

North Regional Early Intervention in Psychosis event

Wifi network: Kings House

Password: Welcome247

27th September 2018



Welcome and purpose of event

Anthony Deery, Clinical Lead, North Mental Health Programme, NHS England & NHS Improvement

10:00 – 10:10





Early Intervention: An overview



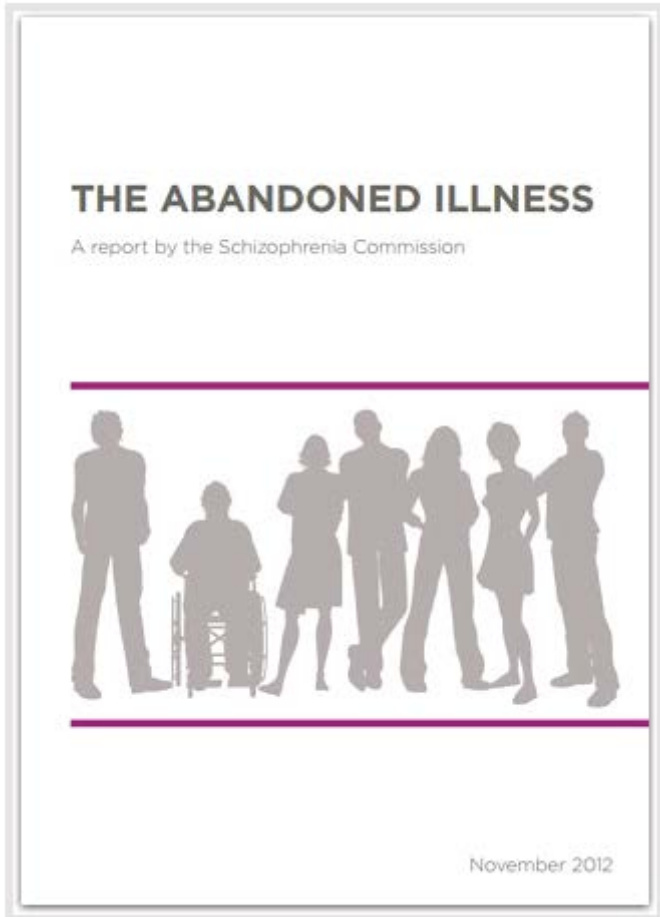
Looking back

Remembering why we are here

“I have been ill for 15 years. I only found out my diagnosis by chance – when on one admission to hospital the doctor announced from a pile of notes “well it says he has schizophrenia”. I was a bit concerned about this diagnosis but it was good in a way because I finally realised that there was a name for how I felt and it could be treated.”



The Schizophrenia Commission





Sir Robin Murray, Chair

The message that comes through loud and clear is that people are being badly let down by the system in almost every area of their lives.



Early Intervention Services

“the great innovation of the last 10 years”

“the most positive development in mental health services since the beginning of community care.”



Findings from the Schizophrenia Commission

...nowhere else have we seen the constant high standards, recovery ethos, co-production and multi-disciplinary team working.



Findings from the Schizophrenia Commission

Those giving evidence emphasised the value base of early intervention services – their kindness, hopefulness, care, compassion and focus on recovery.

They provide treatment in non stigmatising settings, seek to maintain social support networks while an individual is unwell, take account of the wider needs of the individual and deliver education as a core part of the service to families, staff and service users.



Evidence

A recent systematic review and meta-analysis suggested that specialised First Episode Psychosis programmes can significantly reduce the risk of relapse when compared to usual treatment

(Alvarez-Jiménez et al. 2011).



Evidence

Early Intervention Services have a positive impact on the retention and gain of competitive employment.

McCrone et al. (2010)



Evidence

35%
of people in EI
services are in
employment

12%
of people in
standard care
are in
employment

McCrone et al. (2010)



Findings from the Schizophrenia Commission

“Mental illness is a young person’s problem, yet our services are often least effective with this age group – particularly young adults.

Mental health nurse



42 recommendations

THE ABANDONED ILLNESS

We found broad agreement about the changes that need to be made to transform the lives of those with schizophrenia or psychosis and of their families. Encouragingly, we also had support from a range of organisations and practitioners for our approach. We are making 42 detailed recommendations which include:

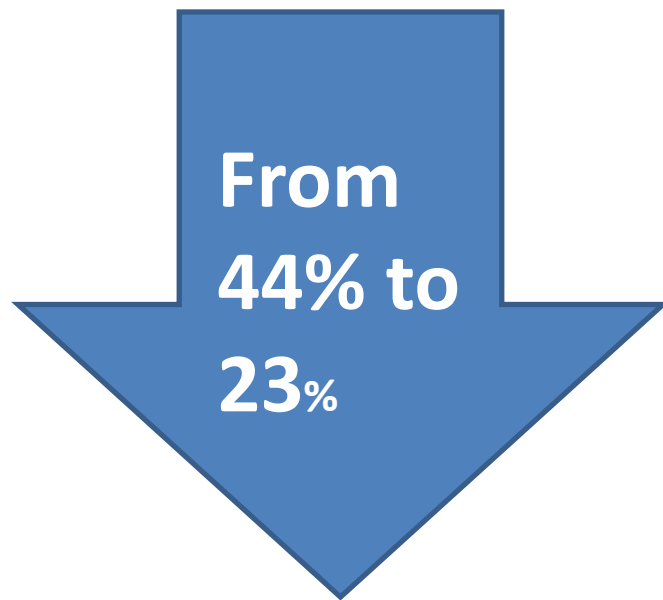
- A radical overhaul of poor acute care units including better use of alternatives to admission like recovery houses to manage the transition between hospital and community services.
- Greater partnership and shared decision making with service users – valuing their experiences and making their preferences central to a recovery focused approach adopted by all services.
- Funding redirected from secure units to strengthen community-based provision and prevention programmes.
- Clarity about who is in charge of delivering care, tackling poor leadership in our services and variations in the quality of care provided.
- Much better prescribing and a right to a second opinion on medication involving, where appropriate, a specialist pharmacist.
- Extending general practitioner training in mental illness to improve support for those with psychosis managed by primary care.
- Extending the popular Early Intervention for Psychosis services (not cutting or diluting).
- Increasing access to psychological therapies in line with NICE guidelines.
- Delivering effective physical health care to people with severe mental illness by improving the training of all mental health staff as well as monitoring the delivery of routine physical health assessment and intervention.
- A stronger focus on prevention including clear warnings about the risks of cannabis.
- Action to address inequalities and meet the needs of all disadvantaged groups.
- A better deal for long-term carers who should be treated as partners.
- Greater use of personal budgets, particularly for those with long-term care needs.
- Extreme caution in making a diagnosis of schizophrenia as it can generate stigma and unwarranted pessimism. The more general term 'psychosis' is preferable, at least in the early stages.

22.
We recommend that all Clinical Commissioning Groups commission Early Intervention in Psychosis services with sufficient resources to provide fidelity to the service model.

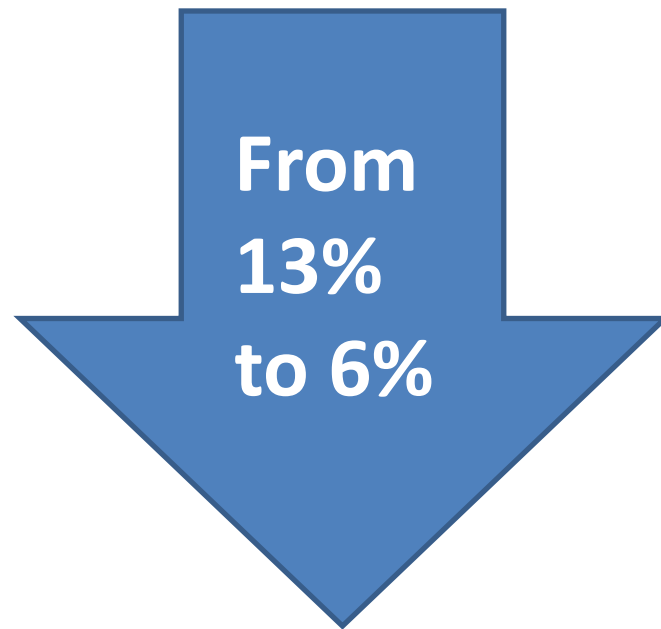


Cost drivers: mental health services

Early Intervention Services reduce the probability of a compulsory admission under the Mental Health Act:



First 2 months



In each 2 month
period thereafter



Lost Generation: 2013

- 15% down to 1%: reduction of risk of young person taking their own life
- Probability of sectioning in first two months, nearly halved
- “Cornerstone of recovery”
- “First time I got help after 7 years of being passed around. Being told the right help is not available.”
- Much to celebrate...



But...

- We are growing this in a difficult climate
- Even then 50% had seen cuts. 50% no growth. 0% Growth...
- Less benign now and elsewhere: forthcoming APPG report
- Remarkable that Q1 17/18 74% seen within two weeks



The next challenge: Parity of Esteem

In 2013, the Department of Health published the first NHS Mandate, setting out NHS delivery objectives for NHS England.

This Mandate contained a commitment to embed 'parity of esteem' for mental health across the NHS.

Prime Ministerial commitment

Ten year plan and productivity



Can Early Intervention services help close that gap?

In physical health services, we're constantly told

- "get help early",
- "prevention is better than cure"
- "check for cancerous lumps"

But in mental health we see

- Huge waiting times for psychological therapies
- Waiting for CPNs
- Service-users sometimes say they have to be desperate before anyone will help



Do you want

- parity of esteem
- good health outcomes for people with mental illness
- cost-effective services...?



If we want:

- parity of esteem
- good health outcomes for people with mental illness
- cost-effective services...

Then we need to use the evidence we've got!



For more info, contact:

Will Higham
Director of Campaigns and Policy
Rethink Mental Illness

william.higham@rethink.org



At the same time...

- **Keep refining the model**
- **Look at wider causes**
- **Quality: excited to see the triangulation tool**

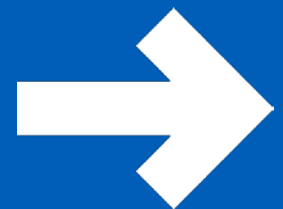
Early Intervention in Psychosis

National update North Regional EIP Event

Amy Clark, Programme Manager, Adult Mental Health

Jay Nairn, Senior Programme Manager, Adult Mental Health

September 2018





Contents

- Early Intervention in Psychosis standard
- 2017/18 self assessment
- Next steps at a national level





EIP access and waiting time standard

By 2020/21, ensure that “at least 60% of people with first episode psychosis [are] starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral”.

Early intervention in psychosis standard	2016/17	2017/18	2018/19	2019/20	2020/21	Measured by
% of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%	UNIFY data collection Moving to MHSDS as soon as possible
Specialist EIP provision in line with NICE recommendations	All services complete baseline self-assessment	All services graded at level 2 by year end	25% of services graded at least level 3 by year end	50% of services graded at least level 3 by year end	60% of services graded at least level 3 by year end	Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) annual quality assessment and improvement scheme.



Overview

Introduction

List of quality statements

Quality statement 1: Referral to early intervention in psychosis services

Quality statement 2: Cognitive behavioural therapy

Quality statement 3: Family intervention

Quality statement 4: Treatment with clozapine

Quality statement 5: Supported employment programmes

Quality statement 6: Assessing physical health

Quality statement 7: Promoting healthy eating, physical activity and smoking cessation

Quality statement 8: Carer-focused education and support

Using the quality standard

Quality standard

[Share](#) [Download](#)

List of quality statements

Next

[Statement 1](#). Adults with a first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral.

[Statement 2](#). Adults with psychosis or schizophrenia are offered cognitive behavioural therapy for psychosis (CBTp).

[Statement 3](#). Family members of adults with psychosis or schizophrenia are offered family intervention.

[Statement 4](#). Adults with schizophrenia that has not responded adequately to treatment with at least 2 antipsychotic drugs are offered clozapine.

[Statement 5](#). Adults with psychosis or schizophrenia who wish to find or return to work are offered supported employment programmes.

[Statement 6](#). Adults with psychosis or schizophrenia have specific comprehensive physical health assessments.

[Statement 7](#). Adults with psychosis or schizophrenia are offered combined healthy eating and physical activity programmes, and help to stop smoking.

[Statement 8](#). Carers of adults with psychosis or schizophrenia are offered carer-focused education and support programmes.

Implementing the Five Year Forward View for Mental Health set the expectation that all EIP services should be graded at level 2 by 2017/18

Level	Descriptor
4	Top performing
3	Performing well
2	Needs improvement
1	Greatest need for improvement

- The level is calculated using a **scoring matrix** which considers:
 - performance against the **NICE concordant elements of EIP care** (effective treatment domain, six indicators);
 - **timely access** (timely access domain, one indicator) and;
 - the recording of **outcome measures** (well managed service domain, one indicator).

Progress

- First data collection July-Sept 2016
- Second data collection Oct 2017-Jan 2018
- More people taking up CBTp and FI
- More carers getting support and education
- More people started treatment within 2 weeks
- EIP in England is world-leading in access and quality of care





THANK YOU!

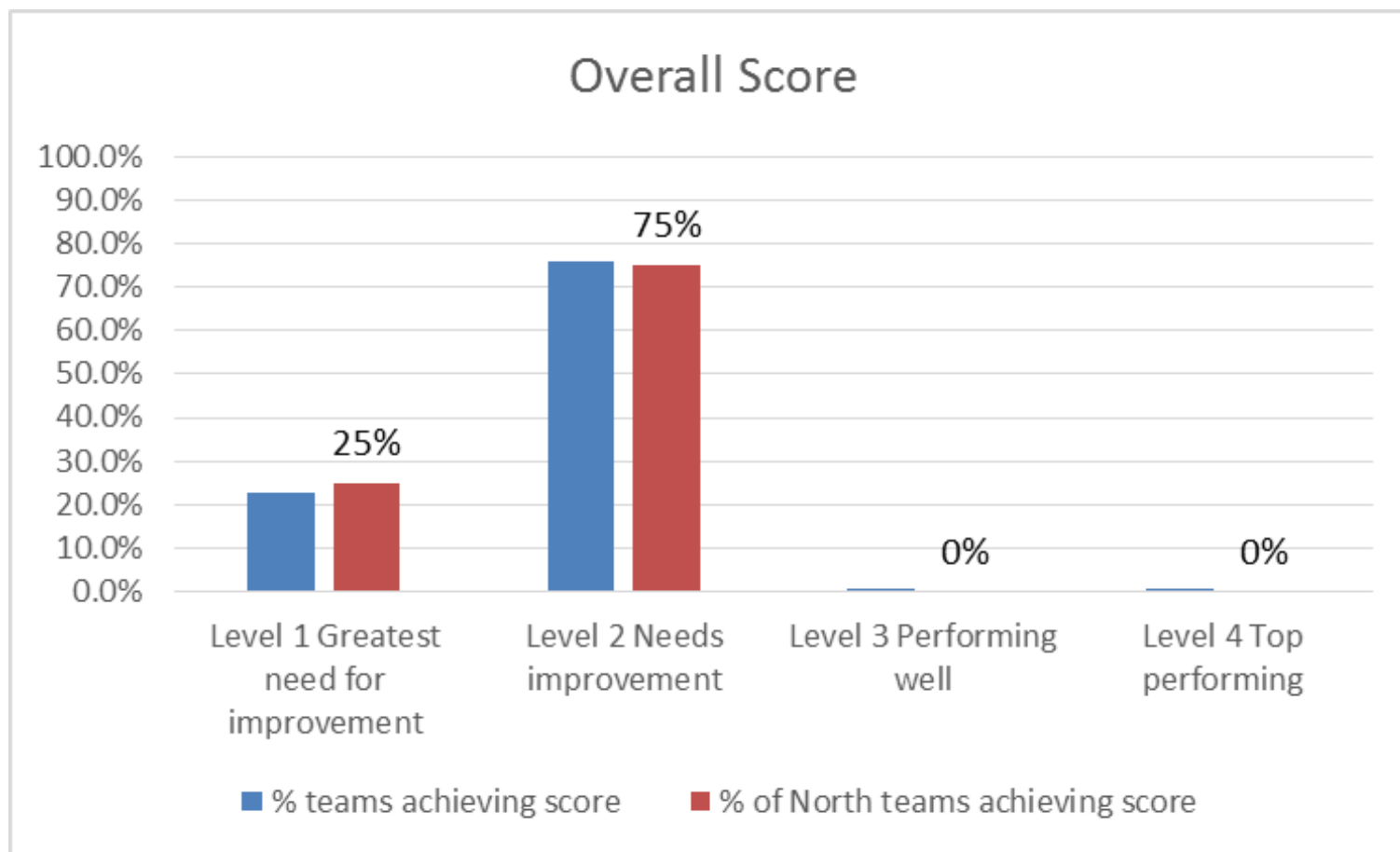


- The EIP standard has reduced variation in access for people with first episode psychosis.
- ‘Envy of the world’: detailed and comprehensive data.
- Strong clinical leadership and investment in workforce training has led to increased delivery of evidence based interventions.
- But we are still not seeing improvements in physical health screening and interventions, and recording and reporting outcomes.
- EIP teams are seeing increased demand and continued investment is needed to ensure improvements in the quality of care delivered.
- Action required to ensure the implementation plan trajectory is met.



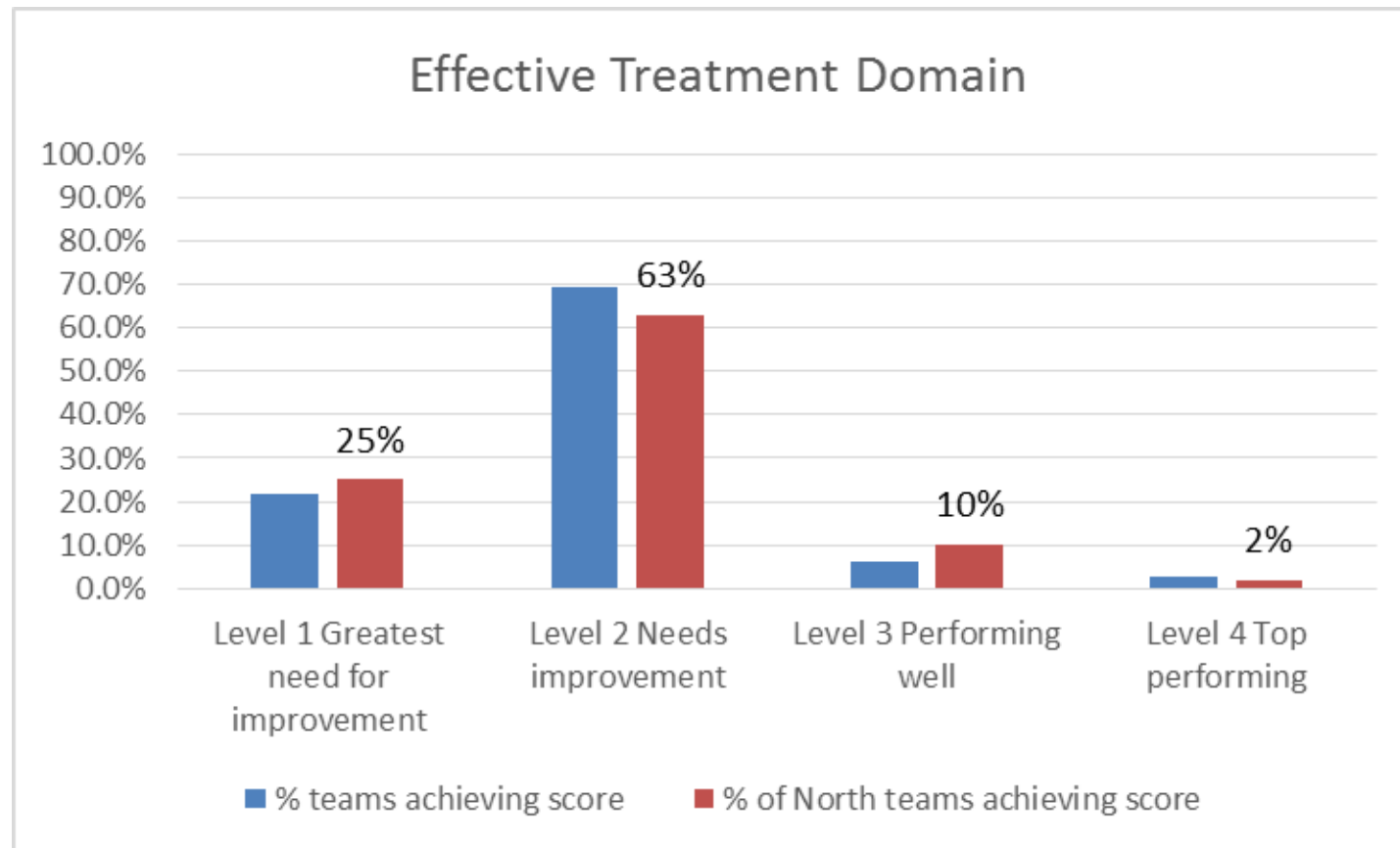
Overall scores

- Approximately 80% of services nationally have achieved at least a level 2. 20% of services have not met this level.



Effective treatment: CBTp, FI, supported employment, carer support, physical health

- Approx. 80% are at level 2 or above for the “effective treatment” domain
- This domain provides a score for the NICE concordant elements of care and demonstrates progress since 2016/17





CBT for psychosis

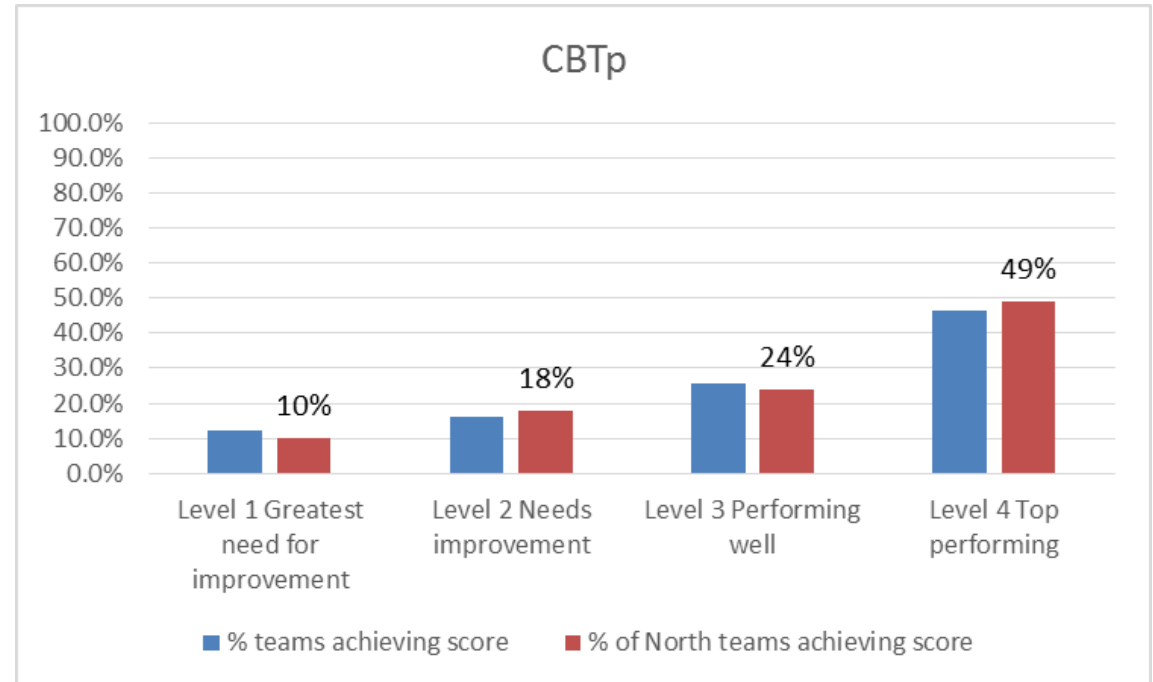
Nationally:

2016/17

- 24% take up CBTp

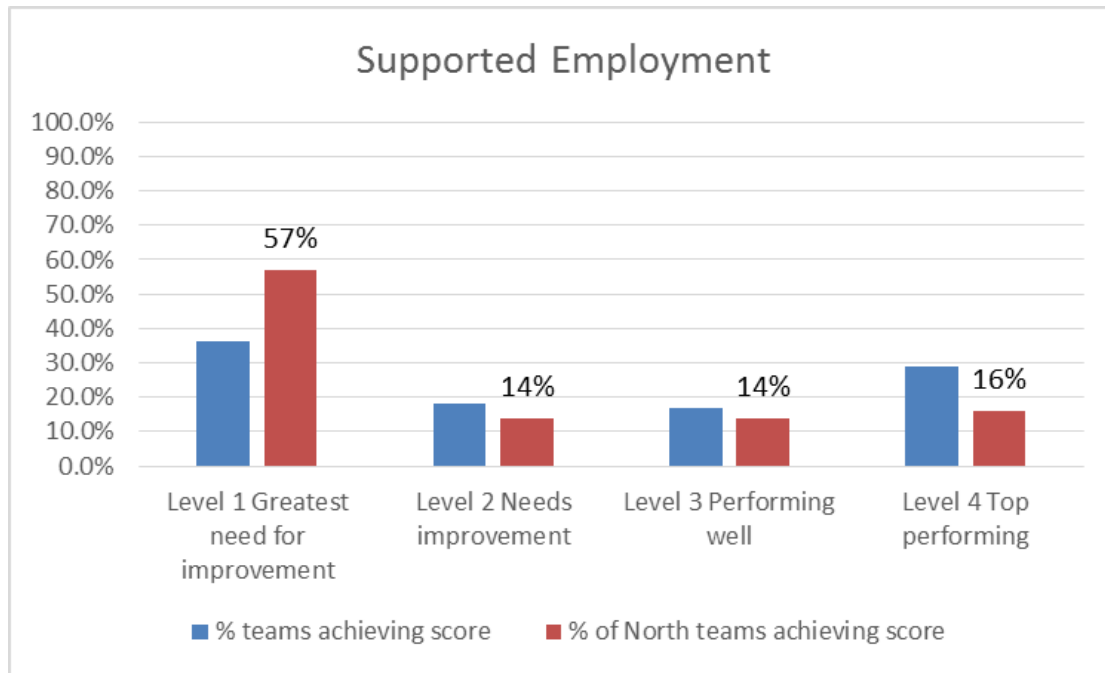
2017/18

- 34% take up CBTp





Supported employment



Nationally:

2016/17

- 30% people took up supported employment

2017/18

- 22% people took up supported employment
- Reduction could be due to tighter interpretation of supported employment





Family interventions

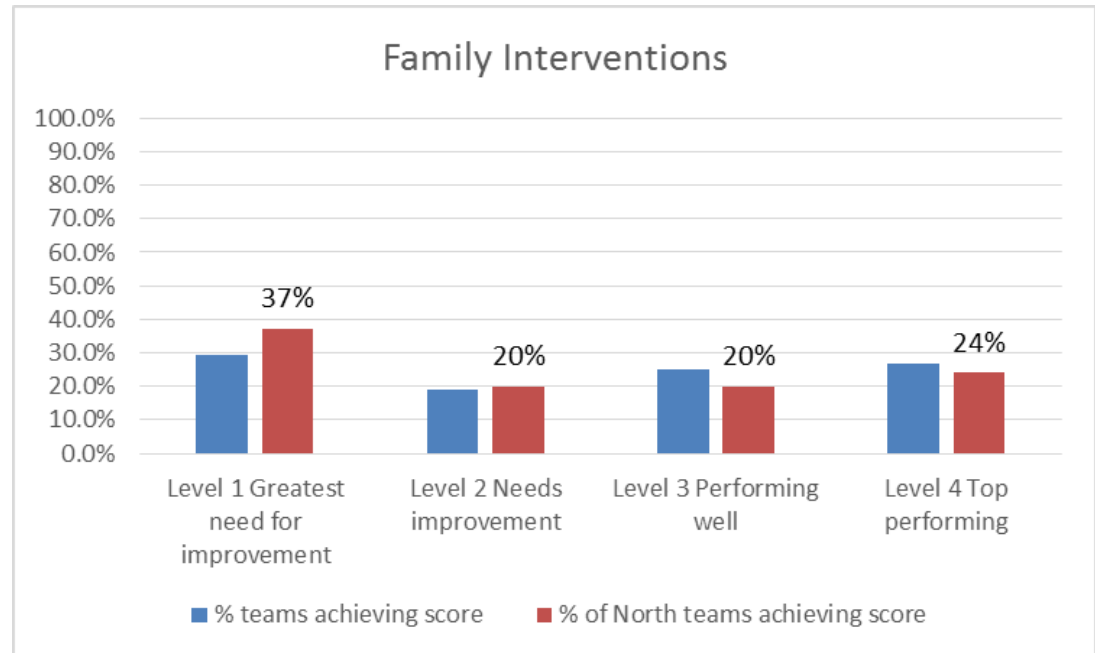
Nationally:

2016/17

- 15% took up a family intervention

2017/18

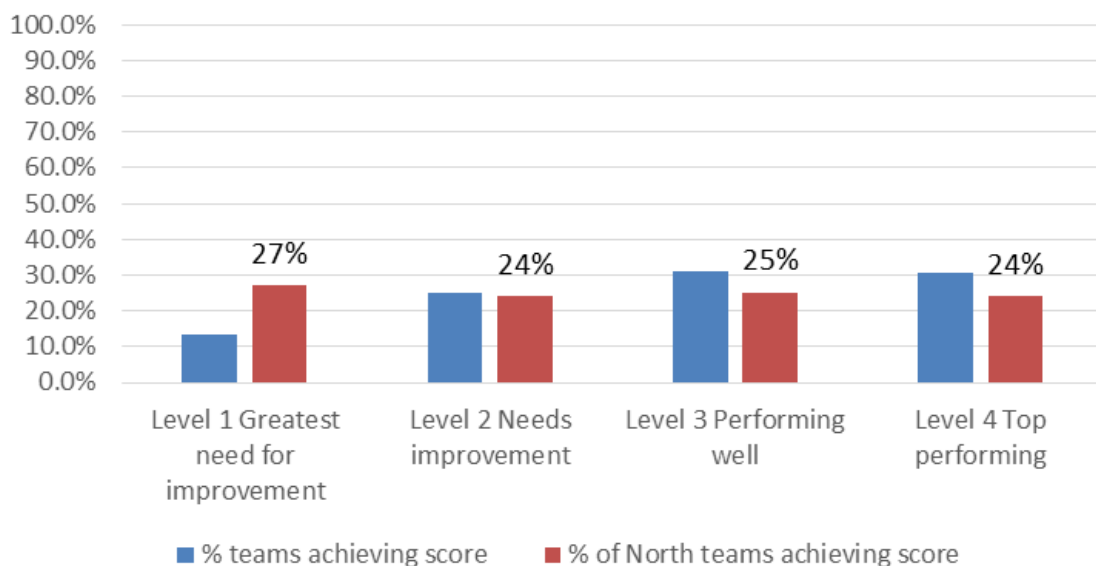
- 18% took up a family intervention





Carer support and education

Carer Support and Education



Nationally:

2016/17

- 38% people took up carer support & education

2017/18

- 51% people took up carer support & education

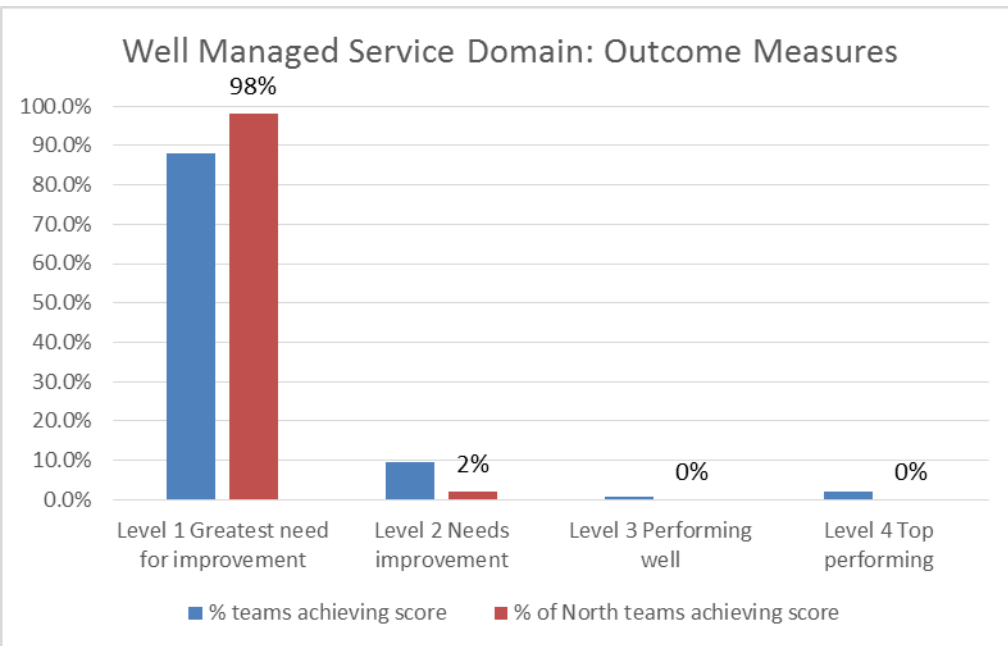
National and North region averages

The table below shows the average % of patients in each setting who received the full set of checks and follow up interventions in each year of the CQUIN scheme:

Year	National inpatient (95% CI)	North region inpatient	National community (95% CI)	North region community	National EIP	North region EIP
2014-15	38.70% (37.5% - 40.0%)	34.43% (33.05% - 37.66%)	-	-	-	-
2015-16	54.90% (53.7% - 56.2%)	58.97% (58.79% - 63.60%)	-	-	-	-
2016-17	59.40% (57.5% - 61.2%)	69.48% (66.04% - 72.79%)	42.40% (41.0% - 43.7%)	58.93% (56.33% - 61.48%)	-	-
2017-18	55.70% (53.3% - 58.1%)	61.05% (57.06% - 64.89%)	43.60% (42.2% - 45.1%)	57.19% (54.75% - 59.59%)	44.18%	61.82%

- Since 2014/15, the number of people receiving the full set of physical health checks and follow up care in inpatient mental health settings has increased.
- The rate of increase has slowed since 2016/17.
- 2016/17 was the first year in which the CQUIN scheme covered community mental health teams and nationally we have similar achievement in 2016/17 and 17/18.

Outcome measures



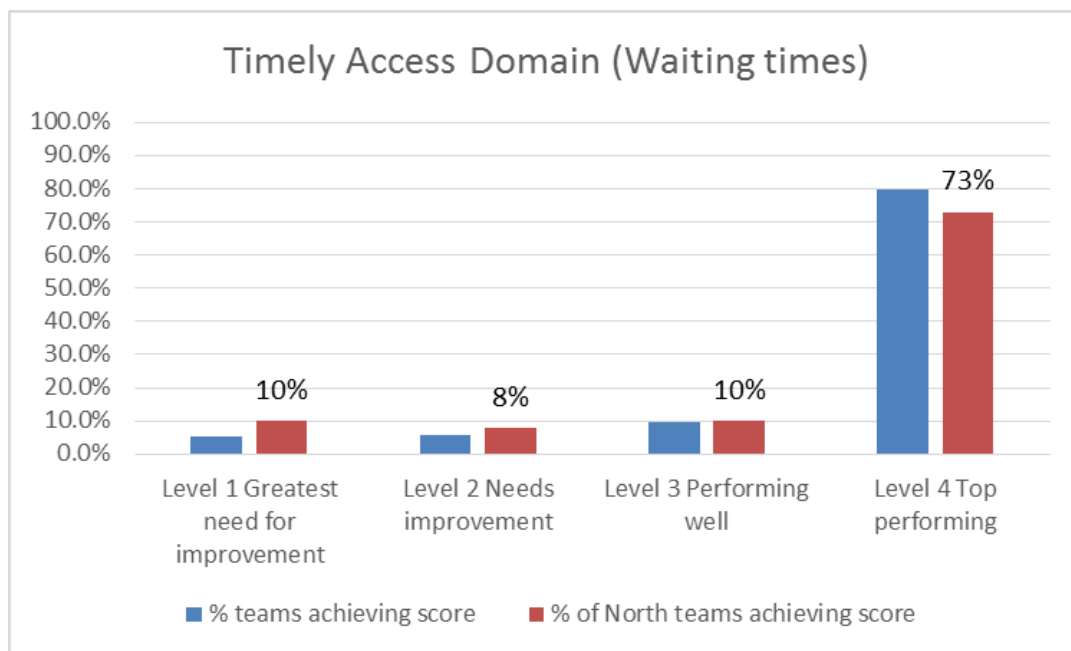
Nationally:

- Only 5.7% of service users had two outcome measures recorded twice
- Most services using HoNOS/HoNOSCa
 - 60% recorded twice or more
 - 88% recorded at least once
- DIALOG and QPR not as well used
 - 5% DIALOG recorded twice
 - 4% QPR recorded twice
 - More recorded once, suggesting implementation underway
- Data flow to MHSDS is poor





Timely access domain: waiting times



Nationally:

2016/17

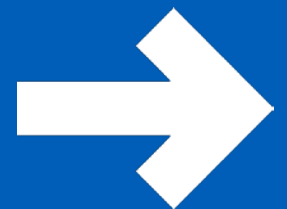
- 73% people start treatment within 2 weeks

2017/18

- 85% people start treatment within 2 weeks



Next steps: NCAP EIP spotlight audit



Clarifying self-assessment

2018/19 assessment of NICE-concordance for the EIP standard

- In 2018/19 NHS England will utilise the National Clinical Audit for Psychosis EIP spotlight audit to collect data from EIP teams on progress made against this element of the EIP standard.
- Timelines and processes for collecting and submitting data for the NCAP can be found on the Royal College of Psychiatrists' [website](#).
- All teams should have received the self assessment tools

2018/19 assessment of the *Improving physical healthcare to reduce premature mortality in people with SMI (PSMI) CQUIN*

- The National Clinical Audit for Psychosis EIP spotlight audit will also collect information related to early intervention in psychosis team's performance against the [PSMI CQUIN](#). This includes new EIP indicators for 2018/19 relating to weight gain and smoking cessation.
- Data collection for inpatient and community teams performance for the CQUIN will be collected through a separate data collection process. NHS England is currently undertaking a procurement process to find this audit partner and further information will be provided when the procurement process has been finalised.



PH SMI CQUIN 18/19

Early intervention in psychosis services – 90%:

- a completed assessment for each of the cardio-metabolic parameters with results documented in the patient's electronic care record held by the secondary care provider.
- a record of interventions offered where indicated, for patients who are identified as at risk as per the red zone of the Lester Tool.



EIP BMI outcome indicator

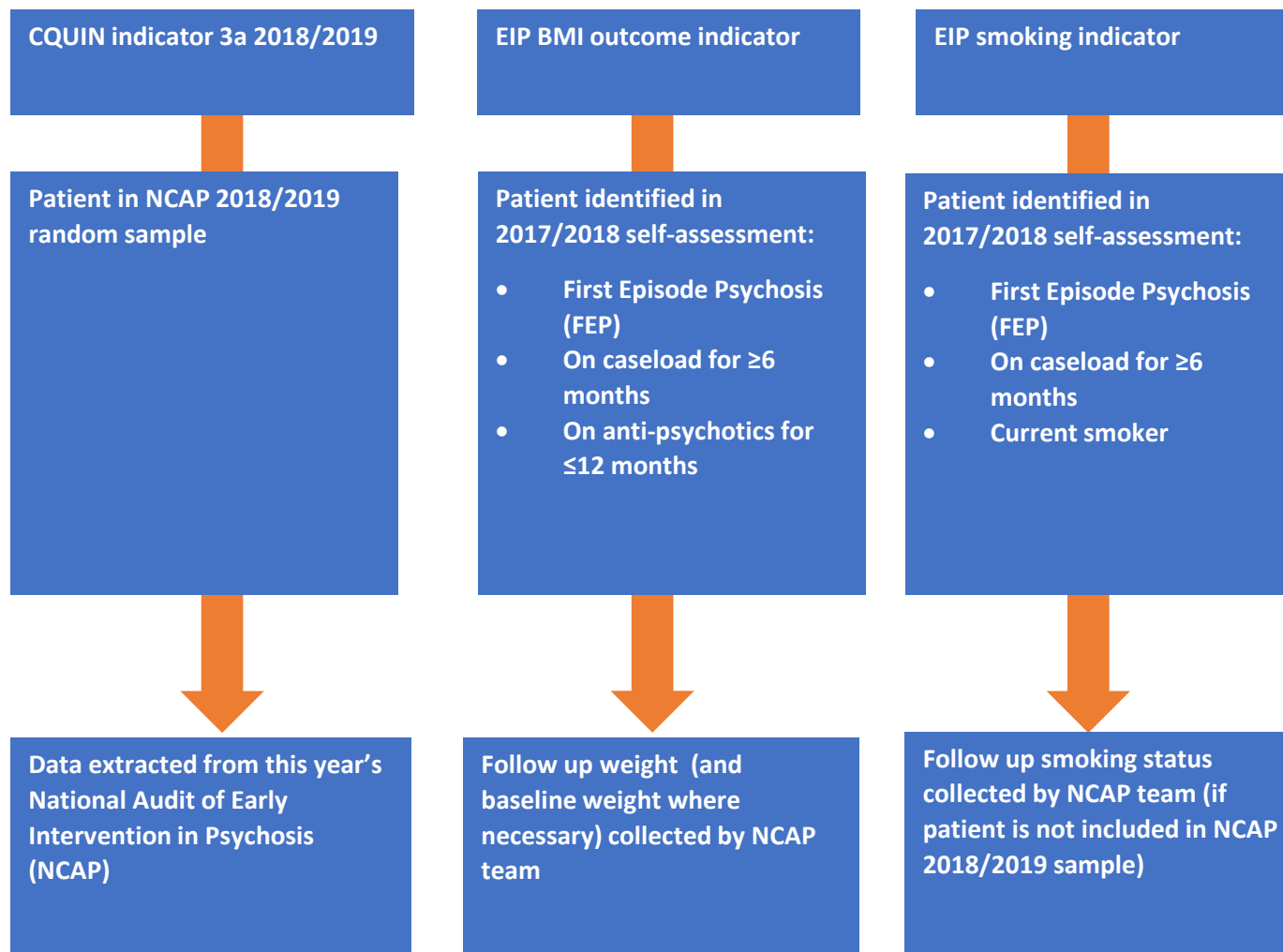
- 35% or more patients should gain no more than 7% body weight in the first year of taking antipsychotic medication.

EIP Smoking cessation outcome indicator

- 10% or more patients who were previously identified as in the Red Zone for smoking on the Lester Tool should have stopped smoking.



CQUIN 3a. Improving physical healthcare to reduce premature mortality in people with SMI: Cardio metabolic assessment and treatment





Data collection going forward

Can we eliminate the need for case note audits?

2018/19:

- NCAP spotlight audit
- comparison of SNOMED vs audit results fed back to teams via EIP triangulation tool

2019/20

- Aim to have switched over to MHSDS for RTT monitoring
- NCAP spotlight audit continues with a formal test of reliability of the MHSDS for use in future clinical audits
- Service user and carer surveys commences



Next steps: national programme





National focus going forward

- Consistent provision: CYP, over 35s and ARMS
- Understanding length of stay on caseload
- Continuing to improve the quality of care
 - Family Intervention
 - Physical health
 - Outcomes measures
- Going further to improve access
 - Waiting time target increasing to 60% by 2020/21
 - Working with commissioners to ensure continued funding of NICE recommended care package and improvements in line with the implementation plan
 - Accountability for delivering quality care

❑ Analyse and disseminate data

New EIP triangulation tool to support service improvement

❑ Mental Health Investment Standard

NHSE will hold CCGs to account on meeting the MHIS to ensure the deliverables outlined in [Refreshing NHS Plans for 2018/19](#) are achieved including EIP provision

❑ Improving physical healthcare programme: PH SMI CQUIN

The PH SMI CQUIN incentivises comprehensive cardio metabolic assessment and interventions with a focus on smoking cessation and weight management outcomes in EIP services. NHSE is working in partnership with clinical networks and NHSI to drive quality improvement.

❑ Investment in employment programmes

NHSE is investing to double access to Individual Placement and Support (IPS) by 2020/21.

❑ Workforce development

NHSE is working with HEE to make further investment in CBTp and FI courses for EIP staff in 2018/19 academic year.

❑ IST whole system reviews

IST will work with EIP services in 2018/19 to provide intensive support for services not yet at level 2 standard by providing whole system reviews and master classes. IST will work with regions to prioritise teams.

❑ Outcomes work stream

NHSE is to launch a working group including IST and EIP clinical lead membership to lead improvement in the recording of outcomes and flow of data to MHSDS. Monitoring will be facilitated through regular reports on the flow of outcomes data.

❑ ARMS and over 35s best practice cases

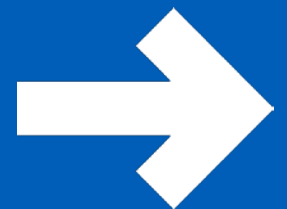
In response to feedback to services NHSE is compiling best practice cases to support services in implementing ARMS and over 35s care.

❑ SNoMED guidance and data workshops

NHSE has worked with NCCMH to publish guidance for EIP services on flowing data to MHSDS. IST will run regional workshops on implementing this guidance, with a particular focus on outcomes recording, and continue to provide support to improve the quality of MHSDS RTT data.



Psychological therapies for SMI programme update





Workforce development: Psychological therapies for people with SMI

- For EIP services: in 18/19 £2.9m will be made available for workforce training to continue a number of CBTp courses.
- Following review of STP workforce development plans, working with HEE regional teams to commission courses to ensure local need is met, and quality monitored.
- Part of broader programme to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
- For beyond 18/19, Expert Advisory Group convened to establish plans and investment strategy for 19/20-20/21.
- Overall goal to develop and equip workforce to deliver evidence-based packages of care to support recovery for people with psychosis, bipolar disorder and personality disorder.

Emerging picture of demand for CBTp and FI for 2018/19-20

Region	Course	Number of places
London	CBTp workshop	0
	CBTp supervisor	0
	CBTP top up	20
	CBTP PGDip	40
	FI	60
	FI supervisor	0
North	CBTp workshop	22
	CBTp supervisor	23
	CBTP top up	12
	CBTP PGDip	26
	FI	50
	FI supervisor	20
Mids and East	CBTp workshop	72
	CBTp supervisor	21
	CBTP top up	24
	CBTP PGDip	15
	FI	80
	FI supervisor	15
South	CBTp workshop	36
	CBTp supervisor	36
	CBTP top up	42
	CBTP PGDip	35
	FI	49
	FI supervisor	0

Region	18/19 planned spend	19/20 planned spend
North	£ 538,156	£ 407,500
Midlands & East	£ 254,516	£ 328,925
South	£ 259,240	£ 290,882
London	£ 110,773	£ 270,067
Total	£ 1,162,685	£ 1,297,374





Individual Placement and Support (IPS)



KEY

- | | | | | | |
|----|--|----|---------------------------------------|----|---|
| 1 | Northumberland, Tyne and Wear | 15 | Leicester, Leicestershire and Rutland | 30 | South East London |
| 2 | West, North and East Cumbria | 16 | The Black Country | 31 | South West London |
| 3 | Durham, Darlington, Tees, Hambleton, Richmondshire and Whitley | 17 | Birmingham and Solihull | 32 | Kent and Medway |
| 4 | Lancashire and South Cumbria | 18 | Coventry and Warwickshire | 33 | Sussex and East Surrey |
| 5 | West Yorkshire | 19 | Herefordshire and Worcestershire | 34 | Frimley Health |
| 6 | Coast, Humber and Vale | 20 | Northamptonshire | 35 | Surrey Heartlands |
| 7 | Greater Manchester | 21 | Cambridgeshire and Peterborough | 36 | Cornwall and the Isles of Scilly |
| 8 | Cheshire and Merseyside | 22 | Norfolk and Waveney | 37 | Devon |
| 9 | South Yorkshire and Bassetlaw | 23 | Suffolk and North East Essex | 38 | Somerset |
| 10 | Staffordshire | 24 | Milton Keynes, Bedfordshire and Luton | 39 | Bristol, North Somerset and South Gloucestershire |
| 11 | Shropshire and Telford and Wrekin | 25 | Hertfordshire and West Essex | 40 | Bath, Swindon and Wiltshire |
| 12 | Derbyshire | 26 | Mid and South Essex | 41 | Dorset |
| 13 | Lincolnshire | 27 | North West London | 42 | Hampshire and the Isle of Wight |
| 14 | Nottinghamshire | 28 | North Central London | 43 | Gloucestershire |
| | | 29 | North East London | 44 | Buckinghamshire, Oxfordshire and Berkshire West |

21 STPs awarded Wave 1 NHS England transformation funding



IPS support initiative – Phase 1

- In order to support the growth of high quality IPS services, the Joint Work and Health Unit funded the ‘discovery phase’ of an initiative in 2017/18. Led by Social Finance and a consortium of IPS experts, they developed materials and a website:
 - For service delivery;
 - For service users;
 - For commissioners;
 - For prospective IPS staff
- The initiative is known as ‘IPS Grow’, and the outputs of this programme can be found under <http://ipsgrow.org.uk/>.





IPS support initiative – Phase 2

- In order to ensure that more people in the UK are able to **achieve job outcomes through the growth of consistently high quality IPS services**, NHS England and the Joint Work and Health Unit intend to invest in a comprehensive support programme in 2018/19 and beyond.
- The support offer will include 3 different areas of activity:
 1. **Hands-on implementation support** from a network of IPS experts;
 2. A **workforce development programme** to support recruitment and training of IPS staff;
 3. Developing, cascading and embedding **tools to facilitate effective reporting, monitoring and evaluation** the support provided by IPS services.
- This programme of work is currently undergoing national procurement processes.





Wave 2 funding (2019/20 – 2020/21)

- NHS England allocation of Wave 2 will hopefully commence later this year and will be open to areas to set up new IPS teams in STP geographies with limited or no provision.
- Areas interested in applying for Wave 2 should begin thinking in STP areas about preparatory work to support IPS service delivery.
- Timelines on this process to be confirmed ASAP.



Wave 2 process – Proposal

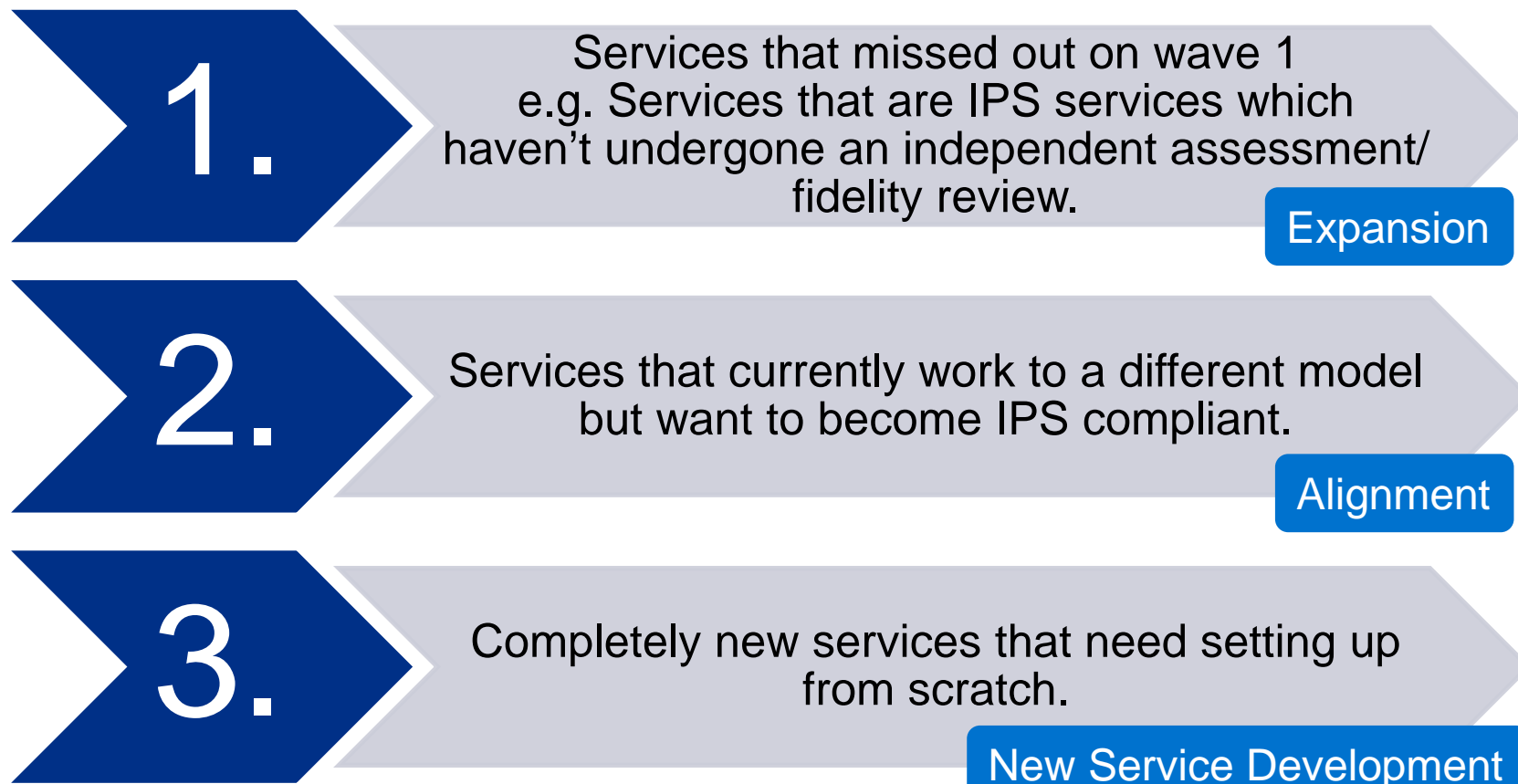
1. In order to better manage demand, we will request **invitations of interest** up front, to help us manage funding. The expression of interest will be requested in the autumn and we will allow areas time to return an initial proposal form to us outlining:

- Current service provision and set up;
- Fidelity review and scores plus dates of reviews;
- Outline of initial plans for expansion;
- Numbers seen at present;
- Accurate estimates of numbers to be seen;
- Rough estimate of costs required

2. This would be followed by a second part to the proposal (likely in January again), which would ask for responses, similar to Wave 1, covering:

- Approach to reducing inequalities;
 - Approach to coproduction;
 - Plan for workforce development;
- Systems for monitoring on activity and outcomes;
 - Plans for sustainability of the services.

Wave 2 process – Proposal (2)





EIPN
EARLY INTERVENTION IN
PSYCHOSIS NETWORK



- A quality improvement network for UK EIP services
- Build on your self-assessment results
- Offering accreditation reviews from June
- EIPN standards on our website (currently being revised)

www.rcpsych.ac.uk/eipn

EIPN@rcpsych.ac.uk

0203 701 2702

Thank you

amy.clark10@nhs.net jaynairn@nhs.net



EIP Triangulation Tool

Carl Money

27th September 2018

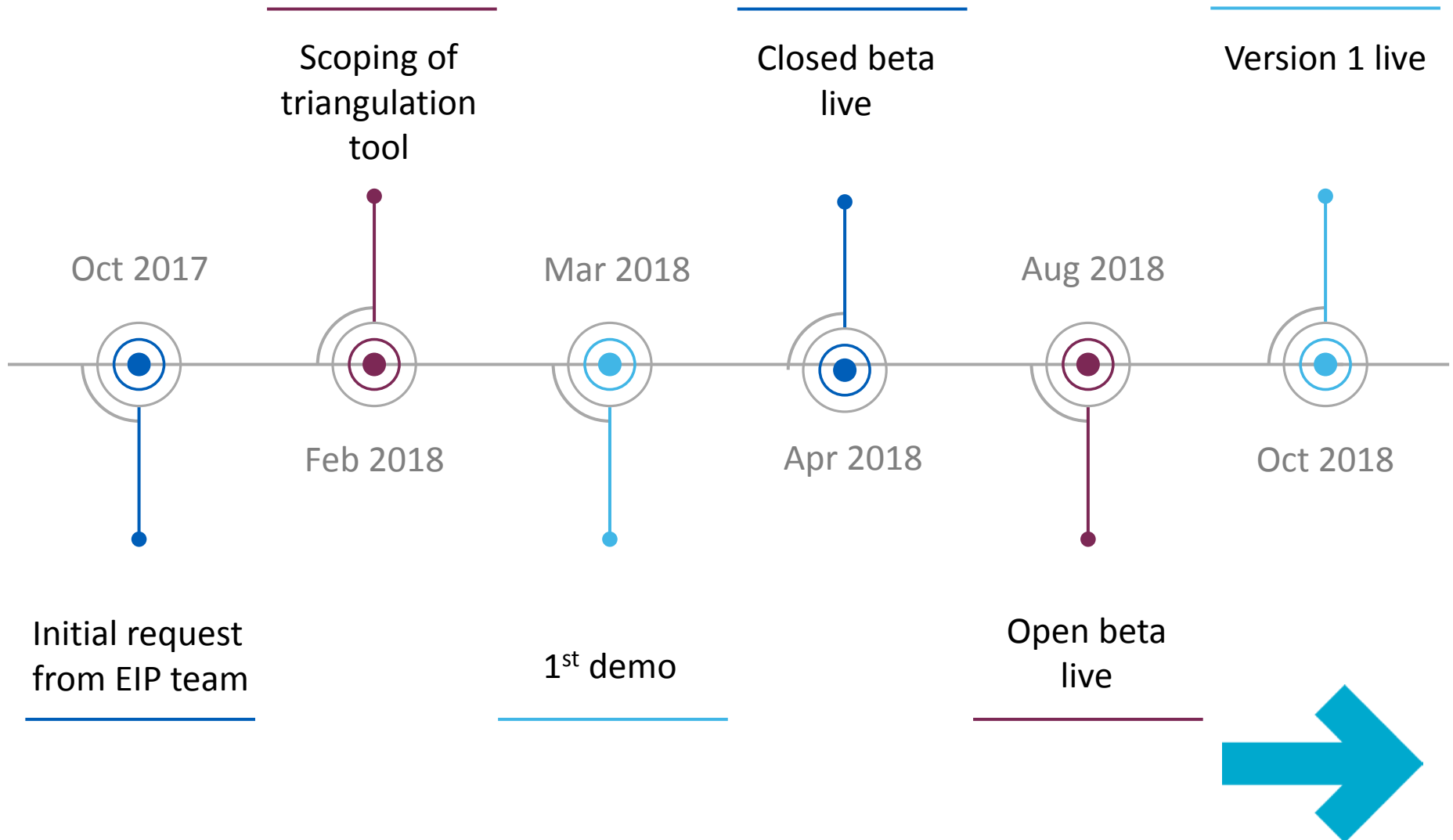


Overview

- Progress to date
- Demo
- Future developments
- Getting access



Progress to date



Demo

- Go to Tableau



Future Developments

- Number of ‘bugs’ fixed
 - No longer need N3/HSCN connection
 - No longer need nhs.net email
 - Automated routine data
- But still currently hosted on NCDR reporting platform
 - Managing sign up ourselves
 - Moving to FutureNHS Collaboration Platform ASAP
- Add new data and functionality iteratively
 - Collab. Platform will have a forum for this
 - Associated documentation



Getting Access

- Interim
 - Email england.mhanalytics@nhs.net
- Longer Term
 - Request access through the Collaboration Platform
 - All users registered to the NCDR portal will be automatically registered with the Collaboration Platform

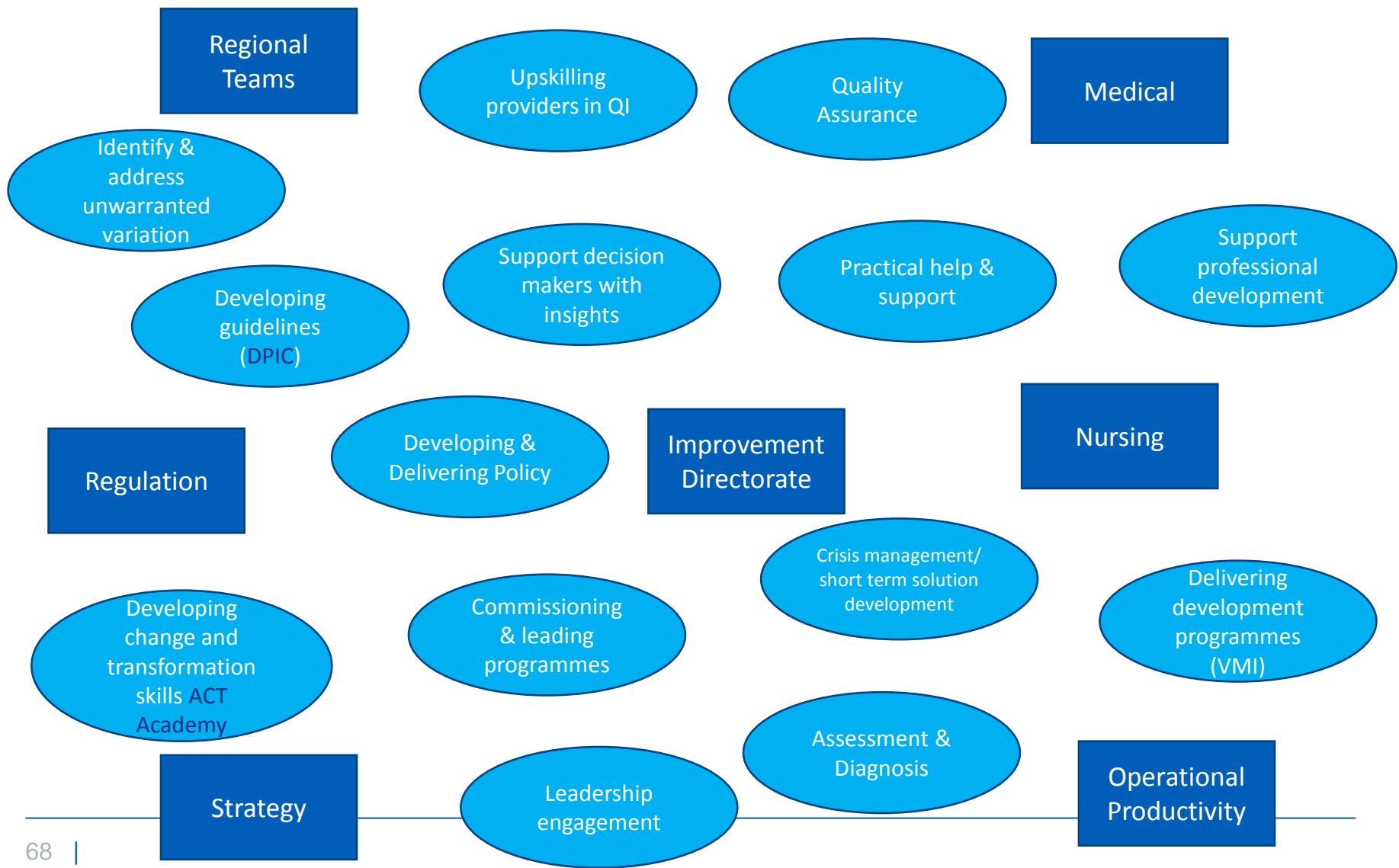


EIP Services Improvement Journey

Sarah Butt 27th September 2018

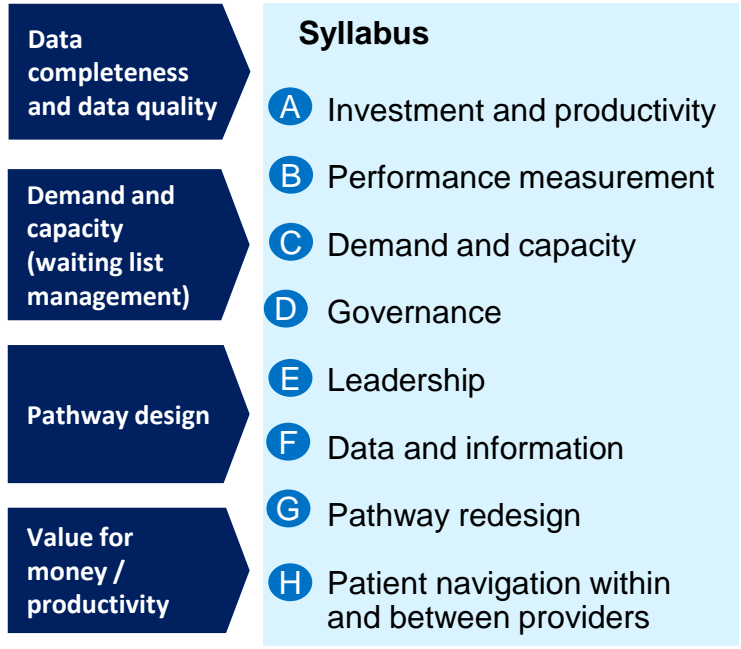


“Improvement“ at NHS Improvement



Mental Health IST offer 2018/19

- Part of NHS Improvement working closely with NHS England
- A free resource to NHS organisations
- Work with local health communities that are facing particular challenges in delivery of national standards within the context of the 5YFV MH.



Individual system support

- **Diagnostic reviews** using relevant IST methodology and tools to deliver recommendations
- **Guide system leaders** on capacity and capability to deliver local recovery plans and agree support mechanisms NHSE/NHSI
- A range of **short interventions** to progress particular challenges
- Training, coaching to build skills knowledge and confidence of senior managers and clinicians
- Provide guidance and support on best practice for leadership, engagement and ownership.

- ### Working to Priority Lists:
- Services not meeting the waiting standard
 - Services of concern in CCQI
 - Local intelligence within clinical networks
 - Discussion with regional/national teams to agree which systems, and how many, are supported.

How IST will deliver support offer

National:

- To contribute to assurance processes as necessary.
- Tools; 'How to' guidance to be published on NHS Improvement Hub.

Regional:

- Master classes / workshops on capacity & demand and waiting list management through Strategic Clinical Networks (SCN's).

Individual Systems:

We work with

- Deliver system wide reviews to individual organisations and commissioners through data collection and diagnostic review.
- Focus to be on Investment and Productivity; Referrals, Access and Waits; Pathways & Flow; Physical Health Checks; IPS; Staffing, Leadership and Management; Improving reporting including interventions (via SNOMED) and outcomes.
- Offer post review support packages based on outcomes and recommendations of review.
- Moving from Unify to SDCS - continue with data support for individual providers that continue to have variations between local and national data.

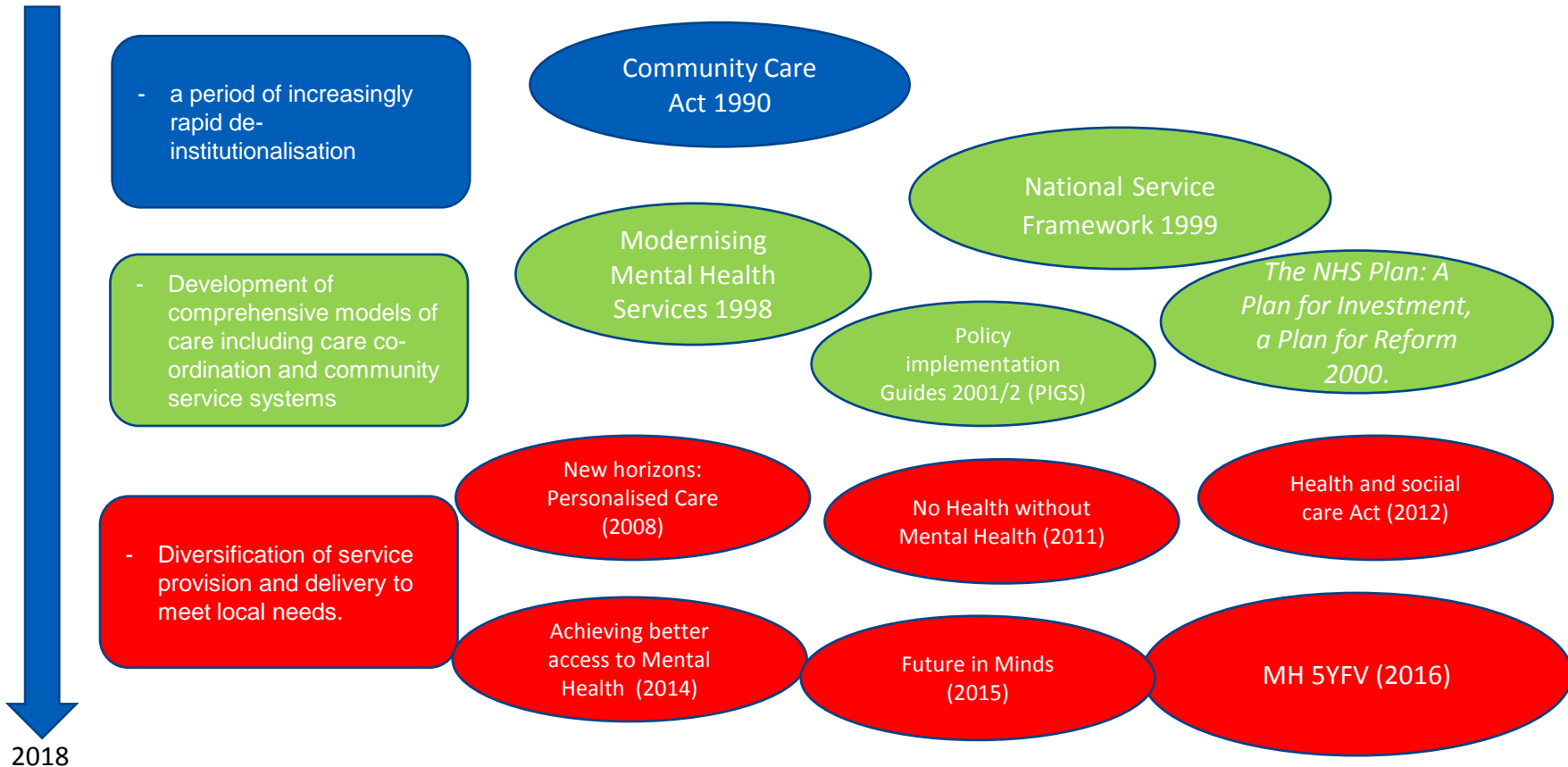
Lets take a step back in time.....



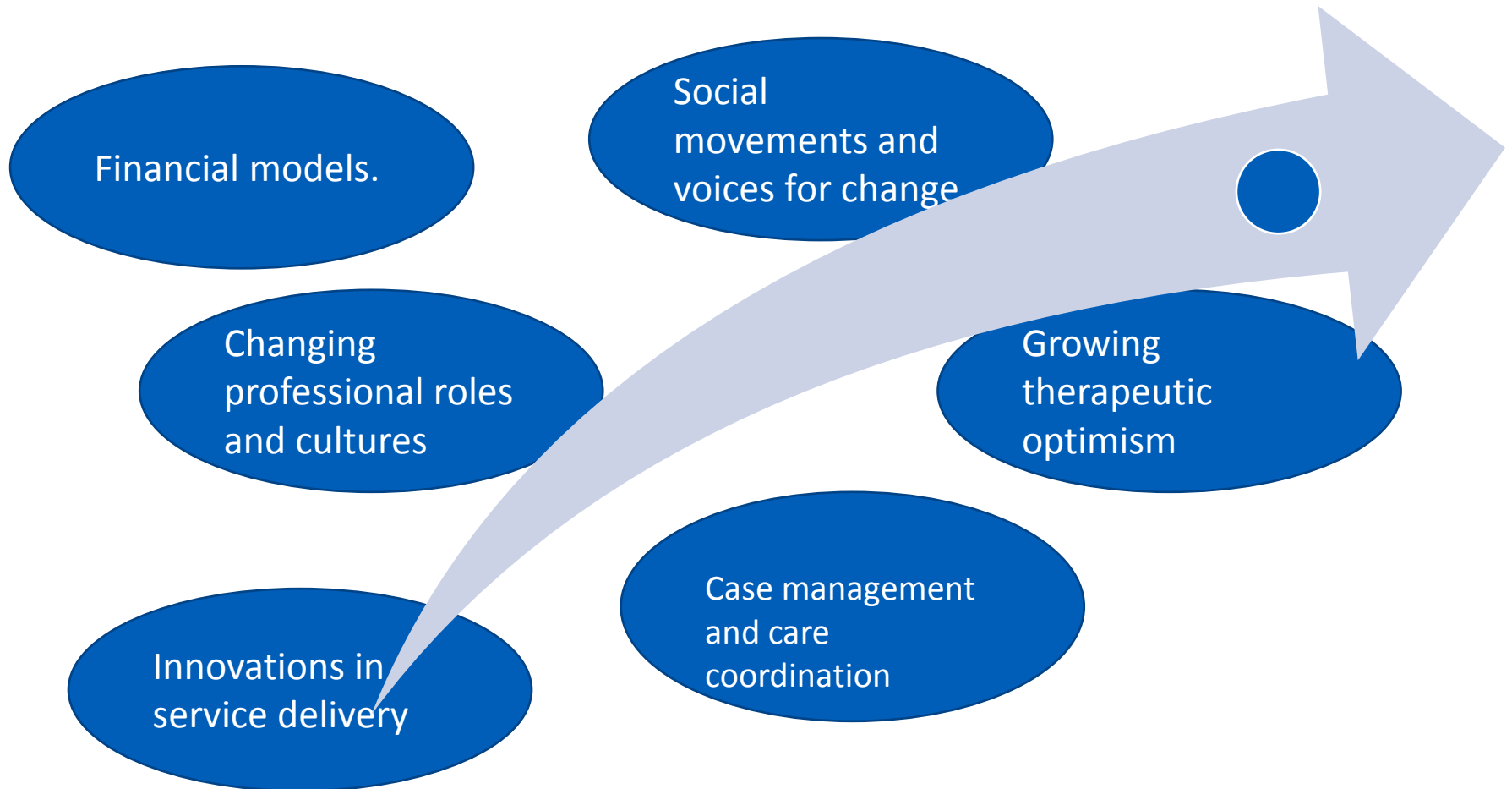
A Walk through time...

- Mental health services have gone through radical change of the past 30 years. From bed based long term care being replaced where care is mostly delivered in community settings. There were three distinct phases to transformation:

1980's



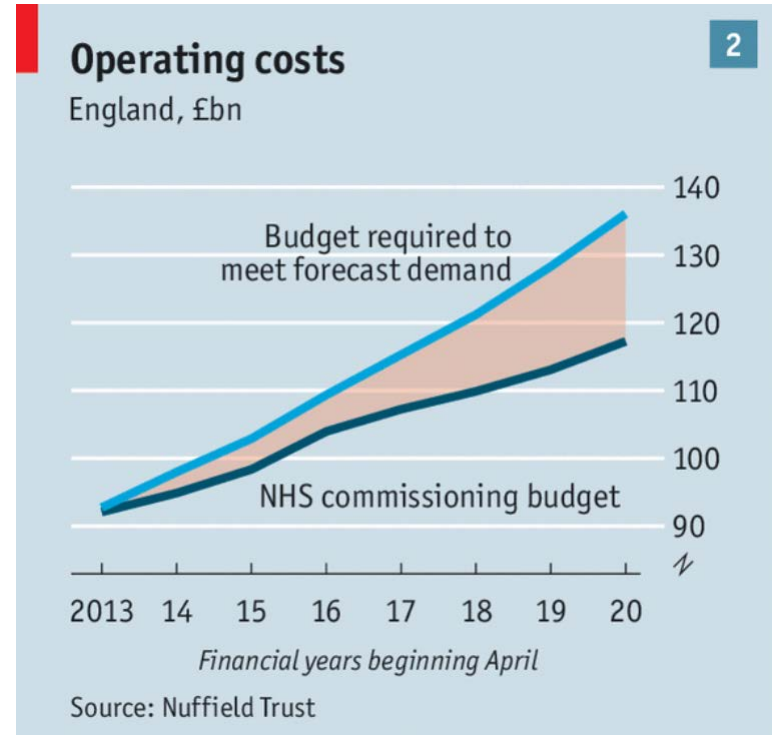
Drivers for change



Fast forward.....



Why do we need to improve?

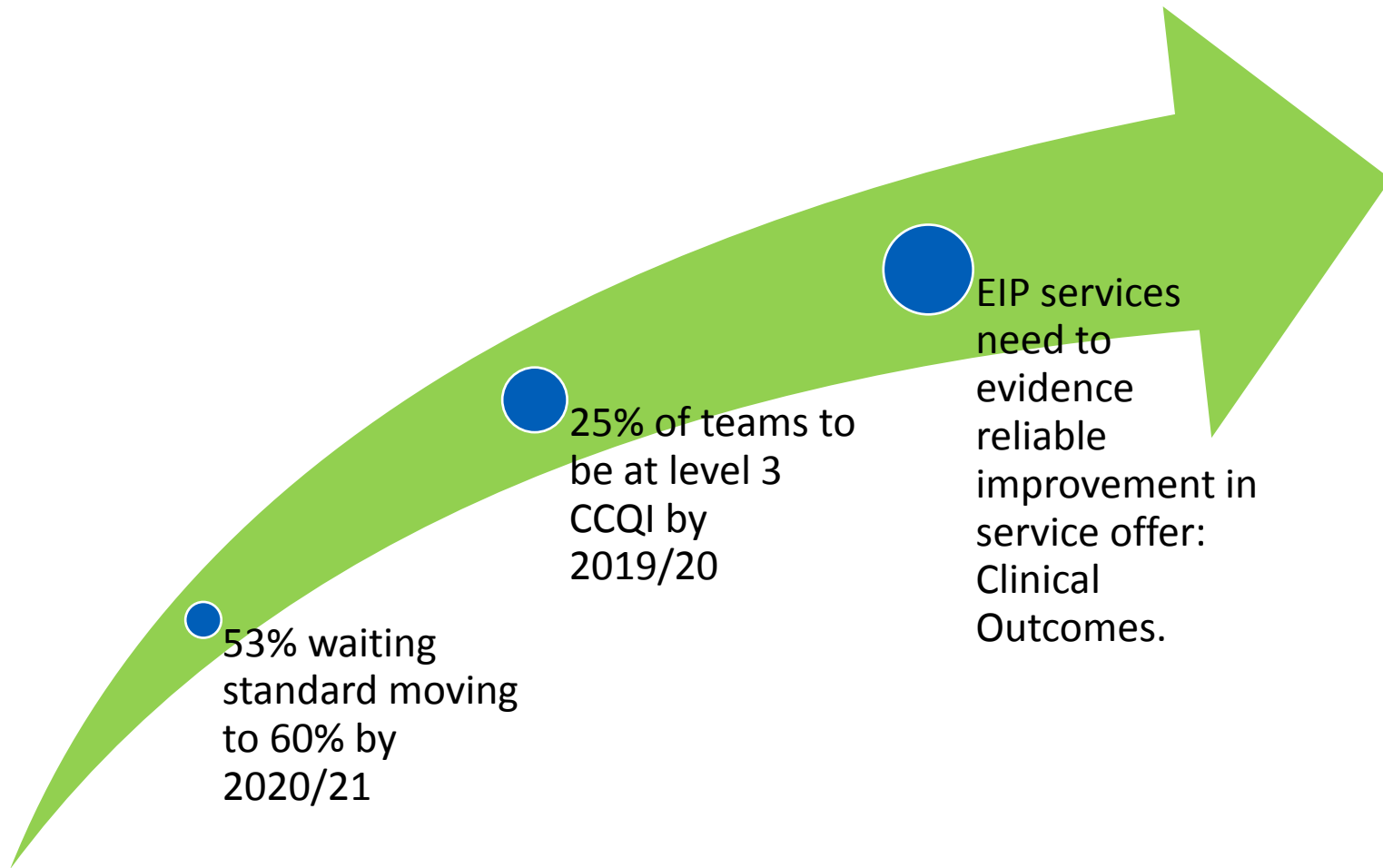


UNSUSTAINABLE

Why improvement in mental Health Systems?

- Quality improvement approaches have been well established in Acute hospitals for some time and play a key role in improving Quality of care (Kings Fund 2017).
- Achieving parity of esteem for people with mental health needs is one of the NHS's core priorities and is written into the Health and Social Care Act. For too long, mental health has languished behind physical health in terms of priority and investment, and people have not received the high-quality support they need.
- *“The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services”*: Five Year forward View for Mental Health
- Unwarranted Variance in access, quality and delivery and performance: The Five Year Forward View for Mental Health calls for a fresh mindset and seeks strong leadership to tackle unwarranted variation in mental healthcare quality and outcomes

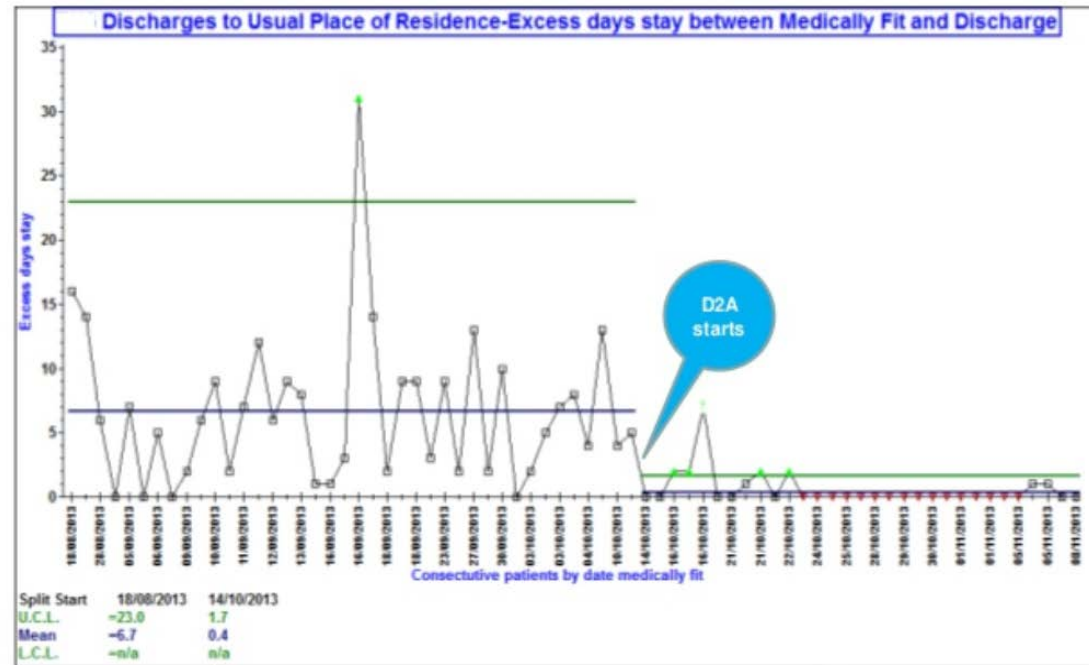
EIP in the context of improvement





How do we improve?

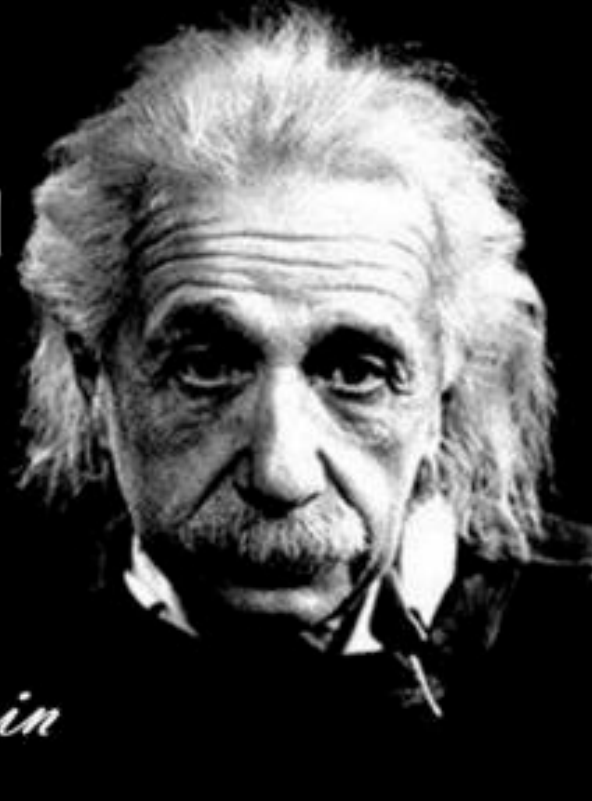
'Every system is perfectly designed to achieve the results it achieves... We must be clear about stressing the current system (relying on more of the same) and introducing a wholly new system. The former butts without much effect against the walls of historic performance: the latter leaps over them' (Berwick, 1996)



Reduction of 6 days waiting on implementing D2A



WE CANNOT SOLVE
OUR PROBLEMS WITH
THE SAME THINKING
WE USED WHEN
WE CREATED THEM



~ Albert Einstein

Improvement Science

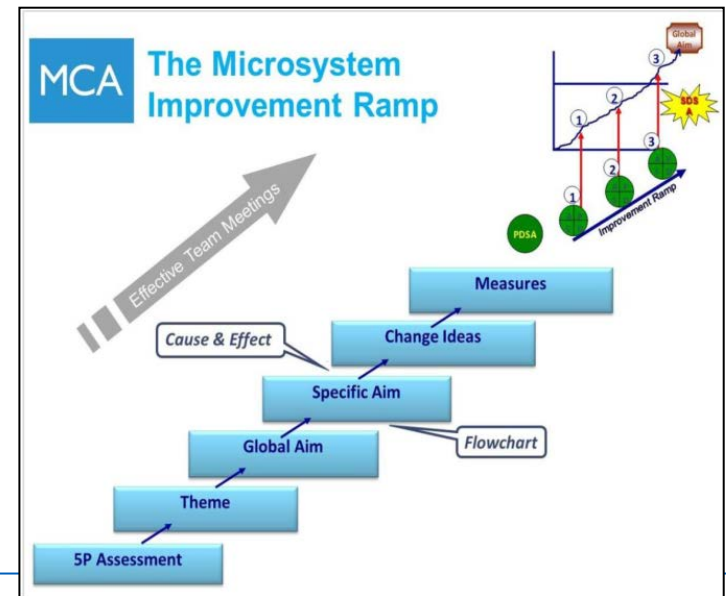
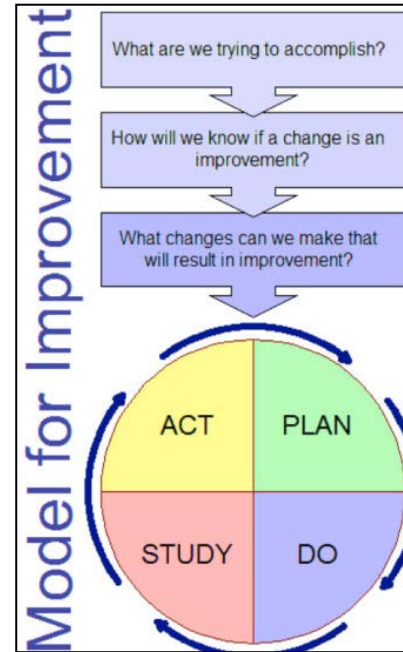
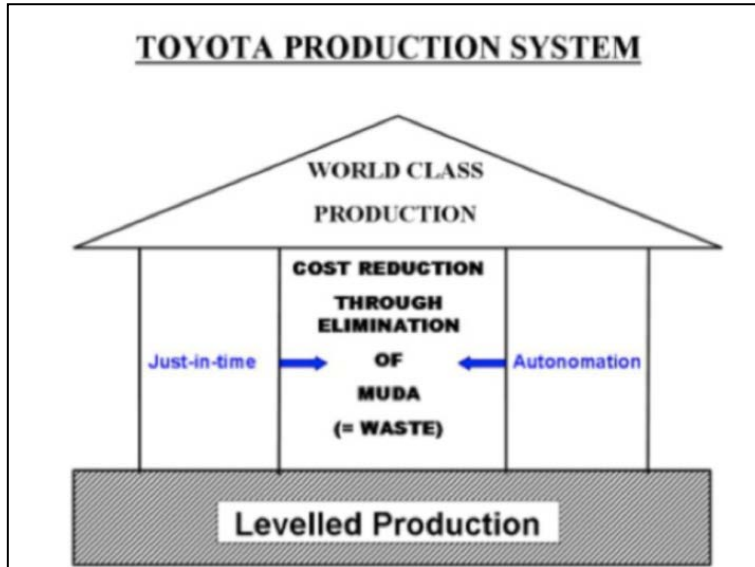


A definition of the Science of Improvement:

The science of improvement includes the interaction of systems thinking, understanding variation psychology of change, and the theory of knowledge that are applied to improve the performance of processes, products services, organisations and communities. The proper application of this science requires the integration of a set of improvement methods and tools with knowledge of subject matter to develop, test, implement, and spread changes

Associates of Process Improvement

Lots of effective models





The Model for Improvement



The model for improvement asks three simple questions that guide our improvement work.

What are we trying to accomplish?

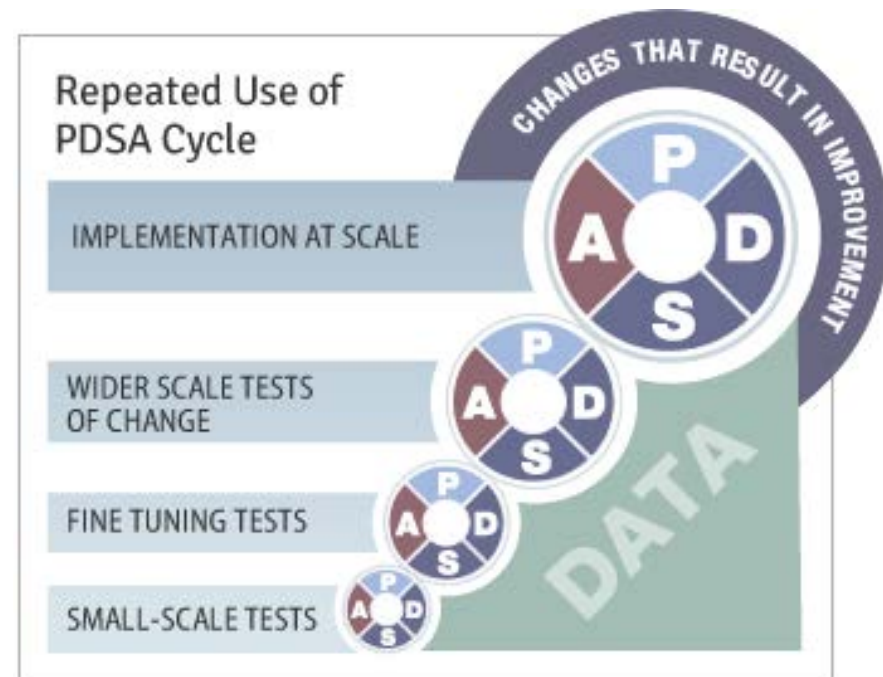
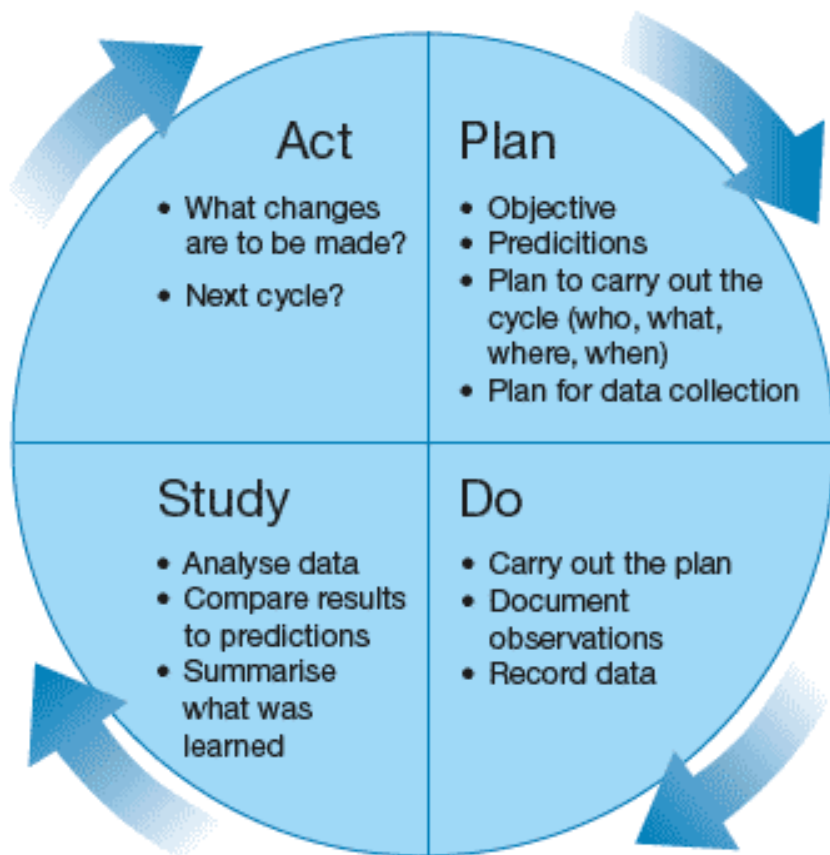
How will we know that our change is an improvement?

What changes can we make that will result in the improvement we seek?

Langley GL, Nolan KM, Nolan TW, Norman CL, Provost LP. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd edition). San Francisco: Jossey-Bass Publishers; 2009

The 'how' – don't over plan or write long term 'strategies

Trial and learning approach using PDSA





Clinical outcomes, measurement and improvement

- The Five Year Forward View for Mental Health outlines the vision for a comprehensive set of evidence-based treatment pathways in place by 2020/21.
- A framework approach is proposed to allow local areas to tailor quality and outcomes measures so they are relevant to individuals, clinicians and match the needs of the service in terms of timeliness, benchmarking and use as an improvement tool
- The Early Intervention in Psychosis (EIP) expert reference group has recommended three outcome tools to be used in EIP services, namely Health of the Nation Outcome Scales (HoNOS), Process of Recovery Questionnaire (QPR) and DIALOG.

Clinical outcomes and measurement

What and Why?

An analysis of outcomes data in the MHSDS for EIP teams showed 15% of cases where there were more than 2 contacts had paired outcome scores recorded. 94% of these are HoNOS, with the collection and reporting of DIALOG and QPR being much lower.

We want to identify and find solutions to the problems with collecting and reporting of outcomes, and in particular PROMS.

Where are we now?

- The EIP Access and Waiting time standard specified HONoS and DIALOG and QPR to be collected as minimum
- The national clinical audit on psychosis is increasing the focus on outcomes. National focus on outcomes from NHS England will need to link with this work
- The Intensive Support Team are supporting providers to improve data flow to the MHSDS
- ICHOM are working on a standard set of outcome measures for psychotic disorders
- NHS England is setting up a working group to identify barriers to the collection of outcomes in EIP services.

Where do we want to be?

Understanding of the issues with outcome collection

- Clinical buy-in (use in clinical decision making)
- Use in management of services
- Reporting to the MHSDS

Each problem presents different solutions, so once we understand what the barriers are, different solutions can be developed to address them.

Some general issues are

- Lack of understanding
- Administration of the outcome measures
- Data flow
- Measuring clinically meaningful change
- Time it takes



Why use clinical outcomes?

- Routine outcome measurement reported at the service level enables decision making around funding of services, particularly at a government level where health resources are limited and need to be distributed to achieve the best outcomes.
- Essential as a component of ongoing service-level quality improvement. Importantly, routine outcome measurement improves clinical practice when it is part of a feedback monitoring system for clinicians
- When mental health measures are regularly provided to the clinician they can inform clinical decision making and enable the clinician to adjust treatment planning accordingly.
- Feedback has been shown to increase accuracy of diagnosis, improve communication between client and clinician, enhance treatment monitoring, and help clients maintain positive effects for longer periods.
- The routine use of clinical outcomes allows measurement of improvement or deterioration. For clients who are not improving or who are deteriorating during therapy, feedback systems can help improve outcomes.
- To be useful, mental health outcome measures must be valid and reliable, sensitive to change, comparable across relevant client groups and service types, and meaningful to both clients and clinicians.

Barriers to improvement

Barriers to improvement

Lack of understanding about what an outcome is, and its use in clinical practice, at all levels of the system.

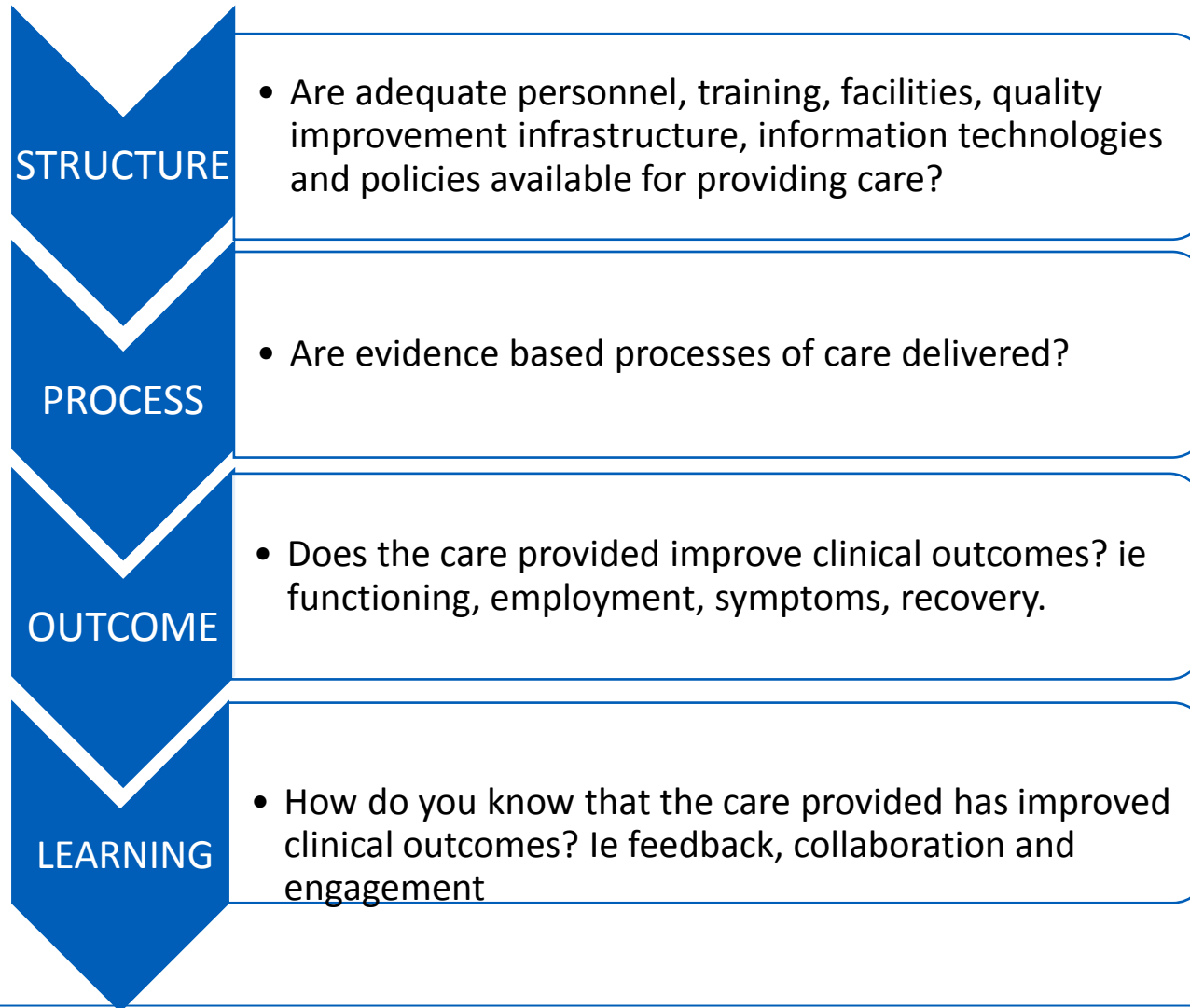
Administering outcomes

There is a lack of training in how and when to administer an outcome tool with a patient, what outcome measure to use and how this can be collected

Data Flow

Measuring clinically meaningful change

System Perspective of Healthcare Quality: Key questions?



Principles to underpin an outcomes based framework

1. Are the outcome measures defined by what the person using the service wants to achieve? (PROMS)
2. Is the outcome based framework supported by appropriately-trained clinicians with access to sufficient time and resources, able to effect change within their care settings?
3. Is there an agreed set of realistic objectives for, all organisations involved in delivering the care pathway?
4. Is the service backed by appropriate infrastructure – IT systems that facilitates work at a clinical level up to national data sharing, eg digital enablement or appropriately skilled support staff, to facilitate the collection and analysis of data?
5. Driven by good leadership – that facilitates and mandates the roll-out and best quality use of data.
6. Is the framework underpinned by relevant quality improvement methodology to ensure continuous feedback and effective roll-out and use of measure(s)?

Principles to underpin good data quality

1. Are Clinicians recording interventions and outcomes electronically in or close to real time?
2. Do Clinicians receive timely feedback on data quality issues?
3. Do Clinicians use clustering consistently?
4. The provider analyst team is adequately resourced and suitably skilled?
5. Do analysts (CCG/CSU and provider) use and share national data on the service?
6. The Board are sighted on national performance data (not just local data)
7. Does the provider have a well documented process for uploading data which is understood by more than one member of staff?
8. Is Data signed off by service leads before being uploaded?
9. Are NHS Digital data checking and validation reports are understood and used; data errors are corrected by those responsible for entering the data?
10. Do Services have a plan to develop/improve SNOMED recording and reporting?



Over to you.....

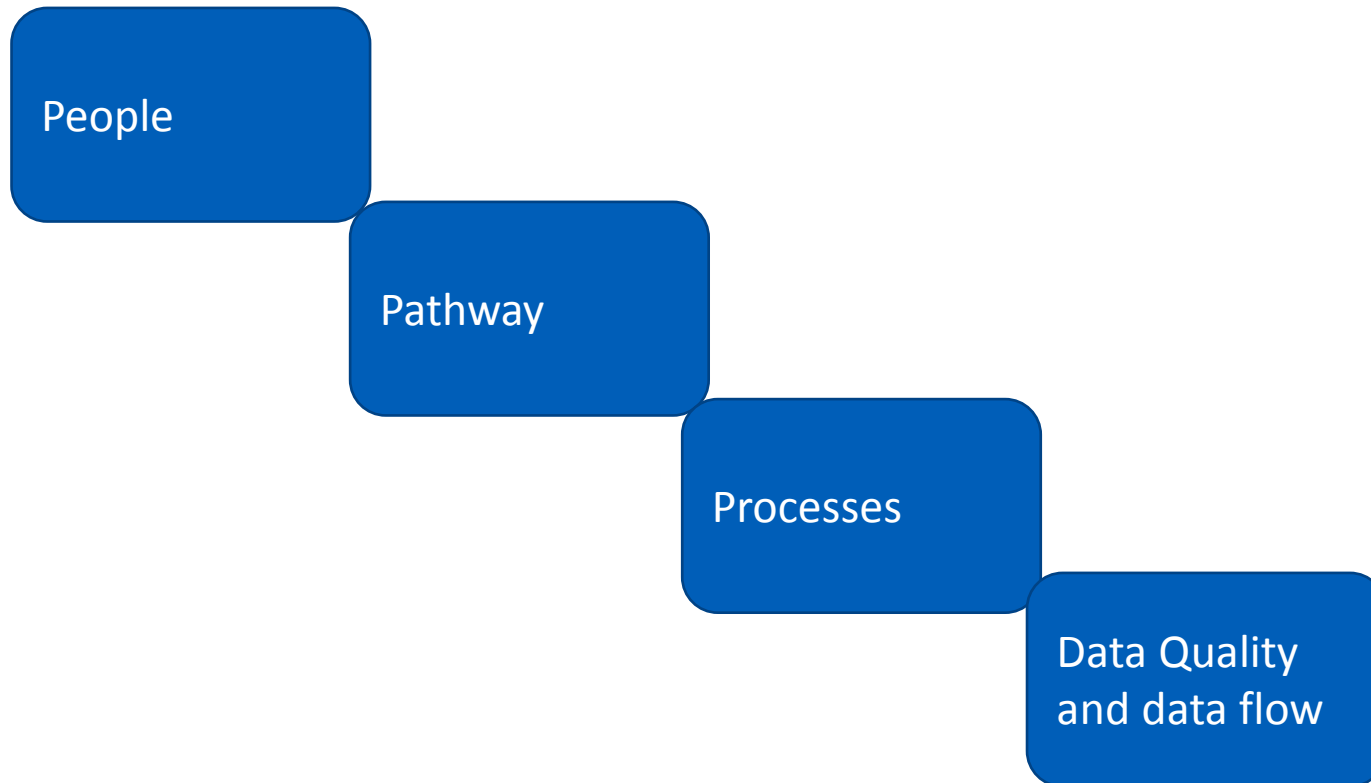


Here is Edward Bear, coming downstairs now, bump, bump, bump, on the back of his head behind Christopher Robin. It is, as far as he knows, the only way of coming downstairs, but sometimes he feels that there really is another way, if only he could stop bumping for a moment and think about it.

Table top exercise

- Take time out to think of where your service is now and where it needs to be, to be able to demonstrate measurement of service user outcomes.

Using the principles of the improvement model, think about improvement in terms of:



Patient Story Ted Talk video

Eleanor Longden – The voices in my head

12:30 – 12:45

[Link](#)



Lunch

Eleanor Longden – by video
12:45 – 13:30



Afternoon workshop A

ARMs Service – Paul French (main room)

13:30 – 14:10



At Risk Mental State for Psychosis

Paul French

Associate Director GMW

Mental Health Clinical Lead, GMLEC SCN

Early Intervention in Psychosis

Clinical Lead NW NHS England (North)

Professor Liverpool University

Paul.french@gmw.nhs.uk

[@pfrench123](#)

Structure of talk

- History / Rationale
- What does the AWT Standard mean for ARMS services
- Future directions
- Discussion – real world implementation

Aims of EI services

1. Prevent psychosis in the ultra high risk individuals

- *identify and intervene on cusp of psychosis*

2. Reduce DUP (Duration of Untreated Psychosis):

- *promote early detection & engagement by community agencies*
- *Comprehensive initial mental health assessments & diagnosis*

3. Optimise initial experience of acute care & treatment:

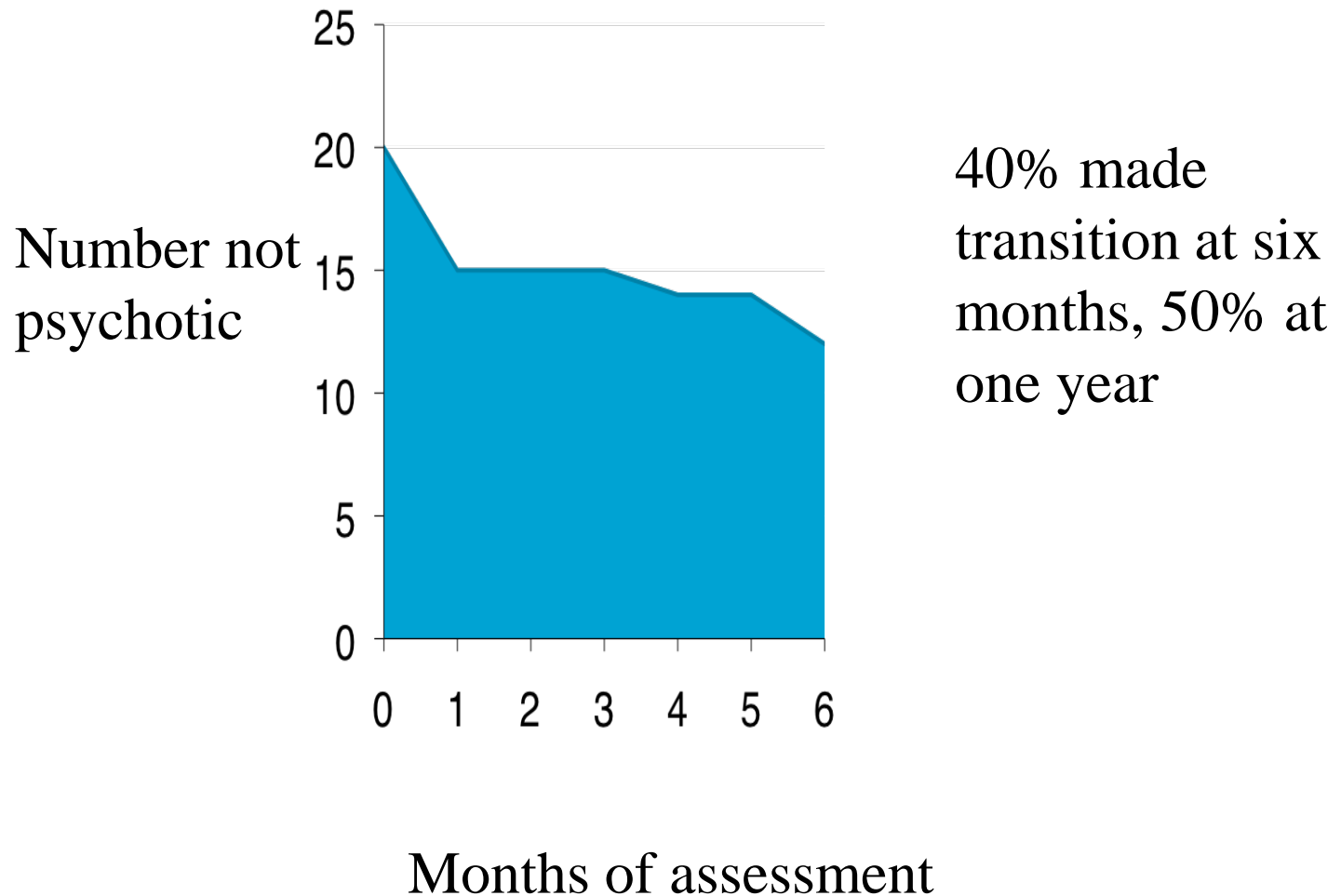
- *'Youth friendly' Acute Home based/Hospital Treatment*

4. Maximise recovery & prevent relapse during critical period:

- *Provide integrated bio/psycho/social interventions*
- *focus on functional/vocational as well as symptomatic recovery*
- *address co-morbidity and treatment resistance early*
- *Support carers and network of community support agencies*

Prediction of Psychosis

Yung et al 1998 British Journal of Psychiatry

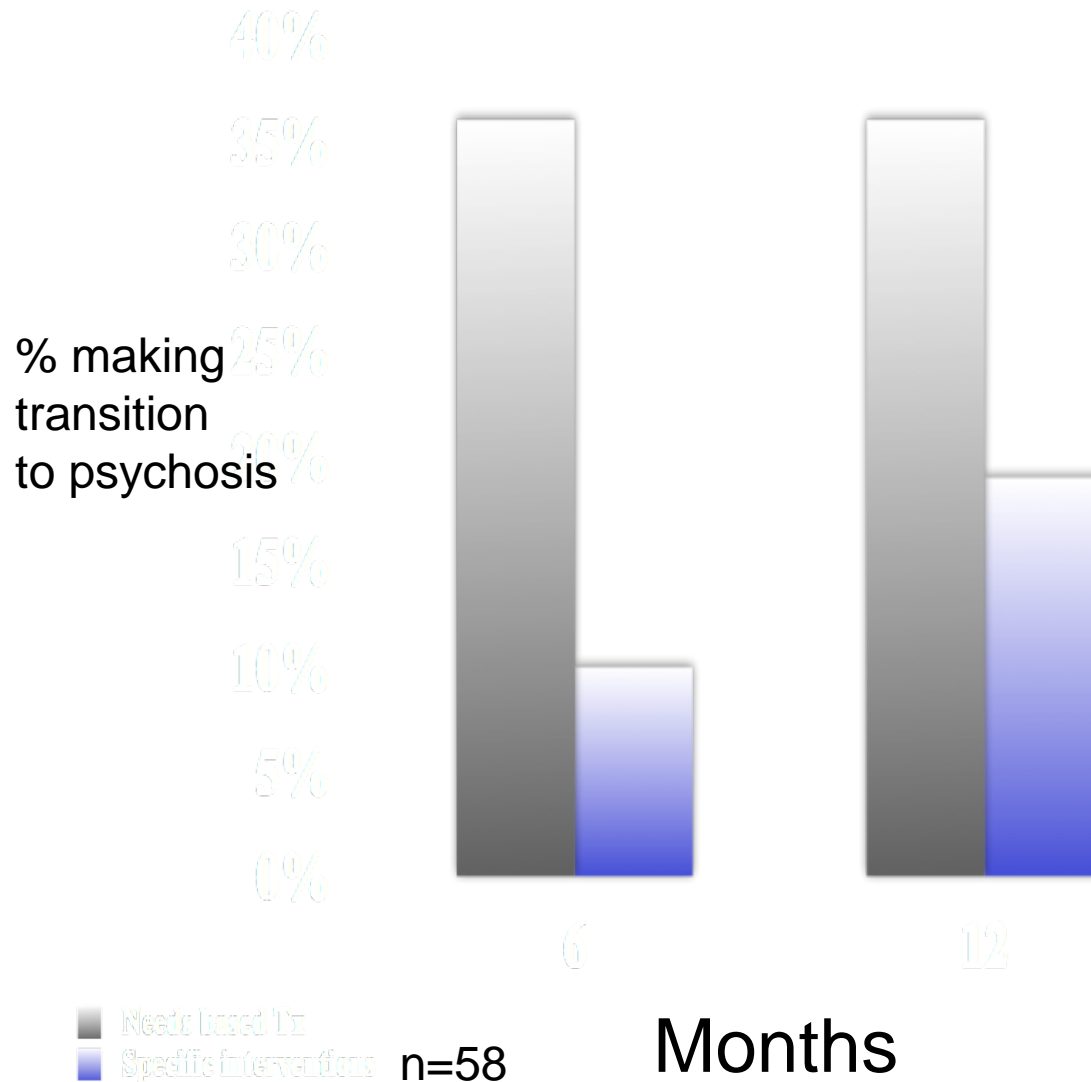


Transition rates?

- Meta analysis on transition Fusar-Poli et al 2012 Archives
- Twenty-seven studies met the inclusion criteria, comprising a total of 2502 patients.
- There was a consistent transition risk, 18% after 6 months of follow-up, 22% after 1 year, 29% after 2 years, and 36% after 3 years.
- There was no publication bias, and a sensitivity analysis confirmed the robustness of the core findings.

Prevention of psychosis

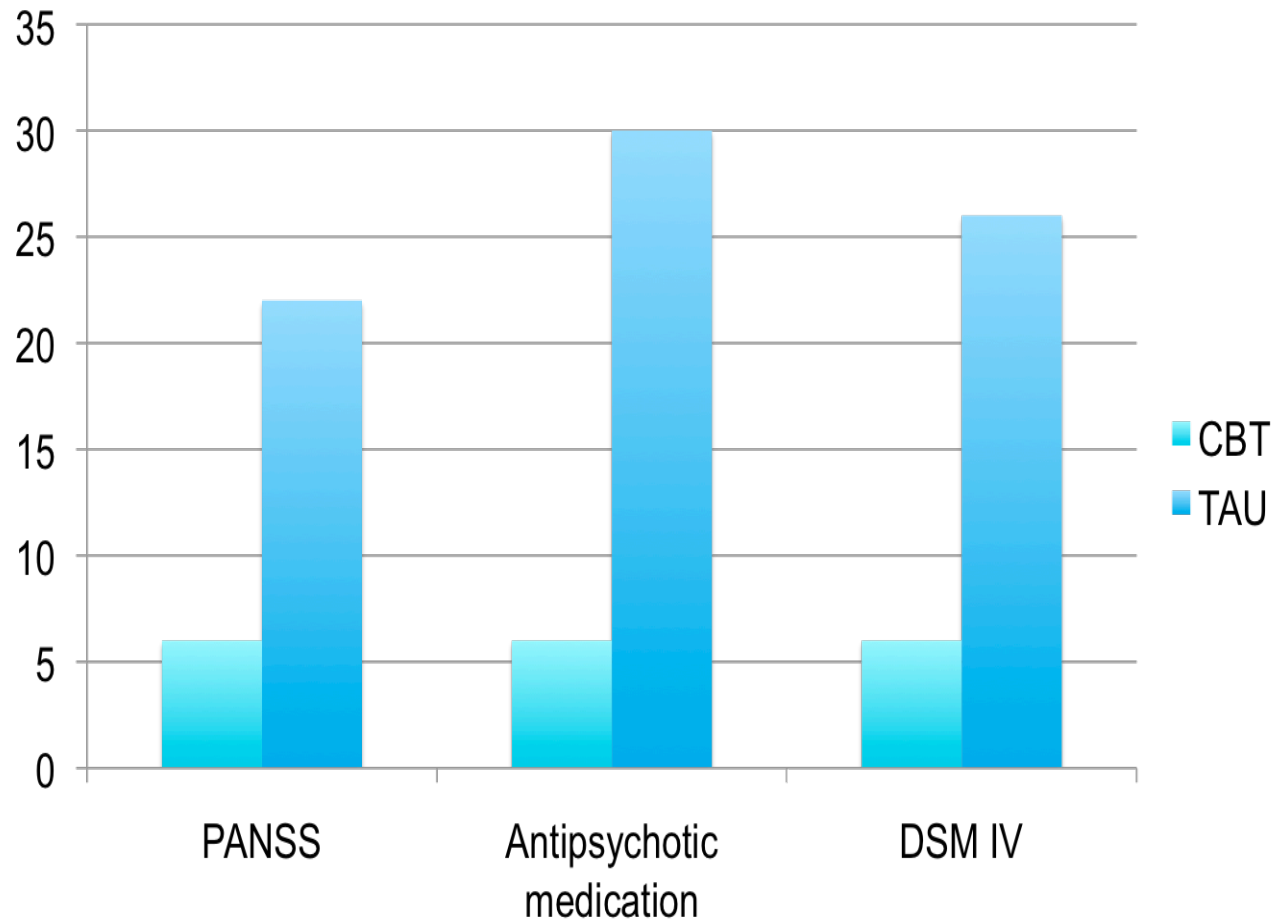
McGorry et al 2002 Archives of General Psychiatry



Prime Study

- A double-blind comparison of olanzapine with placebo
- Prodromal symptoms were measured by the SOPS
- N=60, and the median age was 16 years
- 65% males
- 93% of the patients had mild but definable psychotic symptoms (attenuated symptoms)
- The average GAF was 42.
- The dose of olanzapine included 5, 10, and 15 mg strengths.
- At 1 year, 15 of the 60 patients developed a full psychotic syndrome.
- Of the converters, 8 of 15 converted within the first month from baseline.

A single blind trial to minimise transition to psychosis in at risk individuals. Morrison, French et al 2004.



EDIE2 BMJ

Participants 288 participants aged 14-35 years (mean 20.74, SD 4.34 years) at high risk of psychosis: 144 were assigned to cognitive therapy plus monitoring of mental state and 144 to monitoring of mental state only. Participants were followed-up for a minimum of 12 months and a maximum of 24 months.

Intervention Cognitive therapy (up to 26 (mean 9.1) sessions over six months) plus monitoring of mental state compared with monitoring of mental state only.

Main outcome measures

Primary outcome was scores on the comprehensive assessment of at risk mental states (CAARMS), which provides a dichotomous transition to psychosis score and ordinal scores for severity of psychotic symptoms and distress. Secondary outcomes included emotional dysfunction and quality of life.

Results

Transition to psychosis based on intention to treat was analysed using discrete time survival models. **Overall, the prevalence of transition was lower than expected (23/288; 8%), with no significant difference between the two groups (proportional odds ratio 0.73, 95% confidence interval 0.32 to 1.68).** Changes in severity of symptoms and distress, as well as secondary outcomes, were analysed using random effects regression (analysis of covariance) adjusted for site and baseline symptoms. Distress from psychotic symptoms did not differ (estimated difference at 12 months -3.00 , 95% confidence interval -6.95 to 0.94) but **their severity was significantly reduced in the group assigned to cognitive therapy** (estimated between group effect size at 12 months -3.67 , -6.71 to -0.64 , $P=0.018$).

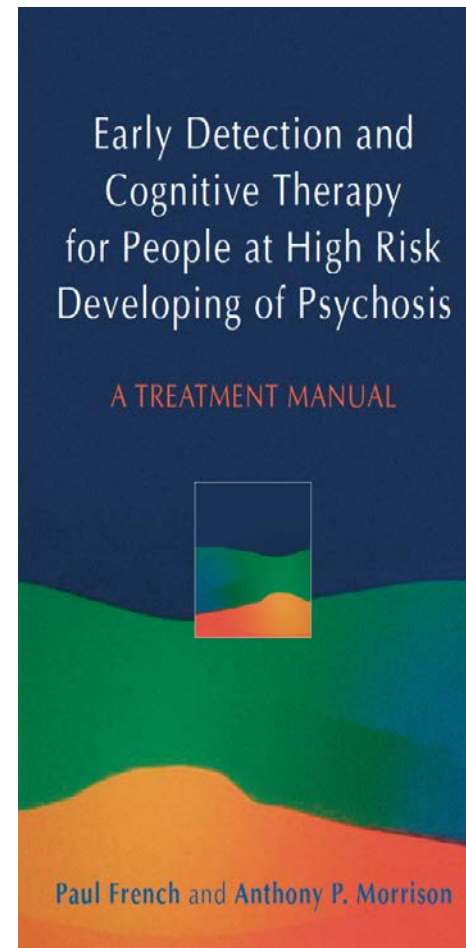
Conclusions

Cognitive therapy plus monitoring did not significantly reduce transition to psychosis or symptom related distress but reduced the severity of psychotic symptoms in young people at high risk. Most participants in both groups improved over time. The results have important implications for the at risk mental state concept.



- Sampling Strategy
- Multiple baseline assessment excluded lots of people
- Started the trial before the reduction in functioning was applied

Addington
Morrison
Morrison
Van der Gaag



Megan R Stafford, Hannah Jackson, Evan Mayo-Wilson,
Anthony P Morrison, Tim Kendall BMJ 2013

- 11 trials including 1246 participants and eight comparisons were included. Median sample size of included trials was 81 (range 51-288). Meta-analyses were performed for transition to psychosis, symptoms of psychosis, depression, and mania; quality of life; weight; and discontinuation of treatment. **Evidence of moderate quality showed an effect for cognitive behavioural therapy on reducing transition to psychosis at 12 months (risk ratio 0.54 (95% confidence interval 0.34 to 0.86); risk difference -0.07 (-0.14 to -0.01).** Very low quality evidence for omega-3 fatty acids and low to very low quality evidence for integrated psychotherapy also indicated that these interventions were associated with reductions in transition to psychosis at 12 months.

Mark van der Gaag, Filip Smit, Andreas Bechdolf, Paul French, Don H. Linszen, Alison R. Yung, Patrick McGorry, Pim Cuijpers.

- The quality of the papers varied from poor to excellent. Overall the risk reduction at 12 months was 54% (RR=0.463 (95%CI:0.33-0.64)) with a Number Needed to Treat of 9 (95%CI:6-15). Although the interventions differed, there was only mild heterogeneity and publication bias was small. All sub analyses showed efficacy. Five studies with 24 to 48-month follow-up still showed a risk reduction of 37% (RR=.635 (95%CI:0.44-0.92)) with a Number Needed to Treat of 12 (95%CI:7-59). Sensitivity analysis excluding the weakest study shows that the findings are quite robust.
- Early detection and intervention in people with an ultra-high risk of developing psychosis prevents or postpones first episode psychosis. Antipsychotic medication showed efficacy, but more trials are needed. Omega-3 fatty acid needs replication. Integrated psychological interventions need replication with more methodologically sound studies. **The findings regarding CBT seem robust, but the 95 percent confidence interval is still very large.**

Meta Analysis

Hutton and Taylor 2013

- The relative risk (RR) of developing psychosis was reduced by more than 50% for those receiving CBT at every time point [RR at 6 months 0.47, 95% confidence interval (CI) 0.27–0.82, $p=0.008$ (fixed-effects only: six randomized controlled trials, $n=800$); RR at 12 months 0.45, 95% CI 0.28–0.73, $p=0.001$ (six RCTs, $n=800$); RR at 18–24 months 0.41, 95% CI 0.23–0.72, $p=0.002$ (four RCTs, $n=452$)].
- **Conclusions. CBT-informed treatment is associated with a reduced risk of transition to psychosis at 6, 12 and 18–24 months, and reduced symptoms at 12 months.**



Mental Health Promotion and Prevention: The Economic Case

Table 13: Total returns on investment (all years): economic pay-offs per £1 expenditure ^a

	NHS	Other public sector	Non-public sector	Total
Early identification and intervention as soon as mental disorder arises				
Early intervention for conduct disorder	1.08	1.78	5.03	7.89
Health visitor interventions to reduce postnatal depression	0.40	–	0.40	0.80
Early intervention for depression in diabetes	0.19	0	0.14	0.33
Early intervention for medically unexplained symptoms ^b	1.01	0	0.74	1.75
Early diagnosis and treatment of depression at work	0.51	–	4.52	5.03
Early detection of psychosis	2.62	0.79	6.85	10.27
Early intervention in psychosis	9.68	0.27	8.02	17.97
Screening for alcohol misuse	2.24	0.93	8.57	11.75
Suicide training courses provided to all GPs	0.08	0.05	43.86	43.99
Suicide prevention through bridge safety barriers	1.75	1.31	51.39	54.45

New 'Standard'

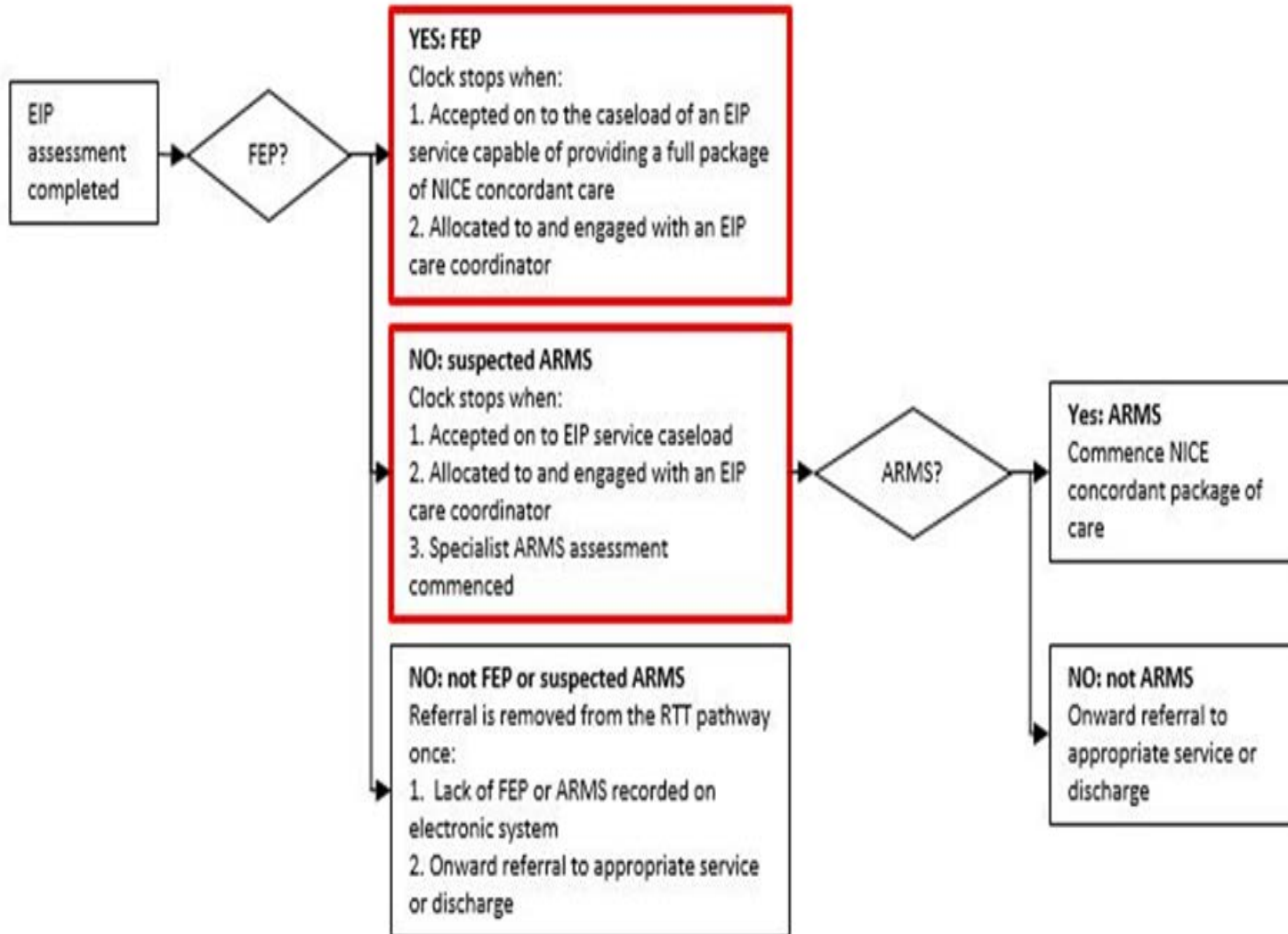
'More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral.'

The three stretches for EIP:-

1. Over 35s, has to lead to an increase of 20-35% in caseload.
2. ARMS, the workforce calculator assumes one ARMS case for each new FEP case. The workforce calculator adds additional resource for this work.

NICE compliance – NICE Guidance has evolved since EIP teams set up. Suggests increase in CBTP, FT and employment support.

Clock Stop



NICE concordant care

For FEP quite clear but perhaps less so
for ARMS?

NICE concordant interventions to maximise outcomes FEP

- Referral to EIP and start treatment within 2 weeks
- Offer CBT for Psychosis
- Offer Family Interventions
- Offer Clozapine (if not responded to other meds)
- Provide Supported Employment Programmes
- Assessment of Physical Health
- Promoting Healthy Lifestyles (exercise, smoking cessation, diet)
- Offer carer focused education and support

But how about for ARMS?

- **1.2.2 Specialist assessment**
- 1.2.2.1 A consultant psychiatrist or a trained specialist with experience in at-risk mental states should carry out the assessment. **[new 2014]**

1.2.3 Treatment options to prevent psychosis

- .2.3.2 Do not offer antipsychotic medication: to people considered to be at increased risk of developing psychosis (as described in [recommendation 1.2.1.1](#)) **or**
- with the aim of decreasing the risk of or preventing psychosis. **[new 2014]**

1.2.3 Treatment options to prevent psychosis

- 1.2.3.1 If a person is considered to be at increased risk of developing psychosis (as described in [recommendation 1.2.1.1](#)):
- offer individual cognitive behavioural therapy (CBT) with or without family intervention (delivered as described in [section 1.3.7](#)) **and**
- offer interventions recommended in NICE guidance for people with any of the anxiety disorders, depression, emerging personality disorder or substance misuse. **[new 2014]**

Suspected psychosis - what GPs need to know

GP Guidance: Early Detection of Emerging Psychosis – What you Need to Know

KEY LEARNING POINTS

- » Psychosis is usually heralded by a gradual deterioration in intellectual and social functioning.
- » GP recognition of early changes, clinical intuition, and acting on family concerns are the key to early detection.

Ask yourself:

“Would I be surprised if this turned out to be psychosis within the next six months?”

To cite: French P, Shiers D, Jones P. GP Guidance: *Early Detection of Emerging Psychosis – 2014 update*; Royal College of General Practitioners & Royal College of Psychiatrists; 2014.

What should a service look like?

- Roughly based on around 1:1 FEP to ARMS
- Focus on the age group 14-35
- Use of suitable clinical assessment such as CAARMS
- Offer individual CBT specific to minimise transition to psychosis
- No real evidence of FI to reduce transition to psychosis
- Provide support and care coordination for those people who are struggling with complex presentations

Future Directions

Family interventions?

Evidence for over 35's?

Integration with IAPT?

Not just about transition to psychosis?

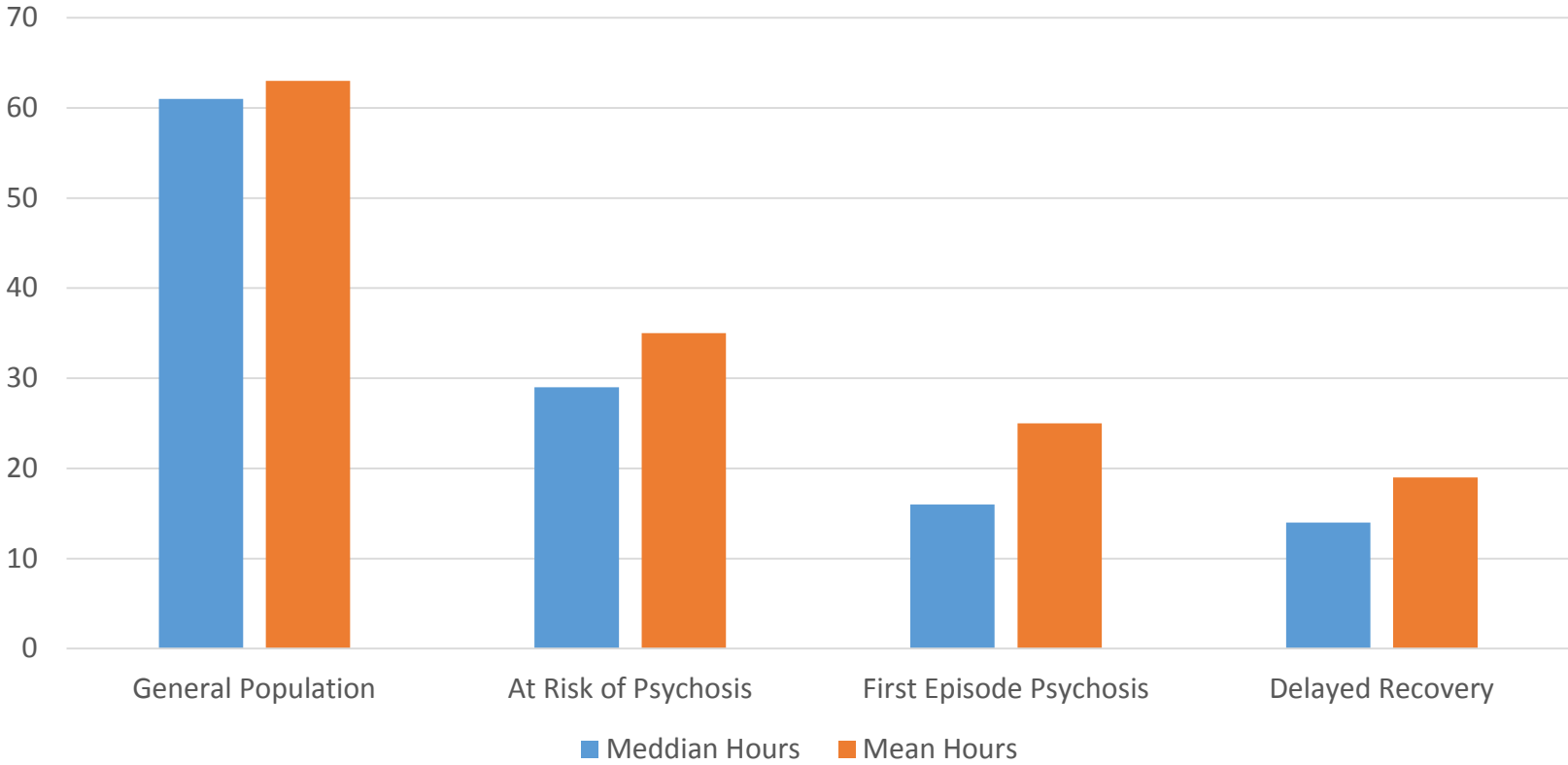
Alternative outcomes – time use?



- NIHR RfPB
- Feasibility RCT
- Recruiting 70 people across Manchester
- Treatment is a combined Individual and Family based intervention
- Individual – based on our previous treatment manual
- Family 4-6 session protocol

Jo Hodgekins, Paul French, Max Birchwood, Miranda Mugford, Rose Christopher,
Max Marshall, Linda Everard Helen Lester, Peter Jones, Tim Amos, Swaran Singh, Vimal Sharma, Anthony P. Morrison, David Fowler
Schizophrenia Research 2015

Weekly Hours Time Use Across Different Groups



prodigy

- Most socially disabling and chronic MH problems begin in adolescence
- Young people at highest risk of long-term social disability present with social decline in context of complex emerging MH problems
 - Typically includes depression and anxiety and other comorbidities
 - Often, but not always, includes sub-threshold psychosis
 - Early intervention for psychosis/psychosis risk only

TYPPEX

- Tailoring evidence-based psychological therapy for People with common mental disorder including Psychotic EXperiences study (TYPPEX).
- A quarter of people who are getting help from Improving Access to Psychological Therapies (IAPT) or psychological wellbeing services for common mental health disorders may have some psychotic experiences, such as paranoia or hearing voices. However, their experiences are not measured routinely and they do not recover very well. These people do not feel supported properly by their local NHS.

Thank you

- Paul.french@gmw.nhs.uk
- @pfrench123

Afternoon workshop B

Supporting Family Work Practice in Early Interventions Services - a practitioners tale – Kevin Hawkes & Justin Woodward-Court (Seminar Room 5)

14:10 – 14:50



Implementing Family Work Within Early Interventions Services

Justin Woodward-Court, Care
Coordinator

Kevin Hawkes, Lead Family Therapist



Caring | Discovering | Growing | **Together**

What is Working Well Where You Are?

In Pairs.....

- Share stories of progress from your agency context include what has contributed to these successes
- Write examples on post-it notes on your table and place these on our resource wall in the workshop room



Working on the Boundary: first contact between family & professional systems

Volunteer Family Members:

Imagine you are a family in which a teenage daughter has been behaving in an unusual and distressing manner in recent weeks. You have been told that the team routinely like to meet with families to talk about the crisis on how best to help the situation. You are waiting for two members of an 'EIP' team to visit for a family meeting.

What might be your greatest concerns (hopes & anxieties)?



Caring | Discovering | Growing | **Together**

Which of these would you be most/least likely to

Working on the Boundary: first contact between family & professional systems

Volunteer Team Members:

Imagine you are two members of the EIP team travelling together to visit a family in which a teenage daughter has been behaving in an unusual and distressing manner in recent weeks.

What might be your greatest concerns (hopes & anxieties)?



Caring | Discovering | Growing | **Together**

Working on the Boundary: first contact between family & professional systems

Volunteer Audience Members:

Join one of two “as if” groups:

- Commissioner of EI Services
- Service or Clinical Leads

Questions:

How might you contribute to creating a positive host culture for the Cook family?

What barriers might you face in achieving this?



The NTW Experience and Lessons Learnt: levels of family work within service



Creating a Positive Host Culture: first contact meetings

Theoretical Influence:

Open Dialogue Approach (Seikkula et al 2005)

- Communicate that resources within familial and personal networks are a resource for recovery
- Socialization of professional, families and community – this is how we prefer to work



First Contact Meetings: Aims

- GETTING TO KNOW ONE ANOTHER
- ENGAGE WITH DIFFERENT POINTS OF VIEW OF FAMILY MEMBERS
- POSSIBLY PROVIDE OPPORTUNITY TO DISCUSS EACH PERSON'S EXPERIENCE OF THE PSYCHOTIC CRISIS
- EXPERIENCE / UNDERSTAND EMOTIONAL CLIMATE OF HOUSEHOLD
- REDUCE/CONTAIN ANXIETIES (FAMILIES & PROFESSIONALS)
- BEGINNING TO ASK HOW PEOPLE ARE GETTING ALONG TOGETHER
- ENQUIRE ABOUT FAMILY LIFE-CYCLE/TRANSITIONS (GENOGRAM)

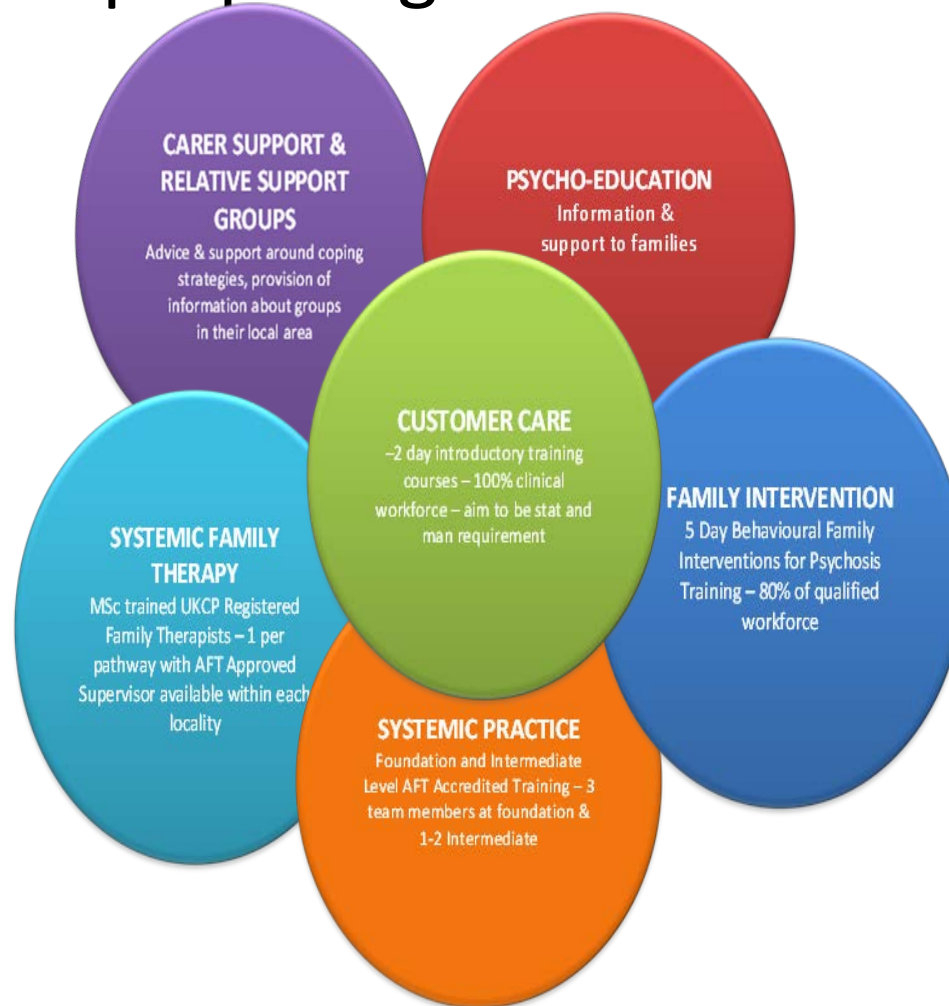


First Contact Meetings: Aims

- ENQUIRE ABOUT FAMILY LIFE-CYCLE/TRANSITIONS (GENOGRAM)
- UNDERSTAND FAMILY CULTURE
- TAKING ACCOUNT of MATERIAL CIRCUMSTANCES
- INFORM & BE INFORMED
- PROVIDE OPPORTUNITIES FOR REFLECTION
- BEGINNINGS OF ENGAGEMENT OF ASSESSMENT PROCESS AS PATHWAYS TO FORMAL FAMILY INTERVENTIONS



The NTW Experience and Lessons Learnt: preparing the workforce



Caring | Discovering | Growing | **Together**

Multi-Relational Identities of Psychological Therapists in FI's

Trainer

Formal Courses

Co-working

Supervisor

Live supervision

Retrospective

Clinical Leader

Team meetings

Formulation

Evaluation



Psychological Therapists – Preparing the workforce

Training

- Influence of a range of models – integration = implementation – Burbach (2012)
- Behavioural Family Interventions – Meriden Model
- Systemic Family Therapy – MSc graduates – UKCP registration
- Train the Trainers – Meriden short course
- Family Therapy – Approved Supervisors



Training

Caring | Discovering | Growing | **Together**

- Supervision of Supervision – individual and

References

Burbach F (2012) Family Interventions
Fundamental Considerations when Developing
Routine and Formal Family Interventions
Services, Chapter 10 in Anastassiou-
Hadjicharalambous X (ed.) Psychosis: causes,
diagnosis and treatment, Nova Science
Publishers

Hawkes K & Reed A (2015) Early Contact
Meetings in Psychiatric Services, Context 138,



Caring | Discovering | Growing | Together

Developing an Outcomes Framework for the New National EIP Standard

Catherine Ding

Bradford District Care NHS Foundation Trust

Stephen McGowan

NHS England (North)

Early Intervention in Psychosis



‘The early phase of psychosis is a critical period influencing the long-term trajectory. The early course of the disorder is particularly malleable to intervention with major implications and opportunities for secondary prevention’

Max Birchwood, 2000

The 'Critical Period' Hypothesis

- Disability develops aggressively in the first 3 years.
- Social/personal functioning stabilises after 3-5 years.
- The critical period is a 'window of opportunity'
- Early Intervention can reduce 3 yr relapse rates from 80% to <20%.



‘With the right care and treatment 85% of people with first episode psychosis can make a good recovery’

Pat McGorry 2010



‘Jewel in the crown of the NHS mental health reform because service users like it; people get better and it saves money’

Professor Louis Appleby, 2009

Research

Harrison et al (2001):

Outcome after three years strongly predicts outcome 25 years later.

Nordentoft et al, (2002):

The OPUS study found decisive advantages for EIP in terms of fewer re-admissions, reduced symptoms and improved quality of life

Yung et al (2003):

EIP service users had shorter Duration of Untreated Psychosis, were less likely to be admitted and police involvement was less common.

Craig et al (2004):

EIP is superior to standard care for maintaining contact with service users and reducing hospital readmissions

Melle et al (2005); Larsen et al (2006):

Reduced DUP and reduced suicide risk can be achieved through a co-ordinated and focussed community awareness campaign (TIPS)

Garety et al, (2006):

33% of EI patients made a full vocational recovery compared with 21% for standard care.

Cochrane Database, Marshall et al., (2006):

The longer the DUP period, the worse the outcomes. More than a third of the DUP period can be attributed to the typically slow engagement process of CMHTs

Fowler et al (2009):

15% of individuals made a full or partial functional recovery under the care of a traditional generic team

52% of the cases made a full or partial functional recovery under the care of a comprehensive EIP service.

A large reduction in in-patient admissions was a further measured benefit from EIP.

**Mihalopoulos C, Harris M, Henry L, Harrigan S,
McGorry (2009)**

EIP subjects had lower levels of positive psychotic symptoms were more likely to be in remission and had a more favourable course of illness. 56% in paid employment compared with 33% of controls.

Mihalopoulos et al (2009):

Specialised EI programmes can deliver a higher recovery rate at 33% of the cost of standard mental health services.

Birchwood et al (2010):

For people with early psychosis EIP services guarantee high levels of engagement in treatment which CMHTs are unable to match

Cheng et al (2010); Johnson et al (2011):

Specialist EIS is more effective at identifying people with FEP than general services

Major et al (2010):

Following EI, 36% of patients were in employment and 20% were in education

Bird et.al (2010):

Early intervention services reduced hospital admission, relapse rates and symptom severity, and improved access to treatment and engagement with treatment.

Ten-Year Outcomes of First-Episode Psychoses in the MRC ÆSOP-10 Study

Symptomatic remission and recovery were more common than previously believed. Researchers, clinicians and those affected by psychosis should countenance a much more optimistic view of outcomes than was assumed when these conditions were first described.

(J Nerv Ment Dis 2015;203: 379–386)



MH promotion and Mental Illness Prevention: The economic case (2011)

- Early Intervention in Psychosis teams save the economy a total of £18 for every pound spent on them
- Low in cost, saving public expenditure as well as radically improving the quality of people's lives.

(Department of Health/Centre for MH, 2011)



NICE 2014 review of Psychosis and Schizophrenia

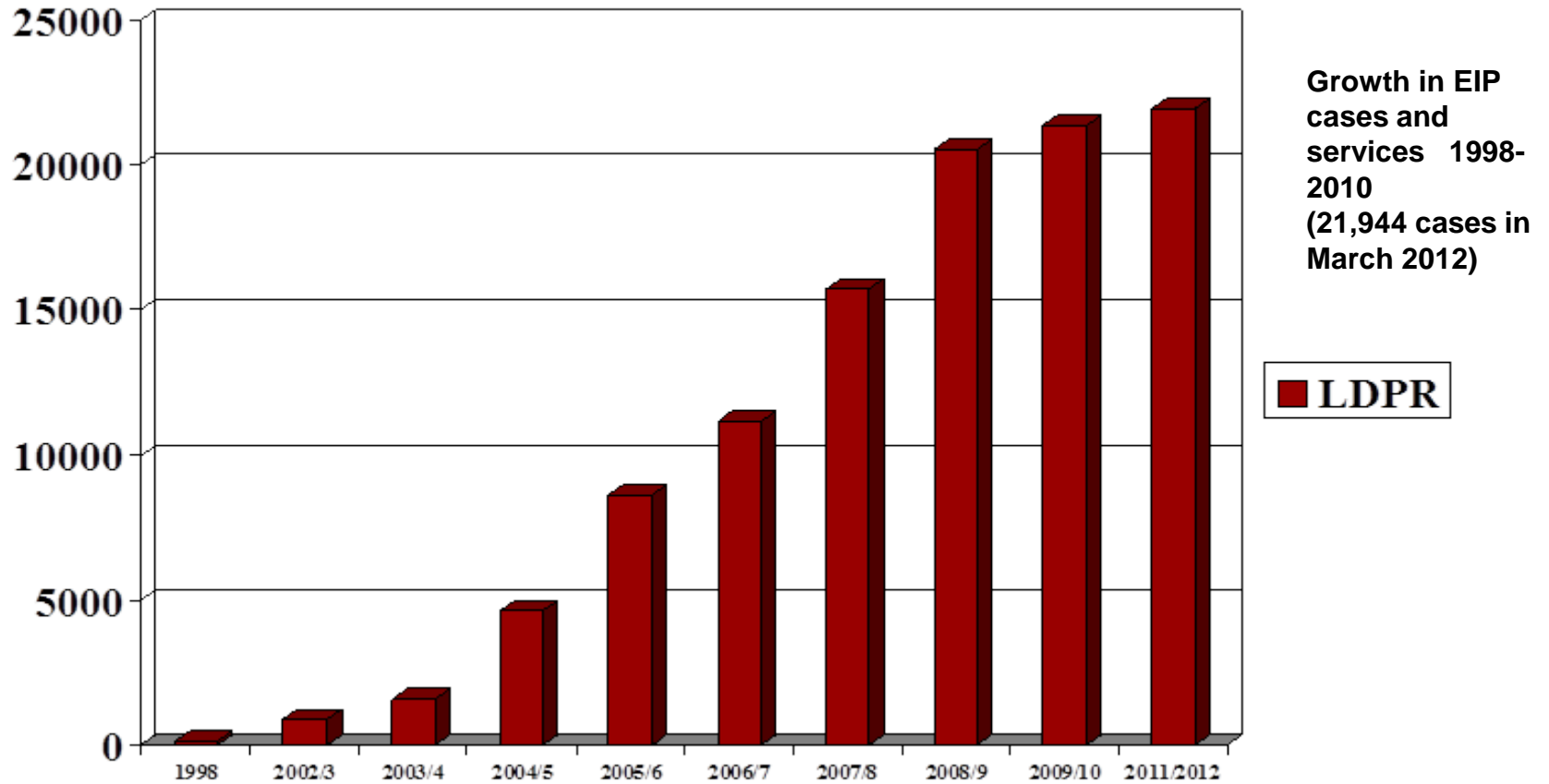
“EIS more than any other service developed to date, are associated with improvements in a broad range of critical outcomes, including relapse rates, symptoms, quality of life and a better experience for service users”. (p551)

<http://www.nice.org.uk/guidance/index.jsp?action=download&o=64924>



- People like it
- They get better
- It saves money

Teams & Cases 1998-2010



Teams: 2 24 41 109 127 160 145 153 178

“We have to be able to measure what we do in a very simple way, and one that means something to the public, the Treasury and to the users and carers themselves.”

Professor Sue Bailey

President of the Royal College of Psychiatrists.

Achieving Better Access Policy

- ‘Parity of Esteem’
- All mental health services to guarantee people access to timely, **evidence-based and effective treatment**
- Clear and clinically informed **waiting time standards**
- To shorten the time that people go without treatment
- To support and **improve outcomes.**


Department
of Health


NHS
England

Achieving Better Access
to Mental Health Services
by 2020





Implementing the Early Intervention in Psychosis Access and Waiting Time Standard: Guidance

Early Intervention
in Psychosis

NATIONAL
COLLABORATING
CENTRE FOR
MENTAL HEALTH

EIPN
EARLY INTERVENTION IN
PSYCHOSIS NETWORK



RC
PSYCH
ROYAL COLLEGE OF
PSYCHIATRISTS



Standards for Early Intervention in Psychosis Services

Pilot Edition

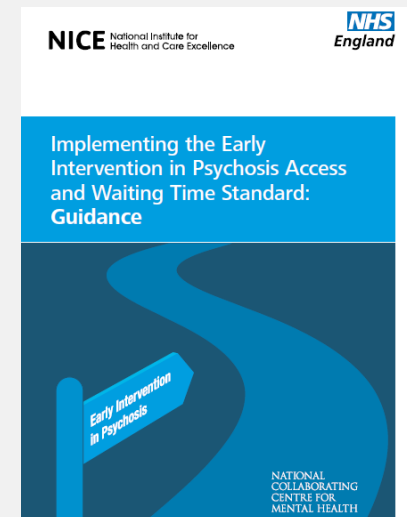
Editors: Francesca Brightey-Gibbons, Sophie Hodge & Lucy Palmer

The access and waiting time standard

4.4 Routine collection of outcomes data

Clarity on expected service user outcomes is key to measuring and monitoring the effectiveness of services. The EIP ERG has recommended that three outcome tools should be used in EIP services:

- HoNOS
- DIALOG
- QPR



Mandated Outcome Measures

- Health of the Nation Outcomes Scores (HoNOS)
- Process of Recovery Questionnaire (QPR)
- DIALOG

75% with at least 2 outcome measures recorded at least twice

By 2021 at least 60% of people with a first episode psychosis starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral

STANDARD	2016/17	2017/18	2018/19	2019/20	2020/21
Waiting Times: AWT % of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%
NICE recommended care package: CCQI/NCAP Service User Level Questionnaire	All services complete baseline assessment	All services graded at level 2 ('Requires Improvement') by year end	25% of services graded at least level 3 ('Good') by year end	50% of services graded at least level 3 ('Good') by year end	60% of services graded at least level 3 ('Good') by year end
A Specialist EIP Service: CCQI/NCAP Contextual data	All services complete baseline assessment	Contextual data collected but not reported	Triangulation: Stand-alone MDT Caseload<15 3-yr service CYP protocols Outcomes	Triangulation: Stand-alone MDT Caseload<15 3-yr service CYP protocols Outcomes	Triangulation: Stand-alone MDT Caseload<15 3-yr service CYP protocols Outcomes
Outcome Measures	All services complete baseline assessment	75% with at least 2 outcome measures recorded at least twice	75% with at least 2 outcome measures recorded at least twice	New NHSE national outcomes framework ?	New NHSE national outcomes framework ?



Early Intervention in Psychosis

Achieving *Ordinary Lives*



Yorkshire and the Humber
Clinical Networks

Yorkshire & Humber Early Intervention in Psychosis Network



Deciding the content

The regional network reviewed and shortlisted the proposed content.

- Clinicians: *‘Simplify data collection’*
- Service users: *‘Include more subjective measures of recovery and satisfaction’*
- Commissioners: *‘Include some post discharge questions to show whether the benefits last beyond discharge’.*

Deciding the content

The 'Appleby' Test:

- Do people like it?
- Do they get better?
- Does it save money?

Four Domains

- Mental Health and Behaviour Outcomes
- Psychosocial Outcomes
- Physical Health Outcomes
- Satisfaction

Mental Health and Behaviour Outcomes

- Overactive/agitated behaviour
- Psychotic experiences
- Self-harm
- Subjective assessment of recovery
- Health satisfaction
- Admissions and relapses
- Discharge destination

Psychosocial Outcomes

- Relationships
- Employment/education
- Housing Stability

Physical Health Outcomes

- Weight gain
- Smoking
- Substance and alcohol misuse
- Death

Satisfaction

- Service user
- Parents/carers/others

Post discharge

- Community admission
- In-patient admission
- Death (including suicide)

Key Questions

- Is data available?
- Can we collect it?
- Can we analyse it?

Key Questions

- Is data available?
 - Can we collect it?
 - Can we analyse it?

Data Sources

All information can now be collected entirely in our electronic patient records (EPR) using only four assessment tools (HoHOS, QPR, DIALOG and the F&F Test).



Data Sources

Mental Health and Behaviour Outcomes

Agitated behavior (HoNOS)
Psychotic experiences (HoNOS)
Self-harm (HoNOS)
Subjective assessment of recovery (QPR)
Health satisfaction (DIALOG)
Admissions and relapses (EPR)
Discharge destination (EPR)

Service Satisfaction

Service user (DIALOG)
Parents/care/other (F&F)

Psychosocial Outcomes

Relationships (HoNOS)
Employment/education (PSA16)
Housing Stability (PSA 16)

Physical Health Outcomes

Weight gain (EPR)
Smoking (EPR)
Alcohol/Substance misuse (HoNOS)
Death (EPR)

Data Sources: Electronic patient record (EPR e.g. RiO) – including demographic data, admissions, PSA 16, CQUINs etc.; HoNOS (MHCT); QPR; DIALOG; F&F Test

The 'Appleby' Test

Do people like it?

- Health satisfaction
- F&F Test

Does it save money?

- Admissions and relapses
- Employment/education
- Self-harm and suicide
- Housing Stability
- Discharge destination

Do they get better?

- Agitated behaviour
- Psychotic experiences
- Relationships
- Self-harm and suicide
- Subjective assessment of recovery
- Physical health
- Employment/education
- Discharge destination

Key Questions

- Is data available?
- Can we collect it?
- Can we analyse it?

SELF-HARM:

Reduction in % who are self-harming at discharge from baseline (admission to EI)

Information requirement:

Number of people discharged who were self-harming on admission to EI -
Of these the number of people discharged who are self-harming at discharge

Threshold:

There is a significant reduction in the number of people self-harming and the severity of the self-harm has decreased consistent with harm minimisation principles (CG16 & 133)

Data:

Discharge audit

N = 61 cases available for analysis, of those discharged from the service in the past year who also had baseline data

2016 report:

17% self-harmed at baseline

17% self-harmed at discharged

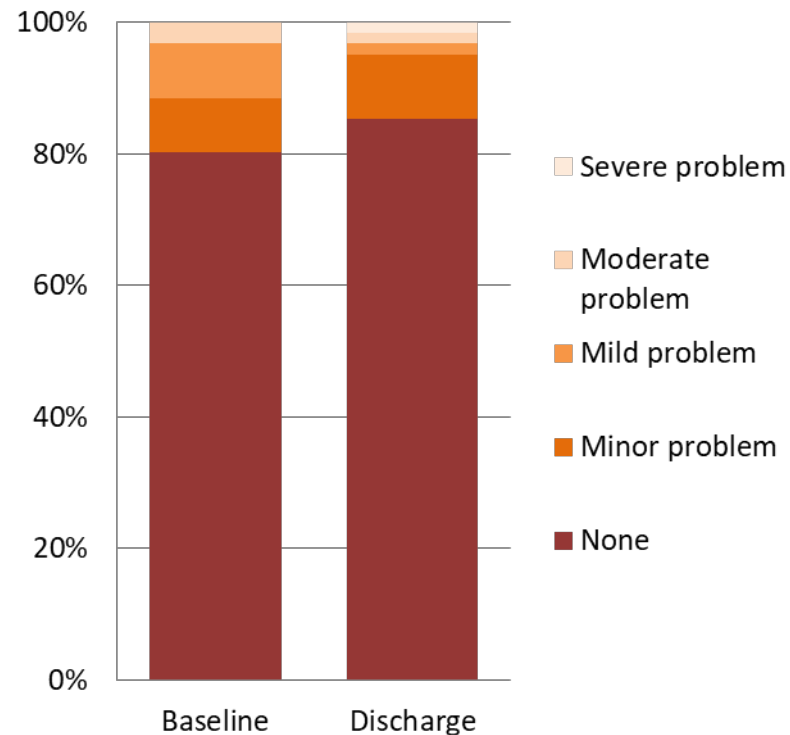
2017 report:

26% self-harmed at baseline

9% self-harmed at discharged

19% of people self-harmed as baseline

15% of people self-harmed at discharge



PHYSICAL HEALTH:

reduction in % of people classed as smokers from baseline (admission to EI)

Information requirement:

Number of clients who were smoking on admission to EI -

Of these, number of clients who are smoking at discharge

Threshold:

Percentage of people ending spell of care classed as smokers is less than baseline

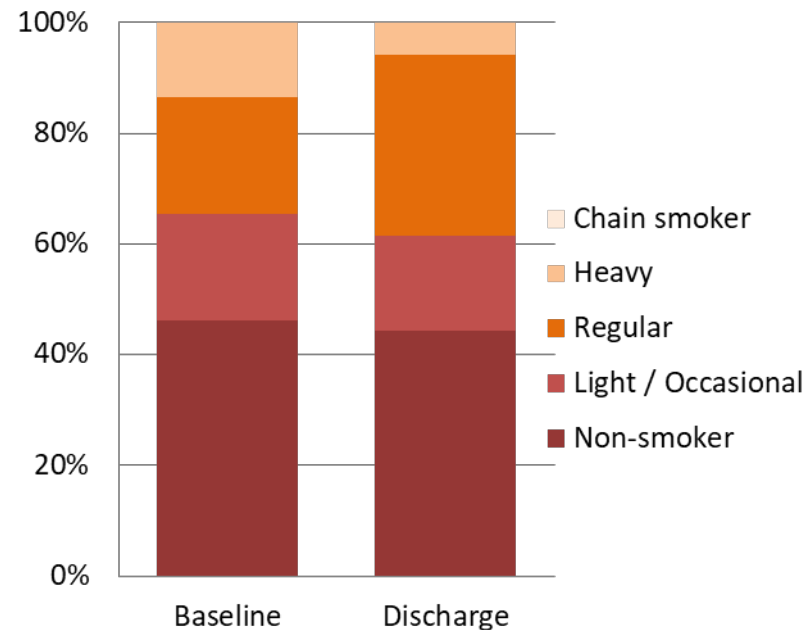
Data:

Discharge audit

N = 52 cases available for analysis, of those discharged from the service in the past year who also had baseline data

2017 report: Reduction

Reduction in severity of smoking



PHYSICAL HEALTH:

reduction in % unhealthy BMI from baseline (admission to EI)

Information requirement:

Number of clients who were had unhealthy BMI on admission to EI -

Of these number of clients who had unhealthy BMI at discharge

Threshold:

Percentage of people whose BMI is unhealthy at the end of spell of care is lower than those with unhealthy BMI on admission.

Data:

Discharge audit

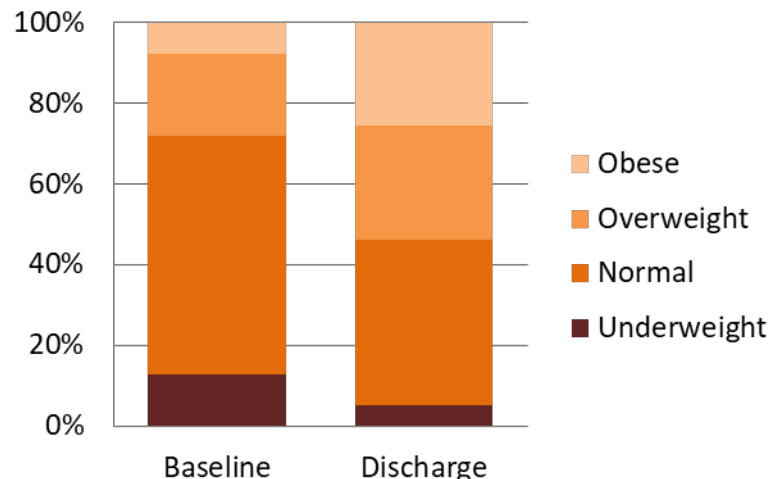
N = 39 cases available for analysis, of those discharged from the service in the past year who also had baseline data

2017 report:

Baseline mean BMI 24.3

Discharge mean BMI: 27.2

Baseline mean BMI **23.6** Discharge mean BMI **27.1**



PHYSICAL HEALTH:

reduction in % unhealthy BMI from baseline (admission to EI)

Information requirement:

Number of clients who were had unhealthy BMI on admission to EI -

Of these number of clients who had unhealthy BMI at discharge

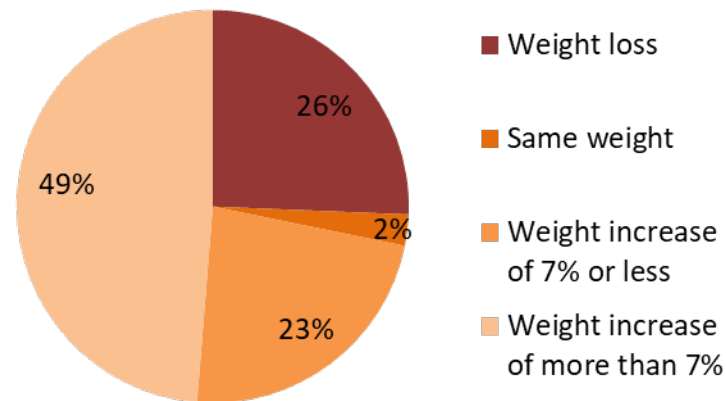
Threshold:

Percentage of people whose BMI is unhealthy at the end of spell of care is lower than those with unhealthy BMI on admission.

Data:

Discharge audit

N = 39 cases available for analysis, of those discharged from the service in the past year who also had baseline data



RECOVERY RATES: Hospital admissions

Information requirement:

Number of people who needed a hospital admission

Threshold:

50%

Data:

Discharge audit

N = 119 cases available for analysis, of those discharged from the service in the past year

2016 report:

Less than 1 month: 8

1-2 months: 7

2-6 months: 6

6+ months: 1

2017 report:

Less than 1 month: 8

1-2 months: 3

2-6 months: 6

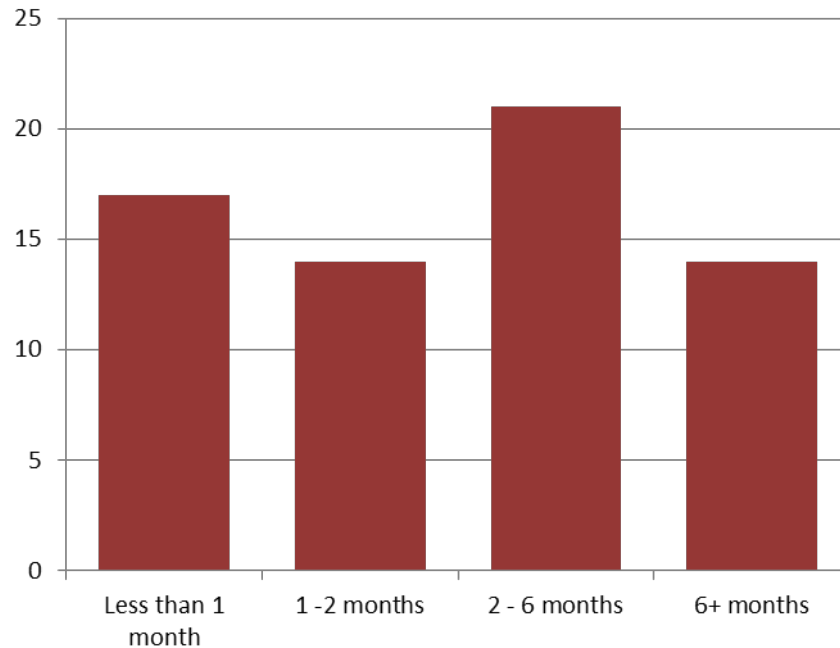
6+ months: 7

Median admission: 65 days

Mean admission: 58 days

44% of those who received a full 3 year service did not need a hospital admission.

For those who did need hospital admissions, Median average stay was 67 days and 150 days mean average admission over a full 3 year service.



RECOVERY RATES:

% who are relapse free at discharge

Information requirement:

Number of people at discharge who have not experienced relapse
Total number of people discharged

Threshold:

50%

Data:

Discharge audit
N = 119 cases available for analysis, of those discharged from the service in the past year

2016 report:

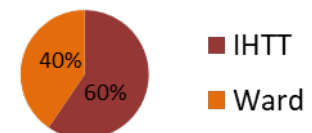
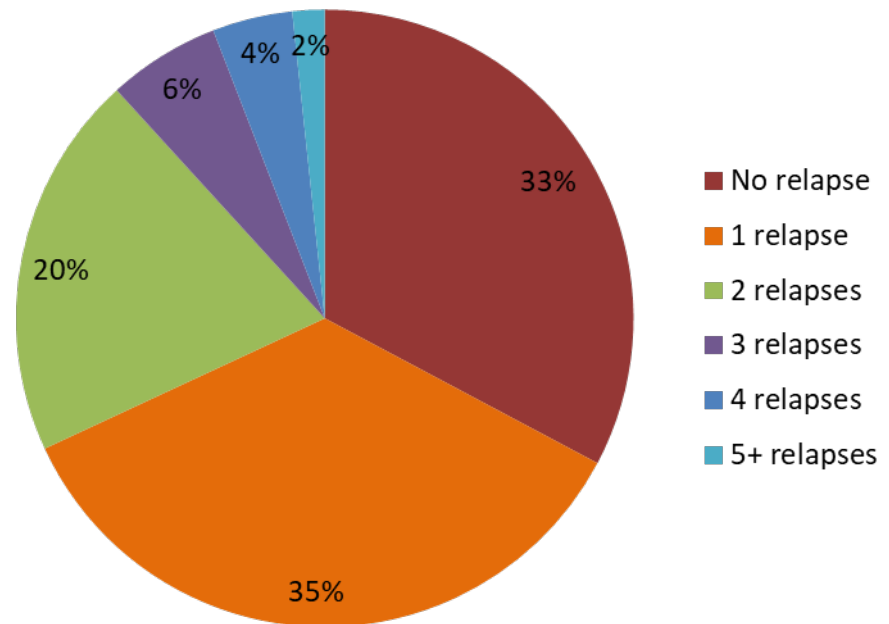
No relapse: 52%
1 relapse: 28%,
2 relapses: 16%, 5+ relapses: 4%

2017 report:

No relapse: 47%
1 relapse: 20%
2 relapses: 17%
5+ relapses: 8%

33% of people at discharge who have not had a relapse during their time with EIP

Of those who had 1 relapse, the following crisis service was involved:



RECOVERY RATES:

% of clients discharged to primary care at the end of receiving an EI service

Information requirement:

Number of people discharged from EI to primary care

Threshold:

IRIS 2012; minimum of 50% of clients discharged to primary care after 3 years of EI

Data:

Discharge audit

N = 119 cases available of those discharged from the service in the past year

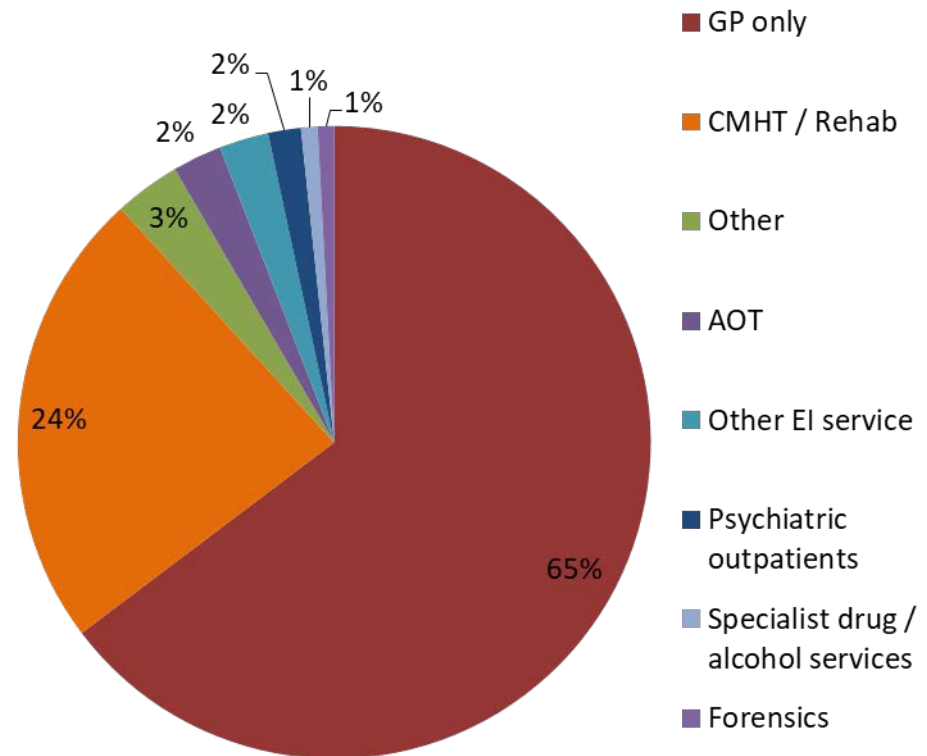
2016 report:

61%

2017 report:

77%

65% of those discharged from EI in the last year were to primary care alone



HOUSING STABILITY:

% of individuals in settled accommodation at discharge

Information requirement:
Number of individuals in settled accommodation at discharge

Threshold:

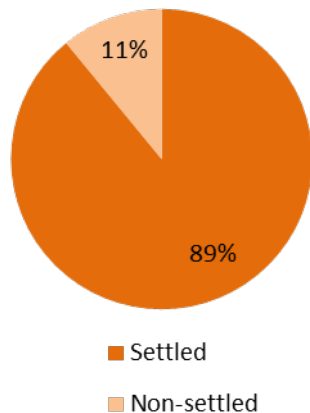
90%

Data:

Discharge audit
N = 119 cases available for analysis, of those discharged from the service in the past year

2016 report: 89% in settled accommodation at discharge
2017 report: 85% in settled accommodation at discharge

89% settled accommodation at discharge



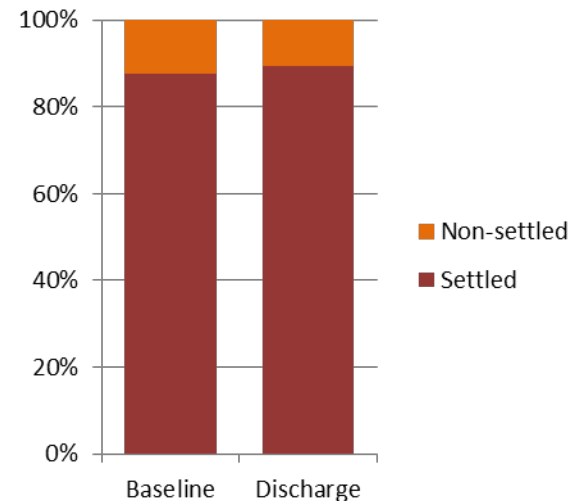
Information requirement:
Comparison of individuals in settled accommodation at admission and discharge to EI

Threshold:

90%

Data:

Discharge audit
N = 57 cases available for analysis, of those discharged from the service in the past year



HOUSING SATISFACTION:

% of individuals in settled accommodation in their final year of receiving an EI service who report satisfaction with their housing

Information requirement:

Number of individuals in settled accommodation in their final year of service who report satisfaction with their housing

Threshold:

90%

Data:

Early Intervention Questionnaire
N = 31

2017 report:

Yes: 90%

Not sure: 10%

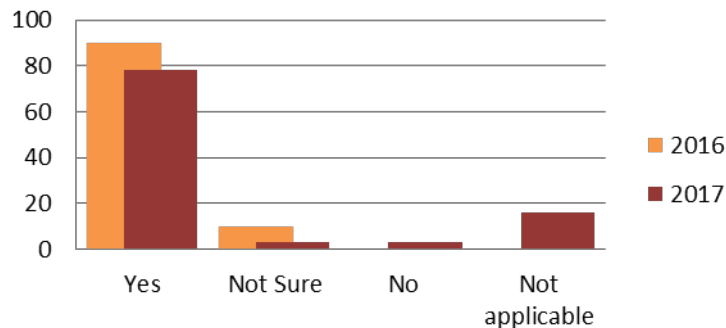
No: 0%

Not applicable: 0%

I am satisfied with my current housing arrangements

Yes 78%

Not sure 3% No 3%



OCCUPATION RATES:

% of individuals who are in education, employment or training at discharge

Information requirement:

Number of individuals at discharge who are in employment, education or training

Threshold:

50%

Data:

Discharge audit

N = 119 cases available at discharge

2016 report:

26% were in employment at discharge

A further 19% were in education

40% were NEET

% not NEET at discharge = 60%

2017 report:

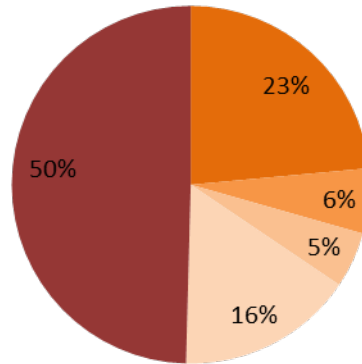
28% were in employment at discharge

A further 18% were in education

39% were NEET

% not NEET at discharge = 61%

23% are in employment at discharge, a further 11% are in education. 50% are NEET % not NEET at discharge = 50%



- Employment
- Higher Education
- Education
- Other
- NEET

Information requirement:

Comparison between of individuals who are in employment, education or training at admission and discharge to EI

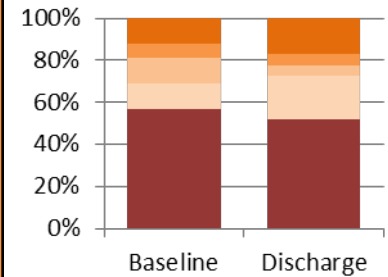
Threshold:

50%

Data:

Discharge audit

N = 58 cases available at discharge



- Employment
- Higher Education

OCCUPATION SATISFACTION:

% of affected individuals who report satisfaction with their employment, education and occupation in the last year of receiving an EI service

Information requirement:

Number of individuals in the final year of service who report satisfaction with their employment, education and occupation, inc. those who remain NEET

Threshold:

90%

Data:

Early Intervention Questionnaire

N = 31

2017 report:

Yes: 71%

Not sure: 19%

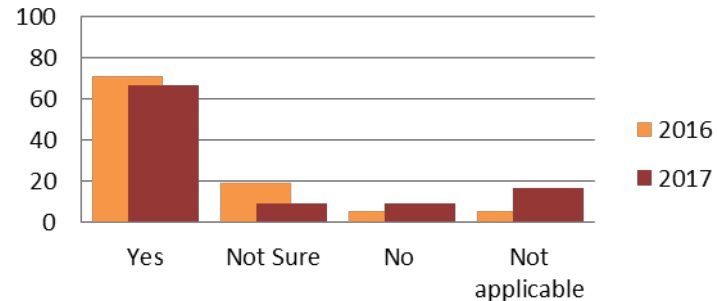
No: 5%

Not applicable: 5%

I am satisfied with my current level of occupation

Yes **66%** a consistent finding for several years – having work/ being in education doesn't always equate to meaningful activity.

Not sure: 9% No 9%



FAMILY & FRIENDS TEST (FFT):

Score	Ward/ Service	Question / Questionnaire Comment	Comment	Sentiment
94.00	EIP -AWC	2.What was good about your care?	Having support when it is needed, someone at the end of phone	Positive
94.00	EIP -AWC	2.What was good about your care?	One to one, person listening to my needs, can get in touch whenever I needed them	Positive
100.00	EIP - District	3.What could be improved?	Tea & biscuits	Neutral
92.00	EIP - City	3.What could be improved?	A bit more flexibility in terms of scheduling e.g evening times for family therapy.	Not Set
94.00	EIP -AWC	8.Did you feel the staff listened to what you had to say?	Staff always great and happy to help	Positive
94.00	EIP – Assessment	11.I was seen in a place that was welcoming?	It was in my home	Not Set
94.00	EIP – Assessment	13.Were you seen on time?	She was on time 98% of the time and let me know when she wouldn't be	Positive

I have felt valued & respected

Information requirement:

Number of clients who report high levels of satisfaction/ endorsing "Yes" statements

Threshold:

90%

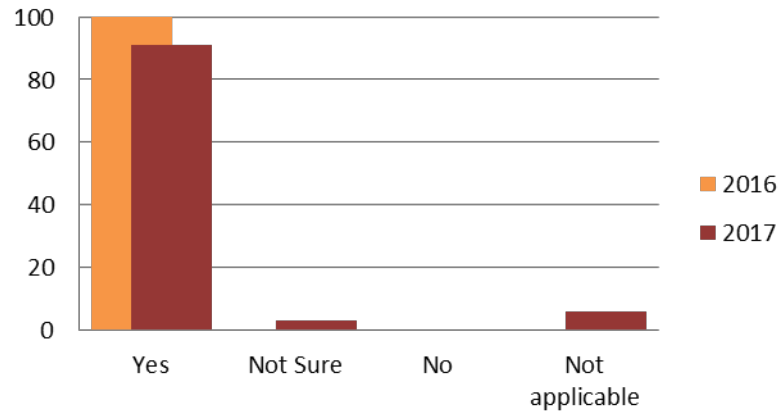
Data:

Early Intervention Questionnaire
N = 31

2017 report:

Yes: 100%
Not sure: 0%
No: 0%
Not applicable: 0%

Yes **91%**, Not sure 3%, No 0%



I have been given enough information about my medication options, their benefits & risks, for me to give informed consent about treatment

Information requirement:

Number of clients who report high levels of satisfaction/ endorsing "Yes" statements

Threshold:

90%

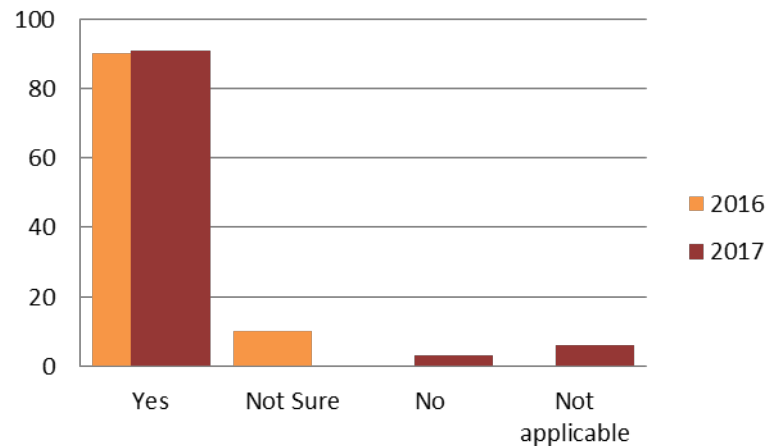
Data:

Early Intervention Questionnaire
N = 31

2017 report:

Yes: 90%
Not sure: 10%
No: 0%
Not applicable: 0%

Yes **91%**, Not sure 10%, No 3%



I am very happy with the level of care & support my care coordinator provided, she was absolutely amazing. She would help me, advise me with anything & everything. She always listened to me & most of all, she was always there for me. There was a lot of day to day things that I would mentally struggle with but my care coordinator would advise me & help me as much as she could and try to help me solve things.

When I am unwell there was always someone from EI to help me. Activities help me to go out & increase confidence & reduce anxiety.

Lessons in theory to support me in maths.

Gym group, snooker & going for drives.

Ongoing support from professionals. I was always given time & my concerns were heard.

Groups & going out.

Friendly and supporting service. Happy to have my medication reduced. Kept in touch with me.

Appointments were scheduled to speak about progress & resolve issues with regards to current issues.

Was happy listening to car music & going for a drive. Sorting out my benefits.

Are there any aspects of the service you received that you are particularly happy with?

I was happy with EI service.

I feel the regular CPA meetings were a great help as well as the occasional home visits.

I am happy with the service overall.

Staff were always polite to me.

All of it! Staffs attitudes are incredible. Having staff still visit despite being in hospital was so appreciated. Flexibility to provide more intensive support is managed really well. You guys rock!

Generally I felt this service was of a very high standard.

They focussed on what was best for the client - helped you discover your own path. Inquisitive staff.

I was happy with the service as a whole.

Overall team approach. A helpful experience.

Found support workers very positive - it helped get me out the house.

Everything - a combination of support.

Everything - people to talk to, medication & friendship.

Access to lots of staff. Clear who I could contact should I need to. Have had loads of time with psychologists.

My previous care coordinator - I have been very happy with. Also the frequency of visits has been great.

Meeting my therapist.

Social workers

Everything. It helped me get to the place I am now.

Meeting in safe environments.

QPR

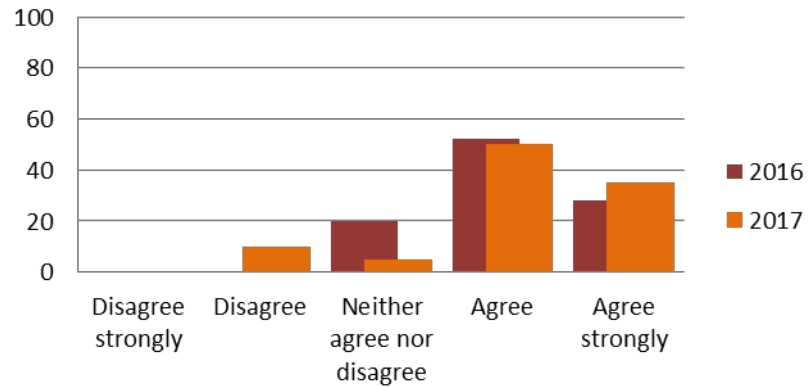
I FEEL BETTER ABOUT MYSELF

Information requirement:

Questions answered on a scale of Agree Strongly to Strongly Disagree

Data:

The Process of Recovery Questionnaire (QPR)
N = 20



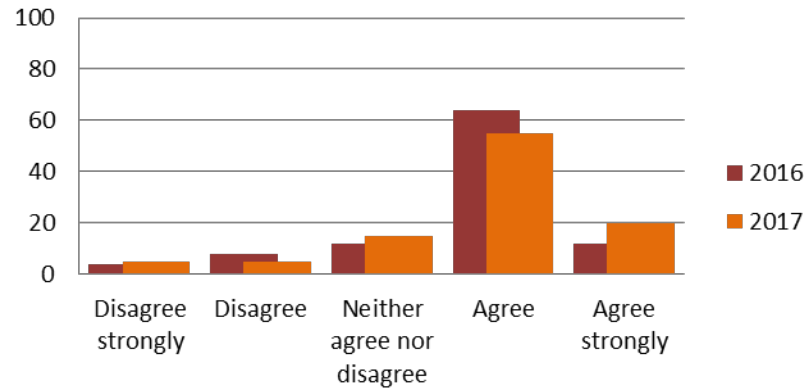
I FEEL PART OF SOCIETY RATHER THAN ISOLATED

Information requirement:

Questions answered on a scale of Agree Strongly to Strongly Disagree

Data:

The Process of Recovery Questionnaire (QPR)
N = 20



Utility?

- Individual recovery record
- Team performance/progress
- National outcomes framework for MH?

NB- agreed standards and baselines

‘Clarity on expected service user outcomes is key to measuring and monitoring the effectiveness of services’.

NHS England 2016

Utility?

- **Individual recovery record**
- Team performance/progress
- National outcomes framework for MH?

NB- agreed standards and baselines

‘Clarity on expected service user outcomes is key to measuring and monitoring the effectiveness of services’.

NHS England 2016

Josh

- White-British Male
- 24
- Married
- Unusual experiences
 - Started hearing voice of wife telling him to kill himself
 - Sees images of wife with objects like knife, and assumes that it is a message to kill himself
 - Believed God wanted him to kill himself
- Paranoid about people in local area
 - Closing curtains and not leaving the house
- 14 attempts to end life
 - 24 referrals to IHBTT
 - 2 admissions to hospital

HoNOS Scores

	Referral	Discharge
Non-accidental self-harm	4	0
Problem drinking/substance	0	0
Overactive/aggressive	2	0
Problems with voices/paranoia	4	1
Problems with relationships	3	0



DIALOG/QPR Scores

	Referral 2015	May 2016	Discharge (Oct 2017)	Follow-Up (Aug 2018)
DIALOG (1-7)	1.7	5	6.3	6.6
Subjective	1.25	4.6	6	6.5
Satisfaction with services	3	6	7	7
QPR (0-4)	0.3	3	3.7 (56)	3.9 (59)



Other Outcomes

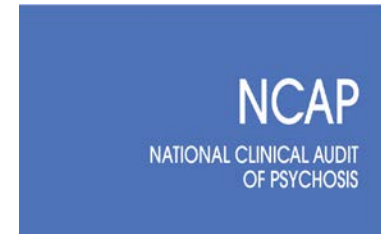
- **Engagement:**
 - lots of cancelling/rearranging in first 2-3 years ('2' on 0-4 scale)
 - fully engaged at discharge (6 month extension) ('0' on 0-4 scale)
 - significant other engagement always good; fully engaged at discharge ('0' on 0-4 scale)
- **Employment/education:**
 - at referral: Unemployed - had given up work due to health issues
 - discharge: starting course and voluntary work
- **Weight:**
 - significant weight gain during first 2½ years with EI. BMI = 49
 - professionals meeting: decision to reduce neuroleptic
 - involvement of partner in sessions and voice dialogue
 - 9kg/3 stone weight loss over last year of input
- **Discharge destination: GP**
 - kept on for extra 8 months to enable discontinuation of neuroleptic

Better Relationships

- Better relationships with family
 - especially partner
 - more realistic understanding of relationship with parents
- Better relationship with his religion
- Better relationship with voice
 - gives advice; speak to each other most days
 - less instructions to end life
 - less problematic/quieter



Thank you



NCAP EIP Spotlight Audit National Clinical Audit of Psychosis

Paul French

EIP access and waiting time standard

By 2020/21, ensure that “at least 60% of people with first episode psychosis [are] starting treatment with a NICE-recommended package of care with a specialist early intervention in psychosis (EIP) service within two weeks of referral”.

Early intervention in psychosis standard	2016/17	2017/18	2018/19	2019/20	2020/21	Measured by
% of people receiving treatment in 2 weeks	50%	50%	53%	56%	60%	UNIFY data collection Moving to MHSDS as soon as possible
Specialist EIP provision in line with NICE recommendations	All services complete baseline self-assessment	All services graded at level 2 by year end	25% of services graded at least level 3 by year end	50% of services graded at least level 3 by year end	60% of services graded at least level 3 by year end	Royal College of Psychiatrists College Centre for Quality Improvement (CCQI) annual quality assessment and improvement scheme.

Early Intervention in Psychosis Self-assessment tool Scoring Matrix

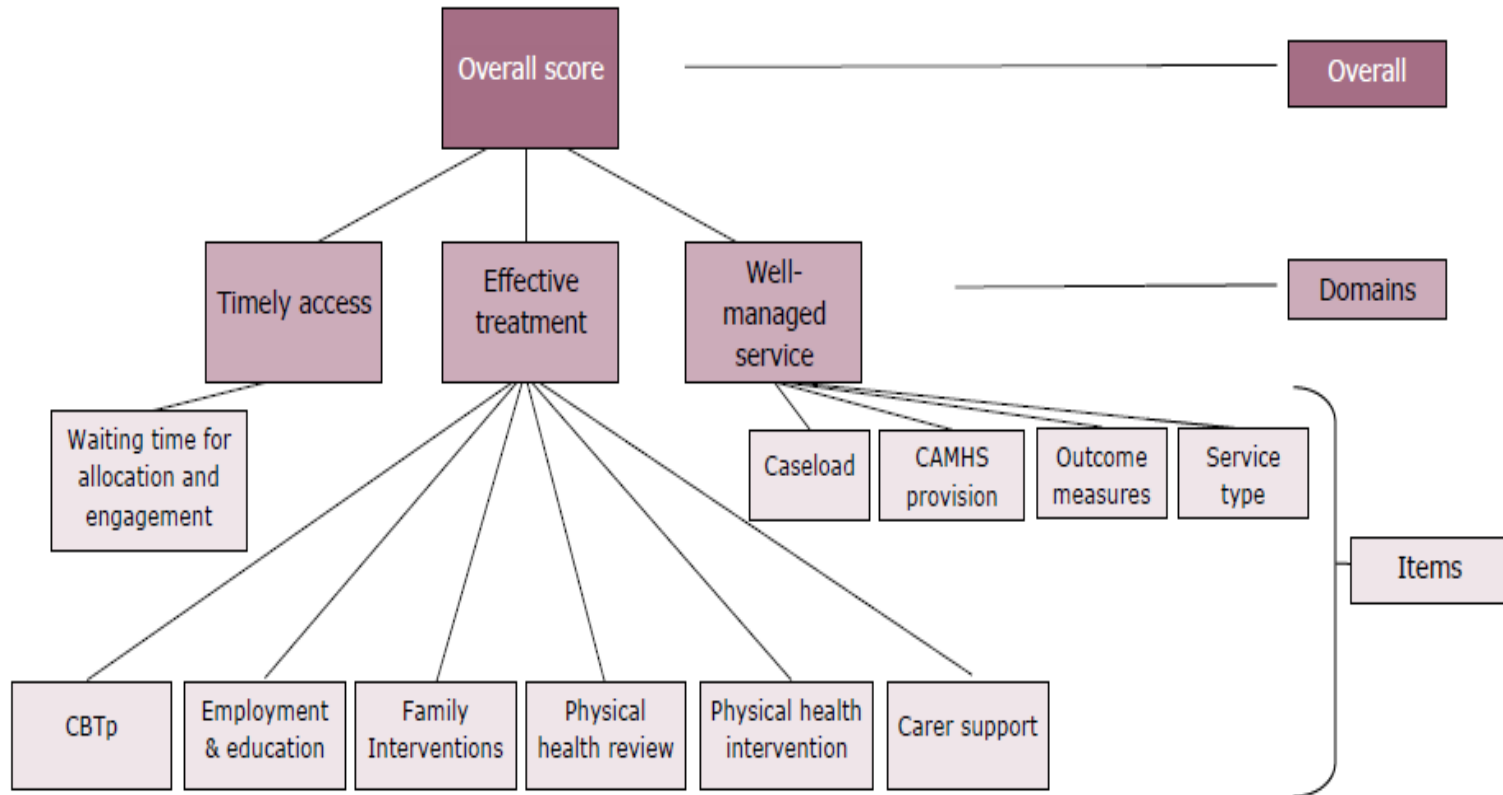


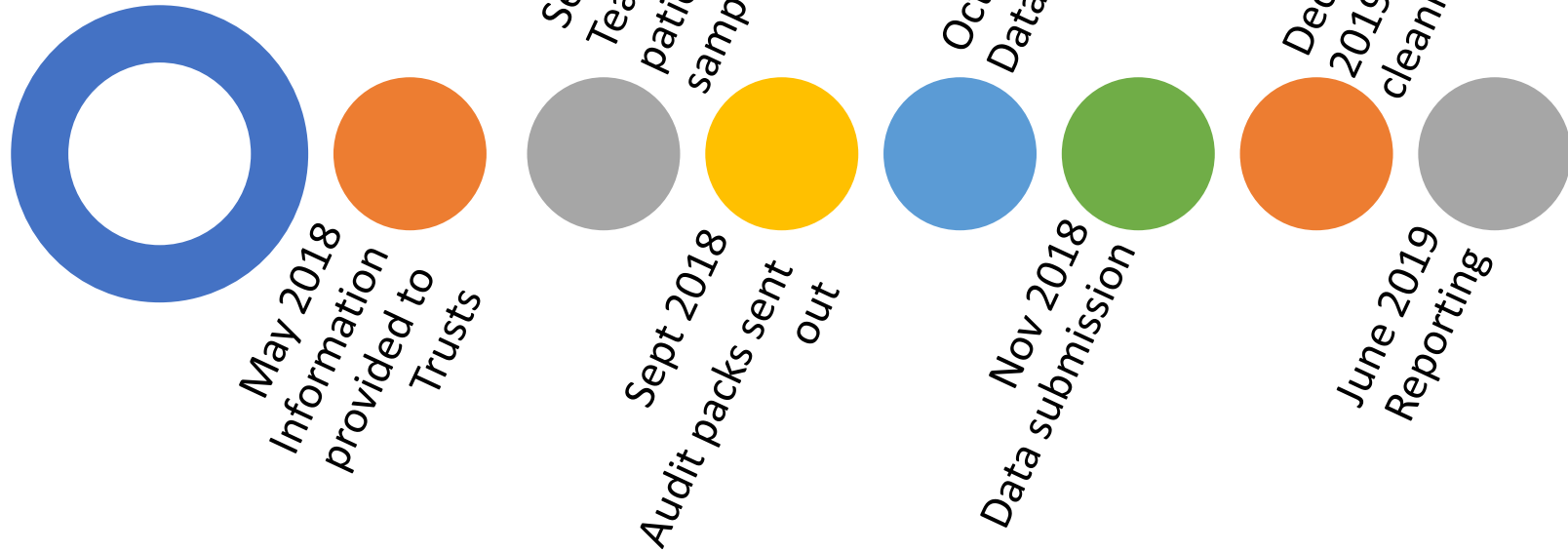
Figure 1. Hierarchy of items, domains and overall score.

As seen in Figure 1, there are 11 *items* placed into 3 *domains*, which in turn inform the *overall score* for an EIP team.



Logistics of the audit

2018 - 2019 EIP
spotlight audit





EIP sample

- Random sample
- Up to 100 patients per team
- Aged 14 – 65
- On the caseload at census date (*01/02/2018*) for 6+ months

EIP Audit standards

- S1*** Service users with first episode of psychosis start treatment in early intervention in psychosis services within 2 weeks of referral (allocated to, and engaged with, an EIP care coordinator)
- S2** Service users with first episode psychosis take up Cognitive Behavioural Therapy for psychosis (CBTp)
- S3** Service users with first episode psychosis and their families take up Family Interventions
- S4** Service users with first episode psychosis who have not responded adequately to or tolerated treatment with at least 2 antipsychotic drugs are offered clozapine

* data will not be collected for this standard, the Early Intervention in Psychosis Waiting Times data published by NHS England will be used November 2018 – January 2019

EIP Audit standards cont.

S5 Service users with first episode psychosis take up supported employment and education programmes

S6 Service users receive a physical health review annually. This includes the following measures:

- Smoking status, Alcohol intake, Substance misuse, BMI, Blood pressure, Glucose, Cholesterol

S7 Service users are offered relevant interventions for their physical health for the following measures:

- Smoking cessation, Harmful alcohol use, Substance misuse, Weight gain/ obesity, Hypertension, Diabetes/ high risk of diabetes, Dyslipidaemia

S8 Carers take up or are referred to carer-focused education and support programmes

EIP Audit standards cont.

Outcome indicator

- I.1 Clinical outcome measurement data for service users (two or more outcome measures from DIALOG, QPR and HoNOS/HoNOSCA) is recorded at least twice (assessment and one other time point)

Clarifying self-assessment

2018/19 assessment of NICE-concordance for the EIP standard

- In 2018/19 NHS England will utilise the National Clinical Audit for Psychosis EIP spotlight audit to collect data from EIP teams on progress made against this element of the EIP standard.
- Timelines and processes for collecting and submitting data for the NCAP can be found on the Royal College of Psychiatrists' [website](#).
- All teams should have received the self assessment tools

2018/19 assessment of the *Improving physical healthcare to reduce premature mortality in people with SMI (PSMI) CQUIN*

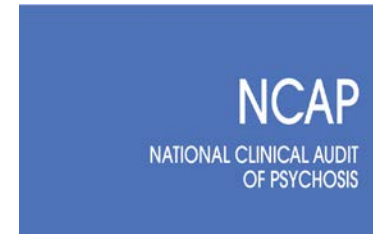
- The National Clinical Audit for Psychosis EIP spotlight audit will also collect information related to early intervention in psychosis team's performance against the [PSMI CQUIN](#). This includes new EIP indicators for 2018/19 relating to weight gain and smoking cessation.
- Data collection for inpatient and community teams performance for the CQUIN will be collected through a separate data collection process. NHS England is currently undertaking a procurement process to find this audit partner and further information will be provided when the procurement process has been finalised.

Service user survey 19/20

- NCAP will launch a Service User Survey to collect data alongside the case note audit in 2019/20.
- Service user focus group, convened by Rethink Mental Illness, to review and provide feedback on draft questionnaire and its implementation which is due to be signed off at NCAP steering group in November.
- Teams will be asked to send out the survey to 150 patients each.
- Prepaid envelopes will be provided along with surveys, and patients will return forms directly to NCAP team (online data submission is also possible).
- It was agreed that the survey would include measures of patient experience to complement the outcome measure data that will be collected from MHSDS and via the case note audit in future.

Future NCAP

- We will compare NCAP results in 2018/19 to MHSDS to support improved DQ
- The 2019/20 process will run at a similar timeline to this year commencing in September 2019 and reporting in April 2020
- As is the case this year, teams will be asked to submit data on a random sample of patients via an online portal. However, in order to match data to that in the MHSDS, we will be asking for patient identifiable data (NHS Number, Date of Birth, Post code) and therefore NCAP is going through CAG approval



Thank you

Paul French
@pfrench123
paul.french@gmmh.nhs.uk

Closing Remarks

Fleur Carney
15:40 – 15:45



#EIPNORTH18

Event Close

15:45

