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Physical healthcare policies in Mental Health Trusts within the North East Midlands (UK)

AUTHORS

Graeme Tosh, Specialist Trainee (ST4), Psychiatry, Nottingham Health Care NHS Trust, UK

Andrew Clifton, Research Fellow, Institute of Mental Health, University of Nottingham, UK

Clive E Adams, Chair of Mental Health Services Research, Institute of Mental Health, University of Nottingham, UK

Contact author

Dr Graeme Tosh

Millbrook Mental Health Unit
Mansfield Road
Sutton-in-Ashfield
Nottinghamshire
NG17 4JT

graemetosh@hotmail.com

ABSTRACT

In recent years there has been an increasing focus on improving the physical health of people with serious mental illness and many policies and guidelines are now tailored to support professionals working in mental health services meet these requirements. We found, however, that the physical healthcare policies produced by Mental Health Trusts in England varied enormously. Policies were often cumbersome, vague and lacked clear guidance on what particular action should be taken, when it should be taken, and by whom. Physical healthcare policy documents of three mental healthcare trusts in the North sector of the East Midlands Strategic Health Authority (UK) were examined in detail. We found significant disparities between the policies in terms of size, readability, external references and reading cost. None could be read swiftly and all incorporated vague language into their directives. It would be beneficial for there to be more consideration given to forming local policies which are readable, succinct, and unambiguous. There is potential for considerable economy of effort with collaboration in production of these documents.

KEY WORDS

Policy, Physical healthcare, Mental health

IMPLICATIONS FOR PRACTICE

- Physical healthcare policies for mentally ill people should be clear, succinct and concise
- Physical Healthcare policies should be produced collaboratively
- We suggest a simple 'why, what and how' checklist for those drawing up these types of policies

BACKGROUND

People with serious mental illness have a reduced life expectancy from chronic diseases compared with the general population (Robson, 2007). Physical health monitoring in people with serious mental illness is poor both in primary care (Burns, 1998) and in the secondary care setting (Paton, 2004). Evidence for, or against, the effectiveness of monitoring is limited (Tosh, 2010). There is much relevant policy guidance but it is easy to get confused as to which policy to follow. Multiple layers of guidance and variation between deaneries, trusts and teams may lead to lack of confidence between team members as to which policy to follow and money could be wasted on duplication, and undermining of the ability of the policy to deliver. For example, Worcestershire Mental Health Partnership NHS Trust has a document five pages long (Worcestershire, undated) whereas East London NHS Foundation Trust publishes a document on the same physical health care guidance which is 63 pages (East London, 2008). This disparity prompted us to systematically investigate local policy in one district (North East Midlands, UK) as regards clarity, consensus and usability of physical health policy for mentally ill people.

METHODS

We identified the physical health policy documents for the three relevant NHS Trusts (Derbyshire Mental Health Services NHS Trust, Lincolnshire Partnership NHS Foundation Trust and Nottinghamshire Healthcare NHS Trust) and, working independently, examined them against the standards listed in Box 1. Disagreements were resolved by discussion. We also extracted data regarding policy length and external references and calculated data on time taken to read the policy and the resultant costs/resources associated. Data were collected January-February 2010.

Box 1. Standard against which policies were measured

Clear statement of Intent
Policy in date
Authorship and provenance
Accessibility
Readable in 15 minutes¹
Cost of reading policy²
Readability: Score of 17 or below in SMOG readability formulae (NIACE, 2009).
Avoidance of vague language³
Individual responsibility
Requirement for follow-up action

¹ "Policies can also get ignored if they're too long and complicated" (Kaniss, 2006)

² Minimum cost of implementation is a simple calculation based on an estimate of time taken to read the policy per person and the assumption that all readers will be earning minimum wage (£5.80) as they read. This gives a very conservative estimate but highlights the economic benefits of shorter, more concise policies.

³ Policies will be ignored if they use language which is too vague or open to interpretation" (Kaniss, 2006)

RESULTS

Accessibility to the policies varied. Lincolnshire's policy was available in the public domain on the trust website; Derbyshire's policy was available on request and was sent electronically within 24 hours. The Nottinghamshire policy was only available on the trust intranet and was not

in the public domain. Accessibility to source documents also varied. For example, all three policies made reference the East Midlands Strategic Health Authority (EMSHA) document 'Minimum Standards for Physical Health of People with Serious Mental Illness' (EMSHA, 2005). We requested this policy from the EMSHA but were informed it was not available and was possibly out of date. The Derbyshire policy was heavily populated with links to external web sites (n=12), although many of these sites were useful in themselves, it meant much more time was required to read the policy. The Lincolnshire and Nottinghamshire policies avoided external web links, however, both policies made reference to other internal and external policies such as the Care Programme Approach policy (Nottinghamshire) and NICE guidelines (Lincolnshire). All policies gave a clear statement of intent, were in date, provided authorship and clearly identified who was expected to follow them. No policy could be read in 15 minutes and all were beyond acceptable limits of readability according to SMOG (NIACE, 2009) (Table 1). The word "should" was used frequently (Nottinghamshire, n=35 and Lincolnshire, n=6) but "how" was conspicuously absent (Nottinghamshire, n=0 and Lincolnshire, n=0) from policy documents. Direction was clear but the means by which direction was to be followed was not described. All three policies gave directions to individual clinicians such as Care coordinators/Key workers, Psychiatrists and in particular General Practitioners (GPs), despite the fact there was no indication if GPs had actually seen the policy or were aware that such a policy existed.

Table 1: Results

NHS Trust	Policy Subject	Date	Clear Statement of Intent	Policy in date	Authorship and Provenance	Accessibility	Readable in 15 minutes	Cost of reading policy * (per person)	Readability score (SMOG)	Avoidance of vague language	Individual responsibility stated	Requirement for follow-up
Nottinghamshire Healthcare NHS Trust	Physical Assessment and Examination of Patients (Minimum Standards)	10/2007	✓	✓	✓	✗	✗	£2.32	19.1	✗	✓	✓
Lincolnshire Partnership NHS Foundation Trust	Physical Healthcare Policy	07/2008	✓	✓	✓	✓	✗	£1.53	18.5	✗	✓	✓
Derbyshire Mental Health Services NHS Trust	Minimum Standards for Physical Health Care of People with Serious Mental Illness	02/ 2009	✓	✓	✓	✗	✗	£2.71	20.9	✗	✓	✗

* Cost of reading is a simple calculation based on an estimate of time taken to read the policy per person and the conservative assumption that all readers will be earning minimum wage (£5.80) as they read. This highlights the economic benefits of shorter more concise policies.

DISCUSSION

Despite examining only three policies, this geographical area of England covers a population of 2 million people (3.3% of the population). Due to the lack of systematic research in the area of policy formation we found it difficult to establish standards against which to examine the policies. We compiled our standards from consensus opinion, acquired, in turn, via a literature search (Kaniss, 2006; Health Education Board for Scotland, 2001; NHS Connecting for Health, 2008). These were mainly opinion pieces unsupported by research.

Even within this small region of England there is considerable duplication of effort and the output of that effort varies in quality and utility. The expense that has been invested in developing even the shortest of these policies must be considerable. We acknowledge that in the spirit of having to go to the fire lectures to comply with institution insurance, Trusts may be compelled to re-invest the wheel to comply with obligations to gain Foundation Trust status.

The cost for a workforce to follow the directions of policies for further information-gathering is potentially enormous. In one instance the reader is directed that they have “responsibilities” to read documents online of such proportions that, we estimate that it would take at least 12 hours to complete this task. This is based on our own experience accessing and navigating the referenced sites. From Derbyshire’s own figures (Derbyshire Mental Health Services NHS Trust Annual Report (2008/2009)) they employ 974 individuals to whom this policy applies. At a conservative estimate, to read the policy and referenced websites would take in the region of 740 minutes per person (12000 hours/Trust or £70,000/Trust – calculated at minimum wage).

Direction to third party information, however, is not the same as achieving the goal of the policy. In the midst of policy directions [i.e. the “should” statements], the “how” of practical implementation is often omitted and then implementation does not happen (Paton, 2004). A collaborative effort at the national level would produce a simple, clear and succinct policy for physical healthcare of seriously mentally ill people. This would help dispel current confusion, policy fatigue and waste. If local policies are to be constructed we suggest a ‘Why, what and how’ checklist (Box 2.).

Box 2. Local policy checklist

- WHY - Does another good-enough policy exist for this topic?
- WHAT - Are the intentions of the policy clear?
- How will I ensure that the policy is easy to access?
 - Is the policy as short and concise as I can make it?
 - Have I avoided ambiguous language in directives?
 - Have I used plain and simple language throughout?
 - Are my external references in date?
- HOW - Have I clarified how directives are to be implemented?
- Do I make it clear who is responsible for implementation?
 - How is this implementation to be recorded?
 - On what date does the policy need re-considered and who will ensure that this is done?

Local policies, however, may be better addressing implementation of national directives rather than reiterating the policy. We, however, identified one national policy statement for oral health care for seriously mentally ill people that was clear and succinct and also gave advice on

practical means of implementing the policy (British Society for Disability and Oral Health, 2000). This is a useful standard by which other policies could be measured.

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