

Manchester Public Health Development Service, NHS Manchester (Manchester Community Health)

Manchester Mental Health and Social Care Trust

Manchester Supporting Health Programme Progress Report to March 2009

Introduction

This report covers development of the Programme between April 2008 and March 2009.

The Programme became operational in March 2007. Programme development up to April 2008 is covered in two previous reports. These reports cover the early shaping of the Programme and progress towards effective interventions for people with severe mental ill health. Although this report depicts the Programme in the full flow of delivery to individuals, it also shows the continuing need to attend to the development of more effective systems and relationships in existing services.

Some of the main features of the Programme to date which are shown in this report are;

- Increasing awareness of the needs of this client group and of effective interventions to improve their health. In particular, the requirement to work intensively and assertively over a period of time with individuals who do not have much motivation or confidence.
- The importance of shaping interventions to individual needs through talking to service users and through innovation in response.
- The development of recording, audit and reporting systems for the health screening programme, linked to the Care Programme Approach (CPA).
- The Programme is to be extended in 2009 to people with dementias and their carers.

Background

People with poor mental health commonly suffer from poor physical health and vulnerability to illness. It is estimated, for example, that people with a diagnosis of schizophrenia will have an average ten years less life expectancy than national population averages.

Choosing Health, the current national public health strategy, highlights mental health as a priority. Improving the physical health of people with mental health problems is indicated as a key area. This was followed up in 2006 with Department of Health guidance for commissioning programmes of work in PCT areas. Click here to view [commissioning framework](#)

This Programme aims to contribute to reducing health inequalities in Manchester through targeting this particularly vulnerable group of people. Amongst the “Lessons Learned by the National Support Team for Health Inequalities” (Dept Health 2008)

was “**Find the Missing Thousands: Be proactive in seeking out people who already have disease or who are at high risk but are accessing services sub-optimally or not at all. Use prevalence models to identify gaps between expected and actual numbers on registers (e.g. Quality and Outcomes Framework (QOF), cancer registers). Pursue them systematically through practice records and by outreach into communities.**”

Local funding is managed by Manchester Public Health Development Service on behalf of the Director of Public Health, Manchester PCT, guided by a Service Level Agreement. The Programme is overseen by a city wide Mental Wellbeing Group, reporting to the Adult Health and Wellbeing Partnership.

It should be noted that much of the work of the Programme has benefits for a wider population, e.g. people experiencing common mental health problems, through its promotion of improved physical health as one route to mental health. Such promotion also includes useful advice for the general population in maintaining good mental health.

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Programme Structure and Purpose

The Manchester Programme is now established for a period up to 2011. Continuation of the Programme beyond then will be considered in the light of evaluation.

The Programme consists of two closely linked elements,

1. **A Health Programme of Health Checks**, based in the Manchester Mental Health and Social Care Trust (MMHSCT), Nurse Practice and Development Team, targeting people with serious mental illness. A health check service for individuals is a citywide service run by two full time mental health nurses, based at the Edale Unit at MRI. Their main roles are,
 - Providing a health check service for individuals, primarily in collaboration with general practice.
 - Referring clients to appropriate medical and health improvement services.
 - Integrating with existing systems in primary and secondary care and providing staff training for improving service users’ physical health.

2. **A Programme of Health Improvement Development Work** to improve the availability of the means to health improvement for people with severe mental ill health. This element of the Programme is based in Manchester Public Health Development Service (MPHDS), part of Manchester Community Health in NHS Manchester, and builds on existing work in the service. The main functions are,
 - The development of strategic links to all health improvement initiatives in the city to ensure the needs of this population group are considered in all aspects of public health strategy.
 - The development of links to practical schemes that deliver health improvement to ensure appropriate inclusion of the needs of people with serious mental illness, e.g. in physical activity schemes, nutrition services and

healthy eating schemes, smoking cessation services. This work includes the provision of training to staff and volunteers in such services to increase their effectiveness in working with people who have severe mental health problems.

- The initiation and evaluation of innovative projects that can demonstrate best practice in engaging and supporting people with mental ill health in improving their own physical health.
3. **A Programme Steering Group.** The Programme is supported and guided by a steering group comprising Programme staff and managers, representatives from MMHSCT, NHS Manchester, general practice, chronic disease management and physical activity referral service, public health, psychiatry and primary care mental health services. This group has proved invaluable to the development of the Programme and for the diffusion of the Programme's aims within other organisations.

Programme Progress

1. The Health Check Programme

The Programme began to engage with referred individuals from October 2007 following a period during which appropriate mechanisms and partnerships were established for a sustainable screening operation. The main aspects of this preparation were,

- Liaison with general practice across the city to establish how a specialist health checking service would best operate in collaboration with GP responsibilities towards the physical health care of people on their Severe Mental Illness (SMI) registers. The SMI registers are subject to a number of standards for audit under the Quality and Outcomes Framework (QOF) arrangements. One of these standards is for the provision of annual physical health checks for people on the register. Investment in the coordination of responsibilities for physical health checks is essential to avoid duplication of effort between the Programme, GPs and secondary services. The Programme has aimed to establish the best continuing systems of communication and to ensure longer term sustainability of effective healthcare and health promotion for this group. The first stage in the application of this collaboration was an invitation to GPs to refer patients to the Programme from their SMI register when they have found engagement with individual patients difficult. The Programme invited referrals from all general practices in the city and consequently developed approaches to health checks that are appropriate to problems of engagement, for example, offering to conduct appointments in the patient's home.
- The use of home visits as a more assertive form of engagement has some additional advantages. It has allowed for a more thorough assessment of user needs than an appointment in, say, a health centre would allow. A home visit provides a more relaxed, less stigmatised, setting for service users, facilitating a more thorough gathering of information, an assessment of problems in the home that may compromise health, for example a lack of cooking facilities or environmental health problems, and the potential for engagement with family members. Home visits do, though, tend to be more time consuming because of longer interviewing time (this is sometimes the first opportunity that someone has

had to discuss their health), occasional failed appointments and the need to conduct initial visits in pairs for an assessment of safety.

- “Depot” clinics. Following receipt of the first wave of referrals from GPs, the Programme began to provide health checks for people using “depot” clinics, i.e. clinics for the administration of long acting psychotropic medication. A recent audit in MMHSCT indicated that users had high levels of poor physical health and it is anticipated that the Programme’s involvement here will help clinics to develop more effective responses to improving users’ physical health in the longer term.
- The programme has developed systems for care pathways, recording, reporting and communication. These processes have been developed to encourage interagency working, case coordination and patient choice and control, e.g. links to the Care Programme Approach (CPA) system and to GP records.
- The health check service has adopted use of the Physical Health Check procedure developed by Rethink, the national mental health charity. This tool has been recommended for adoption by Manchester Mental Health and Social Care Trust in a draft policy for physical health of service users. [Rethink PHC](#) (For evidence of the effectiveness of this tool, see, *The Physical Health Check: a tool for mental health workers*. M.Phelan et al. *Journal of Mental Health* 2004; 13(3).)

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Analysis of Health Check Records to March 31st 2009 (from October 2007, 18 months)

The Health Check Service. This service has developed to provide engagement with service users over the course of one year, delivering at least four health checks annually. This programme is flexible according to individual needs, reflecting the difficulties in engaging with some people and of supporting people to adopt better condition management and healthier behaviours. People discharged from the service will usually have been supported in management of health problems, directed to, or supported in, opportunities for health improvement, and encouraged in the routine use of GP services. Some will have declined any or continued engagement. The Programme has learnt the need to be relatively assertive in engagement with people who are less likely to use routine health services or attend appointments. Home visits have become a common feature of this service.

Referrals. 117 people were referred to the Programme. Sources of referral were

56% were referred by their GP

16.8% were referred by Park House Treatment Suite (NMGH)

11.2% referred by consultant psychiatrists

6.5% referred by Community Mental Health Teams

3.7% self referrals

2.8% referred by a social worker

2.8% referred by Levenshulme depot clinic

Of those referred, 109 assessments were completed. 6 referrals were not appropriate and 2 people declined the service. 16 people have been discharged from the service and 85 remain in receipt of the service.

For these,

- The average age was 46 years
- 51 were men and 34 women
- 59 were white British, 6 were of Asian British or Pakistani origin, 3 were black British, and 4 were Afro Caribbean. The remainder were from various backgrounds (Irish, American, Bangladeshi, and African). Nine people did not disclose their ethnicity.
- For those in receipt of the service, 55.7% have North Manchester postcodes, 25.3% Central Manchester and 16.4% South Manchester. 2.5% reside outside the city boundaries.
- 58 people currently using the service have a diagnosis of schizophrenia. 12 people have a diagnosis of schizophrenia or psychosis alongside other conditions (learning disability, depression, drug misuse), 9 have a diagnosis of bipolar disorder. 4 people have a diagnosis of severe depression.

Significant Findings.

These are noticeable findings so far from screening appointments,

Checking for Illnesses

The service will offer a blood test as a matter of course (see NICE guidelines for schizophrenia), screening for liver and kidney functions, full blood count, cholesterol (lipids), blood sugar levels, prolactin (indicating the side effects of anti psychotic medication) and sometimes for lithium levels. These tests may give indications for a range of health problems including diabetes, raised lipids, alcohol damage, thyroid problems and a range of other conditions.

Blood tests may indicate raised lipid levels showing high cholesterol, a risk factor for heart and circulatory disease. 20 people in the last year have been identified as having high levels and they were referred back to their GP for treatment. The service provided a range of dietary, smoking cessation and physical activity advice and referral to appropriate services if required.

Occasionally blood tests may already have been carried out, for example by a GP or hospital doctor. Where this is the case, this service will seek test results. This procedure will apply to other “invasive” checks, e.g. ECG.

Checking blood pressure is also a routine element in the screening process. High blood pressure is common amongst users of this service. In the last year, 21 people (24.7%) were detected with high blood pressure to a significant degree in repeated tests (using guidelines from the British Hypertension Society), indicating a high risk of heart disease. They were all referred back to their GP. In addition, the service offered an ECG test and a range of health advice, e.g. about weight management, smoking cessation, exercise, diet, alcohol reduction, including introduction to health improvement services (see below).

Of the 21 people with high blood pressure, 6 also had raised blood sugar and cholesterol, 1 had raised cholesterol and 1 raised blood sugar. This combination of

health problems can increase the risk of heart disease. The health risk increases further for many people as they are overweight and smoke.

Having a bodyweight in relation to height that is greater than is considered healthy for adults is a common problem for people using this service. It can be considered a risk factor for ill health and so helping people to manage their weight has proved to be an important aim for the Programme. Increasing weight is commonly associated with some anti psychotic medicines. For those currently using the service, 77% of women and 75% of men are measured as overweight. 66% of women and 54% of men have an unhealthy weight.

The service will offer an ECG reading to anyone with high or low blood pressure, raised or low pulse rate or those prescribed medication known to affect the heart. Seven people were found to have abnormal readings and were referred back to their GP for further tests.

Medication Side Effects

For service users who are prescribed anti psychotic or mood stabilising medication, the Programme will assess and monitor side effects. The direct negative physical health effects of these medicines, coupled with their tendency to make motivation towards healthier behaviours more difficult, have emerged as a significant factor for this Programme. Side effects are measured using the LUNSERS rating scale*. Manchester Mental Health and Social Care Trust are working with the University of Manchester to develop this as an electronic rating scale so that it can be incorporated into Care Programme Approach systems.

Of the 67 people rated for side effects, 44 (65.6%) scored a rating for a variety of symptoms that can be seen as “important clinically” (score more than 20), and 20 people scored a rating as “medium” or “high” (score more than 40). “It is clear that side effects can have a cumulative impact on the individual and can be a major source of distress”.

Additionally, 16 people are being prescribed two different anti psychotic medicines at the same time and a further two are prescribed 3. Prescription of anti psychotic medication may be concurrent with a range of other medications.

The Programme monitors side effect ratings and reports all of them to the prescribing doctor. There is evidence that this monitoring supports concordance with treatment and engagement with the service user*.

* *“The use of the Liverpool University neuroleptic side-effect rating scale (LUNSERS) in clinical practice.” P. Morrison et al, Australian and New Zealand Journal of Mental Health Nursing (2000) 9.*

Health Related Behaviours

Tobacco smoking. 48.2% of people seen were smokers. Of these, 10 said they did not want to give up. Of those who did, stop smoking advice was offered by the Programme staff who are trained as advisors. A number of people have reduced their smoking.

Diet. 35.2% of people reported that they have an unhealthy diet. 76% of these were men.

Exercise. 57.6% of people said they did not get regular exercise (i.e. some form of exercise at least 3 times a week).

Alcohol

Service users are routinely asked about their alcohol consumption. There are not many regular alcohol drinkers amongst this population although nine people were, by self report, drinking more than the recommended national guidelines. This is represented by a wide range of consumption from just over the national guideline to 13 times the guideline. This group appear to be amongst the most vulnerable to a range of health problems including, including depression, anxiety, mood swings, high blood pressure, increased risk of heart disease, strokes and cancer, blackouts, injuries, weight gain and impotency.

Referrals made from Screening Appointments

People who are assessed by the Programme will be referred or guided to services that will help with medical problems and/or provide support in improving health. People are most commonly referred back to see their GP for any medical problems or for further examination where risk of illness is detected. Other services most commonly contacted were dieticians, Health Trainers and exercise on referral service. Other services also contacted include Expert Patient Programme, dentists, opticians, home adaptations, dual diagnosis, sexual health specialist, football team, alcohol services, acupuncture, women's' group, diabetic specialists, continence specialist, chiropody, GUM clinic, money advice.

Many of these findings are mirrored in research by The Institute of Psychiatry who conclude that all these health risks have the potential to be changed and recommend that people with severe mental illness are given targeted physical health support to address these problems. (*Smith S et al. Dec 2007. International Journal of Clinical Practice 61 (12) pp1971-1978*)

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Case Study 1

Mr A is 22 years old and was referred to the Supporting Health Programme by his psychiatrist following rapid weight gain after commencing antipsychotic medication for first onset of schizophrenia. This young man was uncomfortable with his weight gain, experiencing back pain, loss of self esteem and confidence. As a consequence, he had lost contact with all his friends. His family was concerned about his health and his lack of social contacts.

On initial assessment his main concern was his weight gain; he had poor diet and did not take exercise, being unable to motivate himself. Assessment observations showed pulse and blood pressure within normal range. He did not smoke, use alcohol or recreational drugs. He had no family history of heart disease or diabetes. He had had cancer of kidney and only has one functional kidney. A blood test was taken and results indicated no problems. An ECG test showed normal results.

He was referred to the community dietician who he now sees every two months. He attended exercise on referral groups at the gym and now attends his local gym on a regular basis on his own. After making changes in his diet and attending supported activity services he has lost 1st 7lb in weight. A now feels that, through the support of the Programme and subsequent support from other health promotion services, that he

feels healthier and has more self esteem and confidence. His parents are pleased with his progress and are less concerned about him. He is eager to maintain this progress and is keen to be involved in a new group being planned to look at motivation, positive thinking and health education.

Case Study 2

Mr B is 41 years old and referred himself to the Supporting Health Programme. Initial assessment indicated raised blood pressure (180/98) and he was over weight. He complained of left sided pins and needles down left arm and fingers, pain occurring intermittently over a few weeks. He has a family history of heart disease. An ECG was carried out by his GP following a letter from the Programme advising of symptoms.

He smokes 80-100 cigs a day, alcohol 46-56 units per week (weekly recommended alcohol units for male 28 units) and uses cannabis a couple of times a week. He was advised to continue to work with the Dual Diagnosis Service in regard to alcohol and substance use.

Blood tests showed significant abnormal results for serum ALK Phosphate, Cholesterol and Gamma Glutamyl Tranferase. These findings are linked with the liver, possibly associated with B's heavy drinking. An ultrasound scan and further blood test followed. All those involved in B's care (GP, care coordinator, psychiatrist and B himself) were informed by letter of his test results. The Programme continues to monitor his blood pressure to ensure that it had returned to within normal range.

As B was experiencing a lot of extra pyramidal side effect, the Programme made an assessment profile and notified his psychiatrist. His medication was reviewed and reduced. These side effects are no longer a debilitating problem.

Conducting the assessment in B's home has allowed his family to discuss their worries about him. His mother was able to express her concerns regarding his being sedated and, she felt, over medicated. She was able to contribute useful insight as to B's condition and history.

B expressed interest in outdoor activities and he was given information about local opportunities. His alcohol and cannabis consumption has reduced and he is now eating regular meals. He has full activity schedule attending cooking classes and helping to serve meals. He has learnt a lot about nutrition and so has a healthier diet. He has lost 20lb in weight.

Case Study 3

M is 35 years old and of Asian background. She was referred to the Supporting Health Programme by her social worker. She did attend her GP practice for routine health checks and required support with activities to improve her health. Initial assessment by the Programme showed high blood pressure and body mass index. Prolactin levels were raised and the risks indicating potential problems with her medication. This was discussed with M and she was able to make an informed choice to stay on her medication.

M's main concern was related to her weight and lack of motivation to make changes in her lifestyle. She was referred to the Expert Patient Programme (which is for the self management of long-term health conditions).

She reports that this is an excellent programme and she was putting into practice, in her daily routine, the things she had learnt, i.e. stress management, relaxation, sleep, home exercise. She felt that working within the group setting was supportive and she is now very keen to start to engage in an individualised health programme. She has been referred to the Health Trainer service to support her in engaging with a local Asian women's group and in taking up more physical activity. She is now seeing a dietician and keeping a food diary, she is introducing healthier food not only for her self but the rest of her family.

Case Study 4

H is 47 year old African Caribbean man who was referred to the Supporting Health Programme by his care coordinator. He has a diagnosis of type 2 diabetes. He does not attend his GP practice for health checks. H tends to sleep in his chair as it is difficult to get to bed. He reports back pain. He does not go out except to get food and then uses a taxi.

On assessment by the Programme it was not possible to weigh him accurately as he exceeded the 115kg limit on the scales. His blood pressure was 119/81 and his pulse 125. This raised pulse indicates use of ECG testing but this proved difficult due to problems associated with weight and immobility. No ECG recording was able to be obtained.

Following assessment, a management plan was drawn up which included referrals to a dietician, the adaptations team for assessment for home appliances, optician and chiropody referrals. Smoking cessation support was investigated. An appointment made with the GP because of concerns about the rapid pulse rate.

Despite the supporting health nurse organising to support H attending this appointment H did not attend the appointment or any of the others made for him. The dietician and adaptations services could make no contact with him.

Programme staff attempted joint visit with other services but were unable to gain access. His care coordinator was unable to persuade him to attend GP.

The Programme continues to try to engage H for further health checks and keeps his GP informed.

2. Developing Health Improvement Opportunities

This aspect of the Programme supports the health check service through opening health improvement opportunities for those referred to the Programme and for other people with mental health problems. It also takes a broader view in developing these opportunities for a wider public, promoting improved physical health as one means to improving mental health, and vice versa. This is a process of piloting new approaches to engaging service users who are often low in confidence and at the very early stages of improving their health and adopting different habits and activities. It is also a process of working together with all of the other organisations in Manchester that

have a role in improving people's health, to ensure that people with severe mental ill health are able to use these services. Much of this work involves developing capacity and skills in many organisations through additional support and training. Here are examples of such initiatives and collaborations,

Training

- One day training for 12 staff within Manchester Mental Health and Social Care Trust to consider ways to improve the health of their clients, optimising their health promotion role, particularly considering ways to motivate clients to change behaviour. Participants will be followed up to see what has been implemented and support is provided to develop health promotion activity in their work setting. For example: The clinical practice lead in Park House (North Manchester) attended the training and was subsequently supported to implement a week on physical health and health promotion on the wards. A session on Health Trainers took place to which 14 patients and 5 staff took part. Two patients took up the Health Trainer service. MMHSCT are discussing the potential for including physical health care training as mandatory for all staff.
- Brief health promotion training for 171 new Manchester Mental Health and Social Care Trust staff during their induction. Presentations have also been made to Crisis Resolution Team South, Crisis Point, Mainway Enterprises, Community Mental Health Team South and Creative Support staff.
- Presentations and discussion for carers of people with mental health problems, providing support for their own physical health, promoting the Programme and identifying how best they can be supported to improve the physical health of people they are caring for.
- Two one-day training sessions on physical activity and mental health, delivered to 24 people in all, from various services.
- Food and mood training for 24 people provided in collaboration with the Community Nutrition service.

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Developments in Manchester Mental Health and Social Care Trust (MMHSCT)

Physical Health Strategy

MMHSCT has drafted a comprehensive strategy for monitoring and improving the health of its service users.

Care Programme Approach (CPA)

MMHSCT is committed to integration of health check records into the CPA system for care planning for all its service users.

Trainee Assistant Practitioners (TAPS)

These are newly created roles within Manchester Mental Health and Social Care Trust. Support and guidance has been given by this programme to facilitate their health promotion role. Some TAPS have highlighted training needs to develop their capacity to promote health, for example, knowledge about nutrition and diet and skills

to support and motivate clients in leading more healthy lives. It is planned to provide them with a programme of health promotion training.

A network is proposed to bring together TAPS workers and other MMHSCT staff who have a specific role in promoting health. This will help to co-ordinate activity for promoting physical health, sharing good practice, planning further training and identifying new developments within the MMHSCT to improve health for service users.

Staff Training

MMHSCT have commissioned a package of training from The University of Manchester which will be delivered to staff in key areas throughout the Trust in order to support improved physical health care for service users. The training will be based on the Rethink health check procedures, see above.

The Depot Clinic Service

NHS Manchester has funded a quality initiative to review the role and function of depot antipsychotic injection clinics across the city. These clinics provide treatment for hundreds of service users in a variety of locations from GP surgeries to in-patient mental health units. The project will create a one stop service where a range of needs can be addressed. It will run by the MMHSCT Medicines Management team from July 2009 to July 2010.

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Physical Activity.

This continues to be a key area for development given the evidence for positive impacts on physical and mental health combined with the benefits of activity in social settings. Activity is often sustained through the interest and good will of individual workers. This has therefore continued to be supported until a longer term resource is established.

- Weekly physical activity group sessions with an experienced tutor have continued for in-patients at Edale House, MRI. There remains a need for one to one activity sessions for patients requiring a low stimulus environment and this has been supported through the provision of weekly one to one sessions for 20 weeks. These have benefited 12 patients, 10 of whom were able to move onto the group session because of improved mental health, reduced risk and/or improved confidence.

One client explained that the one to one session *“gives me space to improve my confidence around sporting in general, I often feel too self conscious to use the group sessions and the 1:1 therefore allowed me to exercise”*.

Another client said *“The exercise I do in the one to one session helps my back pain for the rest of the week”*.

- A rowing machine has been added to the gym equipment at Edale House. This will be useful to the group activity in having a wider range of equipment to make use of.
- Physical activity for in-patients at Park House, NMGH, has been supported by:
 - Provision of passes for free access to swimming, gym inductions and use of the gym. These have proven useful as incentives for patients to either

experience an activity or to continue it once discharged. Gym induction can be quite expensive for patients; the passes have been useful to get them started so that they can see the benefit. The passes have also been used to get patients inducted at gyms near to where they live to increase the probability of them continuing the activity once discharged. For example one male patient made use of this support and subsequently continued to attend the gym.

- Provision of gym equipment (weights and an exercise bike) to establish an in-patient gym facility. This is currently being set up.
 - Support for a member of staff in training to become a fitness instructor. This training will enhance his current remit to support access to physical activity as the training qualifies him to instruct and induct people in gyms, carry out fitness assessments and put together fitness plans and diet plans to lose weight effectively.
- The football team in North Manchester, The Crumpsall Boa Vistas, provides an invaluable resource and activity for men with severe mental illness which has demonstrated clear positive and sustained outcomes to their health and well being. Men taking part come from the in-patient wards, Community Mental Health Teams, Anson Road rehabilitation project and the Early Intervention Service. Engaging in football has improved and maintained the men's mental and physical health and through taking part men have developed friendships. Some meet outside of the group to have meals together. This activity has been maintained through the support of workers in their own time and requires long term mainstream support. The Programme has supported the team's participation in the North West Mental Health Football League.

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New Developments

- The Programme now has a trainer from the Community Health Trainer Service placed within it. This will enable greater attention to personal support for service users in improving their health and enable the trainer to build up more specialised skills and contacts.
- Links have been developed between Sports Development (Manchester Leisure) and mental health services to increase collaboration in providing opportunities for physical activity for people with severe mental ill health. Services that have particularly benefited include Older Age services in South Manchester and in-patient services in North Manchester. Future possibilities include mental health awareness training for Sports Development coaches.
- Links have been developed with a new Ramblers Association project: "Get Walking Keep Walking" to draw their attention to needs and groups to link with.
- The Programme has developed links with similar programmes of work in the North West and supports regular network meetings.

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Service User Experience

In order to gain a deeper insight into the needs and experiences of service users, a series of structured interviews were conducted with 15 people currently using the health check service. The interviews have provided some useful ideas for improving the service.

This is a brief summary,

- All clients were keen to improve their health.
- 5 people have back pain and for most this is probably a result of weight gain. This is an area which needs exploration to see what options and activities would be best, either one to one or in a group setting. Some will need activity they can do in the home.
- Some clients are fearful about leaving their home and need one to one support at home. This includes access to a health trainer and exercises they could do at home.
- Quite a few people have a number of professionals involved in their care and therefore there is a need for the Supporting Health Programme to link in with these professionals to discuss how each could be supporting the client to improve their health. Ideally this should be part of their care package. Some of these professionals have been highlighted as playing a significant role in motivating them to engage in activity.
- Some clients are confident to make use of services on their own.
- A few clients have one or more carer(s), such as family member(s) who cook for them, provide social company and do their best to encourage them to take up activity. Informing carers about healthy living messages and ways to motivate and encourage the person they are caring for needs to be integrated into the programme. This should be combined with informing the carers about support services for themselves. Some clients play a reciprocal role whereby they are also caring for the carer.
- Practically everyone was interested (9 definitely and another 3 possibly) in a healthy living programme for clients of the Supporting Health Programme. This would have the aim to be a stepping stone for clients to increase their confidence and motivation to make changes and start using health promotion services in the community. The programme intends to bring in service users who have been successful in making use of mainstream services. The programme would also be open to carers.
- Several clients have expressed an interest in having access to a DVD about services in the community.
- Some clients either have or are keen to take up volunteer opportunities. The Supporting Health Programme is liaising with the Mind Inreach Volunteer scheme to explore possibilities for clients.
- Some clients need more intensive support then they are getting from agencies they have been referred to.

Evaluation of Programmes in the North West.

The University of Plymouth, commissioned by the Care Services Improvement Partnership, has produced a report looking at all North West Programmes. The report does not explicitly identify any one programme but looks at the various attributes of programmes according to a set of criteria. The summary and recommendations to the report, however, do highlight as good practice some aspects of the Manchester Programme.

“There is a need to enhance existing services within mainstream primary care, so that people with SMI can have the opportunity to access the same services as the rest of the population. Yet targeted services ensure that the most vulnerable are provided with at least a basic level of physical health care. The most effective and most evaluated models here provide a mixture of the two, with specialist practitioners working with an assertive outreach model to identify people with SMI who have not received annual physical health checks and to offer support where needed, whilst at the same time delivering training to staff at primary care and secondary care levels to promote access to mainstream primary care/public health services and to offer SMI specific targeted services where required.”

North West Boost to the Evaluation of the Impact of the Choosing Health Financial Commitment to Supporting the Physical Health Needs of People with Severe Mental Illness at National, Regional and PCT Level in England. Final Report. (University of Plymouth. J. Woodcock Ross et al.) March 2009.

A copy of this report can be obtained from the Manchester Programme team.

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The Programme for People with Dementia and their Carers.

This Programme has been unable to provide for people experiencing dementias in the past since, although there is no upper age limit for referral, it is recognised that providing such a service for people with dementias would require more specialised skills and range of experience. The Programme has now been funded by NHS Manchester, through funding called “Improving Health in Manchester”, to extend provision both to people with dementia and their carers. The inclusion of carers recognises that they too are particularly vulnerable to poor health and that they will be instrumental in improving health for those they care for.

This part of the Programme will mirror the existing one as a partnership between Manchester Public Health Development Service and Manchester Mental Health and Social Care Trust. It will employ one nurse for a programme of health checks and a public health development advisor to shape new approaches and alliances.

The dementia programme will be launched in mid 2009 and will run for two years to March 2011. It will be independently evaluated by the University of Manchester. It is hoped that this programme will benefit from a multi agency steering group as the current programme has.

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Conclusions.

What is working well?

- People using the health check service are shown to have overall worse health than the general population in Manchester and are less motivated to address health problems. The Programme has been successful in identifying those in need of the service, identifying health risks for individuals and in liaison, on behalf of individuals, with GPs, other medical services and with organisations that support health improvement.
- The Programme has developed assertive engagement with people referred to it where they are reluctant to use health services or to attend appointments.
- The Programme has responded to the side effects of psychotropic medication as an important factor in the relatively worse health of this population.
- The Programme has identified some of the key barriers to improved health for those who are most vulnerable and most disabled by mental ill health.
- The Programme works across a range of secondary care services for people with severe mental ill health, including inpatient services.
- Manchester Mental Health and Social Care Trust have worked with the service to ensure that development and innovation is integrated across their services.
- Collaborative working with a range of community based and voluntary sector services has enhanced opportunities for health improvement for people with severe mental ill health.

What needs to improve?

- There is a need for increased liaison with general practice. This is good with some practices but not consistent across the city.
- There is a need to gain greater focus on health improvement (e.g. diet, exercise, stop smoking) activity for people using the health check service, including greater access to one to one support for service users to motivate them in taking up health improving activities. Increased collaboration with the Community Health Trainer Programme and with TAPS workers (see above) is a promising start.
- Greater collaboration with designated care workers for individuals, to integrate physical health care within care planning. Integration with the CPA system (see above) will facilitate this.

Thanks to Neil Harris

Dr Neil Harris, consultant nurse in Manchester Mental Health and Social Care Trust, has just retired. His work in establishing and supporting this Programme has been invaluable, providing expertise and fresh thinking.

Douglas Inchbold. 23.6.09

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