

Innovating for Improvement

Improving Physical health care for
patients with psychosis (PHCP)
through collaborative working with
local community pharmacies

North East London NHS Foundation Trust



About the project

Project title: Improving Physical health care for patients with psychosis (PHCP) through collaborative working with local community pharmacies

Lead organisation:

North East London NHS Foundation Trust (NELFT)

Partner organisation(s):

North East London Local Pharmaceutical Committee (NELLPC)

Project lead(s):

NELFT: Dr Asif Bachlani (August 2015 – May 2017), Dr Aarohee Desai Gupta (May-December 2017)

NELLPC: Hemant Patel.

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Part 1: Abstract

People with psychotic illnesses are known to die 15–20 years earlier than the rest of the population. Studies have shown that this is related to their psychotic illness as well as cardio-metabolic side-effects of their medication which means they are more likely to have type 2 diabetes, high body mass index (BMI), and are at increased risk of heart attack or stroke. This is compounded by limited access to primary care and reduced uptake of health screening.

The Physical Health Care for patients with Psychosis (PHCP) project was a collaborative approach between secondary care, community pharmacy and primary care.

Patients with a diagnosis of psychotic illness known to the Barking and Dagenham Community Recovery Team were offered physical health checks (assessment of five cardio-metabolic risk factors including blood pressure, cholesterol and BMI) via community pharmacies.

180 patients were offered health checks with 140 attended (77%) with 40 declining or not attending with 71% of attendees having all five Lester cardiometabolic risk factors monitored which is significantly better than the previous model which only 36%. This represents 29% of total eligible population (350) which compares favourably to the previous NELFT average of 15%.

All 140 patients received health coaching to support them with stopping smoking, and improving their diet and exercise showing an increase in their patient activation from level 2 to level 3 There were high levels of satisfaction from both patients and the community mental health team about the health checks.

The project team are now starting discussions about implementing the model across the four London boroughs within the Trust.

Part 2: Progress and outcomes

We feel that this project is unique and innovative as this is the first community based programme in the UK that delivers cardiometabolic physical health checks for people with psychosis in the community close to where they live. It aims to give patients choice as to where they have the healthchecks, explains why the health checks are important and by using self-care health coaching increases their motivation to improve their life-style.

This has been delivered by working closely and in collaborative manner with NELLPC pharmacists who were highly driven, motivated and keen to deliver health checks to people with psychosis who are normally disadvantaged and vulnerable and well recognised in the research as not being proactive or engaged in having their physical health checked. Within Barking and Dagenham 10 community pharmacies were recruited by NEL LPC to deliver these health checks.

In addition we as a team co-developed a care pathway to support the delivery of cardiometabolic physical health checks and health coaching in the community pharmacies for people with psychosis. Secondly we developed systems to share information between the two organisations where we developed a paper recording template which was manually entered into the patient IT systems (EPR) in NELFT by the liaison officer as both organisations had different IT systems. Secondly we developed an alert system where if there was an abnormal result within the health checks how the pharmacist alerted the mental health team to abnormal result so this could be acted on. A further key facet was development of the training package for the community pharmacists which focused on schizophrenia, schizophrenia and health checks, the health coaching and PAM as well as the PHCP health checks care pathway.

Other aspects that made this programme innovative was:

- Location of the health checks - Community pharmacies are convenient for patients to access and associated with less stigma than mental health premises.
- Health checks included on day reporting for both the ECG and blood tests for cholesterol and HB1aC, using specialist machines with same day results that provide give patients and Community Mental Health Trust (CMHT) staff with results of the blood tests and ECGs on site.
- Coaching and follow-up checks provided by the community pharmacists which encouraged patients to become more actively involved with monitoring and improving their own physical health status. This is rarely provided by usual mental health service physical health checks.

Unfortunately the project was unable to recruit a Health Navigator to support recruitment and attendance of patients of health checks which was a key part of the

delivery team. This was partially mitigated by recruiting more pharmacies than originally planned – ten rather than six and by the liaison officer who worked closely with the CMHT to encourage uptake of the health checks. We do however feel that the lack of health navigator is likely to have reduced the uptake of health check appointments, including follow-up appointments, since navigators were intended to help patients access appointments and attend follow-up as required.

The data collected focused on:

1. Health check data – numbers of health checks completed focused on the five lester cardiometabolic risk factors which include BMI, Blood pressure, HB1aC and cholesterol as life-style factors and number of patients to engage in efforts to change their lifestyle i.e. smoking, exercise and diet following the health checks.
2. Patient experience: Completed at final review.
3. Patient self-management using Patient Activation Measure (PAM) tool to measure the improvement in engagement with their own health and care. Evidence suggests that people with higher levels of ‘activation’ experience better health, better health outcomes, have fewer episodes of emergency care and engage in more healthy behaviours (NHS England, <https://www.england.nhs.uk/ourwork/patient-participation/self-care/patient-activation/pa-faqs/>). Interventions can improve activation levels.
4. Referrer satisfaction of health checks
5. Community pharmacist feedback about benefits to themselves and to the patients

Primary outcomes: Health check completion rates

180 eligible patients (patients taking antipsychotics) were offered a community pharmacy based physical health check, and 140 attended. Only 40 declined or did not attend a scheduled appointment. This represents a successful completion rate of 78%.

The total population within Barking and Dagenham mental health services thought to be eligible and requiring a health check was estimated to be around 350. 180 of this population were offered a community pharmacy based physical health check. Therefore 40% of estimated total eligible population were offered and received a physical health check.

Of the 140 patients who had their health checks, 70% of attendees at community pharmacies had all five Lester cardiometabolic risk factors monitored which compares is significantly better than the previous standard care in B&D (treatment as usual TAU) under which only 36% of patients who attended physical health clinics had all five Lester cardiometabolic risk factors monitored. For each individual risk factor, rates of completion were considerably higher under the community pharmacy system compared with previous TAU (see Table 1 in Appendix)

In the current project, 29% of the total population had all five Lester cardiometabolic risk factors monitored. This compares favourably to the previous NELFT average

which was only 15% of the total population (National Audit of Schizophrenia 2014). The national average is 32%, so the current project increases rates of comprehensive assessments closer to the national average from NELFTs historically low levels

Secondary outcomes

Health coaching - 100% of patients attending community pharmacy checks had health coaching to support patients with smoking, diet and exercise. Under TAU only 44% received such help. As part of the health coaching sessions there were patients who received support to improve their lifestyle i.e.

- 22 received support to stop smoking
- 56 received support for exercise
- 78 received support to eat healthier or lose weight

PAM Scores - 120 service users completed the PAM questionnaire during their initial assessment (see Table 2).

- At the initial health check average PAM scores were at Level 2 (taken to indicate that patients are 'becoming aware' of health issues)
- By the first follow-up check, average scores had improved by 4.5 points. This increase represents an increase to Level 3 (judged to indicate that patients are 'taking action to improve lifestyle')
- Of the 40 who completed the 2nd PAM questionnaire - 33 either saw an improvement in patient motivation via PAM measures or have stayed at the same level and 21 moved to level 3 or 4 (level 4 – highest level - Maintaining positive behaviours and pushing further)

Table 2

	Average PAM Scores	Number of Patients	Level
1 st appointment	52.73	120	Level 2
2 nd appointment	57.26	41	Level 3
3 rd appointment	58.46	15	Level 3

Improvements in PAM scores indicate that the community pharmacy health check system helped patients to become more aware and more confident about managing their own health problems in line with the principles of patient-centred care, which is likely to translate into healthier behaviours and better health outcomes.

Patient satisfaction –100% of patients users agreed or strongly agreed that they were happy with the length of time taken to get an appointment and have felt supported when setting goals to improve their health and wellbeing. Most patients agreed that their local pharmacy was the right place to develop their wellbeing plan

and felt more confident in managing their health and wellbeing. The majority also felt it is easier to book appointments for physical health checks at local pharmacies than with doctor/nurse led wellbeing clinics.

CMHT (Referrer) satisfaction – 100% of the CPNs agreed or strongly agreed with the support the person they care for has received from the community pharmacists.

Community Pharmacists Feedback (see table 2)

1. From the programme pharmacists learnt about motivational interviewing and coaching, mental illnesses and how to carry out health checks.
2. Pharmacists also valued the time they were able to spend with patients to support them to improve their lifestyles and felt that they making an impact on patients' lives.

Data was collected using a variety of methods:

1. Healthchecks – patients attending community pharmacies for healthchecks recorded on NELFT EPR system.
2. Change of lifestyle in patients was done using the PAM scores (quantitative) and feedback from patients (qualitative)
3. Patient / Referrer experience was completed by questionnaire (quantitative) completed at community pharmacy for patients and at CMHT for referrers/CPNs.
4. We have recorded a video that demonstrates how the various stakeholders found the project

The results of the project were analysed and evaluated by the evaluation lead – Dr Joanna Moncrieff who is a Reader at UCL and Consultant psychiatrist at the same trust – NELFT but works in different borough and clinical team. Dr Moncrieff was not directly involved in the project concept, organisation or delivery of the project and so we feel provided an independent evaluation of the project.

Part 3: Cost impact

The service was funded using funds from the Health Foundation, NELFT and NELLPC. This innovative service was costed below the Treatment as usual (£150,569 which requires 90% of patients to completed a physical health check or that there is recorded evidence of an outreach attempt to facilitate it)

The actual costs of our project was significantly lower than expected due to the reduced number of checks completed then planned:

-Less health checks completed than planned for – the project completed 140 checks rather than the planned check. Each check was costed at £60. The actual cost was £8,400 with the planned cost was £21,000 and represented 23% of the planned total cost.

- In addition other additional costs which were planned were not used or required – clinical backfill for the clinical lead and project manager.

In planning and development of this project there was not a health economic analysis was not part of the project plan

Part 4: Learning from your project

Although the project had higher uptake of healthchecks for people with psychosis than the treatment as usual model – 77% PHCP project vs 36% having health checks and 71% of patients using PHCP service had all five Lester cardiometabolic risk factors monitored which again compares favourably to TAU which had 15% of patients- the uptake of the healthchecks of the total population was 29% and was lower than what we had expected.

The two main reasons for this lower than expected uptake are:

- The inability to recruit a health navigator who was a key member of the team who would have supported initial and follow up health checks
- limited engagement of the mental health team in offering the opportunity to patients to have the health checks in the community pharmacy.

In considering the limited engagement from the mental health team , we felt the following were significant factors:

- On the initial steering group there was no clinician from the CMHT who would be the champion within the service and encourage the psychiatric nurses (CPNs) to talk and discuss the project with patients.
- The culture within the team about physical health checks was that this was the role

of the GP and not the remit of the CMHT. Previous efforts to engage CMHT in delivering or taking a lead in physical health checks had also met resistance.

- Staff turnover – during the project there was significant turnover of the CPNs which meant that the Liaison Officer had to work with new CPNs to ‘buy into’ the PHCP care model.

- Our impression from discussions with CPNs was that physical health checks was not considered a priority as this was seen as an additional duty to managing the mental health of their patients.

Enablers:

- Community pharmacists – very dedicated and enthusiastic who attended training in their own personal time in evenings and weekends. Community pharmacists bought into the model and carried out the healthchecks to highest standards.

- Liaison Officer (Esther Peinado – NELLPC) – vital member of the team who supported and facilitated the day to day running of the project. Esther’s role included liaising with the CPNs on a weekly basis ; attending the team meetings to discuss the project and the benefits of having the physical health checks in the community pharmacies; and encouraging the uptake, of the health checks. Esther also worked with the community pharmacies to support the booking of the health checks and once the health checks were completed to summarise the results of the health checks were and document them into NELFT patient records.

To ensure uptake of healthchecks with patients, written and verbal information was developed to explain to patients why they required health checks. Secondly the project team were constantly liaising with the community teams ie CCOs & Consultants with reminders of project (verbal & written), obtaining feedback, promptly addressing issues to support uptake of health checks. Towards the end of the project letters were sent directly to patients offering them the health checks.

What helped the project was the national driver of the national CQUIN to improve physical health of patients with psychosis as well as the changing role of community pharmacies in primary care with increased focus of services they can provide to support GPs i.e. health checks/vaccinations.

Aspects that didn’t work out

- Difficulty in recruiting health navigator affecting uptake of health checks – Initially difficult due to suspension of sabbatical in NELFT due to wider recruitment difficulties in mental health services and inability to Arrange backfill. This was somewhat predictable but took longer and proved more difficult than expected.

- IT system – as both organisations had separate IT systems that did not communicate with each other and an IT solution was not possible during the time

period of the project, the liaison officer was required to manually enter the health checks in the NELFT patient records which was very labour intensive and not efficient. We were unable to develop a more efficient system within the time frame of the project.

- Project Team management changes – NELLPC Project Manager left October 2016 unexpectedly and this was mitigated by NELLPC Executive member becoming key part of project team and recruitment of liaison officer. There was also changes in Project Clinical Lead which affected delivery of project and day to day running of the project with the initial start of health checks being delayed from December 2016 to February 2017.

- Separation of social care from Mental Health Services (unexpected) – changes in s75 arrangements within secondary mental health services caused significant uncertainties within CMHT and with these changes affected the project delivery and the uptake of healthchecks. This was mitigated by Liaison Officer providing more hands on input in recruiting patients for healthchecks and the NELFT project manager helping with recruitment.

- One of the pharmacies withdrew due to change of staff.

Feedback that surprised us:

When the physical health checks were first being rolled out the health checks were taking upto 90 minutes so neither the CCO or patients were not prepared for the lengthy assessment. This lack of communication with care coordinators at the beginning resulted in further lack of engagement with them, particularly when referring their service users to the community pharmacies

Specific Learning

1. There is often a presumption that one organisation can often deliver the best outcomes for patients. However this project demonstrates that working with partners (NEL LPC) can be more effective and beneficial to supporting patients in having their health checks. The community pharmacists are a keen, enthusiastic group of health care professionals who are underutilised currently in the NHS. By working collaboratively and developing a close relationship with NEL LPC this has supported the PHCP care pathway, recruiting, engaging and enthusing community pharmacist to deliver health checks for patients with psychosis. This was achieved by setting up a steering group of the key members of the team who met regularly to discuss planning, setting up and delivering the programme as well as managing problems quickly and effectively. In addition we developed training for the community pharmacists, the care pathway and governance structure to ensure abnormal results were flagged up quickly and to the appropriate professional as well as ensuring the

data for the health checks were entered in the NELFT patient records within 48 hours.

2. One key aspect is to have a clinician from the community mental health team as a champion for the project who would champion and support CPNs to promote the health checks as part of routine work of the CPN. A clinical lead was recruited into the steering group towards the end of the programme but should have been recruited right from the start of the programme.

What would be valuable to know from the start

1. As Lead for the project make sure you use your backfill and have enough time to lead the project.

2. Recruitment of new staff for the project i.e. health navigator takes much longer than expected. If you are planning to recruit staff start this before start of the project or during the planning phase.

3. Everything takes longer than often is planned – double the time required to complete each step and really using the planning time effectively to support delivering of the project.

4 How to organise the health check ensuring the pharmacist carries out all the checks with confident use of ECG/Blood test machine and IT computer system to support referral and recording of data.

5 Organisational Development: Pharmacists were for the first time carrying out a bio-psycho-social needs assessment, PAM, physical health check and medication review for psychotic patients.

6 The time taken to complete the health checks/assessments was considerably longer than originally anticipated (upto 90min) as patients required significant support to complete questionnaires.

7 prepare the patient cohort in advance of the project starting about the value of physical health checks and support in the community near their home from specially trained community pharmacists.

Key things others would need to know

1. Develop systems to manage the different IT systems and governance if pharmacists completing healthchecks find an abnormal result.

2. Regular interactions, both informal and formal with the CCO/CPNs to increase the

uptake of health checks are a valuable time investment.

3. Invest time in training and updating community pharmacists on health coaching, mental health and psychotic medicines, health checks and blood testing.

4 Explicitly map out the processes and responsibilities of staff within the community pharmacy such as reception and form filling upon arrival, delegation of dispensing whilst pharmacists is engaged in supporting the patient, support for carers accompanying the patient and computer system to record the intervention.

Part 5: Sustainability and spread

We are currently discussing the scaling up of the project with the NELFT Medical Managers and the board to see if the project can be funded and supported by NELFT past the funding period. This project has been discussed with the NELFT Executive Sponsor throughout the programme and it has been decided that this project will be discussed with NELFT board for future funding once the final results are in demonstrating the benefits for the project.

External interest / recognition:

The project was awarded Winner of Atrial Fibrillation Digital Health Pioneer award in November 2017 - <http://www.nelft.nhs.uk/news-events/news20171117nelftnellpcwinaward-2697> or <http://www.nellpc.org.uk/?p=23506>

We have been asked to deliver a national webinar by Public Health England on delivering healthchecks for patients with psychosis in the community. This webinar will be on 28th February 2018 which will be chaired by Geraldine Strathdee.

This quality improvement Project will be cited by the RCPsych General Adult Faculty Quality Improvement Case Studies Guide which is supporting clinicians leading and delivering quality improvement projects. This is due out Jan/Feb 2018

We have made contacts for the project via using of twitter and have interest in the project by PHE, Geraldine Strathdee and RCPsych.

The project is being entered for the Chemist and Druggist Awards 2018 in the category of Health Initiative of the Year 2018

Do you plan to spread this innovation?

The plan is to discuss the project within NELFT to see if this model can be expanded to the whole four boroughs of NELFT.

With the webinar with PHE and case study in the RCPsych Quality Improvement we hope the project will reach a wider audience and interest will be generated in the project.

The information will be shared with the pharmacy lead at Public Health England with a view to influencing policy. And, also shared with the national negotiating body, Pharmaceutical Services Negotiating Committee and the professional body, Royal Pharmaceutical Society.

There have been around 10 inquiries from other Trusts and pharmacy organisations

and they are all keen to learn more.

Replicable? Most of the project can be replicable but will require training programme for pharmacists, care pathway and governance structure for the health checks and system to input the data in the Mental Health Trust EPR. Aspects which are specific to the programme was on site blood testing and use of specialist devices for ECGs which would need to be sourced as well as using self-care model of health coaching.

Requirements post project?

There will need to be a liaison officer between NEL LPC and NELFT that needs to be funded as well as the Alere on the spot blood test machines and equipment used in the community pharmacies. This will need to be funded by either of the collaborative organisations.

In addition in order for the project to be successful there will need to be a clinical champion in NELFT for physical health checks to ensure the project is implemented in each of the 4 NELFT boroughs.

Appendix 1: Resources and appendices

- What were the key outcomes / impacts (including statistical data where possible)?

There were 350 people eligible for community pharmacies. Of this population 180 were offered health checks with 40 patients declined or did not attend for their health checks and 140 attended (40% of population attended for health checks).

By the end of January 2018 - 140 patients had a physical health check within the community pharmacy (this is 40% of all eligible patients – 350) and 70% of attendees at community pharmacies had all five Lester cardiometabolic risk factors monitored which compares favourably to NELFT standard care (treatment as usual TAU) - 36% of patients who attends physical health clinics.

When comparing to total population – 29% of population had a five Lester cardiometabolic risk factors monitored which again compares favourably to NELFT which had 15% of total population (National Audit of Schizophrenia 2014) and national average of 32% who had all their five Lester cardiometabolic risk factors

Table 1

Measure	TAU (Pre intervention) – Sample 50	%	Comm Pharmacy health checks by Jan 2018	% i.e N/140
Number receiving blood pressure measurement	29	58%	133	95.00%
Number receiving ECG	18	36%	131	93.57%
Number receiving BMI	27	54%	135	96.43%
Number receiving blood glucose	31	62%	102	72.86%
Number receiving blood cholesterol	29	58%	100	71.43%

By the end of December 2017 - 100% of patients attending community pharmacy checks had health coaching to support patients with smoking, diet and exercise compared to TAU 44% From the health coaching sessions with the patients

- 22 received support to stop smoking
- 56 received support for exercise
- 78 received support to eat healthier or lose weight

PAM Scores - 120 service users completed the PAM questionnaire during their initial assessment.

- 40 of the 120 (30%) completed the PAM questionnaire again in their first review at the community pharmacies or with their care coordinator's support which showed an average 4.5 scale improvement moving patients from level 2 (becoming aware) to level 3 (taking action to improve lifestyle)
- Of the 40 who completed the 2nd PAM questionnaire - 33 either saw an improvement in patient motivation via PAM measures or have stayed at the same level and 21 moved to level 3 or 4 (level 4 – highest level - Maintaining positive behaviours and pushing further)

	Average PAM Scores	Number of Patients	Level
1 st appointment	52.73	120	Level 2
2 nd appointment	57.26	41	Level 3
3 rd appointment	58.46	15	Level 3

Patient satisfaction – 100% of the care coordinators were either very satisfied or satisfied with the support the person they care for has received from the community pharmacists, the other 45% were satisfied. 100% of patients users agreed or strongly agreed that they were happy with the length of time taken to get an appointment and have felt supported when setting goals to improve their health and wellbeing.

Table 2 – Community pharmacists feedback

First name	Last name	Pharmacist Benefit	Patient Benefit
Anna	Mironova	The benefit I got from the service its a new knowledge of how to do the full health check at the pharmacy. I improved my consultation skills and learnt new approach to the patients. I managed to do the service at the	I believe that patient benefit from this service a lot. First of all its the fact that they going to the pharmacy, not the hospital made them feel more relaxed. At the sessions patient was getting interested on the process. A lot of

		<p>pharmacy while completing pharmacist duties at the same time (wish I had more time though). Once I got experience I felt a lot more confident and at the same time it highlighted for me what I have to learn more and which existing knowledge I have to refresh/update. Another new skill I learnt is how to do ECG and how to send readings via email.</p>	<p>the patients wanted to lose weight and improve their life style in general and we were creating the plan together. Unfortunately not all of them followed the plan but they were trying.</p>
<p>Mohammad</p>	<p>Saeed</p>	<p>By participation in the project, I found the initial detailed training on the condition, prevalence, and pharmaceutical aspects very useful. Hearing the roles of the consultant, the MHC team and the barriers were a stark reminder of how difficult it is to ensure compliance. The training of coaching and motivational interviewing was again an opportunity to learn and practice these very important consultation skills.</p> <p>The interaction and the opportunity to talk to the patient and their carers (family or otherwise) was a great realization of :</p> <ul style="list-style-type: none"> -there are people out there who are not given "our diligent care" - discrimination on grounds of the mental illness. -background details that led to the mental breakdown -the priorities that they have in order to look after themselves, ie retain some level of independence and live a normal life and be there for others eg parents, siblings, pets etc. - continued support and medication compliance issues that need to be overcome in order to keep the patient stable. - looking at lifestyle issues and motivate them to make small meaningful changes in order to improve their mental well-being. 	<p>I would like to think the patients felt some benefit from the scheme, from building up a rapport with the pharmacist, looking at making changes to their lifestyles and hopefully encouraging them to take a more pro-active role in their mental and physical well-being.</p> <p>I have enjoyed participating in the project and using my skills to build up a relationship with the patients within the project.</p>

Salim	Rashid	<p>I as a pharmacist benefited from the scheme as it gave an enhanced role as a triage between secondary care and the patient. There was a lot of learning to do before the service was commissioned and my knowledge about mentally ill patients and their health problems was enriched. It also gave me professional satisfaction that I was able to contribute to the NHS in a positive way and hopefully saved the NHS money in the long term.</p>	<p>It benefited the patients by them learning more about their health and taking an active interest in themselves, to understand the long term implication of not looking after themselves. But, the most positive outcome was a health professional taking an interest in them as a person and influencing their lifestyle in a positive manner (once they learned about the objective of the program, they were quite agreeable to alter their lifestyle). Overall it resulted in a positive outcome for the majority of patients (even just on their outlook of their condition).</p>
Seema	Khosla	<p>The opportunity to spend significant time with patients- to get to know them and understand mental health conditions better and from their perspective- learning experience</p> <ul style="list-style-type: none"> - variation to daily workload - retain patients prescriptions once they build up rapport with you as a pharmacist- more likely to want to direct their scripts to you or come to you for further advice/products for other ailments - satisfaction of knowing you have made a difference to helping them live a healthier lifestyle and raised awareness of importance in looking after their physical health 	<p>someone else to talk to and to feel like someone cares about them</p> <ul style="list-style-type: none"> - opportunity to encourage them to come out of the house - actual physical health changes due to follow up appointments- eg. weight loss in some patients or healthier lifestyle choices made - sustained motivation to make changes- eg. stop smoking as they are encouraged and the pharmacist makes initial appointments for them - receive better care, advice or add-on medication as a result of taking clinical measurements and referring these to consultant