, including factors influencing practice in relation to physical health (Trust context);
- describe what was planned under the pilot and the rationale for proposed actions (What was planned);
- describe implementation of the pilot (What was implemented; Pilot activities);
- assess impact and outcomes of the pilot activities (Impact and outcomes; Completion of screening and intervention according to NICE guidelines, as summarised in the Lester tool protocol);
- summarise process and context factors associated with impact and outcomes.

Additionally, to contextualise findings of WP1 and 2, a questionnaire-based survey of service users was conducted across pilot sites. The broad aim of the survey was to develop understanding of perceived need for, and acceptability of, physical health care in mental health hospitals and the community.

2.2. Ethics

The study is an evaluation, not research, so NHS ethics approval was not required. However, to ensure that ethical practice was followed the study was reviewed and approved by the Ethics Committee of the CCQI at the Royal College of Psychiatrists (ref. 2015-1). Site visits were conducted with appropriate approvals from trusts and data were collected with permission and/or informed consent of those involved, as applicable to the type of data collection.

2.3. Service user involvement

Service users were involved in the evaluation in various ways from the outset. An independent service user consultant (AE) worked with the CCQI team to design the evaluation and participated actively in its conduct, contributing to the design and conduct of the service user survey. AE contributed to the design of the topic guide for, and co-facilitated, a focus group with service users conducted to inform the questionnaire design. AE also commented on an earlier draft of the inpatient survey results (Section 3.1. Inpatients' views on physical health screening and intervention: survey results).

2.4. Methods

Data were collected over the course of the evaluation from a range of sources as appropriate to evaluation aims and the objectives of the work packages.

2.4.1. Work Package 1: Outcome audit

Data collection

Audit data were collected by the evaluation team at two time points: baseline and follow up. Each trust received guidance on data collection at baseline (Appendix 2: Guidance on baseline audit data collection and follow up (Appendix 3), and online data submission (Appendix 4) in addition to the data collection tool (Appendix 5).

The pilot sites were given the following options for generating baseline data:

1. Use an online data collection tool.
2. Use a spreadsheet.
3. Use the data they submitted for the mental health CQUIN in January 2015.

The pilot sites were given the following options for generating follow up data:

1. Use an online data collection tool.
2. Use a spreadsheet.

Sampling

For options 1 and 2 at both baseline and follow up, each trust was asked to complete a data collection form/field for each patient that had been selected for inclusion in the evaluation. Trusts were asked to select 100 consecutive case notes from the time period before the implementation of pilot activities, i.e. to establish how things were before the pilot started. The sample needed to consist of inpatients who had a minimum three-night stay.

Follow up data were collected after the implementation of pilot activities to establish if they had an impact on levels of screening and intervention for the Lester tool domains. Again, trusts were asked to select 100 case notes, or as many as they could, from the time period after the implementation of pilot activities. It is important to note that this evaluation did not aim to measure outcomes of interventions for individual patients, which would have required follow up with the same patients after 6 months at least.

The 'start' and 'end' dates for the pilot was a judgment made in consultation with the NHS England Sustainable Improvement Team (SIT), as this was different for each pilot site (see Table 1).

Table 1: Baseline data collection at the pilot sites

Trust	Pilot sites	Baseline data collection finished	Collection method	Sample size
NTW	Inpatient and community	January 2015	CQUIN data*	100
TEWV	Inpatient only	March 2015	Online data collection tool	52
2gether	Inpatient and community	April 2015	Excel spreadsheet	100
Mersey Care	Inpatient only	January 2015	Excel spreadsheet	98
Total sample				328

*CQUIN data were collected using a random sample

Table 2: Follow up data collection at the pilot sites

Trust	Pilot sites	Follow up data collection finished	Collection method	Sample size
NTW	Inpatient and community	30 October 2015	Online data collection tool	100
TEWV	Inpatient only	30 October 2015	Online data collection tool	29
2gether	Inpatient and community	30 October 2015	Online data collection tool	100
Mersey Care	Inpatient only	19 October 2015	Excel spreadsheet	31
Total sample				260

The demographic characteristics of the baseline and follow up audit samples are shown in Appendix 6.

2.4.2. Work Package 2: Qualitative investigation

Data for case studies were collected using a mix of qualitative methods selected as applicable to the aims and nature of the improvement projects in each of the four pilot sites. The majority of data, across sites, was collected using focused participant observation (e.g. sitting with staff to observe their interaction with local IT systems), in-depth interviews and informal conversations with staff and service users. The data were collected during site visits (at or near commencement of pilot activities and around six months later and at meetings and learning events related to the pilot projects, attended by representatives of participating trusts, and in communication with site representatives over the course of the evaluation.

Site visits

Each case study site was visited twice during the evaluation by two members of the evaluation team.

The first visit was primarily 'introductory' - to afford an opportunity for the evaluation team and pilot site representatives to get to know each other and to develop a shared understanding of the aims of the project and its evaluation. The visit lasted one day with a project worker accompanied by a senior researcher (co-applicant Alan Quirk) with expertise in qualitative case study methods. Data collection during this visit was concerned principally with understanding the context and background to the proposed pilot activities and approach.

The second visit was much more immersive, involving a project worker accompanied by the senior researcher observing pilot activities and interviewing key informants. Each visit lasted three to four days with the senior researcher attending for the first two days.

Observations made during site visits and networking meetings were recorded in extensive field notes made by a project worker and checked for accuracy by the senior researcher.

Key informant interviews

A total of 82 key informants were formally interviewed for the evaluation. Half were interviewed individually (41/82), the others in pairs (n=28) or groups (n=13). The interviews gave the evaluation team the opportunity to talk to people who had been involved in and affected by the project, so that implications of the project could be better understood. At each site an initial sample of key informants was drawn up by the site's evaluation lead, in consultation with the evaluation team and NHS England. During the site visits we utilised a 'snowball sampling' approach, where additional key informants were identified through interviews and conversations with the initial sample.

A wide range of informants were interviewed, including nurses, care assistants, health and exercise practitioners, pharmacists, consultants, senior managers and directors of nursing.

Topic guides were developed to address the aims of the evaluation and were used flexibly to enable collection of data appropriate to the context and to encourage informants to explore matters of concern to them. In each instance informants were invited to describe their role in relation to the Lester tool implementation. The full topic guide is presented in Appendix 10. To summarise, the main topic areas were:

- A. **Processes of screening and intervention at the pilot site**, e.g. how, when and where are patients screened for the CVD risk factors covered by the Lester tool and whose responsibility this is.
- B. **Process of the Lester tool implementation and service improvement**, e.g. what have people been doing to implement the Lester tool and what factors have supported or prevented this.
- C. **Cost effectiveness**, e.g. does duplication of effort occur, and is this a barrier to implementation.
- D. **Interface between primary care and secondary care**, e.g. whose responsibility is the patient's physical health when they are in hospital.

Interviews were tape recorded with permission and fully transcribed for analysis.

2.4.3. Service user survey

Questionnaire development

Mersey Care NHS Trust initiated development of a service user survey to evaluate views of mental health inpatients on CVD screening and intervention. The evaluation team began the process by facilitating a focus group with Mersey Care patients. The group discussion was facilitated by the evaluation team's service user consultant with assistance from a project worker. Notes from the focus group are shown in Appendix 8.

Questions were developed from the data generated from the focus group by the evaluation team, together with the service user consultant and Mersey Care. Questions from earlier health surveys (e.g. RAND) were also included. The final version of the inpatient survey questionnaire is shown in Appendix 9.

Distribution

The four pilot sites distributed the questionnaire to self-selecting samples of service users in their trusts. A total of 195 questionnaires were completed by inpatients and included in the analysis.

2.5. Data analysis

2.5.1. Work Package 1: Audit data

Characteristics and the proportion of patients who were screened in accordance with recommendations in the Lester tool audits were calculated, and the characteristics and proportion of patients who received interventions for their physical health were compared before and after the initiatives were introduced.

Caution is required when interpreting cholesterol screening data.

The case study reports (Section 3.2) present data on the proportion of patients whose cholesterol screening results indicated the need for an intervention. The low levels of interventions indicated need to be interpreted with caution.

The audit data collection instrument was cloned from the one used to collect data for the national physical health CQUIN (see Appendix 5). This means that for each case, total cholesterol (mmol/l) and/or non-HDL (mmol/l) and/or QRISK-2 scores (%) were collected. The QRISK-2 Tool is a prediction algorithm for CVD that uses risk factors, such as age, blood pressure, smoking status, ratio of total cholesterol to HDL cholesterol, diabetes, blood pressure treatment, body mass index and ethnicity to calculate the risk of someone having a heart attack or stroke within the next 10 years.

Following NICE guidelines (CG81), published in July 2014 the Lester tool recommends that intervention should be offered to patients falling into any one of the following categories:

1. Total cholesterol >9
2. Non-HDL (high density lipoprotein) cholesterol >7.5
3. QRISK-2 score >10 (i.e. >10% risk of a CVD event over the next 10 years)

Feedback received from pilot site leads was that the threshold of intervention based on cholesterol results alone is set quite high, whereas if the same cholesterol results had been fed into the QRISK tool, intervention might have been indicated at lower cholesterol levels, because other risk factors are taken into account.² This means that while the cholesterol screening results are technically correct, the threshold for intervention was probably higher than it would have been had QRISK-2 scores been used, thus underestimating the need for interventions. In addition, due to the way in which the QRISK-2 algorithm considers age as a risk, using QRISK-2 for service users under the age of 40 can sometimes result in lower levels of intervention for elevated blood lipids than for their older counterparts. As many of the service users included in the pilot are under 40, they will rarely reach a 10 year CVD risk of greater than 10%, which is the trigger for an intervention set by NICE. This is a problem with regards to lipid intervention because the NICE lipid guidelines only suggest statins if the 10 year risk is above 10%.

² For patients where a QRISK score had been entered, the calculation as to whether an intervention for dyslipidaemia was required was double checked to ensure that it was supported by the QRISK score.

2.5.2. Work Package 2: Qualitative data

Data from interviews and field notes were analysed by members of the evaluation team using a modified framework approach (Gale et al. 2013). After developing familiarity with each data item and the body of data, team members coded data using a coding framework (see Appendix 12). Data were then charted and a process of constant comparison was used to discern patterns.

2.5.3. Integrating the two work packages

To help integrate the two work packages and coherent case study reports, we presented the results of the outcome audit at a meeting with all pilot sites, and asked informants if they could account for the changes in screening and intervention recorded between baseline and follow up. People's feedback were recorded with permission, typed up and analysed alongside the other qualitative data.

2.5.4. Service user survey

Data from service user questionnaires returned to the evaluation team were entered onto SPSS for descriptive analysis.

3. Results

In this section we start by presenting the results of the service user survey to provide some context for the four case studies of the Lester tool implementation that follow.

3.1. Inpatients' views on physical health screening and intervention: survey results

This section presents the results of a questionnaire-based survey of inpatients conducted for the evaluation. Data collection and analysis are described in the methods (Section 2.4.3).

The evaluation team received 206 questionnaires from across the four pilot sites between July and September 2015. Eleven were excluded from analysis because the respondent reported being an outpatient or did not respond to this question. Thus, data from 195 questionnaires from the four pilot sites (TEWV=83; NTW=39; Mersey Care=48; 2gether=25) were included in the analysis.

3.1.1 Demographics and care settings

Respondent demographics are summarised in Table 3.

The sample included more men (n=114; 59%) than women (n=68; 35%) (missing, n=13; 7%). The vast majority were aged between 26 and 65 years and identified as White British. Just over half (103; 53%) of the 185 respondents who completed the item reported being treated on an acute ward or PICU.

Table 3: Respondent demographics (n=195)

Demographic characteristics; ward setting		N	%
Ward	PICU	8	4%
	Acute	95	49%
	Rehabilitation	59	30%
	Other	23	12%
	Did not state	10	5%
Gender	Male	114	59%
	Female	68	35%
	Did not state	13	7%
Age	18-25	42	22%
	26-45	83	43%
	46-65	64	33%
	Over 65	5	3%
	Did not state	1	1%
Ethnicity	White British	168	87%
	Other White	3	2%
	background	8	4%
	Mixed	2	1%
	Asian/Asian British	6	3%
	Black/Black British	0	0%
	Chinese	2	1%
	Other	6	3%
	Did not state		

3.1.2. Self-reported physical health status and concern about physical health

Respondents were asked to rate their physical health 'in general' on a five-point scale anchored by 'very good' and 'very poor' (n=194), and their concern about their physical health, with options ranging from 'a lot' to 'not at all' concerned (n=193). Minorities of respondents rated their health as 'very good' (n=26; 13%) or 'very poor' (n=8; 0.4%). With around one-fifth (n=40) of respondents rating health as 'poor' or 'very poor', health was most commonly rated as OK (n=81; 42%).

Less than one-quarter (n=45; 23%) of respondents reported being 'not at all concerned' about physical health. Just under half reported being either 'a little'

(n=47; 24%) or 'moderately' (n=42; 22%) concerned, with nearly one-third (n=59; 31%) reporting substantial ('quite a bit' or 'a lot') concern.

Table 4 summarises reported physical health status by health concern, gender, age group and ethnicity. No discernible patterns in physical health status or concern with regards to age group, gender or ethnicity were found. There did appear to be some, albeit inconsistent relationship, however, between reported physical health status and concern. Almost two-thirds (24/40; 60%) of those respondents reporting 'poor' or 'very poor' physical health rated themselves as 'a lot' or 'quite a bit concerned' about their physical health. Respondents reporting being 'not at all' or 'a little' concerned about their physical health typically rated their physical health as 'OK', 'good', or 'very good' (82/91; 90%). Few of those respondents who reported little or no concern about their health rated it as 'poor' or 'very poor' (9/91; 10%). However, the majority of those who were 'a lot' (13/23; 57%) or 'quite a bit' (22/36; 61%) concerned about their physical health rated it as 'OK', 'good' or 'very good' (total 35/59; 59%).

Table 4: Respondents' reported physical health status with regards to health concern, gender, age group and ethnicity

Health status		Very good N (%)	Good N (%)	OK N (%)	Poor N (%)	Very poor N (%)	Total
Health concern	A lot concerned	4 (17%)	3 (13%)	6 (26%)	5 (22%)	5 (22%)	23
	Quite a bit concerned	0 (0%)	10 (28%)	12 (33%)	13 (36%)	1 (3%)	36
	Moderately concerned	3 (7%)	8 (19%)	25 (60%)	6 (14%)	0 (0%)	42
	A little concerned	4 (9%)	14 (30%)	21 (46%)	7 (15%)	0 (0%)	46
	Not at all concerned	15 (33%)	12 (27%)	16 (36%)	0 (0%)	2 (4%)	45
	Total	26	47	80	31	8	192
Gender	Male	20 (18%)	27 (24%)	48 (42%)	16 (14%)	2 (2%)	113
	Female	5 (7%)	19 (30%)	25 (37%)	14 (21%)	5 (7%)	68
	Total	25	46	73	30	7	181
Age	18-25	4 (10%)	7 (17%)	24 (57%)	7 (17%)	0 (0%)	42
	26-45	16 (19%)	21 (25%)	32 (39%)	12 (14%)	2 (2%)	83
	46-65	6 (10%)	18 (29%)	22 (35%)	11 (17%)	6 (10%)	63
	Over 65	0 (0%)	1 (20%)	2 (40%)	2 (40%)	0 (0%)	5
	Total	26	47	80	32	8	193
Ethnicity	White British	22 (13%)	44 (26%)	68 (41%)	26 (16%)	7 (4%)	167
	All other ethnicities	4 (19%)	2 (10%)	11 (52%)	3 (14%)	1 (5%)	21
	Total	26	46	79	29	8	188

3.1.3. Confidence in mental health team

Respondents were asked to rate their level of confidence that their mental health team takes their physical health concerns seriously, on a five point scale anchored by 'very' and 'not at all'. Most people who responded (156/186; 84%) reported being at least 'somewhat' confident, with 52 (27%) of respondents selecting 'very confident'. Few respondents (n=10; 5%) indicated that they were 'not at all' confident.

3.1.4. Help seeking when medication adversely affects physical health

Respondents were asked to nominate who they would speak to if they thought their mental health medication 'was having a bad effect on' their physical health. Responses are summarized in Table 5. As shown, around half the respondents nominated their care coordinators. Pharmacists (n=3) were rarely mentioned and eight respondents selected 'none'.

Table 5: Responses to question: Which health care professional(s) would you speak to if you thought your medication for your mental health was having a bad effect on your physical health?

Health care professional	N	%
Care coordinator	104	54%
GP	94	49%
Psychiatrist	91	47%
Nursing staff	30	16%
Other	21	11%
Summary		
Chose one or more professional	183	95%
Chose only 'other'	2	1%
Chose 'None'	8	4%

3.1.5. Sources of health related information and advice

Respondents were asked to identify sources of information about 'how to be physically fit and healthy', either when they are in hospital or in the community, by selecting from a list of possible sources (Table 6). This item was completed by 190 respondents. 'Care coordinator' was the most commonly identified source of information (n=65; 40%), which may reflect frequency of contact.³ GPs and family/friends were roughly on a par as the next most common source, each selected as a source of information by just under one-third of respondents. Fewer respondents indicated that they sought this information from psychiatrists, nursing staff and the internet.

Table 6: Where do you get information about how to be physically fit and healthy?

Information source	N	%
Care coordinator	75	40%
GP	61	32%
Friends/family	56	30%
Leaflets	46	24%
Psychiatrist	40	21%
Internet	39	21%
Nursing staff	21	11%
Other	36	19%
Summary		
Chose one or more information source	148	78%
Chose only 'other'	19	10%
Chose 'none'	23	12%

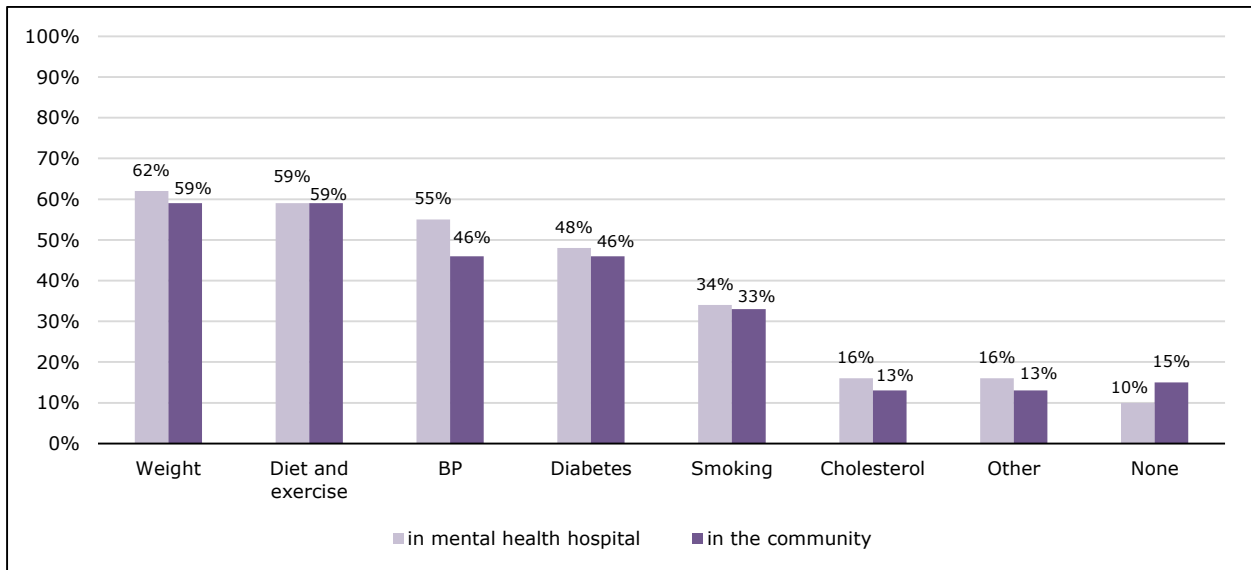
³ For example, service users living in the community are typically likely to see their care coordinator much more frequently than they see their psychiatrist

3.1.6. Tests and support wanted in hospital and the community

Respondents were asked to indicate whether, and which of a range of physical health related tests (screening) or support (interventions) they would like to receive in the community and when in a mental health hospital. A text box was provided for respondents to report other tests they would like, as well as an option stating '*None – I do not want any of these types of testing and support*'. The vast majority of respondents reported wanting one or more of the specified tests both in a mental health hospital and in the community (89% and 83% respectively), with only 10% and 15% respectively indicating they did not want any of these types of testing.

The proportions of respondents wanting particular tests in either environment varied widely, as shown in Figure 1. Whereas around 60% of respondents reported wanting their weight to be monitored in each environment, minorities ($\leq 16\%$) wanted blood testing to check cholesterol levels in either. Around half of the respondents indicated they wanted blood pressure tests while in a mental health hospital, with slightly more seeking this in hospital (55%) than in the community (46%). While most (59%) wanted support in relation to diet and exercise in both settings, support to help cut down or quit smoking was wanted by only a third in either environment, despite current national moves towards smoke-free inpatient environments.

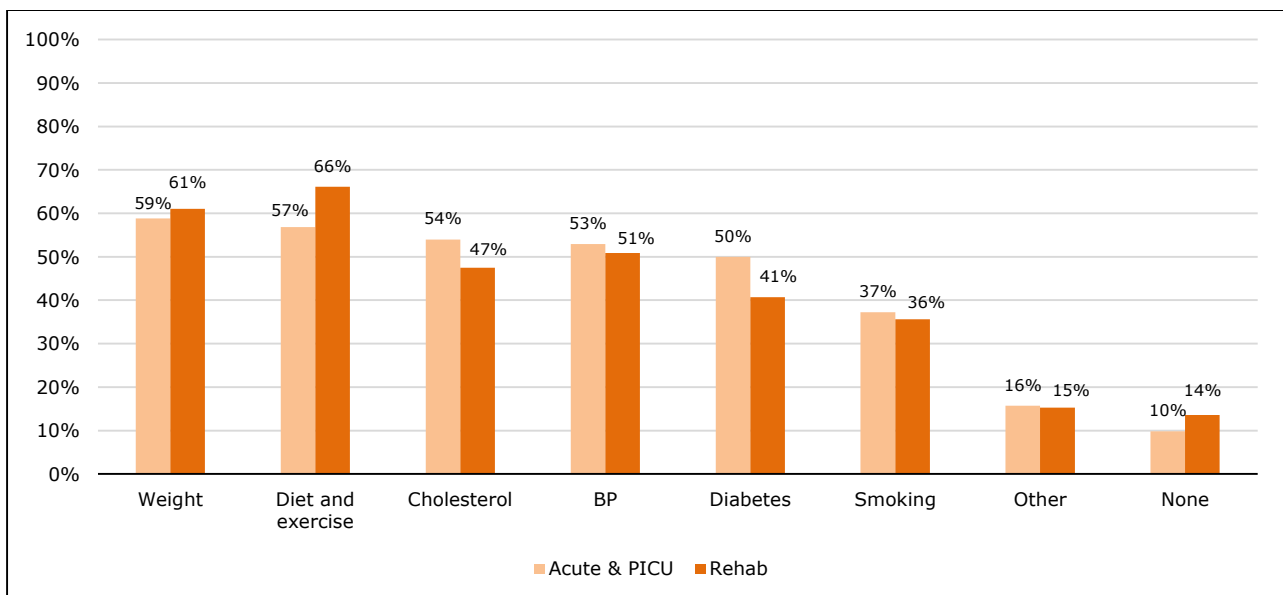
Figure 1: Proportion of respondents wanting assessment of physical health problems in hospital and in the community*



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

Figure 2 depicts the proportions of respondents in given care (acute and PICU vs rehabilitation) settings seeking one or more of the specified tests or support. As shown, the proportions of respondents wanting given tests was similar across settings.

Figure 2: Proportion of respondents wanting assessment of physical health problems in acute/PICU wards and rehabilitation wards



3.1.7. Impact of mental health problems and hospital admission on physical health

Respondents were asked in three separate questions whether and how their mental health problems, and being in a mental health hospital, affected their ability to 'be' physically fit and healthy.

Respondents were asked to rate the frequency (on a scale from always to never) with which their mental health problems stopped them being physically fit and healthy. Nearly three-quarters of respondents (141/191; 74%) reported that their mental health problems stopped them being physically fit and healthy at least some of the time.

When asked whether being admitted to a hospital made it harder to keep fit, 74 (40%) said it did, 56 (30%) that it made no difference and 56 (30%) that it was easier to keep fit while in hospital. Comparison of responses by care setting (short stay acute/PICU vs long stay rehabilitation wards) demonstrated differences in views among respondents. Greater proportions of respondents from acute and PICU (49%) than rehabilitation (23%) ward settings reported that being in hospital made it harder to keep fit and conversely, more respondents from rehabilitation (43%) than acute and PICU (24%) settings reported that it made no difference.

Similarly mixed views were found in relation to the impact of being in hospital on the ability to eat healthily. Nearly half (n=90; 48%) of the 188 respondents who answered this item reported that being in a mental health hospital made eating healthily easier. Around one in four (n=45; 24%) reported that it made no difference, with others (n=53; 28%) reporting it made it harder. Again, responses varied by the ward setting. A greater proportion of respondents from PICU or acute settings (32%) reported that being in a mental health hospital made it harder to eat healthily than respondents in rehabilitation settings (24%).

The 82 free text comments provided shed light on these responses.

Some respondents reported that being in hospital enabled access to meals that would not normally be available to them, either due to cost or capability.

When in the community I eat junk food and hospital provides vegetables, salads and gym.

If was at home I wouldn't cook very much. If did would be very basic.

Conversely some respondents reported that limited choice (especially vegetarian options), a lack of availability of healthy foods such as fruit or salad and poor quality food made eating healthily more difficult. Moreover institutional timetables were considered problematic by some.

Set mealtimes aren't good (and set meals). Limited to when and what you can eat. Should be able to buy own food and keep in kitchen.

Some noted that boredom in the hospital environment led to a desire to eat unhealthy snacks.

Encouragement, guidance and advice available in the hospital was described by some as promoting healthy eating.

Meals are healthy and you are encouraged to have your meals. When you live on your own you have no-one to keep an eye on eating healthily.

Similarly, some respondents reported that being able to access a gymnasium and other 'keep fit' activities that would not necessarily be either available or affordable when in the community made it easier to keep fit than otherwise.

I have enrolled with the gym and use the OT service. All the staff have been first class. The OT staff are very open and receptive. I have toned up during my stay with the particular help of [named person] in the gym. I have almost had a personal trainer and all the staff have helped me feel better about myself.

Being in mental health hospital means opportunities can be found to get into the gym and monitor my physical health while I'm exercising.

You have a professional instructor to guide you over the barriers of anxiety about going to a gym.

Whereas some described the environment and support available as encouraging engagement in activities, others reported that the symptoms of mental illness or the hospital environment led to low motivation and disinclination to engage in health promoting activities.

Gym or exercise time is limited to certain times in the day and I can't always attend. If the gym was open throughout the day it would be easier. Being depressed and on medication makes the motivation suffer.

Constraints on freedom of movement and the perceived adequacy of facilities was also described as influencing ability to keep fit.

If I was in the community I could do more activities for example long walks and bike rides.

I feel that it's not uncommon for me to be physically healthy but I find it hard motivating myself and sometimes feel that a psychiatric hospital isn't always the best place to keep fit - mainly based on the equipment and/or facilities that are offered up to me.

3.1.8. Summary

The survey was designed to elicit inpatients' views on CVD screening and intervention in mental health hospitals and the community. The four pilot sites distributed questionnaires to service users in their trust. A total of 195 questionnaires were completed and included in the analysis (see Section 2.4.3).

Nearly one third of respondents (31%) reported substantial ('quite a bit' or 'a lot') concern about their physical health. The large majority of respondents (84%) reported being at least 'somewhat' confident that their mental health team takes their physical health concerns seriously. Care coordinators were the most commonly identified source of information about how to be physically fit and healthy.

We found no discernible pattern in perceived health status and concern with regards to age group, gender or ethnicity and there was an inconsistent

relationship between health status and concern. For example, while only 10% of those respondents who reported little or no concern about their physical health rated it as 'poor' or 'very poor', the majority (59%) who reported substantial concern about their physical health rated it as 'OK', 'good' or 'very good'.

Across all sites 89% of service users reported wanting one or more tests or support when in a mental health hospital. That noted, the acceptability of particular tests varied widely: around 60% of respondents wanted their weight monitored in hospital or the community, compared with the minorities ($\leq 16\%$) who wanted blood testing to check cholesterol levels in either environment.

For some respondents, being admitted to hospital made it harder to keep fit and eat healthily (e.g. through having restricted choice over food and constraints on freedom of movement) while for others it made it easier (e.g. where the hospital enabled access to meals and activities to keep fit that were not available or affordable in the community).

3.2. Case studies

3.2.1. Influences on CVD screening and intervention that pilot sites addressed

This part of the report presents the four case study reports in turn. In each we present data on the changes in CVD screening and intervention achieved in the 6 – 9 months between baseline and follow up, and use qualitative data to shed light on how and why those changes occurred. We have defined the quality of screening and intervention in the audit data according to the following categories: Low = less than 50%, Moderate = 50-74%, High = 75-89%, Very high = >90%.

Each pilot site produced a Project Initiation document (PID) for NHS England, which specified objectives and how they would be achieved. From these, we have identified various constructs perceived by the pilot sites to influence the rate and quality of CVD screening and intervention in psychiatric inpatient settings (see Figure 3).

Figure 3: Perceived influences on the amount and quality of CVD screening and intervention in psychiatric inpatient settings*



*As identified in the Project Initiation Documents produced by the four pilot projects for NHS England.

While each site aimed to address their own unique combination of these influences (or 'causal mechanisms', to use realistic evaluation terminology⁴), all focussed on improving the efficiency of their information systems and upskilling staff through training.

⁴ See Pawson & Tilley, 1997

3.2.2. 2gether case study report

Introduction

2gether NHS Foundation Trust provides a wide range of mental and social health care services across two counties encompassing rural and urban areas. The majority of the catchment population of around 780,500 is predominately white British. Services are community based, delivered by teams to people who meet identified criteria, with links to day care services and inpatient acute and rehabilitation care. The trust additionally delivers specialist IAPT, early intervention, eating disorders and drug and alcohol services.

Trust context

The trust had been working in recent years to improve the physical health care provided and outcomes for service users. Commitment to enacting the national policy agenda was evidenced in various ways, at strategic and operational levels.

Strategic documents articulate a commitment to improving the physical health of people with mental illness and other service users; 'Improve the physical care of people with schizophrenia' is first among seven specific goals aligned to the NHS Outcomes Framework. This commitment was strongly endorsed by staff who took part in interviews.

No-one would argue that it's the right thing to do, the National Audit of Schizophrenia data and our lack of success on our physical health component gives all the compelling information of why we should focus on this organisationally. [Senior nurse]

Senior trust staff commonly reported high levels of awareness of 'compelling' evidence regarding poor health outcomes with SMI and the findings of the National Audit of Schizophrenia, and also spoke of pressure to adhere to NICE guidelines. However they emphasised that the primary motivation of the trust in pursuing practice improvement was driven by a belief that it was 'the right thing to do'.

We want to do a good job for our services users ... you use compelling information as levers for changes ... like a virtuous cycle really of information and events. [Senior trust Manager]

The trust reports participation in an NHS Patient Safety Network physical health improvement group and active involvement with the CQUIN, using the Lester tool. The CQUIN particularly was seen as promoting and embedding good practice in relation to physical health care.

CQUINs always help, in my opinion... [to] push an agenda and try to change practice really or influence practice... [The CQUIN is] what we'd been waiting for almost, because we'd done a lot of work behind the scenes. [Senior Nurse]

The trust has an established expert reference group: the Physical Health Clinical Expert Reference Group (PH CERG) comprising of senior staff from a range of disciplines who provide oversight of physical health issues that affect the trust, such as CQUIN activities, and promote practice development. To 'add authority' and promote engagement of medical staff in integration of physical health care in the services provided by the trust, the group is chaired by a consultant psychiatrist. The pilot proposal and application for pilot funding was generated by members of the PHCERG and thus had top level trust support.

Senior frontline staff were described as 'being on board' and familiar with the Lester tool, in part due to overlap with the National Early Warning Score (NEWS) tool implemented in the trust in 2012 to monitor the health of service users within inpatient services.

The trust has for many years employed Health and Exercise Practitioners (with career progression to Band 7) to monitor patients' physical health and support them to lead a healthy lifestyle. A 'health facilitation' role (see below) with responsibility for championing, developing and spreading best practice in physical health facilitation across the trust, in line with the Lester tool, had been temporarily established just prior to the pilot.

However documents and site visits also highlighted challenges to the trust's efforts to improving the health outcomes of service users that contributed to the application for pilot funding. Key concerns identified related to:

- Organisation of health care
 - funding of the trust by two CCGs, meaning that different parts of the trust had access to different services and difficulties negotiating access to specialist care;
 - inconsistent quality of communication and pathways for joined up working between primary and secondary care to enable timely access for patients needing support outside the mental health trust (reliance on 'gentlemen's agreements');
 - difficulties sharing information between providers related to confidentiality and the incompatibility of IT systems.
- Workforce
 - variable skill mix relating to physical health amongst staff teams, which could impact on levels of engagement;
 - staff turnover and use of bank workers making it difficult to embed new practices and processes.
- Patients
 - high patient turnover and throughput, meaning constraints on opportunities to intervene (particularly in acute inpatient settings);
 - acuity of presentation making mental health care the priority (particularly in acute inpatient settings);
 - patient expectations and relative acceptability of interventions.

What was planned?

The trust proposed in their application for funding as a pilot site and PID that funding would be used to 'further establish' the health facilitation role (see above) with a view to expanding the scope and reach of work related to physical health.

We are planning to expand the remit beyond the scope of the Lester tool and improve access to other physical health care such as sexual health and dental care for example. [Senior nurse]

Reflecting the challenges outlined above, the PID articulated the view that a collaborative approach was critical to provision of the holistic care needed to improve outcomes. Thus building partnerships and capacity, and enhanced communication of physical health information between secondary and primary care were central to pilot activity. The project team planned to develop documentation and communication tools, proposing:

Design and implementation of a simple and sustainable process and a range of activities including; development of processes and procedures, implementation of staff coaching, facilitated workshops, intranet resources, improved clinical equipment availability and other media.

The PID specified various interventions including ensuring community hubs had access to 'the necessary clinical equipment', opening lines of communication by editing an existing letter to GPs to include a request for information regarding physical health of service users. Interventions were further specified in the Project Deliverables Matrix prepared by the trust.

In other documents, incorporation of the Lester tool on RiO (the trust's IT system) to monitor and track progress (including care planning and progress notes), and ongoing provision of support to staff were identified as tasks to enable implementation of the Lester tool in inpatient units.

A series of objectives specified target rates of completion of screening and intervention:

e.g. Lester tool completion across 95% of inpatients prescribed anti-psychotics or mood stabilisers by December 2015 with clearly demonstrated onward referrals for further interventions as required by the Lester Care Plan for 100% of patients screened.

Achievement of objectives, specified in terms of rates of screening and intervention (e.g. above), was described in the PID as benefitting diverse stakeholders.

What was implemented?

Funding awarded to 2gether was £75,000. This funding was applied primarily to employment of a Band 6 nurse in the existing health facilitation role, for 12 months, enabling dedication of time and expertise to further the work underway. The general purpose of the role was to lead improvement of physical health care in a range of trust settings. The job description included delivery of clinical care, specifically engaging in complex physical health assessments as appropriate and planning relevant care in partnership with services users. The incumbent was also to contribute to planning and delivery of education for staff within and external to the trust and to contribute to service development and quality initiatives in line with local and national policies. Though not specified in the job description, the incumbent was also to undertake a range of activities to embed the use of the Lester tool in inpatient assessment and care processes.

Funds were also used to support implementation of the Lester tool; around £3,000 were allocated to costs associated with venues for education, educational events, printing, clinical equipment and materials.

The pilot was overseen by the PHCERG of which the Health Facilitator was a member with leadership provided by the Deputy Director of Nursing.

Pilot activities

Our approach has been a reflective and considered approach constantly...we think through how we're going to deliver this issue, how do we get it well known... think of what success looks like and work backwards. [Senior nurse]

Pilot activity focused during the evaluation period on inpatient settings (acute and rehabilitation wards) with a view to rolling out across community teams as the project developed. Key targets for the activities were:

- information technology, management and communication;
- capability and motivation of frontline staff;
- establishment of clarity of responsibility and accountability for delivery of physical health care.

In addition to acting as an 'ambassador' promoting attention to physical health across the trust, the Health Facilitator led on, and undertook a range of activities to support implementation of the Lester tool. The primary activity was incorporation of the Lester tool in the routinely used paper based nursing assessment tool (Essence of Care) as well as a Lester tool Care Plan which was embedded on the trust-wide electronic record systems.

Additional activities included:

- design and delivery of training to promote and support use of the Lester tool processes;
- provision of coaching to individual staff members to build confidence and skills in screening and intervention;
- development of processes and resources to support staff to complete and record screening;
- establishment of processes to enable communication of blood test results to team (allocation of responsibility to administrator);
- establishment of processes/procedures to communicate with doctor (allocation of responsibility to administrator);
- provision of support to managers to prioritise physical health.

The Health Facilitator also took a lead role in revision and development of the trust's Physical Health Policy to support ongoing practice development. The policy specifies roles and responsibilities of each locality and job role, and time scales for each physical health screening and intervention duty. From the funder NHS England's perspective, this was considered one of the greatest achievements of the

project in terms of making roles and responsibilities absolutely clear and joining up the trust's approach to physical health care.

Other project related activities and processes identified in site visits and interviews were:

- nomination of staff as 'link workers' or champions to coordinate and promote screening and intervention;
- incorporation of training regarding blood tests in the induction provided to junior doctors.

Impact and outcomes

That's part of the admission process, the Lester care plan, it's in the admission checklist. We don't sign that off until the whole checklist is completed. [Ward manager]

Data indicate that the activities undertaken by the Health Facilitator under the auspices of the pilot served to further embed attention to physical health in clinical practice in inpatient units. Interviewed staff reported that having the Lester tool integrated with the nursing assessment tool and the care plan on RiO provided structure and streamlined processes, serving to 'tighten up' or formalise practice. Along with this, documentation of who should do what and when, in policy was described as increasing clarity about roles and responsibilities in relation to physical health.

Inclusion of blood tests for lipids and glucose in admission processes was described as promoting performance of these tests, particularly. More generally staff were described as becoming more proactive and comfortable with screening. Some informants spoke of enhanced interdisciplinary working around physical health with members of the MDT considered more likely to 'look at other aspects like smoking, BMI and exercise'.

A bit easier in terms of making it all a bit more focused. [Frontline staff]

Not all informants found the Lester tool easy to use on RiO, with the system described as less easy to manage than paperwork. However, having a single point of reference (on one screen) for patients' physical health monitoring and intervention information, and associated guidance, was described as enabling monitoring of practice such that any outstanding screening or intervention could be 'flagged until it's done'.

Formalisation of the processes of screening, intervention and recording was commonly regarded as a 'good thing' but some clinicians noted that greater formality required more time and changed ways in which care was delivered. Whereas advice about smoking may previously have been given 'over a cup of coffee' a more structured approach was being adopted to enable documentation. Some concern was also expressed in relation to shifting of responsibility for various activities to 'other' disciplines, such as the reallocation of certain screening tasks from nurses to Health and Exercise Practitioners.

Completion of screening and intervention as per the Lester tool protocol

The trust submitted audit data for 100 patients at baseline and follow up. The data were collected from all inpatient services trust-wide (Herefordshire and Gloucestershire) including acute, PICU, low secure, learning disabilities and older adult wards.

Screening

Data in relation to screening were descriptively summarised in two ways: by Lester tool domain (Figure 4) to quantify the number of patients for whom screening was completed or refused and by patient to assess the completeness of screening (Figure 5).

As shown in Figure 4, very high (>90%) rates of screening at baseline for weight, smoking and hypertension were maintained at follow up with 100% of patients for whom data were returned being screened in each of these domains. Improvement was observed in rates of screening for glucose (moderate to high) and cholesterol (low to high).

As shown in Figure 5, which graphically represents the proportions of patients screened (including refusals of screening) in 1, 2, 3, 4 or all 5 Lester tool domains, (including refusals) at baseline then follow up, a substantial shift was observed in the patient screening profile. Complete screening (all five domains) was recorded for around one-quarter of patients at baseline but nearly all (92%) at follow up, with the remaining 8% being screened in four domains.

Intervention

At baseline, the majority (>60%) of those screening 'in the Lester tool red zone' (i.e. needing an intervention) in each domain were offered an intervention (see Figure 6) with very high rates of intervention in relation to weight. A range of interventions were offered in respect of each domain. Most commonly offered were, in relation to smoking 'brief intervention' and, in relation to weight 'advice or referral about exercise' and less frequently 'advice or referral about diet'. These data are consistent with observations of staff that attention to physical health was 'normal practice' before the pilot:

I think that even before the Lester tool I think we were doing these things.
[Frontline nurse]

At follow up, increases were observed in the proportions of people offered an intervention where screening indicated it was needed, in each domain *except* glucose. Noteworthy is the increase in documented offer of intervention for smoking from two-thirds (of 42) to 100% (n=55) of smokers. However a substantial increase was also observed in 'refusal' of intervention from 9/28 (32%) to 39/55 (70%). The slight increase in recorded offer of intervention in relation to weight was also accompanied by an increased rate of documented refusal.

Explaining the changes

Invited to comment on rates of screening and intervention at baseline and follow up (and to account for changes) key informants spoke primarily of the integration of the Lester tool care plan in RiO (prompting and facilitating documentation) but also identified greater clarity about responsibilities for completion and appreciation of the need for practice development.

Observed changes in relation to screening and intervention for smoking (including increased refusals of intervention), weight and hypertension were primarily related to changes in recording and access to data rather than practice. Increased recording was attributed to integration of the Lester tool within routine nursing assessment tools and embedding the Lester tool Care Plan on the trust IT system leading to visibility and affording the opportunity to record conversations. It was also noted that medical staff had been asked to document blood pressure for every admission; whereas they might have previously recorded 'clinical obs' completed' they were now detailing the readings.

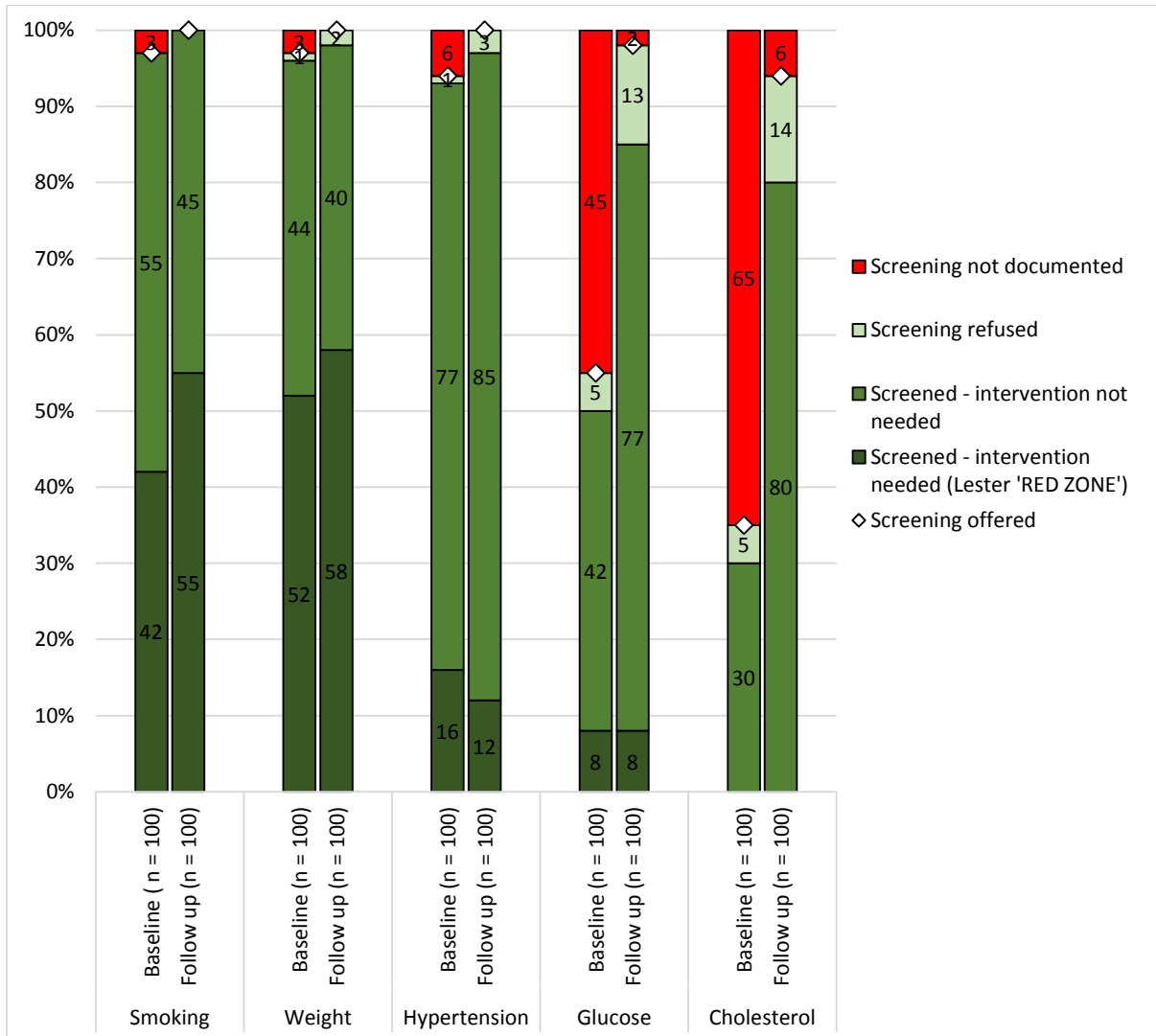
Changes in relation to glucose and blood pressure however, were considered more likely to reflect a 'real' change in practice. Informants noted that junior doctors who were responsible for obtaining baseline blood samples on admission and blood pressure for each admission were now routinely receiving an introduction to the physical health policy and expectations of practice in their induction. Practice was also thought to have been influenced by the introduction of link workers on the wards – these 'link workers' acted as champions for physical health care, prompting doctors when expected tests had not been completed and/or recorded in the appropriate way and supporting medical staff by providing information as needed. Training around QRISK was included in the training packages for nurses and medics. The trust has predominantly recommended its use if lipids readings are slightly too high, or to engage with primary care services. Feedback was offered via training package (ward specific) and updates on ward progress were given via telephone and email. This was reportedly variable, but ultimately, the trust will be aiming for monthly feedback.

[Link workers] also prompt other nurses if the Essence of Care hasn't been fully completed. They'll just sweep up anything that has been missed.

[Health Facilitator]

In relation to very high rates of intervention (and low refusal rates) for weight, informants noted that patients were commonly concerned about their weight and therefore welcomed interventions.

Figure 4: Completion of screening in 2gether pilot sites by Lester tool domain



Note: Caution is required when interpreting cholesterol screening results (see pg. 17)

Figure 5: Completed screenings in 2gether pilot sites by patient

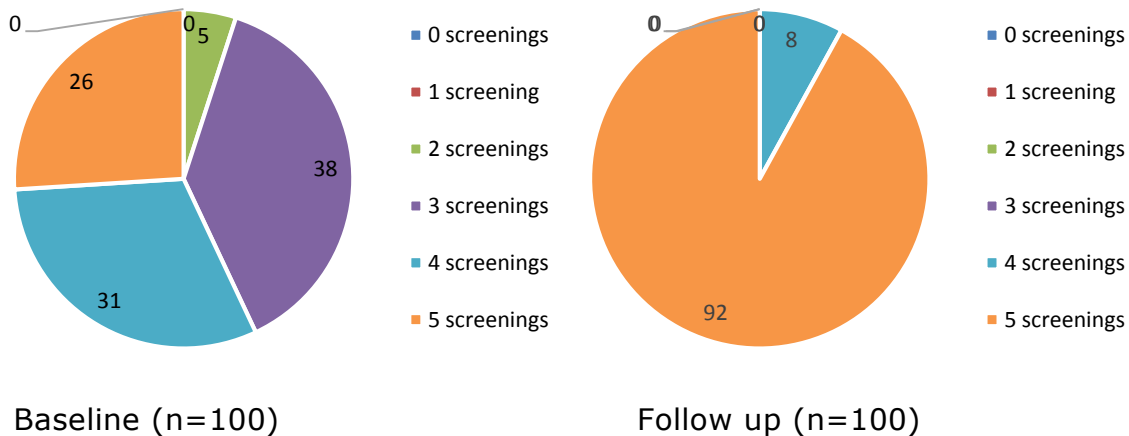
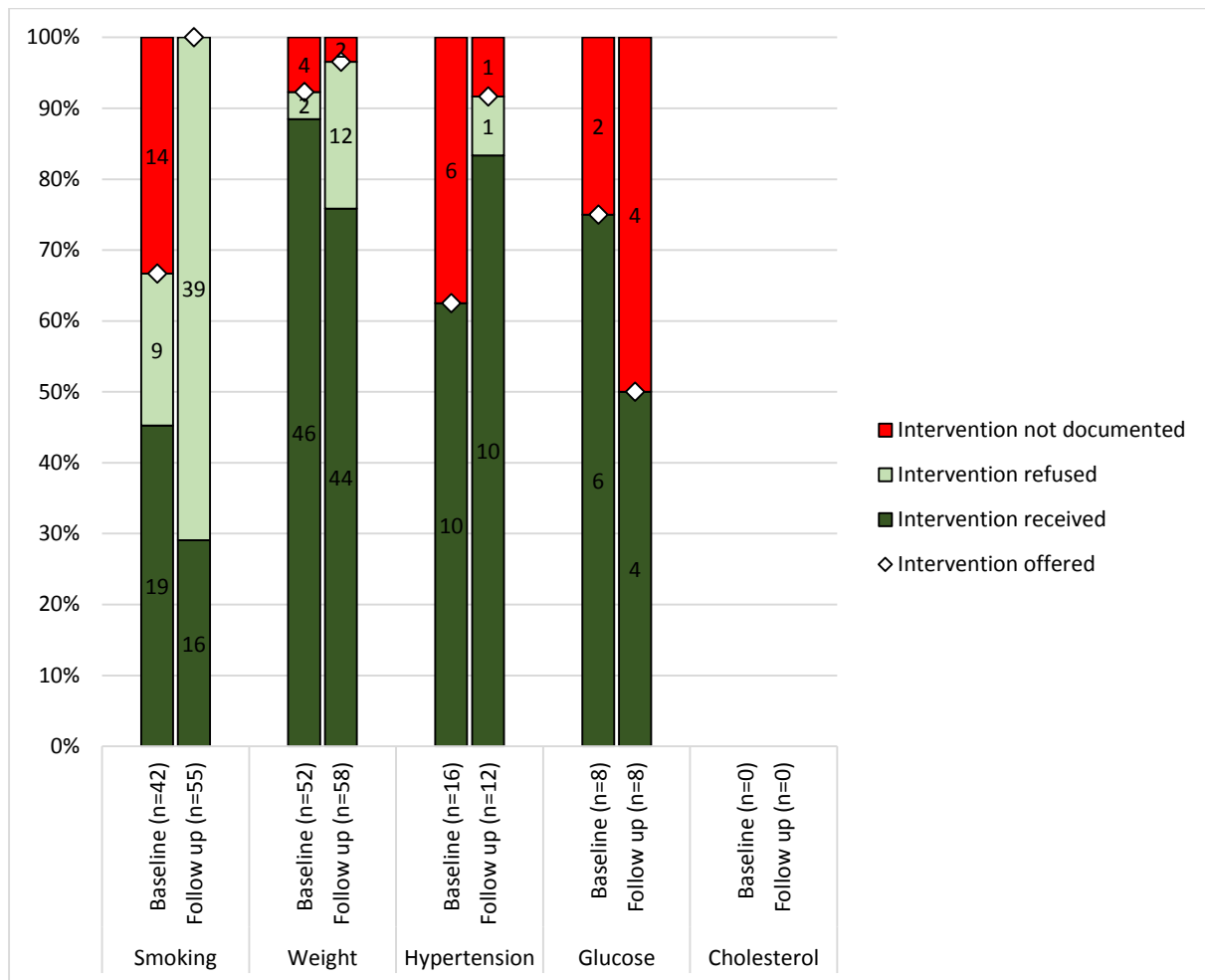


Figure 6: Interventions offered and received in 2gether pilot sites: what happened to patients in the Lester tool 'Red Zone'



Summary

2Gether began the pilot from a position of strength: strategic commitment to improving the physical health of people using services was already being enacted when the pilot commenced, providing a foundation for development. The trust had established a high level working group to oversee activities and senior managers and clinicians were aware of evidence regarding the physical health of people with SMI, and were 'signed up' to national policy. Consistent with assertions by staff that they were already attending to physical health, rates of screening were very high for three Lester tool domains (weight, smoking and hypertension) and the majority of patients found to need an intervention in any domain were offered one. Room for improvement was found in relation to screening for glucose and cholesterol and in relation to intervention, particularly in relation to smoking and cholesterol. The trust had identified areas for development and applied for funding

with a view to streamline recording systems, increase staff confidence regarding physical health, and build partnerships with other agencies.

Funding was used to extend and embed an already established role with responsibility to lead the implementation of trust commitment to ensuring that service users receive physical health care checks in accordance with current best practice. The Health Facilitator worked closely with an expert reference group and senior staff to engage frontline clinicians in practice improvement. In line with identified need for development, integration of the Lester tool with the nursing updated assessment tool and the care plan on the trust IT system, provision of training and support, and articulation of responsibilities of various clinicians in policy were the key pilot activities. Interviews with staff indicate that these activities provided structure for screening and intervention and enabled engagement of staff as they came to understand the reasons behind these activities.

I think it's helped inform the team, not just qualify, but also you could say beginning to understand a bit more. [Ward manager]

Consistent with these views, analysis of audit data demonstrated very high rates of screening and intervention with the majority of patients screened in all domains and receiving interventions when needed.

The pilot may thus be regarded as successful in achieving the primary goal of integration of screening and intervention in routine clinical practice. Observation and interviews during site visits suggest that the success of the project is directly related to the capabilities and commitment of the person appointed to the Health Facilitator role and the opportunity afforded within the trust to use them to good effect. Collaboration and alliances with senior and frontline staff were critical. Staff spoke of the credibility of the Health Facilitator, relating this to her nursing background, clinical expertise and membership of the PHCERG. With the endorsement of the PHCERG she was able 'encourage' frontline staff to engage in the project and provide expert advice as needed. Knowledge of the IT system and its workings was also seen as critical in enabling collaboration with the trust's IT department to embed the Lester tool in RiO.

While acknowledging substantial achievements of the project and good results, informants identified a range of risks to sustainability of improvement and the need for further work. They noted that while the Lester tool would remain integrated in the assessment process and on RiO, completion could become a 'tick box exercise' – undertaken to satisfy requirements rather than improve health outcomes. Referencing high staff turnover they also emphasized the need to continuously work to promote attention to physical health. Development of collaborations and clinical pathways was also seen as critical to ensuring that screening led to effective interventions that would improve patient outcomes.

Conclusion

In summary, this evaluation indicates that work funded by the pilot in 2gether has supported operationalisation of a strategic commitment to improving physical health care and outcomes of service users. Incorporation of the Lester tool in the assessment processes on RiO was understood as contributing to a broader objective: to enable integration of attention to physical health care in routine practice.

The project appears to have been well targeted and executed with activities consolidating and building on previous work. The importance of the enabling context (articulated commitment and prioritisation of the 'physical health agenda', high level support) cannot be underestimated but success of the project can in large part be attributed to the qualities and skills of the Health Facilitator. The 2gether pilot developed operations in line with endorsed strategic directions and laid firm foundations for further work (e.g. formalisation of policies will likely to lead to sustained improvement).

3.2.3. NTW case study report

Introduction

Northumberland, Tyne and Wear NHS Foundation Trust (NTW) provides a wide range of mental health, learning disability and neuro-rehabilitation services to 1.4 million people in the North East of England. Covering six socio-demographically diverse regions, the trust is one of the largest mental health, learning disability and disability organisations in the country with an income of around £300 million and over 6,000 staff. The trust provides services through 60 sites.

Trust context

NTW had been actively working to improve the physical health of service users for many years prior to the pilot. Informants attributed the strategic and operational commitment to improving services provided and health outcomes to various national and local factors. The CQUIN (and its financial implications) were regarded as important but informants also commonly spoke of the importance and prominence of the 'parity of esteem' agenda and the consistency of government messages about the physical health of people with SMI and premature death of patients with a learning disability and mental health problem. Senior staff involved with the pilot said that trust leadership had a 'passion' for physical health and that frontline staff were aware of evidence and believed that improvement in care would make a real difference to patients' lives. Whilst it is acknowledged there has been some focussed work within the trust, it has not had a dedicated resource, which it has now. Some clinical areas within the trust had very good, well-resourced physical health processes, whilst others did not.

The trust has a dedicated physical health policy, stating that every patient should have a regular assessment of their physical health and be offered appropriate interventions. Describing a range of strategic and operational initiatives to promote attention to physical health and promote wellbeing, key informants commonly spoke of a cultural shift toward holistic care. Improvement in services was considered a process, requiring ongoing investment rather than an event:

We're trying to change cultures, it's not just about changing bits of equipment or putting pathways in place, it's actually getting people to think differently about the way they deliver care. [Programme, Project and Improvement Manager]

Trust commitment to improving care and outcomes was reflected in various organisational structures and processes. With service development overseen by a trust-wide committee (the Physical Health and Wellbeing Group: PHWBG); the CQUIN is a standing item on the PHWBG agenda. Informants described a collaborative multi-disciplinary approach to working across the trust but also noted substantial variability in physical health related knowledge and skills of staff. To support engagement of staff, the PHWBG convened two conferences on physical health entitled 'Improving Health and Wellbeing – Everybody's Business'; each had around 150 delegates attending. The objective has been to harness the enthusiasm and learning from these events and integrate knowledge into practice.

The trust has established a range of positions dedicated to physical health care. These include a team of 16 dieticians, exercise therapist posts in some areas, and dedicated physical health nurses on older adults' wards. Additionally, in most inpatient areas across the trust, staff members with specific interest and perhaps additional training in physical health had been nominated as 'link workers'. These link workers have responsibility for a variety of activities relevant to improvement in the physical health and wellbeing of service users. They have been identified as an important component of the local implementation and embedding the use of the Lester tool, i.e. Screen and Intervene, for patients with SMI. They are supported by a project manager and clinical nurse managers; meeting monthly with a standardised physical health agenda, they review clinical and performance priorities and provide extra support through training and education to embed this knowledge and use of the Lester tool into practice in their clinical area.

In part to enable the trust to meet CQUIN requirements, various physical health parameters were incorporated in the electronic patient record and core physical health monitoring record prior to the pilot.

Prior to the project commencing, investment had also been made in facilities with some sites having newly built gymnasiums and outdoor exercise areas.

Challenges to optimisation of care identified in site visits and by informants were:

- variability and gaps in existing cardiovascular pathways;
- variability in knowledge and skills of staff including link workers, which has been, and is, being addressed through physical health training courses;
- imbalance in care such that inpatients were able to access support not available from community services;
- difficulty coordinating and standardising care provided across multiple sites;
- disjunction between inpatient units and community care: inconsistency in capacity of community mental health services to continue screening and interventions commenced in inpatient units and 'gaps' in communication between care settings.⁵

Application was made for funding as a pilot site, following discussion with the Northern England Strategic Clinical Network Delivery Manager and Quality and Performance Team.

What was planned?

With the aim of developing physical health care with a systematised approach, the trust proposed using pilot funding to employ a project manager to coordinate and support:

- the development of 96 Band 6 physical health link nurses already working across the trust, using a 'train the trainer approach';
- the development of clinical pathways to link with external NHS and community based services (for example cardiology and endocrinology services in acute trusts and smoking and weight management programmes in the community).

⁵ Many frontline staff spoke to us about the variability in this. Sometimes there were very good interventions that could be continued from the wards to the community (e.g. football groups), but sometimes there were not (e.g. smoking cessation started on the ward but not continued after discharge). Similar issues were reported across all sites.

The trust additionally proposed clarification of the governance framework related to physical health including establishment of clear lines of accountability supported by clinical skills development training and supervision.

Proposing that the pilot and associated activities would enable NTW to demonstrate health improvement of service users using QRISK2, specified objectives were to:

1. ensure that all inpatients have access to a consistent, high quality physical health care service by April 2016;
2. ensure that all inpatients with physical health issues identified during screening which need treatment elsewhere in the system have equal access to consistent clinical and health promotion services.

An evaluation designed to assess outcomes was also proposed. Identified outcomes were:

- QRISK scores for service users;
- rates of recording of information in the physical health core documentation on RiO;
- facilitation of physical health meetings, support and supervision of link nurses;
- attendance at clinical skills training by link nurses and confidence of link nurses in application of clinical skills.

The proposal was predicated on the understanding that development of capability and motivation of all staff was critical to achieving trust aspirations and pilot goals, and that acceptance and embedding new processes in routine practice 'takes time'.

What was implemented?

As specified in the PID, funding of £50,000 was applied to appointment of a project manager at Band 7 (in post March 2015). The appointee, who had been monitoring physical health within their clinical area for a number of years, was described as clinically experienced and skilled in delivery of training. Having worked clinically in the trust for 27 years, the project manager has extensive knowledge of nursing practices within the trust.

Working closely with the Group Nurse Director, Chair of the PHWBG and trust lead, the project manager undertook a range of activities as outlined in the PID, aiming first to establish a network for link workers across the trust and embed the roles as appropriate in various settings. Oversight of activity and support were provided by the PHWBG.

Pilot activities

The project manager worked with managers, frontline staff and (already) identified 'link workers' generally acting as 'a conduit between the clinicians on the ground within the trust, and the Physical Health and Wellbeing Group.' [Programme, Project and Improvement Manager]

Key activities undertaken by the project manager were:

- training link workers in clinical skills relevant to physical health;
- organising and coordinating regular meetings of link workers working in geographically defined areas. These formal meetings were designed to support establishment of collaborative relationships and build capacity of link workers to work with clinicians in their service areas to embed physical health care in routine practice. Additionally these meetings were to function as a communication hub, providing a mechanism for dissemination of information from the PHWBG (to be 'cascaded' by link workers to clinicians) and for feeding local site concerns 'up' to the PHWBG. Meetings were also to enable 'troubleshooting' of local issues, for screening and intervention performance data to be scrutinised and actions agreed, and to provide a forum in which training on specific issues (e.g. vitamin D deficiency) could be provided;
- working with link workers to identify training and skill development needs and in conjunction with specialist staff developed training using scenario-based skills lab training and use of a 'SIM Mannequin';
- revision (in collaboration with the PHWBG and link workers) of the electronic physical health monitoring form (already on RiO – the trust IT system), embedding Lester tool domains with guidance for clinicians. Guidance provided is pertinent to the Lester tool, NICE guidelines and the CQUIN. The electronic form hyperlinks to other documents and screening tools (e.g.

Nutritional Screening tool). The revised tool includes all information needed to calculate a QRISK score;

- review of cardiometabolic care and pathways across the trust. Mapping has taken place on Diabetic and COPD pathways, with recommendations to go to the PHWBG regarding service improvements and gaps in access to specialist services for inpatients identified (for example, diabetes specialist care and monitoring for those within forensic units).

Impact and outcomes

The primary impact of the activities noted above, identified by trust staff was increased awareness and knowledge regarding the purpose and process of attending to the physical health of patients within the trust. Use of the Lester tool by clinicians was described as promoting awareness of the complex problems and co-morbidities associated with SMI and medicines and thus more engagement. However it was also observed that using the tool meant that assessments and interventions could take longer, though were clinically appropriate. The increased attention to physical health was also described as contributing to formalisation of the roles of both exercise and therapy team members.

It focuses your mind on how people with mental health issues do face more challenges with regard to their physical health. [Triage Nurse]

Incorporation of the Lester tool domains on the trust IT system was described as facilitating screening and monitoring of performance against standards.

Work undertaken under the auspices of the pilot had also supported identification of areas for development. These included the need to clarify and articulate roles and responsibilities of clinical staff in provision of care, and provision of additional support to ensure staff were able to correctly complete documentation on RiO, in order to develop a clinically appropriate and robust physical health history record.

The trust provided baseline data regarding screening and intervening in Lester tool domains for 100 patients. Rates of screening for all five domains were very high.

Completion of screening and intervention as per the Lester tool protocol

The trust submitted audit data for 100 patients at baseline and 100 at follow up. Case notes were sampled at baseline and follow up in the same way, i.e. as per national physical health CQUIN instructions. Case notes were included from the following services:

- Forensic Medium Secure Unit (n=8);
- High Dependency Unit (n=22);
- Adult Acute (n=29);
- PICU (n=2);
- Low Secure (n=2);
- Long Term Complex Care (n=32);
- Older People (n=4);
- LD Medium Secure Unit (n=1).

Screening

Data in relation to screening were descriptively summarised in two ways: by Lester tool domain (Figure 7) to quantify the number of patients for whom screening was completed or refused and by patient to assess the completeness of screening (Figure 8).

Very high rates of screening in all domains at baseline (100% for smoking, weight and hypertension) were maintained at follow up (Figure 7).

As shown in Figure 8, which graphically represents the proportions of patients screened (including refusals of screening) in each domain of the Lester tool (including refusals) at baseline then follow up, the majority of patients at both time points were screened in all five domains.

Intervention

Intervention was most commonly indicated in respect of smoking and weight with around two-thirds screening positive in each of these domains at baseline, rising to 89% and 75% respectively at follow up.

As shown in Figure 9 interventions were offered at baseline to the majority (>50%) of those who screened 'in the red zone' in each domain, with high rates (>75%) observed for all but hypertension. Similar rates of offer of intervention were observed at follow up in each domain except cholesterol, for which only 4 people were identified as needing an intervention in the follow up audit (see pg. 17 in section 2.5.1. for why caution is required when interpreting cholesterol screening results).

A wide range of interventions were offered in respect of each domain at both time points. Most commonly offered were, in relation to smoking 'brief intervention' and, in relation to weight, 'advice or referral about diet' and 'advice or referral about exercise'. 'Advice or referral about diet' was also most commonly offered in relation to both hypertension and glucose. Most commonly offered in relation to cholesterol was 'mental health medication review'.

Explaining the changes

Invited to comment on observed rates of screening and intervention at baseline and follow up (and to account for changes), site informants spoke of increased knowledge among staff of physical health pathways, improved access to interventions and different documentation processes.

Increased awareness of the need and opportunity for intervention was considered particularly important given the size of the trust and number of sites which made it difficult to educate everyone on what was available, and to promote consistency in practice.

The observed increase (from 89% to 100%) in interventions related to smoking was attributed to the forthcoming shift to 'smoke-free' (scheduled for March 2016). Informants spoke of a trust-wide strategy involving educating staff, particularly about brief interventions. Increased aggression and potential for patients developing weight gain when not smoking was described as contributing to staff concern, and therefore supported staff engagement.

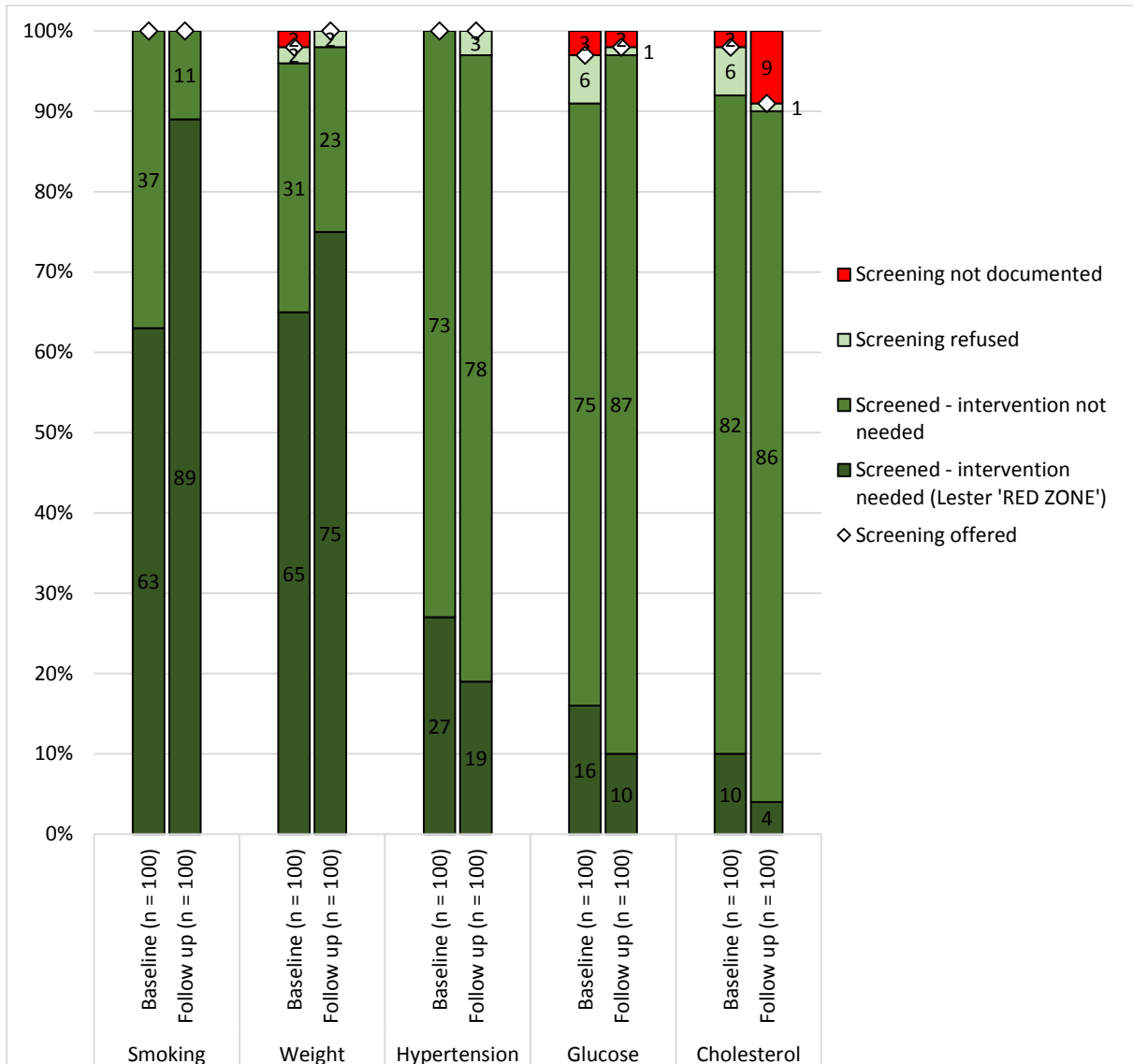
The observed increase in proportion of interventions received was related to the increasing activities of link workers across the trust. While the purpose and function of these roles was described as still developing, link workers were

described as a resource: coordinating activity, ensuring actions are undertaken, and educating staff on cardiometabolic risk. Knowledge of available resources and capacity to 'pull them in to busy wards' was seen as critical to improvement in practice. It was the responsibility of ward managers to roster as per ward or staff role demands, to ensure release of link workers to attend link meetings, training and so on.

Informants also attributed observed improvements in intervention rates to the changes in recording related to revision of electronic forms (on the electronic recording system). Whereas staff previously had to enter information about interventions using free text they were now able to specify and follow the types of interventions suggested on the Lester tool and NICE guidelines. This had both helped in development of understanding about what was required and facilitated collection of data for the audit.

In relation to high rates of intervention for weight and observed shifts in the types of interventions received (e.g. drop in number of mental health medication reviews and referrals to primary/secondary physicians, and an increase in advice provided for exercise and diet), informants spoke of trust-wide dietetic services and the inclusion of exercise therapists as part of the team completing reviews on admission to acute wards as having an impact. These changes were considered helpful in identifying and targeting patients who might benefit from intervention.

Figure 7: Completion of screening in NTW pilot sites by Lester tool domain



Note: Caution is required when interpreting cholesterol screening results (see pg. 17)

Figure 8: Completed screenings in NTW pilot sites by patient

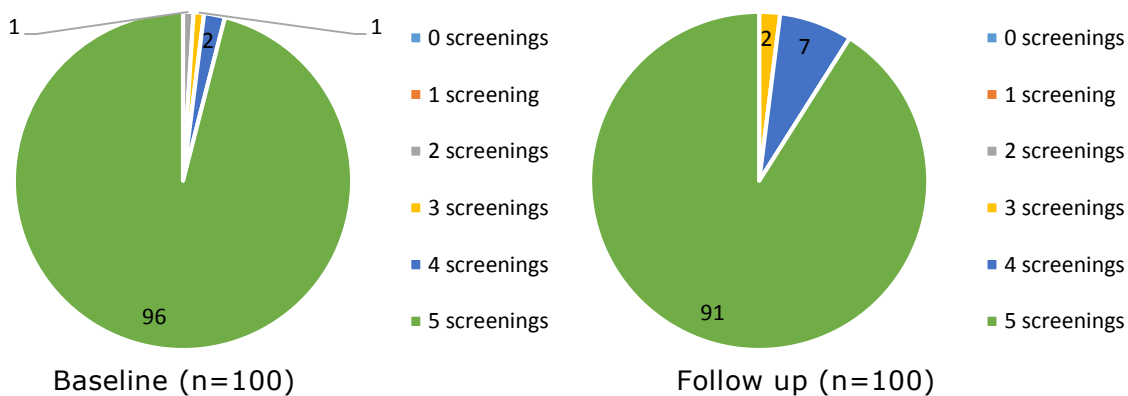
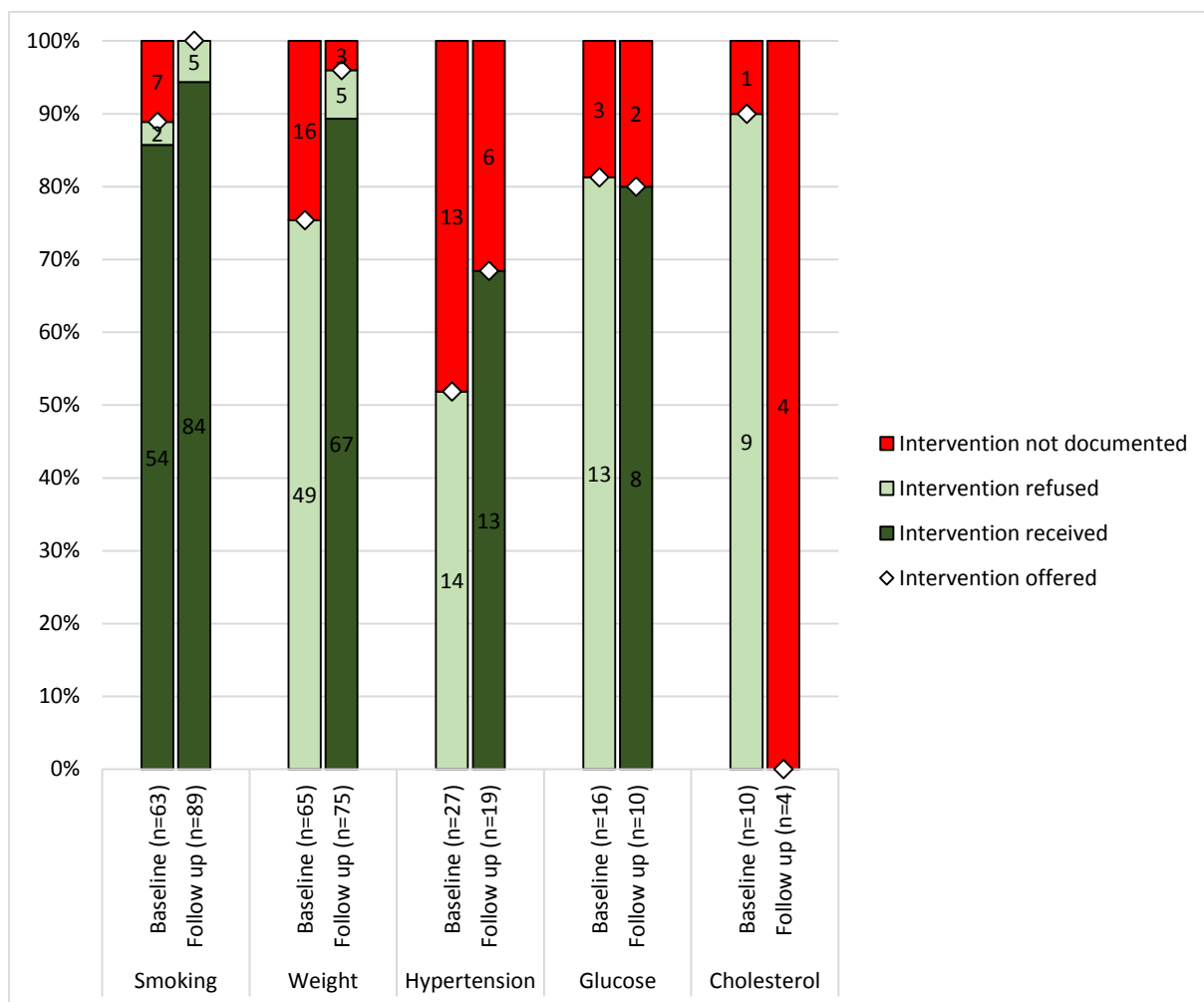


Figure 9: Interventions offered and received in NTW Pilot sites: what happened to patients in the Lester tool 'Red Zone'



Summary

Work undertaken in NTW under the auspice of the pilot built on a solid foundation laid down over recent years. Longstanding commitment to improving physical health care within the trust and outcomes for service users had supported establishment of an authoritative committee (the PHWBG) charged with ensuring that physical health care be embedded in routine practice. Efforts to improve care, supported in part by the CQUIN were reflected in very high rates of screening and moderate to high rates of intervention observed at baseline.

To begin to address challenges associated with changing practice across multiple sites in a large geographic area, the trust had created 96 locality based 'link worker' roles. 'Link workers' were responsible for a range of activities relevant to

improvement in the physical health and wellbeing of service users. However, with consistency in knowledge and practice recognised as important in sustaining high rates of screening, and improvement in interventions, the trust recognised a need to facilitate collaboration among link workers and to develop clinical pathways. It was felt that dedicated resources were needed to achieve these goals, so the PHWBG applied pilot funding to employment of a Band 7 Nurse to manage the processes. The project manager's primary role was to further ongoing service development related to physical health including embedding screening and intervention as per the Lester tool.

Working closely with senior staff including the Group Director of Nursing and the PHWBG, the project manager set out to develop collaboration among link workers and to establish (two-way) communication between link workers and the trust. Additionally the project manager identified learning needs and developed training to address these needs. In parallel with these capacity building approaches, the project manager undertook a revision of the physical health assessment and tool already in use on RiO to ensure consistency with the Lester tool.

Feedback and observations indicate that pilot goals had partially achieved:

- the proposed link worker network has been established and meetings were being held regularly but a consistent understanding of the roles and responsibilities of link workers continued to develop. This is being addressed with the revision of the terms of reference, and the project manager meeting all the link workers and chairs of the meetings, to reinforce their role. This is clarified in a physical health link worker role descriptor which has been available since the start of the project. The key component is ensuring this programme has support from 'board to ward' and all staff are aware of the importance of this role;
- training and activities of the link workers had promoted increased awareness and knowledge of the 'physical health risks' for patients with a serious mental illness or learning disability, and basic skills needed to 'screen' and 'intervene' as per the Lester tool;
- substantial work had been undertaken in relation to mapping cardiac clinical pathways across the trust (a decision had been taken to limit activity under the pilot to this pathway).

My expectation is that we'll have a proposal that's mapped out, we'll have mapped what those clinical pathway gaps are. And I would be expecting that to be the main thrust of the work for next year. [Group Nurse Director]

Audit data indicated that the high rates of screening observed at baseline were maintained and that moderate improvements in intervention were made for all domains except cholesterol. The trust recognises that further work is needed to 'normalise' intervention and to develop services to support this.

Conclusion

In summary, this evaluation indicates that work funded by the pilot in NTW has supported ongoing development of practices reflecting strategic commitment to improving physical health care and outcomes of service users. Although achievements within the evaluation time frame are modest measured against the ambitious aims set out in the PID, substantial progress has been made. The link worker network has potential to facilitate sustainable improvement in knowledge and practice.

3.2.4. TEWV case study report

Introduction

Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provides a range of mental health, learning disability and eating disorders services around County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton, Richmondshire and the Vale of York. The trust has over 160 sites covering 3,600 square miles, which includes rural, coastal and industrial areas. The catchment population is approximately 2 million.

Trust context

Senior managers reported that the trust has moved towards a more holistic approach to care over the past four to five years. They said this had been motivated in part by evidence related to poor health of people with SMI and government policy prompting a change in practice. The trust has a dedicated physical health policy and a committee comprising of senior members with expertise and interest in physical health (the Physical Health and Wellbeing Group; PHWG) to oversee service development in line with the policy. The PHWG reports to the Quality Assurance Committee. In addition to participating in the National CQUIN, TEWV is engaged in a local CQUIN focusing on weight management and smoking cessation. The Trust has further invested through their business plan by committing to a two year physical health project which would develop the standards required for the assessment and monitoring of physical health.

Notwithstanding strategic commitment to delivering services in line with national policy, site visits and interviews drew attention to variability in approach to improving physical health care and practice within the trust. Staff identified various factors related to the structure and organisation of the trust, collaboration between services within and outside the trust, workforce capability, knowledge management, and information technology, as influencing practice and service development.

Challenges to optimisation of care identified in site visits and by informants were:

- the size of the trust and number of service sites within the trust, which created challenges in disseminating information and maintaining consistency of message and coordinating activities across multiple sites;
- variable and limited access to specialised services across the trust (e.g. dietetics and staff who have physical health expertise);
- inconsistent levels of 'joined up' working between different organisations (e.g. mental health trust, general hospital, primary care, specialist services, etc.) to provide patient care;
- variability in knowledge and skills of clinical staff in relation to physical health needs of service users; divergence in views of clinicians about timing of screening and interventions during acute admissions, particularly if a patient presents in acute mental health crisis⁶;
- inconsistency and difficulty recording and accessing clinical information about physical health care (e.g. electronic care record and paper record).

In part to enable the trust to meet CQUIN requirements, various physical health parameters were incorporated in PARIS (the trust's electronic care records system) prior to the pilot, but further development of systems and processes to enable timely and accurate recording and accessing physical health information was seen as critical to improvement in practice and outcomes.

The trust meets twice a year with the software provider to agree required updates. Resource and practice implications make it critically important that any proposed changes to PARIS are thoroughly tested 'in the field' before recommendations are made.

⁶ Frontline staff told us this was quite common, i.e. where if patients presented in a severe mental health crisis, stabilising their mental state would take priority over some of the screenings and interventions outlined in the Lester tool. Some said they were reluctant to bring up factors such as smoking and lifestyle during admission if they felt the patient was not well enough to discuss this.

What was planned?

Application for the pilot was informed by a Kaizen Quality Improvement event led by adult mental health teams in one locality (Durham & Darlington), involving senior staff members, in September 2014. At this meeting, it was agreed that the service should focus on the development of a physical health monitoring system and standardisation of the work processes related to this. These activities (particularly tool development and testing of the tool in practice) were seen as critical to ongoing negotiation between the trust and the software provider about enhancing the functionality of PARIS to enable recording of physical health information.

The primary goal of the pilot was to embed the new electronic physical health monitoring tool in practice within the pilot inpatient areas. The monitoring tool was not intended to be a permanent feature; the plan was to test the feasibility of the system so that, if the test was successful, something similar could go onto PARIS. An additional pilot goal was training the staff to develop 'physical health knowledge and skills'.

Pilot activity focused on people with psychosis admitted to two inpatient settings: one acute admissions ward (for men) and one rehabilitation unit. The trust estimated that around 20 eligible patients were in these settings at any time.

Objectives specified in the project initiation document were to improve:

- recording of physical health monitoring within specified wards;
- the interface between inpatient, community and primary care services in relation to the physical health of service users with psychosis;
- service user awareness and understanding of the importance of physical wellbeing, and afford service users the opportunity to adopt a healthy lifestyle.

To achieve these goals the trust proposed:

- identifying staff training needs and designing and delivering staff training;

- sharing more accurate, timely information with regard to the physical health status of patients (with others involved in care).

Targets and timeframes identified in the PID were:

- By August, 2015: Screen 100% of patients admitted using the tool electronically.
- By March, 2016: 100% of patients have observations (screens) for all six parameters of the Lester tool recorded electronically.

In addition to improvement in the care provided and outcomes for patients, the trust expected the pilot activities to have benefits for staff, the executives and boards. The PID said that staff benefit would include increased knowledge, skills, confidence and job satisfaction and that the reputation of the trust would be enhanced.

To enable achievement of these goals and targets (through implementation and testing of the tool), the trust proposed:

- employing a clinically experienced project manager (0.4 WTE Band 6) to coordinate the pilot;
- providing dedicated medical sessions in the pilot wards within existing resources.

Administrative support and other ancillary activities including training were also included.

What was implemented?

TEWV was awarded £33,352 by NHS England to undertake the pilot, which was implemented in conjunction with a range of projects designed to improve the management of physical health within the trust. These projects included a project designed to enhance engagement with GPs and other care providers by standardising communication, a project to develop a weight management pathway, and a project designed to develop and implement standards in relation to physical health knowledge and skills.

Oversight of the pilot was provided by the PHWG and an internal project steering group.

Despite difficulties in recruiting a project facilitator, the trust was determined to improve the physical health of service users and the work involved was shared between the CQUIN team and the physical health project, supported by the clinical audit team.

Pilot activities

As planned, the core pilot activity was the development and testing of an electronic tool, which would enable recording of screening and intervention in specific settings. The tool implemented under the auspice of the pilot was based on one developed by a trust pharmacy team seeking to enable collection of data for the physical health of service users with severe mental illness. The tool, a standalone spreadsheet, enables entry and collation of data derived from assessments, and recordings of interventions. Graphs depicting measures over time can be generated and printed.

The tool sits outside the electronic medical record (PARIS) on a shared drive and while some clinicians (e.g. medical staff) have access in order to read the data, others (including HCAs who undertake screening) do not. Records are completed on paper based forms for data entry by a ward clerk (paid for by pilot funding). Only the ward clerks have access to edit the tool.

Other activities included:

- analysis of training needs;
- design and delivery of training targeted at different staff groups and Lester tool domains (e.g. smoking);
- development of standard process descriptions to assist teams in completion of the tool.

Impact and outcomes

Senior staff in the trust stated that the pilot had an impact on service culture and practice on wards in various ways. Informants spoke of physical health becoming 'ingrained' and part of the ward thinking. They described observing changes in attitudes supporting increased staff engagement in a range of physical health related activities. As one member of the PHWG said "there's now a real appetite for physical health in TEWV". Staff from the inpatient acute ward observed that, whereas physical health had previously been 'monitored', use of the Lester tool had led to the discussion of physical health of service users every day in greater detail. Use of the tool, specifically printed graphic records, was described by ward staff as enabling them to better engage with service users about physical health problems.

'But actually using this tool, for all they [service user] say, I'm fine, I'm fine, I'm fine, this is a way of saying, it shows that you're not fine, something's wrong. So it gives us an advantage on that type of thing.' [Health Care Assistant]

Staff also expressed the view that having information in 'one place' and being able to track progress over time could improve treatment and patient safety.

'[You can] access the information faster and you'd get it collated so you can make the decision. So I think you'll probably intervene far faster and then hopefully then you'll be able to make [a decision], because you've got the information you can then treat it more appropriately.' [Clinician]

Staff were generally in favour of the increased focus on physical health and endorsed use of the IT tool and Lester tool, although some reservations were expressed.

Mixed views were expressed about the training provided and its impact, as other physical health training was being provided on the wards in conjunction to what was being provided as part of the pilot. Generally, informants were positive about training, but some staff (particularly from the acute ward) noted that while they were aware of the training and wanted to attend, other commitments made this impossible.

Completion of screening and intervention as per the Lester tool protocol

The trust returned audit data for 52 patients at baseline and 29 at follow up. These were sampled from the two wards in the pilot: one acute, one rehabilitation.

Screening

Screening data were descriptively summarised in two ways: by Lester tool domain (Figure 10) to quantify the number of patients for whom screening was completed or refused, and by patient to assess the completeness of screening (Figure 11).

As shown in Figure 10, rates of screening at baseline varied by domain. Rates were very high (>90%) for smoking and hypertension, high (>75%) for weight, moderate (74%) for glucose and low (<50%) for cholesterol. It is noteworthy that a proportion of the data collected at baseline was prior to implementation of the Lester tool via national CQUIN 2014/15. Improvement in rates of screening was observed in all domains at follow up, with achievement of 100% screening for smoking, and there was a substantial improvement (from low to high) in cholesterol. Few refusals of screening were observed at baseline and at follow up.

As shown in Figure 11, there was a shift from baseline to follow up in the patient screening profile. Complete screening (all five domains) was recorded for around one-quarter of patients at baseline, and for over three-quarters (76%) at follow up. All patients received screening in at least three domains at follow up, with 93% receiving screening in four domains or more.

Intervention

At baseline, over half of those who needed an intervention for weight and glucose management were offered one (Figure 12), and for those who needed an intervention for smoking and hypertension, this was less than a third. A range of interventions were offered in each domain. In relation to smoking, 'brief intervention' was used most often; in relation to weight this was 'advice or referral about exercise' and 'advice or referral about diet'. At follow up, increases were observed in the proportions of people offered an intervention for smoking, weight and hypertension. There was no change in the proportion of people offered an intervention for glucose management. The increase in documented offer of

intervention for smoking from under one-third to 100% of smokers is of note. However, a substantial increase was also observed in 'refusal' of intervention from 8% to 62%, which suggests a trend towards an increase of refusals with an increase in screening. The increase in recorded offer of intervention in relation to weight was also accompanied by an increased rate of documented refusal. At follow up two new cases of diabetes were treated by medication, but there was a record in the case notes that they had been referred to a GP or diabetologist.

Explaining the changes

When asked to comment on rates of screening and intervention, key informants emphasized the importance of understanding practice as shaped by the various physical health related projects going on in the trust, and their coming together 'under one umbrella'.

It's very much the work of [named staff member] doing the CQUIN and [named staff members] running the physical health project ... from all three projects under the same umbrella as well ... it seems to be driving forward much faster. [Project team member]

Changes were also linked to national policies and initiatives, the inpatient smoke-free project (in advance of the trust becoming 'no smoking' in March 2016) and the CQUIN in particular.

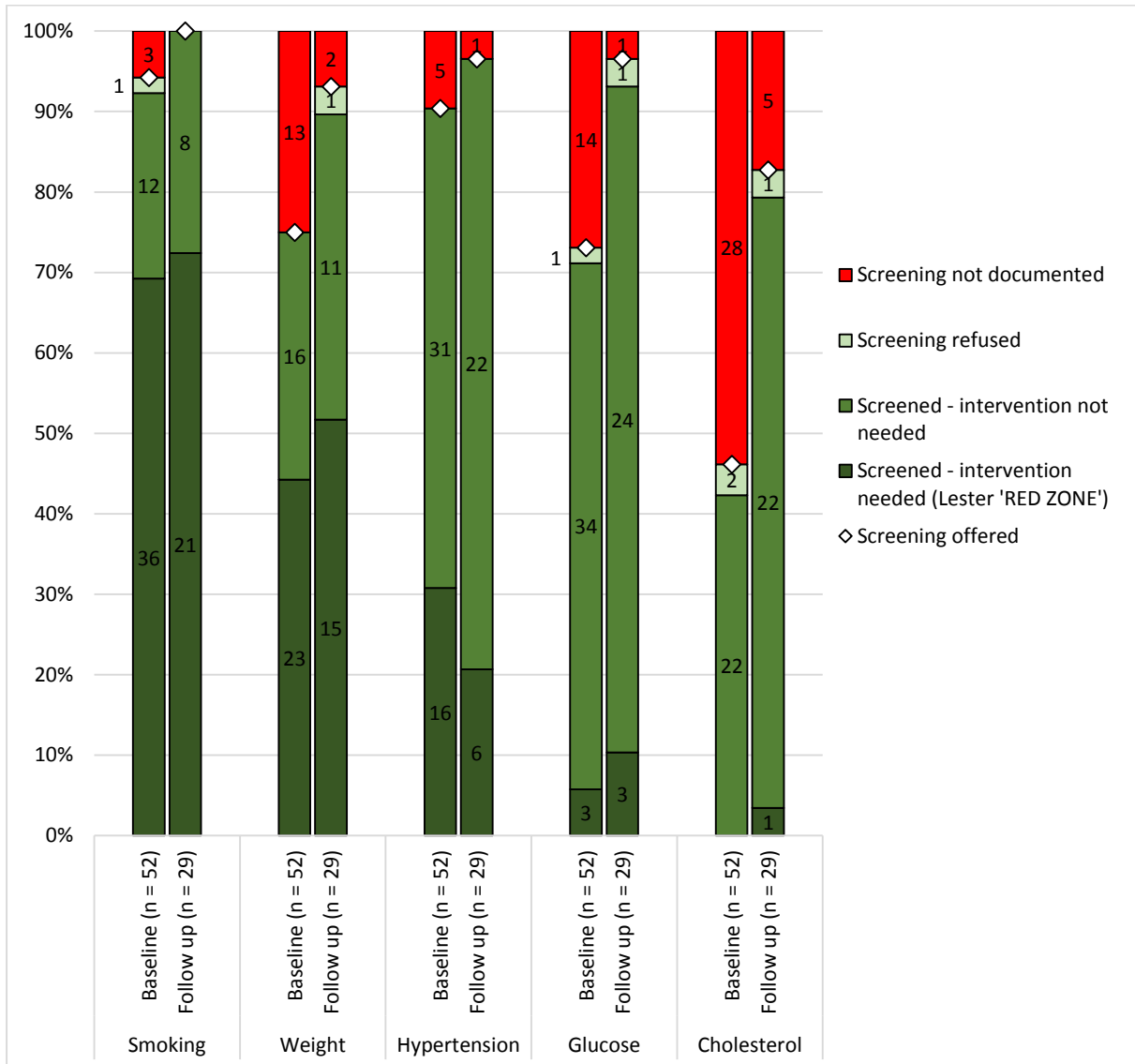
Specifically in relation to the pilot, informants spoke primarily of the development of the tool, and the impact of being able to record screening and interventions in a specific location and access this information. The 'tool' was said to both make recording easier, and clarifying responsibility and processes for staff. Incorporation of reminder functions in the tool was considered helpful in prompting completion of required action, and leading to an increase in the rates of screening. Whilst informants were confident that the practice was changing, they also speculated that difficulty locating records at baseline may have led to an underestimation of activity.

Training for staff on the two pilot wards was also considered likely to have contributed to improvement, particularly in relation to screening, but also as it informed intervention delivery.

Informants attributed the shift in the types of interventions offered (e.g. reduction in medication reviews, and increase in offers of advice regarding exercise and diet) to improved confidence among ward staff, meaning that they were more likely to offer to intervene themselves, rather than to refer service users to other professionals (doctors or pharmacists).

Informants also noted that data from the trust combined information from both acute and rehabilitation wards. They stated that this could obscure differences between the two settings, with rehabilitation wards described as delivering better physical health care due, in part, to a GP holding clinics and providing leadership in relation to physical health on the ward.

Figure 10: Completion of screening in TEWV pilot sites by Lester tool domain



Note: Caution is required when interpreting cholesterol screening results – see pg. 17

Figure 11: Completion of screenings in TEWV pilot sites by patient

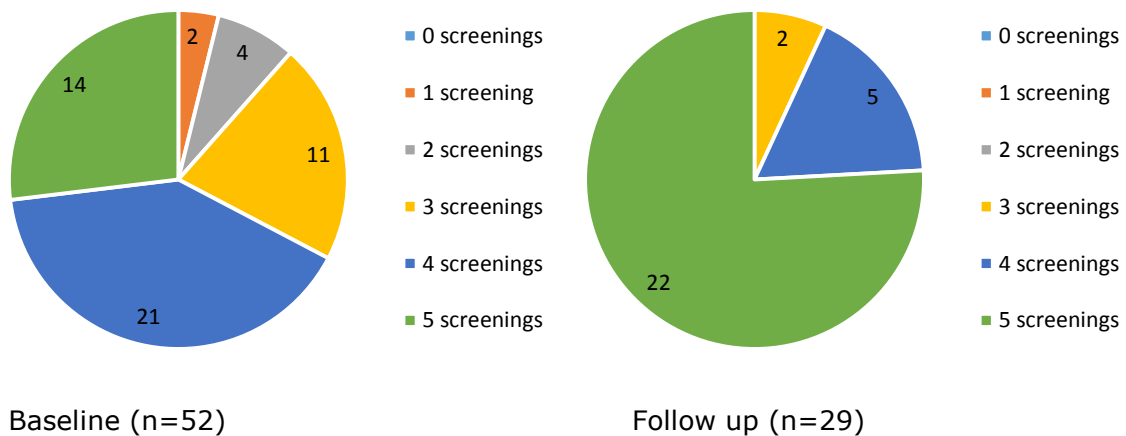
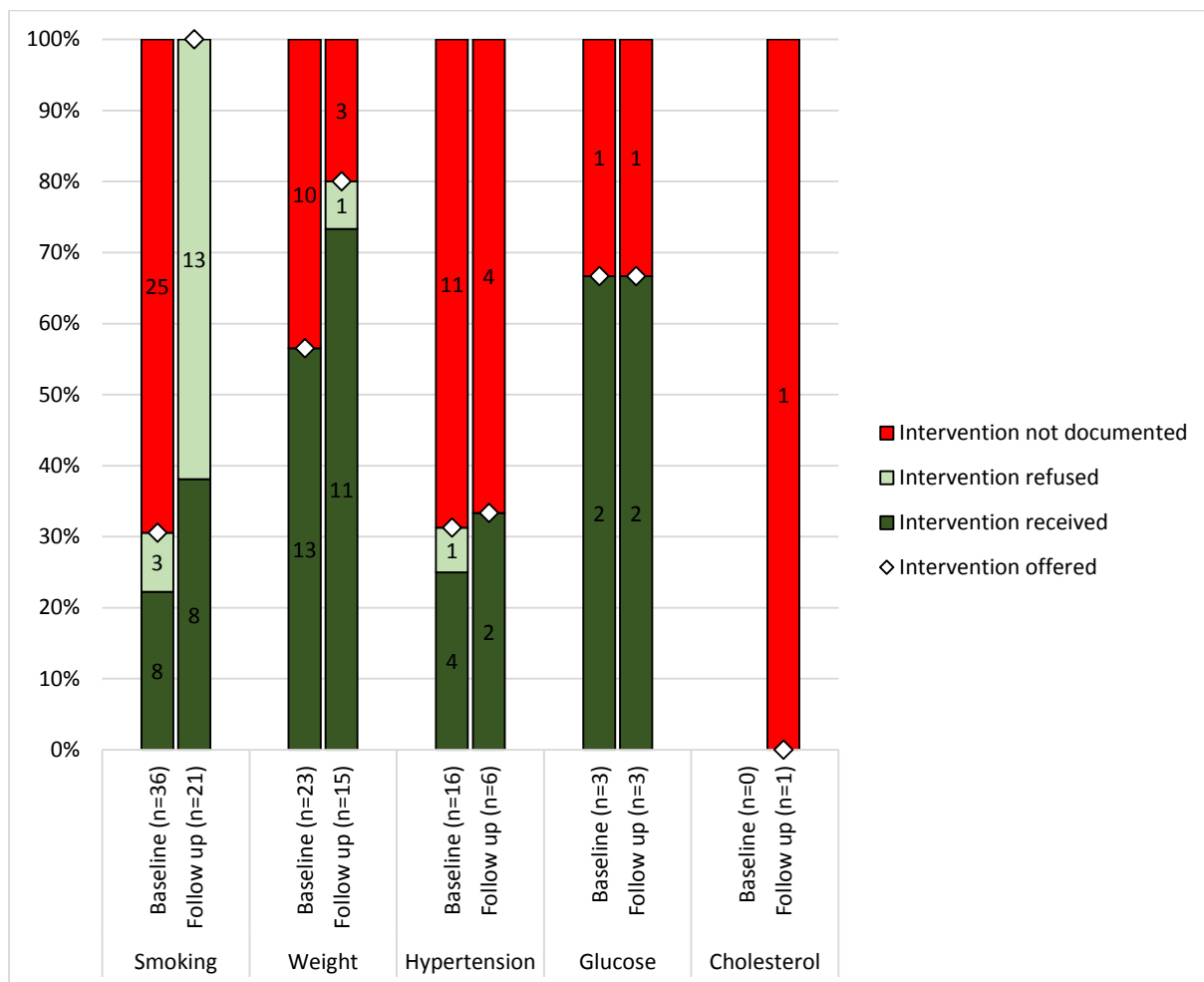


Figure 12: Interventions offered and received in TEWV pilot sites: what happened to patients in the Lester tool 'Red Zone'



Summary

Work funded by the NHS England pilot centred on testing an electronic tool designed to enable recording of physical health assessments and intervention, in two wards within the trust. This work was designed to inform development of the trust electronic care record system, needed to improve delivery of physical health care across the trust.

The pilot was implemented in TEWV in conjunction with several related projects designed to improve physical health care for service users. Collectively these projects appear to have supported improvement in recording of rates of screening and intervention for physical health issues.

'The [related] physical health project, that's made a difference in the last 18 months as well because we are quite a big resource and we've done an awful lot of campaigning and raising awareness and changing hearts and minds which I don't think you can ever underestimate. And having those face to face conversations with clinical leads in all the settings.' [Senior clinician]

The core pilot activity – testing the feasibility and acceptability of a bespoke tool designed to enable recording and monitoring of physical health screening and intervention – contributed to the achievement of the trust's goal of demonstrating the need for a dedicated physical health care section on the trust's electronic record system. While shortcomings of the tool tested in the pilot mean it is unlikely to be adopted in its current form, lessons from its use and demonstration of staff engagement will support the trust's case for incorporation of a dedicated physical health care record in PARIS. The pilot may be considered successful in achieving its implicit goal.

The pilot may also be considered successful in contributing to achievement of specified objectives, particularly improvement in monitoring of physical health care in specified wards. Indications are that the pilot activity has promoted awareness of physical health among staff and service users in the target wards, and that use of the tool and related training have promoted an appreciation of the need to attend to the physical health of service users, which could enhance relationships with other providers.

Conclusion

In summary, the evaluation indicates that implementation and testing of a standalone tool designed to enable recording of physical health has supported improvement in physical health screening and intervention in particular settings. This, in turn, will support the trust to mount a case for development of the trust-wide electronic recording system, support ongoing improvement in practice and, potentially, outcomes.

The sustainability of the use of the tool in its current form is unclear, as it was never intended to be a permanent feature. It is evident from the evaluation that this is part of a wider piece of work to develop the most appropriate physical health care record tool for the trust to incorporate onto PARIS.

3.2.5. Mersey Care NHS Trust case study report

Introduction

Mersey Care NHS Trust provides specialist inpatient and community mental health, learning disabilities, addiction management, and acquired brain injury services for the people of Liverpool, Sefton and Kirkby, Merseyside. It also provides secure mental health services for the North West of England, the West Midlands, and Wales. Clinical services are provided across more than 30 sites across Merseyside. These teams are supported by a corporate team based at trust offices in Prescot. The Trust employs 4,000 staff who serve a population of almost eleven million people. In 2014/15, Mersey Care provided care, treatment and support to more than 36,000 people in Liverpool, Sefton and Kirkby, and neighbouring St Helens. At 31 March 2015, the Trust had 641 inpatient beds.

Trust context

The pilot fitted Mersey Care's existing strategic priorities. The trust's strategic framework is centred on achieving what the trust have defined as 'Perfect Care' - care that is safe, effective, positively experienced, timely, equitable and efficient – and 100% compliance with implementation of the Lester tool is one of its objectives. The strategic level focus on physical health care had been prompted by a mix of national factors (e.g. the CQUIN and its financial implications) and local factors (e.g. a coroner's report highlighting this issue).

The trust's Physical Health Strategy Group is the governance group for physical health care which reports to the Executive Director of Nursing; the accountable officer. Membership of the group is multi-professional, with senior nursing and medical representatives, as well as dieticians and pharmacists. The pilot reported to this group and the Centre for Perfect Care and Well-Being.

Mersey Care NHS Trust has recently established a Centre for Perfect Care and Well-Being, which played a key role in the pilot. This centre has a focus on supporting clinical and support staff in achieving perfect care across the organisation. It provides quality improvement support and governance through use of the Advancing Quality Alliance (AQuA) improvement model, which is based on the model for improvement

developed by the Institute for Healthcare Improvement. In summary, the model aims to ensure that individual project aims connect to organisational goals and uses Plan, Do, Study, Act (PDSA) cycles to test and implement changes.

In 2014 the trust began developing a new joint medical-nursing electronic health screen, designed to improve current systems of practices for monitoring and addressing cardiovascular health. The trust's information system (ePEX) was variously described by informants as "unique" and "old but flexible", the implication being that they were unable to use an existing template and so had to build the screen "from scratch."

The trust provided a comparatively challenging context in which to attempt quality improvement. First, the trust strategy was described by one interviewee as complex, due to the number of physical health initiatives and projects ongoing within the trust. Second, access to the gym and physiotherapists was reportedly very limited at the psychiatric unit in which the pilot ward was based.

What was planned?

The vision for the project was expressed in the PID:

Mersey Care will use this funded pilot to improve current systems and practices for monitoring and addressing cardiovascular health. The full implementation of the Lester tool in one pilot ward will allow further understanding of how to affect behaviours that impact on physical health and wellbeing. This will allow us to accelerate improvements in non-pilot wards and community services as part of a roll-out phase in line with the [AQuA] Model for improvement. [Mersey Care Project Initiation Document]

The plan was for a project group to work alongside staff on a single ward to determine the best way of utilising the Lester tool in practice and support them with quality improvement tools and techniques, such as process mapping. There was a conscious decision by the project team to choose a 'very acute', all-male, busy Mersey Care NHS Trust ward, serving an inner city area – the rationale being that if they could embed the Lester tool successfully there, they should be able to embed the tool successfully on any other ward and learn lessons that can be applied across the trust. Documents

and site visits highlighted challenges to the trust's efforts to improving the health outcomes of service users that contributed to application for pilot funding. Key concerns identified related to:

- Organisation of health care
 - lack of formal care pathways with specialist services such as cardiology (reliance on 'gentleman's agreements').
- Workforce
 - current level of staff knowledge, skills and confidence in relation to physical health.
- Patients
 - high patient turnover/throughput, which constrains the opportunity to intervene (especially in acute inpatient settings);
 - acceptability of physical health screening and intervention to patients.

The project's objectives therefore included to:

- embed the Lester tool as a trust standard of physical health care within a 24 bedded acute male inpatient ward;
- identify the level of staff training required to effectively embed the Lester tool in practice;
- improve staff knowledge, skills and confidence in relation to physical health;
- improve where care pathways need to be developed with specialist services;
- facilitate a greater understanding of attitudes to physical health within mental health patients;
- refer patients that are identified as 'at risk' through screening to appropriate specialist services.

Achievement of these objectives was described in the PID as benefiting diverse stakeholders, including service users (through giving them access to enhanced staff skills and expertise in relation to physical health screening and intervention) and chief executives and boards (by contributing to the achievement of strategic objectives).

What was implemented?

The £42,469 funding from NHS IQ was used to pay for a percentage of a project manager from the trust's Perfect Care quality improvement team. The project manager's role included linking the pilot with other Lester tool related activities within the trust, including local and national CQUINs, and reporting monthly to the trust board.

While not mentioned explicitly in the PID, the core part of the project was to continue the development and implementation of a joint medical-nursing electronic health screen in which the Lester tool was embedded. The development process was already under way when the pilot officially started in February 2015, which begs the question for this evaluation – 'would what was implemented under the auspice of the pilot have happened anyway?' Members of pilot project group argued in interviews that the NHS IQ funding had probably *accelerated* the development process, which seems to us a fair assessment, to the point where they were ready to implement the electronic forms across the trust on August 1st 2015.

The pilot project group consisted of these core members:

- Perfect Care project manager (an expert in quality improvement and nurse by background);
- Management/strategic lead (associate medical director for physical health care and medicines safety, and consultant psychiatrist);
- Modern matron for physical health care;
- Clinical lead (consultant psychiatrist for the pilot ward).

The model for the project was to link 'this small project' into wider trust developments while at the same time using trust performance management resources to make sure changes happen in practice, e.g. via regular feedback of monitoring data.

Pilot activities

The main pilot activities undertaken between baseline (February) and follow up (August/September) were:

1. a basic survey of nursing staff knowledge, skills and confidence of nursing staff knowledge, skills and confidence;
2. back to basics training in screening to upskill staff, which was informed by the audit;
3. assisting the evaluation team with the design and implementation of a service user survey, thus achieving the pilot objective to facilitate greater understanding of service users' attitudes to physical health care (for survey results, see Section 3.1);
4. continued development and implementation of the integrated physical health care electronic screen, which was considered central to the project:

This project has clearly been the development of the physical health care screen. [Management lead]

Previously the ePEX information system held a suite of physical health assessment tools; these were amalgamated into one 'joint assessment form', which went live in August. The benefit of the new system is that all the information on the patient is held in one place. There is a full assessment form, and separate forms for reviews at one, six and twelve weeks. The review form content is narrower because the full assessment will have already been completed.

The forms include sections which to document screenings of all of the Lester tool domains, in addition to sections to record any required interventions, based on the results of the screenings. At the time of the case study visit, some difficulties were reported in accessing the data recorded on these forms for audit purposes. As one project group member acknowledged: '*it just didn't meet the targets for Lester tool in terms of being able to report on those things*'. While certain data about Lester tool implementation could be pulled off the system, others could not. The project team are continuing to work with their IT department to improve this.

In addition to activities listed above, the consultant on the pilot ward, in her role as the trust's director of medical education, fed Lester tool-related training into the induction of psychiatric trainees and junior doctors:

In August we have a whole new intake of trainees and I said it might be useful to get the new ones to know that this is the only system so it's easier to teach new people than to change old habits... Because I am also responsible for junior doctor training, teaching, it came naturally to me that I could use those skills... I could tell them that this Lester tool is big in the trust, so everybody is going to do the Lester tool and these are the only forms you fill in. [Consultant psychiatrist, pilot ward]

Impact and outcomes

The results presented below need to be understood in context of the disruption experienced by the pilot ward in 2015. This meant that nearly all of the nurses who had received the back to basics training in screening in April were no longer working on the pilot ward at follow up. As a result, much of the learning was lost, thus removing one of the pilot's main mechanisms for improving quality.

The introduction of the new integrated information system on August 1st was consciously scheduled to fit in with the intake of new junior doctors (n=78) in the first week of August. While a lot of work had gone into normalising CVD screening and the use of new integrated assessment forms among junior doctors, this did not seem to have occurred with frontline nursing staff, who spoke of how physical health care seemed little different at follow up. Interviewed five weeks after the implementation of the new forms, two nurses on the pilot ward indicated that there was some way to go before it would become normalised into everyday nursing practice:

I've used the form, yeah. I don't really like it much. Some of the things they ask are a bit unclear to me. I thought they were going to go through it with us before it came out, but they just said, that's the new form, and that's it... So it's just more work for us to do unfortunately. It's very difficult trying to get everything done as it is. And then I suppose when you're used to one

form and then you change over, it's always going to be tricky, isn't it?

[Nurse]

I kind of think that at the moment physical health's kind of got lost in a way... I suppose the more it's implemented, the more it's done, it'll just become part and parcel of your daily work... They want less paperwork kind of thing so that's why you go electronic, but then you find that you're still doing the same amount of paperwork. [Nurse]

Unfortunately, there was some delay in fully operationalizing the new electronic physical health care screens. This led to a decision being made not to 'pilot' the screens on the ward first before being rolled out across the trust, as originally intended, in order for their introduction to coincide with the intake of new trainees and for them to be trained on these as part of their induction. This, combined with the nursing staff changes, evidently caused some confusion among frontline staff:

I was at the meeting when they said [about the new electronic assessment forms], but it was months in advance and they said it'll be this date or whatever, and then I just forgot about it. It would have been helpful to get a big reminder or something beforehand, but we didn't. But it just wasn't there anymore and there was a bit of confusion around that, so some of them didn't get done. Some of the other staff were just like, I couldn't do the physical health because there was no form there. [Nurse]

Completion of screening and intervention as per the Lester tool protocol

The trust submitted audit data for 84 patients at baseline, and 31 patients at follow up. The data were collected from the one acute ward involved in the Mersey Care pilot.

Screening

Data in relation to screening were descriptively summarised in two ways: by Lester tool domain (Figure 13) to quantify the number of patients for whom screening was completed or refused and by patient to assess the completeness of screening (Figure 14).

As shown in Figure 13, there was a decrease in rates of screening for smoking and weight from very high (>90%) from baseline to follow up, (>80%) although screening rates remained high. A substantial increase was seen in rates of screening for cholesterol (from very low to moderate) and there was a small increase in rates of screening for hypertension at follow up with 100% of patients for whom data were returned being screened. A small decrease was seen in rate of screening for glucose from high (70%) to moderate.

As shown in Figure 14, which graphically represents the proportions of patients screened (including refusals of screening) in one, two, three, four or all five Lester tool domains at baseline then follow up, the patient screening profile remained similar. All patients at follow up received screening in at least two domains (compared to 98% at baseline). Complete screening (recorded for all five domains) increased from one quarter of patients at baseline to 39% at follow up.

Intervention

At baseline, over 80% of those found to be in need of an intervention for smoking were offered one. The proportions of people offered interventions for weight, hypertension and glucose were much lower, at less than 20% (see Figure 15). Table 10 shows that a single intervention was offered for all domains except smoking, where two interventions were offered (brief intervention or referral to smoking cessation service). In relation to weight all patients received 'advice or referral about diet' and in relation to hypertension and glucose all patients received a pharmacological intervention.

At follow up, the proportion of patients offered an intervention for smoking, where screening indicated it was needed, dropped slightly; for weight and hypertension no interventions were recorded. None of the patients screened for glucose and cholesterol at follow up were found to be in need of an intervention. No data were provided on the type of interventions provided at follow up, so we are unable to comment on whether any changes had occurred in relation to this.

Explaining the changes

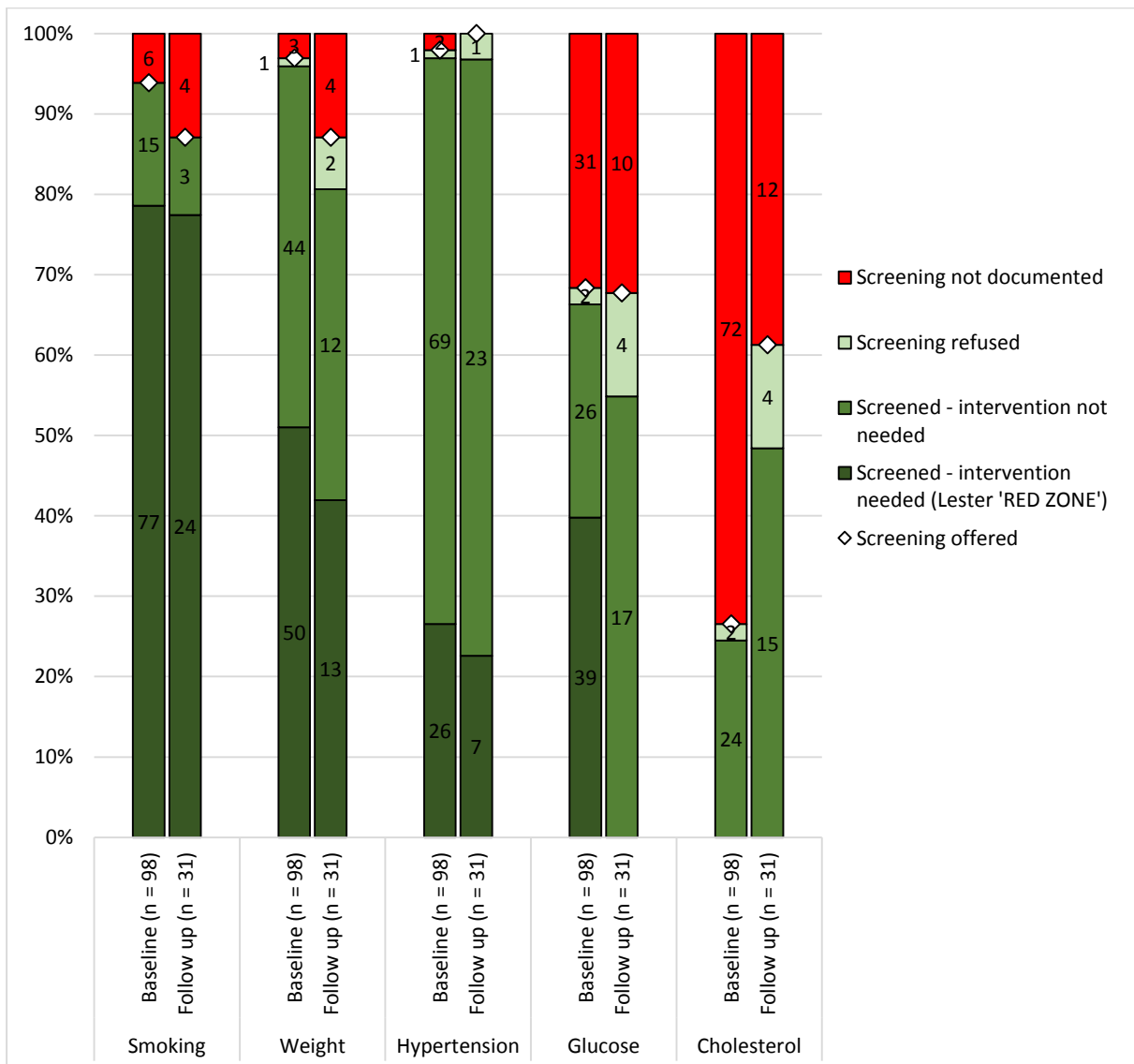
When invited to comment on rates of screening and intervention at baseline and follow up (and to account for changes), informants fed back that the significant

changes to the nursing staff team over the past year were seen to have been a major barrier to quality improvement and were thought to have led to the clinical team's focus moving away from physical health.

The increase in levels of cholesterol screening perhaps partly reflected a trust-wide push to improve the collection of glucose and cholesterol baseline figures. More specifically, on the pilot ward itself strong leadership had been given to the junior doctors by the consultant psychiatrist, and as noted above this was perceived to have had a clear impact on the screening carried out by junior doctors.

As context for the decrease in screening, a drop in nursing-led assessments had also been seen in recent figures across the whole trust. This could perhaps reflect that there has been less focus on screening undertaken by nursing rather than medical staff, due to the high rates of nurse-led assessments in the past.

Figure 13: Completion of screening in Mersey Care pilot site by Lester tool domain



Note: Caution is required when interpreting cholesterol screening results (see pg. 17)

Figure 14: Completed screenings in Mersey Care pilot site by patient

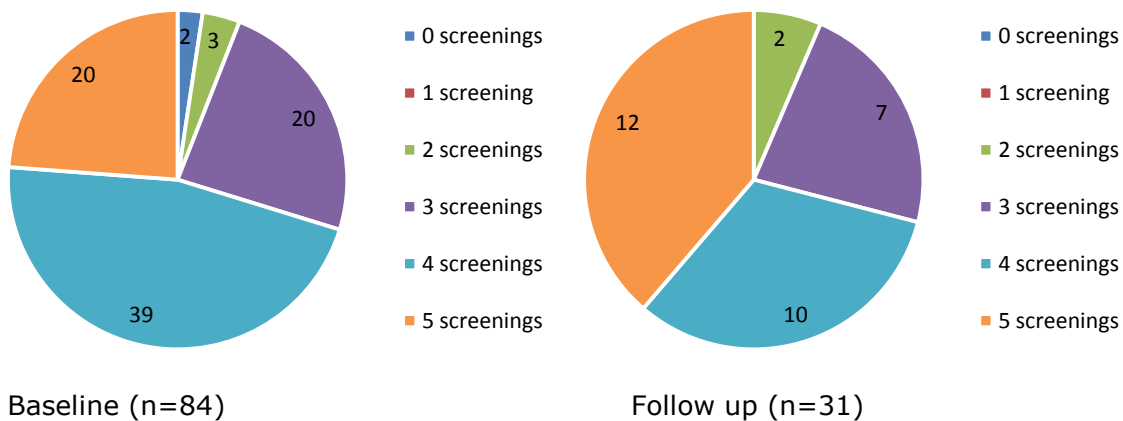
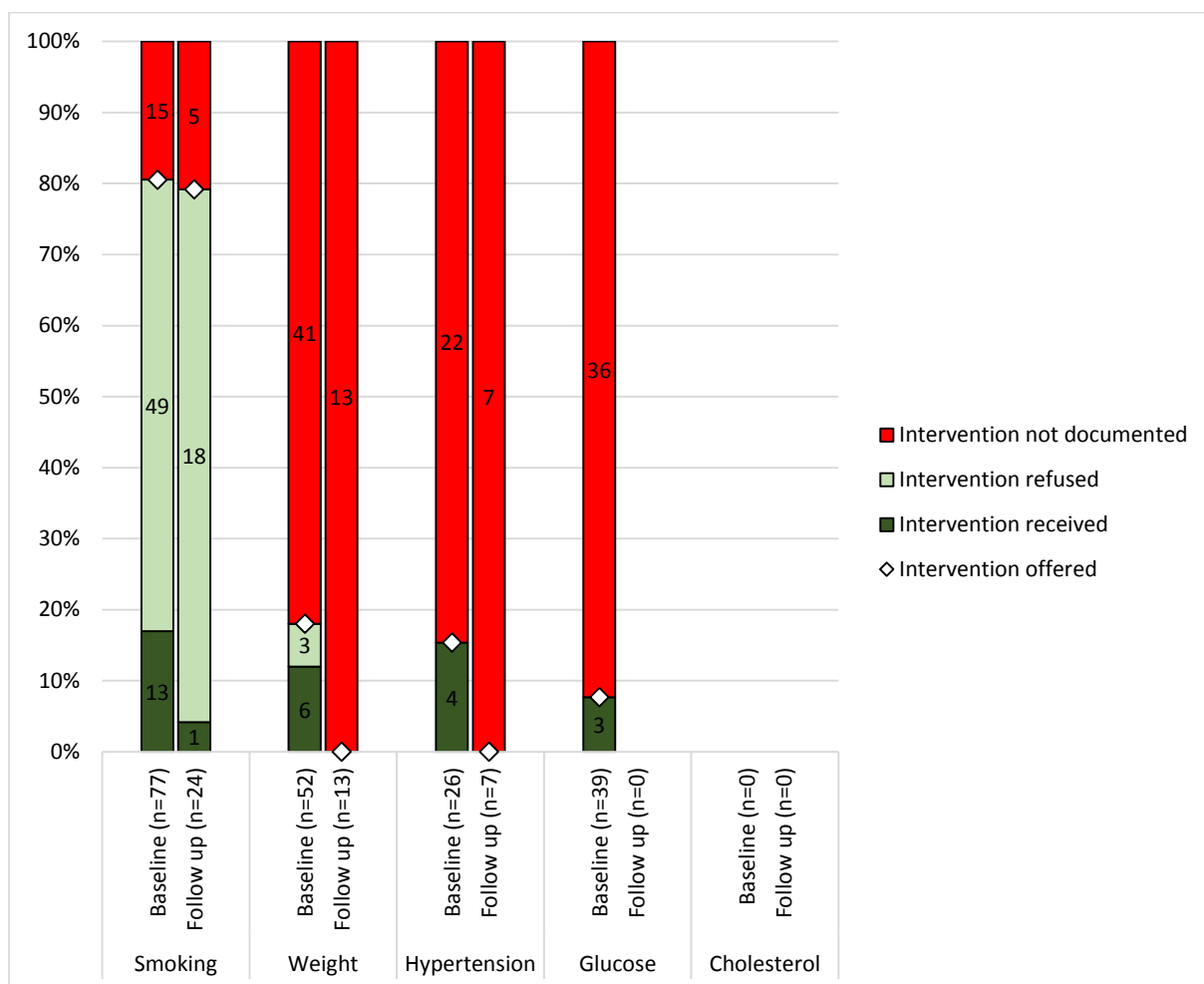


Figure 15: Interventions offered and received in Mersey Care pilot site: what happened to patients in the Lester tool 'Red Zone'



Summary

The follow-up audit data were collected in August/September 2015, when the case study interviews were undertaken, and shortly after implementation of the new electronic assessment forms. It seems plausible that the confusion referred to by frontline staff, caused by the decision to implement the new assessment forms without initial piloting on the ward in order for introduction to coincide with the intake of new trainee doctors and lack of transitional support to staff, accounts for some of the reduction in nurse-led screening between baseline and follow-up.

In addition, the disruption experienced midway through the Pilot made this choice of ward even more challenging than the Pilot project group could ever have envisaged at the outset; participants agreed with the evaluation team's

characterisation of the context in which they were working as a 'worst case scenario' for this kind of quality improvement work. The project group spoke of having been concerned midway through the Pilot about whether the ward chosen would be able to show improvements in such a challenging context, but made a decision to stick with it, following consideration of limited availability of alternative wards and the current relatively advanced stage of the pilot project.

These difficulties were compounded by the lack of authority – and capacity – that some of the project group perceived themselves to have to get things changed. Indeed, they argued that the project would have benefitted from a senior operational manager to oversee the project, as they would have been better able to (a) ensure that performance data were fed back to the wards quickly so that change occurred as part of a cycle of quality improvement, and (b) help staff to see the initiative as having come from central Trust management. The project manager also commented on the importance of strong nursing leadership in *motivating* staff to want to change practice, rather than simply 'performance manage' them into doing so via regular feedback of performance data.

Given the extent and complexity of the wide range of physical health initiatives taken forward by Mersey Care, many of them relating at least to some extent to the project, and the need for significant service change, the project team did identify the need for high level service managerial support. However as they were only able to appoint an appropriate manager in August 2015, this was too late to significantly impact on the course of this project and data collection.

The Pilot ward's consultant spoke of how there had previously been ambiguity over whether blood glucose and cholesterol screening is the responsibility of primary or secondary care, and how the Lester Pilot allowed her to "ask the question" of her Trust. She said that the Trust had responded with a guarantee that they would fund such screening, "so I think I've stopped worrying about it now". Interviews with frontline staff indicate that this may have had an impact on referrals for high cholesterol:

One of the doctors literally just asked me to refer someone to the dietician because they've got high cholesterol. I was thinking, oh that's funny, that's

the first time anyone's ever said that. So they're obviously starting to do it a bit more. [Nurse]

Conclusion

This was a very difficult context in which to attempt quality improvement; arguably a worst case scenario. All the mechanisms for bringing about a change in physical healthcare had either been undermined (nearly all of the nursing staff on the Pilot ward who had received training had moved on), not been triggered (work to develop clinical pathways was limited by the time follow up data were collected) or not had time to take effect (follow up data were collected very soon after implementation of the new screening forms, before nurses had had the time to familiarise themselves with them).

A number of interviewees commented on the absence of strong nursing leadership in the Pilot and about the need for greater attention to have been paid at a senior level to motivating front nursing staff into *wanting* to undertake physical healthcare screening and intervention as part of their role.

That noted, some improvements occurred, resulting partly from the role of the ward's consultant in helping to normalise Lester screening and intervention among junior doctors. This was helped by the decision to coordinate the timing of the introduction of the new assessment screening system with the rotation of junior doctors. Mersey Care came up with the idea for the evaluation's service user survey, which succeeded in facilitating greater understanding of what physical healthcare means to inpatients.

4. Discussion

4.1. Short summary of findings

The study's headline findings indicate that, across the four sites, pilot activities had a positive impact on the CVD screening and interventions that people received and that this is something service users want when they are in hospital.

- Four trusts were funded by NHS England: 2gether, NTW, TEWV and Mersey Care.
- Each used their funding to support existing programmes aimed at ensuring that people with mental health conditions receive screening for common physical health problems, and interventions and treatments for these.
- Pilot site activities included training in physical health screening (all sites), development/implementation of information systems to improve efficiency (all sites), development of networks of physical health link workers or champions (NTW, 2gether) and mapping and development of clinical pathways to link with external NHS and community based services, e.g. cardiology (NTW, Mersey Care).
- Inpatients receiving all five screens increased from 46% across all sites at baseline to 83% at follow up.
- Interventions delivered to those who needed them as a result of appropriate screening increased from 79% to 94%.
- Across all sites 89% of service users surveyed reported wanting one or more tests or support when in mental health hospital.
- A cause for concern is that at follow up 41% of patients who needed an intervention for abnormal blood pressure and 33% of patients who needed an intervention for abnormal blood glucose did not receive one.

4.1.1. Service user experience

Evaluation of four pilot projects conducted under the auspices of NHS England's 'Improving the cardiovascular health of people with a serious mental illness' project has demonstrated that service users and providers share the aspiration of improving services and outcomes.

A questionnaire based survey of inpatients at each of the pilot sites established that the majority of service users want to have tests for various cardiovascular risk factors and are open to having these tests in mental health hospitals and the community. However findings also demonstrate that service users have differing preferences for tests and suggest that tests are not equally acceptable. Desire for physical health testing was inconsistently related to reported level of concern about health. This implies that from a clinical perspective different approaches to screening and intervention may be needed for patients with different levels of concern about, and motivation to change, their physical health. The survey indicated that being 'in' a mental health hospital impacted on service users' health and fitness in various ways. Whereas for some service users being in hospital increased opportunity to eat well and/or keep fit, others found it more difficult due to constrained food choice and lack of opportunity for exercise.

4.2. Making a difference

4.2.1. Aspects of projects that stakeholders felt made a difference

The pilot sites used a range of methods to embed the Lester tool into practice and thereby to address factors perceived as influencing the amount and quality of screening and intervention undertaken. These influences – or 'causal mechanisms' – are summarised in the figure below.

Figure 3: Perceived influences on the amount and quality of CVD screening and intervention in psychiatric inpatient settings*



*As identified in the Project Initiation Documents produced by the four pilot projects for NHS England.

Below we summarise the main methods used by the pilot sites to improve quality in five key implementation domains and the mechanisms through which change may be brought about.

1: Improving recording of physical health data

The pilot sites developed or improved electronic tools in which the Lester tool is embedded, for the purpose of recording and monitoring patients' physical health.

Potential change mechanisms

- Electronic tools make it easier for staff to know if and when they should be checking blood pressure, blood sugar levels, and other well-known CVD risk factors.
- The integration of physical health screening in routine assessment processes supports completion, e.g. through automated reminders to do certain tasks.
- All physical health information is stored in one place, so information retrieval is easier, thus improving clinical decision-making.
- Easier retrieval means monitoring data should be more complete and reliable.

Examples

1. The primary pilot activity of 2gether was the incorporation of the Lester tool into the routinely used paper based nursing assessment tool (Essence of Care) and a Lester tool care plan, which was embedded on the trust-wide electronic record systems (RiO).
2. The primary pilot activity of TEWV was the introduction of a tool – a standalone spreadsheet, accessed from a secure trust shared drive - that enables entry and collation of data derived from assessments and recording of interventions. Graphs depicting measures over time could be generated and printed. The feasibility of this system was piloted on one acute and one rehabilitation ward. Its success in these wards supports wider roll out of such a system.

Interviews with staff in both trusts have led us to conclude that (a) these pilot activities succeeded in triggering some of the change mechanisms referred to above, and (b) the recorded improvements in screening and intervention in these trusts are largely attributable to this activity.

2: Improving clinical skills and confidence to use them

The pilot sites delivered a range of staff training relating to physical health, from 'back to basics' training in screening, to more advanced training in interventions. Additionally pilot sites developed networks of physical health link workers or champions to cascade learning.

Potential change mechanism

- Staff are better able to undertake screenings and interventions prompted by the Lester tool.

Examples

1. TEWV ran a series of training sessions for staff in the two pilot wards.
2. The key pilot activity in NTW was the development of a network of 96 Band 6 Physical Health Link Nurses already working across the trust, using a 'train-the-trainer' approach.

Ensuring that staff who are required to undertake screening and offer interventions are appropriately equipped and motivated to do so was seen as critical in all sites. This we agree with, however it is a challenge in an evaluation of this scale to demonstrate an association between staff training and outcomes. Further evaluation is needed to establish whether and how the train-the-trainers networking approach introduced by NTW is able to normalise good practice in the longer term.

3: Improving interface with primary care and other specialist services

Access to specialist services was variable across different geographical areas of the individual trusts. Pilot sites undertook mapping and development of clinical pathways, to identify gaps in patient access to appropriate care. The rationale for such work is that interventions which cannot be delivered by the mental health trust (e.g. specialist cardiometabolic or diabetic care) require robust clinical pathways to these services.

Potential change mechanism

- Equal access to appropriate interventions is ensured across the trust.

Example

NTW reviewed their cardiometabolic care and pathways. They also mapped diabetic and COPD pathways and made recommendations to the trust's Physical Health and Wellbeing Group with regard to service improvements and gaps in access to specialist services.

Clearly activity was aimed at improving access to appropriate physical health interventions rather than improving screening. Feedback from pilot sites was that it is a comparatively complex and time consuming process and is unlikely to have a significant impact on intervention levels in the short term.

4: Clarifying roles and responsibilities

Trust-wide policies specifying which type of staff are responsible for which physical health screenings and interventions were developed and issued.

Potential change mechanisms

- Demonstrates senior management commitment and 'top down' endorsement of physical healthcare.
- Makes it clearer to staff which physical health screenings and interventions they are expected to carry out, and which their colleagues are expected to carry out, within a certain timeframe.

Example

2gether produced a clear, concise policy on 'Physical Examinations in Inpatient Settings'. It included a table summarising admission and review procedures and specified (a) the health care professional (e.g. admitting doctor) responsible for each assessment (e.g. routine bloods), and (b) the timescale for completing the assessment.

Staff at 2gether acknowledged the importance of this issue and agreed that the policy clarified matters.

5: Improving communication with service users about their physical health

A survey was undertaken by the pilot sites to find out what physical health means to service users and about the forms of screening and intervention they want. Also, the Lester Postcard Prompt⁷ was actively used to facilitate communication with patients on some wards, and was made freely available on others.

Potential change mechanisms

- Survey results can be used to inform communication approaches, e.g. the results indicate that different screening and intervention approaches may be required for patients with different levels of physical health concern and motivation.
- In one-to-one communication with patients the Lester Postcard Prompt can be presented as an authoritative tool and be used to encourage discussion about a range of health issues. The postcard was developed by the National Audit of Schizophrenia service user reference group to empower service users to approach their GP surgery or Mental Health Team to ask how the Lester tool could help improve their physical health.

Examples

1. Mersey Care initiated the development of a service user survey to inform the results of the evaluation. A focus group was run on site, facilitated by a service user consultant from the CCQI evaluation team, to understand which questions should be included in the survey. All sites distributed the questionnaire and were provided with individual reports summarising feedback from service users in their trust.
2. The Lester Postcard Prompt was ordered by the pilot sites for distribution on the wards. TEWV ordered more than 2000 copies, which were disseminated in order to help meet their objective of improving service user awareness and understanding of the importance of physical wellbeing.

⁷ <http://www.rcpsych.ac.uk/pdf/LesterPostcardPrompt.pdf>

Further study is needed to explore the best ways of using the Lester Postcard Prompt in inpatient settings.

4.2.2. Context – importance of CQUIN and other contextual factors

A range of contextual factors will influence whether the quality improvement will be achieved at the local level. In other words, whether change mechanisms are triggered by the activities described above will not only be determined by how well those activities are done but also by the context in which those activities and interventions are introduced.

The wider policy and commissioning context in which the pilot sites were operating – including the current physical health CQUIN, the parity of esteem agenda and availability of the Lester tool – helped to create favourable conditions for local quality improvement. The contexts within which the pilots were implemented were varied with respect to geography, catchment population and number of service sites. As reflected in the baseline audit data, practice was variable at the beginning of the pilot, with some sites, notably NTW, performing much better overall with regard to screening than others.

Case studies demonstrated strong support in each Trust for the national 'agenda' and commitment to improving physical health care provided to people with a severe mental illness. Across sites key informants spoke of high levels of awareness of evidence demonstrating excess morbidity and mortality among service users and referred to the findings of the National Audit of Schizophrenia. Sites were all actively participating in the CQUIN related to physical health care.

We found variation however in the extent to which high level policy had translated into practice at trusts' strategic and operational levels, prior to the pilot. Three trusts (2gether, NTW and TEWV) had established multi-disciplinary working groups which had responsibility for improving practice. Responsibility for physical health care seemed more diffuse in the fourth trust (Mersey Care). This particular trust provided a comparatively challenging context in which to attempt quality improvement, partly because access to the gym and physiotherapists was reportedly very limited.

4.3. Barriers to improvement

Concerns about the applicability and usefulness of the Lester Tool in improving outcomes

Across trusts stakeholders expressed the view that Lester tool is not universally applicable and had limitations in guiding clinical practice. The tool was described as more appropriate with some population groups than others. Use with older people was considered particularly problematic at some pilot sites, with reservations expressed about the appropriateness of introducing smoking cessation, physical exercise and diet plans with those who are particularly elderly and have mobility issues. Other concerns were expressed about the tool's appropriateness with younger people. More work is needed to establish how transferable the Lester tool is to different population groups.

Some clinicians said they found the Lester tool's guidance about how to intervene non-specific, and others felt that the tool lacks advice on how to manage refusal of screening and interventions. This is likely to be more of an issue for staff in trusts lacking detailed physical health policies.

Setting in which screening and intervention should be undertaken

Across sites stakeholders expressed concern about the appropriateness and potential for conducting screening and interventions in units providing short term care for patients who were in acute mental distress. Concern related to the resource capacity of staff working 'under pressure' with such patients and the need to prioritise management of mental health concerns was thought to make it difficult to develop the relationships needed to engage patients in management of their physical health. Smoking and weight were particularly identified as being better dealt with in long stay wards due to these domains not taking priority when trying to stabilise someone's mental state.

Recovery and rehabilitation wards, in contrast, were seen by some to afford greater opportunity for screening and intervention. Service users on these wards were thought likely to be more receptive to attention to their physical health, in part due to stability in mental state and the length of stay. Staff felt better able to support and monitor lifestyle changes on these wards.

Acceptability of CVD screening and interventions to service users

As noted, acceptability of different types of screening and intervention varied widely. However, while staff at the pilot sites felt that some screenings and

interventions may be more appropriate on long stay wards, the results of the service user survey show that there was no significant difference between the type of tests and support service users wanted to receive in hospital versus community settings.

Complex IT systems

A recurrent theme across the pilot sites was the struggle that management and staff have with complex and varying IT systems. All pilot sites introduced or developed electronic tools to overcome this barrier in some way. Case studies demonstrated the importance of information technology in prompting assessment and intervention, and accessing and recording accurate patient information. Difficulties with IT systems were discussed extensively at each pilot site. The main issues identified were:

- inflexibility of systems, which makes them difficult to modify to accommodate the needs of staff and patients;
- contractual agreements with external parties, which limits the type and number of changes that can be made;
- incompatibility with IT systems of external organisations (including primary care and other specialist services), which makes it more difficult to access patient information.

Governance and data sharing

Informants across the sites discussed the resource and time input required to establish governance and data sharing agreements for patient information between trusts and external organisations (including primary care and other specialist services). While many had established working agreements with external organisations, some still reported issues with accessing such data.

Absence of joined up working between services within the trusts

Whilst good MDT working was reported within teams across most of the trusts, there appeared to be gaps in communication between different teams (e.g. from inpatient to community), affecting the continuity of care as patients move between teams. Some informants noted concerns that interventions they had started with patients on inpatient wards would not be continued in the community, however did not have the pathways or resource capacity to follow up with patients once they had left the wards. Limited infrastructure in the community to continue interventions started on wards was also noted.

4.4. Limitations of the evaluation

This evaluation had a number of limitations. First, the limited timescale meant that it was necessary to have a short, 6-9 month gap between baseline and follow up, which did not give pilot sites much time to evidence improvement. Second, there were insufficient resources to collect data on outcomes for individual patients, only on changes in overall levels of screening and intervention. Third, the sample for the inpatient survey was not randomly selected, so the results should be interpreted with caution. Finally, methodologically we cannot determine whether and to what extent the improvements recorded were the result of better recording of what staff were already doing or a reflection real changes to practice. Qualitative feedback suggests that it was a combination of both, but this means that the changes in screening and intervention recorded between baseline and follow up should be interpreted with caution.

4.5. Conclusions

Pilot activities across the four sites evidently had a positive impact on the recording and practice of CVD screening and intervention in psychiatric inpatient settings, which leads us to conclude that the Lester tool is suitable for further roll out. The inpatient survey results and detailed case studies presented in this report offer important lessons for trusts seeking to improve physical health screening and intervention for inpatients. These lessons will be distilled in upcoming resources produced by NHS England. The transferability of the Lester tool to learning disability services will be addressed in a separate report.

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Appendix 1: Descriptive information for each pilot site

A comparison of the four case study mental health NHS Trusts

	2gether NHS Foundation Trust	Northumberland, Tyne and Wear NHS Foundation Trust	Tees, Esk and Wear Valley NHS Trust	Mersey Care NHS Trust
Population served	780,461	1.4M	2 million	1 million+
Turnover (2014-2015)	£106M income	Budget £300M+	£330m	
Service profile	<p>2gether NHS Foundation Trust provides specialist social and mental health care services across Gloucestershire and Herefordshire.</p> <p>The Trust delivers community and inpatient NHS learning disability services; adult and older adults inpatient mental health care at Stonebow (Hereford), Wotton Lawn (Gloucester); Charlton Lane (Cheltenham); psychiatric intensive care at Greyfriars (Gloucester); assertive outreach and recovery services; children and young people emotional wellbeing services; eating disorder services; and Section 136 care at the Maxwell Centre Assessment Suite in Gloucester.</p> <p>Within Gloucestershire, The Back 2 Work service facilitates vocational opportunities and promotes social inclusion for people in recovery from mental ill</p>	<p>Mental Health and Learning Disability, Neuro Disability</p> <p>Northumberland, Tyne and Wear</p>	<p>TEWV provides a range of mental health, learning disability and eating disorders services around County Durham, the Tees Valley, Scarborough, Whitby, Ryedale, Harrogate, Hambleton, Richmondshire and the Vale of York. The Trust has over 160 sites covering 3,600 square miles, which includes rural, coastal and industrial areas.</p>	<p>Mersey Care NHS Trust provides specialist inpatient and community mental health, learning disabilities, addiction management, and acquired brain injury services for the people of Liverpool, Sefton and Kirkby, Merseyside. It also provides secure mental health services for the North West of England, the West Midlands, and Wales. Clinical services are provided across more than 30 sites across Merseyside. These teams are supported by a corporate team based at trust offices in Prescot. The Trust employs 4,000 staff who serve a population of almost eleven million people. In 2014/15, Mersey Care provided care, treatment and support to more than 36,000 people in Liverpool, Sefton and Kirkby, and neighbouring</p>

	<p>health using an evidence based model (IPS).</p> <p>The Trust's occupational health service provides services to public and private organisations through the 'working well 2gether' identity.</p>			St Helens. At 31 March 2015, the Trust had 641 inpatient beds.
No. of staff (WTE)	In December 2015 the Trust WTE was: 1710.18	6000 staff	6,700+	4000+
Structure	<p>In 2010, the Trust started a restructure of services to provide a clinically conceived approach to delivering existing services based on individual need rather than more traditionally based age and IQ criteria.</p> <p>The resultant multi-disciplinary approach is delivered by a devolved locality based model with each county's senior management team in Gloucestershire and Herefordshire, monitoring governance and service delivery through countywide Boards.</p>	<p>3 Clinical Care groups:</p> <ul style="list-style-type: none"> • Community • Inpatient • Specialist <p>Each organised into directorates, including children, adults and older people</p>	Services organised on a Locality Directorate basis split by town for each of the Services i.e. AMH, LD, CAMHS, MHSOP, Forensic MH and LD.	Trust unable to provide detail
Recent history and significant events/changes	2gether was one of the first mental health trusts to achieve Foundation trust status. The applicant organisation, Gloucestershire Partnership NHS Trust, was established when four different organisations came together. These were: Severn NHS Trust, East Gloucestershire NHS Trust, Gloucestershire	<p>Formed in 2006 merging three former organisations. Achieved FT status in 2009.</p> <p>New Chief Exec appointed 2014, introducing a devolved management structure.</p>	<p>In Apr 2006 Tees & North East Yorkshire NHS Trust merged with Co Durham & Darlington Priority Services NHS Trust.</p> <p>In June 2011 TEWV took over the Services of Hambleton & Richmondshire and Harrogate.</p> <p>In September 2015 TEWV took over the Services in York & Selby.</p>	Trust unable to provide detail

	<p>County Council and Gloucestershire Health Authority.</p> <p>The Trust became '2gether NHS Foundation Trust' in April 2008 as part of an initiative to strengthen its identity and pursue a purpose to help 'make life better'.</p>		<p>In July 2008, TEWV became the North East's first mental health trust to achieve foundation trust status under the NHS Act 2006, which enabled the Trust to be accountable to local people through our council of governors and are regulated by Monitor, the independent regulator of foundation trusts.</p>	
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A comparison of the four case study mental health communities

	2gether NHS Foundation Trust	Northumberland, Tyne and Wear NHS Foundation Trust	Tees, Esk and Wear Valley NHS Trust	Mersey Care NHS Trust
No of CCGs	Two – Gloucestershire and Herefordshire	6 CCG's and significant specialised commissioning via NHS England	9 Darlington CCG DDES CCG North Durham CCG Hartlepool & Stockton CCG South Tees CCG Scarborough Ryedale CCG Hambleton & Richmondshire CCG Harrogate & Rural CCG York CCG	<ol style="list-style-type: none"> 1. Liverpool CCG 2. South Sefton CCG 3. Southport & Formby CCG 4. Knowlsey CCG 5. Halton CCG 6. St Helens CCG 7. West Lancashire CCG
CCG engagement and relations	Engagement with both our CCG's is very positive. 2gether have been fortunate to work in partnership with Gloucestershire CCG to develop seamless care through challenging times, such as development of	Relationships generally good and collaborative across the board.	Regular Clinical Quality Resource Groups with Commissioners	Reasonable.

	urgent care/crisis services in line with the crisis concordat. Together continue to work with Herefordshire CCG to ensure delivery and consideration of high quality services through whole system transformation.			
No. of local authorities	Two – Gloucestershire and Herefordshire	6 Local Authorities: Northumberland, North Tyneside, Newcastle, Gateshead, South Tyneside, Sunderland	14 Darlington BC Durham BC Hartlepool BC Stockton BC Middlesbrough BC Redcar & Cleveland BC Craven BC } Hambleton BC } Harrogate BC } - North Richmondshire BC } Yorkshire Ryedale BC } Council Scarborough BC } Selby BC } York BC }	1. Liverpool City Council 2. Sefton City Council 3. Knowsley City Council 4. Halton City Council 5. St Helens City Council 6. Lancashire City Council (all)
Voluntary sector engagement and relations	Our social engagement team are involved with the Herefordshire Sports Festival which aims to promote wellbeing and resilience in our communities, workplaces, schools and homes and promote the fact that good physical health can lead to better mental health. Our Social Inclusion Team also	Significant partnerships with co-commissioned services as well as voluntary and 3 rd sector partners. Significant Home Office and Ministry of Justice partnership working. NTW also has a Volunteer service which supports employed staff by linking	Many voluntary organisations involved with services including: MIND Breakthrough Pybus Citizens Advice Arms Length Mental Health Support Lifeline Stoneham Three Rivers	

	<p>worked as part of a wide range on stat and non-stat services delivering wellbeing sessions to young people which aims to educate primary school children on issues such as road, water and fire safety, first aid and emotional wellbeing.</p> <p>Within Gloucestershire, we work closely with the recovery college which offers courses such as mindfulness and more recently we have been working with people and places (a community interest company). Within Gloucestershire south locality we have been working with the Cotswold Volunteers and Stroud Volunteer and Community Action (VCA) to create a 'green gym'.</p>	<p>with volunteers across the Trust. They are involved with around 300 a year, who are comprised of service users, students and retired people. They are DBS and reference checked, and complement staff in social activities for example, on the units with service users. The service also links with other volunteer Bureaus as service users volunteers move out into the community based voluntary sector services.</p>	<p>Working in partnership with Public Health</p>	
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Appendix 2: Guidance on baseline audit data collection



Lester Pilot Evaluation

Guidance on baseline data collection

About this guidance

This guidance has been provided to assist your Trust/ organisation in collecting data for the Lester Pilot Evaluation.

Data collection

Each Trust/ organisation is expected to complete a data collection form for each patient that has been selected for inclusion in the Evaluation.

Please select **100 consecutive case notes** from the time period before the implementation of pilot activities, i.e. to establish how things were before the pilot started. They need to have been an **inpatient with a minimum 3-night stay**.

NB The 'start date' for the pilot – and consequently the time period for the baseline (before implementation) data collection - is a judgment that needs to be made **in consultation with NHS IQ**, as this will be different for each pilot site.

Please complete a separate form for each patient.

The data collection form

All questions in the data collection form are mandatory except where marked by an asterisk (*).

Please ensure that the information collected about each patient relates to the patient admission that was selected for inclusion in the Evaluation.

The data collection form is split into 3 sections:

1. PATIENT INFORMATION:

This includes date of admission and discharge, year of birth, gender, main ward the patient stayed on and ethnicity.

- **Date of admission and date of discharge:** complete in DD/MM/YYYY format e.g. 05/10/2014.
- **Year of birth:** complete in YYYY format e.g. 1984.

2. SCREENING:

This section looks at screening/ assessments that were carried out at any point during the inpatient stay; from the point of admission up to 30 September 2014 (*for patients who were admitted between 23-30 September completion of screening/ assessments can be extended to 5 working days from date of the admission, i.e. 07/10 if admitted on 30/09*). **If the patient was admitted over a year ago, there should be evidence of screening within the last 12 months.**

At least one response per question is required.

Please note the “not documented” box in this section relates to the information for this screening measure not being recorded in the patient notes.

- **Q1 Smoking status:** Number of cigarettes sub question is optional. If completed, use NNN format e.g. 040
- **Q2 Weight:** Please complete in NN.N format e.g. 26.8 (BMI).
Change in weight over 3 month period can be completed if the patient was in hospital for more than 3 months.
- **Q3 Blood pressure:** Please complete the systolic and diastolic boxes in NNN format e.g. 120 mmHg.
- **Q4 Glucose:** Please complete in N.N format e.g. 6.7 mmol/l. Please ensure you use the correct units. If these levels are in mg/dl, please use an online converter to calculate into mmol/l or mmol/mol (according to data collection form).
- **Q5 Cholesterol:** Please complete in N.N format e.g. 7.5 mmol/l. Please ensure you use the correct units. If entering QRISK-2 percentage score, please complete in NN.N format e.g. 14.3%.

REFUSALS/ EXCEPTIONS: If there is documented evidence that the patient refused to provide information/ undergo screening on more than one occasion this can be recorded on the data collection form and will be treated as an exception. Exceptions can also be recorded for pregnant patients (or who gave birth within the previous 6 weeks) on questions 4 and 6.

3. INTERVENTIONS:

This section looks at interventions that were carried out for each measure, where clinically indicated. Interventions could have been carried out at any point during the inpatient stay; from the point of admission up to 28 November 2014.

- **Q6-Q10:** please tick all that apply.

REFUSALS/ EXCEPTIONS: If there is documented evidence that the patient refused intervention this can be recorded on the data collection form and will be treated as an exception.

Online data submission

Each data collection form has to be submitted online. Information about how to submit data online will be emailed to contacts for the evaluation at pilot sites in January.

Support and guidance from the RCPsych evaluation team

For further assistance and information please contact Sonya Chee on schee@rcpsych.ac.uk or 020 3701 2686.

Appendix 3: Guidance on follow up audit data collection



Lester Pilot Evaluation

Guidance on follow up data collection

About this guidance

This guidance has been provided to assist your Trust in collecting data for the Lester Pilot Evaluation.

Data collection timeline

31 August 2015	Start data collection
16 October 2015	Data entry deadline if submitting data via a spreadsheet
30 October 2015	Data entry deadline if submitting data via the Formic website

Data collection

Each Trust is expected to complete a data collection form for each patient that has been selected for inclusion in the Evaluation.

Please select **100 consecutive case notes** from the **31 August 2015**. They need to have been an **inpatient with a minimum 3-night stay**. If necessary, e.g. to get a large enough sample, you can go back to **3 August 2015**. However, we strongly recommend that you collect data as late as is feasible to allow for as much time as possible from the implementation of pilot activities, i.e. to establish any changes to results during the pilot.

Please complete a separate form for each patient.

The data collection form

All questions in the data collection form are mandatory except where marked by an asterisk (*).

Please ensure that the information collected about each patient relates to the patient admission that was selected for inclusion in the Evaluation.

The data collection form is split into 3 sections:

4. PATIENT INFORMATION:

This includes date of admission and discharge, year of birth, gender, main ward the patient stayed on and ethnicity.

- **Date of admission and date of discharge:** complete in DD/MM/YYYY format e.g. 05/10/2015.
- **Year of birth:** complete in YYYY format e.g. 1984.

5. SCREENING:

This section looks at screening/ assessments that were carried out at any point during the inpatient stay.

At least one response per question is required.

Please note the “not documented” box in this section relates to the information for this screening measure not being recorded in the patient notes.

- **Q1 Smoking status:** Number of cigarettes subquestion is optional. If completed, use NNN format e.g. 040
- **Q2 Weight:** Please complete in NN.N format e.g. 26.8 (BMI). Change in weight over 3 month period can be completed if the patient was in hospital for more than 3 months.
- **Q3 Blood pressure:** Please complete the systolic and diastolic boxes in NNN format e.g. 120 mmHg.
- **Q4 Glucose:** Please complete in N.N format e.g. 6.7 mmol/l. Please ensure you use the correct units. If these levels are in mg/dl, please use an online converter to calculate into mmol/l or mmol/mol (according to data collection form).
- **Q5 Cholesterol:** Please complete in N.N format e.g. 7.5 mmol/l. Please ensure you use the correct units. If entering QRISK-2 percentage score, please complete in NN.N format e.g. 14.3%.

REFUSALS/ EXCEPTIONS: If there is documented evidence that the patient refused to provide information/ undergo screening on more than one occasion this can be recorded on the data collection form and will be treated as an exception. Exceptions can also be recorded for pregnant patients (or who gave birth within the previous 6 weeks) on questions 2 and 4.

6. INTERVENTIONS:

This section looks at interventions that were carried out for each measure, where clinically indicated. Interventions could have been carried out at any point during the inpatient stay.

- **Q6-Q10:** please tick all that apply.

REFUSALS/ EXCEPTIONS: If there is documented evidence that the patient refused intervention this can be recorded on the data collection form and will be treated as an exception.

Data submission

Each data collection form has to be submitted online by **30 October 2015**. Information about how to submit data online can be found in the separate ‘Guidance for online data submission’ document.

As at baseline, we will also allow Trusts to submit their data via a spreadsheet, if this is more convenient. However, due to the need for data cleaning the deadline for using this data submission method is earlier: **16 October 2015**.

Please note that we will be unable to grant any extensions for data submission, regardless of which method is used

Support and guidance from the RCPsych evaluation team

For further assistance and information please contact the eLester team:

Suzie Lemmey on slemmey@rcpsych.ac.uk or 020 3701 2689, or

Sonya Chee on schee@rcpsych.ac.uk or 020 3701 2686.

Appendix 4: Guidance on online data collection



Lester Pilot Evaluation

Guidance for online data submission

About this guidance

This guidance is provided to assist your Trust/ organisation in submitting data online for the Lester Pilot Evaluation.

Accessing the online data entry form

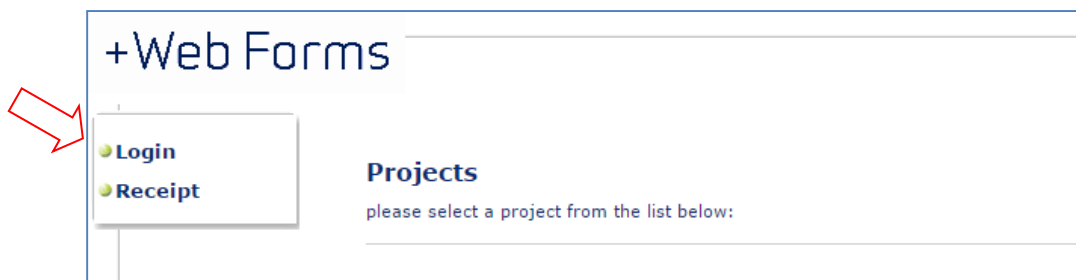
The local lead for the evaluation for your Trust/ organisation will be emailed your username and password. You will need this information to access the online data entry form. Please note, the password is case-sensitive.

Your username is unique to your organisation and enables the Lester Pilot Evaluation team to link your submissions to your Trust/ organisation.

How to access the data collection form online

Link for the online data collection form is: <http://rcop.formic.com>

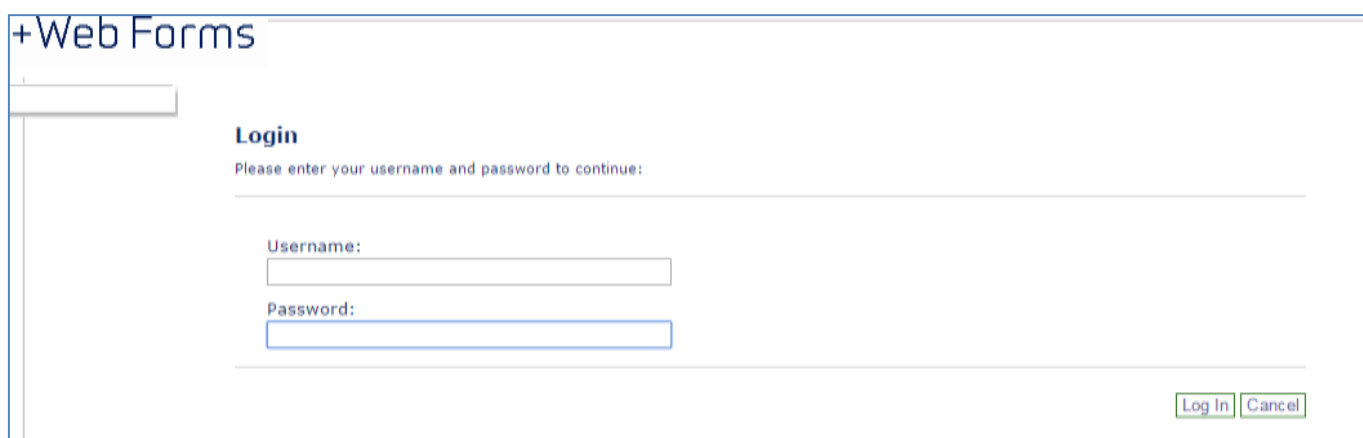
Click 'Login' at the left hand side of the screen.



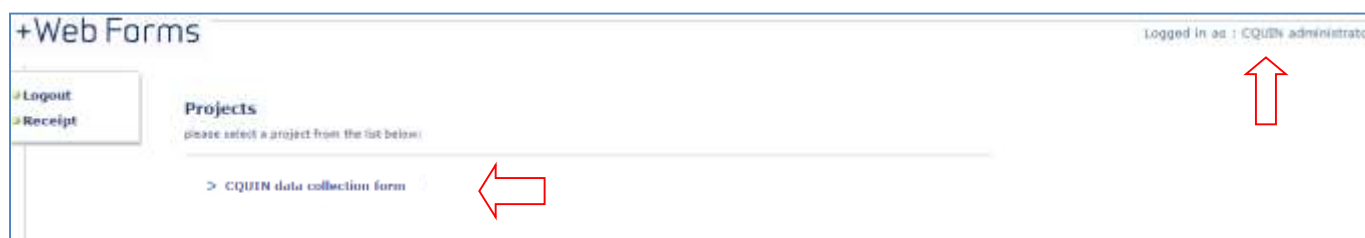
This leads you to the Login page where you need to enter your username and password. These details have been emailed to the lead for the evaluation for your Trust/ organisation. Enter your username and password (passwords are case-sensitive).



Click on the 'Log In' button located in the bottom right hand corner of the screen.

A screenshot of the login page. The title is '+Web Forms'. Below the title, there is a 'Login' section with the instruction 'Please enter your username and password to continue:'. There are two input fields: 'Username:' and 'Password:'. At the bottom right, there are two buttons: 'Log In' and 'Cancel'.

This takes you to the Projects page where the link to the online data entry form '**Lester Pilot Evaluation data collection form**' is available. Your Trust/ organisation name is displayed in the top right hand corner. Clicking on the survey link takes you to the online data collection form.



Navigational tools

Links to help you navigate through the form are available at the top left hand corner of the survey and at the bottom of the page. **Note: The snapshots below are for the CQUIN data collection form, but the navigational tools are the same on the Lester Pilot Evaluation form.**

The screenshot displays the 'Mental Health CQUIN 2014/2015 (Indicator 1) Data collection form'. At the top left, a '+Web Forms' header is visible with a red arrow pointing to it. Below this is a 'Project Navigation' sidebar containing links for 'NEXT PAGE', 'PREVIOUS PAGE', 'CANCEL', 'CLEAR', 'SAVE', and 'SUBMIT'. The main content area features the logos for 'RC PSYCH' (Royal College of Psychiatrists) and 'NHS England'. A central box contains instructions: 'Please complete this CQUIN form for each patient. Before completing this form please read the guidance document. All data must be submitted online by 16 January 2015.' Below this, a form field is shown with a checkbox for 'Patient was pregnant/gave birth within the last 6 weeks (weight not measured)'. Further down, there are input fields for 'BMI (Body Mass Index) (kg/m2) and/or' and a section for 'Change in weight over a 3 month period' with checkboxes for 'No sig' and '< 5kg increase'. At the bottom, a navigation bar includes 'PREVIOUS PAGE', 'CANCEL', 'CLEAR', 'SAVE', 'SUBMIT', and 'NEXT PAGE'. A red arrow points to the 'CANCEL' button.

The navigational tools include options to go to the 'previous page', 'next page' or to 'cancel', 'clear', 'save', and 'submit' your data.

Clicking 'cancel' takes you back to the 'Projects' page. Please note that clicking 'clear' **deletes all the information you have completed on the form**, not just on that specific page. The 'save' option enables you to save partially completed forms for completion at a later date.

Data missed or completed inaccurately on the form will be displayed in the 'Completion Errors' box. Details include the page where the error(s) are, and what the error for that particular question is. To return to the question simply click on the link in the box.

How to access a partially completed form

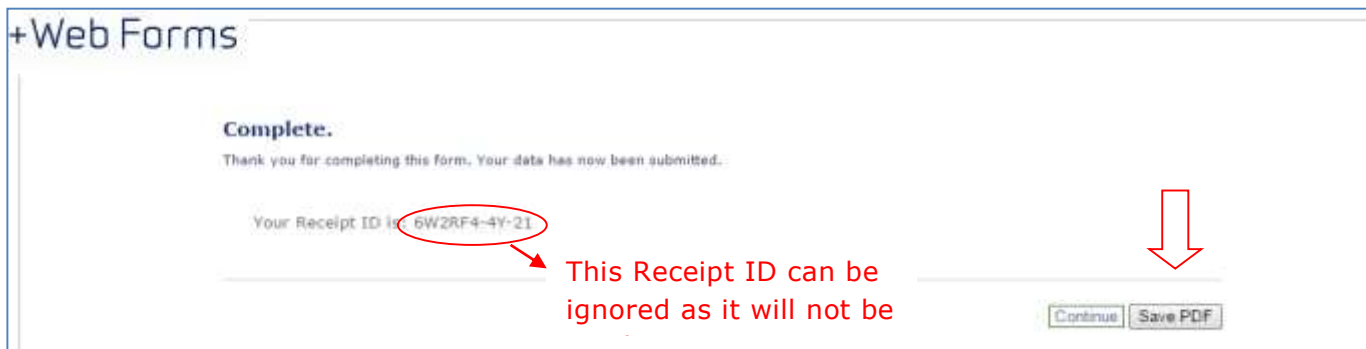
A receipt number will be generated for each form you save for completion later. If more than one person is entering data for your organisation then we advise you save this receipt number to avoid mistakenly opening and entering data on your colleagues incompleated forms.

To access the incompleated form, navigate back to the Projects page and click on the message “You have partially completed copies of this form”. A list of saved forms will appear showing the date and time it was last saved. To access the form, click on the receipt number:

Project	Date/Time	Receipt ID
> CQUIN data collection form	10/12/2014 15:13	(6S2QF8-4R-29)
	10/12/2014 15:16	(6T2Q77-4R-29)
	10/12/2014 15:16	(6U2QY6-4R-29)

After submission you will be taken to the ‘Complete’ page which will display a thank you message (once you have submitted a form you will not be able to return to it).

On this screen, you can save your submitted form as a PDF. This is located in the bottom right corner of the page. Clicking on 'continue' will take you back to the Projects page where you can submit data for another patient.



Contact information

For further assistance and information please contact Sonya Chee on schee@rcpsych.ac.uk or 020 3701 2686.

Appendix 5: Audit data collection tool



Lester Pilot Evaluation

Data collection form

Please complete this form for each patient. Before completing this form please read the guidance document.

All data must be collected and submitted online. Information on how to submit data online will be provided by NHS IQ.

For further assistance and information please contact Suzie Lemmey on slemmey@rcpsych.ac.uk or 020 3701 2689.

All questions are mandatory except where marked by an asterisk (*)

Patient identifier

(this can be a code which allows you to identify the patient on whom data are collected)

Initials of data collector/clinician

PATIENT INFORMATION

Date of admission

D	D	/	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Date of discharge

Patient was discharged on

D	D	/	M	M	/	Y	Y	Y	Y
---	---	---	---	---	---	---	---	---	---

Still an inpatient at time of data collection

Year of birth

Y	Y	Y	Y
---	---	---	---

Gender

- Male
 Female
 Other

Main ward the patient stayed on during this admission

- Acute inpatient ward
 Psychiatric intensive care unit (PICU)
 Low secure unit
 Medium or high secure unit
 Child and adolescent mental health ward
 Older adults ward
 High dependency/rehabilitation ward
 Other (including learning disability, eating disorder, mother and baby units)

Ethnicity

White	Black or Black British	Asian or Asian British	Mixed	Other ethnic groups
<input type="checkbox"/> British	<input type="checkbox"/> African	<input type="checkbox"/> Bangladeshi	<input type="checkbox"/> Asian & White	<input type="checkbox"/> Chinese
<input type="checkbox"/> Irish	<input type="checkbox"/> Caribbean	<input type="checkbox"/> Indian	<input type="checkbox"/> Black African & White	<input type="checkbox"/> Any other ethnic background
<input type="checkbox"/> Any other White background	<input type="checkbox"/> Any other Black background	<input type="checkbox"/> Pakistani	<input type="checkbox"/> Black Caribbean & White	<input type="checkbox"/> Not documented
		<input type="checkbox"/> Any other Asian background	<input type="checkbox"/> Any other Mixed background	

SCREENING

The next questions relate to whether information has been recorded during the inpatient stay.

Q1 Smoking status

- Current smoker ---> *Enter number of cigarettes smoked per day(optional):
- Ex-smoker or non-smoker
- Not documented
- Documented evidence of refusal to provide information on more than one occasion

Q2 Weight

Is information about weight recorded in the patient's notes?

- Yes (please enter at least one value below)
- Not documented
- Documented evidence of refusal to be weighed/measured on more than one occasion
- Patient was pregnant/gave birth within the last 6 weeks (weight not measured)

. BMI (Body mass Index) (Kg/m²) **and/or**

Change in weight over a 3 month period: > 5kg < 5kg increase

Q3 Blood pressure during inpatient stay

Is information about blood pressure recorded in the patient's notes?

- Yes (please enter at least one value below)
- Not documented
- Documented evidence of refusal to take blood pressure on more than one occasion

Systolic (mmHg) **and/or**

Diastolic (mmHg)

Q4 Glucose during inpatient stay (please ensure you use the correct units)

To convert from mg/dl into mmol/l please click [here](#)

Is information about blood glucose recorded in the patient's notes?

- Yes (please enter at least one value below)
- Not documented
- Documented evidence of refusal of blood test when offered on more than one occasion
- Patient was pregnant/gave birth within the last 6 weeks (glucose screening not carried out)

. Fasting plasma glucose (**mmol/l**) and/or

. Glycated haemoglobin or HbA1c (**mmol/mol**) and/or

. Random plasma glucose (**mmol/l**)

Q5 Cholesterol during inpatient stay (please ensure you use the correct units)

To convert from mg/dl into mmol/l please click [here](#)

Is information about cholesterol recorded in the patient's notes?

- Yes (please enter at least one value below)
- Not documented
- Documented evidence of refusal of blood test when offered on more than one occasion

. Total cholesterol (**mmol/l**) and/or

. Non-HDL cholesterol (**mmol/l**) and/or

. QRISK-2 score (%)

INTERVENTIONS

Please tick all that apply.

Q6 Interventions for smoking cessation

- Brief intervention
 - Referral to smoking cessation service
 - Combined NRT (nicotine replacement therapy) and/or varenicline
 - Individual/group behavioural support
 - Documented evidence of refusing intervention
 - No intervention needed
 - Not documented
-

Q7 Interventions for weight gain/obesity

- Mental health medication review with respect to weight (e.g. antipsychotic)
 - Advice or referral about diet
 - Advice or referral about exercise
 - Behavioural therapy/intervention
 - Pharmacological intervention for obesity commenced or reviewed (e.g. orlistat or sibutramine)
 - Referral to primary or secondary care physician
 - Documented evidence of refusing intervention
 - No intervention needed
 - Not documented
-

Q8 Interventions for hypertension

- Mental health medication review with respect to high blood pressure (e.g. antipsychotic)
 - Advice or referral about diet/salt intake
 - Advice or referral about exercise
 - Anti-hypertensive drug treatment commenced or reviewed
 - Referral to primary or secondary care physician
 - Documented evidence of refusing intervention
 - No intervention needed
 - Not documented
-

Q9 Interventions for diabetes/high risk of diabetes

- Mental health medication review with respect to glucose regulation (e.g. antipsychotic)
 - Advice or referral about diet
 - Advice or referral about exercise
 - Pharmacotherapy for diabetes commenced or reviewed (e.g. metformin, insulin, acarbose or exenatide)
 - Referral to structured lifestyle education programme
 - Referral to primary or secondary care physician
 - Documented evidence of refusing intervention
 - No intervention needed
 - Not documented
-

Q10 Interventions for dyslipidemia

- Mental health medication review to lower blood lipids (e.g. antipsychotic)
- Advice or referral about diet
- Advice or referral about exercise
- Lipid modification medication (e.g. statin)
- Referral to primary or secondary care physician
- Documented evidence of refusing intervention
- No intervention needed
- Not documented

Thank you for completing the form for this patient

Click "submit" to enter.

Appendix 6: Demographic characteristics of the audit samples

Baseline: gender

Trust	Male	Female	Sample size
NTW	76	24	100
TEWV	44	8	52
2gether	56	44	100
Mersey Care	84	0	84
		Total sample	336

Baseline: ethnicity

Trust	White	Black or Black British	Asian or Asian British	Mixed	Other ethnic groups	Not documented	Sample size
NTW	89	3	7	0	1	0	100
TEWV	50	1	1	0	0	0	52
2gether	90	3	1	2	2	2	100
Mersey Care	65	4	5	3	5	2	84
						Total sample	336

Follow up: gender

Trust	Male	Female	Sample size
NTW	70	30	100
TEWV	26	3	29
2gether	58	42	100
Mersey Care	31	0	31
Total sample			260

Follow up: ethnicity

Trust	White	Black or Black British	Asian or Asian British	Mixed	Other ethnic groups	Not documented	Sample size
NTW	92	3	3	2	0	0	100
TEWV	28	0	0	0	0	1	29
2gether	88	2	1	7	1	1	100
Mersey Care	24	5	1	0	0	1	31
Total sample						260	

Appendix 7: Breakdown of interventions carried out by Trusts

Table 7: Breakdown of interventions carried out: 2gether

Intervention	Smoking		Weight		Hypertension		Glucose		Cholesterol	
	Base line n=19	Follow up n=16	Base line n=46	Follow up n=44	Base line n=10	Follow up n=10	Base Line n=6	Follow up n=4	Base line n=0	Follow up n=0
Brief Intervention	13 (68%)	10 (63%)								
Referral to smoking cessation service	4 (21%)	4 (25%)								
Pharmacological intervention	7 (37%)	6 (38%)	0 (0%)	0 (0%)	2 (17%)	2 (12%)	1 (17%)	2 (50%)	0 (0%)	0 (0%)
Mental health medication review			1 (2%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (25%)	0 (0%)	0 (0%)
Advice or referral about diet			18 (39%)	42 (95%)	3 (25%)	7 (41%)	3 (50%)	2 (50%)	0 (0%)	0 (0%)
Advice or referral about exercise			36 (78%)	40 (91%)	5 (42%)	5 (29%)	1 (17%)	1 (25%)	0 (0%)	0 (0%)
Behavioural therapy/intervention	0 (0%)	3 (19%)	0 (0%)	0 (0%)						
Referral to primary or secondary care physician			0 (0%)	0 (0%)	2 (17%)	3 (18%)	4 (67%)	1 (25%)	0 (0%)	0 (0%)
Referral to structured lifestyle education programme							0 (0%)	0 (0%)		
Average number of interventions received per patient	1.26	1.44	1.2	1.86	1.2	1.7	1.5	1.75	0	0

Table 8: Breakdown of interventions carried out: NTW

Intervention	Smoking		Weight		Hypertension		Glucose		Cholesterol	
	Base line (n=54)	Follow up (n=84)	Base line (n=49)	Follow up (n=67)	Base line (n=14)	Follow up (n=13)	Base line (n=13)	Follow up (n=8)	Base line (n=9)	Follow up (n=0)
Brief Intervention	54 (100%)	84 (100%)								
Referral to smoking cessation service	7 (13%)	4 (5%)								
Pharmacological intervention	3 (6%)	1 (1%)	1 (2%)	1 (1%)	5 (36%)	2 (15%)	4 (31%)	3 (38%)	5 (56%)	0 (0%)
Mental health medication review			42 (86%)	4 (6%)	11 (79%)	0 (0%)	10 (77%)	1 (13%)	7 (78%)	0 (0%)
Advice or referral about diet			45 (92%)	62 (93%)	13 (93%)	9 (69%)	13 (100%)	7 (88%)	5 (56%)	0 (0%)
Advice or referral about exercise			45 (92%)	58 (87%)	11 (79%)	9 (69%)	12 (92%)	5 (63%)	5 (56%)	0 (0%)
Behavioural therapy/ intervention	3 (6%)	3 (4%)	13 (27%)	1 (1%)						
Referral to primary or secondary care physician			13 (27%)	0 (0%)	2 (14%)	2 (15%)	3 (23%)	1 (13%)	2 (22%)	0 (0%)
Referral to structured lifestyle education programme							2 (15%)	0 (0%)		
Average number of interventions received per patient	1.24	1.12	3.24	1.88	3.00	1.69	3.38	2.13	2.67	0

Table 9: Breakdown of interventions carried out: TEWV

Intervention	Smoking		Weight		Hypertension		Glucose		Cholesterol	
	Base line (n=8)	Follow up (n=8)	Base line (n=13)	Follow up (n=11)	Base line (n=4)	Follow up (n=2)	Base line (n=2)	Follow up (n=2)	Base Line (n=0)	Follow up (n=0)
Brief Intervention	6 (75%)	6 (75%)								
Referral to smoking cessation service	0 (0%)	4 (50%)								
Pharmacological intervention	2 (25%)	3 (38%)	0 (0%)	0 (0%)	1 (25%)	2 (100%)	1 (50%)	2 (100%)	0 (0%)	0 (0%)
Mental health medication review			3 (23%)	1 (9%)	1 (25%)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)
Advice or referral about diet			5 (38%)	5 (45%)	0 (0%)	0 (0%)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
Advice or referral about exercise			5 (38%)	10 (91%)	2 (50%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Behavioural therapy/intervention	0 (0%)	0 (0%)	0 (0%)	0 (0%)						
Referral to primary or secondary care physician			0 (0%)	0 (0%)	0 (0%)	0 (0%)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
Referral to structured lifestyle education programme							0 (0%)	0 (0%)		
Average number of interventions received per patient	1.00	1.63	1.00	1.45	1.00	1.00	3.00	1.00	0	0

Table 10: Breakdown of interventions carried out: Mersey Care

Intervention	Smoking		Weight		Hypertension		Glucose		Cholesterol	
	Base line (n=11)	Follow up (n=1)	Base line (n=5)	Follow up (n=0)	Base line (n=4)	Follow up (n=0)	Base line (n=3)	Follow up (n=0)	Base Line (n=0)	Follow up (n=0)
Brief Intervention	5 (45%)									
Referral to smoking cessation service	6 (55%)									
Pharmacological intervention	0 (0%)		0 (0%)		4 (100%)		3 (100%)		0 (0%)	
Mental health medication review			0 (0%)		0 (0%)		0 (0%)		0 (0%)	
Advice or referral about diet			6 (100%)		0 (0%)		0 (0%)		0 (0%)	
Advice or referral about exercise			0 (0%)		0 (0%)		0 (0%)		0 (0%)	
Behavioural therapy/intervention	0 (0%)		0 (0%)							
Referral to primary or secondary care physician			0 (0%)		0 (0%)		0 (0%)		0 (0%)	
Referral to structured lifestyle education programme							0 (0%)			
Average number of interventions received per patient	1.00		1.00		1.00		1.00		0	

Appendix 8: Notes from service user focus group

Mersey Care Service User Focus Group, Wednesday, 16th April, 2015

Attendees

5 adult service users from Mersey Care Trust: 4 men, 1 woman; all white British aged 35+, four out of five patients had experience of acute inpatient care

Angela Etherington (RCPsych service user consultant, facilitator)

Sonya Chee (RCPsych project worker, minutes)

Introduction

Angela and Sonya introduce themselves to the group, the [Lester tool](#), and the project. The objective of the focus group is to find out about people's experience of physical health and physical health support who have used services in Mersey Care Trust.

The Lester Positive Cardiometabolic Health Resource provides practitioners with a simple assessment and intervention framework to protect the cardiovascular and metabolic health of patients with severe mental illness receiving antipsychotic medication.

The following challenges relating to improving physical health screening and intervention were made during initial discussions:

- Physical pain claims were dismissed by GPs as products of mental health problems. One service user explains that they had to go to 3 different GPs until one referred him to have an ECG which revealed heart problems
- Confusion over staff responsibility of physical health problems. Suggestion that there should be a lead person (perhaps a GP) when a person is receiving complicated treatments.
- One service user explains that their cardiologist advised them to speak to their psychiatrist about side effects of their antidepressants and the psychiatrist said dismissively "what does a cardiologist know about antidepressants?"
- NHS needs to improve how mental health staff are treated and perceived by other health care professionals. Physical health is prioritised.

A. Service users' expectations regarding physical health

- i. How much choice do you have when having physical health checks? (i.e. location, time of day, practitioner)
 - "If there is a choice, I don't know what it is"
 - "I have to go to two different places for my diabetes tests"
 - No coordination of services
 - "If you miss specific times and dates – it's really hard to get another appointment"
 - The group did report that they have a choice of practitioner and with providing bloods after fasting

B. Value placed on physical health

- i. What would make you want to look after yourself? What would make it easier for you to look after your physical health?
 - A better quality of life would make it easier to prioritise physical health
 - Coming off medication (because it causes weight gain, demotivates)
 - If improving my physical health would help me avoiding pain then this would motivate me to do so
 - Shorter waiting times for results
 - An understanding, knowledgeable carer to support you. Too often carers are not informed about diagnoses, medication or side effects
 - More physical health doctors in mental health settings
 - Clarity over who to approach to get help – “I get tired easily – but I don’t know if that’s to do with my antidepressants, diabetes, depression or age – and I don’t know where to go to get answers.”
- ii. To what extent did you feel you were given information about potential adverse physical effects of medication and were empowered to make a decision weighing up the risks and benefits?
 - No information given about medication and the side effects – “when I experienced difficulties swallowing, I didn’t know if they were side effects from my medication or another problem”.
 - To help with my choice of medication, I developed an advanced statement when I was well, which I hold on to when I’m feeling unwell to direct people on how to treat me. Others should be empowered to do this when they are well.
 - The Trust has a good pharmacy website – but it is not clear how many people are aware of this, and access this.
 - Recovery sessions, in which such information is provided, happen on wards
 - Involvement in the Trust as a service user representative improves my awareness of how to access information
- iii. To what extent was information shared with you about why specific physical health checks may be needed to check that you were not experiencing adverse effects from your medication?
 - Mixed response from the group. One service user said that they did not even get told what their diagnosis was or what it meant
 - “If you ask them, they will tell you”
 - “The nature of my psychiatrist makes me feel like I can ask them”
 - “I don’t always know what the tests are for”

C. How best to support service user engagement in physical health improvement

- i. Are you aware of local resources, and what are they?
 - Care coordinator or CPN should be responsible for linking into local resources
 - Recovery College
 - People are aware of local resources but at the end of the day it’s also a lifestyle choice: “everyone knows that a bag of apples of healthier than a bag of crisps, but people will still buy the crisps”
- ii. How realistic are interventions in practice? I.e. smoking cessation – how much of this type of support can people access, is there a financial cost, is the support joined up between services if the patient uses a range of services or is moving between services, etc.
 - Food – it is not always cheap or easy to access healthy options (e.g. if you do not have a car, you can’t drive to a big supermarket).

- Smoking – if people are on 20/day and are very ill, you cannot expect them just to give up instantaneously and cut them off.
- iii. What would enable you to improve your physical health? I.e. how would you like to monitor your physical health/do or would you like to use technology to monitor your physical health?
- Not sure what is available
 - Most people don't have smartphones to use apps
 - More regular care plan reviews would help
 - More information about illicit drugs and effects on physical health
- iv. What would be the best way of reminding you if a physical health check was due?
- Whatever your preference is, e.g. phone, letter or text, it should be recorded in your case notes, so that reminders come to you that way.
- v. How do you access information? How would you like to access information?
- Contact someone like a service user/carer representative
 - Internet search (although it is not always clear which sites are reliable)
 - GP, CPN
 - Other service user
 - Information packs from Trusts – mixed feedback on usefulness and some need to be updated
 - There are lots of adhoc initiatives (e.g. stalls at GP surgeries or Trust sites on what's available), it would be good if there was something more regular
 - Sometimes people from an organisation will develop a list of everything that is available, but that person will leave, and the information is lost
 - It would be good to be able to access information somewhere in the community that is not stigmatised – like a community café or similar.
- vi. How can questions/suggestions for interventions around physical health be asked without conveying judgement?
- Role modelling is important – it's not fair for someone to give me advice on weight if they are overweight themselves
 - Conveying information in a diplomatic, social, non-prescriptive way
 - Ask questions in the following style: *What kind of exercise do you do? (not 'do you exercise?')/how do you feel about diet/smoking/exercise? /What do you find difficult about giving up smoking/What would help you give up smoking?/What would you like to see change to help you stop?*
 - Explain why you are asking the questions you are

D. Views on the form, content and distribution of the survey questionnaire (developed out of the focus group)

- Postal surveys will not get a good response
- Get care coordinators/GPs/psychiatrists to go through the questionnaire with people
- Put up posters to raise awareness about them
- Put information about the College on the questionnaires – people will think it is important because it has come from a big national organisations
- Give out a SU Lester resource with the questionnaire
- Enter people into a raffle/financial incentives

Additional questions might include: Are people confident in challenging information/advice?

Appendix 9: Inpatient survey questionnaire



Physical Health Questionnaire

Keeping fit and improving your physical health helps you to live healthier and longer.

Your mental health Trust is working to help people who use their services improve their physical health, as part of a pilot funded by NHS-Improving Quality.

Your mental health Trust would like you to fill out this questionnaire, so they can change their services to help you to be as physically fit and healthy as possible.

Your feedback is private, and confidential. You won't be asked to provide your name or any other personal details.

How to complete the questionnaire:

Please complete this paper copy of the questionnaire and return it in the pre-paid envelope provided by the Friday, 28th August, 2015. You do not need a stamp.

If you would prefer, you can complete this questionnaire online by following the instructions at: www.rcpsych.ac.uk/elester

Frequently asked questions are at the back of the questionnaire.

If you have any further questions, please contact Sonya Chee, phone: 0203 701 2686, email: schee@rcpsych.ac.uk

Please answer the questions below as honestly as you can. There is an open question at the end where you will be able add any further comments you may have.

PHYSICAL HEALTH CHECKS AND SUPPORT

This section is about your views on the screening tests that are sometimes made to keep a check on people's physical health and the support that may be offered afterwards.

1. Which types of support or testing do you want to have when you are in a mental health hospital (sometimes called psychiatric hospital)?
(Please tick any that apply.)

Support to help me cut down or quit smoking

Support to help me improve my diet and exercise habits

Monitoring of my weight

Blood pressure tests

Blood testing to check for my risk of diabetes

Blood testing to check my cholesterol level

Other (please specify):

None – I don't want any of these types of testing and support when I'm in a mental health hospital

2. Which types of support or testing would you like to have at other times - when you are not in a mental health hospital? (Please tick any that apply.)

Support to help me cut down or quit smoking

Support to help me improve my diet and exercise habits

Monitoring of my weight

Blood pressure tests

Blood testing to check for my risk of diabetes

Blood testing to check my cholesterol level

Other (please specify):

None – I don't want any of these types of testing and support for my physical health

YOUR PHYSICAL HEALTH

This section is about how you feel about your physical health.

3. In general, would you say your physical health is:

Very good

Good

OK

Poor

Very Poor

4. How concerned are you about your physical health?

A lot concerned

Quite a bit concerned

Moderately concerned

A little concerned

Not at all concerned

BEING PHYSICALLY FIT AND HEALTHY

This section is about things that may stop you from being physically fit and healthy.

5. How often do your mental health problems stop you from being physically fit and healthy?

Always

Often

Sometimes

Rarely

Never

6. Which healthcare professional(s) would you speak to if you thought your medication for your mental health was having a bad effect on your physical health? (Please tick all of those you would speak to.)

Care coordinator

Psychiatrist

GP

Other, please specify:

None

7. Does being in a mental health hospital make keeping fit:

A lot easier

A little easier

Makes no difference

A little harder

A lot harder

Please explain your answer:

8. Does being in a mental health hospital make eating healthily:

A lot easier

A little easier

Makes no difference

A little harder

A lot harder

Please explain your answer:

9. How confident are you that your mental health care team takes your physical health concerns seriously?

Very confident

Confident

Somewhat confident

Not very confident

Not at all confident

Not applicable – I don't have any concerns about my physical health

10. Where do you get information about how to be physically fit and healthy?

Care coordinator

Friends/family

Other, please specify:

Psychiatrist

Internet

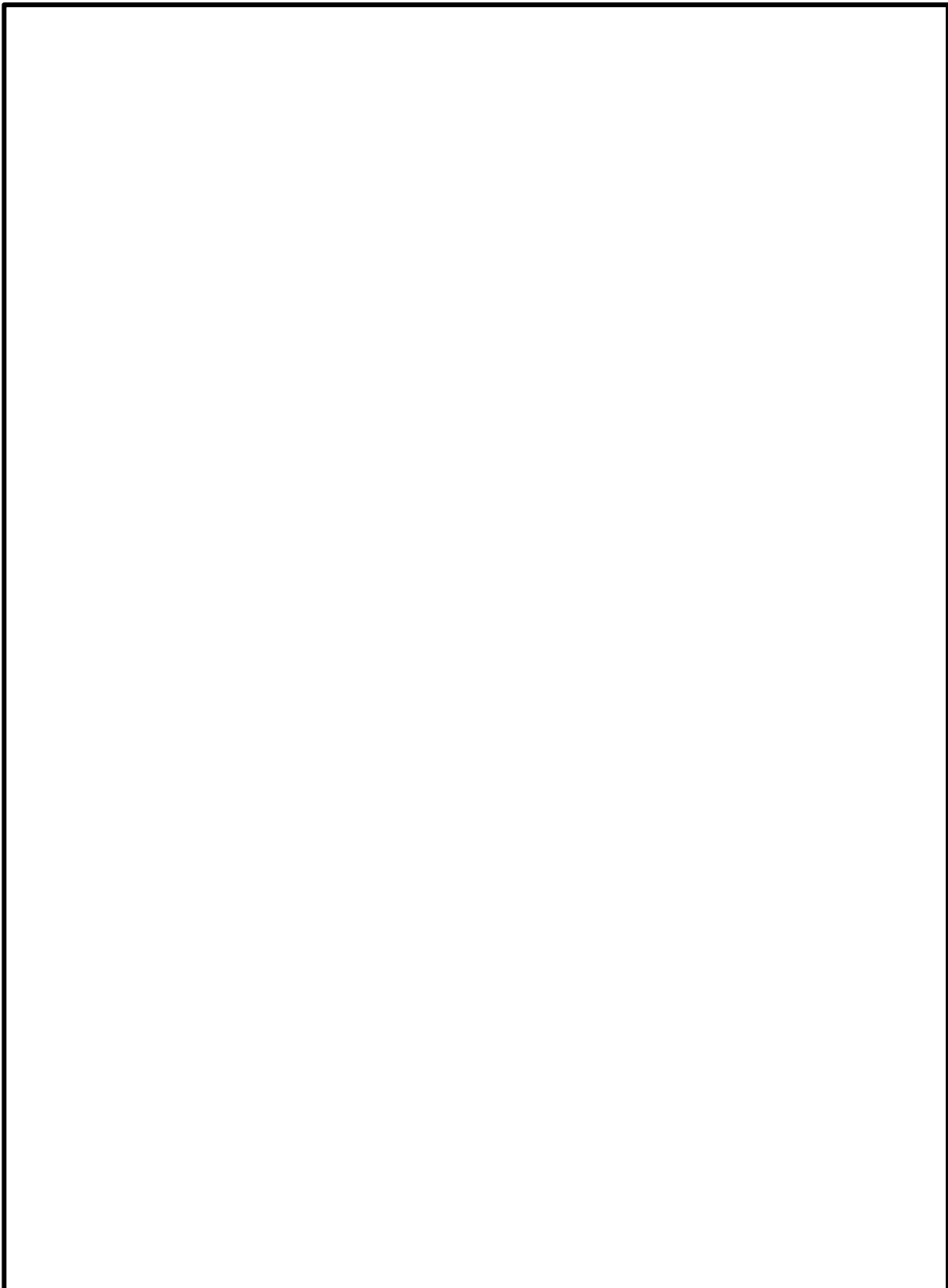
GP

Leaflets

None

OTHER COMMENTS AND FEEDBACK ABOUT WHAT YOU NEED TO BE PHYSICALLY FIT AND HEALTHY

If you would like to add anything about what help you need to be physically fit and healthy, please write it in the box below.

A large, empty rectangular box with a black border, intended for the user to write their comments and feedback.

BACKGROUND INFORMATION

The following information will help us to understand your situation better and interpret your answers more effectively.

1. Are you a patient in a mental health hospital at the moment?

Yes

No

If yes, please tick the type of ward or unit you are currently in:

PICU (psychiatric intensive care unit)

Acute

Rehabilitation

Other, please specify:

2. What is your age?

Under 18 years old

18-25 years old

26-45 years old

46-65 years old

Over 65 years old

3. What is your gender?

Female

Male

4. Your ethnic background? (Please tick one box.)

White British

Other White background

Mixed
(including White and Black Caribbean; White and Black African; White and Asian; Other Mixed background)

Asian or Asian British
(including Indian, Pakistani, Bangladeshi, Other Asian background)

Black or Black British
(including Caribbean; African; Other Black background)

Chinese

Other

***MANY THANKS
FOR YOUR HELP.***

Frequently asked questions

1. Why is the information being collected by the CCQI?

The CCQI is working with your mental health Trust to find out how they can help people who use their services to be as physically fit and healthy as possible. This is part of a pilot project funded by NHS-Improving Quality.

2. Who are the College Centre for Quality Improvement (CCQI)?

The Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) aims to raise the standard of care that people with emotional or mental health needs receive by helping providers, users and commissioners of services to assess and increase the quality of care they provide.

More than 90% of mental health services in the UK take part in the work of the CCQI.

3. How do I get help completing the questionnaire?

If you need help completing the questionnaire, you can always ask a member of staff in your Trust, relative, friend or carer for support. You can also contact Sonya Chee at the CCQI – who is happy to help. You can contact her in a number of ways:

Phone: 0203 701 2686

Email: schee@rcpsych.ac.uk

Post: Sonya Chee, CCQI, Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB

4. Will anyone know what I've said?

No, **your response is completely confidential**. You are not asked for your name, address or any other information that would make you identifiable. We hope you will therefore feel you can be as honest in your answers as possible.

As this information is anonymous, the professionals responsible for your healthcare will never know whether or not you have completed the questionnaire. It certainly won't affect the care you receive in any way. Questionnaires will be destroyed once they have been analysed.

5. How can I find out the results of this project?

We will produce a report for NHS-Improving Quality, which will also be provided to your mental health Trust. This report will also be published on our website www.rcpsych.ac.uk/elester at the end of 2015.

Appendix 10: Interview topic guide for case study visits

Interview Topic Guide: Evaluation of implementation of Lester 2014

Part A: Processes of screening and intervening in physical health

In this part of the interview we are aiming to explore the processes of screening and intervention at each pilot site, in order to get a better understanding of the baseline results.

What are the processes involved in screening and intervention for the Lester tool cardiovascular risk factors (listed below)?

1. Smoking
2. Lifestyle and life skills
3. Body mass index (BMI) and weight
4. Blood pressure
5. Glucose regulation (diabetes screening)
6. Blood lipids (cholesterol screening)

Prompts

- How do you screen and/or intervene for these risk factors?
- When do you screen and/or intervene for these risk factors?
 - When is it acceptable or not acceptable to screen and/or intervene for these risk factors?
 - How often do you screen and/or intervene for these risk factors?
- Where do you screen and/or intervene for these risk factors?
 - Where is it acceptable or not acceptable to screen and/or intervene these risk factors?
- Who is involved in the screening and/or intervening for these risk factors?
- Once these screenings have been done, is there a system for interpreting and acting on the results?
 - Are GPs part of this?
 - How do you know if GPs are doing this?
 - If an abnormal results is picked up from screening, whose job is it to intervene?
 - How do the results get to the patient?

- What are the barriers and facilitators to screening and intervention for these risk factors?
 - What equipment do you have for physical health screening and intervention (e.g. scales, BP cuff, blood tests, smoking cessation, etc.?)
- Are there any patients who are not screened for the above risk factors, and why?
- Why were there low levels of screening for glucose regulation and blood lipids at baseline (compared to smoking, BMI and blood pressure)?
- Are there any patients who are not screened for the above risk factors, and, if so, why?

Part B: Process of Lester implementation and service improvement

In this part of the interview, we will explore the process of service improvement at each pilot site, so that the evaluation team will be in a better position to account for the changes achieved (or not achieved) between the baseline and follow up. The interview questions in Parts B and C have been informed by (a) diffusion of innovation theory and normalization process theory (theories of organisational change), and (b) feedback from the NHS IQ Project Lead, Emma Stark, based on her observations made during visits to the four sites.

1. What have people been doing to implement the Lester and improve quality (including addressing the challenges identified in Part A)?
 - a. What was the rationale for [insert site's focus in the pilot, e.g. NTW's focus on improving care pathways]?

Prompt: [insert pilot site's objective from PID]
2. What factors have supported the process of your Trust's service improvement initiative(s) for this project so far?
 - a. What have been the facilitators to change?
3. What factors have prevented the process of your Trust's service improvement initiative(s) for this project so far?
 - a. What have been the barriers to change?
4. Can you tell me about the effects of this work described in your answers to the above, including the most helpful and least helpful for you and your colleagues to improve the physical health care of your patients?
5. What are staff attitudes to physical healthcare and have they changed over the course of the pilot?

6. What information is provided to service users regarding physical health, and in which contexts?
7. How do staff motivate services users to improve their physical health?

Part C: Cost-effectiveness

In this part of the interview, we will examine the cost effectiveness of Lester implementation. We will seek to gather as much 'hard' data as possible on changes to workload for staff at different grades, so that we can estimate cost-effectiveness.

1. How has this project affected your work?
 - a. Has this project changed your work in practice?
 - i. If so, how much additional time do you spend on this?
 - b. Are there tasks that you have stopped doing, or cut back on because of it?
2. Are there any other kinds of costs (including equipment) that have resulted from the Lester resource implementation?
3. Does duplication of effort occur, and is this a barrier to implementation?

Part D: Interface between primary and secondary care

In this part of the interview, we will seek to get a better understanding the broader context in which screening and intervention in hospital occurs.

[for staff who work on inpatient wards]

1. Whose responsibility is the patient's physical health when they are in hospital?
 - a. How many of your patients have GPs?
 - b. How often to people go and see GPs when they are in hospital?
 - c. Who provides medical care to patients in hospital?
 - d. What communication happens with primary care?
2. What is done to transfer responsibility from the ward to the community when a patient is discharged from hospital?
 - a. What does your discharge letter template say about physical health? Is physical health part of the pro forma?
3. Whose responsibility is the patient's physical health after they leave hospital?
 - a. Is there a ward role after the patient leaves hospital?
 - b. If you are not involved, who is involved?
 - c. Do you think that it is the responsibility of the CMHT (or local equivalent), or of primary care?

4. Can you tell me about a recent time when you've been involved with a physical health screening where something has been wrong, and what has been the process in communicating the results to the patient, and providing support for intervention?

[for staff who work in community teams]

1. What do you think the role of primary care is in physical health monitoring and intervention?
2. What do you think the role of secondary care is in physical health monitoring and intervention?
3. Do you have a system of communication with primary care regarding physical health (e.g. a standard GP letter/pro forma with diagnosis and medication)?
 - a. What is the process of communicating physical health needs prior to CPA meetings?
 - b. What is the system for addressing physical health care at CPA meetings?
4. Can you tell me about a recent time when you've been involved with a physical health screening where something has been wrong, and what has been the process in communicating the results to the patient, and providing support for intervention

Appendix 11: Participant information sheet: qualitative interviews



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Evaluation of the Implementation of Lester 2014

Staff participant interview consent form

1. I confirm that I have read and understood the Staff participant information sheet for the above evaluation and have had the opportunity to ask questions.
2. I agree to be interviewed by the researcher in order to provide the information specified in the information sheet for staff.
3. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason.
4. I consent to the interview being audio recorded.
5. I understand that all information provided will be kept anonymised, and only accessed by the CCQI project team, unless there is a safeguarding issue.
6. I consent to anonymised quotes being used in the final evaluation report.
7. I agree to take part in the above stated evaluation.

Name of Participant

Date

Signature

Researcher

Date

Signature

Appendix 12: Coding frame for qualitative interview data

1. Contextual factors

1.1. Inner context factors

- The environment of the organisation into which the intervention is introduced

1.1.1. Policy/ governance

- Within the trust

1.1.2. Culture

- Supportive, no blame system
- Prepared to experiment with new ideas
- Give high priority to quality and want to improve things

1.1.3. Leadership

- At different levels of organisation e.g. ward level, board level
- Inspire, support and motivate the team
- Involve staff and patients in planning improvements

1.1.4. Team working

- Time to develop skills of whole team
- Recognises teamwork essential

1.1.5. Technological

- Effective IT supports intervention

1.1.6. Capacity

- Finances
- Resources
- Equipment available

1.2. External context factors

- Environmental factors in the world at large

1.2.1. Evidence base

- What works elsewhere (developing a learning network would change this aspect of context)
- Evidence-based guidelines followed

1.2.2. Political/ regulatory

- Political priorities, parity of esteem
- CQUIN, CQC

1.2.3. Social/ demographics

- Intervention appropriate for demographics
- Follows a social trend e.g. towards patient-centred care
- Appropriate for economic climate

1.2.4. Interface

- Primary
- Secondary

2. Causal Mechanisms

- The perceived causes of low levels of CVD screening and intervention as identified in, or inferred from, the pilot site project initiation documents

2.1. Lack of clarity around roles and responsibilities

2.2. Lack of clinical skills

2.3. Lack of IT skills

2.4. Lack of confidence to use skills

2.5. Lack of efficient systems for recording, monitoring and communicating physical health information

- 2.6. Lack of perceived appropriateness/ motivation/ engagement
- 2.7. Interface problems
- 2.8. Lack of communication about physical health information to service users
- 2.9. Lack of learning network
- 2.10. Lack of necessary equipment/ facilities
- 2.11. Other

3. Screening processes

- 3.1. Screening – Smoking
- 3.2. Screening – Lifestyle and life skills
- 3.3. Screening – BMI and weight
- 3.4. Screening – Blood pressure
- 3.5. Screening – Glucose regulation (diabetes screening)
- 3.6. Screening – Blood lipids (cholesterol screening)

4. Intervention processes

- 4.1. Intervention – Smoking
- 4.2. Intervention – Lifestyle and life skills
- 4.3. Intervention – BMI and weight
- 4.4. Intervention – Blood pressure
- 4.5. Intervention – Glucose regulation (diabetes screening)
- 4.6. Intervention – Blood lipids (cholesterol screening)

For more information about the evaluation, please contact:

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