Top tips for mental health teams to increase the value of care and improve respiratory outcomes for people with mental health problems.

1. Organise annual flu vaccination for staff and patients and actively encourage them to have it. Talk about the benefits and make it as easy as possible. See our factsheet https://www.networks.nhs.uk/nhs-networks/london-lungs/documents/flu-vaccination-protects-you-your-family-and-your-patients-still-time-to-make-a-difference/file_popview

2. Seek training in helping patients and staff who are smokers to quit so you and your team are able to identify and treat tobacco dependence which is a high value intervention for physical health. Be reassured that quitting smoking is actually associated with reduced depression, anxiety, and stress and improved positive mood and quality of life compared with continuing to smoke. The 2014 systematic review shows these benefits are as great for those with mental illnesses who stop smoking, as those without. The effects of stopping smoking are equal to or larger than those of antidepressant treatment for mood and anxiety disorders. http://www.bmj.com/content/348/bmj.g1151.

3. Check exhaled carbon monoxide (CO) levels on admission to a ward or at first visit in the community so i) nicotine withdrawal is dealt with early ii) people "know their level" and what their options are. More patients are transferred by ambulance to Emergency Departments because of tobacco rather than alcohol use. http://www.londonsenate.nhs.uk/wp-content/uploads/2015/04/Helping-Smokers-Quit-Programme-The-expired-carbon-monoxide-CO-test.pdf
See the *Key aspects of smoking cessation in mental health settings* chapter for more information; including that varenicline is safe and effective and should be on every formulary and guidance on effects of quitting smoking on dosages of medication.

4. Ask your patients about breathlessness, cough, sputum and sleepiness - three common respiratory symptoms that may be indicative of a number of common and treatable respiratory conditions such as asthma, COPD and sleep apnoea. Arrange spirometry for any patient with a history of smoking and any of these symptoms. The IMPRESS breathlessness algorithm is a good example of the types of questions and the cyclical nature of the assessment. http://www.respiratoryfutures.org.uk/knowledge-portal/impress-documents/impress-breathlessness-algorithm/

5. Arrange an urgent chest X-ray if new or worsening respiratory symptoms or any unexplained new symptoms in a current or ex-smoker.

6. Have and use a pulse oximeter and act on the findings. Remember oxygen is a treatment for hypoxia not breathlessness. Finger pulse oximeters are now cheap, easily available to buy, easy to use, reliable, save clinicians' time and could make it less likely that low oxygen saturations are missed in people with mental illness.

Consider providing key staff each with their own finger pulse oximeter (eg eProc Code 901002). https://www.networks.nhs.uk/nhs-networks/london-lungs/documents/responsible-oxygen-prescribing-messages-adults/file_popview

7. Consider referral to pulmonary rehabilitation to help patients "*breathe better, feel good and do more*". To find out about pulmonary rehabilitation contact your local respiratory team. If pulmonary rehabilitation is not available to your patient group, identify the number of patients missing out and the potential impact of them missing out. If you work in an inpatient unit and there are sufficient in-patients who would benefit, discuss with the respiratory team and commissioners about the possibility of a dedicated programme. Audit its effectiveness. http://www.respiratoryfutures.org.uk/knowledge-portal/impress-documents/impress-guide-to-pulmonary-rehabilitation/

8. Prescribe inhalers responsibly and take inhaler technique and use by patients seriously. Follow our responsible respiratory prescribing messages: https://www.networks.nhs.uk/nhs-networks/london-lungs/responsible-respiratory-prescribing-rrp

9. People with lung cancer who need palliative care will be transferred to the care of the respiratory team. People with non-malignant disease where the prognosis is less predictable will benefit from shared care. Ensure it is clear where responsibility for palliation of a patient with mental health problems and respiratory symptoms lies. http://www.cuh.org.uk/breathlessness-intervention-service-bis

10. Include deaths in people with serious mental illness under the age of 75 in reviews of adverse incidents. Set up a meeting with the respiratory team lead for mental health. Ensure you have their phone number. Consider holding a joint mortality meeting with your local respiratory team for any premature deaths due to asthma, pneumonia, lung cancer or COPD.

    http://ash.org.uk/files/documents/ASH_107.pdf

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20 November 2015