The Regulation and Quality Improvement Authority

Evaluating the Service Provision for Meeting the Physical Health Needs of People with a Mental Illness and Learning Disability 2014

informing and improving health and social care
www.rqia.org.uk

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA was established in 2005 as a non-departmental public body under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 to drive continuous improvements in the quality of services, through a programme of inspections and reviews.

The Mental Health and Learning Disability (MHLD) Directorate undertakes a range of responsibilities for people with mental ill health and those with a learning disability under the Mental Health (Northern Ireland) Order 1986 (MHO) as amended by the Health and Social Care Reform Act (Northern Ireland) 2009. This includes preventing ill treatment, remedying any deficiency in care or treatment or terminating improper detention in hospital or guardianship.

RQIA takes into consideration relevant standards and guidelines, the views of the public, health care experts and current research, in any review of services provided. We highlight areas of good practice and make recommendations for improvements and report on our findings on our website at www.rqia.org.uk.

Contents Page

1.0 Background

Compared to the general population, patients with serious mental illness have much higher rates of many physical illnesses including hypothyroidism, dermatitis, obesity, epilepsy, hypertension, chronic obstructive airways disease and cardiac disease. For example the prevalence of diabetes mellitus is two to three times higher in people with schizophrenia.[1] Patients with serious mental illness tend to have fewer investigations and less appropriate interventions carried out. Among the seriously mentally ill, mortality rates are two to four times greater than in the general population; these patients die on average over 20 years earlier than the general population.[2]

The situation in relation to those with learning disability is equally concerning and has been captured in various reports and enquiries, notably, the government response to the confidential enquiry into the premature deaths of people with learning disabilities.[3]

An evaluation of the service provision for the physical health needs of people with mental illness or learning disability was undertaken by RQIA. Information was provided by Health and Social Care Trusts to describe how trusts are addressing this inequality, and meeting the needs of patients with mental illness or learning disability.

2.0 Methodology

Each trust was asked to complete a self-assessment proforma detailing service provision and supporting the narrative with any supplementary evidence, such as leaflets and audit reports for example.
Proformas were sent to each trust on 2 May 2014 requesting a return by 13 June 2014.

[1] Brown S, Kim M, Mitchhell C, Inskip H (2010) Twenty-five year mortality of a community cohort with schizophrenia. *The British Journal of Psychiatry.* 196:116-121.
[2] Wahlbeck K, Westman J, Nordentoft M, Gissler M and Munk Laursen T (2011) Outcomes of Nordic mental health systems: life expectancy of patients with mental disorders. *British Journal of Psychiatry*.; 199: 453-458.
[3] Department of Health. Government response to the Confidential Inquiry into premature deaths of people with learning disabilities. 2013.

3.0 Review of information

3.1 Smoking Cessation Services Provided to Patients with Mental Illness

Smoking is the single most important factor in the premature mortality of those with psychiatric illness and learning disability. The previous nihilistic attitude to smoking cessation is changing but much more needs to be done regarding smoking among psychiatric patients and people with learning disability which evidence shows is amenable to intervention.

Over the last 25 years the frequency of smoking in the general population has decreased.[4] This reduction has not been mirrored in those with serious mental illness and now more than 40% of all tobacco is smoked by people with serious mental illness.[5] However, people with mental illness are less likely to be given support to stop smoking. There remains a culture within psychiatric services that smoking is acceptable, with the erroneous belief that smoking cessation among psychiatric patients is neither desirable nor achievable. Yet, more than 50% of those with mental illness who smoke say they want to quit.[6]

Psychiatric Services

Standard 2 of the Mental Health Services Framework, DHSSPS, October 2011,[7] states that all health and social care professionals should identify those who smoke, make them aware of the dangers of smoking, advise them to stop and provide information and signposting to specialist cessation services. Trusts were asked to provide details regarding Smoking Cessation Services available to patients with mental illness, including how Trusts:

- identify those who smoke
- make patients aware of the dangers of smoking
- advise them to stop
- provide information and signposting to specialist cessation services in a format suitable to their specific needs; and
- monitor uptake of services and the success rate of the service provision.

All five trusts reported that they have Smoking Cessation Services. With the exception of the Southern Trust, evidence of available psycho- educational material was provided by trusts. All five trusts reported that they screen patients on admission for smoking. The South Eastern, Southern and Western Trusts reported that they have staff trained in smoking cessation. The Western Trust has a trust wide, smoke free campus policy. South

[4] http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2011/rpt-chapter-1.html#tab-The-prevalence-of-cigarette-smoking
[5] http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf
[6] http://www.ash.org.uk/files/documents/ASH_120.pdf p6
[7] http://www.dhsspsni.gov.uk/service_framework_for_mental_health_and_wellbeing_-_consultation_version.pdf

Eastern Trust reported on an audit on the smoking status of admissions to an acute psychiatric unit and monitoring of the uptake and impact of a Stop Smoking group.

Learning Disability Services

Each trust reported that patients can access the trust's Smoking Cessation Services. The South Eastern, Southern and Northern Trusts report that they have learning disability staff trained in smoking cessation. Each trust has a health facilitator who can support patients to stop smoking. The South Eastern Trust submitted a health action plan booklet which addresses, among other things smoking. The South Eastern Trust reported monitoring of those who entered the Smoking Cessation Service.

i. Recommendation

Trusts should increase their efforts in relation to encouraging cessation of smoking among psychiatric patients and people with learning disability which evidence shows is amenable to intervention.

3.2 Lifestyle Clinics

Psychiatric Services

Patients with serious mental illness have higher rates of obesity, high blood pressure, heart disease, diabetes and stroke.[8] Life style can play an important part in lessening the likelihood of developing such conditions. Trusts were asked to provide details in relation to the availability of life style clinics which might address, among other things, healthy nutrition and diet, cooking and budgeting skills, physical and purposeful activity, use of tobacco, alcohol and drugs. Reference was made to Standards 3, 5, 6 and 9 of the Service Framework for Mental Health and Wellbeing,[9] DHSSPS, 2011; Standards 19, 21, 23, 24 and 25 of the Service Framework for Learning Disability, DHSSPS, 2012[10] and the Royal College of Psychiatrists' Statement of December 2013: Improving the Physical Health of People with Mental Illness – what can be done?[11]

All trusts have a variety of community clinics with variable liaison with the community and voluntary sectors. Examples include exercise and sporting activities, budgeting, cooking and baking groups, groups addressing the adverse effects of tobacco, alcohol and drugs. Provision in this area appears to be particularly locally based with some trusts such as South Eastern, Southern and Western Trusts reporting a great variety of different activities and others such as Belfast and Northern Trusts reporting relatively few. The provision within trusts appears also to be patchy, e.g. the Northern Trust

[8] http://www.rethink.org/media/810988/Rethink%20Mental%20Illness%20-%20Lethal%20Discrimination.pdf
[9] http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf
[10] http://www.dhsspsni.gov.uk/learning_disability_service_framework.pdf
[11] http://www.rcpsych.ac.uk/pdf/FR%20GAP%2001-%20final2013.pdf

reported that some Community Mental Health Teams within the Trust have established life style clinics, such as in Whiteabbey, and this, perhaps, suggests that the provision of such clinics is not widespread within the Trust, dependent upon local initiatives.

Learning Disability Services

Each trust reported various programmes for activities such as walking, swimming and aerobics. There appears to be variation within trusts. The Western Trust is currently developing a health promotion and wellbeing strategy. The South Eastern and Northern Trusts submitted relevant leaflets and the South Eastern Trust submitted a PowerPoint presentation about fluid intake. Following intervention, the South Eastern Trust demonstrated that knowledge improved as did the access to, and intake of, water.

ii. Recommendation

Lifestyle clinics should be more available throughout Trust areas to ensure all patients have access to such health promoting interventions.

3.3 Physical Health and Antipsychotic Medication

Psychiatric Services

Antipsychotic drugs are effective in treating psychotic illness such as schizophrenia and bipolar disorder. These drugs are toxic with many side effects, particularly metabolic effects, which adversely affect the physical health of those taking the medications. Similarly, Lithium is an effective agent in bipolar illness but also potentially highly toxic. Trusts were asked about their adherence to the guidelines for monitoring the physical health of patients receiving such drugs. Standards 35 and 37 of the Service Framework for Mental Health and Wellbeing, DHSSPS, 2011 were referenced.[12]

All trusts carry out physical examinations and blood investigations where appropriate, for all patients on admission to acute psychiatric wards. Each trust reported adherence to the regionally agreed Lithium Care Pathway. All trusts are taking part in the regional scoping exercise regarding the need for physical health checks for patients in the community.

Only two trusts, the South Eastern and Western, reported use of a Clozapine Care Pathway. The Western Trust also reported using a care pathway for antipsychotics, in general, with the South Eastern and Northern Trusts reporting having such a care pathway in draft form. The Belfast and Northern Trusts reported carrying out Clozapine and Lithium monitoring clinics although one would assume all Trusts are carrying out lithium monitoring if adhering to the regional lithium Care Pathway. The Southern Trust uses a health passport containing blood results held by the patient. Both South Eastern and Western Trusts showed evidence of the Clozapine Care Pathway and these

[12] http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf pp151-153, 156-159.

two trusts along with the Northern Trust provided evidence of patient leaflets used in support of their monitoring arrangements. The Belfast Trust reported problems with physical monitoring of medication other than Clozapine or lithium in the community setting. The Belfast Trust reports that it does not have the resources to ensure full implementation of such monitoring and that those in primary health care are increasingly reluctant to do this work.

Learning Disability Services

The Belfast and Western Trusts report blood and cardiac monitoring of inpatients on antipsychotic medication. All trusts, except the Belfast Trust, report liaising with general practitioners (GP) regarding the monitoring of community patients on antipsychotic medication. This appears to be via the DES (Health screening for people with learning disability).[13] The South Eastern, Southern and Northern Trusts also report community nurses being involved in the education, monitoring and assisting of patients on antipsychotic medication, with the South Eastern Trust nurses using the MINI PAS -ADD[14] and LUNSERS (Liverpool University Neuroleptic Side Effects Rating Scale)[15] scoring forms to assess the mental health and wellbeing of people with a learning disability. The Belfast Trust reports a multidisciplinary audit of antipsychotic inpatient prescribing which is currently in draft form. The Belfast Trust reports difficulty in the community setting –as with psychiatric services, existing community clinics are not resourced to carry out this monitoring and primary care increasingly declines to do this work. This is another area where good work is carried out, however more could be done.

iii. Recommendation

All trusts should develop care pathways for all anti-psychotic prescribing.

3.4 Liaison Arrangements with Primary Care

Psychiatric Services

Close working relationships between those in primary care and those in secondary care are clearly very important. This is particularly so in relation to the physical health needs of those who are mentally ill or have a learning disability. Difficulties in such relationships can lead to patients being adversely affected (note comments of Belfast Trust previously). Trusts were asked to describe arrangements in place for liaising with primary care.

[13] http://www.improvinghealthandlives.org.uk/uploads/doc/vid_7646_IHAL2010-04HealthChecksSystemticReview.pdf

[14] Prosser H, Moss SC, Costello H, Simpson N, Patel P & Rowe S (1998) Reliability and validity of the Mini PAS-ADD for assessing psychiatric disorders in adults with intellectual disability. *Journal of Intellectual Disability Research.* 42 264–272.

[15] Day JC, Wood G, Dewey M, Bentall RP (1995) A self-rating scale for measuring neuroleptic side-effects: Validation in a group of schizophrenic patients. *The British Journal of Psychiatry.* 166: 650-653.

Standard 23 of the Service Framework for Mental Health and Wellbeing, DHSSPS, 2011[16] and Standards 9 and 21 of Service Framework for Learning Disability, DHSSPS, 2012[17] are relevant.

All trusts confirmed that they liaise with primary care but this appears to relate to individual patients. The Belfast Trust reports a pilot being undertaken looking at the effectiveness of information being sent to patients on their discharge from the acute mental health wards. Feedback from general practitioners to date has been very positive. In Belfast GP fora have been established within Mental Health Services to discuss and explore patient pathways with regards to both physical health and mental health. None of the other trusts has reported regular meetings with primary care colleagues regarding the care of mutual patients.

iv. Recommendation

Trusts should consider having either a regular meeting or, alternatively, a named individual from the CMHT, to liaise with colleagues in primary care for the benefit of patients.

Learning Disability Services

This is an area in which Learning Disability programmes are significantly more active than Mental Health programmes, with all trusts liaising via the health facilitators. The Northern Health and Social Care Trust also arrange a formal annual meeting between learning disability practitioners and individual practices. A learning disability nurse facilitates access to dental treatment and there is access to specialist visual assessment, audiology and podiatry clinics. The health facilitators ensure equal access to screening opportunities.
The Northern Trust reviews access to bowel screening and cervical screening during the annual review with practices. The Western Trust keeps a record of the number of patients who receive annual health screening.

The Belfast Trust reports that hospital inpatients do not have access to primary care during normal working hours and their physical health needs are provided by psychiatrists. The Belfast Trust is endeavouring to enlist the help of the commissioner to provide trained primary care input to hospital inpatients.

3.5 Long Stay Patients' access to Holistic Health Care Provision

Psychiatric Services

Long stay mentally ill or learning disability inpatients do not usually have access to primary care services. Therefore, the onus is on those in secondary care to ensure that patients have access to holistic health care provision including appropriate screening, dental care and dietetics input. Trusts were asked to provide details of mechanisms in place for referral to screening

[16] http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf pp118-119.
[17] http://www.dhsspsni.gov.uk/learning_disability_service_framework.pdf pp 96-98.

services, the arrangements in place to monitor uptake of services and the success rate of the service provision. Standard 23 of the Service Framework for Mental Health and Wellbeing, DHSSPS, 2011 and Standards 19 and 21 of the Service Framework for Learning Disability, DHSSPS, 2012 apply.[18]

All trusts provided a statement commenting upon the care provided to long stay patients. Two trusts, the South Eastern and the Northern Trust, showed evidence of a physical health pathway for their long stay patients. The Belfast Trust reported that general practitioners attend long stay patients either once or twice weekly to address the primary care needs of the patients.

Learning Disability Services

Belfast Trust long stay hospital patients have a range of provisions available including dietetics, physiotherapy, dentistry, occupational therapy, orthotics but the Trust comments that each could be enhanced. The Trust is aware of difficulties in access to screening programmes either because the patient has no GP, and changes have been made to address this, or because of issues relating to capacity, consent and co-operation. The Southern Trust reports that most long stay patients are now residing in community based facilities and patients have access to health checks and screening programmes. Dental treatment is facilitated by the Community Dental Department. The other trusts do not have long stay hospital patients.

v. Recommendation

Consideration should be given to making arrangements with primary care to provide appropriate services to long stay patients to ensure that physical checks are carried out regularly so that patients have optimum physical health.

vi. Recommendation

All trusts should also consider having physical health pathways for long stay patients to ensure their hospitalisation does not restrict their access to services enjoyed by the general population.

3.6 Service Provision for People with Comorbid Conditions (Drugs/ Alcohol)

Psychiatric Services

There is a high rate of comorbid alcohol and drug abuse/dependence among those with serious mental illness. Several years ago the DHSSPSNI provided resource for the establishment of a dual diagnosis service within each trust. Trusts were asked to provide details regarding the provision of dual diagnosis service for those with serious mental illness/learning disability and comorbid substance abuse problems.

[18] http://www.dhsspsni.gov.uk/learning_disability_service_framework.pdf pp91-92, 72-74

The South Eastern, Belfast and Southern Trusts confirmed that they have a Dual Diagnosis Service while the Western and Northern Trusts specifically stated that they do not. The South Eastern Trust submitted a dual diagnosis strategy which referenced user satisfaction surveys indicating a high level of satisfaction with the service. The strategy also included an audit of Community Mental Health Team practitioners with a significant number of staff indicating they had good understanding of dual diagnosis issues, the majority rating their skills in acute stabilisation and harm reduction intervention as excellent. Suggestions for developing services further are being considered. The Belfast Trust submitted an information sheet/leaflet for its dual diagnosis service.

Learning Disability Services

Each trust reports having access to trust specialist services, although none specifically reports accessing the trust dual diagnosis service where that is available. The Southern and Western Trusts report the numbers who require onward referral for substance abuse/dependence as low. The Belfast Trust reports awareness that its services in this area are inadequate and it is making representation to the commissioners for enhancement of service.

vii. Recommendation

Trusts with a dual diagnosis service need to consider consolidating the service making arrangements for those with learning disability to access these or similar services, and trusts should introduce a dual diagnosis service if not currently available.

viii. Recommendation

Trusts that report low numbers of learning disability patients with substance misuse problems should audit their population to ensure there is not an unidentified unmet need.

3.7 Other Service Provisions/Interventions including Voluntary / Community Sectors

Psychiatric Services

Trusts were asked to describe other services provided by the trust addressing the physical health needs of their patients. All trusts reported varying degrees of joint working with the voluntary/community sectors. The Belfast Trust reported liaison with general hospital services with interface meetings between Mental Health and Physical Disability Services and the development of close links between the Addictions Services, genito-urinary medicine and hepatology clinics. The Western Trust reported a joint exercise programme between the physiotherapy department and the Parkinson's service.

Learning Disability Services

The Western Trust reports this as an area in need for further development and intends addressing this as part of their health and wellbeing strategy.
The other four trusts report work on sexual health and behaviour. The Belfast Trust reports the development of a health promotion group while the Northern Trust reports a new multidisciplinary learning disability improvement group which is looking at the experiences of learning disability people in district general hospitals aiming to develop the skills of staff. The South Eastern and Southern Trusts report staff training in, and provision of, various activities addressing physical health and social needs. The South Eastern Trust also reports provision of leaflets, a health programme athletes pack, an epilepsy specialist nursing service and GAIN Guidelines, regarding caring for people with learning disability in General Hospital settings. The South Eastern Trust submitted its health action plan reporting that 87 staff members completed full day training sessions on personal and sexual relationships in people with a learning disability. The Northern Trust submitted its staff policy and practice guide for people with learning disability regarding personal and sexual relationships and its Type II diabetes information booklet and education programme.

ix. Recommendation

There should be improved liaison and joint working between psychiatric services and services in general hospitals in order to address the physical health and social needs. This should be addressed in each trust's health and wellbeing strategy.

4.0 Conclusion

The physical health problems of patients with serious mental illness, and learning disability, are significant. As noted above, our patients die approximately 20 years earlier than they should. RQIA decided to examine this important area of potentially preventable illness and premature death.

This initial self-report highlights areas of good work in relation to the addressing of the physical health problems of patients with psychiatric illness or learning disability. However, there is considerable variability between the trusts regarding services provided. There is much variability within trusts with certain services being provided in some sectors of trusts, but not others. It seems that much of this is dependent on the initiative of individuals locally. If good work is carried out in certain areas, one has to ask why such work is not carried out throughout the individual trust.

There are a number of regional initiatives in which each trust is involved. These include the Lithium Care Pathway and the Regional Scoping exercise regarding the need for physical health checks in the community.

Much of what has been submitted relates to statements about the availability of services, but there appears to be very little monitoring of uptake of services. Many of the services referenced are generic services and there appears to be no record of whether or not the services are accessed. Some trusts have provided considerable evidence, such as information leaflets and audits, while other trusts have provided relatively little evidence.

Within Learning Disability programmes, all trusts have health facilitators for whom a major role appears to be ensuring the individual patients receive hospital care for their physical health needs, with much good liaison with general practice. This is a practice that could be usefully considered by psychiatric services.

Lack of resources is cited as a problem in relation to some services being provided. Some developments, such as liaison services, may indeed require discussion with the Health and Social Care Board regarding additional resources, but much can be done within existing resources. Each trust should share best practice within its own service to ensure that good work is replicated and provided throughout the trust area for the benefit of all patients. Trusts should also share best practice with each other.

In some trust areas, there is an issue regarding the boundary between primary and secondary care and the relative responsibilities. There is a requirement to address any such difficulties so that patients receive the services they deserve.

For services that are provided, it is important that their uptake and effectiveness is monitored. If uptake is poor, the services need to be promoted better and/or changed to make them more appealing to patients

who may avail of them. We would like to be assured that patients have access to meaningful interventions which can address the current inequality.

As part of its regular meetings with trusts, RQIA will discuss its findings with each individual trust and agree a plan of action to improve the provision of the services, the monitoring of uptake and the effectiveness of these interventions.

5.0 Recommendations

i. Trusts should increase their efforts in relation to encouraging cessation of smoking among psychiatric patients and people with learning disability which evidence shows is amenable to intervention.

ii. Lifestyle clinics should be more available throughout Trust areas to ensure all patients have access to such health promoting interventions.

iii. All trusts should develop care pathways for all anti-psychotic prescribing.

iv. Trusts should consider having either a regular meeting or, alternatively, a named individual from the CMHT, to liaise with colleagues in primary care for the benefit of patients.

v. Consideration should be given to making arrangements with primary care to provide appropriate services to long stay patients to ensure that physical checks are carried out regularly so that patients have optimum physical health.

vi. All trusts should also consider having physical health pathways for long stay patients to ensure their hospitalisation does not restrict their access to services enjoyed by the general population.

vii. Trusts with a dual diagnosis service need to consider consolidating the service making arrangements for those with learning disability to access these or similar services, and trusts should introduce a dual diagnosis service if not currently available.

viii. Trusts that report low numbers of learning disability patients with substance misuse problems should audit their population to ensure there is not an unidentified unmet need.

ix. There should be improved liaison and joint working between psychiatric services and services in general hospitals in order to address the physical health and social needs. This should be addressed in each trust's health and wellbeing strategy.

Dr Oscar Daly
Sessional Medical Officer
RQIA

31 December 2014