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NHS
Yorkshire and the Humber Strategic Clinical Networks

# Yorkshire and the Humber Mental Health Network

# Early Intervention in Psychosis Network 3rd March 2016


- **Stephen McGowan, EIP Clinical Lead for Y&H SCN and NHSE (North)**
- **Rebecca Campbell, Quality Improvement Manager and Sarah Boul, Quality Improvement Lead**
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- **March 2016**

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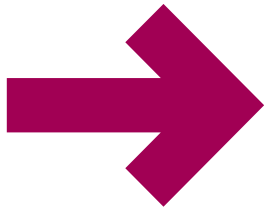
# Yorkshire and the Humber
# Early Intervention in Psychosis Network

# Welcome!

## Introductions
## Aims, Objectives and Terms of Reference

**Steve Wright, Consultant Psychiatrist, Tees Esk Wear Valleys NHS Trust**



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## Yorkshire and the Humber
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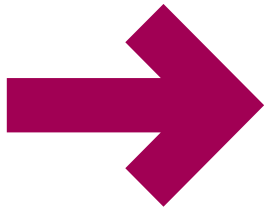
# Strategic Clinical Network Overview


## Alison Bagnall, SCN Network Manager – Mental Health, Dementia and Neurology (MHDN)

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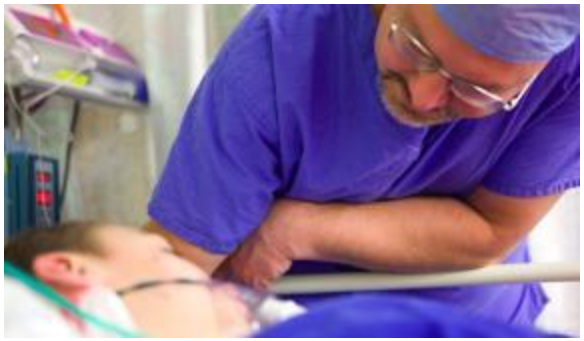


Alison Bagnall
SCN Network Manager – MHDN
March 2016

THE NHS CONSTITUTION
the NHS belongs to us all

# What are Strategic Clinical Networks?

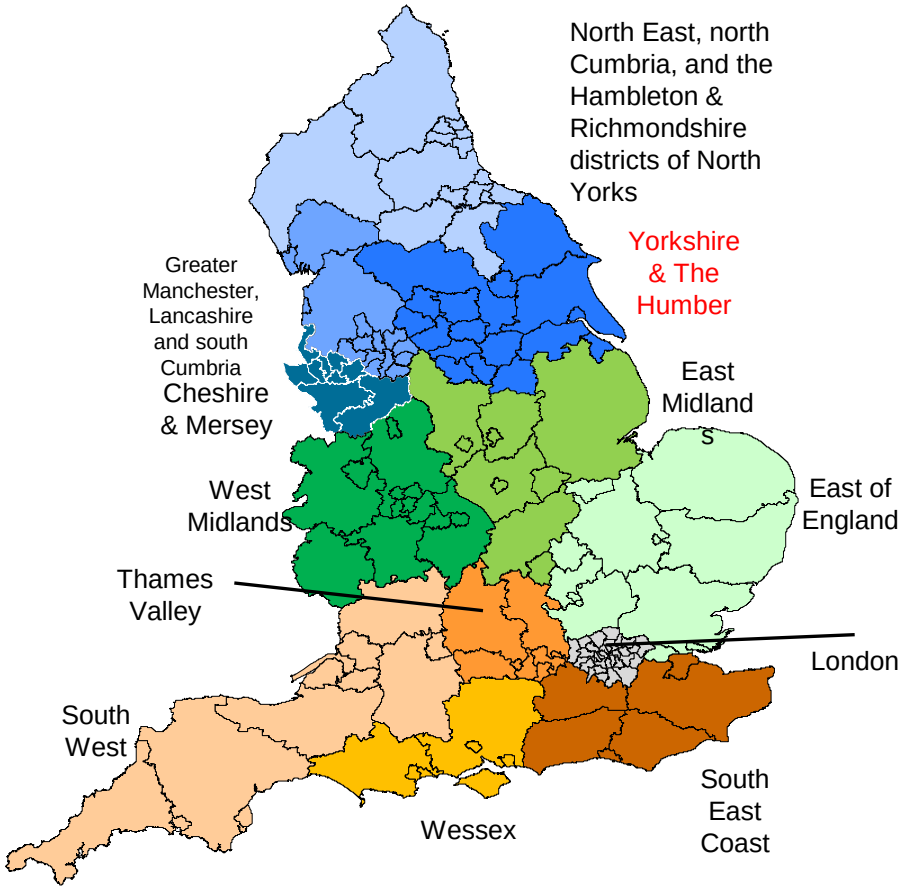
SCNs operate as engines for change across complex systems of care, maintaining and or improving quality and outcomes. They bring primary, secondary and tertiary care clinicians together with partners from social care, the third sector and patients

In future SCNs will be nationally mandated, hosted by NHS England and will receive national commissioning funding for their core functions

Within Y&H, SCNs are hosted by NHS England (Y&H) but work closely with NHS England (North) and NHS Policy leads for MH

# SCN and Senate Geography

- 12 senate geographical areas
- One core support team per senate
- Number and size of each network is locally determined, to take account of patient flows and clinical relationships



# What can the SCNs do for you?

SCNs are established to:

- Work across the boundaries of commissioning and provision, as engines for change in the modernised NHS
- Support commissioners with their core purpose of quality improvement and ultimately the achievement of outcome ambitions for patients – allowing flexibility for health communities to develop their services in line with local need and circumstances
- Provide a link between national policy MH leads, NHS England (North) and (Y&H) to ensure up to date advice and best practice is shared

# How SCNs can be effective

- Added value for patients, professionals and constituent organisations – pulling together common themes
- To support the development of coherent and effective network arrangements – fostering a culture of collaboration and engagement for quality improvement
- Supporting groups with clear terms of reference relating to outcome ambitions and quality improvement and helping with day to day actions
- Support CCGs in their annual assessment (authorisation process) by providing help, assistance and insight into what is being assured

# How SCNs can support work in EIP

- Bring together everyone with an interest in EIP not just practitioners
- Facilitate engagement and information sharing from relevant national leads, including arranging for them to attend meetings to present when appropriate
- Support EIP teams to understand demand by highlighting available incidence profiling
- Disseminate information on the baseline position of teams in Yorkshire and the Humber including gap analysis, staffing, skill mix and ability to deliver NICE concordant interventions
- Assist with preparation for the new data collection requirements by sharing best practice and guidance
- Work with EIP teams to consider workforce capacity, skills and leadership

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# Overview of New Commissioning Guidelines

**Moggie McGowan, EIP Clinical Lead (Yorkshire & The Humber),**
**NHS England North**

Awaiting permission to share access to slide set

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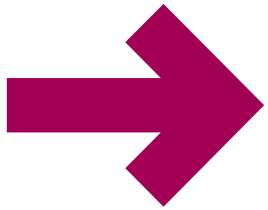
# Identifying Key Concerns

**Steve Wright, Consultant Psychiatrist, Tees Esk Wear Valleys NHS Trust**



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# Time for a break?

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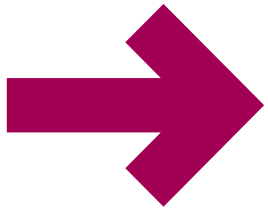
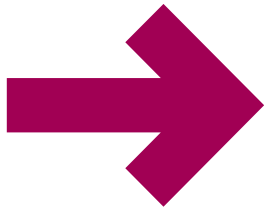
# Table Discussions on Key Concerns



# Topics to Consider:

- The Money!
- Over 35's
- Establishing the CBT Workforce
- Family intervention
- Engagement and disengagement of the AWT pathway
- Role of the care coordinator



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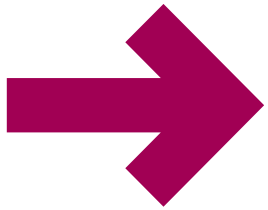
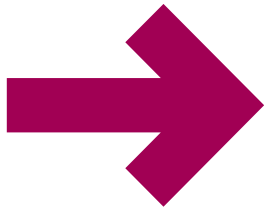
# Feedback, Discussion and Actions



# The Money

- CCGs ought to look at redeployment of resource from CMHT to other service models.
- EIP services are poaching staff from IAPT services (as they employ the CBT trained staff) so what can providers do to stop this.
- Workforce calculator highlighted gaps of £2m, £1m and £750k around the 3 CCGs represented.
- Consider more CBT practitioners for psychosis - good retention likely if graded B7.
- Cluster 10 in patient beds consume a disproportionate amount of income- should CCGs review this?
- Medical o/p services in CMHTs may need a review as often there is no incentive for patients to be discharged.
- CCGs wont get this all right (NICE compliance etc) by end March 2016- it will take a few years to transform services.
- No one is clear where all the revenue has gone for MH.



# Over 35s

- Concerns raised over capacity within services to accommodate a potential upsurge in referral numbers and the potential for inappropriate referrals.
- Concerns raised over knowledge and training for working with older adults. Whilst services have worked with adults up to the age of 65, and have seen successes, such patients tend to be very complex.
- Discussed the disparity between EIP in men and women up to the age of 40 and the potential for post menopausal issues for women.
- Discussed that current treatments and services are geared towards younger people and considered that for older patients family dynamics and health conditions could be very different. Additionally, social care needs are often different and potential more complex.
- Discussed the evidence base for screening tools and how to identify and treat EIP in older adults.
- Discussed the potential to co-work with Community Mental Health Teams and utilise skills already in place.

# Establishing the CBT Workforce and Family Intervention

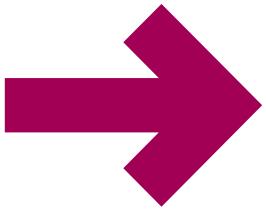
- Consider meeting standards through recruitment versus training staff from scratch. Several providers are advertising for clinical psychologists with CBT skills and /or CBT Therapists. The JD is therefore a hybrid including both psychologists & therapist in the person spec.
- Maintaining the skills of the trained staff – concerns regarding being able to use & maintain skills, ensure supervision.
- Concerns also that in 2 years' time when people are trained that they will be back in their original jobs or will leave. Some providers were putting staff into a new post 'Trainee for CBTp' and their previous post to be advertised. The post holder would then be re-graded when training was complete. This would not be the case for all.
- Money – questions & concerns regarding the funding which has been absorbed in most cases. Negotiation is required regarding funding to fill the posts of those who have moved into training.
- Family Intervention (Behavioural Family Therapy) – there were some comments that the training provided for FI was only an introduction and did not provide someone with the confidence to practice FI. Also that there was no ongoing supervision provided. Versus systemic / open dialogue.
- Assessment & Waiting lists – who undertakes assessment, how are waiting lists managed, how long is a person waiting from assessment to therapy?

# Engagement and Disengagement of the AWT Pathway

- Clarification on length of time to leave a referral open 3-6 months?
- There needs to be guidance developed for the region on good practice in engaging with patients, for example, How many times you try to visit a patient in the time before you can close the referral. There needs to be a set minimum requirement.
- As above but guidance for the referrer and the expectations on them if the individual has not engaged with the service.
- There was a lot of discussion about how to link into other services that the individual may use and using them to help bring the patient in.
- Being able to shut the referral down if there is no engagement was also important as services are being measured against this. This would be defined in the guidance though after the minimum level of trying to engage has been reached.

# Role of the Care Coordinator

- Discrepancies in roles and questions about accountability were discussed.
- Some services do not have fully qualified Care Coordinators.
- Supporting Recovery workers – but in some areas they aren't able to due to number ratios of staff to patients.
- Supply and demand issues – more demand then supply.
- Staff are paid more in some areas then others doing the same job.
- High caseloads, which cause issues with implementing different interventions.
- Paperwork issues within some areas.
- Concerns from Care Coordinators with recovery, flexibility and outreach.
- Care Coordinator teams need to work on internal communications within their Trusts – currently there is a feeling of segregation.



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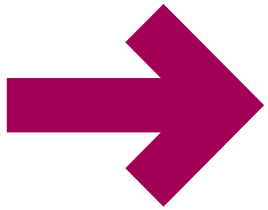
# Any Other Business

## Future Meeting Planning
## Closing Remarks
## Evaluation

**Moggie McGowan, EIP Clinical Lead (Yorkshire & The Humber),**
**NHS England North**



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# Thank You for Attending!

## Don’t forget to fill out your online evaluation!