Good Health for All: Promoting the Physical Health of People with Mental Health Needs

Keywords:
Mental health, physical health screening, health promotion, multidisciplinary team

Duration of project:
June 2008 – June 2010

Project leaders:
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Summary of project
The project aimed to improve physical health screening and health promotion for mental health service users by offering a physical health check to those service users who have not seen a doctor or had a physical health check in the last six months. Initially a physical health screening clinic was trialed but attendance was low. Although service reconfiguration acted as a hindrance to the progress of the project, it also provided valuable time for the project leaders to undertake work to explore and understand the value that staff placed on physical health screening, engage with the team and wider stakeholders and seek opportunities created by new service configurations to raise awareness about physical health screening and health promotion. A process was agreed and implemented to identify and offer physical health screening to service users; however, further service reconfiguration following the election of a new Government is expected.

Background
The Crisis Assessment and Home Treatment Team
The Crisis Assessment and Home Treatment Team (CAHT) is a community based mental health service within Sheffield Health and Social Care (SHSC) Foundation NHS Trust. The service was first set up in 2005 with a team of 25 multidisciplinary staff; this has gradually expanded to 50 staff. The team includes nurses, social workers, medical staff, support time recovery workers and occupational therapists. The team also have dedicated secretarial and administrative staff. Users of the service may be people with no past mental health background or people with severe and enduring mental health problems.

The team provides acute community based treatment, 24 hours a day including weekends and bank holidays. This involves the team assessing and managing service users with serious mental illness or those experiencing a mental health emergency. They deliver treatments which are user and carer focused, evidence-based, outcome orientated and time limited. Using their mental health experience, the team are also able to offer specialist support to the service user’s families and carers by providing a detailed assessment of their needs. This is important as The Princess Royal Trust for Carers and the National Mental Health Development Unit (2010) reports there are currently 1.5 million carers in the UK who look after someone with mental health problems. The CAHT team is also in a position to liaise with other agencies for example, voluntary services, the police, and social services, hence providing a seamless service that meets the needs of the service user.
When the CAHT service was devised the criteria for service user referral covered people between the ages of 18 and 65 years. It was set up to provide extra support to service users when their condition became unmanageable for the community psychiatric teams due to the deterioration of their mental health, thereby aiming to provide an alternative to hospital admission. Referrals to the service came from either the service user’s community mental health worker (CPN), their GP or from other health care professionals who may have had concerns, for example social workers and health visitors.

The service user who receive care from the team experience a range of mental health problems which impact on their day to day life, for example work and relationships. Home treatment is offered when these problems have reached crisis point. The demand for staff is to offer a quality service whilst juggling with service demands and targets. The team offers a broad range of support to help the service user to get things ‘back to normal’. This includes:

- Monitoring the service user’s mental health and associated risk to see if things get better or worse
- Helping with psychiatric symptoms by providing support and if necessary commencing or reviewing medication that can help to reduce distressing symptoms
- Helping with psychological problems by providing short term counselling, offering emotional support and short term focused therapy
- Helping the service user and their carer to understand mental health and other associated problems
- Helping to prevent a future mental health crisis by educating the service user to help understand what may have led to the current crisis
- Helping with social problems such as sorting out benefits and housing issues
- Helping with physical health problems identified by screening
- Assisting with visits to general medical services and own GP if needed

To enable the team to provide this extra support to service users and to manage risk effectively, twice weekly MDT meetings are necessary. These meetings allow for service user’s daily progress records and care plans to be discussed.

**Promoting physical health**

It is a known fact that people with chronic mental health problems experience elevated morbidity and mortality rates of preventable diseases (Department of Health, 2005); yet physical health and health promotion initiatives and care are not always accessible to people with mental health needs. By the very nature of their mental health need and associated medication regime, physical health and well-being can often suffer as a result. The Royal College of Psychiatrists (2009) found that people with mental health problems will die on average 5-10 years younger than the general population. If service users do not engage with their GP (which is often the case for someone who is in crisis), physical health issues can be difficult to monitor. The GP has time constraints and service users are sometimes not able to communication difficulties effectively. Even if physical health needs are addressed, health promotion information is often not given.
The Chief Nursing Officer’s review of mental health nursing (Department of Health, 2006) clearly identifies a role for mental health nurses in improving the physical well-being of service users through better assessment and health promotion. Prince et al. (2007) highlighted that people with mental health problems did not receive equitable services compared to those people without mental illness. However, NICE guidance (2009) states that GPs and other healthcare professionals should monitor the physical health of people with schizophrenia and bi-polar disorder.

During the MDT meetings, it became apparent to the project team that the nursing staff were confident about planning care relating to mental health deterioration but felt out of their depth when discussing physical health complaints deterioration. Such issues were left for the doctors in the team to investigate further; however, these issues may not always be picked up. Additionally, when the project team did a random check of service user’s records, it was noted that many service users who were made appointments to see the doctor were not attending. This was usually due to the fact that they were either too mentally or physically unwell. A chicken and egg scenario became apparent when at times it became difficult to identify if deterioration in a service user’s physical health had led to a worsening in their mental health or vice versa. In some instances service user’s poor or non-compliance with both physical and psychotropic medication exacerbated the situation. This was usually because they were too mentally unwell to take medication or in some cases felt the side effects of the medication outweighed the benefit.

The project leaders also identified that many of the service users who came into contact with the CAHT team only saw their GPs when they were called for a prescription review and in some cases, physical health screening had not be done for several years. So on discharge from the CAHT team, service user’s physical health again may be at risk.

All in all it seemed that when working in a busy CAHT team that physical health and health promotion can become overlooked. In recognition of these statutory and local issues, the project leaders therefore wanted to develop a project that would enable them to improve physical health screening and health promotion for service users who were receiving care from the CAHT team.

**Project aims and objectives**

The project aim was to improve physical health screening and health promotion for service users who receive care from the CAHT team by offering a physical health check to service users who have not seen a doctor or had a physical health check in the last six months. The project leaders aimed to achieve this by developing a working model that would enable the CAHT team to incorporate physical health screening into everyday practice. However, recognising that this would have to be done in small stages, the following objectives were identified to enable the aim to be achieved. To:

- Benchmark current practice and service provision in relation to physical health screening to identify areas of practice that need to improve
- Clarify the level of need by looking at ways to identify and screen service users for physical health/health promotion needs on admission to the CAHT service
• Work alongside service users to empower them to access appropriate services and information – service users do not always have the information or confidence to access help, information and services
• Identify appropriate programmers for service users to access in primary care and the independent sector regarding health promotion
• Promote well being and self esteem with service users – physical and mental health are interlinked and low self esteem can affect both
• Improve education of service users and colleagues in primary and secondary care of both physical health and psychiatric medication and its effect – there is a need to work more closely with service users and across services
• Develop improved links with health care disciplines to provide on going support and continuity of care – the CAHT team is in an ideal position to bring primary and secondary care services together
• Evaluate and disseminate the work - sharing best practice

Audit of current practice
During three separate weeks in 2008, the notes of service users admitted to the service were reviewed to determine if they had had a physical health check within the last six months (see Table 1).

Table 1. Audit of service user’s notes regarding review of physical health status

<table>
<thead>
<tr>
<th>Week in 2008</th>
<th>1-7 June</th>
<th>6 June-2 July</th>
<th>24-30 August</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of service users</td>
<td>15</td>
<td>20</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>New to service?</td>
<td>6.6%</td>
<td>30%</td>
<td>6.6%</td>
<td></td>
</tr>
<tr>
<td>Do they have a care coordinator?</td>
<td>80%</td>
<td>60%</td>
<td>86.6%</td>
<td></td>
</tr>
<tr>
<td>Seen by GP in last 12 months?</td>
<td>13.3%</td>
<td>5%</td>
<td>6.6%</td>
<td></td>
</tr>
<tr>
<td>Blood pressure checked in last 6 months?</td>
<td>6.6%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Written in the care plan?</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Written on MDT board?</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>Have they been consulted about physical health status?</td>
<td>0%</td>
<td>10%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

The audit showed that the vast majority of service users were not new to the service and the majority had a care coordinator (i.e. someone who is responsible for coordinating all aspects of a service user’s care). Most service users had not seen a GP within the last 12 months nor had their blood pressure recorded in recent months. Very few had been consulted about their physical health status and nothing was recorded about this. The audit suggested that there was a need for the CAHT service to determine if service users had had a physical health check and to provide a screening service for those who had not.
Getting started: trialling a physical health screening clinic
At the start of the project (June 2008), the project leaders set aside some clinical time so that they could invite service users to come to the clinic setting for physical health screening.

To aid the screening process, the project leaders developed a physical health and lifestyle questionnaire (see appendix 1) to act as an aide memoire, based on the elements identified by a national audit of health promotion. This was funded by the Department of Health and conducted by Greater Manchester Hospitals (see http://www.nhphaudit.org/).

Informing staff
Prior to commencing the clinic, a short presentation was given to the CAHT staff in one of the weekly team meetings. The project leaders explained their interest in physical health, that the project had received support from FoNS, and provided facts and figures around the physical health and medication concordance of mental health service users. The staff expressed interest and enthusiasm in the project and it was agreed that the project leaders would be responsible for setting up and running the clinics for a trial period of three months. The idea was to see if service users would engage and to see if staff had a positive response to the project.

Trial of clinic
Initially, the clinics ran on a weekly basis and were successfully attended; the next step therefore was to spread the word and get other staff involved. To do this, the project leaders ran further information sessions in team meetings and suggested to the staff that a workshop session could be set up for the five support time recovery workers (STRWs). The idea was that any member of staff could identify a service user who would benefit from a clinic appointment and initiate an appointment but the project leaders and STRWs would run and trial the clinics for a further three months; however all members of staff were invited to sit in on clinic sessions so as not to exclude them. This was agreed and a workshop was held to enable the STRWs to explore and become more aware of the:

- issues relating to the physical health of mental health service users
- proposed approach to physical health screening

The workshop went well, resulting in positive outcomes around empowerment and owning the project. The STRWs were able to see how they would be able to influence the project by having an extended role in taking blood pressure and testing urine for blood, sugar, ketones, proteins etc. as well as asking questions on lifestyle. They were also able to raise practical concerns about how they would fit this work in which could be addressed with the larger team.

The following plan for the involvement of the STRWs arose from the workshop:

a) Decide commencement date for "Good Health for All"
b) STRWs to have structured time to do physical health screening work
c) Project leaders to provide supervision for STRWs (frequency to be decided later)
d) STRWs to have extended role in the team
e) Information file to be developed to support the project
Following the workshop, the clinic was run for a further three months. Initially the STRWs worked alongside the project leaders until they felt confident and then the clinics were run either by the project leaders or an STRW, depending on who was available on the day taking in to account shift patterns.

After running the clinic for approximately six months in total, it was evident that problems were emerging. Many service users did not turn up for their appointments; on average, only one in ten service users that had been booked in attended. The project leaders quickly realised that this was not a sustainable or effective approach. When the project leaders asked staff about their input into identifying suitable service users and checked service user’s daily records re non-attendance, it was acknowledged that staff did not share the beliefs of the project leaders about the value of physical health screening or recognise it as a priority within the overall mental health picture. It was also identified that a number of service users had been too unwell to take part in the screening at that time and had been referred either too early or inappropriately. It also came to light that even though medical staff had been included in the presentation about the project, junior doctors were doing physical examinations on an ad hoc basis and not using the service user questionnaire that had been developed or sharing information.

Despite these challenges, the project leaders were aware that using the physical health and lifestyle questionnaire with service users who had attended the clinic was enabling issues around physical health to be uncovered that had not been anticipated. For example, service users were identified that needed treatment for blood pressure and diabetes. It was evident that these service users needed leaflets/health information to follow up what was identified and that it would be most helpful if a trust wide pool of leaflets could be identified to enable staff to provide consistent advice.

**Contextual barriers**

It is important to note that at this time, the CAHT team was reconfigured and were under a tremendous amount of pressure to change the main focus of their work in order to increase the number of patients that were seen over the year.

Because of the demands on the service the team was asked to develop a dedicated assessment team which would then refer on to two geographically based home treatment teams; this meant that in reality, the staff had to work in a different way to what they had been doing and they became very demoralised. The trust also introduced a new patient pathway protocol called the Acute Care Pathway and announced it had to be put in to place by November 2009 (see appendix 2). Many discussions took place in the team meetings about patient safety and the quality of care that the team could provide. It seemed likely that physical health screening would potentially become even less of a priority and this was confirmed by the responses to a questionnaire that was sent to the staff, regarding their views about physical health (see below).
Getting back on track

Due to the recent service reconfiguration, it was decided to allow the team six months to settle down and during this time the project leaders worked with their manager and the FoNS practice development facilitator to develop an alternative strategy which could be implemented in the near future. The project leaders also recognised that the project may be further helped by the launch of the trust’s physical health policy in February 2009. The policy requires that practitioners and teams should adopt a truly holistic approach to care that includes effective planning to promote the physical health and well-being of service users. This is based on the recognition that there is a duty of care which extends to promoting physically healthy lifestyles and identifying, meeting and/or responding to specific health care needs (Department of Health, 2004; Chief Nursing Officer Review, 2006).

To keep the project moving forward during this time, the project leaders were active in a number of ways:

- They developed a questionnaire to capture staff’s views about physical health screening (see section below)
- By attending a number of meetings across the trust, they introduced the physical health and lifestyle questionnaire in to the MDT setting to see if it could be used as a point of entry into health screening
- They encouraged staff within their team to take the physical health and lifestyle questionnaire along to their first visit with a service user and role modeled this process
- By attending and contributing to trust meetings on physical health and being involved in the rewriting the physical health policy, the project leaders met a number of colleagues who are trying to improve their patient’s physical health within their own area of work (e.g. community, acute ward, occupational therapy and continuing needs team). This stimulated the creation of a multidisciplinary steering group for the project. This involved some members of the CAHT team (project leaders, nurse consultant, a STRW), a service user representative; other professionals from across the trust who had an interest in physical health issues including a community mental health nurse, the lead nurse of service user involvement, a university lecturer, a nurse from the enduring mental health service, an occupational therapist, and staff from the clinical effectiveness department and IT department who were involved in the development of new patient records which would include the recording of physical health screening. Two meetings were held in April 2009 and November 2009 and in addition, some of the steering group members (including the service user representative) attended the staff workshop in September 2009 (see below). The steering group enabled trust-wide discussion about the issue of physical health screening, raised awareness of issues relating to continuity of care and record keeping and allowed for some practical sharing of ideas and problem solving. The project team's efforts were recognised in the annual service review report at this time
- They attended and contributed to meetings on redesigning the trust electronic records system (INSIGHT) looking at ways to incorporate service user's physical health and life style record to enable continuity in communication
The project leaders also continued to raise the profile of physical health screening at the twice weekly MDT meetings. In this way, they could identify, suggest and introduce ways in which physical health screening could become part of everyday practice.

**Staff views about physical health**
In the spring of 2009, the project leaders developed a questionnaire to explore the views that staff held about the physical health of service users within the context of a mental health service. The questionnaire included the following questions:

1. Have you identified service users that may have been suitable for the physical health screening?
2. Can you explain why this has not been appropriated?
3. Are the present process/criteria easy to understand?
4. What ways do you think would work in identifying service users for health screening?
5. Do you feel it is right for the assessment team to identifying service users for physical health screening?

A questionnaire and letter of explanation was sent to all clinical staff via the internal post system (n=28). Of the 28 questionnaires that were given out, only 7 were returned (25%). This meant that the majority of staff i.e. 75% did not respond. However, a summary of the responses to the questions is provided below.

![Identifying service users](image)

**Fig 1.** The responses to question 1 suggests that staff may have had some problem/difficulties in identifying people who might benefit from having a physical health check as 5 out of 7 respondents had not identified service users for the screening. This could be due to a number of factors. For example, the service user was too unwell; the worker forgot to ask the service user about their physical health at that time; the staff may have been unclear about the criteria for screening; or staff assumed that because the
service user had been in A&E or seen their GP recently then they have already been assessed physically. These latter suggestions were supported by the responses to question 2, see Fig 2.

**Fig 2.** Staff provided a number of reasons for not identifying service users for physical health screening. Although 1 respondent stated that they were not aware of the criteria for physical health screening, all respondents confirmed that the present process/criteria were easy to understand (question 3).

**Fig 3.** The responses to question 4 suggest that some staff believe that a prompt or aide memoire would be useful to identify service users. Others felt that all service users should be asked if they needed/wanted a physical health check.
**Fig 4.** All respondents felt that the assessment team should identify service users requiring a physical health check (question 5); although their follow up answers to question 6 suggested that there was still some uncertainty about this process.

![Who should do this](image1)

**Fig 5.** All respondents felt that medication compliance/concordance was very important (question 7). Some staff commented that they felt that it was important that service users had the right medication but that often service users did not know what medication they were on or what they were for. This suggests that there is an educational aspect of giving medication to the service user. One person felt that discussing medication with a service user was a ‘nursing thing’ which raises a question around which members of a MDT could or should give advice to service users about their medication. For example, can only
doctors or nurses give information about medication or can other professional be competent to give this kind of advice?

Fig 6. Question 7 asked respondents for ideas about how to improve access to the assessment service.

Fig 7. There was a mixed response to the question which asked if staff would like more training about physical health.

In summary, the low response rate (25%) and the responses to the questionnaire suggested to the project leaders that more work needed to be done to engage with the staff team to develop a greater awareness of the project and the ways in which staff could be actively involved in enabling physical health screening.
Staff workshop
In September 2009, a lunchtime workshop was held for multidisciplinary members of the team, to provide an opportunity to further explore the values and beliefs that they held about physical health screening and to create a shared understanding of how this could be realised in practice. 16 team members and two consultant psychiatrists attended (approximately half the whole team compliment). The workshop, facilitated by a FoNS practice development facilitator stimulated a lot of discussion and questions. Key themes relating to values and beliefs were identified (see appendix 3) and there was much discussion around how these related to the trust’s new patient pathway protocol.

Overall, there was a general sense that staff were in support of the initiative to introduce physical health screening and encouragingly, the majority of questions focused not on ‘why do we need to do this?’ but more positively on ‘how will this work?’ and ‘when will it start?’

Working towards the Acute Care Pathways protocol
In December 2009, the mental health care trust became a foundation trust; as part of this process new policies and ways of working were introduced to enhance the service users’ experience of mental health services and ensure their journey through the service was a seamless one. Targets and time frames were introduced to ensure their needs were met efficiently. One such document was the Acute Care Pathways document (see appendix 2 for part of this document) which outlines the process and standards that working age adults experiencing a mental health crisis can expect from Sheffield Mental Health services. It maps the service user’s journey from initial referral to discharge from acute mental health services.

To meet the standards outlined in the pathway and to action the trust’s physical health policy, the project leaders facilitated discussions with staff and during the MDT meetings to gain agreement about a process to assess the physical health of service users using the CAHT service. The following was agreed and implemented:

- Clerical staff to print off a list of new patients – these are discussed at the MDT meeting (held twice weekly) with regards to considering the need for a physical health check
- All patients need a physical health check, unless they have been an in-patient on a mental health or acute general ward within the last 6 months, or there is evidence of screening in the last 6 months
- Where possible, the checks should be done within 72 hours of admission to the service
- Use questionnaire that has been developed trust-wide and ratified by Chief Nurse
- Physical health checks are completed by nurses and STRs either in the patients home or they are invited to a clinic
- The outcomes of the check should be recorded in the care plan
- If the check is not done, the rational for this should be recorded in the care plan
- Issues raised from the screening are addressed within the team (by CAHT doctors) or referred back to GP
• Currently, admin staff record that the check has been done on the database. When the INSIGHT system goes live, this will be done by staff
• Findings and actions from the physical health check should be included in the discharge summary to the GP

Summary and conclusion
Psychiatric nursing history would remind us that two or three decades ago it was the norm to screen service user’s physical health as part of everyday practice; in psychiatric hospitals physical health screening would be part of the admission process. However, the centralisation of services into large general hospitals has taken this element of care away from mental health nurses and therefore staff have become deskillled in this area over time. Whilst patients have access to GP services, in reality many do not access these for issues relating to their physical health leaving a gap in health care provision.

There is well documented evidence of poor physical health and increased physical health risk factors in individuals with mental health concerns (Department of Health, 2005). The New Horizons document (Department of Health, 2009) highlights this further stating that physical health affects our mental health and vice versa. To explore this further, the Centre for Mental Health is working with partners The King’s Fund and the London School of Economics to review research evidence on the extent of these co-morbidities, their impact on the quality and cost of care and the ways in which people with both a long-term condition and a mental health problem could be better supported.

Aside from the personal suffering of the individual there are massive cost implications for the NHS related to the management of chronic, preventable, physical disorders. Given the current economic climate, it is inevitable that budgets will continue to be tight and therefore the prevention of physical ill-health could enable more effective use of valuable resources.

While service users are under the care of the CAHT team, there is a golden opportunity to work with them towards improving their health outcomes. MacHaffie (2002) suggests that health behaviour changes optimise physical health. Offering service users the opportunity to have their physical health screened provides an opening to engage an individual in the process of making modifications to their lifestyle which will support them in improving their quality of life and enabling them to access appropriate healthcare services to meet an identified physical health needs. A study carried out by Camden and Islington NHS Trust (Harper and Abraha) suggests that with training and support any health and social care professional can deliver health promotion interventions.

Despite major service reconfigurations, by engaging with staff and wider stakeholders, a process was developed and put in place to identify service users who had not had a physical health check within the last six months and to offer this service to them. At the time of reporting approximately 6-10 service users per week were being identified. A new trust computer system (INSIGHT) is being introduced that will provide all staff with access to shared service user information. This will provide a central point for recording if a service user has had a physical health check, providing seamless communication between
services and a built in audit tool will automatically flag where gaps occur. This should help to raise awareness of the physical health needs of service users.

Unfortunately during the project timescale, it was not possible to move forward with the objectives relating to identifying and enabling service users to access health promotion services and resources; however, the networking undertaking by the project leaders and the steering group meetings created a greater awareness across the trust of health promotion activity which can be built upon.

At the time of writing, a consultation is taking place about the future of the CAHT service and proposals have been recommended by the trust in line with new health and wellbeing boards. This reflects the Future Vision Coalition’s document (2009) drawn up by the mental health network in partnership with a range of mental health groups, and charities and staff organisations. Greater emphasis must be given to those who find it difficult to absorb public health initiatives. Since the election of a new Government, the NHS is again embarking on radical change including the way services are commissioned and managed. PCTs are to be abolished and their commissioning role will come under the umbrella of GP practices; there will be a new NHS commissioning board and foundation trusts including Sheffield, will be given extra freedom about how they work. A Rethink survey of GPs in 2010 revealed that under a third of the GPs who responded felt ready to take on mental health services commissioning and 42% of GPs said they lacked knowledge about specialist services needed for people with severe mental illnesses such as schizophrenia and bipolar disorder. This could provide a real opportunity for joined up working between health professionals and the mental health sector for the benefit of mental health service users.

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References
**Appendix 1. Physical health and lifestyle questionnaire**

**Physical Health and Well Being Sheet**

PLEASE ANSWER THE FOLLOWING QUESTIONS

Have you had a physical health check with GP in the last 12 months?

Weight

Height

Waist Measurement

Do you drink alcohol? If so how much?

Have you used or are you using illicit drugs? (Cocaine, Cannabis, Heroin)

What type of illicit drug used and how much?

Do you smoke (Yes/No)?

Number of cigarettes smoked per day?

Do you take exercise / activity for 30 minutes per day?

What type?

How many days per week?

Do you consider your diet to be healthy?

If no, would you like some advice how to improve your diet?

Have you visited a dentist in the last 12 months (Yes/No)?

Have you had an eye test in the last 12 months (Yes/No)?

Are you taking any regular medication?

If possible please provide a list

Have you noticed any changes in you Bowel Habits? (Any blood or mucus in stools, change in bowel habits lasted more that 6 weeks).
For Women:

Have you had a cervical smear test in the last 5 years (Yes/No)?

Do you feel you need advice on Sexual Health (including contraception and pregnancy)?

Do you examine your breast for any lumps (Yes/No)?

For Men:

Do you examine your testicles for any lumps?

Do you feel you need advice on Sexual Health issues?

Do you have any concerns about your bladder function?

STAFF ONLY TO COMPLETE

Urinalysis

Peak flow

Blood Pressure (Average [120/80 to 130/90])

Body mass index

Comments for GP
Appendix 2. Acute Care Pathway Standards

Admission to Home Treatment Service - Standards

Within 2 hours:

2.1.1 Immediate needs and intervention recorded and agreed with carer/user
2.1.2 Agree purpose of home treatment
2.1.3 Risk assessment and management plan completed (if not already done) and recorded on INSIGHT
2.1.4 HONOS scores completed
2.1.5 Review advance directive
2.1.6 Service info leaflet given
2.1.7 Cultural and spiritual needs considered

Within 72 hours:

2.1.8 Medical/psychiatric assessment/review
2.1.9 Nursing/physical health check/review
2.1.10 CMHT psychiatrist and care co-coordinator informed of admission
2.1.11 Care plan agreed and treatment objectives explained to user and career
2.1.12 MDT review agreed
2.1.13 Arrangements to involve careers in care planning process
2.1.14 Discharge planning initiated
2.1.15 Working diagnosis recorded
Appendix 3. Key themes arising from staff workshop

We believe that the ultimate purpose of improving the physical health and well being of mental health service users is:

To create a nation of people who are as fit and well both mentally and physically as possible
  • To enable people to live longer happier lives
  • To give people a good quality of life
  • To reduce incidences of major disease
  • To promote good physical health for all persons
  • To pick up side effects from medication
  • To facilitate change

To give individuals control over their own lives
  • A better understanding of what a person needs to feel well
  • Person-centred approach

We believe this purpose is achieved by:

Joined up approach
  • Good communication/rapport
  • Participation
  • Support for all
  • Positive attitude and ownership from HCPs

Raising awareness
  • Demonstrate need to service user, staff, commissioners

Education
  • Demystifying health promotion for service users
  • Helping patients to create healthy lifestyle habits

Person-centred approach
  • Individual goals – service users and professionals and commitment to achieving them
  • Being realistic
  • Choice and explaining pros and cons
  • Working with avoidance

We believe our role in achieving this purpose is:

Incorporating physical health care into everyday practice
  • Asking clients about physical health
  • Discuss physical health on visits
• Encourage healthy mind, healthy body

Using evidence-based practice
• Educate on how to maintain healthy lifestyle
• Diagnosing
• Prescribing
• Sharing information and ideas

Signposting resources e.g. activities, groups
• Pointing in right direction for services, activities
• Considering liaison issues

Leadership
• Providing education, supervision, support
• Motivating others
• Advocacy/feedback to services
• Wider health promotion role

We believe factors that will enable us to achieve this purpose are:

Supportive systems/policies
• Policy to support
• Good systems e.g. IT, care pathways
• Clear care plans/documentation
• Wider support – local gov, resources
• Peer support

Resources
• Facilities
• Staff
• Skill mix - plan to ensure effective use
• Equipment
• Sufficient time
• Use resources to support healthy habits – access, support

Everyone has good knowledge and understanding
• To have a common aim
• Everyone taking responsibility
• Positive attitude
• Recognising path may be long

Other values and beliefs we hold about this purpose are:

Being person-centred:
• To enable a person to function to the best of their ability
• Improving QoL – in their eyes
• Consider budgets, culture, family history
• Realise/accept some people don’t want to change

Holistic approach

Planting seeds – may come to fruition later

Ensuring people have information, support, knowledge to make good life choices

Basic human right