

*Promoting quality for
better health services*



National clinical audit - 3rd November 2009

Workshop: Supporting local change

**The Prescribing
Observatory for Mental
Health; a national program
to improve prescribing
practice in mental health**

Prescribed medication

- Key intervention for almost all patients who use mental health services
- Sub-optimal prescribing associated with:
 - Failure to get maximum benefit
 - A high burden of possibly avoidable side effects
 - Adverse influence on medication adherence
 - Increased morbidity and mortality
 - Adverse incidents and complaints

- Initially funded by a tapering grant from the Health Foundation
- Now funded through subscriptions
- Aim is to improve the quality of prescribing practice in mental health services

Partner Organisations

- Royal College of Psychiatrists
- British Association for Psychopharmacology
- College of Mental Health Pharmacists/UKPPG
- Royal Pharmaceutical Society
- Royal College of General Practitioners
- Mind
- Rethink
- Royal College of Nursing
- National Patient Safety Agency



Royal
Pharmaceutical
Society
of Great Britain



National Patient Safety Agency

Quality improvement programmes

- Identify discrete areas of prescribing practice (topics) worthy of national audits
- Set **evidence-based audit standards** derived from published literature.
- Provide **audit tools** and **data analysis**
- Provide **'benchmarked'** feedback at Trust and team level against the total national sample.
- Develop **bespoke change interventions**
- **Re-audit** 1 year to 18 months later and provide **'benchmarked'** feedback on changes from baseline

- Prescribing of high dose and combination antipsychotics for patients on adult acute and psychiatric intensive care wards
- Prescribing of high dose and combination antipsychotics for patients in forensic settings
- **Screening for metabolic side effects of antipsychotic drugs in patients treated by assertive outreach teams**
- Benchmarking prescribing of anti-dementia drugs
- Quality of assessment of antipsychotic side-effects
- Quality of lithium monitoring
- Medicines reconciliation
- Prescribing psychotropics in people with learning disabilities

P O M H U K

PRESCRIBING OBSERVATORY
FOR MENTAL HEALTH

Screening for metabolic side effects of antipsychotic drugs in patients treated by assertive outreach teams

CVD RISK FACTORS IN PEOPLE WITH SMI

Estimated prevalence and relative risk

Modifiable risk factors	Schizophrenia	Bipolar disorder
Obesity	45–55% RR: 1.5–2	21–49% RR: 1–2
Smoking	50–80% RR: 2–3	54–68% RR: 2–3
Diabetes	10–15% RR: 2	8–17% RR: 1.5–2
Hypertension	19–58% RR: 2–3	35–61% RR: 2–3
Dyslipidemia	25–69% RR: ≤ 5	23–38% RR: ≤ 3
Metabolic Syndrome	37–63% RR: 2–3	30–49% RR: 1.5–2

RR: relative risk.

(De Hert et al 2009)

SCREENING FOR THE METABOLIC SYNDROME

- A host of reviews conclude that there is a need for active, routine physical health screening of all patients treated with antipsychotic drugs
(*Holt et al 2004, American Diabetes Association 2004, NICE Schizophrenia Guideline 2009*)
- Pragmatic guidance on screening for diabetes and dyslipidaemias can be found in the Maudsley Prescribing Guidelines, 10th edition (*Taylor et al 2009*)

TABLE

Recommendations for Metabolic Monitoring in Patients Receiving Atypical Antipsychotic Agents¹²

	<u>Baseline</u>	<u>4 Weeks</u>	<u>8 Weeks</u>	<u>12 Weeks</u>	<u>Quarterly</u>	<u>Annually</u>	<u>Every 5 Years</u>
Personal/family history	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X			X

*More frequent assessments may be warranted based on clinical status. BMI=body mass index.

Reprinted with permission from: American Diabetes Association; American Psychiatric Association; American Association of Clinical Endocrinologists; North American Association for the Study of Obesity. Consensus development conference on antipsychotic drugs and obesity and diabetes. *J Clin Psychiatry*. 2004;65:267-272.

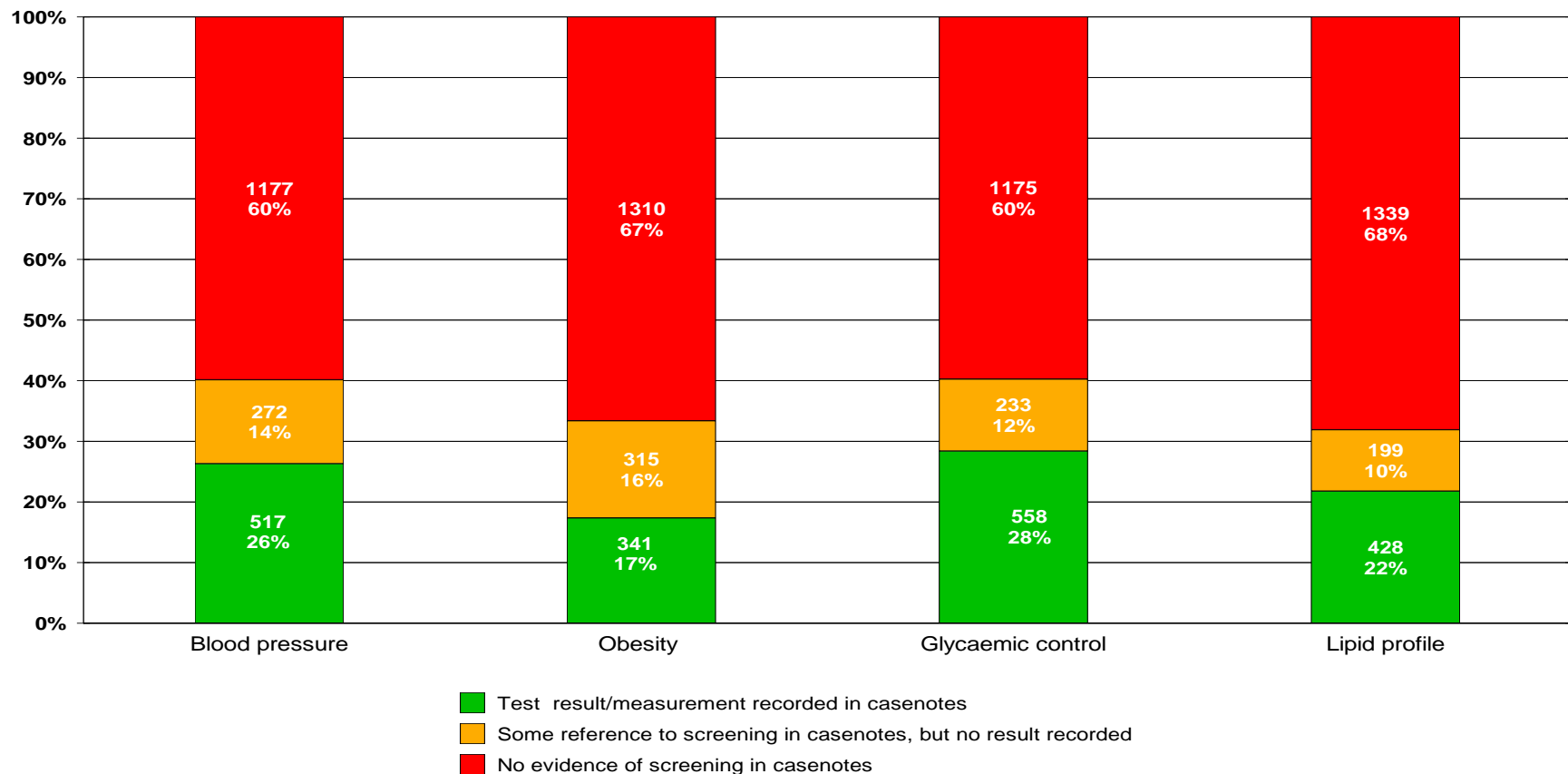
Audit standard

- All patients prescribed continuing antipsychotic medication should have their blood pressure, body mass index (or other measure of obesity), blood glucose (or HbA1c) and lipids measured at least once a year.

Relevant targets

1. To reduce the proportion of adults who smoke from 28% to 24% or less by the year 2010 (Health of the Nation white paper; DoH, 1999).

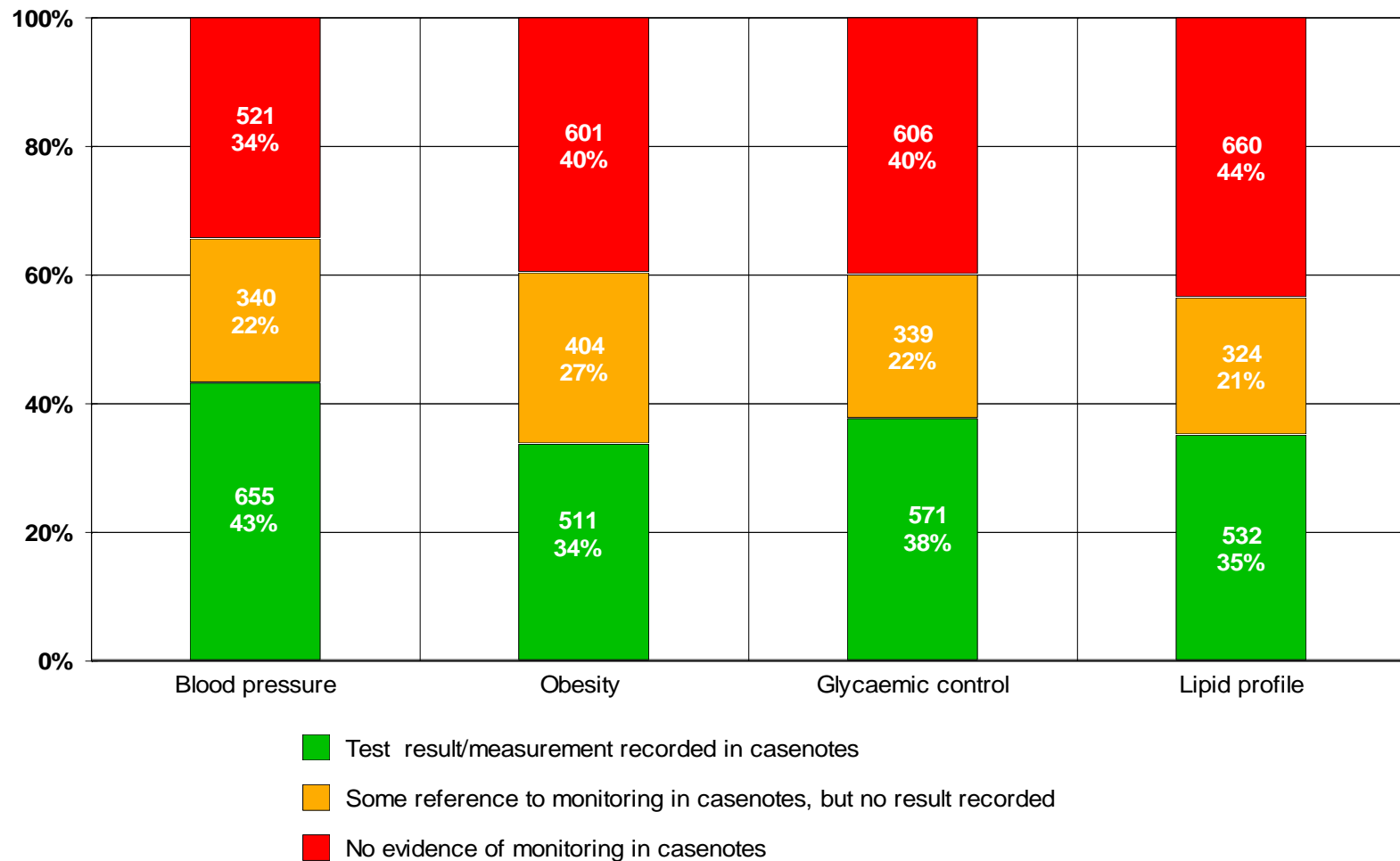
PROPORTIONS OF PATIENTS SCREENED FOR EACH OF THE FOUR ASPECTS OF METABOLIC SYNDROME IN THE TOTAL NATIONAL SAMPLE, BASELINE 2006 (N=1966)



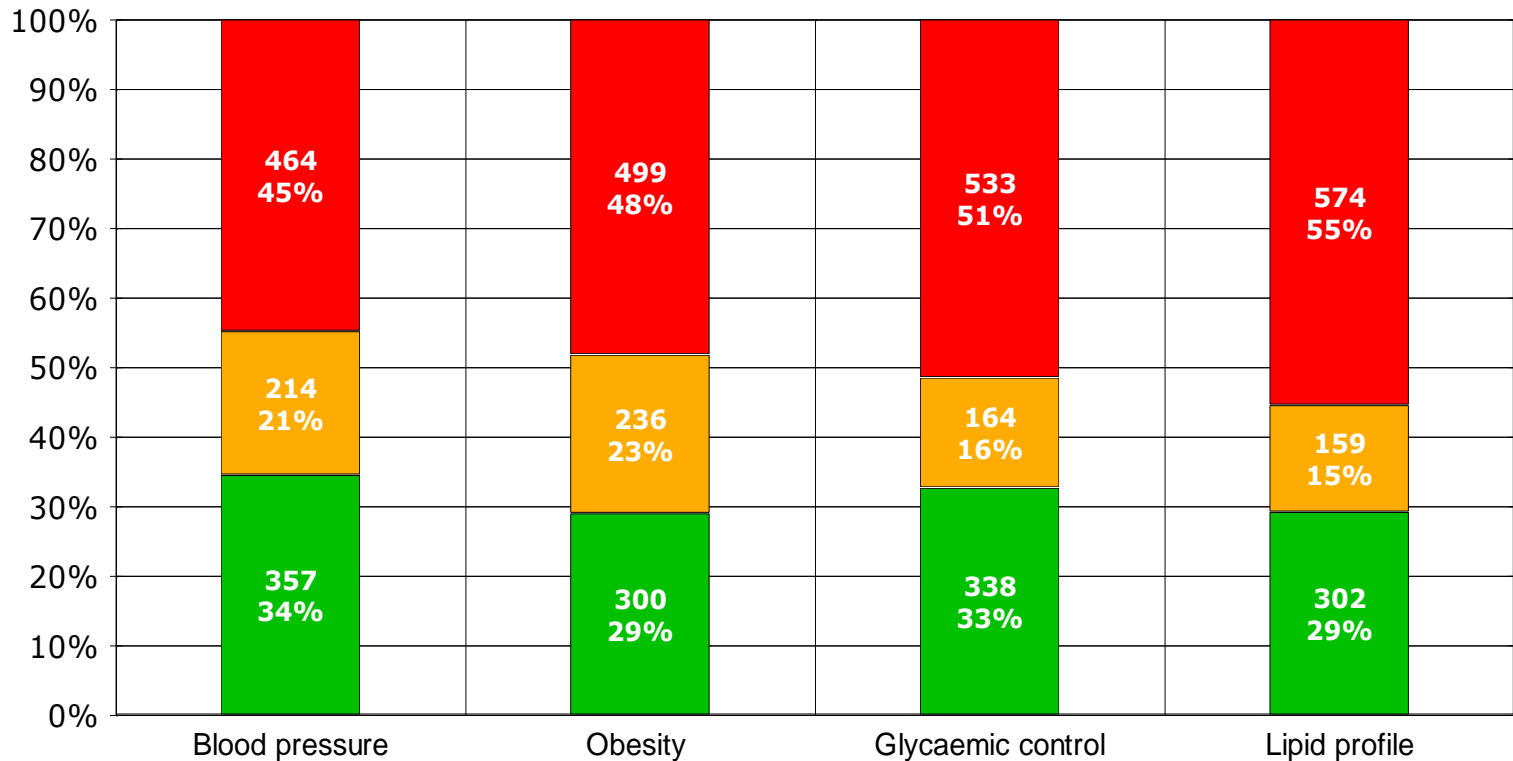
For every case of diabetes identified, 1 missed
For every case of hypertension identified, 4 missed
For every case of dyslipidaemia identified, 7 missed

Risk factors for cardiovascular disease (CVD) include: increasing age, gender (male), family history, schizophrenia, smoking, alcohol, diet high in fat and sugar, lack of exercise, diabetes & hypertension. The last 6 can be modified (intervention reduces risk).	Weight /BMI	Blood Pressure	Glucose	Lipids
Why is this important?	Being overweight; <ul style="list-style-type: none"> Makes you feel tired and lethargic. Leads to poor self esteem Increases the risk of minor health problems such as varicose veins. Increases the risk of serious health problems such as heart disease, diabetes and some cancers. 	High blood pressure increases the risk of developing; <ul style="list-style-type: none"> Heart disease Stroke Irreversible damage to organs such as the kidneys. 	Diabetes = excess sugar in the blood. If untreated/poorly controlled it will: <ul style="list-style-type: none"> Cause tiredness, thirst, increased number of infections & a general feeling of 'unwellness'. Increase the risk of heart disease. Lead to 'end organ' damage (eg kidney failure, blindness, stroke). Smoking increases the risk of developing complications.	'High cholesterol' (increased LDL and/or decreased HDL): <ul style="list-style-type: none"> Increases the risk of CVD (heart attacks and strokes)
Normal no action required	Body Mass Index (BMI) 18.5-25kg/m ²	120/80	Fasting ≤ 6mmol/L	Total cholesterol <5mmol/L LDL <3 mmol/L HDL >1 mmol/L Triglycerides <2 mmol/L
Borderline/high Lifestyle advice & additional monitoring required	Everyone with a BMI > 25 should be advised to lose weight by: <ul style="list-style-type: none"> Increasing exercise Eating a healthy balanced diet. Support groups can help and attendance should be encouraged. 5-10% weight loss improves physical health.	130-139/85-89 Advice (as appropriate) to reduce salt & alcohol intake, stop smoking and lose weight. Monitor at least once/year. Refer if the patient has diabetes.	Fasting 6.1-6.9 mmol/L If confirmed by 2 readings, refer to GP for an oral glucose tolerance test (OGGT). Regular exercise and a healthy diet can prevent progression to diabetes.	<ul style="list-style-type: none"> If outside of optimal values, use the Framingham tables (back of the BNF) to determine CVD risk. If < 20% over 10 years and the patient does not have diabetes or established CVD: Give lifestyle advice as appropriate (diet, weight, smoking, exercise).
High Action required Refer to GP/medical team	Overweight: BMI 25-30kg/m ² Obese: BMI >30kg/m ² A waist circumference of >102cm (men) or 88cm (women) leads to increased health risks. If BMI >40 (or >35 if the patient has high BP or other complications) refer to hospital obesity clinic	≥140/90 Refer for full assessment/treatment	Fasting ≥7.0mmol/L Random ≥11.1 mmol/L If >25mmol/L and/or ketones are detected in the urine or smelled on the breath ('pear drops'), URGENT referral is required	If outside the optimal values above and: <ul style="list-style-type: none"> The patient has diabetes <i>or</i> The patient has established CVD <i>or</i> The Framingham charts show the risk of CVD is 20% over 10 years. Refer for treatment
How to measure	Divide the patient's weight (in kg) by the square of the height (in metres).	Seat patient with arm supported at heart level. Use correct size cuff for arm circumference (12x25cm for <33cm; 12x40cm for < 50cm; 20x42cm for <53cm).	Blood taken in the morning after an overnight fast (including nothing to drink) is a fasting sample. Blood taken at any other time is a random sample	A fasting blood sample is best. A random sample is acceptable but will not measure triglycerides accurately.
Recommended monitoring	Minimum acceptable: Weight/BMI, BP, glucose and lipids should be measured every 12 months. Remedial action as above. All patients should receive lifestyle advice covering, at a minimum, diet, exercise & smoking. Ideal: Weight/BMI weekly when a new antipsychotic drug is started. Lifestyle advice and support and possibly switching to a different antipsychotic should be considered for those who gain weight rapidly in the first few weeks of treatment. Measure glucose and lipids at baseline, after 3 months, and subsequently at least annually, in line with the advice in the table above.			

PROPORTIONS OF PATIENTS SCREENED FOR EACH OF THE FOUR ASPECTS OF METABOLIC SYNDROME IN THE TOTAL NATIONAL SAMPLE, RE-AUDIT 2007 (N=1516)

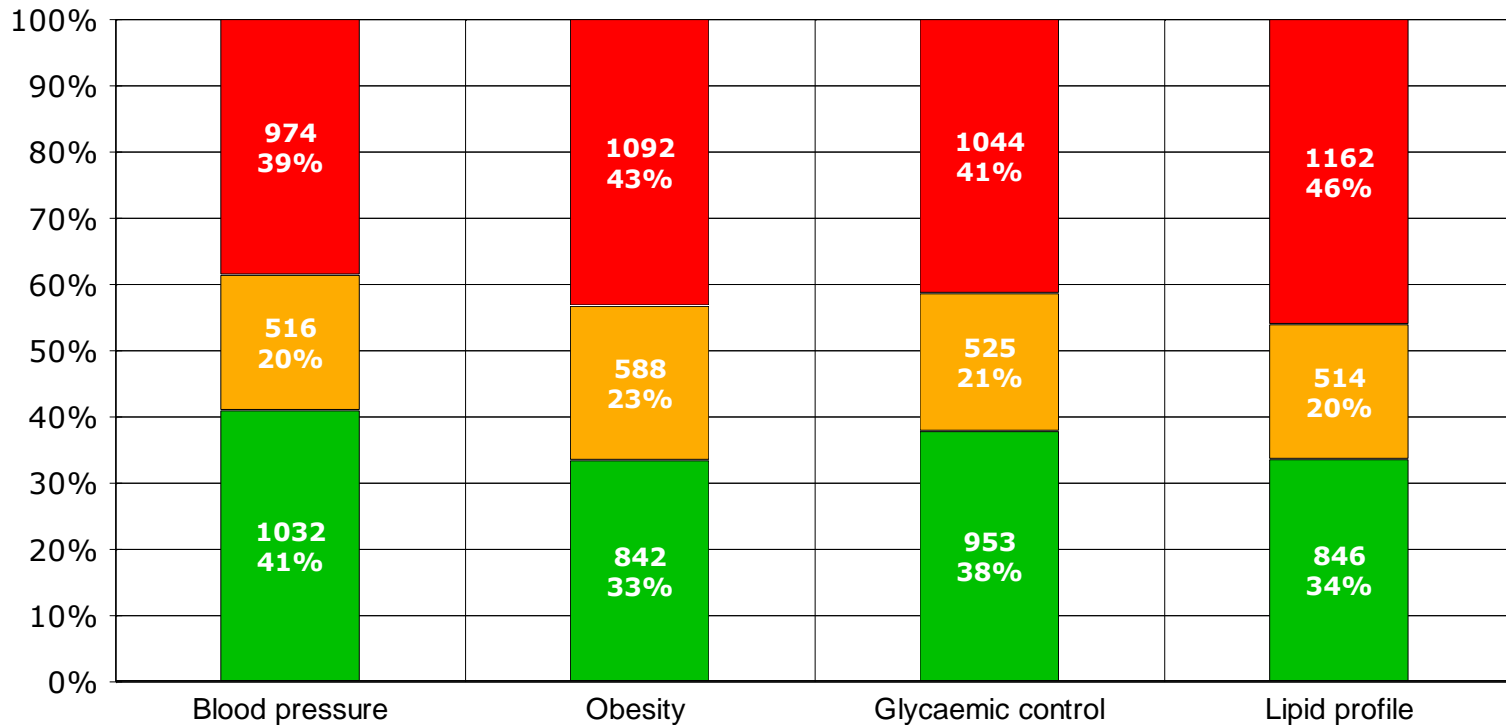


PROPORTIONS OF PATIENTS SCREENED FOR EACH OF THE FOUR ASPECTS OF METABOLIC SYNDROME IN THE TOTAL NATIONAL SAMPLE, BENCHMARKING AUDIT 2008 (N=1035)



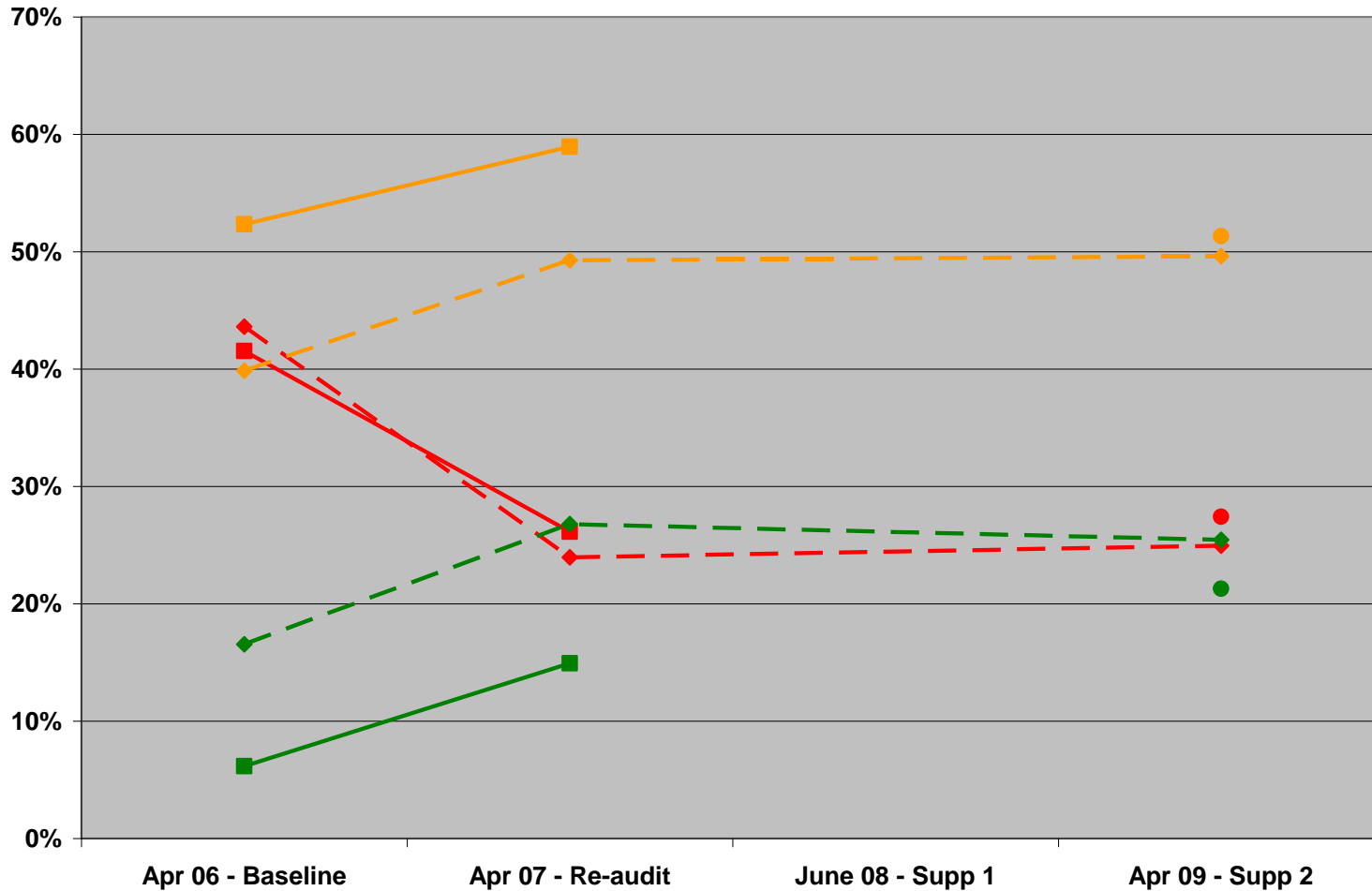
- Test result/measurement recorded in casenotes
- Some reference to monitoring in casenotes, but no result recorded
- No evidence of monitoring in casenotes

PROPORTIONS OF PATIENTS SCREENED FOR EACH OF THE FOUR ASPECTS OF METABOLIC SYNDROME IN THE TOTAL NATIONAL SAMPLE, BENCHMARKING AUDIT 2009 (N=2522)



- Test result/measurement recorded in casenotes
- Some reference to screening in casenotes, but no result recorded
- No evidence of screening in casenotes

Proportion of patients for whom there was evidence of screening for the 4 aspects of metabolic syndrome, with Trusts grouped according to which stages they participated in



Conclusions from national QI programme

- Screening rates for metabolic syndrome in people with SMI **fall short** of the recommendations in evidence based clinical guidelines
- Participating clinical teams identified a number of **barriers** to screening (knowledge based and systems based)
- Practice moved **towards the standards** between baseline and re-audit
- Although early gains were maintained overall, there was **little further improvement** in subsequent audit cycles
- **New approaches** likely to be required if this is to be achieved

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

QoF indicators in development and for further review

June 2009

<i>ID</i>	Full title – as presented to June 09 Committee	Committee outcome
<i>SMI - proposed new indicator 2</i>	<ul style="list-style-type: none"> The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose body mass index has been recorded in the preceding 15 months. 	In development
<i>SMI - proposed new indicator 3</i>	<ul style="list-style-type: none"> The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose blood pressure has been recorded in the preceding 15 months. 	In development
<i>SMI - proposed new indicator 4</i>	<ul style="list-style-type: none"> The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses aged over 40 whose blood cholesterol level has been recorded in the preceding 15 months. 	In development
<i>SMI - proposed new indicator 5</i>	<ul style="list-style-type: none"> The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose blood glucose level has been recorded in the preceding 15 months. 	In development