Complex conditions: encouraging and supporting better integration of cardiac care and mental health

Hilary Walker
Head of Programme
Living Longer Lives
Our vision

We will demonstrate value and strength by:

• Delivering real benefits for people using NHS services
• Being the leader of improvement in England and the ‘go to’ organisation
• Being a catalyst for change and a partner to drive transformation in the NHS, creating innovative and new knowledge of how to achieve transformational change
• Acting as a focal point for the system - creating impact through connectivity and support
• Being a source of expertise for healthcare around the world
NHS Change Model

Our shared purpose

- Leadership for change
- Spread of innovation
- Engagement to mobilise
- Improvement methodology
- System drivers
- Rigorous delivery
- Transparent measurement

www.changemodel.nhs.uk
What success will look like

- Improved experience and outcomes
- Improvements spread and sustained
- Methodologies to deliver change and implement, measure and evaluate improvements
- Improvements and interventions change services and practice
- Integration with engagement across services
- Commitment to service improvement
- Return on investment and achievement of major change at minimal cost.
What is integrated care?

- Individuals and communities having a better experience of care and support
- Less inequality and better outcomes.

“I can plan my care with people who work together to understand me and my carer(s), allow me control, and bring together services to achieve the outcomes important to me.”

*National Voices, May 2013*
What are the benefits?

• Person-centred, coordinated care for communities – delivering what people want
• Efficient services and improved outcomes
  • Remove gaps and duplications in existing services
  • Improve effectiveness, safety, and service user experience
• Promote equality and improve access for all
• Better value for money through efficient joint working and creative thinking
CVD Outcomes Strategy: action 1

• NHS IQ required to: “work with all relevant interests to develop and evaluate service models to manage CVD as a family of diseases, in the community and in hospital.”

• This involves testing a standardised template to assess fully patients with cardiovascular problems for hospitals and the community, incorporated into service specifications

• NHS England working in parallel to implement national CQUIN focused on improving the physical health of people with serious mental illness (SMI)
People with SMI: key facts

- Up to 12,000 fewer deaths from CVD annually if people with SMI had same outcomes as general population
- At some of the greatest risk of poor health and premature mortality, dying on average 20 years earlier than general population – life expectancy similar to 1950s
- Overall mortality rate three times higher than general population – around two and a half times higher from circulatory diseases
- Depression associated with 50% increased mortality from all diseases
- People with mental health problems account for half of all smoking related deaths
People with SMI represent 5% of total population...

People with SMI face a 3.6 times higher mortality rate than the general population and even higher in some parts of the country.

But 18% of total deaths

44,000 fewer deaths would occur if people with SMI had the same mortality rates as the general population.

Almost half of the excess mortality is due to the ‘Big Killer Diseases’

- 12,000 from Cardiovascular Diseases
- 1,000 from Cancer
- 6,000 from Respiratory Diseases
- 1,000 from Liver Diseases

Source: Public Health England presentation ‘A tale of two populations’
... But this is just the tip of the iceberg. A large proportion of people with mental health problems are not in contact with secondary mental health services!

Around 1 in 5 people\(^1\) have **common mental health problems**\(^2\) (most of these people are in frequent contact\(^3\) with primary care services).

People with CMHPs face a 70% higher **mortality rate**\(^4\) than the general population.

**54,000 fewer deaths** would occur if people with CMHPs had the same mortality rates as the general population.

Over 2/3 of which are due to the ‘**Big Killer Diseases**’

- 18,000 from Cardiovascular Diseases
- 11,000 from Respiratory Diseases
- 5,000 from Cancer
- 3,000 from Liver Diseases

Source: Public Health England presentation ‘A tale of two populations’
Crossing Boundaries: Improving integrated care for people with mental health problems

Mental Health Foundation inquiry report September 2013 identified:

• NHS physical care and mental health services largely disconnected
• Silo working: people’s overall health needs ignored
• Integration supported in principle but not delivered in practice
• Diagnostic overshadowing and discrimination
“On the whole, physical health is not addressed by mental health services. Even to the extent of mental health services ignoring the impact of psychiatric medication on weight.

…. People don’t know what support they are entitled to and do not ask - they expect services to inform them and support them.

Mental health services do not necessarily know about physical health support so don’t offer it. Physical health services assume the person is supported in mental health services.”

Policy Panel member
What promotes integrated care

- Information sharing systems
- Shared protocols
- Joint funding and commissioning
- Co-located services
- Multidisciplinary teams
- Liaison services
- Navigators
- Research
- Reduction of stigma
Being bothered about Billy

Helen Lester’s RCGP James Mackenzie Lecture 2012: Being bothered about Billy

www.youtube.com/watch?v=tqyACm5OQOM
Proposed NHS IQ work programme

- NHS IQ programme will test out approaches to assessment for CVD and effective treatment of people with SMI
- Individual examples of excellence do exist
- Need to be delivered systematically at scale and pace to effectively tackle health inequalities and transform patient experience and outcomes
- Work aligns to the CVD Outcomes Strategy
- Learning will inform health care delivery across the NHS, transforming care for people with CVD including those who also have mental illness
Positive Cardiometabolic Health Resource

An intervention framework for people experiencing psychosis and schizophrenia

**Smoking**
- Current smoker
  - AND/OR Sedentary lifestyle

**Lifestyle and Life Skills**
- Poor diet
  - AND/OR
  - Weight gain >5kg over 3 month period

**Body Mass Index (BMI)**
- BMI ≥ 25 kg/m²
  - (≥ 23 kg/m² if South Asian or Chinese)
  - AND/OR
  - >90 mmHg diastolic

**Blood Pressure**
- >140 mmHg systolic
  - AND/OR
  - >90 mmHg diastolic

**Glucose Regulation**
- Fasting plasma glucose
  - HbA1c ≥ 42 mmol/mol (≥ 6%) AND/OR
  - FPG ≥ 5.5 mmol/l OR
  - RPG ≥ 11.1 mmol/l

**Blood Lipids**
- Total Chol/HDL ratio
  - To detect high (>90%) risk of CVD based on QRISK2 Tool
  - http://www.uk.org/
  - Note: CVD risk scores can underestimate risk in those with psychosis

**Lifestyle advice to include diet and physical activity**

**Medication review**

**NB** Family history of diabetes and/or premature heart disease heightens cardiometabolic risk.

**Refer for investigation, diagnosis and treatment by appropriate clinician if necessary.**

- Brief Intervention
  - Combined NRT and/or varenicline
  - Individual/group behavioral support or specialist support if high dependency
  - Referral to Smoking Cessation service

**Target**
- Stop smoking
- Improve quality of diet
  - Contain calorie intake
  - Daily exercise of 30 mins/day

**Target**
- BMI 18.5-24.9 kg/m²
  - (18.5-22.9 kg/m² if South Asian or Chinese)

**Target**
- <140/90 mmHg
  - (<130/80 mmHg for those with CVD or diabetes)

**Target**
- Prevent or delay onset of diabetes
  - HbA1c < 42 mmol/mol (≤ 6%)
  - FPG < 5.5 mmol/l

**Target**
- Reduce 10 year CVD risk to <10% based on QRISK score
  - OR
  - Treating with statins reduce non-HDL Chol by 40% within 3 months

**Follow NICE hypertension guidelines**
- http://www.nice.org.uk/hypertension CG127
- Consider anti-hypertensive therapy
- Limit salt intake in diet

**Follow NICE guidelines for obesity**
- http://www.nice.org.uk/CN43

**Follow NICE diabetes guidelines**
- http://www.nice.org.uk/CB87

**Follow NICE guidelines for lipid modification**
- AND
  - Refer to specialist if total cholesterol >7.5 or TG >20 (mmol/l)

- Consider lipid modification for those with CVD or diabetes

**At High Risk of Diabetes**
- HbA1c ≥ 48 mmol/mol (≥ 6%)
  - FPG ≥ 7.0 mmol/l
  - RPG ≥ 111 mmol/l
  - Endocrine review

**Diabetes**
- HbA1c ≥ 47 mmol/mol (≥ 6.5-7.5%)
  - FPG < 5.5 mmol/l

**FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TG/HDL = Triglycerides**
Barriers to integrated care

- Staff attitudes: “taking last remaining pleasure away”
- Skills, training, confidence
- Lack of parity of esteem
- Referral routes and pathways
- Diagnostic overshadowing, stigma
- Commissioning of services e.g. stop smoking, laboratory
- Access to equipment e.g. to check pulse, blood pressure
Other NHS IQ action

- National Collaboration on Integrated Care and Support: Integrated Care Pioneers
- Working with NHS England, Public Health England and others to ensure access to NHS Health Check and physical healthcare interventions in prisons and detained settings
- Long term conditions and emotional support: series of digests being produced
- Better outcomes, better value: integrating physical and mental health into clinical practice and commissioning event planned
Improving health outcomes across England by providing improvement and change expertise