North East and Yorkshire and the Humber EIP Network – 15.08.19
Table Top Discussions

Dr Steve Wright introduced the group discussion session focussing on what are the unintended consequences of the current quality framework and how can we address these?

The attendees were asked to focus on the following topic areas:

1. What did AWT standards ever do for us (service users and carers)?
2. The benefits and side effects.
3. What else happened?

Attendees to were asked to discuss, share best practice and capture feedback on the forms provided. The collated feedback from the discussions is included below:

Table Top Discussions Summary - 1

- Original staff from beginning of EIP feel ethos of EI, creativity and spontaneity has been lost. The focus on AWT has led to resource being taken away from therapeutic work.
- Document focussed on specialist skills and day to day recovery, the bread and butter still needs to be done.
- Roles as care coordinators has changed for the better as there's more to refer to e.g. family team, STR worker.
- More training available
- Mental Health Act assessment work has increased over recent years.
- Ethos of 'young person in distress, lets work with them' has been overtaken by standards (e.g. refer straight away) and resource issues.
- Not getting as many under 18s as should be
- Average case loads used to be x12. Now moved up to 15 or 16, victim of own success. CCG sees as a well-functioning service and therefore not committing additional funding to expand services.
- Overwrite the clusters, only way
- Thought people 35+ years old would have obtained more life skills to be able to manage however, found that the people who are damaged from a young age haven't had the opportunity to gain these skills and need more work with them.
- Care coordinators struggle to make the differentiation between EI patients and ARMS patients. ARMS pathway – presentation is clear more trauma based.
- Struggle to put limits on how long see people for.
- ARMS service from DEC (Newcastle) and people over 35 years of age will only get x 18 month of services – are they going to be getting as much as 35 years and under? Bit of flexibility on timescales needed.
- Patients of different ages might be impacted by unconscious bias e.g. younger ones fitting the description for 1st episode of psychosis for services whereas older ones referred on.
- Major issues in managing on to enhanced teams across the board. Hull now have a policy where EIP must be picked up by CMHTs within 3 months.
- Joint management meeting of EIP and CMHT teams every 2 weeks
- GPs in Newcastle more aware and have been talking more.

- 3-year service period.
  - Newcastle.
    Selecting and offering to patients that after a year, that can keep the remaining 2 years in the bank and come back at a later stage. So, a lot of patients (who are well and not engaging much) are taking this up.
  - Hull. Say the 3-year service period start from a specific date and runs for 3 years and can engage or not and come back within a 3-year period as needed.
    OT stretched since implementation of new standards.
  - Sheffield
    OT perspective – focus on job retention, starting out e.g. your risk of losing college/uni course/jobs
    Are getting IPS workers to look at people who aren't in education/employment
    Just got a band 5 employment and education worker for vocational interventions
    Access to O.T has got better since had to concentrate on AWT as have been able to get in quicker with patients. Maximising efficiencies.
    Some IPS services only open to primary care and not secondary care.

  - Barnsley
    Trying to implement more open dialogue ideas. Useful driver for commissioners.
    Ensuring e.g. OT's are involved in this.

- Sheff = not great take up on family interventions
- Hull & Barnsley = family intervention take up going well. Care coordinators have done some of the training.
- CBT – a lot indicate doing CBT but underneath are using different approaches which are similar to CBT. Should still have a personalised approach, make the best approach for the client.
  Not everyone getting CBT as not enough trained. Can give CAT therapy but no evidence that it works for psychosis. Has to be practice based evidenced approaches for EI.

Table Top Discussions Summary - 2

- Consequences of AWT, challenges on assessments/capacity "suspicion of psychosis" = ↑ referrals ↑ complexity of presentation

  Recruitment – Band 5s? Why is EI not attracting?
  Recovery – group work ↓ as ref ↑ capacity challenges. No current groups.
  Training – PSI lost – culture of team/basic skills set → increasing.
  Clinician confidence/skill DBT/Trauma – skills needed.

- IPS model too restrictive – support greater volume of work would be more useful. More support workers.
- Little room to innovate/be creative due to pressure on outcomes/capacity. Increased pressure on time due to admin
- Are getting bigger – more travel time, less capacity.
- Lack of meaningful service user involvement/peer workers. Any money currently goes to care co due to capacity.
- Carers/family's needs not met/becoming less meaningful
- Youth focus? What's that? LOST!! Are the over 35's a group of long DIP – differing needs, challenges.

Table Top Discussions Summary - 3

- ARMS pathway developed
- Losing youth focus
- Care Coordinators feeling less space for creativity, more forms, making sure performance managed. Risks of being de-skilled.
- MARMS – ends up taking a back seat as not included in the NCAP audits.
- Family interventions = ARMS gets left out – can be tick boxed, not as meaningful when offered.
- Created protected roles, helps focus on interventions
  - Different strategies
  - Going out to families as a standard
  - Offering group sessions at point of referral
  - Formulation at 10 weeks
- Service has changed – influx of new people. Focus changed. Prescribed. If other things might help but feel they are not the NICE recommended intervention.
- Groups – e.g. football – now don't have time to do. Moved towards voluntary sector. Some groups have been adapted to fit into vocational intervention or physical health interventions.
- More capacity has been created – but more pressure around how to use capacity e.g. BFT, physical health, audit time.
- Issues with CAMHS – caseloads not allowing to meet 14 day, now have joint worked to find resolution.
- Barriers in transferring on to Adult MH services affecting caseload numbers.

Table Top Discussions Summary - 4

- Push on activity – increased demand on clinicians
- Affect quality of work
- Expansion in areas however takes away from other essential areas in relation to recovery.
- Target key areas only
- NCAP doesn't capture essential areas of recovery such as social inclusion and does not facilitate progression/funding in these areas as it is not measured/paid outcome.
- Need to consider impact of failing targets on future funding
- If a team doesn't have an embedded member of the team but interventions are offered – this isn't captured.
- AWT Pressures
  - Resulting in changes in processes and development of pathways
  - Age range needed to be altered, impacted on what can be offered
  - Criteria can be unclear
  - AWT can result in increased referrals as they will get assessed quicker
  - More of an assessment team
- Although they should be collaborative – meeting targets can result in increasing targets and restrictions on what services can offer. It becomes a service that excludes and not includes.

Table Top Discussions Summary - 5

- ARMS care coordination isn't always easy to access
- Less psychological work from CC's – therapies and waiting list getting higher
- Loss of friends and family forums – just starting again now
- Loss of team work with therapists
- Linked nominated individuals in CAMHS and alcohol substance services
- Length of time people in extended assessment.

Table Top Discussions Summary – 6

Key Points: Question One	Question Two	Question Three
- Staff loss of confidence → Assessments ↑ - Service users on extended assessment → Time limits → Dedicated time - Joint working → Different targets in each team → looses networks → Patients having to have separate assessments - Youth focus - Referrals from services → understanding	- Youth focus - Collaborative working - More defensive in terms of referrals - Time scales → ARMS to FEP →too long (lack of staff, confidence and understanding) - Basics → starting point work - Family interventions → some services are separate → lack of co-working → lack of family work eg diving assessment - Staff workload Time pressures More work – less time More 'tick boxes' - Medic Reviews → reviews not happening as often as they should - Pathways - Staff panic - Feeding back from assessment	- ARMS - CBTp → suitability - Therapy formulation with staff as patients - Offering more structured interventions - What pathways → what clients can assess certain therapies