Haringey Council

Report for:	Overview and Scrutiny Committee	**Item Number:**	

Title:	Mental and Physical Health: Adults & Health Scrutiny Panel Project Report

Report Authorised by:	Cllr Gina Adamou, Chair, Adults & Health Scrutiny Panel

Lead Officer:	Melanie Ponomarenko Senior Policy Officer (Scrutiny) Melanie.Ponomarenko@Haringey.gov.uk 0208 489 2933

Ward(s) affected:	**Report for Key/Non Key Decisions:**

1. Describe the issue under consideration

1.1. Under the agreed terms of reference[1], the Adults and Health Scrutiny Panel can assist the Council and the Cabinet in its budgetary and policy framework through conducting in depth analysis of local policy issues.

1.2. In this context, the Adults and Health scrutiny panel may:

- Review the performance of the Council in relation to its policy objectives, performance targets and/or particular service areas;
- Conduct research, community and other consultation in the analysis of policy issues and possible options;
- Make recommendations to the Cabinet or relevant non-executive Committee arising from the outcome of the scrutiny process.

1.3. Cabinet Members, senior officers and other stakeholders were consulted in the development of an outline work programme for Overview & Scrutiny Committee and Scrutiny Panels. Project work undertaken by the Adults and Health Scrutiny Panel on mental health was agreed as part of this work programme by the Committee on the June 17th 2013.

[1] Overview and Scrutiny Protocol, 2012, Haringey Council

1.4. The Panel therefore undertook two mental health projects – mental health and accommodation and mental & physical health.

2. Cabinet Member introduction

N/A

3. Recommendations

3.1. That the Overview & Scrutiny Committee:

(i) Note contents of the attached final report;

(ii) Agree the recommendations contained in the final report.

4. Alternative options considered

N/A

5. Background information

5.1. The Terms of Reference for the project were as follows:

To make an assessment of the physical health interventions and advice given to people with mental health needs across the care pathway in order to improve their physical health and wellbeing.

To include:

- Smoking
- Obesity/weight management
- Physical activity
- Alcohol use
- Drug use

To make recommendations to improve the physical health of people with mental health needs in Haringey based on available evidence.

5.2. The Panel heard from a range of stakeholders, both in project meetings and externally. These included BEH MHT, Haringey CCG, Mind, Haringey User

Network, Mental Health Support Association, Public Health, St Mungos, service users and carers.

5.3. A number of themes emerged from the project, which are outlined in more detail in the main body of the report. In summary:

- **Smoking Cessation** – There is a high prevalence of smoking amongst the mental health population and continued emphasis should be placed on targeting those with mental health needs for this service. There should also be continued emphasis on the recording of mental health data in the smoking cessations service.
- **Physical Activity** – There is evidence to suggest that physical activity is beneficial to mental health and that a greater emphasis and awareness is needed of this link.
- **Weight Management** – People with mental health needs face particular barriers relating to weight management, which includes the impact of medication therefore a specific, targeted weight management class would be beneficial.
- **Cardio Vascular Disease and Cancer Screening (Health Checks)** – Health Checks are a valuable part of the preventative agenda and lessons should be learnt from the community mental health programme to ensure that future programmes have an increased uptake of the Health Checks.
- **Health Trainers and Health Champions** – Increased awareness is needed amongst the mental health population as to the services offered by Health Trainers and Health Champions.
- **Dual Diagnosis** – The dual diagnosis service faces a challenge in ensuring that people complete the course due to hospital discharge, there is therefore a need for a better link between the service and GPs.
- **BEH MHT** – Whilst the Physical Healthcare Policy is thorough the Panel felt that there is room for improvement in ensuring that where a patient is referred for services, this referral is followed up by the patient and/ or the service which the patient is referred to.
- **Primary Care** – There should be an increased primary care presence in the acute sector. NHS England and Haringey CCG should work with GP Practices who are underperforming on mental health Quality Outcome Framework Indicators.

- **Communication between GPs and BEH MHT** – Communication and joint case management needs to be strengthened and improved.
- **Role of Pharmacies** – Pharmacies have a valuable role to play in the care pathway and the development of the Healthy Living Scheme is an opportunity to explore how the role of pharmacies can be developed in relation to mental and physical health.
- **Community Mental Health Teams** – The Panel felt that Care Coordinators could play an enhanced role in physical health and that as part of the Better Care Fund Plans for 2015/16 a pilot project should be considered based on the Manchester model (further detail is outlined in the main body of the report).
- **Recovery Houses** – Physical health checks should be undertaken systematically when a person is admitted to a Recovery House and all those admitted should be given the opportunity to register as a temporary patient with a GP surgery nearby.
- **Social Isolation** – The Panel acknowledged the huge impact which social isolation and loneliness have on a person's mental health.

6. Comments of the Chief Finance Officer and financial implications

6.1 This report makes a number of recommendations, some of which have fairly minimal financial implications and should be able to be funded from within existing resources. (Recommendations 4 and 14.) However others could have more significant cost impacts.

6.2 Recommendations 3, 5, 6, 13, 15, 16, 21, 23, 27 concern a number of small improvements to services, mostly concerning increased training, information sharing between organisations or better sign posting of existing services. These are all likely to have some cost requiring identification of funding – probably through reprioritisation of existing budgets. However before full implementation is considered a more detailed consideration of the impact – especially the indirect impacts should be carried out.

6.3 Recommendations 14, 17, 18, 19 and 26 recommend changes to the way Primary Care supports people with mental health issues. These will have no financial implications for the Council but could have signification impacts on the

local financial arrangements within the NHS.

6.4 Recommendations 4, 8, 9 and 25 propose the creation of new services or the extension of existing services provided by BEHMHT. This will require the identification of new resources or the reprioritisation of existing budgets. This also applies to recommendations 7, 9, 11, 12, 22 and 24 which concern services provided by the Council.

6.4 Proposal 2 is a recommendation concerning allocation of NHS resources at the local and national level. Although the Council can make representations this lies largely outside of Council control.

6.4 At this stage, the proposals are high level recommendations. If adopted further work will need to be undertaken to identify resources and put in place appropriate control arrangements. It will be important that any proposals that are put before Cabinet for formal adoption are fully costed and the risks properly assessed before Cabinet are asked to agree to them.

7. Head of Legal Services and legal implications

7.1. The Assistant Director Corporate Governance has been consulted on the contents of this report.

7.2. 7.2 Although there are no legal implications arising, the report makes a range of findings and recommendations that aims to promote the physical and mental health of patients. They cut across the responsibilities of providers and commissioners of mental and public health services of which include the Health Trust, Clinical Commissioning Group and the Local authority all referred to in the report.

8. Equalities and Community Cohesion Comments

8.1. Overview and scrutiny has a strong community engagement role and aims to regularly involve local stakeholders, including residents, in its work. It seeks to do this through:

- Helping to articulate the views of members of the local community and their representatives on issues of local concern

- As a means of bringing local concerns to the attention of decision makers and incorporate them into policies and strategies
- Identified and engages with hard to reach groups
- Helping to develop consensus by seeking to reconcile differing views and developing a shared view of the way forward
- The evidence generated by scrutiny involvement helps to identify the kind of services wanted by local people
- It promotes openness and transparency; all meetings are held in public and documents are available to local people.

9. Head of Procurement Comments

N/A

10. Policy Implication

10.1. It is intended that the work of the Overview & Scrutiny Committee will contribute and add value to the work of the Council and its partners in meeting locally agreed priorities. In this context, it is expected that the work of the Committee may contribute to improved policy and practice for the following corporate priorities:

- Safety and Wellbeing for all: A place where everyone feels safe and has a good quality of life.
  Priority – Reduce health inequalities and improve wellbeing for all

- Opportunities for all: A successful place for everyone
  Priority - Ensure that everyone has a decent place to live

11. Reasons for Decision

11.1. The evidence behind the recommendations are outlined in the main body of the report.

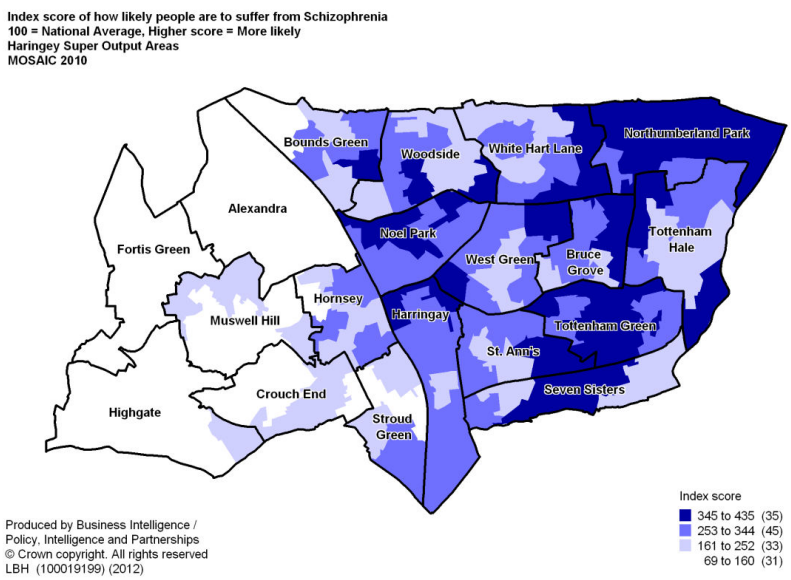
12. Use of Appendices

12.1. As laid out in the main body of this report.

13. Local Government (Access to Information) Act 1985

Haringey Council

Project report
Mental and Physical Health



A PROJECT BY THE ADULTS AND HEALTH SCRUTINY PANEL

April 2014

www.haringey.gov.uk

Chair's Foreword

As a Panel we were shocked to hear that nationally the life expectancy of those with mental ill health is up to 20 years lower than the general population, and that this gap is largely from treatable conditions associated with modifiable risk factors such as smoking, obesity substance misuse and inadequate medical care.

It is clear that poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems and therefore the physical health of mental health patients and service users is very important.

As a Panel we were pleased to hear of the work being done to improve the physical health of mental health patients and service users in the borough. However, we have identified areas where closer links and partnership working across the organisations involved in mental health services would be beneficial.

I hope that the recommendations made in this report will further the progress already made by the Council and its partners and that they will contribute to an increased life expectancy for residents in the borough with mental health needs.

On behalf of myself and the Adults and Health Scrutiny Panel I would like thank all of those who spent time contributing to this interesting and important project, particularly service users, patients, carers and voluntary and community sector representatives.

Cllr Gina Adamou
Chair, Adults & Health Scrutiny Panel

Panel Members:

Cllr Gideon Bull
Cllr Sophie Erskine
Cllr Anne Stennett
Cllr David Winskill
Helena Kania (co-optee)

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Recommendations

The £3.8 billion Better Care Fund (formerly Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care. The Better Care Fund is a single pooled budget to support health and social care services to work more closely together in local areas[2].

Haringey intends to focus on mental health Better Care Fund Integration Plan on mental health services in 2015/16. Whilst recognising that this is not new money, recommendations below are made with the opportunities this presents in mind.

Leadership

We support the following recommendations which are made in the '*Whole-person care: from rhetoric to reality Achieving parity between mental and physical health[3]'* report and recommend that the mental health partnership consider the following recommendations:

1. "That Mental Health providers and Commissioners in Haringey should have the following aspiration:

'*People with mental health problems who are in crisis should have an emergency service response of equivalent speed and quality to that provided for individuals in crisis because of physical health problems'*

2. Achieving Parity - The NHS Commissioning Board and CCGs should allocate funding in a way which supports and promotes parity. This should include ensuring that any person with mental health problems (including co-morbid mental and physical health problems) can expect the same access to services and the same quality of care and treatment as people who have only physical health problems".

Smoking cessation

3. Public Health should continue to make those with mental health needs a priority group for smoking cessation services. There should also be continued emphasis and strength placed on the recording of data by smoking cessation services.

[2] http://www.local.gov.uk/health-wellbeing-and-adult-social-care/-/journal_content/56/10180/4096799/ARTICLE#sthash.XD4CAk4F.dpuf

[3] Whole person care: from rhetoric to reality – Achieving parity between mental and physical health, Occasional paper OP88, March 2013, Royal College of Psychiatrists

4. BEH Mental Health Trust should have a smoking cessation champion who is responsible for those who are in direct contact with mental health patients both in the community and in the acute setting. This person should be responsible for raising awareness of the high prevalence of smoking amongst mental health patients and of encouraging staff to record, undertake brief interventions and refer patients to appropriate services.

Physical Activity

5. Providers and commissioners should raise awareness of the benefits of physical health on mental health, specifically targeting service users, patients and carers.

6. Where appropriate providers and commissioners should consider physical activity as an integral part of the treatment and recovery model for those with mental health needs.

7. Haringey Council should work with Fusion Lifestyles to raise awareness of the concessionary membership scheme for Haringey Leisure Centres.

8. BEH MHT should include a 'green gym' on their site in the St Ann's redevelopment.

9. Active for Life should continue to have a Key Performance Indicator to increase the number of referrals of people with mental health needs and this target is stretched as the programme progresses.

Weight Management

10. BEH MHT should ensure that healthy eating options and dietary advice is available to everyone at St Ann's hospital and in Recovery Houses as an integral part of the services provided to patients.

11. Public Health should consider commissioning weight management classes specifically for people with mental health needs, which reflects the unique barriers which people with mental health needs may face when trying to lose weight, for example the impact of medication.

Cardio-Vascular Disease and Cancer screening (Health Checks)

12. Public Health should review the lessons learnt from the community Health Check programme commissioned for mental health and investigate best practice examples to increase the uptake of Health Checks amongst those with mental health needs.

Health Trainers & Health Champions

13. Information on the Health Trainer and Health Champion service should be shared across mental health services, specifically those who are most likely to come into contact with mental health service users for example mental health social workers, Care Coordinators, Key workers.

Dual Diagnosis

14. The dual diagnosis service should work more closely with GPs when those with dual diagnosis problems are discharged from hospital back into care in the community and where the mental health issues are minor. Processes should be put in place to ensure that this happens as standard.

BEH MHT

15. BEH MHT should review their Physical Healthcare Policy to include mechanisms to ensure that when someone is referred this is followed up by the patient and/or the service which the patient is referred to.

- Patients, Carers and Voluntary & Community Sector organisations should be actively engaged with the policy review.

16. BEH MHT should roll out a systematic training programme for front line staff in the delivery brief interventions and physical healthcare indicators.

Primary Care

17. We acknowledge the importance of continuity of care for people with mental health needs and recommend that Haringey CCG puts arrangements in place to ensure that as far as possible (and where appropriate) all mental health service users enjoy continuity of care with their GP from the moment of diagnosis. For example consideration should be given to those with severe mental health needs having a named GP, who is also a point of contact for other mental health services.

18. Haringey CCG and BEH MHT should develop a system to increase the access of primary care on Wards for example; consideration should be given to a GP attending Haringey inpatient mental health Wards on a regular basis.

19. That NHS England, in collaboration with Haringey CCG, works with local GP practices who are under-performing in relation to Quality Outcomes Framework scores around care plans for people with serious mental illness e.g. blood pressure monitoring, documented comprehensive care plan in order to improve their performance.

Communication between BEH MHT & GPs

20. Haringey CCG and BEH MHT work together to explore best practice examples to develop ways to improve communication and joint case management of patients with mental and physical health needs.

21. BEH MHT should raise awareness of the benefits of the telephone advice for GPs and consideration should be given to the development of a two way advice line so that Psychiatric Consultants are also able to contact GPs for primary care advice.

Role of pharmacies

22. The Local Pharmaceutical Committee and Public Health should develop programmes as part of the Pharmacy Healthy Living Scheme to focus on the overlap between mental and physical health e.g. medicine use queries, smoking cessation services and prescription reviews.

- Where appropriate, mechanisms should be put in place to ensure that information is fed back to GPs.

Community Mental Health Teams

23. That Physical healthcare training is given to Care Coordinators who do not have a medical background to ensure that they understand physical health care indicators.

24. That as part of the Better Care Fund plans for 2015/16 consideration is given to learning from best practice examples, such as the Manchester model outlined in this report and the proposed Older People model in Haringey, with a view to

running a pilot project on increasing the role of Community Mental Health Teams on the coordination of physical health. For example integrated teams around and supporting groups of GP practices which enable a single point of contact for GPs to coordinate care of most complex and vulnerable patients.

Recovery Houses

25. BEH MHT should ensure that Physical Health checks are undertaken on admission to Recovery Houses, including referral and follow up where appropriate.

26. Within 72 hours of admission to a Recovery House patients should be offered registration as a temporary patient at the local GP practice.

Social Isolation

27. We recommend that social isolation and loneliness are considered for a specific piece of project work for Overview and Scrutiny in 2014/15.

Introduction

1. Terms of Reference

To make an assessment of the physical health interventions and advice given to people with mental health needs across the care pathway in order to improve their physical health and wellbeing.

To include:

- Smoking
- Obesity/weight management
- Physical activity
- Alcohol use
- Drug use

To make recommendations to improve the physical health of people with mental health needs in Haringey based on available evidence.

Methodology

2. The project was led by the Adults & Health Scrutiny Panel:

- Cllr Gina Adamou (Chair)
- Cllr Gideon Bull
- Cllr Sophie Erskine
- Cllr Anne Stennett
- Cllr David Winskill
- Helena Kania (Co-optee)

3. The review consisted of a number of Panel meetings, external meetings with stakeholders, a survey (See Appendix A) and service user engagement.

3.1. Evidence from a wide range of stakeholders was presented at Panel meetings (See Appendix B for a full list of review contributors). Following presentations the panel and other attendees had the opportunity to ask questions. The Panel was delighted that those who were invited to give evidence at a Panel meeting attended meetings prior to their slot and also chose to attend Panel meetings afterwards. This meant that throughout the review there was a wide range of attendees with different perspectives and professional and personal experience allowing for a thorough look at the issues relating to the target group.

3.2. The survey was designed in consultation with panel members, local officers (Policy, Public Health), BEH Mental Health Trust and local organisations such as Healthwatch Haringey and Mind.

3.3. The survey was made available online and distributed via a range of avenues including Housing Related Support, Adult Services, Healthwatch Haringey, Mental Health Support Associated, Mind in Haringey, Haringey Disability First Consortium and St Mungos.

Policy **Context**

4. National context

4.1. The **Health and Social Act of 2012**[4] put a responsibility on the health secretary to secure improvement "in the physical and mental health of the people of England".

4.2. The government's mental health strategy, "**No health without mental health**[5]" aims to mainstream mental health. The strategy includes a number of objectives to improve the mental health of the population. Most relevant to this project is objective 3:

More people with mental health problems will have good physical health:

- Fewer people with mental health problems will die prematurely; and
- More people with physical ill health will have better mental health.

4.3. The following points are taken from "**Whole person care: from rhetoric to reality – Achieving parity between mental and physical health**"[6]:

4.4. Poor mental health is associated with a greater risk of physical health problems, and poor physical health is associated with a greater risk of mental health problems. Mental health affects physical health and vice versa."

4.5. A 'parity response' should enable health and social care services to provide a holistic 'whole person' response to each individual and should ensure that people's mental health is given equal status to their physical health.

[4] Health and Social Care Act 2012, www.legislation.gov.uk
[5] No health without mental health, 2011, HM Government
[6] Whole person care: from rhetoric to reality – Achieving parity between mental and physical health, Occasional paper OP88, March 2013, Royal College of Psychiatrists

4.6. Research shows that people with mental health problems have higher rates of physical ill health and die earlier than the general population, largely from treatable conditions associated with modifiable risk factors such as smoking, obesity substance misuse and inadequate medical care. These factors lead to a reduced life expectancy and higher levels of physical ill health several decades later (relevant to Domain 2).

4.7. The life expectancy of those with severe mental illness is on average 20 year less for men and 15 years less for women, when compared to the population as a whole.

4.8. People with severe mental illness are significantly more likely to have worse physical health than those without; for example, those aged under 50 years of age are 3 times more likely and those aged 50-75 are 1.9 times more likely to die from coronary heart disease.

4.9. Efforts to reduce premature mortality must include a strong focus on increasing the life expectancy of people with mental health problems. This can contribute to achieving a reduction in deaths across all aspects of Domain 1 (NHS Outcomes framework Domain 1: Preventing people from dying prematurely).

4.10. People with mental health problems are less likely to receive interventions to address or prevent such behaviour. For example people with severe mental illness appear to be less likely to be prescribed several common medications for physical health conditions (largely cardiovascular problems).

4.11. **Smoking**

- People with mental health problems smoke more than the general population.
- Smoking is the largest cause of health inequality in people with mental disorder yet only a minority receives smoking cessation intervention.
- NHS stop smoking services do not record whether someone has a mental health problem or is taking medication for a mental health problem, despite national guidance requiring up to 50% reduction in doses of some medications for mental health problems within 4 weeks of cessation to prevent the risk of toxicity.

- Royal College of Physicians' Tobacco Group will publish a report on smoking and mental disorder in 2013.

4.12. **Diagnostic overshadowing**

- This describes what happens when healthcare staff incorrectly attribute symptoms of physical health to a mental health condition. For example people with diabetes who present at A&E are less likely to be admitted to hospital for diabetic complications if they have a mental illness.

4.13. Major public health issues, such as cardio vascular disease, cancer and obesity have complex presentations, encompassing both mental and physical health and social care interventions must be designed to respond to this complexity. For example, depression is associated with:

- 50% increased mortality from all disease
- Two fold increased risk of coronary heart disease and diabetes
- Three fold increased risk of death in the subsequent 4 years.

Schizophrenia is associated with:

- A two fold increased risk of diabetes and a two to three fold increased risk of diabetes.
- A two and a half times increased rate of mortality from all disease.
- Reduced life expectancy of 20.5 years for men and 16.4 years for women.
- Increased likelihood of death from coronary heart disease[7].

4.14. Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis

4.15. "This Concordat is a shared agreed statement, signed by senior representatives from all the organisations involved [including the Association of Directors of Adult Social Services, Care Quality Commission, College of Social Work, Local Government Association, NHS England, Public Health England and Mind]. It covers what needs to happen when people in mental health crisis need help – in policy making and spending decisions, in anticipating and preventing

[7] Whole person care: from rhetoric to reality – Achieving parity between mental and physical health, Occasional paper OP88, March 2013, Royal College of Psychiatrists

mental health crises wherever possible, and in making sure effective emergency response systems operate in localities when a crisis does occur.

4.16. The Concordat is arranged around:

- Access to support before crisis point
- Urgent and emergency access to crisis care
- The right quality of treatment and care when in crisis
- Recovery and staying well, and preventing future crises

4.17. The Concordat expects that, in every locality in England, local partnerships of health, criminal justice and local authority agencies will agree and commit to local Mental Health Crisis Declarations. These will consist of commitments and actions at a local level that will deliver services that meet the principles of the national concordat"[8].

5. Local Policy context

5.1. The Haringey Health and Wellbeing Strategy is the Borough's overarching plan to improve the health and wellbeing of children and adults in our borough and to reduce health inequalities between the east and west. The strategy is informed by the Joint Strategic Needs Assessment and supported by a delivery plan.

5.2. The Strategy sets out three objectives:

- Outcome 1 - Every Child has the best start in life;
- Outcome 2 - A reduced gap in life expectancy; and of particular reference to this project
- Outcome 3 - Improved mental health and wellbeing

"We want all residents to enjoy the best possible mental health and wellbeing and have a good quality of life – a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates *and a suitable and stable place to live*."

5.3. Priorities for outcome 3:

- Promote the emotional well being of children and young people

[8] http://www.nhsconfed.org/Networks/MentalHealth/LatestNews/Pages/Crisis_Care_Concordat.aspx

- Support independent living
- Address common mental health problems among adults
- Support people with severe and enduring mental health problems
- Increase the number of problematic drug users in treatment

6. Mental health needs assessment

6.1. As mentioned above Research shows that people with mental health problems have higher rates of physical ill health and die earlier than the general population, in this context it is important to remember that Haringey already has stark differences in life expectancy between deprived and affluent wards in Haringey, particularly in men and therefore mental health may exacerbate this life expectancy gap[9].

6.2. Estimated prevalence of non-psychotic disorders in Haringey:[10]

Condition	**Estimated number of people locally**
Mixed anxiety and depression	15, 962
General anxiety	10,072
Depression	6,667
All phobia	4,159
OCD	2,941
Panic disorder	1,593
Total	34, 485

[9] http://www.haringey.gov.uk/jsna-tackling-life-expectancy-gap.htm
[10] Mental Health and Wellbeing, Public Health (Mental Health Observatory, NEPHO)

7. Survey Results

7.1. A mental and physical health survey was compiled in collaboration with partners and the voluntary and community sector. The survey was available on-line and paper copies were sent to a range of organisations and groups who requested them.

7.2. There were a total of 101 responses to the survey, with a mixture of responses on-line and paper copies returned. Of those who responded:

Age

No reply	11
Under 20	3
21-24	4
25-29	6
30-44	26
45-59	45
60-64	3
65-74	1
75-84	2
85-89	-
90+	-
Total	101

Ethnic group

No reply	16
White category	46
Mixed category	15
Asian or Asian British	1
Black or Black British	23
Chinese or any other ethnic group	-
Total	101

Gender

No reply	11
Male	46
Female	44
Total	101

Religion or belief

No reply	23
Christian	37
Muslim	3
Jewish	-
Buddhist	2
Other	1
Hindu	-
Sikh	-
Rastafarian	-
No religion	28
Prefer not to say	7
Total	101

Sexual orientation

No reply	14
Heterosexual	65
Bisexual	5
Gay	-
Lesbian	1
Prefer not to say	16
Total	101

Relationship status

No reply	14
Single	66
Married	7
Co-habiting	4
Separated	4
Divorced	3
Widowed	3
In a same sex civil partnership	-
Total	101

Refugee or Asylum seeker

No reply	97
A Refugee	3
An Asylum Seeker	1
Total	101

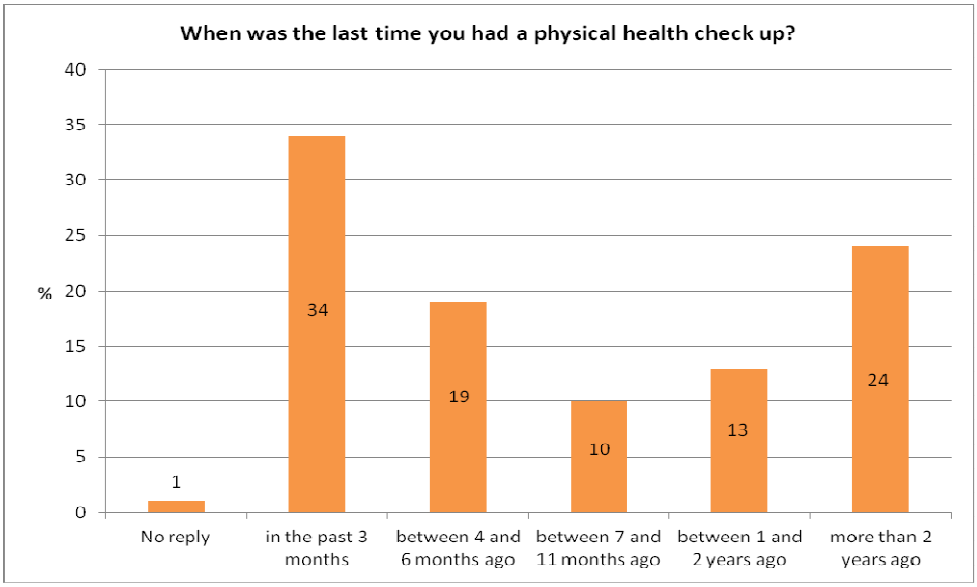
Primary language

No reply	26
Albanian	-
Arabic	2
English	67
French	2
Lingala	-
Somali	-
Turkish	1
Other	3
Total	101

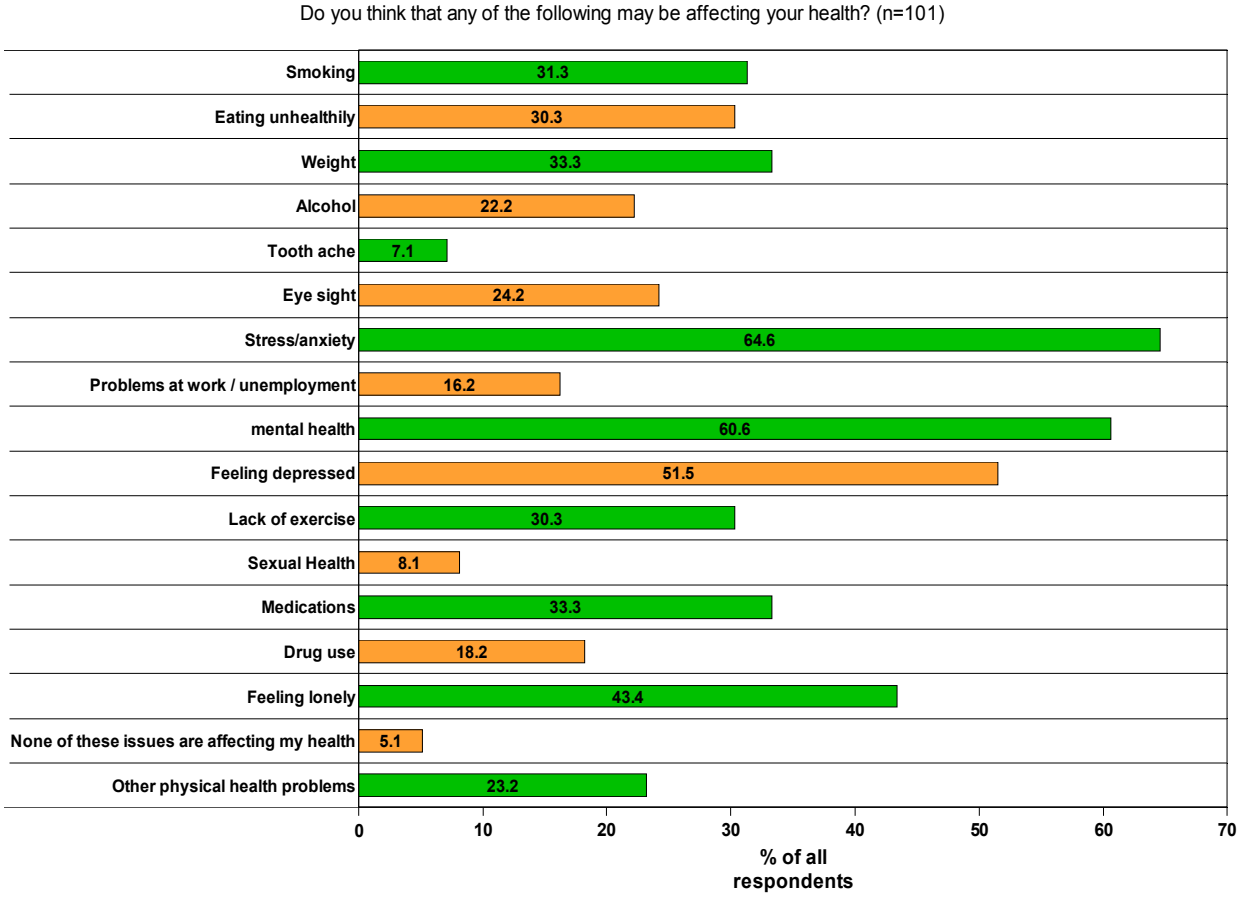
7.3. In the context of the responses received, it is important to remember that those likely to have completed the survey are also likely to be those who are engaged in services already, specifically as the survey was disseminated via organisations and surveys such as Adult Services, Healthwatch, Mind in Haringey, St Mungos and Housing Related Support.

7.4. Points to note from the survey are as follows:

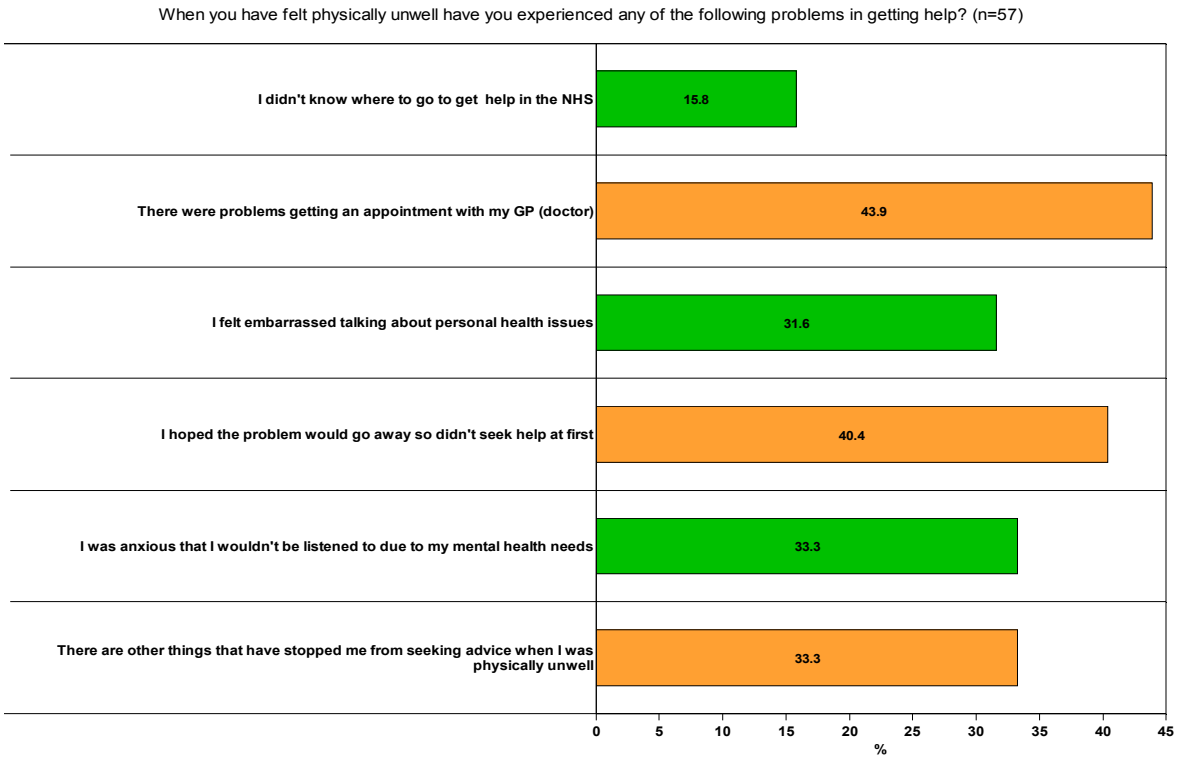
- Almost 34% of respondents stated that their physical health was good, with a further 27% stating fair and 22% poor. Only 17% stated their physical health was very good or excellent.
- When asked about current mental health, 36% stated fair and 24% poor, with only 5% stating excellent, 10% very good and 25% good.
- The majority of respondents (94%) are registered with a GP, with 77% stating that they had visited them within the last 3 months and a further 15% stating that they had visited them in the last 4-6 months.
- When asked when they had last had a physical health check for 37% of respondents this was over a year ago.



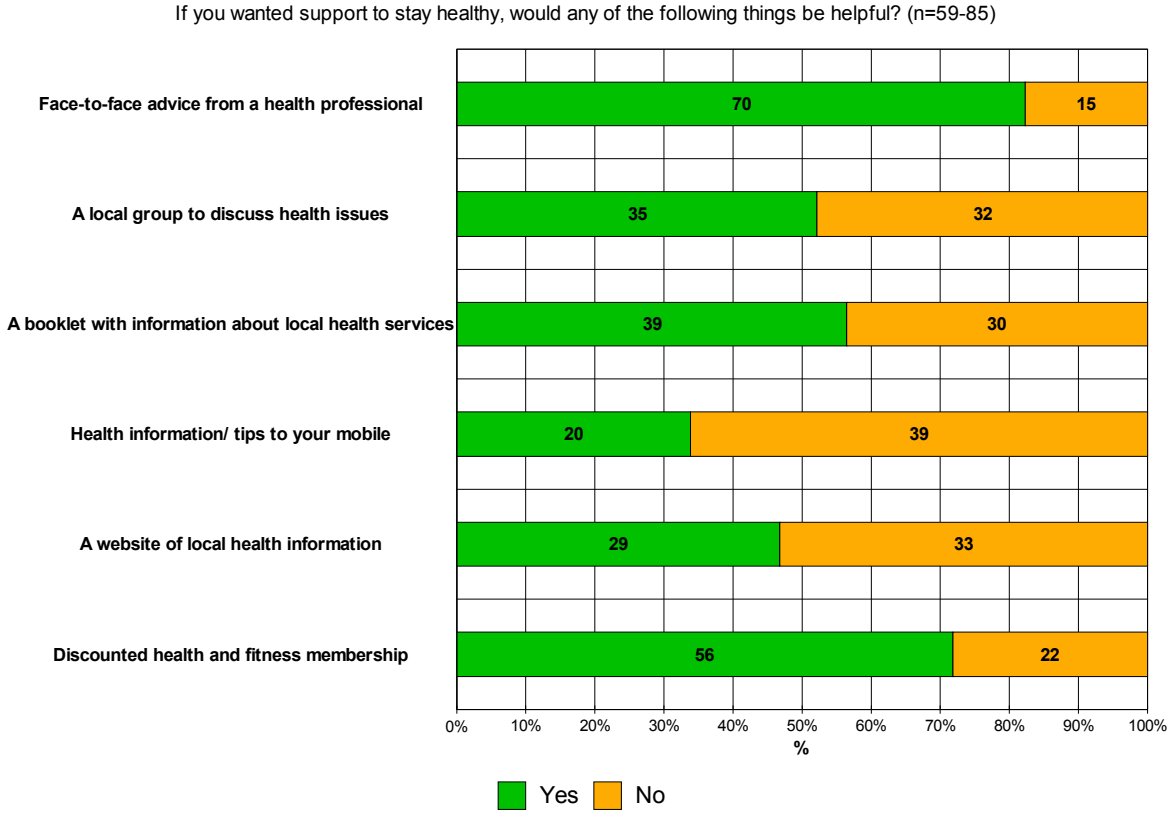
- When asked what factors may be affecting respondents health the factors which were most common responses were stress/anxiety (64.6%), mental health (60.6%), feeling depressed (51.5%) and feeling lonely (43.4%).



- 80% of respondents stated that they had felt unwell over the past 12 months. Respondents who had felt unwell were then asked whether they had experienced specific problems in getting help. 57 responded to this question of which almost 44% stated that they had problems getting a GP appointment and 40% hoped that the problem would go away.



- When asked whether there was anything which would be helpful in staying healthy the most popular answers were face to face advice from a health professional (70%) and discounted health and fitness membership (56%).



7.5. For further detail on the survey and results please contact Melanie Ponomarenko, Senior Policy Officer (Scrutiny), Melanie.Ponomarenko@Haringey.gov.uk .

8. Smoking

8.1. It is estimated that the NHS spends approximately £720m per annum in primary and secondary care treating smoking related disease of people with mental health needs. These costs arise from avoidable hospital admissions, GP consultations and prescriptions costs and are mainly associated with people diagnosed with anxiety and/or depression[11].

8.2. The Royal College of Physicians and Royal College of Psychiatrist's note that addressing high prevalence levels in those with mental health needs has the

[11] Royal College of Physicians and Royal College of Psychiatrist's report, Smoking and Mental health, 2013

potential to offer cost savings benefits, as well as improving quality of life and life expectancy of smokers with mental health needs[12].

8.3. The Panel heard that in Haringey smoking is a huge problem noting that as well as the physical health effects of smoking it has a direct effect on medication, for example a person can need a higher dose of mental health medication when they are smoking due to the impact on metabolic rates[13].

8.4. 'Rethink Mental Illness - Lethal Dissemination'[14] suggests that all smoking cessation services should check the mental health status of their clients and also record whether someone is taking mental health medication to ensure that dosages can be adjusted as necessary. The Panel was pleased to hear that in line with this, Haringey has started recording whether someone has a mental health problem or is taking medication for a mental health problem at smoking cessation services.

8.5. A new automated referral system would also be in place for 2014/15 enabling anyone who is recorded as a smoker to be automatically referred to smoking cessation services. However, there is a need to remember that there may be added complications around smoking cessation and mental health for example; a person may not want to access the services. There is also a need to consider the reasons why a person started smoking in the first place.

8.6. There is a Mental Health Stop Smoking CQUIN which is currently in its second year. Performance data for this CQUIN is shown in the table below.

[12] Royal College of Physicians and Royal College of Psychiatrist's report, Smoking and Mental health, 2013

[13] Mental and Physical Health project meeting, 2013

[14] Rethink Mental Illness – Lethal Discrimination, 2013

CQUIN Performance for BEH MHT 2013/14.

N.B data is for the whole Trust rather than Haringey specific

INDICATOR	TARGET	Q1	Q2	Q3
% of patients seen by community services with smoking status established and recorded at time of admission	90%	92%	90%	78%
% of patients recorded as current smoker who have had very brief advice	90%	94%	100%	97%
% of patients who are current smokers referred for, or receiving in-house, stop smoking support	98%	74%	98%	87%
Community and inpatient staff trained in smoking cessation	30% of all clinical staff	N/A	N/A	37% (450 staff trained)

9. Physical Activity

9.1. There is evidence that exercise reduces anxiety and depression and is beneficial to mental health. Exercise has also been linked with improvements in quality of life for people who have schizophrenia[15] with exercise being particularly beneficial given the increased risk of weight gain due to their medication[16].

9.2. *Active for Life* is a large physical activity programme in Haringey for those living in disadvantaged communities. It is a primary and secondary care referral scheme targeting those at risk of cardio vascular disease/those with cardio vascular disease to become more physically active in order to prevent and/or manage a long term conditions over a 12 week period. The Active for Life service specification[17] includes a Key Performance Indicator on access which is "% of total referrals to the service with a diagnosis of severe mental illness"

- Last year there were 800 referrals – 11% of which was people with mental health needs.
- 54% of those referred to the scheme are still active 6 months after the programme ends.

9.3. When asked in the mental and physical health survey over 70% of respondents (who answered that particular question) stated that discounted gym

[15] Exercise: a neglected intervention in mental health care? P. Callaghan, Journal of Mental Health Nursing, 2004

[16] Exercise for Mental Health, Primary Care Companion Journal of Clinical Psychiatry. 2006

[17] Service Specification, Appendix A, Key Performance Indicators

membership would be helpful to support them to stay healthy. Haringey Leisure Centres (managed by Fusion Lifestyles) have a concessionary membership scheme which includes those on various benefits including housing benefit, incapacity benefit, carers allowance, disability living allowance. It is anticipated that mental health patients and service users would be captured within this.

9.4. At a project meeting there was discussion around local health and fitness services, whereby it was noted that there had previously been exercise classes run by BEH MHT at Tottenham Green Leisure Centre which were specifically for those with mental health needs and that these no longer took place. Carers felt that this was a loss given that those who they cared for had enjoyed the classes and had felt that they were a beneficial social activity as well as feeling comfortable in a class which was targeted to their specific needs.

9.5. Mind in Haringey does run specific wellbeing classes for those with mental health needs for example such as art classes, gardening, cycling, reiki healing and stress management[18].

10. Weight Management

10.1. As outlined above, there is an increased risk of weight gain due to certain medication; this is a risk which BEH MHT is very aware of. One carer noted that her son gone from 12 stone to 19 stone over ten years and since being on medication.

10.2. Feedback from carers suggested that patients are not always told about the weight impact of medication they are prescribed from the outset. BEH MHT informed the Panel that the reason is often as the priority is stabilising a person who may be having a severe episode, with a view to focusing on impacts once the person is more stabile.

10.3. Barriers to weight loss shared included patients finding it difficult to motivate themselves given other issues they may also be facing.

10.4. A BEH MHT Clinical Director informed the Panel that there is a Wellbeing clinic and that at the clinic a patient's BMI and waist circumference is taken at

[18] www.mindinharingey.org.uk

this clinic. However a carer noted that whilst this is the case, nothing is done with the information. Patient representatives also noted that should someone be referred from the Wellbeing clinic the referral is not necessarily followed up by the patient and/or the service which the person is referred to.

10.5. The Panel felt that there should be an intervention around weight management and that a weight management/loss class for people with mental health needs would be beneficial.

11. Cardio Vascular Disease and Cancer Screening (Health Checks)

11.1. Under the Health and Social Care Act it is mandatory for Councils to provide Health Checks for those between the ages of 40-74 years of age.

11.2. Health Checks are aimed at people who haven't yet got an illness – it is a preventative programme mainly commissioned through GP practices. If you already have, for example, diabetes then you should already be being treated and have an annual review of your physical health. However, there are currently two main community programmes which have been commissioned; men's health and mental health.

11.3. As of the project meeting in November 2013 62 people had received a health check through the mental health community programme. The Panel heard that there are challenges in getting mental health service users to attend and complete the Health Checks. Carers at the project meeting also shared examples of attending the Health Check sessions with patients but being ineligible as they already had pre-existing conditions. There is clearly a challenge in this respect, as those who are attending for the Health Checks are again more likely to be engaged with services overall whereas those who may find a Health Check most beneficial are those who are harder to reach and may not be engaged in services.

12. Health Trainers and Health Champions

12.1. Public Health tries to target or make accessible all programmes to people with mental health needs. An example of this is the Health Trainer and Health Champion service whereby the focus has historically just been on physical health; however they have now had Mental Health First Aid training. Health

Trainers offer one to one support with a focus on behaviour change, for example smoking cessation, physical activity and alcohol. Health Champions are volunteers who sign post and raise awareness of services in the borough and can offer a 'hand holding' role for example attending a gym with a person for the first time to offer moral support.

12.2. Anyone can refer to a health trainer, including in the West of the borough, however, services are located in the East. The Panel heard that:

- Over 1000 people were seen by Health Trainers last year including:
  - 80% were from deprived areas;
  - 85% were from BME communities;
  - 80% achieved their goals.

12.3. When asked in the mental and physical health survey 'If you wanted support to stay healthy, would any of the following things be helpful?' over 80% of respondents to this particular question stated that 'face-to face advice from a health professional would be helpful'.

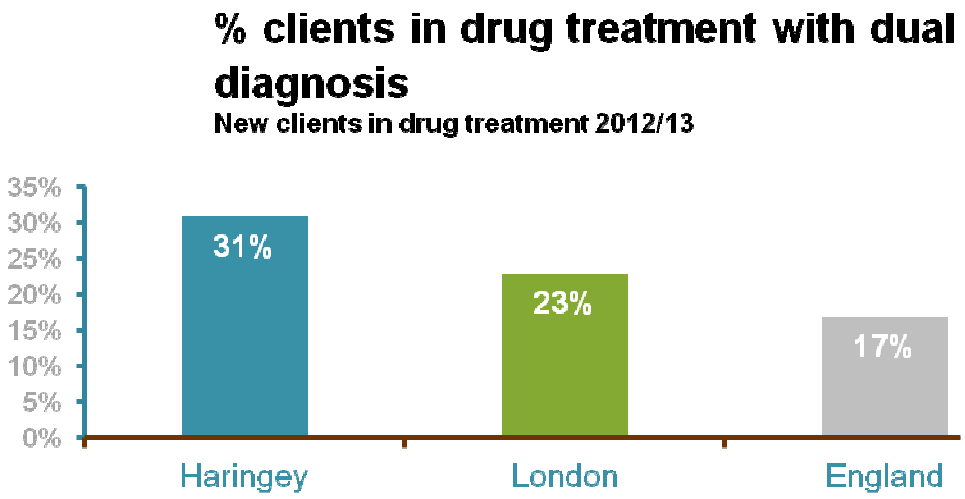
12.4. The Panel also heard anecdotal evidence to suggest that the Health Trainer and Health Champion service does not have a particularly high profile amongst mental health service users, and some professionals who come into contact with those with mental health needs. The Panel therefore felt that there was potential to raise awareness of the role and benefits of the Health Trainer and Health Champion service amongst this client group.

13. Dual Diagnosis

13.1. 70% of those who go through the drug and alcohol services have mental health needs[19]. 'Issues associated with dual diagnosis can include a poorer prognosis and greater disability. This includes a greater likelihood of medical, psychiatric and social problems that arise as a result of poor compliance with treatment, unplanned discharge, relapse and rehospitalisation. Self-harm, often by overdose, and eventual suicide are also strongly associated, as is early mortality'[20].

[19] Panel Project meeting
[20] The relationship between dual diagnosis: substance misuse and dealing with mental health issues, SCIE, 2009

13.2. Haringey has high levels of problematic drug use (higher than London and England averages). Data from Haringey adult drug treatment services in 2011-12 indicates that our treatment population experience a range of social issues and that one in four (25%; 160) were identified with dual diagnosis, a term which is used to describe co-existing mental health and substance misuse.



Source: National Adult Social Care Intelligence Service [21]

13.3. Public Health and the CCG have a contract with BEH MHT to provide a dual diagnosis service. The service provides advice, help, support and more specialised interventions to those with a dual diagnosis. Mental health and drug and alcohol misuse support services include:

- Physical Health Check and advice regarding smoking;
- Referral for screening/ vaccination for Hepatitis;
- Specialist assessments (e.g. psychiatric);
- Referral for specialist substitute drug treatment and community care assessment;
- Harm Reduction advice;
- Access to community and specialist teams in Haringey;
- Motivational Interviewing;
- Own key worker;
- Group therapy;
- Relapse Prevention;
- Referral into substance misuse education, training and volunteering programmes;

[21] http://nascis.ic.nhs.uk

- Drug Free Treatment Contingency Management;
- Teaching and training for professionals within Trust[22].

13.4. The panel heard that there is a challenge in ensuring that people completing the course as people can come out of hospital before it has finished and that there is a need to better link with GPs in order to complete these.

14. BEH MHT

14.1. When a patient is admitted to a mental health ward they receive an initial assessment of their need. This includes whether they smoke, what medication they are on and also lifestyle questionnaire. The checks which should be carried out are outlined in the BEH MHT Physical Healthcare Policy.

14.2. The Panel received a copy of the BEH MHT Physical Healthcare Policy which aims to "set out processes for ensuring that BEHMHT clinical staff manage the risk associated with the physical assessment, examination and ongoing physical care of services users.[23]". The Panel noted the stated scope and purpose of the policy:

- "Scope – The policy provides minimum standards and procedures to be implemented by medical and nursing staff within Inpatient Services. It also provides information on additional procedures and guidelines used by community services. Practitioners from different professional backgrounds have differing levels of responsibility under this Policy. Different services, caring for groups of service users with different needs, have different responsibilities under this Policy.
- Purpose - The purpose of this policy is to set out the arrangements for managing the risks associated with the physical assessment, examination and ongoing physical care of service users in Inpatient Services..... It is to:
    - Increase the health potential of people with a mental illness and/or learning disability
    - Reduce the current health inequalities in terms of morbidity and mortality rates experienced by people with a mental illness.
    - Reduce stigma and promote inclusion of individuals with a mental illness into specialist medical or primary care services.

[22] http://www.beh-mht.nhs.uk/mental-health-service/mh-services/dual-diagnosis-network.htm
[23] BEH MHT Physical Healthcare Policy, BEH MHT, Reviewed 2012.

- Support service users to engage with specialist medical or primary care services.
- Engage service users in health promotion and health prevention strategies.
- Improve the skills and competencies of mental health workers (MHW) in identifying, assessing and prioritising the physical health care needs of service users[24]".

14.3. The policy includes amongst others, sections on:

- Requirements for Physical Assessment On Admission
- Inpatient Physical Assessment
- Ongoing Assessment
- Long Stay Wards
- Care Planning and Community Patients
- Follow- Up Care of Physical Symptoms
- Training and Information
- Monitoring Compliance and Effectiveness
- Inpatient Physical Healthcare Flowchart
- Community Physical Healthcare Flowchart
- Most (Malnutrition and Obesity) Screening Form
- Guidance Practice Guide Cardiovascular Disease
- Guidance for Diabetes – Type I And II

14.4. The Panel felt that the policy was thorough and clear, however based on feedback from carers and voluntary and community organisations during the project the Panel questioned whether the policy is fully adhered to across the whole of BEH MHT.

14.5. BEH MHT monitors targets associated with the policy on a monthly basis with recent performance information showing high compliance with staff undertaking physical health assessments. However, patients representatives and carers have expressed concerns about the following up of these referrals. For example, whether completing a check list of tests and questions and subsequently referring a patient for a service actually means that the patient and/or organisation referred to follows up to ensure that the service is received.

[24] BEH MHT Physical Healthcare Policy, BEH MHT, Reviewed 2012.

15. Primary Care

15.1. Throughout the project the Panel heard of the importance of having a good GP, with one mental health patient, who had recently had a heart bypass, saying that he felt that that without a good GP who referred him for Counselling he may not be here today as he was beginning to feel suicidal following the heart bypass.

15.2. The Royal College of General Practitioners clinical example for the care of people with mental health needs says:

- Consideration should be given to "the mental health of a patient in every primary care consultation, but be aware of the dangers of medicalising distress;
- 90% of people with mental health problems across the lifespan are managed in primary care;
- Mental health problems contribute to disability, unemployment and social exclusion;
- Depression and anxiety are common in people with long-term physical conditions, and increase the morbidity and mortality from these conditions;
- People with severe mental health problems have an increased risk of morbidity and mortality owing to cardiovascular disease and diabetes; as a general practitioner (GP) you have a significant role in prevention, detection and management of this physical co-morbidity;
- People with unexplained physical symptoms may have underlying psychological distress. Repeated investigation is costly in terms of patient suffering and healthcare costs".[25]

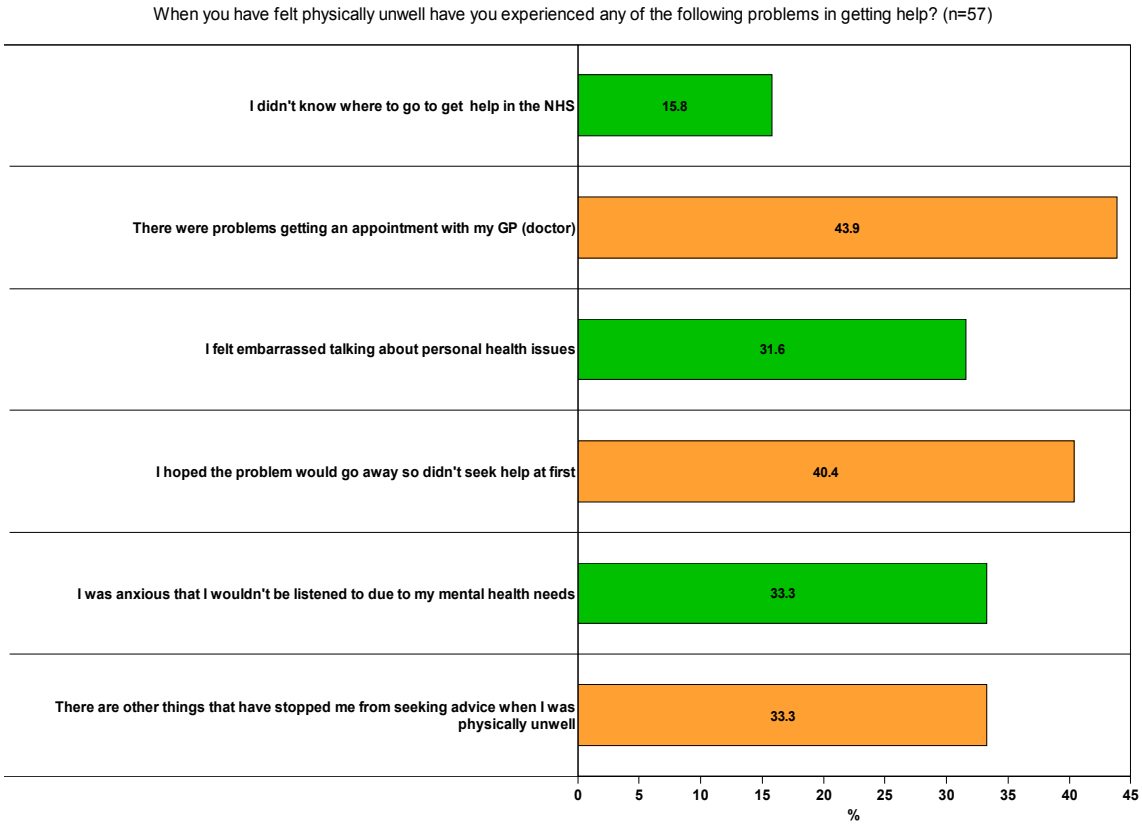
15.3. The Mind in Haringey representative noted that people with mental health needs who have visited their GP to discuss issues have often been referred to their consultants rather that the GP deal with issues.

15.4. Rethink's report, Lethal Discrimination notes that people can find it very difficult to access GP surgeries. They might be anxious about attending or might struggle with the early morning booking system because of medication side-

[25] RCGP Curriculum 2010, revised 14 August 2013 : Statement 3.10 Care of People with Mental Health Problems

effects. GP practices need to make sure reasonable adjustments are in place so that people are not missing out on crucial care[26].

15.5. Respondents to the Mental and physical health survey were asked whether they had felt physically unwell within the last 12 months. Those who answered 'yes' were then asked a further question on whether they experienced particular issues in getting help. Almost 44% said there had been problems with getting a GP appointment, 33% said that they didn't feel they would be listened to due to their mental health problems and almost 16% said that they did not know where to seek help within the NHS. It is important to remember that those who responded to the survey are those who are most likely to be already engaged in services.



15.6. Under the **Quality Outcomes Framework** (QOF) GPs are financially rewarded for meeting a range of quality targets with practices being awarded 'points' for delivery against certain indicators. The following data was provided by Public Health in relation to mental health QOF data:

[26] Rethink mental health – Lethal Discrimination, 2013

Haringey's registered population, people with long term conditions aged 18-74, using GP extraction data and QoF, combined January 2013

- There were 38,135 people diagnosed with long term condition (LTC) in 2013; prevalence of 17%. Of those who have coronary heart disease (CHD) and diabetes, 91% were screened for depression and of those who have other LTCs, **only 10% were screened for depression**.

- Table below suggests the proportion of people with one of the following long term conditions and a diagnosis of at least one of dementia, chronic depression, or serious mental illness; Although prevalence of mental illness in people with LTCs is higher than in general population, it is likely that these proportion are underestimated due to potential inaccuracy in coding at GP practice level;

Atrial fibrillation	Cancer	Chronic Kidney Disease	Chronic Liver Disease	COPD	Diabetes	Heart Failure/ LVD	High blood pressure	MI/CHD	Stroke/ TIA
6.5%	6.7%	9%	13%	14%	7.5%	8.3%	6.5%	8%	9.3%

15.7. The Panel asked for the reasons behind: "Of those who have coronary heart disease (CHD) and diabetes, 91% were screened for depression and of those who have other LTCs, only 10% were screened for depression" and was informed that it could be reasons such as whether one screening was incentivised for example through QOF or it could be that there is a greater awareness of the link between CHD and depression.

QoF data 20112/13 on care plans for people with serious mental illness aged 18+ (psychosis, schizophrenia and bipolar disorders)

- Most people (86%) diagnosed with serious mental illness have a documented **comprehensive care plan** agreed between individuals, their family and/or carers as appropriate; this varies substantially across Haringey GP practices, **ranging between 58% and 100%**.
- The vast majority (90%) of eligible people diagnosed with serious mental illness have had their alcohol consumption reviewed in the past 15 months.
- The vast majority (89%) of eligible people diagnosed with serious mental illness have had their body mass index (BMI) reviewed in the past 15 months.

- Most eligible people (77%) diagnosed with serious mental illness have had their cholesterol reviewed in the past 15 months.
- The percentage of people diagnosed with a serious mental illness who have had a blood pressure reading in the past 15 months ranges from **43% to 96%** across Haringey GP practices, with an average of 79%.
- The vast majority (83%) of eligible people diagnosed with serious mental illness have had their blood glucose reviewed in the past 15 months.

15.8. The Panel was concerned with some of the very low QOF scores, for example around blood pressure checks, particular given the link between strokes and high blood pressure. The Panel felt that there needed to be further investigation into QOF scores to identify particular GP Practices which may be under performing in mental health indicators and that work should be done with these practices in order to improve performance.

15.9. Support for GPs has includes the introduction of a telephone advice line to enable GP's to ask questions relating to mental health, however it was noted than in the initial nine months of the telephone advice line only 13 calls had been made by Haringey GPs, compared to approximately 140 calls by Barnet GPs.

15.10. BEH MHT also has a Primary Care Academy which focuses on supporting primary care practitioners to deal appropriately with mental health issues. The Panel recognised the work being done by BEH MHT Primary Care Academy on mental health training, particularly in light of hearing that mental health only forms a relatively small part in GP training. However, it felt that there is a need to systematically roll out programmes such as this to ensure that all GPs in the borough receive the training as it would be likely that those GPs who took part in the training were most likely to be actively engaged in developing their practice and skills and those practices which may be under performing may not be engaged in programmes such as this.

16. Communication between BEH MHT and GPs

16.1. Rethink has held summits across England to discuss mental health issues with people affected by mental illness and with health professionals. Their report, Lethal Discrimination notes that "again and again, we have heard that

the physical health care of people affected by mental illness is falling through the gaps between GP services and secondary mental health care. It is often unclear, both to professionals and people affected by mental illness, who is responsible for coordinating this support. As a result, no support is offered. This responsibility needs to be clarified so that people's physical health isn't overlooked. Tools like the Integrated Physical Health Pathway could support professionals to agree processes locally so checks are not missed"[27].

16.2. The Panel heard that in Haringey Care Plans incorporate physical health and are shared with GPs. The GP would be primarily responsible to deliver this as GPs need to have a full picture of all of a person's health needs. If a person is on a Care Programme Approach then it would be the responsibility of the Care Coordinator liaising with the GP.

16.3. The Panel heard views from Carers and voluntary and community groups, e.g. Mind and Mental Health Support Association, that the relationship and communication between primary and secondary care could be improved. The need for improved communication had been recognised, and a CQUIN implemented, however the Panel felt there was room for improvement, particular given the performance for '% of discharge, assessment and review letters sent to GPs within 24hrs' given that the average over the first three quarters in 2013/14 was just 44% with a target of 98%. However, it is anticipated that this may increase with the recent introduction of e-faxing. The Panel also noted that the CQUIN did not show whether the GP followed up the information that they were given by BEH MHT.

CQUIN Performance for BEH MHT 2013/14.

N.B data is for the whole Trust rather than Haringey specific

INDICATOR	TARGET	Q1	Q2	Q3
% of discharge, assessment and review letters sent to GPs within 24 hours	98%	34%	40%	58%
% of discharge, assessment and review letters sent to GPs containing mandatory content	98%	76%	82%	87%

[27] Rethink Mental health – Lethal Discrimination, 2013

17. Role of Pharmacies

17.1. The Adults & Health Scrutiny Panel received a report on the role that Haringey's 57 pharmacies play in the care pathway and how they are working in partnership with organisations in the borough. The Panel heard that over the next year public health will work with pharmacies, the LPC and the CCG to implement the Healthy Living Pharmacy framework, at the same time building on the enhanced services already being commissioned. The intention is to increase the number of pharmacy's offering sexual health services alongside broadening the range of sexual health services to under 25 year olds to provide a range of sexual health services, such as STI and HIV screening and increased access to condoms and emergency contraception for the over 25 year olds and also to consider what other health promoting services could be commissioned through this framework[28].

17.2. The Panel felt that this would be an opportune time to develop the role of pharmacies in relation to mental health and to develop programmes within the healthy living scheme to focus on the overlap between physical and mental health.

18. Role of Community Mental Health Teams

18.1. The role of care coordinators and the Care Coordinators is to join up the planning of those accessing more than one service by assisting with accessing and planning services for example around physical health (including nutrition), support networks, health treatment (including medication side effects). The work is done in partnership with others who are involved in a person's needs. It is important to note that the role of the Care Coordinator is to coordinate services, and not to provide them directly. Every person known to BEH MHT has a Care Coordinator assigned to them.

18.2. It was noted that Care Coordinators have a range of backgrounds and therefore skill mixes e.g. Occupational Therapy, nursing and social work. Therefore as not all Care Coordinators have a medical background it may be

[28] Public Health and Local Pharmaceutical Committee submission to the Haringey Adults & Health Scrutiny Panel, 'Partnership working and pharmacies role within care pathways; February 2014

more difficult for those who don't to pick up on key physical health indicators which may need referral or follow up.

18.3. The pressures which the Care Coordinator service is currently under is covered in the Scrutiny project report on Mental Health and Accommodation where it is recommended that the service is assessed with a view to alleviating the work load and increasing the number of posts, capacity and skill mix. The Panel felt that an enhanced role in physical health should be included in this assessment. Whilst the Panel recognises the financial strains there are within the mental health sector it felt that this offered an opportunity to fully integrate the link between physical and mental health in the community mental health teams and that lessons could be learnt from the Manchester Mental Health and Social Care Trust Pilot on 'Improving the physical health care of people with severe and enduring mental illness[29]':

An excerpt from the NHS Institute for Health Research outlines the project as below:

"*CLAHRC Greater Manchester worked in collaboration with Manchester Mental Health and Social Care Trust (MMHSCT) and Manchester Academic Health Science Centre (MAHSC) to develop and test the implementation of effective and sustainable ways to improve the physical health of people with SMI who are under the care of MMHSCT*

The project aim

We worked with MMHSCT to develop and implement a sustainable and integrated service user pathway that supports the prevention and early diagnosis, treatment and management of physical health problems, as part of the overall treatment of people with SMI under the care of community mental health teams.

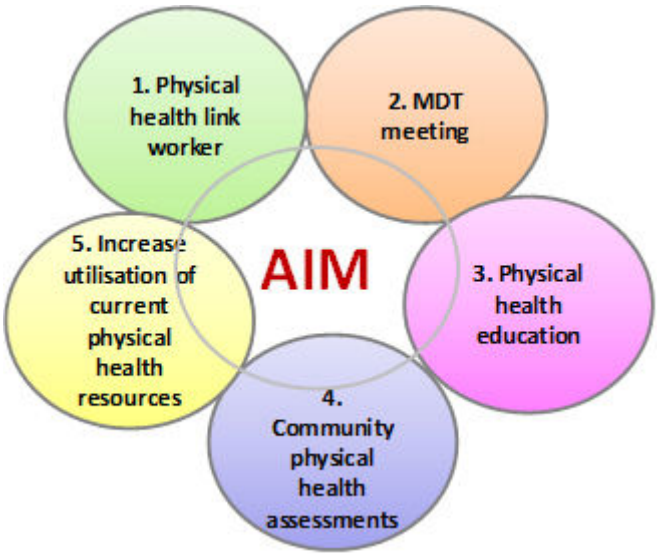
Objectives

The project aimed to deliver the following objectives:

[29] Improving the physical health care of people with severe and enduring mental illness; Manchester Mental Health and Social Care Trust Pilot Project Evaluation Report, NHS National Institute for Health Research, 2013

1. *To establish a clear joint responsibility for the physical health of people with SMI by strengthening the co-ordination and collaboration between primary care and the community mental health teams*
2. *To improve the health outcomes for service users by developing clear pathways and guidance on delivering physical health checks in a community setting, whilst ensuring that the physical health of people with SMI is assessed on a more regular basis and access to the appropriate care/service is promoted*
3. *To ensure that people with SMI are provided with improved access to, and made aware of, lifestyle services available within MMHSCT. In addition, improving existing health information targeted at service users to empower them to take care of their own physical health needs.*

To achieve these objectives the project focussed on the following five areas:



1. *Developing a boundary-spanning Community Physical Health Co-ordinator (CPHC) role, to address the physical health needs of service users under the care of the North West Community Mental Health Team (NW CMHT) and GP practices*
2. *Establishing regular multi-disciplinary team (MDT) meetings (held in GP practices) between the CPHC and GP practices, to develop joint management plans with the NW CMHT*
3. *Identifying the training needs amongst the NW CMHT staff and delivering appropriate training to improve capacity to address physical health needs and support lifestyle changes*

4. *Establishing regular physical health assessments delivered in a community setting*
5. *Increasing the use of existing physical health resources*.[30]"

19. Recovery Houses

19.1. BEH MHT commissions Rethink to run three Recovery Houses across BEH MHT. The service is for adults, 18 years and over experiencing a mental health crisis that do not require hospital admission but are still not suitable for treatment within their own home. It is for people with mental illness experiencing an acute psychiatric crisis of such severity that without the involvement of crisis intervention, hospitalisation would result.

19.2. The aims of the service are as follows:

- To support service users on their recovery journey, achieve and maintain their best possible level of mental health wellbeing, within the shortest possible time and enable them to live as normal a life as possible during their stay, taking into account health-related needs.
- To provide a stepping-stone between hospital discharge and community care.
- Minimise the effect of ongoing psychological symptoms and facilitate the development of coping skills, knowledge, confidence and motivation in service users.
- Promote and support service users to maintain their own wellness in the community and in line with the needs identified in their care plan.
- To provide optimum care to service users in a multidisciplinary environment.

19.3. The service is able to provide:

- An alternative to hospital admission, in a therapeutic and non- stigmatising environment.
- Comfortable, clean and en-suite rooms.
- 24hr staff presence.

[30] http://clahrc-gm.nihr.ac.uk/2014/02/mental-health-new-model-of-working-to-be-spread-across-manchester/

- Emotional and practical support in order to achieve positive outcomes; with one to one support and group settings.
- Signposting to and information on appropriate agencies/services
- Support in identifying triggers to crisis and developing new coping strategies.
- Support in completing a physical health check.
- Support, supervision and prompting with personal care.
- Encouragement that supports compliance with medication.
- The BEH MHT will also support users of service by offering support from OT on site, either individually or as a group, as part of the agreed support[31].

19.4. The Panel heard evidence from voluntary and community groups that their experience is that patients in the Recovery Houses do not always receive adequate support around their physical health for example support in completing a physical health check. The Panel also heard that patients are not registered as temporary patients at local GP surgeries and can end up with less physical health follow up than when at home. This could be avoided by being registered on admission to the Recovery House. This is particularly important for patients sent to Recovery Houses outside of Haringey.

20. Social Isolation

20.1. Social isolation and loneliness can have a significant impact on a person's mental health. Attendees at an Enabling Haringey meeting which Panel members attended to talk about this project shared examples of people with mental health needs feeling isolated and the impact being exacerbated by physical health problems which mean that a person is unable to leave their home alone. One attendee shared an example of where they had experienced this and said they their situation had left them feeling 'lonely, depressed and suicidal'.

20.2. The Panel felt strongly that further work was needed in the borough to tackle social isolation and loneliness, however did not feel it had enough evidence at this time in order to make an informed recommendation on such a large area.

[31] http://www.beh-mht.nhs.uk/mental-health-service/mh-services/recovery-houses.htm

APPENDICES

Appendix B – Review contributors

Name	Job Title/Role	Organisation
Cllr Gina Adamou	Chair of Panel	Haringey Council
Cllr David Winskill	Panel Member	Haringey Council
Cllr Sophie Erskine	Panel Member	Haringey Council
Cllr Gideon Bull	Panel Member	Haringey Council
Cllr Anne Stennett	Panel Member	Haringey Council
Helena Kania	Panel Co-Optee	Haringey Forum for Older People
Melanie Ponomarenko	Senior Policy Officer (Scrutiny)	Haringey Council
Diane Arthur	Advocacy Services Manager	Mind in Haringey
Sarah White	Carer	Mental Health Support Association
Peter Johnson		Mental Health Support Association
Nuala Kiely		Haringey User Network
Mike Wilson	Director	Haringey Healthwatch
Fiona Wright	AD, Public Health	Haringey Council
Tamara Djuretic	AD, Public Health	Haringey Council
Oliver Treacy	Service Director	BEH MHT
Andrew Wright	Director of Strategic Development	BEH MHT
Dr Ken Courtney	Clinical Director	BEH MHT
Dr Therese Shaw	Consultant Psychiatrist for older people	BEH MHT
Dipika Kaushal	Head of Project Development	Rethink Mental Illness
Staff Members		St Mungos
Tristan Brice	Adult Commissioning Manager (MH and LD)	Haringey CCG
Amer Akber	Interim Haringey CCG Mental Health Lead	Haringey CCG
Dr Jaydeokar	Consultant Psychiatrist	

	and Vice Chair of Adult Panel	
Beverley Tarka	Deputy Director of Adult & Community Services	Haringey Council
Jennifer Plummer	Team Manager, Mental Health Services	Haringey Council
Sarah Hart	Joint Commissioning Manager	Haringey Council & Haringey CCG
Marion Morris	Drug and Alcohol Strategy Manager	Haringey Council
Mhairi McGhee	Disability Representation Worker	Haringey Disability First Consortium
Also:		
Service user, patients and carers who all contributed to the project via email submissions, telephone submissions, one to one meetings and local organisation groups.		