Sheffield Health and Social Care NHS Foundation Trust

Board of Directors - Open

Date:	12th August 2020	Item Ref:	10

TITLE OF PAPER	**Physical Health Strategy**
TO BE PRESENTED BY	Dr Mike Hunter, Executive Medical Director
ACTION REQUIRED	Members are asked to: • Receive this inaugural Physical Health Strategy • Approve the Strategy

OUTCOME	Members are assured we have a Strategy that covers the needs of all our different service users, and ensures collaborative partnership working with city-wide initiatives.
TIMETABLE FOR DECISION	August 2020 meeting
LINKS TO OTHER KEY REPORTS / DECISIONS	• Physical Health Outline Strategy, presented to Board in May 2020 • Back to Good Programme Board
STRATEGIC AIM **STRATEGIC OBJECTIVE** **BAF RISK NUMBER & DESCRIPTION**	Strategic Aim: Quality and Safety Strategic Objective: Deliver safe care at all times BAF Risk A102: Inability to provide assurance regarding improvement in the safety of patient care
LINKS TO NHS CONSTITUTION /OTHER RELEVANT FRAMEWORKS, RISK, OUTCOMES ETC	• Care Quality Commission Fundamental Standards • NHS Litigation Authority • Safety Thermometer Framework • Physical Health Implementation Group
IMPLICATIONS FOR SERVICE DELIVERY & FINANCIAL IMPACT	Business case will be developed to address any implications for service delivery and associated financial impact.
CONSIDERATION OF LEGAL ISSUES	Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Author of Report	Julie E King
Designation	Programme Lead, Nursing Quality Improvement
Date of Report	4th August 2020

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Sheffield Health and Social Care NHS Foundation Trust

Summary Report

1. Purpose

For approval	For assurance	For collective decision	To seek input	To report progress	For information	Other (Please state)
✓	✓			✓	✓	

2. Summary

This Strategy sets out our vision for meeting that considerable challenge and how we will go about improving the life expectancy of the people who use our services. It is unacceptable that people with serious mental ill health live some 15 to 20 years less than the mainstream population, or that people with a learning disability or autistic spectrum condition can expect a broadly comparable reduction in their life expectancy.

The Trust is ambitious in its desire to bring about fundamental change and ensuring that the physical healthcare needs of our patients receive equal consideration when looking at their specialist needs and circumstances. Consequently, we will be working with our partners in Sheffield's 'Physical Health Implementation Group' to take forward the radical programme for systemic reform this strategy document promotes.

3 Next Steps

Effective delivery of the Strategy in all our clinical areas, and an early review of progress via the newly established physical health group. Additional service user feedback and involvement, and regular reporting of continued progress to Members.

4 Required Actions

i. Members are asked to receive this inaugural Physical Health Strategy.
ii. Members are asked to approve the Physical Health Strategy.
iii. Members are assured by the achievement and progress made.

5 Monitoring Arrangements

- Monthly Physical Health Group.
- Weekly Physical Health Executive Oversight Meeting.
- Clinical Governance and Performance Meetings.
- Regular reporting to the Quality Committee
- Annual reporting to Board

6 Contact Details

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Sheffield Health and Social Care
NHS Foundation Trust

Physical Health Strategy 2020-2023

Contents

Version Control and Amendment Log

Version no.	Type of change	Changed by	Date	Description of change(s)/action
0.1	Draft strategy creation	Jonathan Mitchell & Julie King	June 2020	Creation of strategy
0.2	Amendments based on feedback	Julie King	July 2020	Amends from collated feedback from our staff
1.0	Ratification of strategy			

Contributors

Jonathan Mitchell, Julie King, Mike Hunter, Anthony Bainbridge, Christopher Wood, Moira Leahy, multidisciplinary team (MDT) staff group.

Document Owners

Executive Medical Director

Executive Director of Nursing & Professions

Executive Summary

The Trust is committed to improving the physical health and wellbeing of all its patients and service users. We work closely with local stakeholders in a collaborative endeavour to address the many barriers that people with mental ill health, learning disability and autistic spectrum condition experience in accessing good quality physical health services.

If we are to tackle the significant inequalities that the artificial separation of specialist healthcare provision presents, a holistic approach to the needs of the whole person will be required. Only by addressing longstanding cultural and structural obstacles to integrated healthcare provision can we begin to change the lived experiences of the people in need of our care and support.

This strategy sets out our vision for meeting that considerable challenge and how we will go about improving the life expectancy of the people who use our services. It is unacceptable that people with serious mental ill health live some 15 to 20 years less than the mainstream population, or that people with a learning disability or autistic spectrum condition can expect a broadly comparable reduction in their life expectancy.

The Trust is ambitious in its desire to bring about fundamental change and ensuring that the physical healthcare needs of our patients receive equal consideration when looking at their specialist needs and circumstances. Consequently, we will be working with our partners in Sheffield's Physical Health Implementation Group to take forward the radical programme for systemic reform this strategy document promotes.

Service User Case Study

This is me, Amara

Hi, I am Amara, and this is my story. I am a 25-year-old woman, homeless and have a long history of schizophrenia. I also have drug and alcohol abuse problems, and looking after myself is a real challenge. I often choose not to take my medication, which affects my underlying mental health condition. I am also overweight, have type 2 diabetes and smoke 30 cigarettes a day.

Because of this, my risk of having a stroke or heart attack is 31% higher than the general population. For me, the risk of other related physical health conditions, including cancer and blood borne viruses, is up to 100% higher. Without holistic mental and physical health support, I could lose at least 20 years of my life.

What you need to do for me

I need access to a personalised detoxification programme, smoking cessation services, nutritional support, holistic therapies, sexual health support, dental care, diabetes management, housing and social support services, GP and regular physical health screening.

What next?

With help, I can reduce the risk of developing severe cardiovascular illnesses by 27%, some cancers by 33%, and diabetic complications and blood-borne virus by up to 100%. These services are readily available to the general public, but not for me. With support I can live a better quality of life, rather than living the life I have.

If I had been offered early intervention services at the start of my journey, I could now be drug-free, use alcohol socially, be an ex-smoker, have a healthy weight and nutrition, and be significantly within the ‘normal’ parameters of the general population.

My message to you

Don’t see me as just a drug addict, don’t see me as just an alcoholic, please don’t just see me as someone with mental health problems. See me for who I really am inside, the person I was before my current lifestyle, and the person I can be again. Treat me as a whole person and support me in addressing my physical health needs as well as the many challenges my mental health presents. Remember, there is no mental health without physical health, and no physical health without mental health.

Staff Experience Case Study

The vital importance of a holistic, physical-mental health approach to patient care and health promotion can be illustrated with the following example of good practice.

Stanage Ward, an acute inpatient service, had repeated difficulties providing a smoke-free therapeutic environment. After research, the staff commenced an impact study offering patients the option of e-cigarettes, as an adjunct to the first line recommendation of nicotine replacement products. As an example, one patient, a 45-year-old man detained under the Mental Health Act from another city, arrived with very few belongings and was requesting cigarettes from other patients and staff. He had no money to purchase cigarettes. He moved from cigarettes onto e-cigarette and nicotine replacement patches, reported benefits from using these replacement options, and stopped smoking tobacco before the end of his admission.

This is just one successful case of many, with staff reporting patients smoking less, more opportunities to develop therapeutic relationships with patient and a calmer ward environment. Reflections from staff included:

I think the trial's been really successful. Patients seem to be much more receptive to being offered it as an NRT than other forms and it's a better offer when de-escalating patients demanding cigarettes. Patients are much more proactive in asking for them which suggests that they are working. Patients seem to enjoy having a variety of flavours and will request their preferred choice. – Jess, Staff Nurse

I think the e-cigarettes are good because they help patients who do not currently have leave and are craving cigarettes. I have spoken to patients who have also said that the e-cigarettes are helping them to cut down on cigarettes.
– Georgie, Staff Nurse

I think the e-cigarettes are good because they have been used lots and patients seem to like them and find them useful; as part of a quit attempt, cutting down smoking or an alternative when they can't get to the shop to buy cigs. I think they are the future.
– Lucas, Staff Nurse

I believe it's very difficult for the patients to come to a ward and be restricted from smoking particularly when they have been smoking their entire lives. It can also be difficult for staff to put these restrictions in place. The e-cigarettes have been a good way to support patients with these restrictions.
– Di, Support Worker

I think they're fantastic. Best thing we've ever had. They have definitely helped people to go fully smoke free.
– Cheryl, Deputy Ward Manager

With thanks to Abigail Crowley, Ward Clinical Lead for reducing harm from tobacco; and Jonathan Kearney, Ward Manager, for sharing their story.

Introduction

This strategy has been written to support the Trust to deliver our vision to improve the mental, physical and social wellbeing of the people in our communities. Physical health and mental health are intrinsically linked and at times their complex relationship can make delivery of the appropriate physiological intervention at the right time a difficult process to safely manage.

In order to provide staff and service users with a framework that supports their understanding of the full range of interventions required in this area, the delivery of the strategy is shaped around a common language that seeks to separate physical health management in to the following four event-based concepts.

1. Use of the updated National Early Warning Score (NEWS2) to identify and support the management of **deteriorating patients**.
2. **Planned and scheduled events**: annual physical health reviews for patients with severe mental illness (SMI) and learning disabilities (LD), including management of known physical health problems and physical side effects of medication.
3. **Unplanned events** including seclusion, rapid tranquilization, physical restraint, management of known physical health problems and physical side effects of medication.
4. **Health behaviours** including smoking, drug and alcohol use, nutrition and weight management, fitness and exercise, and housing.

Clustering physical interventions in a way that maps to recognised clinical events will support standardisation and provision of early identification of variation.

We have said that we will support our patients by:

- Working with and advocating for the local population,
- Refocusing our services towards prevention and early intervention,
- Continuous improvement of our services,
- Locating services as close to peoples' homes as we can,
- Developing a confident and skilled workforce, and
- Ensuring excellent and sustainable services.

The Trust provides a wide range of services for people with different needs. In each of our services care provided will take account of services users' individual needs including those relating to their physical health. Examples include:

People with SMI

People who have SMI die on average 15-20 years earlier than the general population. Research has shown that most of the premature deaths are due to long

term physical health problems such as cardiovascular, respiratory and infectious diseases, diabetes and some types of cancer. It is known that people with SMI are more likely than the general population to have risk factors and behaviours that increase risks of these conditions. Smoking is the biggest single contributor to preventable ill health and this difference in life expectancy. Whilst smoking prevalence in the Sheffield population as whole is 12.5% (2018), smoking prevalence for people admitted to our inpatient wards is around 60% (Insight 2019), and for people on the SMI register in primary care, smoking prevalence is 37.9% (2019).

People with SMI are twice as likely to be obese, less likely to engage in physical activity, more likely to have a poor diet and more likely to have problems with alcohol or substance misuse. It is estimated that about two thirds of the premature deaths could be prevented by undertaking appropriate screening and offering intervention for risk factors and behaviours that cause higher rates of these conditions.

People with an LD or ASC

On average, men with an LD die 23 years earlier than men without an LD and for women it's 27 years earlier. People with ASC die on average 16 years earlier than the general population. People with an LD are more likely than the general population to have long term physical health problems such as epilepsy, swallowing problems and congenital malformations/chromosomal abnormalities. There is evidence that many people with an LD or ASC die prematurely due to difficulties in care pathways leading to difficulties in accessing services that would enable their physical health problems to be diagnosed and treated as required.

Older People

Older people are more likely to have physical health problems and may have more than one physical health problem at the same time. They are also more likely to have conditions that increase their risk of falling such as frailty, sensory impairment, confusion and being treated with combinations of medication.

Alcohol and Substance Misuse

When a person consumes a substance repeatedly over time, they begin to build a tolerance and prolonged substance abuse can result in a dangerous cycle of addiction. Addiction is a chronic, relapsing brain disease defined by a physical and psychological dependence on drugs, alcohol or a behaviour. When an addictive disorder has formed, a person will pursue their toxic habits despite putting themself or others in harm's way. The prevalence of harm includes the following: around 20% of children in need are affected by drug misuse; 18% of children are affected by alcohol misuse, one quarter of child protection register cases involve drug and alcohol dependence, and 38% of drug misuse is involved in serious case reviews. Common physical health conditions resulting from drug and alcohol misuse include: stroke, alcohol related brain damage, heart disease, high blood pressure, liver disease and cancer, depression, anxiety and suicide, cancer, and harm to unborn

babies. Patients require a full multidisciplinary healthcare approach both in the community and inpatient services, plus additional support from partner agencies such as housing and social care.

Carers

Caring for someone with a mental or physical health impairment, an LD or ASC can have an adverse impact on the health of the carer. We recognise that carers could need support to sustain their role and enhance their ability to enjoy a life outside their caring role. We will work with our colleagues across Sheffield to signpost our carers to regular peer support networks, carers groups, advice on statutory and voluntary services, access to training, emotional support and help to access other services offered.

Links with Sheffield Physical Health Implementation Group (PHIG)

Our Trust is one of a number of key stakeholders working together, through the PHIG, to look creatively at how we can support people living with SMI, an LD and ASC to have the best possible physical health. We have agreed five key commitments (accessible healthcare, mental healthcare that fully recognizes physical health needs, access to community wellbeing support, opportunity to influence plans, and how partner organisations deliver the strategy), and will ensure that our strategy is interlinked with our city-wide ambitions. As part of this city-wide, multiagency programme, our Trust is also a partner within the South Yorkshire and Bassetlaw Integrated Care QUIT Programme.

Key Priorities

The following key priorities relating to physical health have been identified to enable us to deliver our vision to improve the mental, physical and social wellbeing of the people in our communities.

Implement appropriate and effective interventions	1. Screen and intervene for cardiovascular risks. 2. Increase access to annual physical health reviews for people with an LD. 3. Ensure people in hospital at increased risk of falling have a multifactorial risk assessment and a falls prevention plan in place. 4. Ensure people admitted to hospital who are at risk of having meticillin-resistant Staphylococcus aureus (MRSA), venous thromboembolism (VTE) and malnutrition have appropriate screening on admission and receive treatment if required.

	5. Optimise medication and where possible reduce use of high dose medications and polypharmacy. 6. Monitor for and mitigate side effects of medication. 7. Recognise tobacco addiction as a chronic relapsing clinical condition, and embed assessment and treatment offer within clinical pathways. 8. Promote healthy behaviours, including exercise, healthy food and access to healthy environments. 9. Promote the principles of infection prevention and control, and be 'sepsis aware'. 10. Ensure all our service users have holistic, personalised integrated care plans.
Improve the clinical information we record and use	1. Collate baseline information and monitor for progress and trends to improve care. 2. Use learning from deaths gained through investigations, mortality reviews and Learning Disabilities Mortality Review (LeDeR) to focus on prevention. 3. Develop care plans and reporting related to physical health priorities to be used by clinical teams to improve practice.
Develop digital systems to improve information sharing	1. Update Insight to achieve better accessibility of physical health information. 2. Ensure that improved accessibility of physical health information is maintained during transition between systems.
Support staff to improve their awareness, knowledge and skills	1. Provide training on the specific physical health needs of the service users the staff are working with. 2. Plan and recruit the workforce aligned with physical health priorities. 3. Work in collaboration with other organisations to develop skills and improve care. 4. Ensure staff have access to the right equipment and are trained in its safe use. 5. Encourage and support staff to improve their own wellbeing including physical health.

Collaborate, coordinate and integrate across organisations	1. Co-produce whole system pathways. 2. Work with partner organisations including primary care transform services to deliver integrated physical/mental health care. 3. Improve information with partner organisations including primary care.

Key Enablers

Information Technology

Insight developments will enable staff to record, access and use information related to physical health to improve care individual service users receive and support information sharing with primary care. Improved reporting will enable team leadership to have a clearer oversight of performance against physical health priorities and enable them to use quality improvement methodologies to lead to improvement in standards of care delivered by their team. Collated reports from teams will enable the Trust to have a clear oversight on physical health priorities.

Equipment and Environment

Staff working in clinical teams will need access to medical devices and other equipment that has been checked and calibrated to enable them to undertake physical health screening and examinations. Clinical environments will need to be appropriate for physical health checks, examinations and treatments to be given. Trust environments should be designed to promote healthy lifestyle choices and behaviours.

Education and Training

Staff will need to receive training so that they know the key physical health priorities for service users accessing services they work in. They will need to understand the importance of physical health issues for their service users and have the knowledge and skills to undertake reviews of physical health and act on the findings. This will include supporting people to make healthy choices, access primary care services and relevant community-based group and individual support programmes.

Collaborative working

Successful implementation of the strategy will require collaborative working with service users, carers, partner organisations including primary and secondary health care services, PHIG colleagues, social services, voluntary and community groups and our commissioners.

Implementation, Monitoring and Assurance

Key Indicators

1. Presence of appropriate monitoring templates and reporting systems in the patient record.
2. Audit of equipment and environment in clinical settings.
3. Proportion of staff in each team who have completed training as required.
4. Proportion of people with SMI receiving Trust services who have had a cardiovascular risk review with appropriate interventions offered.
5. Proportion of people with an LD receiving Trust services who have had an annual physical health check.
6. Proportions of people admitted to hospital who are at risk of having falls, VTE, MRSA and malnutrition have appropriate screening and receive treatment when required.
7. Infection prevention and control data, including sepsis.
8. Care plan and risk assessment audits.

Implementation

Our Physical Health Strategy will be implemented via the re-launch of the Physical Health Group, which has a multidisciplinary healthcare team membership. This group is co-chaired by senior clinical representatives from both corporate and clinical operational services. Monitoring and auditing outcomes will be reported via this group to the Back to Good programme, and via Quality Assurance Committee to Trust Board, plus directly feeding into local patient safety clinical groups for improvements at an individual service level.