Essex Partnership University
NHS Foundation Trust

Freedom of Information Request

Reference Number: EPUT.FOI.22.2464
Date Received: 13.04.2022

Information Requested:
Do you offer a service or program which:
Aims to increase exercise levels, improve eating habits or reduce weight, and is aimed at patients with mental illness or learning disability, inpatients or outpatients
Yes, the Trust offers this programme as part of "Closing the Gap". Closing the Gap is an Allied Health Professional (AHP) led initiative jointly led by Physiotherapists, Occupational therapists and dietitians on adult wards to deliver healthy lifestyle interventions to mental health inpatients on antipsychotic medication that are identified as being at risk of gaining weight and developing Type 2 Diabetes.

If yes, we would like to see:
Referral criteria
Open referral for patients admitted to adult wards particularly inpatients on antipsychotic medication.

Any documents (i.e.referral criteria, flowcharts of interventions offered, manuals for treatment, patient information leaflets about the service etc) related to the treatment pathway or services offered by this program and the number of patients who have accessed this program since 2017
Please find attached a copy of the documents related to the treatment pathway and services offered:

- Lester Update June 2014
- Closing the Gap Process
- Closing the Gap leaflet Proposal

The Trust is unable to provide you with the number of patients who have accessed this program since 2017 as this would require a manual trawl of all its records on each of the wards where closing the gap sessions exist exceeding the time and cost limits, as set out in the Act. The Trust is therefore applying Section 12 of the Act (where cost of compliance exceeds appropriate limit.

If yes, are any doctors involved in the delivery of this program?
MDT including doctors on wards are engaged and involved in the process of delivery, however this is not consistent across areas.

Applied Exemption:

Section 12 (Exemption where cost of compliance exceeds appropriate limit):

(1) Section 1(1) does not oblige a public authority to comply with a request for information if the authority estimates that the cost of complying with the request would exceed the appropriate limit.

(2) Subsection (1) does not exempt the public authority from its obligation to comply with paragraph (a) of section 1(1) unless the estimated cost of complying with that paragraph alone would exceed the appropriate limit.

(3) In subsections (1) and (2) "the appropriate limit" means such amount as may be prescribed, and different amounts may be prescribed in relation to different cases.

(4) The Secretary of State may by regulations provide that, in such circumstances as may be prescribed, where two or more requests for information are made to a public authority—

(a) by one person, or

(b) by different persons who appear to the public authority to be acting in concert or in pursuance of a campaign, the estimated cost of complying with any of the requests is to be taken to be the estimated total cost of complying with all of them.

(5) The Secretary of State may by regulations make provision for the purposes of this section as to the costs to be estimated and as to the manner in which they are to be estimated.

Publication Scheme:

As part of the Freedom of Information Act all public organisations are required to proactively publish certain classes of information on a Publication Scheme. A publication scheme is a guide to the information that is held by the organisation. EPUT's Publication Scheme is located on its Website at the following link https://eput.nhs.uk

Lester UK Adaptation | **2014 update**

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**

Don't just SCREEN – INTERVENE

for all patients in the "red zone"

This clinical resource supports the implementation of the physical health CQUIN http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf (page 36) which aims to improve collaborative and effective physical health monitoring of patients experiencing Serious Mental Illness. It focusses on antipsychotic medication for adults, but many of the principles can be applied to other psychotropic medicines given to adults with long term mental disorders, e.g. mood stabilisers.

For all patients in the "red zone" (see center page spread): The general practitioner, psychiatrist and patient will work together to ensure appropriate monitoring and interventions are provided and communicated. The general practitioner will usually lead on supervising the provision of physical health interventions. The psychiatrist will usually lead on decisions to significantly change antipsychotic medication.

Download Lester UK Adaptation: www.rcpsych.ac.uk/quality/NAS/resources

Lester UK Adaptation | **2014 update**

Positive Cardiometabolic Health Resource

An **intervention framework** for people experiencing **psychosis** and **schizophrenia**

	Smoking	Lifestyle and Life Skills	Body Mass Index (BMI) Weight	Blood Pressure	Glucose Regulation Assess by fasting blood glucose (FPG); random blood glucose (RBG); HbA_{1c}	Blood Lipids
RED ZONE	Current smoker	Poor diet **AND/OR** Sedentary lifestyle	BMI ≥25 kg/m² (≥23 kg/m² if South Asian or Chinese) **AND/OR** Weight gain >5kg over 3 month period	>140 mm Hg systolic **AND/OR** >90 mm Hg diastolic	HbA_{1C} or Glucose threshold: HbA_{1C} ≥42 mmol/mol (≥6%) **AND/OR** FPG ≥5.5 mmol/l **OR** RPG ≥ 11.1 mmol/l	Total chol/HDL ratio to detect high (>10%) risk of CVD based on QRISK-2 Tool http://qrisk.org/ *Note: CVD risk scores can underestimate risk in those with psychosis*
INTERVENTIONS	**Medication review and lifestyle advice to include diet and physical activity** ***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		Follow NICE guidelines for obesity http://www.nice.org.uk/CG43	Follow NICE hypertension guidelines http://publications.nice.org.uk/hypertension-cg127 Consider anti-hypertensive therapy Limit salt intake in diet	**At High Risk of Diabetes** HbA_{1c} 42-47 mmol/mol (6.0% - 6.4%) FPG 5.5 - 6.9 mmol/l i) Offer intensive structured lifestyle education programme ii) If ineffective consider metformin	**Diabetes** HbA_{1c} ≥48 mmol/mol (≥6.5%) FPG ≥7.0 mmol/l RPG ≥11.1 mmol/l Endocrine review Follow NICE diabetes guidelines http://www.nice.org.uk/CG87	Follow NICE guidelines for lipid modification **AND** Refer to specialist if total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l) **AND** Consider lipid modification for those with CVD or Diabetes
TARGET	Stop smoking	Improve quality of diet Contain calorie intake Daily exercise of 30 mins/day	BMI 18.5-24.9 kg/m² (18.5-22.9 kg/m² if South Asian or Chinese)	<140/90 mm Hg (<130/80 mm Hg for those with CVD or diabetes)	Prevent or delay onset of diabetes HbA_{1c} <42 mmol/mol (<6%) FPG <5.5 mmol/l	HbA_{1c} 47-58 mmol/mol (6.5-7.5%)	Reduce 10 year CVD risk to <10% based on QRISK score **OR** If treating with statins reduce non-HDL chol by 40% within 3 months

FPG = Fasting Plasma Glucose | RPG = Random Plasma Glucose | BMI = Body Mass Index | Total Chol = Total Cholesterol | HDL = High Density Lipoprotein | TRIG = Triglycerides

History and examination following initiation or change of antipsychotic medication

Frequency: Normally supervised by the psychiatrist. As a minimum review those prescribed a new antipsychotic at baseline and at least once after 3 months.

Weight should be assessed weekly in the first six weeks of taking a new antipsychotic, as rapid early weight gain may predict severe weight gain in the longer term.

Subsequent reviews should take place annually unless an abnormality of physical health emerges. In these cases, appropriate action should be taken and/or the situation should be reviewed at least every 3 months.

At review

History: Seek history of substantial weight gain (e.g. 5kg), especially where this has been rapid (e.g. within 3 months). Also review smoking, exercise and diet. Ask about family history (diabetes, obesity, CVD in first degree <55 yrs male relatives and <65 yrs female relatives) and gestational diabetes. Note ethnicity.

Examination: Weight, BMI, BP, pulse.

Investigations: Fasting estimates of plasma glucose (FPG), HbA1c, and lipids (total cholesterol, non-HDL, HDL, triglycerides). If fasting samples are impractical then non-fasting samples are satisfactory for most measurements except for triglycerides.

ECG: Include if history of CVD, family history of CVD; where examination reveals irregular pulse (if ECG confirms atrial fibrillation, follow NICE recommendations http://guidance.nice.org.uk/CG36); or if patient taking certain antipsychotics (See SPC) or other drugs known to cause ECG abnormalities (eg erythromycin, tricyclic anti-depressants, anti-arrhythmics – see British National Formulary for further information).

Chronic Kidney Disease*: Screen those with co-existing diabetes, hypertension, CVD, family history of chronic kidney disease, structural renal disease (e.g. renal stones) routinely:

1. Monitor renal function: a) urea & electrolytes
   b) estimated glomerular filtration rate (eGFR)
2. Test urine: a) for proteinuria (dip-stick),
   b) albumin creatinine ratio (laboratory analysis)

*Presence of chronic kidney disease additionally increases risk of CVD: follow appropriate NICE guidelines on chronic kidney disease.

Monitoring: How often and what to do

Applies to patients prescribed antipsychotics and mood stabilizers.

	Baseline	Weekly first 6 weeks	12 weeks	Annually
Personal/FHx	■			■
Lifestyle Review[1]	■		■	■
Weight	■	■	■	■
Waist circumference	■			■
BP	■		■	■
FPG/HbA_{1c}	■		■	■
Lipid Profile[2]	■		■	■

[1]Smoking, diet, and physical activity [2]If fasting lipid profile cannot be obtained, a non-fasting sample is satisfactory

Monitoring table derived from consensus guidelines 2004, j clin. psych 65:2. APA/ADA consensus conference of 2004 published jointly in Diabetes Care and Journal of Clinical Psychiatry with permission from the Ontario Metabolic Task Force.

Specific lifestyle and pharmacological interventions

Specific lifestyle interventions should be discussed in a collaborative, supportive and encouraging way, taking into account the person's preferences:

- **Nutritional counselling:** reduce take-away and "junk" food, reduce energy intake to prevent weight gain, avoid soft and caffeinated drinks and juices, and increase fibre intake.
- **Physical activity:** structured education-lifestyle intervention. **Advise physical activity such as a minimum of 150 minutes of 'moderate-intensity' physical activity per week (http://bit.ly/Oe7DeS).** For example suggest 30 minutes of physical activity on 5 days a week.

If the patient has not successfully reached their targets after 3 months, consider specific pharmacological interventions:

Anti-hypertensive therapy: Normally GP supervised. Follow NICE recommendations http://publications.nice.org.uk/hypertension-cg127.

Lipid lowering therapy: Normally GP supervised. (If total cholesterol >9, non-HDL chol >7.5 or TG>20 (mmol/l), refer to metabolic specialist.) Follow NICE recommendations http://www.nice.org.uk/nicemedia/pdf/CG67NICEguideline.pdf.

Treatment of diabetes: Normally GP supervised. Follow NICE recommendations http://www.nice.org.uk/CG87.

Treatment of those at high risk of diabetes: FPG 5.5-6.9 mmol/l; HbA_{1c} 42-47 mmol/mol (6.0-6.4%)

Follow NICE guideline PH 38 Preventing type 2 diabetes: risk identification and interventions for individuals at high risk (recommendation 19) – **http://guidance.nice.org.uk/PH38**.

- Where intensive lifestyle intervention has failed **consider a metformin trial** (normally be GP supervised).
- Please be advised that **off-label** use requires documented informed consent as described in the GMC guidelines, **http://www.gmc-uk.org/guidance/ethical_guidance/14327.asp**. These GMC guidelines are recommended by the MPS and MDU, and the use of metformin in this context has been agreed as a relevant example by the Defence Unions.
- Adhere to British National Formulary guidance on safe use (in particular ensure renal function is adequate).
- Start with a low dose e.g 500mg once daily and build up, as tolerated, to 1500–2000mg daily.

Review of antipsychotic and mood stabiliser medication:

Discussions about medication should involve the patient, the general practitioner and the psychiatrist. Should be a priority if there is:

- Rapid weight gain (e.g. 5kg <3 months) following antipsychotic initiation.
- Rapid development (<3 months) of abnormal lipids, BP, or glucose.

The psychiatrist should consider whether the antipsychotic drug regimen has played a causative role in these abnormalities and, if so, whether an alternative regimen could be expected to offer less adverse effects:

- As a first step prescribed dosages should follow BNF recommendations; rationalise any polypharmacy.
- Changing antipsychotic medication requires careful clinical judgment to weigh any benefits against the risk of relapse of the psychosis.
- An effective trial of medication is considered to be the patient taking the medication, at an optimum dosage, for a period of 4-6 weeks.
- If clinical judgment and patient preference support continuing with the same treatment, then ensure appropriate further monitoring and clinical considerations are carried out regularly.

It is advised that all side effects to antipsychotic medication are regularly monitored, especially when commencing a new antipsychotic medication **(GASS questionnaire http://mentalhealthpartnerships.com/resource/glasgow-antipsychotic-side-effect-scale/)**, and that any side effects, as well as the rationale for continuing, changing or stopping medication is clearly recorded and communicated with the patient.

The Psychiatrist should maintain responsibility for monitoring the patient's physical health and the effects of anti-psychotic medication for at least the first 12 months or until the person's condition has stabilised, whichever is longer. Thereafter, the responsibility for this monitoring may be transferred to primary care under shared care arrangements.

Discuss any non-prescribed therapies the patient wishes to use (including complementary therapies) with the patient, and carer if appropriate. Discuss the safety and efficacy of the therapies, and possible interference with the therapeutic effects of prescribed medication and psychological treatments.

Public Health England

NAS NATIONAL AUDIT OF SCHIZOPHRENIA CCQI

NHS

This resource was co-produced by NHS England, NHS Improving Quality, Public Health England and the National Audit of Schizophrenia Team.

The following organisations support the use of this resource:

Royal College of Psychiatrists (RCPsych)
Royal College of General Practitioners (RCGP)
Royal College of Physcians
Royal College of Nursing
Royal College of Surgeons (RC Surgeons)
UK Faculty of Public Health (FPH)
UCL Partners – Academic Health Science Partnership
Healthcare Quality Improvement Partnership (HQIP)
National Collaborating Centre for Mental Health (NCCMH)
Diabetes UK
Rethink Mental Illness

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

RCGP Royal College of General Practitioners

Royal College of Physicians

Royal College of Nursing

RCS ADVANCING SURGICAL STANDARDS

FACULTY OF PUBLIC HEALTH

UCLPartners Academic Health Science Partnership

HQIP Healthcare Quality Improvement Partnership

NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

DIABETES UK CARE. CONNECT. CAMPAIGN.

Rethink Mental Illness.

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Closing the Gap Process

Patient admitted

Information Gathering

- Review Notes
- Handover
- MDT
- Diagnosis
- Observation of patient

Identification of Closing the Gap Candidate

- On antipsychotic medication
- Use of Lester Tool (when information is available)

Complete Relevant Paperwork

- 5.2 Mobius Therapy Plan
- Paris care plans

Encourage Engagement

- Closing the Gap team
- Ward rounds
- Poster and leaflet

Facilitate Closing the Gap Interventions

- Interventions facilitated by OT, Physio and Dietetics staff
- Psychoeducation to be provided as appropriate for client's level of function during closing the gap interventions

Data Collection

In relation to decisions made at Closing the Gap meetings

Review and Evaluation

- Reviewed by CtG team
- Therapy programme review

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YOUR MENTAL HEALTH UNIT

As a mental health unit we are committed to promoting improvements in physical health among our inpatients. We truly believe that we should promote lifestyle changes as part of the care provided and with a direct positive impact on mental health.

CLOSING THE GAP - PHYSICAL HEALTH PROGRAMME

The programme aims to help you to improve your general health and especially to reduce your risk of developing Type II Diabetes which may be higher because of the need to take specific types of medication (anti-psychotics) along with other factors. Diabetes is two to three times more common in people with serious mental illness than in the general population. Many people with serious mental illness have multiple risk factors for type 2 Diabetes (such as: family history of diabetes, higher risk ethnic origin, obesity, sedentary lifestyle and smoking).

The *Closing the Gap* Programme aims for a better understanding on our inpatient wards of the potential health risks associated with a lack of physical activity and a poor diet.

"People with serious mental illness are half as likely to know about healthy lifestyles and risk factors, and half as likely to take exercise or eat a healthy diet as people without mental health illness (…)"[1]

This Physical Health Programme is part of your multidisciplinary treatment plan and uses the skills of Dietician Physiotherapy and Occupational Therapy staff to encourage activities with a special focus on diet/healthy eating alongside medical support. While admitted to the ward, all the participants of the programme will have a weekly offer of activities with the aim of helping you to make lifestyle changes and develop healthier habits after discharge.

WHAT IS DIABETES!?[2]

We can help you to understand why Diabetes is a major concern and why it is potentially related with some mental health illnesses. Diabetes is a condition where the insulin your pancreas makes can't work properly, or your pancreas can't make enough/any insulin.

[2] The British Diabetic Association - https://www.diabetes.org.uk/

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About 90% of people with Diabetes have Type 2 Diabetes. Insulin does an essential job, allowing the glucose in our blood to enter our cells and fuel our bodies. When you have Type 2 Diabetes, your body still breaks down carbohydrate from your food and drink and turns it into glucose. The pancreas responds to this by releasing insulin. But because this insulin can't work properly, blood glucose (also called sugar) levels keep rising. So more insulin is released. For some people with Type 2 diabetes this can eventually tire the pancreas out, meaning their body makes less and less insulin. This causes even higher blood sugar levels.

But with the right treatment and care, the effects of diabetes and high blood sugar levels can potentially be reversed and certainly managed (Diabetes UK).

DIABETES RISK FACTORS	
↑40	Your risk increases with age. You're more at risk if you're white and over 40 or over 25 if you're African-Caribbean, Black African, or South Asian.
	Type 2 diabetes is two to four times more likely in people of South Asian descent and African-Caribbean or Black African descent.
	You're two to six times more likely to get Type 2 diabetes if you have a parent, brother, sister or child with diabetes.
	You're more at risk if you've ever had high blood pressure.
	You're more at risk of Type 2 diabetes if you're overweight, especially if you're large around the middle.

Certain mental health conditions are also a risk factor for Type 2 diabetes, these include: Schizophrenia, bipolar disorder and depression.

You can reduce your risk of developing Type 2 Diabetes by:

- ✓ EATING WELL
- ✓ MOVING MORE
- ✓ LOSING WEIGHT, IF YOU`RE OVERWEIGHT.