Treatment and Recovery In PsycHosis (TRIumPH)

Improving psychosis care through faster access to assessment and treatment

Foreword

Wessex Academic Health Science Network (AHSN) connects NHS and academic organisations, local authorities, the third sector and industry.

We help create the right conditions to facilitate change across whole health and social care economies, with a clear and consistent focus on citizens, service users and patients. Our twenty-five members work with each other, and with a broad range of stakeholders, to support the creation of wellbeing and wealth in Wessex through making innovation happen at speed and scale.

Our Mental Health Programme has been working in partnership with Southern Health NHS Foundation Trust to improve access and treatment for people experiencing psychosis. The write up that follows details their journey.

Acknowledgements

We would like to acknowledge the contribution of all service users, family members, carers, clinicians, commissioners and partner organisations who came together to support this work.

Executive summary

<u>Southern Health NHS Foundation Trust</u> and <u>Wessex Academic Health Science Network (AHSN)</u> have been working together to improve the care and outcomes for people experiencing psychosis.

National and local data demonstrated that access to services and current treatment provision was not meeting the needs of this group, their families and of the staff supporting them.

What was delivered?

- The development and implementation of a co-produced care pathway within **four Early Intervention in Psychosis (EIP) teams** across Hampshire, covering a population of approx. 1.3 million: over **900 people** have entered the pathway to date

- Improving access: since implementation of the pathway **60% of people have been assessed within seven days of referral** and **82% people have been assessed within 14 days of referral**, supporting earlier engagement and recovery (compared with baseline where 36% were assessed within seven days and 59% within 14 days)

- Implementation of a **standardised assessment** procedure across all teams

- **Co-production and roll out of a carers' pack**, providing support and information for this important group

- Development and roll out of a comprehensive **physical health assessment**, supporting teams to reduce the 15 – 20 year mortality gap for those experiencing severe mental illness

- Increasing numbers of staff have been **trained in evidenced based interventions:** CBT (Cognitive Behavioural Therapy), family therapy, employment support and physical health

- **Engagement and investment from commissioners**

- The programme was highly commended at the national **Positive Practice in Mental Health Awards** in October 2016

- The evaluation protocol was published in the **<u>British Medical Journal (BMJ) Open</u>** in December 2016

As a result of the work, a one page visual road map has been developed to outline the process for supporting or leading organisational change. This report follows the stages of the road map. **You can download it for free right here**
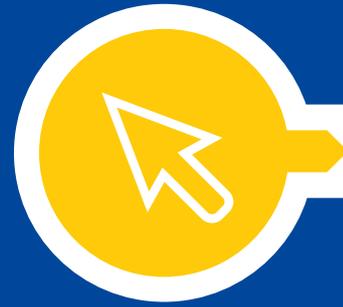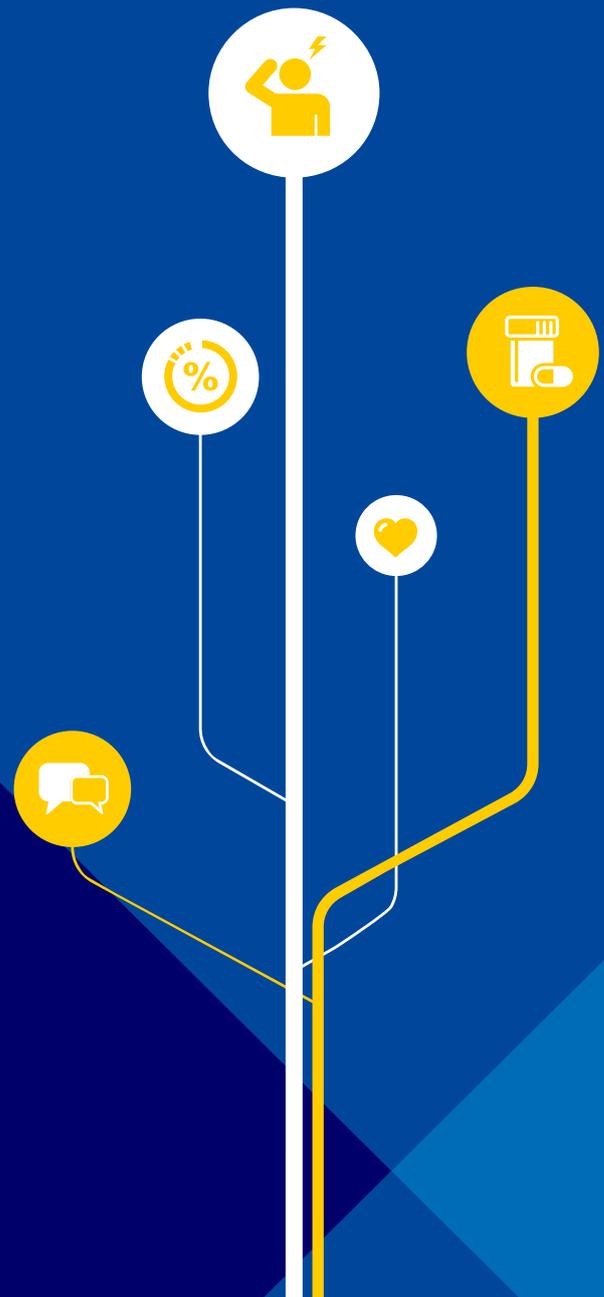
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The big picture

PHASE 1

Planning, preparation & initiation

What is psychosis?

Psychosis represents a cluster of psychiatric disorders including schizophrenia, in which a person's perception, thoughts, mood and behaviour are significantly altered. Psychosis can occur at times of high stress when there might be heightened worry, anxiety, fear and depression. Symptoms might include hearing voices, seeing, feeling or tasting things that others cannot, holding unshared beliefs or experiences, difficulty concentrating and losing touch with reality. Sometimes these experiences are accompanied by feelings of low mood, lack of motivation and apathy.

In England, at least **32 in 100,000 people develop psychosis each year** [1]. Factors such as age, gender, ethnicity, population density and social deprivation are determinants. First episode psychosis occurs more often in young people especially in men from their teens to twenties. Black and minority ethnic groups have an elevated risk of developing psychosis even after adjustment for socio-economic status [2]. Whilst people do recover from a first episode of psychosis it is estimated only **10-20% will not experience a further episode** [3].

Evidence-based treatments are available which make a substantial difference in reducing relapse and promoting recovery, but gaps remain in service delivery [4, 5]. Data has highlighted that spending is skewed towards expensive inpatient services rather than community support [4]. Delays in access to services and treatment are apparent, which impedes recovery. Evidence demonstrates the longer the time between onset of symptoms and the start of treatment (known as the Duration of Untreated Psychosis – DUP) the more significant the impairment in function and social outcomes, resulting in increased distress and disability [6].

The 'Abandoned Illness' report published by the Schizophrenia Commission evidenced that:

· Psychosis is associated with a **15 – 20 year reduction in lifespan** due to poor physical health

· Only **1 in 10 of those who could benefit have access to true CBT**

· Only **8% of people with schizophrenia are in employment**

· **87% of service users report experiences of stigma and discrimination**

· **Families who are carers save the public purse £1.24 billion per year,** but they are not treated as equal partners

· **£1.2 billion** or **19% of the mental health budget is spent on secure care services,** with many people spending too long in expensive units

· Schizophrenia and psychosis **costs society £11.8 billion in England alone**

The government strategy **'No health without mental health'** acknowledged that more must be done to address the disparity in care for people experiencing psychosis. It highlighted the importance of prevention, early detection, and support for evidence-based models such as Early Intervention in Psychosis (EIP) services. There is a strong cost-effectiveness argument supporting EIP services; they have been shown to be more effective than the traditional community mental health team approach [4] delivering savings of **£38,000 per person over 10 years** [7].

You can find out more about psychosis right here

Understanding the problem

To understand the local picture, Wessex AHSN worked in partnership with Janssen Healthcare Innovation to analyse Hospital Episodes Statistics (HES) data and data held within the Mental Health Minimum Data Set (MHMDS, now called Mental Health Services Data Set). This provided a picture of the needs of service users with psychosis in Wessex.

**It was found that people experiencing psychosis:**

- are more likely to be admitted to a mental health inpatient ward when compared to those with other mental health conditions

- stay significantly longer as an inpatient than other groups

- receive almost three times as many contacts with healthcare professionals as those with other mental health conditions

- who are from ethnic minorities are more likely to be admitted to mental health inpatient wards and stay for longer

- would, in many cases, like to work but do not have the opportunity to do so

A local audit of clinical notes also demonstrated variation in care provision and delays to commencing assessment and NICE recommended treatments:

- Administrative delays were identified between referrals being made and them reaching EIP services

- Variation was identified in the quality of assessments being undertaken

- Minimal documentation was found in relation to physical health and there was a lack of clarity in where to record this information

- Staff reported a lack of confidence in delivering physical health assessments

- There was a difference in anecdotally reported performance when compared to audit data

- There was variation between teams in the support available for carers

- It was difficult to understand from current documentation if people had been offered NICE interventions and when this had occurred

- It was also identified that teams entered lots of data on to the current IT system, but there wasn't a way of using it to inform future practice

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Developing a shared purpose
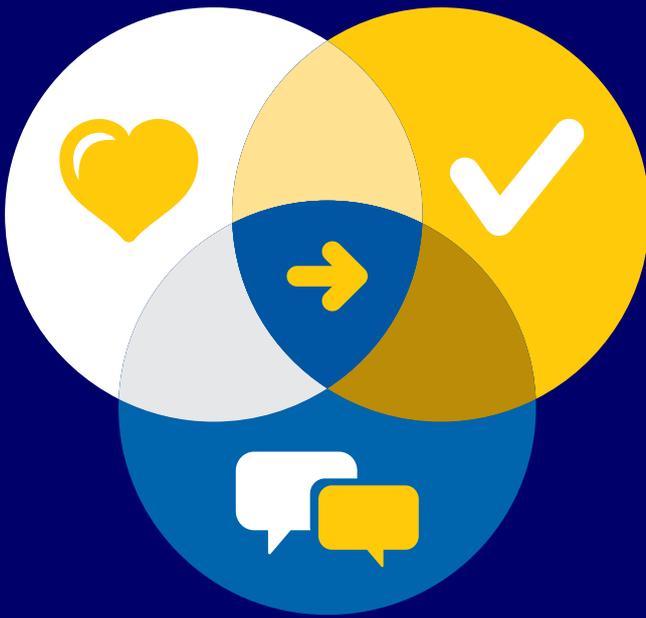
The perspective of service users, carers and staff was critical to understanding how improvements could be made. Wessex AHSN worked with **Stripe Partners** to facilitate a workshop to understand key issues for people using and working in services. To record views, the facilitators encouraged participants to describe stories from their patient journey that they felt others should hear. **Over 100 postcards were written** yielding many first hand experiences. Feedback was collated into themes and formed a shortlist of key areas to focus on:

· The need for compassionate care and more contact time

· The significance of early intervention

· A more holistic and person-centred approach

· Empowering the patient to lead their own recovery

· Better access for places of safety in a crisis

· The importance of peer support

· A greater need for more intensive care available at home

· Better signposting to support services

· A family centred approach

· The need for services to be consistent, seamless, and personalised

The feedback and personal stories were invaluable in making sure the person and their family were at the heart of the work undertaken and were critical in informing the next part of the journey.

Establishing a steering group

Following the joint workshop between service users and staff, a steering group was set up to take the findings forward. The group was initially established to map out a pathway of care which detailed specific treatments and interventions and also included timeframes for the delivery of care.

Developing the pathway and the narrative document was an iterative process, with different individuals and groups contributing to the final documents over a number of weeks.

The final pathways and accompanying narrative document are available to view here:

Routine and crisis referral pathways

Psychosis pathway narrative document

Latterly, the steering group became a forum for service improvement and a safe space to share challenges and discuss solutions regarding implementation.

Another important function of the steering group was in facilitating governance and accountability; it allowed for regular updates which provided senior members of the group with the knowledge to feed into wider Trust structures, such as divisional board meetings.

It was at this time that the **National Access and Waiting Time (AWT) Standard** for psychosis was announced. The Standard required that from 1 April 2016, more than 50% of people experiencing first episode psychosis commence a NICE recommended package of care within two weeks of referral. Treatment is deemed to have commenced when the person:

a. has had an initial assessment; AND

b. has been accepted on to the caseload of an EIP service capable of providing a full package of NICE-recommended care; AND

c. has been allocated to, and engaged with, an EIP care coordinator

The pathway had now become the vehicle for successful delivery of the newly announced national standards.

Find out more about the **Access and Waiting Time Standard for Psychosis**

For more information on the **NICE quality standards for psychosis and schizophrenia**

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Stakeholder Engagement

Ensuring practice could now be aligned with the pathway meant that a number of key people needed to be involved. The following groups were actively engaged to ensure the right people were at the steering group:

- Senior clinical/non-clinical leaders

- Team leaders

- Service users, their friends and family

- Team members, e.g. care coordinators psychologists, psychiatrists, support workers

- Commissioners

- Third sector

- Information Technology (IT)

- CAMHS

- Referring services e.g. GPs

- Performance Team

Priority Setting
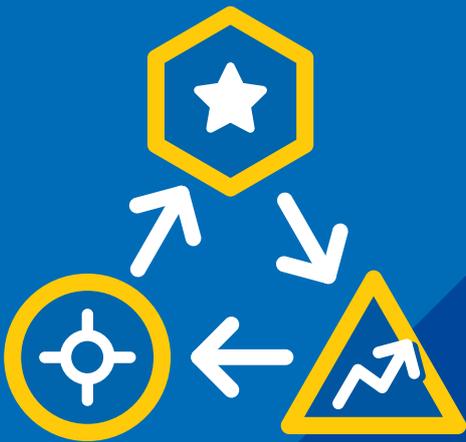
It was important to understand the areas of focus which would deliver better outcomes for people accessing and using services. Following discussions and in line with the newly announced national standards, it was agreed that we would focus on and measure the following:

- **Population impact** – the number of patients assessed and then accepted or discharged from the pathway

- **Access** – the time taken from receiving the referral to assessment by the EIP team

- **Physical health** – as recommended by **NICE guidance**

- **Interventions** – the number of people offered and then engaged with evidence-based interventions; CBT, Family Intervention, medication, employment and vocational support and carer support

- **Healthcare utilisation** – the number of admissions to mental health inpatient units and attendances at Emergency Departments
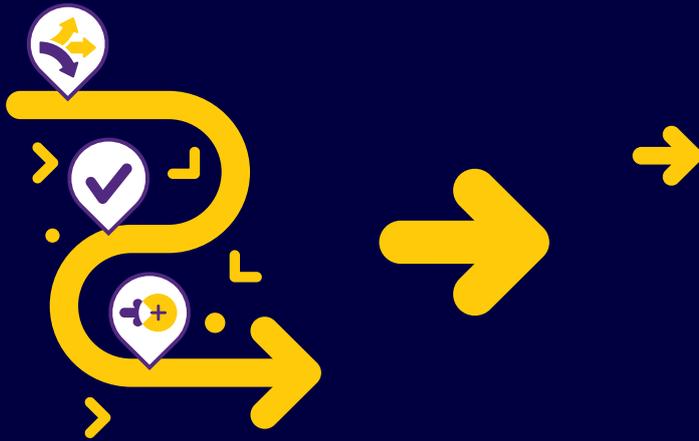
Timeframes

It was agreed that the steering group would be held on a monthly basis with dates set in advance. Notes were recorded during each meeting and shared, with a focus on reporting progress against actions and milestones. A rolling agenda ensured meetings had purpose and were productive.

Putting plans into practice

PHASE 2
Implementation

On 1st June 2015 the pathway went live across four EIP teams in Hampshire. A part time Band 5 Psychology Assistant supported EIP teams during implementation by promoting the pathway, educating individuals and teams about the purpose of the work, and the anticipated outcomes. They also shared team performance data, encouraged people to think about solutions to problems and supported individual team progress.

To make implementation of the pathway a reality, there was plenty of work to do. Following consultation with staff, a mixture of quick wins, stakeholder priorities, high impact actions, and longer term priorities were identified:

Quick wins:

- Streamlining administration procedures to enable faster access to assessments and engagement
- Introducing a standardised assessment procedure across all teams
- Better signposting for employment/vocational support
- An increased focus on involving family/carers

Stakeholder priorities:

- Increasing the availability of physical health monitoring equipment
- Recruitment of psychologists/therapists
- Carers' information packs
- Offering education to referrers to reduce delays in referrals reaching EIP services

High impact actions:

- Data collection and regular feedback to teams on progress and performance
- Process mapping to understand current practice
- Physical health training
- Developing and implementing a clinical checklist
- Updating referral form criteria
- Improving communication with colleagues working in the central triage centre

Longer term aims:

- Increased training for staff
- Increased resources/capacity within teams
- Advanced business planning
- Development of peer support services
- More supportive IT systems to enable recording (and using this for performance feedback)
- Improve office facilities and clinical spaces for 1:1 and group activities

The priorities listed above were integral to reducing variation, improving quality and efficiency and providing teams with clear guidance and a vision to work towards.

Measure, evaluate and learn

Making the changes required was an iterative process, using a combination of service improvement techniques, incremental changes and careful evaluation to measure progress. There are a variety of service improvement techniques that can be used. The links here provide excellent information and examples of what's available.

Rethink Mental Illness.
www.rethink.org

The Academy fab of Fabulous Stuff
www.fabnhsstuff.net

NICE National Institute for Health and Care Excellence
www.nice.org.uk

The King's Fund
www.kingsfund.org.uk

Wessex Academic Health Science Network
www.wessexahsn.org.uk

MINDSet
www.mindsetqi.net

NHS England
www.england.nhs.uk

NHS Improvement
www.improvement.nhs.uk

The Health Foundation
www.health.org.uk

Communication with stakeholders

Regular and effective communication was essential. The importance of involving teams and keeping them up to date with progress cannot be underestimated. The following have been really helpful:

- **Understand the personal values, beliefs and interests of stakeholders;** to help and support the spread of good practice

- **Prepare to pitch and share data at different levels;** to whole teams, individuals, commissioners, clinicians, management and senior leadership

- **Share the good news and the bad;** celebrate peoples' efforts and small wins, learn from what hasn't worked

- **Use influencing skills;** empathetic, facilitative, comfortable with conflict - if people are struggling, creating a safe space to explore challenges and discuss solutions can be invaluable

- **Keep momentum going;** good meeting notes and tracking actions were key

- **Keep the big picture in mind;** regularly remind people what it's all about and the benefits

- **Get people involved;** plan, do, study, act (PDSA) cycles

- **Remember, a change in culture takes time;** it's a marathon, not a sprint

Sustainability and spread

The pathway approach has been a vehicle for identifying, communicating and shaping practice. Two years on, although there have been tangible successes, there is still work to do. A complicating factor is that resource issues remain a challenge across mental health, and EIP services are no exception. However, as a result of this journey, teams are in a much stronger position to continue to improve their services. Long term actions identified by teams are ongoing, for example, peer support workers are being trained and their impact evaluated before considering roll out to other teams.

The following have been key learning points for ensuring sustainability:

- **Ensure senior buy-in and clinical leadership from the start** – work with directors, clinical leads and commissioners to ensure the right people can advocate for the project. The involvement of commissioners is critical for effective forward planning, especially if major service changes are required

- **Use data to understand what's happening in services** – it wins 'hearts and minds', speeds up progress and means you have a benchmark to reflect upon. Identify/work towards the availability of real time data

- **Identify champions within teams** – they are important advocates who build relationships and can navigate boundaries. They can be anyone; for example, it could be a support worker who is passionate about physical health

- **Build capability** - employees must have the skills required to make improvements

- **Have a strategy** – exit plan from the start

- **Set up regular meetings** for the duration of the work to keep momentum going

- **Use subgroups to progress work** – one person can't do it all. Use these groups to progress actions identified in the steering group

- **Delegate tasks and empower people** – this could be to anyone with an interest; a service user, a care coordinator or a director

- **Include stories** – regularly utilise personal experiences to shape practice, both from service users and staff

- **Reduce variation** – implement systems to standardised delivery and ensure quality, find the best practice then adapt and adopt it

- **Involve IT services early** – make people's work as easy as possible; remodel systems to assist in data recording and provide performance insight. It empowers teams to monitor their own progress. Don't underestimate how long this can take – involve the experts as early as possible

- **Have a regular stocktake** – measuring project progress against milestones, have staff attitudes changed? Have new ways of working been normalised?

- **Identify and gain support from corporate functions** – e.g. admin support, business planning expertise, the communications team to update your web page

- **Ensure that learning and success can be shared** and utilised by other teams as a way of creating efficiencies both locally and on a wider scale across the NHS

Sustainability and spread

Improvement is a journey and is rarely smooth; however, perseverance can have a huge impact on service users, their family and staff by reducing variation and promoting better and ever evolving care. Learning from one area often provides valuable insight into another. If you would like to know more about the work described, please contact us.

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