Improving the physical health of patients with mental health conditions

Rhiannon England
GP Clinical Lead for Mental Health
City and Hackney CCG
Rhiannon.England@nhs.net
This problem of health inequality is well known

- Patients with ANY enduring mental illness have a *reduced life expectancy*. *(This is not limited to SMI)*

<table>
<thead>
<tr>
<th>Condition</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe and enduring Mental Illness</td>
<td>10-19 years</td>
</tr>
<tr>
<td>Recurrent depression</td>
<td>9-24 years</td>
</tr>
<tr>
<td>Drug and alcohol use</td>
<td>9-24 years</td>
</tr>
<tr>
<td>Bipolar illness</td>
<td>9-20 years</td>
</tr>
<tr>
<td>Personality disorder</td>
<td>9-18 years</td>
</tr>
</tbody>
</table>
But why?

- **Lifestyle**: smoking, poor diet, substance misuse, inactivity. All more prominent in patients with SMI, PD and depression.
- **Medication**: diabetogenic meds, sedative effects.
- **Ethnicity risk factors**: psychosis diagnosis prevalence increased in some BME communities for example
- **Stigma and social isolation**: loneliness is also associated with reduced life expectancy.
- **Suicide**: patients with BPD have x50 rate of competed suicide, patients with psychosis x8 rate of completed suicide than general population.
Problems with Medication

- Anti-psychotic medication is **diabetogenic**.
- Some anti-depressants cause **weight gain**.
- We had 1100 patients in C&H on **antipsychotics with no coded diagnosis**, therefore are not on QoF and have no mandated health screening. (I’ll guess that this is not just in C&H!)
- Both Quetiapine and Mirtazepine can be **abused** (the new Benzos?)
- Primary care unconfident about **reducing/stopping meds**, secondary care poor at issuing clear management plans for this.
- **Secondary care initiation** - are these drugs overused? Are we weighing up risk/benefit?
Patients with long-term mental illness and associated risks, e.g., substance misuse.

- Patients on antipsychotics
- QoF patients: Psychosis and Bipolar illness

QoF patients (NHSE check eligible) are only a subset of the population at risk of premature mortality.
New cases of psychosis

New cases of psychosis: estimated incidence rate per 100,000 population aged 16-64

2011 Source: www.psymaptic.org / PHE Fingertips
Excess under 75 mortality

Excess under 75 mortality rate in adults with serious mental illness 2014/15 (most deprived areas in UK) Source: NHS Digital / PHE Fingertips

Indirectly standardised ratio - %

England
Barking and Dagenham
Birmingham
Blackburn with Darwen
Blackpool
Hackney
Kingston upon Hull
Knowsley
Liverpool
Manchester
Middlesbrough
Nottingham
Rochdale
Sandwell
Stoke-on-Trent
Tower Hamlets
Wolverhampton
Comparative Mortality (2014/2015)

Excess under 75 mortality rate in adults with serious mental illness: ratio of observed to expected mortalities (expressed as a percentage)

Excess under 75 mortality rate

Percentage

London Average:

Data Source: Fingertips (Public Health England)

NHS

City and Hackney Clinical Commissioning Group
% of patients receiving full check in the 12 months up to the end Q4 (18/19)

Source of data: https://www.england.nhs.uk/statistics/statistical-work-areas/serious-mental-illness-smi/
How are we doing well?

1. Incentivising primary care to do checks and getting clinical buy-in through a Confed contract and primary care Alliance.

2. Commissioning a mental health dashboard- this collates primary care data on mental health and physical health by practice and neighbourhood.

3. Using recovery care plans that emphasise physical health improvements. (listen to the patient!)

4. Presenting and representing the facts through training: having a MH condition can make your physical health worse, and having a LTC can make your mental health worse. There is help for both.
How we found solutions

1. MH trust uses RIO, GPs use EMIS: So we commissioned 2 HCAs who are based in CMHTs, using EMIS and RIO live data entry and completing gaps in SMI health checks. This allows completion and avoids duplication of parameters.

2. Incentivising primary care for SMI **and non SMI on meds** health checks. This at least means that some non-QoF patients are covered.

3. Enhanced primary care service – step down for stable patients with a strong physical health focus in recovery care plans.


5. Neighbourhood dashboard for some healthy competition between practices

6. Incentivising structured depression reviews including physical health measures.
IT systems?
HCAs work with both systems - live data entry, no duplication. Insist on ECG and blood training.

Primary care?
Incentivise, templates, clinical imperative, data feedback, start small and work up.

Multi-system approach: Primary Care Alliance (ELFT, CEG, GP Confed, FA)

Secondary care?
Contract, NICE standards, get staff involved, training, audits, think population not caseload

Clogged up CMHTs?
Establish step down to PC with strong emphasis on physical health and put capacity into PC to help
What is the mental health dashboard?

- Data dashboard extracting primary care data looking at depression, psychosis, dementia and physical health data.
- Acts as a practice/network resource and as a payment dashboard.
- Identifies low performing practices and vulnerable groups of patients.
- Allows feedback on performance and promotes some competition.
- Data gathered on many physical health/lifestyle/referral routes.
The Primary Care MH Dashboard

Mirrors dashboards for other LTCS e.g. Diabetes

<table>
<thead>
<tr>
<th>Listsize</th>
<th>Register</th>
<th>Physical Health Check</th>
<th>Medication</th>
<th>Non-SMI + Antipsychotic med</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>QOF SMI register</td>
<td>% of SMI Regist with completed annual physical health check</td>
<td>QOF SMI register + anti-psychotic medication</td>
<td>QOF Register + Anti-Psychotic + Med + Med Review</td>
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<tr>
<td>2895</td>
<td>54</td>
<td>22%</td>
<td>28</td>
<td>52%</td>
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<td>44%</td>
<td>2440</td>
<td>58%</td>
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</tbody>
</table>
Current Antidepressant Meds / Depression Review + Activity in last 12 months

TARGET EXCEEDED BY

38

COMPLETED

53%

TARGET

35%

ELIGIBLE

COMPLETED

TARGET

35%

Allerton Road Surgery

F84716 NW1 1

MHA Depression Review + Activity (12M)

MH1-DEP01 MH1-DEP51

Current Antidepressant Meds / Depression Review + Activity in last 12 months

TARGET EXCEEDED BY

38

COMPLETED

53%

TARGET

35%

Smoking Intervention

BMI

Talking Therapy offer

Social Prescribing offer

Smoking status

Depression Leaflet

Meds Review

Depression Review

All Criteria

0.0% 10.0% 20.0% 30.0% 40.0% 50.0% 60.0% 70.0% 80.0% 90.0% 100.0%

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Brooke Road...

Clapton Surgery...
Primary Care Information Liaison worker discusses data profile with each practice.
2016/17 figures shown for 641 patients. All patients have a recovery care plan which focuses on both physical and mental health improvement, and get extra health support from the GP.

- High BMI (39%)
- Smoking (34%)
- High alcohol intake
- Q-RISK (11% > 20)
- Drugs

Lifestyle interventions
- Goal settings (63% offered, 90% acceptance)

Community Resources
Conclusions

• All patients with all long term mental illnesses are at increased risk of physical ill health and reduction in life expectancy.
• We need: a systematic joined up process between primary and secondary care for meds management and review, clear policies about length of treatment, psychiatry taking a much more population based approach to providing guidance for primary care.
• Good data is the key to addressing inequality- and good results in reduction of excess mortality can be achieved over time, even in areas of high deprivation and prevalence.
• QoF should include ALL potentially long term mental illness. Then we could start reducing excess mortality across all diagnoses.
• Training dispels myths about mental illness and lifestyle and promotes parity of health care.