Care Services Improvement Partnership CSIP

National Institute for
Mental Health in England

10 High Impact Changes

for Mental Health Services

June **2006**

Contents

Forewords

The 10 high impact changes were first launched in 2004. The changes aimed to make sure that every single service user received the best possible care, every single time. The original high impact changes demonstrated how staff and organisations improve the quality of care service users received.

Now, building on the success of the original work, this guide sets 10 High Impact Changes for use across mental health services. The scope is wider but our aim of improving quality and efficiency of care for each and every service user remains the same and will continue to guide our service improvement activity through 2006 and beyond.

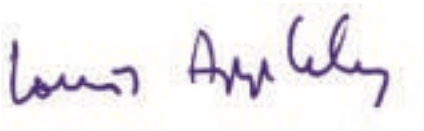
The 10 high impact changes aim to improve quality of care but they are also about improving the efficiency of services – making the best use of resources to benefit service users. In this sense the drive to increase efficiency provides a more streamlined and effective service tailored to individual service user needs.

I am grateful to all of those organisations who have worked to identify what the 10 High Impact Changes can mean to mental health services and to capture their invaluable learning and experience.

Building on the success of the original 10 High Impact Changes and the early work undertaken by pioneering organisations, this resource is based on experience in the field. But we also recognise that this is only the start of knowing more about what works and what has the greatest impact. We will continue to increase that evidence base and improve our working knowledge.

The 10 High Impact Changes for mental health services reflect the journeys that service users and carers make through services and ways in which we can improve their experience. This way of working will help us all deliver and demonstrate the system reforms outlined in the White Paper 'Our Health, Our Care, Our Say'.

Offering real choice and improving access require us to look at the whole picture and how each component of the system impacts on others. Our challenge is to continue building on the successes already achieved, sharing learning and securing benefits. The High Impact Changes for mental health services confirm that making a real difference is possible.



Louis Appleby
National director for mental health
Department of Health

It is a particular pleasure to introduce the Care Services Improvement Partnership's guide to the 10 High Impact Changes for mental health services. The guide extends the scope of the original work to include a 'whole systems' approach to incorporate all types of services that support people with mental health problems whatever level of support and care is required.

The 10 High Impact Change evidence included in this guide has been gathered from regional and local initiatives, giving details of changes made to services, the results achieved, and the role of the staff and service users in improving services.

The 'impact measures' demonstrate in real terms the improvement in service provision through implementation of the 10 High Impact Changes, particularly in terms of service user experience and the efficiency of care they receive.

This evidence is presented as case studies which set out in detail the changes made, who was involved in those changes and – most importantly – how the benefits realised have been measured.

This guide includes examples of effective partnerships between staff, service users and carers and how we can change practice in ways that will make a genuine difference to the lives and experience of people with mental health problems, and to the working lives of staff. For example, implementation of the High Impact Changes has resulted in service users spending shorter times in hospital, being discharged more efficiently, receiving more appropriate or less contact with services and increased employment opportunities.

In conclusion, the 10 High Impact Changes have made a real difference to service users' experience of mental health services. I hope that within CSIP we can build on the already substantial achievements of staff and service users to extend this work more widely and look to enhance the growing evidence base across the range of care groups within mental health care services.

Peter Horn
National mental health lead
Care Services Improvement Partnership

10 High Impact Changes for Mental Health Services

1. Treat home based care and support as the norm for delivery of mental health services.
2. Improve flow of service users and carers across health and social care by improving access to screening and assessment.
3. Manage variation in service user discharge processes.
4. Manage variation in access to all mental health services.
5. Avoid unnecessary contact for service users and provide necessary contact in the right care setting.
6. Increase the reliability of interventions by designing care based on what is known to work and that service users and carers inform and influence.
7. Apply a systematic approach to enable the recovery of people with long-term conditions.
8. Improve service user flow by removing queues.
9. Optimise service user and carer flow through an integrated care pathway approach.
10. Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce.

This document refers to people that use services as 'service users' and the people that support them as 'carers'. We have used this wording throughout for consistency and continuity. We understand that our choice of words may not be everyone's preferred phraseology.

Introduction

The Care Services Improvement Partnership

The main goal of the Care Services Improvement Partnership (CSIP) is to support positive changes in services and in the wellbeing of:

- people with mental health problems
- people with learning disabilities
- people with physical disabilities
- older people with health and social care needs
- children and families with health and social care needs; and
- people with health and social care needs in the criminal justice system.

We aim to:

- provide high-quality support to help services improve
- help services to put national policies into practice and provide them with a link to government
- involve people who use services and their carers in all improvement work
- share positive practice and learning about what works and what doesn't
- pass on research findings to organisations to help them improve services; and
- encourage organisations to work in partnership across all sectors.

The 10 High Impact Changes underpins the majority of the work of the Care Services Improvement Partnership and reflects the principles adopted in its service improvement activity.

How CSIP will support implementation of High Impact Changes in mental health services

CSIP is committed to supporting service improvement in health and social care. The ways of doing this are negotiated locally and in response to local need and existing resources.

We have eight regional development centres (RDCs) spread across the country. All RDCs employ staff with service improvement expertise to advise and support local implementation of new ways of working, including the 10 High Impact Changes for mental health.

Contact details for all RDCs are at the end of this document.

National Institute for Mental Health in England

As a CSIP programme, the National Institute for Mental Health in England (NIMHE) supports and improves services for people with mental health problems and runs a range of programmes that support positive changes in mental health services.

We support service improvement and help to deliver change in local health communities in a variety of ways including:

- providing examples of positive practice
- sharing learning
- sharing skills; and
- sharing tools and techniques for service improvement.

Background to the 10 High Impact Changes for mental health services

In 2004 the NHS Modernisation Agency published the 10 High Impact Changes for service improvement and delivery: a guide for NHS leaders.

Based on evidence derived from work with clinical teams and services around the country, the document identified areas of service improvement that have the biggest impact and can realise maximum benefit for service users and carers and on clinical outcomes, service delivery and staff and their organisations.

Essentially the document provided measurable evidence gained from work that involved redesigning systems, processes and roles.

While some of the Modernisation Agency work included examples from mental health settings, it was uncertain whether the 10 High Impact Changes (2004) could be applied across the full range of mental health services.

In summer 2005 NIMHE released a discussion paper, The ten high impact changes: making them relevant for mental health. The paper was designed to support evidence collection in order to find out how the 10 high impact changes are relevant to service improvement throughout mental health services.

During 2005 and early 2006, CSIP regional development centres (RDCs) began to identify examples of service and process redesign within local health and social care communities where demonstrable impact is evident and which supports one or more of the high impact change areas.

How has the evidence been collated?

Case studies and data from the field that have been mapped against the NIMHE 10 High Impact Changes (Discussion Paper 2005) have been highlighted and selected through CSIP Development Centres and pooled nationally.

Our case studies have been peer reviewed by a small project group made up of service improvement leads and representatives from service providers and commissioners. All other material has been reviewed in relation to the strength of qualitative and quantitative evidence of impact of service or process redesign on the service user and carer experience, service delivery, outcomes and organisations.

We have included case studies as well as supplementary impact measures taken from other examples that indicate components of the high impact change.

This initial collection only reflects the evidence we have been able to capture to date as a result of this exercise.

Details of the services and organisations that have provided case studies and supplementary information and data are listed at the end of this document. Further details of case studies can be found at: *www.nimhe.csip.org.uk/10highimpactchanges*.

An independent literature review has been mapped against each of the high impact change areas to further validate experience from the field.

While not all of the literature reviewed directly supports the high impact change areas the rest of the material does specifically relate.

We know there are gaps in this collective evidence base, not least in relation to individual high impact changes. There are a variety of possible reasons for this:

- we have not captured much of the good practice and experience in the field yet
- the data collection exercise identified 'work in progress' that was not yet ready to demonstrate impact and realisation of benefits'; and
- there has been some service improvement work which while representative of good practice has not included a measurement system to demonstrate the level of impact.

The ongoing high impact changes programme will continue to identify and collate case-study examples of service improvement so the evidence base will continue to grow.

How will we build on this evidence base?

In the longer term, and in response to feedback from local health and social care communities the high impact change programme will target areas where the evidence base needs strengthening.

Practice based evidence will continue to be identified and supported through the RDCs and from localities who wish to highlight and share service improvements.

If you would like to contribute to this evidence base please go to *www.nimhe.csip.org.uk/10highimpactchanges* to download the case study template.

Future focus areas

In the context of the implementation of White Paper 'Our Health, Our Care, Our Say', both the literature review and the evidence collection suggest we need to pay particular attention to:

- service user and carer involvement
- integrated health and social care settings
- progress of service improvement initiatives to improve the experiences of people with dual diagnosis
- children and adolescent mental health services (CAMHS)
- older people services
- specialist mental health services undergoing redesign and at early stage of development such as early intervention psychosis
- health and social care criminal justice
- complementing the National Framework to Support Local Workforce Strategy Development (2005). Subject to the review of central returns (ROCR) approval collate evidence of the impact of new roles like the support time and recovery workers, graduate workers and in relation to the other High Impact Changes
- supporting the continued work of the BME focused implementation sites that will in time provide more material about their impact
- the impact of work to improve the physical health of people with mental health problems; and
- increasing knowledge on the High Impact Changes that lead to greater efficiency and resource savings.

The launch of this High Impact Changes programme is just beginning. We have produced this resource specifically so it can be updated on the web and accessed in a bespoke way that will be most helpful to NHS and social care organisations.

Using the 10 High Impact Changes for mental health services

What is the scope of this work?

The 10 high impact changes for mental health services are relevant across the range of health and social care statutory and non-statutory mental health organisations and settings from children's' services to older peoples mental health services to specialist services within the criminal justice system. Often the principles and application of service improvement are transferable and learning can be usefully shared across different areas of the health and social care community.

The 10 High Impact Changes for mental health services will be most helpful if used in the wider context of service improvement. The Integrated Service Improvement Programme (ISIP) stepped guide to service improvement 'Delivering quality and value: the ISIP guide to strategy and benefits' (2005), provides a framework for delivering integrated service improvement.

ISIP is based on the principles that achievement of benefits of service improvement can be enhanced by aligning process redesign, workforce and technology reform.

Key principles of benefits management are outlined below:

- a benefit can be defined as an advantage to a person or a group of people i.e. a stakeholder or group of stakeholders
- a benefit is only a benefit when the recipient says it is
- benefits are often retrospective i.e. they come to light afterwards rather than having been planned for
- we often rely on perceived benefits rather than articulating what benefits we expect to see before the change and identifying measures to show us that they have been realised
- benefits must at the very least be observable and should be measured; and
- realising benefits usually means: doing something new, doing things better or stop doing something.

Benefits management

Using a 'balanced scorecard' approach to identify the potential benefits and their measures can be helpful in ensuring a cross-section of measures are incorporated including quantitative and qualitative measures.

Measures of the impact of the change are what inform us that the benefits have been realised and sustained, ensure resource efficiency, avoid duplication, reduce waste and streamlines processes.

How can the high impact changes programme support local health and social care communities?

The 10 high impact changes programme presents just a small sample of service improvement work from around the RDCs areas from which we will develop an ongoing programme of work.

Case study evidence will be updated and accessible through the website (*www.nimhe.csip.org.uk/10highimpactchanges*).

Through the RDC service improvement role

- the work programme will support local health and social care communities to implement the White Paper 'Our Health, Our Care, Our Say' (2006). It will underpin and support the system transformation and process redesign components of the White Paper. In particular: service redesign that will support the shift to providing treatment in the community, integration of health and social care services, choice, support for service user-focused services, service user and carer involvement and support for self-care; and
- it will provide a framework for service improvement alongside Connecting for Health and workforce reform (ISIP)

Integrated Service Improvement Programme (ISIP)

The work programme will also support local health communities within the context and framework outlined through ISIP. The focus on care which provides both quality and value is central to the delivery of a patient-led NHS.

ISIP sets out how local health and social care communities can align their efforts to maximize the benefits of workforce reform (new roles and new ways of working, pay modernisation), process (high impact changes) and technology (Connecting for Health) by integrating these three key enablers of change within service improvement.

ISIP provides tools, techniques and support to assist the delivery of transformational change by encouraging local health communities to focus on planning and delivering benefits from their service improvement activities.

The identification of common goals and working in an integrated way are essential to deliver the quality and efficiency improvements required to achieve financial health.

By promoting collaboration across local health communities, ISIP provides an integrated approach to transformational change, reconciling local imperatives with national priorities and focusing improvements to deliver an efficient, patient led NHS. (ISIP 2005)

Local health and social care communities can use the 10 high impact changes for mental health services in relation to the following CSIP resources:

What works?

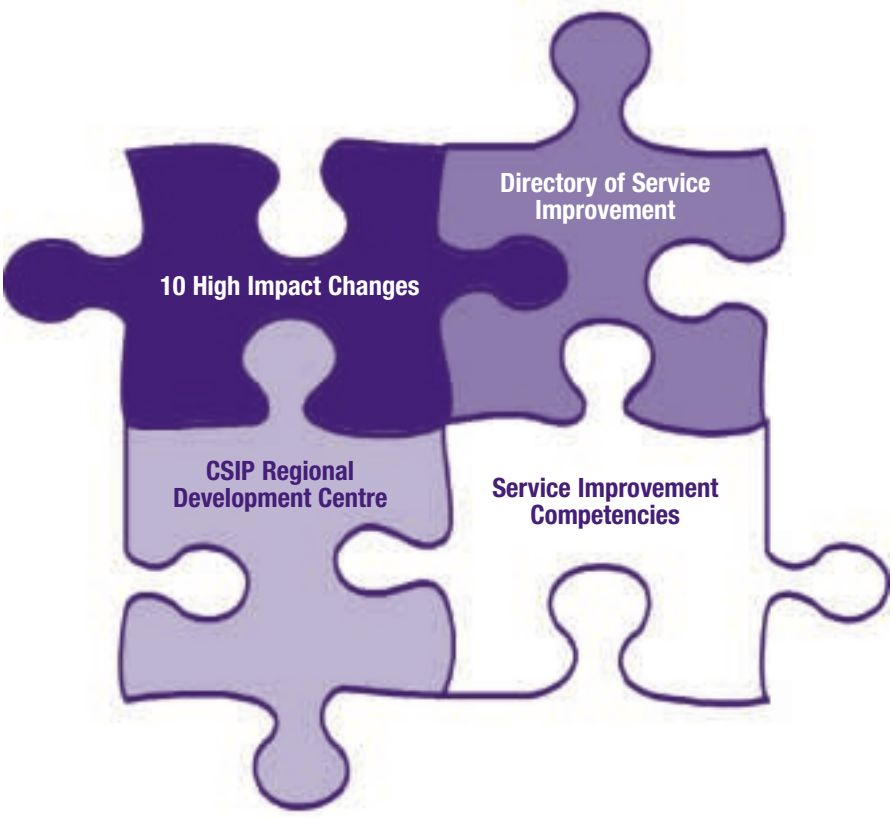
The 10 high impact changes for mental health services can inform what service improvements work based on practical experience from the field. A baseline assessment tool can be downloaded on *www.nimhe.csip.org.uk/10highimpactchanges* to help in initial mapping against the 10 high impact change areas.

What skills are required?

The competencies required to undertake service improvement activity are included on the NIMHE and Skills for Health websites. (*www.nimhe.csip.org.uk/serviceimprovement* & *www.skillsforhealth.org.uk*)

What are the tools and techniques?

Building on the NHS Modernisation Agency Improvement Leaders Guides (2005), the CSIP Directory of Service Improvement includes practical methods that will support implementation of the 10 high impact changes (*www.csip.org.uk/serviceimprovementdirectory*). The directory is further supported by the ISIP website (*www.isip.nhs.uk*) which provides a resource linked to tools and techniques that aid the delivery of effective change.



The High Impact Change service improvement award

NIMHE Positive Practice Awards scheme will include an award to be made to an outstanding example of a high impact changes service improvement initiative where compelling and robust impact has been evidentially demonstrated using the 'balanced scorecard' approach. Further details will be made available on the website *www.nimhe.csip.org.uk/10highimpactchanges*

Achieving a balance of benefits through a variety of measures

The improvement dividend framework or 'balanced scorecard' approach outlines some examples of potential benefits from process or service redesign in mental health services. From every benefit identified in any service improvement or change process the questions to ask are:

- **How will we know that we have achieved the benefit we identified?**
- **How can the benefit be measured and demonstrated?**

Achieving benefits and demonstrating High Impact Change requires robust baseline assessment and ongoing measurement of the service improvement.

A balanced scorecard of benefits

IMPACT ON SERVICE DELIVERY

- improved process flow across service boundaries
- co-ordinated and integrated care packages e.g. through single assessment process (SAP) or care programme approach (CPA)
- unnecessary admissions avoided
- re-admissions reduced
- shorter length of stay
- early and co-ordinated discharge planning
- fewer cancellations and Did Not Attend (DNA) appointments
- more effective use of existing resources: cost savings and redistribution
- reduction of out of area treatments.

IMPACT ON SERVICE USERS & CARERS

- less duplication
- absence of 'ping-pong' effect
- access to services closer to home
- improved choice
- better co-ordination of care
- carer recognition
- reduced delay in discharge
- fewer delays shorter waiting times
- less anxiety and greater satisfaction
- clearer decision-making
- greater control of self-care
- information on where to get help
- better quality of life.

IMPACT ON OUTCOMES

- speedier access to effective treatment
- implementation of National Institute for Clinical Excellence (NICE) guidelines
- DUP (duration of untreated psychosis) reduced
- better crisis management and relapse prevention
- improved recovery rates
- improved clinical care for people with long term conditions
- improved physical health
- increase in up-take of Direct Payments
- increase in service users accessing employment
- effective utilisation of advanced directives.

IMPACT ON STAFF

- less turnover
- improved sickness and absence rates
- improved recruitment
- complimentary skill mix
- better demand management
- improve staff satisfaction and morale
- reduce 'firefighting'
- professional and career development
- role development e.g. supplementary prescribing
- gaining dual qualifications
- opportunities to work across professional boundaries.

High Impact Change 1

Treat home based care and support as the norm for the delivery of mental health services

Hospital admission can be used efficiently and effectively when it is the most appropriate intervention required but can be avoided when alternatives are in place.

This means that inpatient services should be seen as a specialist and intensive intervention; and that there should be provision of a range of self-help and home treatment and care options, including appropriate community based support that can realise multiple benefits.

Case study 1 Demonstrating the impact of a crisis resolution and home treatment team (CRHT)

Easington CRHT, Tees, Esk and Wear Valleys NHS Trust (formally Tees and North East Yorkshire NHS Trust)

The Easington area had links to two specialist mental health trusts (now reconfigured) which had led to a variation in service provision for people in the community.

In the north of Easington there was no community based crisis service provision outside of 9-5 Monday - Friday. In the south there was a home treatment team that provided a 9-5, seven day per week service to people already within secondary care.

The intention was to improve care so that an equitable service based on social inclusion, recovery and home based treatment could be delivered and provide a genuine alternative to hospital in-patient admission. The project included involvement from the two provider trusts previously known as Tees and North East Yorkshire NHS Trust and South of Tyne and Wearside Mental Health NHS Trust (now part of Northumberland, Tyne and Wear NHS Trust), together with Easington PCT and Durham County Social Services.

Impact on service delivery

- a comprehensive 24 hour crisis service is now provided 365 days a year
- referrals increased from 210 in 2003 to 412 in 2004
- admissions reduced significantly from 175 in 2002, to128 in 2003 and to 92 in 2004; and
- projections for 2005 predict a 70% reduction against 2002 statistics, compared with the national norm of 30% following the introduction of a crisis service.

Impact on service user experience

- 97% of service users found CRHT easy or very easy to access or contact
- 100% found the appointment/response system good or very good
- 92% were aware of the out of hour's procedure
- 95% were informed of the care co-ordination procedure
- 97% were involved in the planning and evaluation of care; and
- 100% were satisfied or very satisfied with the care they received

Impact on staff and organisation

- staff sickness rates were 2.86% compared with the trust average of 3.97%
- worker testimony indicates increased confidence and reduction in stress as a result of shared decision making
- the implementation of the European Working Time Directive for medical staff was supported; and
- the delivery of the trust's capital programme was achieved by reducing inpatient bed use from 40 inpatient beds to 28.

Between June 2003 and May 2004 Easington PCT purchased 2,234 inpatient bed days. Between June 2004 and May 2005, Easington PCT purchased 1,585 bed days. The reduction in bed days achieved was 649 and at a cost of £220 per bed day, the total saving was £142,780.

Case study 2

Crisis resolution home treatment teams and crisis house, South Warwickshire PCT and Rethink

- 2 CRHT teams set up and Crisis House run by RETHINK

- care is provided to people who would have been previously admitted to acute inpatient wards and who are now offered Home Treatment as an alternative; and
- Crisis House is also available as a crisis resolution service.

Impact on service delivery

- reduction in bed occupancy, average 85% over last year on acute wards
- reduced length of stay
- increase in range of services offered. The CMHT offer a wider range of interventions including housing and occupation; and
- comprehensive service offered 365 days a year, 24-hours per day.

Impact on service user experience

- choice of treatments and places to be treated
- more recovery focused, flexible and individually tailored care

Impact on outcomes

- targeted treatments

Impact on staff and organisations

- staff focused in area of work
- more effective working with Social Services, and RETHINK (Crisis House providers); and
- rotation of staff from acute ward to CRHT improves range of services offered by PCT

Case study 3

South Essex Partnership NHS Trust

The Trust has focused on reducing the number of admissions to adult inpatient wards. Prior to this there was a bed occupancy rate of 115% with pressure on acute beds resulting in a total of 42 out of area placements at any one time.

As part of the Trust's work in examining admissions and discharges a series of meetings took place with senior medical staff within the Trust. Analysis of admissions revealed that a significant percentage of admissions occurred as a result of out of hours assessments.

This review also coincided with the introduction of crisis resolution and home treatment teams within the Trust. Senior medical staff concluded that a number of admissions to acute inpatient wards could be avoided by changing the existing model of service to incorporate the role of the new crisis teams and the development of an assessment facility, prior to admission onto the wards.

The Trust opened its new eight-bed assessment unit during early 2005 and aimed to integrate this service with the newly formed crisis resolution and home treatment teams. The role was to review and assess all referrals (not those under the Mental Health Act 1983) and to develop alternatives to admission.

This approach helped to avoid any breaches to the four hour A & E target. This new service model enables sufficient time for the crisis teams to assess each referral in a safe, calm environment and to determine and arrange for intensive support in the community, where appropriate. The operational policy for the new assessment unit is based on a maximum stay of 72 hours.

As part of this change process, senior medical staff across the Trust increased the number of ward rounds to ensure that admissions and transfers to acute wards were appropriate.

Where necessary they engaged the crisis resolution and home treatment teams to accelerate discharge arrangements.

The Trust believes the success of this initiative is due to a close review and identification of the factors influencing admission, particularly by junior doctors and the need to provide a safe environment to enable sufficient time for an appropriate community response.

Impact on service delivery

- within four weeks of implementation of the new model there were no new out of area placements
- dramatic reduction in the level of bed occupancy across the adult service and release of adult acute bed capacity
- the Trust has now taken the opportunity to close one adult ward (23 beds) and is confident that this excellent record of avoiding out of area placements can be maintained in the medium to long term
- the Assessment Unit has an average length of stay of 17 hours
- the new service provides appropriate support away from the A & E Department for service users, their families and carers; and

- provision of an effective gateway for all potential admissions.

Other impact measures identified from the field:

CRHT adult mental health

- 50% of available beds closed within 4 months of CRHT being in operation
- admissions into acute inpatient services of people from the area were reduced by 33%
- average bed occupancy reduced from 109% to 85%
- mean length of stay in inpatient services reduced by 33%
- estimate of 2,750 to 3,000 in-patient days made available due to avoiding admission and facilitating early discharge over an 11-month period; and
- average wait time for initial assessment reduced to 4 days and 2 hours for urgent referrals.
- over 60% of all trust service users aware of how to contact services in a crisis. (Mori poll)
- audit demonstrates a 98% satisfaction rate over a number of issues related to CRHT input; and
- reduction in sickness absence to an average of 2% from a service average of around 6%.

CRHT older people

- reduced utilisation of in-patient beds
- after 6 months 14% increase in available bed days for two in-patient assessment units. After 18 months bed reductions in same two units (20 to 12 in dementia unit and 24 to 20 in mental health unit) have been sustained with typical occupancy rates below 100%; and
- increased capacity for home based care

  Before
  1) 52% hospital contact
  2) 48% community contact

  After
  1) 34% hospital contact
  2) 66% community contact
- 2% overall increase in capacity for contacts.

Case study 4 Demonstrating the impact of an adult mental health day service as an alternative to hospital admission

Acute Day Hospital Banbury, Oxfordshire & Buckinghamshire Mental Health Partnership Trust

The introduction of this acute day hospital as part of an integrated community service in Banbury followed the relocation of acute inpatient beds to Oxford.

The day hospital has been set up as a multi-disciplinary assessment and treatment service for people who are acutely unwell and at risk of admission to hospital.

Medical cover is provided by the locality CMHT consultants. The service is available 9 - 5pm 7 days per week. Around 45% of clients are referred from the crisis resolution team or are worked with jointly by the Day Hospital and CRHT. The service works primarily with people on enhanced CPA. The service also works with people on discharge or during extended leave.

Reason for Referal

Alternative to Admission	60
Early Discharge	3
Post Discharge	1
Relapse	20

71% of all admissions provide alternative to acute inpatient admission, 23% are to prevent relapse of illness and 6% support potential discharge from the acute units.

63% of service users reported success in recovery after receiving treatment at the Day Hospital.

Other benefits repeatedly identified in the field:

- reduced inpatient days
- service user stay reduced
- delayed discharges decreased
- greater service user and staff satisfaction with home based care services; and
- alternatives to admission improves range of options to service users and carers.

High Impact Change 2

Improve the flow of service users and carers across health and social care by improving access to screening and assessment

This change makes it easier for service users and carers to access screening and assessment services throughout their journey. It includes:

- improving access to expert screening and assessment in primary care e.g. talking therapies
- improving access within and to secondary services
- implementing referral guidelines and protocols
- improving efficiency of referral process by reducing inappropriate referrals
- provision of pre-referral consultation for primary care teams
- demonstrating the impact of integrated mental health services.

Case study 1 Demonstrating the impact of improving access and response times

Newcastle and North Tyneside Perinatal Service, Northumberland, Tyne and Wear NHS Trust (formerly Newcastle, North Tyneside and Northumberland Mental Health NHS Trust)

From February 2003 to February 2004 the service received 381 referrals from primary care and secondary care services. 138 (36%) were women who received a psychiatric assessment but required no further involvement.

The waiting time for a psychiatric assessment ranged from 1 day to 49 days with the average length of waiting time being 21 days. 'Full booking' (DoH 2004) was introduced utilizing process mapping and demand and capacity methodologies.

Impact on service delivery

- the average response time was almost halved from 21 days to 11 days
- the referrers report more confidence in the Postnatal Depression protocol illustrated by a 50% reduction in unnecessary referrals for assessment
- a redistribution of resources has allowed the clinical team to redirect some of their time to work with existing service users; and
- regular audit of activity data allows planning in response to any changes in demand for assessment e.g. during school holidays.

Impact on service user experience

- Service users, when surveyed, indicated they are very satisfied with the response times

Impact on outcomes

- introduction of a three day response time for urgent assessments; and
- an audit of the referral data demonstrates that the response time improvements have been sustained over a 12-month period.

Impact on staff

- More effective management of assessment activity has increased capacity in the team for clinical interventions allowing for more effective time management.

Other impact measures identified from the field:

Primary Care Mental Health Team

- all service users are seen within a ten week time frame and approx 80% are seen within 6/52. Once assessment has been done therapy begins, people are NOT assessed to go on a waiting list
- waits reduced from nine months to 6 weeks
- 91% of service users report an improvement in their ability to manage anxiety symptoms
- 89% reported satisfaction with treatment provided; and
- reduction in referrals to secondary services by 33% and to psychology services by 25%.

Early intervention team

- Trained 75% of secondary care, mental health and voluntary sector colleagues in use of screening tool which is also the team referral form.

Other benefits identified from the field:

- improved data quality
- clarity of roles in teams
- improved information available for service users, carers and families
- pathway re-design involving process mapping
- designing team based protocols and guidelines
- implementation of partial or full booking as per Choose & Book
- provision of a single point of access
- improved staff morale due to the reduction in DNA rates
- inpatient and CRHT staff able to interchange roles and responsibilities
- appointment of a single consultant to manage both the Inpatient Ward and Crisis Resolution Home Treatment Service; and
- simple, clear, consistent and defined process of admission and discharge overseen by same consultant with immediate input from CRHT and inpatient team.

High Impact Change 3
Manage variation in service user discharge processes

This change looks for a timely and consistent discharge regardless of the day of week or clinician availability. Discharge from all services should be integral to care planning and in collaboration with service users and carers.

Case study 1 Demonstrating the impact of service redesign on variation in discharge

Southwark Adult Mental Health Services, South London and Maudsley NHS Trust

Southwark has seen extreme pressure on beds leading to acute overspill into the private sector.

In 2000/01 36% of admissions went to the private sector. Service redesign to reduce admissions and provide alternative home treatment now means private sector beds are not required. Delays are now routinely monitored from the time of the decision to admit.

Reducing the variation in discharges has been addressed without incurring additional costs. An initial assess-ment of the causes of variation in patient discharge and the causes of delayed discharge was achieved by a comprehensive clinical audit of wards activity.

This identified significant differences in length of stay between inpatient units and differences in clinical practice and leadership. The following targeted interventions were introduced:

1) the introduction of a weekly bed management meeting involving inpatient and community teams, designed to free beds, to problem solve issues relating to delays and to manage within existing capacity

2) use of Statistical Process Control charts to clarify daily bed capacity required

3) home Treatment/Crisis Resolution Teams screen all admissions and treat at home where possible.

4) a new bed management database that does not rely on central IT systems is accessible to all clinical team leaders, medical staff, and managers. This is now the primary system for managing admissions and discharges and for obtaining information required for performance management.

5) the introduction of a Daily Bed Management Handover Report. This is circulated by bed managers to senior Directorate managers who are now able to monitor bed activity on a daily basis

6) a bed management seminar was convened involving key stakeholders. The purpose was to feedback systems analysis information, discuss audit findings and identify methods to overcome the primary causes of bed pressures. The seminar was designed to gain staff consensus and ownership regarding the next steps for service improvements

7) interventions to prevent the admission of service users known to the service are being planned. These will include improvements in the application of the CPA process and the introduction of a more systematic approach to relapse prevention and crisis planning by CMHT staff; and

8) statistical Process Control technology is gradually spreading throughout the Directorate so that clinicians and managers can measure the impact of service changes as they are introduced and monitor progress over time.

Impact on service delivery

- less unnecessary admissions: The admission rate is below that predicted for population and morbidity.
- reduction in length of stay: The Home Treatment Crisis Resolution Teams help to achieve early discharge
- fewer delayed discharges
- easier access to beds
- beds are now available when required without excessive numbers of service users 'sleeping out'
- reduction in bed numbers by 15 to ensure that no ward has more than 18 beds
- bed managers report that the pressure on beds has reduced.

Impact on service user experience

Greater service user satisfaction due to less delay on admission, a shorter length of stay, fewer delayed discharges and the choice of Home Treatment as an alternative to admission.

Impact on outcomes

- fewer re-admissions leading to improved mental health stability and social inclusion: Readmission rate is 4% compared to the national rate of 10.7%
- HoNoS (Health of the Nation Outcome Scales) are now routinely used by staff to evidence the improvements in health outcomes: Preliminary HoNoS results suggest a high level of acuity is being managed at home

Impact on staff and organisations

- reduced pressure on bed managers
- no private sector acute bed placements
- financial savings: reduction in bed numbers enabled provision of single sex wards, better staffing levels and more space to manage higher levels of activity and over 60% of service users who are detained; and
- reduction in stress for community staff: there is now less stress associated with delays in admitting people who are acutely unwell.

Case study 2 Demonstrating the impact of a discharge facilitator

Adult Mental Health Care Group, Sheffield Care Trust

- during 2003/ 04 bed occupancy was on average 119% (on 4 Wards with 106 beds in total) and on average 20 beds were occupied by service users who were ready for discharge
- referrals for Out of Town Admissions within Sheffield occurred for 52 service users (out of a total 968 admissions)
- some of the delayed discharges were due to waits to access rehabilitation units and generally around half would include waiting for supported accommodation: basic tenancy, benefits and grant applications to support furnishing new homes or secure funding arrangements
- review highlighted difficulties in co-coordinating the interface between the full range of services involved often due to the shift pattern systems within wards which meant key staff were often not available during normal working hours to liaise with Community Teams, Housing Offices, and Supported Accommodation providers; and

- also it was considered to be a time consuming and in-effective process for staff who had a range of other day to day; and responsibilities e.g. supporting service users to visit several accommodation options could take a couple of weeks.

The discharge facilitator initiative aimed to create well co-coordinated and timely discharge for people who experience difficulties with benefits or accommodation during their period of inpatient care.

This was to be delivered through two dedicated posts, each working into two of the wards focused on people identified as being vulnerable to protracted lengths of stay. The client group included people who;

- were at risk of becoming homeless or who had financial difficulties e.g. through rent arrears
- were homeless upon admission, or became homeless during their inpatient care
- housing requirements had changed due to their care needs

The main focus of the initiative was to:

- prevent people from becoming homeless by resolving identified issues
- address the needs of homeless people before discharge and prevent unnecessary delays
- reduce delays as far as possible.

Impact on service delivery

- 2004/ 05 – The acute inpatient service had 892 admissions, of which 182 were supported by the discharge facilitators
- bed occupancy is down from 119% (2003/04) to 108% (2005/06)
- out of town referrals have reduced from 52 (2003/04) to 13 (2005/06) (26 pro rata); and
- permanent funding from November 2004.

Impact on service user experience

- of 182 service users identified as at risk of losing their home or needing a change in accommodation, during 2004/ 05, 67% did not experience any delays in being discharged
- periods of delay have reduced by 50%, from on overage 11 weeks to 5 weeks
- 20% service users accessed the support
- 60 individuals benefited from assistance in obtaining new accommodation; and
- service user feedback indicates a positive response to the proactive work of the Discharge Facilitators: focus on service user choice, practical support provided including being accompanied during a 'move' and whilst 'settling in'.

Impact on outcomes

Re-admission rates for the 182 service users during 2004/05 were 2% at 1 month and 8.8% at 3 months.

Impact on staff and organisations

- the reduction in Out of Town Admissions has significantly resulted in savings for the commissioners
- closer links and networks with the voluntary sector, housing providers and organizations for the homeless
- removal of a range of administrative tasks from nursing duties enables more time for direct care delivery; and
- feedback from CMHT indicates improved communication and interface working.

High Impact Change 4
Manage variation in access to all mental health services

This change is about having in place effective and consistent processes that ensure responsive access to services regardless of day of week or clinician availability through a co-ordinated approach. This includes:

- service user choice
- single point of access where appropriate
- consistent booking systems
- primary care liaison
- secondary care and the flow between specialist services such as A&E to mental health services, CAMHS to adult mental health services and adult mental health service to older peoples mental health service
- proactively manage the interfaces between mental health services; and
- flow between health and criminal justice services and mainstream services.

Case study 1 Demonstrating the impact of a choose and book system

East Cambrigeshire and Fenland locality, Cambridgeshire and Peterborough Mental Health Trust

Following a choose and book launch event, one clinician and one administration worker formed a locality steering group to take implementation forward. As a result:

- adult services chose to set up weekly assessment clinics
- CAMH and older people's teams opted to identify regular assessment slots spread over the course of the working week
- four of the six teams have developed the use of Outlook calendars and transferred assessment slots onto the calendars to make appointment booking easier
- adult and CAMH services make the initial contact with service users by letter, giving them a reference number to quote to confirm identity when they telephone in
- in older peoples services, clinicians now make the initial contact by telephone to arrange assessment

Feedback from service users has been positive:

"blimey, that was quick"
(one of the comments from an adult service user.)

CAMHs service users said:

"Really good, felt in control of booking appointment and not just told when to come. I felt more inclined to attend this appointment because it was convenient for us."
Mother

"Good idea, my calendar was checked at the same time as the phone call. I could then feel confident in confirming our attendance."
Mother

"No problems – works fine every time I've needed an appointment."
Father

Impact on service delivery

- CAMHs rolled out the new system in September 2005 and have since reported a steady decline in DNA's: October 2005 – January 2006, of the 67 referrals received, 6 were reported as DNA's.
- Older People's Services have a zero DNA rate for 96 referrals received over the same period of time.

High Impact Change 5
Avoid unnecessary contact and provide necessary contact in the right care setting

Follow up appointments should only occur when needed or requested by the service user.

This change requires planned and negotiated care including effective interface arrangements.

Follow up contact is determined by clinical need or service user led request. Unnecessary contact is avoided through effective caseload management, which reduces waste and ensures efficient use of resources.

This supports social inclusion of users in active rehabilitation and recovery.

Case study 1 Demonstrating the impact of effective caseload management

Tooting and Furzedown CMHT, South West London and St Georges Mental Health NHS Trust

Analysis of variation from performance reports demonstrated that Tooting and Furzedown CMHT was an outlier in terms of bed use and caseload. A review of team caseload management was undertaken to identify people without an allocated care coordinator, to review the out-patient clinic population and the rationale for follow up and to analyse and review the need for continuing care and the care setting.

Impact on service delivery

- baseline caseload 420 with 100 unallocated cases. The team caseload reduced at one year to 294
- there are now no unallocated cases with exception of new referrals awaiting allocation; and
- 10-15 patients were identified living out of area and transferred.

Impact on service user experience

- no unnecessary out patient follow up by junior doctor on rotation

Impact on staff and organisation

- culture and practice change within team regarding caseload management.

Case study 2 Demonstrating the impact of an assessment pathway

Newcastle Adult Inpatient Services, Northumberland, Tyne and Wear NHS Trust (formerly Newcastle, North Tyneside and Northumberland NHS Trust)

The process of developing the pathway was multi dimensional and incorporated the following elements:

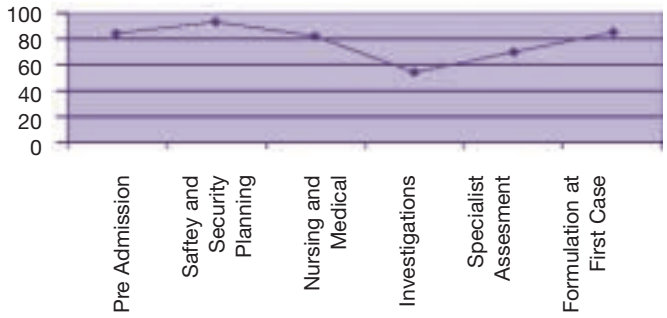
- a multi disciplinary group: with representation from the inpatient service; CMHTs; crisis assessment team; occupational therapists, senior nurses; medical consultants; nurse consultants; senior managers; and clinical nurse leaders. The group met monthly to review and develop the pathway
- user and carer involvement
- cross pathway approach
- process mapping and analysis: patient journey methods were utilised to develop the pathway, which was refined following wider dissemination and discussion with stakeholders. Service redesign methodology allowed staff to identify steps in the process that were of no value to the service user or the service provider.
- integrated notes: senior nurses mapped the desired service user pathway against the multi-disciplinary integrated notes to reduce duplication; refine the documentation and develop an ideal set of notes together with an information guide to support the use of the pathway and integrated notes; and
- training and dissemination: senior nurses utilised a cascade approach to training respective teams on the use of the assessment pathway and this was also supported by in-patient consultants with their medical colleagues.

The pathway comprises the following elements:

- pre admission – 7 items
- safety – 6 items
- medical and nursing assessment – 20 items
- investigations – 14 items
- specialist assessment – five items; and
- formulation for 1st Case review – nine items.

The assessment pathway has helped to develop consistent standards across the adult acute in-patient service:

- staff have been involved in the approach throughout
- the auditing process has brought tangible results in that teams are able to identify areas of strength and development across the pathway; and
- it provides a benchmark for all wards and staff teams within the service to review practice and promote cross pathway learning.



Impact on service delivery

- reduced variation in the assessment process across the division
- development of performance monitoring framework to improve service delivery
- identification of areas for improving practice development across the pathway; and
- benchmarking of services across the division.

Impact on service user experience

An audit of service user experience identified the following benefits of the pathway on their experience:

- reduced delays in interventions
- involvement in a range of therapeutic activity
- reduction of multiple assessment processes
- needs clearly identified to aid treatment planning: service user views incorporated in care decisions
- clearer engagement strategy during admission to hospital: Purpose of admission clearly outlined, early engagement during first two days of admission, including orientation and meeting key professionals involved in care; and
- satisfaction with adult acute admission and care review processes.

Service user surveys are being repeated on a regular basis and the findings will further influence the implementation of the pathway process.

Impact on outcomes

Evaluation reports that there is greater consistency across the pathway and these relate to the following:

- performance tool identifying strengths and areas for development in pathway components
- enhanced problem and need analysis and timing of interventions
- more focused interventions and specialist assessments.

Impact on staff and organisations

- clear and focused approach to collaborating with service users during admission to hospital
- strengthened links with community mental health and crisis resolution teams
- improved multi-disciplinary care
- more effective and efficient use of staff resources
- improved cross pathway care-co-ordination
- provides benchmark with other wards
- improved quality assurance for pathway components; and
- a redistribution of resources has allowed the clinical team to focus intervention and spend more time in service user engagement.

Case study 3 Demonstrating the impact of providing necessary contact with Pharmacy Services

Pharmacy Services, Mersey Care NHS Trust

Service users were accessing medication from the trust Pharmacy on a repeat basis because of problems in accessing supplies from GPs or community pharmacies.

Many service users had been receiving medication in this way for several years. Some service users may also have been receiving medication from a GP. This meant that the same or a similar medication could be supplied from two different sources.

Service users were either visiting day hospitals to pick up their medication or community nurses were delivering it to them.

A 'seamless care' model involving a pharmacy technician role was developed. An MTO 3 (Medical Technical Officer) pharmacy technician was employed to lead a seamless medicines management approach to the supply of medications following discharge. As part of the process service users are able to choose where they want to pick up their medication.

Long-standing repeat prescriptions were identified as below:

total repeat prescriptions = 55

one location accounted for 56% of these repeat prescriptions.

Work undertaken

The 31 service users at this specific location were identified as the first group that would be approached regarding their medication. Following the intervention of the seamless care technician these changes have been made:

- 8 service users receive their medication on a repeat basis from community pharmacies
- service users receive their medication via a trust depot clinic
- 5 service users had their medication reviewed and stopped
- 4 service users stated a preference that they continued to receive medication via the trust pharmacy service
- in four cases appropriate access is still being sought; and
- two service users have since been re-admitted to inpatient wards.

Cost impact

The monthly average expenditure for the locality community prescription prior to the interventions was £7,116.33. The current monthly expenditure is £6,136.34.

Therefore an average saving of £979.99 per month is being made.

Impact on service delivery

- reduction in drugs expenditure; and
- reduced risk: cases have been identified where co-prescribing was taking place e.g. service users receiving one type of antidepressant via the trust and another via their GP.

Impact on service user experience

Service users are now able to access all of their medications via their GP/community pharmacy services

Impact on outcomes

Each case is reviewed

Impact on staff and organisations

- freeing up of time for CPNs and day hospitals
- improved dialogue between the Trust, community pharmacies and general practitioners; and
- pharmacy technician leads a seamless medicines management approach to the supply of medications following discharge.

High Impact Change 6

Increase the reliability of interventions by designing care based on what is known to work and that service users inform and influence

This change aims are to increase the reliability of therapeutic interventions by enabling service users and carers to be at the centre of decision-making and establishing systems that support meaningful service user and carer involvement and participation.

Case study 1 Demonstrating the impact of service user involvement in service delivery

The Haven Project: Core partnerships – North Essex Mental Health Partnership NHS Trust, local service user groups, local and commissioning PCTs, local voluntary agencies inc. Mind, A&E Dept, Essex Police, Colchester Borough Council. Extended Partnerships: - Psychology Dept, North Essex Mental Health Partnership NHS Trust

The Haven Project is a voluntary sector agency dedicated to the support and treatment of people with a personality disorder in the Colchester, Tendring peninsula and Halstead areas in Essex.

The project combines a full day services programme with crisis services that are available 24 hours 7 days per week. It opened in June 2004 and has 110 registered service users and on average provides 1600 contacts per month.

Service users play a central role in the shaping and running of the service. The Haven Community Advisory Group consists of members drawn from registered Haven service users and its function is to advise staff, management, The Haven Partnership Steering Group, and Board of Directors.

There are two members of staff and one volunteer that have used mental health services and 5 members (50%) of Board of Directors have used mental health services.

Impact on service delivery

- reduction in use of Mental Health Act Section 136's by 87% per annum
- acute inpatient admissions down by 85% per annum; and
- reduction in use of A&E services by 60% per annum.

Impact on service user experience:

"'Since I've been using The Haven, I haven't been admitted once to the acute hospital and that to me is a big break through and I'm sure they're relieved too"

Service user Haven project.

"I like the open notes policy. That helps me, that's about trust, knowing what's written about you. I also really like the fact that it's client-led, service-user led. I mean it's one of its kind and I think it's setting a lead I think mental health services are going to be following because I think, no I seriously do, I think this is the way forward."

Service user Haven project.

"For me personally having somebody, anybody, and it was The Haven for me, believe in me as a person and my potential, actually enabled me to have the confidence and courage to go out and get a job and was my first step to recovery. Just somebody having faith in me brought out the fact that I had faith in myself. Somebody believed in me and that came from The Haven."

Service user Haven project.

Case study 2 Demonstrating the impact of service user involvement

The Service User Network (SUN), funded by the Department of Health's National Pilot Programme for Personality Disorders, and hosted by South West London and St George's Mental Health Trust.

The SUN reflects the national agenda that personality disorder should no longer be a "diagnosis of exclusion" and follows a user led approach where service users significantly influence and contribute to service development.

National strategy is implemented in a local context and has helped shape personality disorder services in South West London.

The SUN's target group is adults with personality disorder (with or without a formal diagnosis) who cannot access existing services or who may feel that existing services cannot meet their needs.

An example of this would be a client group who may not meet the criteria for their CMHT and has no other support, or who has been discharged because they are well and who can then only access emergency services when in crisis (which may be precipitated by the lack of other support).

The overriding aim of the SUN is service user inclusion, empowerment and averting or better management of crises thereby preventing unplanned emergencies. The SUN aims to:

- support, train and empower key service users to be an integral part of the SUN project, including service development
- provide sustained and consistent support from dedicated mental health care professionals to allow this to happen
- enable individuals who do not access existing services improve and manage the difficulties with having personality disorder; and
- have an inclusive client group to help diverse needs, specifically including black and minority ethnic groups and people who experience other problems in addition to their personality disorder.

The SUN achieves this by creating a new approach to services. It works to a new model using coping process theory, following a user led agenda, new staff roles have been designed to maximise service use involvement and empowerment including a new service user role to work alongside the staff team.

As part of the core service, the SUN provides a liaison function to help members access existing services as well as the SUN. This aims to simplify pathways with the Trust and voluntary sector services.

Impact on service delivery

The SUN conducts quarterly review and evaluation by service users about the effect of the service. Service users said they were:

- feeling more supported: 100% either agreed or strongly agreed
- feeling more included: 91% either agreed or strongly agreed
- feeling more empowered: 83% either agreed or strongly agreed
- learning more coping strategies: 82% either agreed or strongly agreed
- experiencing fewer crises that become emergencies: 67% either agreed or strongly agreed
- finding difficulties easier to manage: 66% either agreed or strongly agreed
- satisfied with the SUN: 75% either agreed or strongly agreed
- finding groups are easy to understand: 83% either agreed or strongly agreed; and
- more able to express themselves: 83% either agreed or strongly agreed.

As part of the quarterly review the SUN asks service users what they find most/least useful about the service. Service users then ascribe it a rank of most of least important (5 being the highest and 1 the lowest).

The comments below come from the most recent review of service users views:

"That there is actually a service for people with personality disorders."

Ranked 5

"Self-empowerment through support from other members, accessing accessing the right help (The) group know what to do in an emergency to access help (and the) group is very beneficial in situations of crisis. The service makes sure people don't get left out in the cold. The group is proactive e.g. we can ring our CPN or consultant, otherwise we might just leave it/self advocacy – it gives use more confidence to say things"

Ranked 5.

"Having your own crisis and support plan/self referral is quick and simple. (It is very) positive that people with mental health problems are able to work within and for the SUN. and the trust."

Ranked 4 and

"A sense of being involved, a feeling of empowerment, it feels like you are being listened to and that your views actually count for something/organising and taking part in SUN events"

Ranked 4.

Impact on staff & organisations

- introduction of a new role including a service user role which works as part of the SUN team.
- a training package is offered to the service user post holder and links with the Trusts User Employment Programme.

High Impact Change 7
Apply a systematic approach to enable the recovery of people with long term conditions

This change aims to provide an approach that supports and empowers people with long term conditions to better manage their mental health. It also aims to demonstrate the benefits of mental health interventions with people with long-term conditions.

Case study 1 Demonstrating the impact of supported employment

Café On the Hill, West London Mental Health NHS Trust

The Café was established as a work unit where service users gain genuine work experience and qualifications within a support structure that provides a pathway to education, employment and meaningful activity.

The Café operates as a small business with a requirement that it covers all costs including development but excluding current staffing.

On average there are 13 Team Workers (service users) working in the Café. 8 of whom have completed the NVQ in Food Preparation and of those 4 went on to further study – 3 to the next level of catering training and 1 to a Health and Social Care access course. From the opening in January to May the number of customers using the Café has risen from 200 to 600 per week.

Impact on service user experience

- experience being treated as competent and capable adults, and
- increased social contact with a mixed group and the opportunity for mutual peer support and team work: development of social and work skills.

Impact on outcomes

- educational success of the service users.

Impact on staff and organisation

- culture and attitude shift from service users providing a service for staff (as well as others): essential participants rather than recipients
- provision of a social space and facility for people living and working on site away from wards and offices; and
- won a quality award for improving working lives and has inspired other services to develop new partnerships i.e. with the local college.

Case study 2 Demonstrating the impact of employment and education opportunities

Employment and Education service, North Yorkshire Social Services

This service is provided by an Employment and Education Opportunity Officer (EEOO) based in Hambleton and Richmondshire. This service is available to people:

- with severe and /or enduring mental health problems
- with drug and alcohol problems; and
- aged 18 to 65, although occasionally supports people of other ages.

The EEOO role is very diverse and the interventions can be very long term. People are visited in their own homes or in local venues where appropriate, so the service is easily accessible by service users. The EEOO works with the community mental health teams, the community support officers and service development officer.

The main ethos of the service is to enable service users to return to or obtain full-time work and/or access appropriate educational or training courses and individual programmes are service user led.

Service users are encouraged to access meaningful occupation by doing voluntary, paid or unpaid work, training or education with a long term aim for them to obtain full time employment appropriate to their abilities and needs.

Support to do this can be over several years, until the person has recovered sufficiently to return to full time work. This service therefore reflects the need for social inclusion and encourages service users to improve their self esteem, and become confident and independent.

The priority aims of this service are:

- to help people retain their employment or education status when they become ill, either by retaining current employment or by seeking alternative employment
- to offer supported employment to those eligible for Supported Permitted work (working less than 16 hours per week for as long as necessary) or for those wanting to work longer hours
- to help people who have been out of work or education for up to 2 years to return to work or education; and
- to support anyone who wants to access voluntary work, training and education.

Examples of the support provided: Job Profiling, job search, education retention, medical retirement, accessing education and training, signposting to other agencies and organisations and obtaining in-house support from employer, college or other support services.

Impact on service delivery

- out of 55 referrals, over 500 hours per week of paid work is being done and several service users have returned to full-time (30+ hours) work
- 20 service users are involved in voluntary work
- 21 service users were involved in education or training to progress to full-time work; and
- 10 service users have been helped to retain their existing work.

Impact on service user experience

Asked about in impact on independence and inclusion service users report:

- 87% feel they have increased their independence
- they have been enabled to access other services within their local community e.g. Learn Direct, Disability Employment Advisor, Outreach Services, Advice and Guidance.

100% of service users feel that their confidence and self esteem have increased

100% agreed that they had been enabled to work at their own pace and without pressure and they had been given the correct amount of support to meet their needs; and

100% of service users were satisfied with the service.

Impact on staff and organisations

Positive feedback from care co-ordinators indicates a positive difference to the employment prospects of people with mental health problems and substance misuse needs, satisfaction with the referrals

guidelines and a sense that there is appropriate support to them as well as service users.

Case study 3

Community Support Service, North Yorkshire Social Services

The main ethos of the service is to ensure service users, and their immediate families, have adequate and suitable accommodation and that their income is maximised.

The take up of Welfare Benefit 2004 was over £401,000.61 improving the financial situation for service users and in some cases housing conditions.

There were 74 successful outcomes relating to housing issues. Of the cases closed in 2004, 21 people were helped who were homeless and a further 8 who were threatened with homelessness to remain housed, as well as support with housing benefits, home improvements, fuel costs, etc.

There were 33 successful outcomes for employment issues including support and signposting for cases such as unfair dismissal, supporting people who had not received statutory sick pay from their employer and help with employment tax credits

There were 49 successful outcomes for other issues, such as fuel costs, debt and tax rebates.

Another example identified from the field:

Care Programme Approach (CPA) system, South Warwickshire PCT

The CPA system is recorded using a format that was devised to enable scanning onto the electronic system in a way that ensures all workers can access the correct service user information and input what care is needed.

High Impact Change 8
Improve service user flow by removing queues

The aim is to reduce the time service users wait at any point in the health and social care process e.g. between referral and the first appointment and any referrals to internal services.

Case study 1 Demonstrating the impact of removing queues in an adult mental health service

Mersey Care NHS Trust Mental Health Directorate

Mersey Care's NHS Trust adult mental health directorate undertook a project in January 2005 to improve how people access local mental health services in the Southport and Formby locality. The key reasons for this project were:

- regular criticism from referrers, service users and carers about the difficulties and delays they experience when accessing services
- the development of new teams (e.g.) crisis resolution home treatment teams covering 24 hours a day, potentially adds more complexity to local provision
- high rates of DNA's, cancelled clinics, and low rates of discharges back to primary care
- future changes to waiting time targets
- the relatively high number of "crisis / emergency" referrals
- caseload sizes and "blocked" outpatient clinics
- national policy encouraging better gateway processes and more choice. With primary care being able to electronically book appointments direct
- advances in information technology and changes in consumer expectations means services need to have prompt responses; and
- national policy introducing payment by results and practice based commissioning means services need more effective information and data processes.

The gateway worker started in April 2005. An audit was completed for a six month period.

Activity	Baseline Figure April '04 – March '05	After Gateway figures April – Dec 2005
Average Out-patient Waits	7 weeks	4 week
Outpatient DNA's	26.6%	13.8%
Referral Received	364 per annum	884 in a six month audit period
Discharges form service	157	258 in 9 month period (344 estimate for the year)
CRHT targets	N/A	CRHT team achieving LDP targets for home treatment

Impact on service delivery

- 884 referrals were received in the audit period, an average of 34 referrals per week
- 59% of referrals were received from primary care
- 22% of referrals were not seen in secondary care. They were given advice, support and sign posted on to other services
- anxiety and/ or depression were the main reasons for referral in 43% of the referrals received from primary care
- the gateway worker completed 81 face to face mental health assessments (9% of total number of referrals). An additional 26 service users were seen face to face by the gateway worker for advice / support
- 17% of referrals received an outpatient appointment, 17% of referrals we sent on to counseling / psychology, 7% received a crisis resolution home treatment assessment, 4% received a CMHT assessment
- enabled CRHT and other teams to focus on serious mental illnesss
- enabled service to comply with Choose and Book initiatives
- improved relationship with primary care; and
- reduced DNA rate for new referrals by 16%: from 26.6% in 2004 to 13.8% in 2005, for outpatient referrals.

Impact on service user experience

- more prompt response – decisions made in 24 hours
- better customer care – telephone calls rather than letters; and
- current routine referral waiting time is 4 week, emergency same day, urgent one week.

Impact on outcomes

- achieving CRHT targets; and
- improved rate of discharges in outpatient clinics.

Impact on staff and organization

- freed up staff time in outpatients and other teams
- enabled decisions about referrals to be made and communicated to service users in 24 hours
- enabled the Crisis Resolution / Home Treatment (CRHT) team and other teams to focus on supporting people with serious mental illness; and
- improved the relationship with primary care by providing dedicated time to develop a partnership approach.

Case study 2

Greenwich CAMHS, Oxleas NHS Trust

The information department provided monthly reports about numbers of people seen to be breaching the waiting time targets for discussion and action by a group of senior staff: 2 consultant psychologists, the locality team manager, the borough administration manager, the business manager for the service, the information manager and the trust service improvement lead.

Key results include:

- administrative procedures for intake have been clarified
- referrals with inadequate information are being returned to the referrer and so no longer affect waiting times
- the guidelines also clarify procedures for dealing with a referral for a further episode of care for a known service user. A new referral needs to be opened rather than re-opening the original referral; and
- information gaps have been identified and working groups set up to devise the content of additional leaflets.

Having piloted the analysis and intervention in one locality team, there is potential to roll this out across the service and borough. Better systematic

administrative procedures and clarity about clinical roles and responsibilities results in better prediction of the number of people accessing services.

Impact on service delivery

- reduction in average waiting time
- reduction in longest waiting time from 28 weeks in September 04 to 17 weeks in September 05
- care pathways clarified for different subgroups of service users.

Impact on staff & organisation

- clarity of roles and responsibilities, especially for the team manager and team administration in relation to data quality, but also for all staff in relation to assessment as a proportion of their workload
- created clinic slots within which most of the assessment work is carried out
- more reliable internal information about caseloads and activity
- staff roles support a breadth of skills; and
- more integrated service planning and delivery evidenced by wider range of referral sources.

Other impact measures from the field

Adult CMHT

Single point of access and use of full booking. Subsequent reduction of DNA's and reduced wait for initial appointment from 6-8 weeks to 1-2 weeks.

Primary Care Mental Health Team

Waits reduced from nine months to 6 weeks.

High Impact Change 9
Optimise service users and carers flow through the service using an integrated care pathway approach

This change increases efficiency and outcomes through a whole service evidence based systematic approach to delivering a care package. It may involve the use of service improvement tools to identify the causes of blocks and delays and implement sustainable solutions.

Case study 1 Demonstrating the impact of an Older People's Memory Clinic

Centre for the Health of the Elderly, Northumberland, Tyne and Wear NHS Trust (formerly Newcastle, North Tyneside and Northumberland NHS Trust)

Development of Memory Clinics are advocated as part of National Guidance (e.g. National Service Framework for Older People; 2001 NICE Guidance on anti-dementia drugs) and provide an important route for early diagnosis, as advocated by users and carers (e.g. Alzheimer's Society).

Calculated incidence rates for dementia show an expected 450 new cases each year in the local area. The Newcastle Memory Clinic receives 120 new referrals each year for assessment and diagnosis of early dementia and mild cognitive impairment.

This group has previously not been well served by existing resources and services. Several service users below the age of 65 would have been seen by general psychiatry or neurology services. Many service users, both older and younger, would not have been seen for specialist assessment at all. For example, outcomes from a published audit indicate that the clinic sees service users, on average, 2 years earlier than traditional services (Luce A, McKeith I, Swann A, Daniel S, O'Brien J (2001): How do memory clinics compare with traditional old age psychiatry services? International Journal of Geriatric Psychiatry 16:837-45).

The service aimed to:

- develop clear referral procedures and care pathways and standardised assessment procedures for outpatient assessment and diagnosis of early cognitive problems
- establish a memory remediation group run jointly by nursing/psychology to inform and empower users and carers about their mild memory problems and to provide practical advice, aids and strategies to optimize memory function in a supportive environment. This is a seven week course.
- develop, in conjunction with the Alzheimer's society, new patient information leaflets and advice on practical issues (i.e. driving) commonly encountered by those with mild cognitive impairment and early dementia
- provide a clear framework for regular monitoring of those with suspected early dementia, including provision of antidementia drugs in accordance with current NICE guidance; and
- assess patients under 65 who may have early onset dementia and work closely with the Lewis Team (multi disciplinary team for the under 65's).

Impact on service user experience

Two consumer surveys/audits demonstrated high levels of service user satisfaction with the service received, which also led to service change.

Service users were asked if they:

- received appointments in sufficient time (95% yes)
- received adequate information before appointment (100% yes)
- adequate parking (75% yes)
- staff courteous and helpful (100% yes)
- diagnosis was clearly explained (85% yes)
- understand investigations (95% yes)
- understand future management plan (100% yes); and
- overall experience 65% excellent, 35% good

A new carers group was set up for those caring for people with early (mild) dementia run jointly with staff from the local Alzheimers Society and clinic CPN.

New information packs were developed for people diagnosed with early dementia that are given to all service users at the time of diagnosis.

- Assessment packs containing detailed information about what is required is made available when relevant

Impact on outcomes

- annual follow-up procedures in place for those with mild cognitive impairment
- guidance on anti dementia drugs confirmed by clinical audit first 12 cases prescribed medication through clinic. Standards assessed;
- specialist diagnosis AD (100% compliance)
- MMSE>12 at baseline (100% compliance)
- regular review (100% compliance); and
- continue only while MMSE>12 (92% compliance)

Each memory remediation group is fully evaluated by participants with good feedback and evidence of continued benefit at follow-up.

The Group was awarded the Queens Nursing Institute Award for excellence and innovation in dementia care nursing (2003)

Impact on staff and organisations

Audit of referrers found over 90% extremely satisfied with waiting time, information provided and the service the clinic provided.

Memory Clinic and Memory Remediation Group are now fully integrated into the care pathway for Newcastle Older People's Mental Health services. Regular audits and reviews will continue to be carried out.

Case study 2 Demonstrating the impact of redesign across a whole system of older people's services

Nabcroft Older Peoples Service, Kirklees, South West Yorkshire Mental Health NHS Trust

This service re-design initiative aimed to focus the community intervention offered by a range of teams 7 days per week. This included:

- prolonged and intensive community support for people with severe and enduring needs
- brief interventions in support of other professionals with less severe or enduring difficulties; and
- a reduction in Day Hospital places and the formation of an Assertive Outreach Team that could offer alternatives to in-patient admission whilst in-reaching to wards in order to facilitate earlier discharge.

Services included:

Primary intervention and liaison

- memory assessment service
- care homes liaison team
- acute hospital liaison team

Secondary services

- multi-agency/interdisciplinary CMHTs
- assertive outreach team/day services; and
- in-patient assessment.

Impact on service delivery

- fewer in-patient beds needed
- 8 months after service redesign, 5% increase of service users with recent history of hospital admission on CMHT caseload corresponded with a 14% increase in available bed days for two in-patient assessment units
- 18 months after service change, bed reductions in same two units (20 to 12 in Dementia Unit & 24 to 20 in Mental Health Unit) have been sustained with typical occupancy rates below 100%
- caseload audit indicates 72% of CMHT caseload in severe and enduring needs target group after service change; and
- day service meeting needs of population with more severe and enduring difficulties reduction in day hospital places (from 300 per week to 100 per week) resulted in freed staff time being used to form assertive outreach team.

Prior to service change

- 89% attending for anxiety/depression of these;
- 80% no or mild symptoms on HADS; and
- 74% no or mild symptoms on GDS.

After service change

- 53% attending with psychotic condition
- 33% attending for anxiety/depression
- Of the 33%; and
- 80% score in severe range on HADS/GDS.

Impact on service user experience

Increased capacity for home based care

Before service change

- 52% hospital contact
- 48% community contact

After service change

- 34% hospital contact
- 66% community contact

Some 63% of people attending the Day Hospital indicated they would be satisfied attending on a sessional basis as opposed to full day.

Impact on outcomes

Service users now choosing intensive support at home rather than hospital admission.

Impact on staff & organisation

There was no increase in resignations or sickness/absence despitesignificant service change. There was an increased number of staff trained in psychosocial interventions

Prior to service change

- 0 staff qualified/training in relevant Post-Registration Dip/Degree

After service change

- 6 staff qualified/training in relevant Post-Registration Dip/Degree

Case study 3 Demonstrating the impact of a whole system approach to early intervention

Gloucestershire Recovery in Psychosis service (GRIP), Gloucestershire Partnership NHS Trust and Cheltenham Community Projects

The GRIP approach emphasises the development of coherent links between a number of inter agency organisations, both statutory and non statutory. The service is based in the community and shared with a youth agency, Cheltenham Community Projects (CCP). This encourages a symbiotic relationship and sharing of expertise to support a potential shared young client group.

Extensive and meticulous planning was undertaken prior to setting up GRIP. This involved consultation with primary and specialist health agencies and the voluntary sector, particularly youth agencies.

A formal research project incorporated a combination of questionnaires and interviews designed to elicit the views of GPs, service users and carers. A local stakeholders steering group was set up, its remit informed by the consultation and site visits to national/international centres of excellence.

The steering group drew up a service specification was drawn up by the steering group with the key strategic aim to reduce Duration of Untreated Psychosis (DUP), which led to series of operational service deliverables which include:

- widen access to allow direct access for potential users and concerned family members
- offer a lower threshold for GPs to refer on suspicion rather than certainty; supplemented by communicating rapid feedback of assessments and treatment proposals
- offer a programme of awareness raising: conducted across the community including formal presentations to GP's, statutory and secondary teams and also to the non statutory sector. Supporting information and leaflets were distributed and a number of helpful suggested initial assessment questions; and
- a screening tool developed by GRIP was distributed to potential referrers.

The clear majority of service users are visited and assessed at home but can choose to be assessed at the GRIP offices. The community based nature of the GRIP services places an emphasis on recovery which supports clinical improvement and reintegration with social networks. Service users also have the chance to explore opportunities to work in vocational, unpaid or paid employment.

A number of clear operational targets have been defined within the Mental Health Service Response to First Episode Psychosis in Gloucestershire Research document (Davis and Morgan 2004 see *www.gripinitiative.org.uk*).

Impact on service delivery

There was reduced bed occupancy.

Impact on service user experience

Comparing treatment as usual (TAU) services with the GRIP service:

- TAU offered behavioural family intervention (BFI) to 17% of first episode psychosis users and their families. With GRIP 93% of users and their families now access BFI
- TAU services offered 10% of carer's formal carers assessment. GRIP now ensures that 100% of carers receive this assessment
- TAU services only ensured that 17% of users before knew what the care programme approach (CPA) was. GRIP has aimed for and achieved a 100% success rate in ensuring that users know what CPA is
- both users and carers are more satisfied with the community and home treatment based style of delivery; and
- they are also pleased with the range of individual and group based activities (including social and sports groups) together with a holistic emphasis upon recovery aiming for social integration and meaningful occupation / employment.

Impact on outcomes

- DUP has reduced within Gloucestershire from 13 months (achieved by TAU services) to 3 months by the GRIP Team from April 2003 to March 2006; and
- fewer mental health act assessments.

At April 2006 GRIP has lost no service users to follow up. This compares with an expected loss of around 50% in TAU services at 12 months (McGovern et al 1994).

At the same time there have been no incidents of suicide despite this client group expecting a 70 times higher risk of suicide. 0% suicide reflects the potential that EI services such as GRIP have to recognise and attend to suicide risk factors such as social isolation, unemployment, and depression.

- For example two undergraduate service users recently resumed their studies, and GRIP successfully liaised with local early intervention (EI) services close to the respective universities to ensure they continued to receive appropriate support.

Suicide is the single largest cause of premature death: 10% of people with psychosis will ultimately kill themselves, two-thirds within the first 5 years (Wiersma et al 1998). Around the time of emerging psychosis young females have a 150 times higher and young males a 300-fold higher risk for suicide than the general population.(Mortensen 1995). The

most vulnerable time follows the first episode, often some months later, when the young person may have experienced their first relapse or disengaged from services (linking with the benefits of GRIP's assertive approach to follow-up).

Impact on staff and organisations

Opportunity to achieve better outcomes and trajectories for service users means that staff can see tangible benefits of this way of working. There was high interest from staff to join early intervention in psychosis services thereby supporting recruitment and retention of staff

To date the impressive reduction in DUP and use of the Mental Health Act and reduction in suicide rates together with increased user and carer satisfaction levels and employment / occupation rates for service users together with 0% of users lost to follow up demonstrates value for money.

To sustain the improvement the following is critical. An audit cycle has been set in place to listen to and learn from GPs and users and carers of the service. Any unmet needs or more effective ways of helping to deliver early intervention would be expected to help further improve the service.

It is hoped to expand the service approach across Gloucestershire.

Case study 4

Northumberland Early Interventions Team (NEIT), Northumberland Care Trust

NEIT focuses on improving engagement of service users with first episode of psychosis. Typically, service users are engaged after long delays and frequent failed attempts by families to access help.

This often results in a crisis which usually requires hospital admission often under the mental health act. NEIT particularly works with families and service users to promote hope and prevent social exclusion, by encouraging service users to reintegrate with their social and occupational networks.

Research suggests that by reducing DUP people will have less traumatic entry into services, and an admission at presentation can be avoided. The NEIT developed two practical local measures:

- care coordinators from the NEIT offer education to GPs on the importance of early detection and referral of possible cases of psychosis to the service
- enhanced family work (family interventions): working proactively with families to acknowledge and help them deal with their own needs, and to help them be more effective in their caring role.

The following vignette displays how care pathways were used to decide who to target and what information to give them. This illustrates what can be achieved if people are referred earlier and the service is prepared and able to work with families as co-therapists.

Following an educational session a GP approached a care coordinator to ask for advice. A mother, had asked them to see her son, who was behaving oddly, however he had refused to see the GP. The Care Coordinator's subsequent attempts to see the young man were met with refusal but, through the policy of encouraging family work, an alternative approach could be offered. The use of legal detention was discussed, but the family felt this should be a last resort. Thus having defined some clear boundaries around risk it was agreed that the young man be offered a formulation based psychosocial intervention approach, conducted by the mother and supervised by the Care Coordinator. Improvement slowly followed and over many months he was able to re-engage some old friends, eventually returning to work.

Impact on service delivery

	PACE	NEIT 2004	NEIT 2005
Total First Admission Days	3146	708	1248
Total number of patients in data	71	33	69
Total Actually Admitted	48	13	23
Percentage Admitted	67.6%	43.3%	33.3%
Average length of first admission	65.5	54.5	55.8
Average length of admissions by total clients	44.3	21.5	18.1
Total relapse days	-	40	41
Relapse days per month of care	2.01	0.054	0.320

NEIT 2004	NEIT 2005	PACE
96%	97%	49% after 2 years retain contact with mental health services

Impact on outcomes

Employment in service users has increased from 20% to 36%	NEIT 2005
Unemployed	36
Full time employed	15
Full time education	6
Part time employment	12

Impact on staff and organization

Cost Savings	NEIT 2004	NEIT 2005
Reduction in first admission/length of stay	752.4	1807.8
Reduction in relapse days	1407.9	2162.8
Unit cost of health and social care 2001 (mental health acute)	£153	£153
Total saving	£215,409	£607,502
Total cost of NEIT (approx.)	£160,000	£439,120
Net saving so far (not including medication)	£55,409	£168,381

High Impact Change 10

Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce

This change aims to develop staff roles to make sure that the services provided meet the needs of service users and carers and to attract and retain skilled and motivated staff.

Case study 1 Demonstrating the impact of employing a memory nurse in older people's services

Memory Assessment & Research Centre, Hampshire Partnership NHS Trust

A memory nurse was employed at the Memory Assessment and Research Centre, following publication of NICE guidance and the NSF for Older People. The role requires working at a number of levels within health services and performing a range of functions that require a variety of interpersonal and communications skills not solely targeted at working with service users.

The role is challenging due to its diversity and coherent inter-working is needed to maintain and improve upon aspects such as the communication of individual patient information and the access to and maintenance of service user records.

A further aspect of inter-working within a system of healthcare is the need for other professions to understand and appreciate the nature and diversity of the memory nurse role and the factors and requirements, which underlies its realisation.

This presents a particular challenge as it involves explaining a new role at the same time as it evolves and develops.

One particular area worth noting is that the memory nurses were originally called community dementia nurses (CDN's) but reported that sometimes the word "dementia" in the job title caused upset or distress to service users and carers. After discussion it was agreed that the CDN job title should be changed to Memory Nurse.

Impact on service delivery

- service capacity has been greatly increased
- eduction of waiting for new referrals in the Memory Clinic to 4 weeks from receipt of referral
- increase by 50% of new service users are now being seen: additional 200 people can be seen per year by Memory Nurses in addition to Memory Clinic
- an additional 1000 follow-up appointments can be undertaken each year by Memory Nurses in addition to Memory Clinic
- response to increasing demand from GPs with rising referral rates, especially increasing referral numbers for younger and earlier specialist assessment (early onset dementia)
- three of the Memory Nurses are currently supplementary prescribers course and the other is intending to start this course in 2006; and
- increased volumes of activity undertaken by the memory nurses for far less average cost (average £15 per staff contact cost of memory nurses as opposed to average £50 per staff contact cost for memory clinic).

Impact on service users and carers

- memory nurses have been able to co-ordinate and facilitate the memory matters carers' education course and extend the service; and
- qualitative analysis showed that service users (78%) and carers (91%) are either very happy or quite happy for the memory nurse to be the main contact regarding dementia medication rather than a doctor

Impact on staff & organisations

- increased communication and liaison with wider older people's mental health (OPMH) services; and
- OPMH consultants now have better practical knowledge and experience of dementia medication treatments.

Impact on outcomes

- provided a cost effective way or providing and monitoring dementia treatment in keeping with national guidance and advice; and
- introduction of patient specific direction for Donepezil with the Memory Nurses supplying Donepezil packs from MARC base which is less expensive than prescribing on FP10's (a saving of £40 per 28 days pack of Donepezil 10mg).

Other impact measures and benefits identified from the field:

Adult mental health senior nurse practitioner (SNP), West Sussex Health and Social Care NHS Trust

- SNPs undertake first line assessments and are authorised to decide upon appropriate treatment plans. This avoids unnecessary contact with SHOs.
- Where admission is required the project has developed a care pathway where SNPs can authorize admission

Specialist liaison nurse, Barrow-in-Furness, Morecambe Bay PCT

- nurse led clinics working with consultants to create capacity and facilitate discharge
- easier to slot in any urgent requests indicating that some capacity has been created for the consultant; and
- 285 appointments with a total of 204 attendances (71.5% attendance rate) = 22% reduction in consultant overall caseload.

Feedback taken from a service user satisfaction survey

"No I don't think there needs to be any improvements to these clinics as they are very helpful and understanding"

"I think she does a very good job as she listens to what you have to say and explains things if you have any problems. I think she does a very good job"

"I think it's a good idea to have a liaison nurse"

Adult mental health support time and recovery Workers (STR), Humber Mental Health Teaching NHS Trust

- collaborative working with positive assets has resulted in 31% of STR workers with personal experience of mental health services being employed
- successfully recruited to all STR posts
- retention of all STR workers with the exception of promotions
- positive media coverage of the role; and
- user focused approach to care.

STR workers, South Warwickshire PCT

STR workers were introduced. There was a fairly positive response to how the new role impacted on service users. The STR role was identified as:

- allowing the worker to be more proactive by being able to develop recovery plans on a one-to-one basis in line with care plans
- allowing for more initiative from the worker
- emphasising recovery
- being able to spend more time with the client to find out what means of practical support might help recovery in all aspects of their life
- having more time with service user to meet needs
- working with a personalised recovery plan allows a more structured way of working with service users
- the STR role legitimises some of the "extra" work that was already being done; and

Adult mental health BME STR workers, South Warwickshire PCT

- culturally competent workforce that take a holistic approach to the person/the family and understands and appreciates cultural norms and values; and
- staff are enabled to feel confident in building therapeutic relationships with BME service users by seeking out the strengths of the individual but also the communities they live in and the structures they operate within.

Adult associate mental health practitioner, Hampshire wide collaborative

- addresses recruitment challenges
- offsets agency costs
- provides staff with the right skills, knowledge and attitude to deliver care to service users
- trainees are based in setting where this facilitates more experienced staff to extend and expand their roles; and
- the trainee role becomes cost neutral.

Conclusions and recommendations

The 10 high impact changes for mental health services illustrate where demonstrable change can be achieved and how a range of benefits can be realised.

As the evidence base grows the discipline of service improvement will become more robust and rigorous and this will enable health and social care communities to more widely learn and share from experience.

The 10 high impact changes then provide a framework to underpin service improvement programmes of work that builds on the good practice across the wide range of mental health services and will support achievement of organisational priorities.

Supporting implementation of High Impact Changes in Mental Health Services

The Care Services Improvement Partnership (CSIP) has eight regional development centres spread across the country. Every CSIP development centre has staff with service improvement expertise that can advise and support local implementation.

CSIP is committed to supporting the development of service improvement capability and capacity in health and social care and how this is undertaken will be negotiated locally and in response to local need and existing resources.

North East, Yorkshire & Humber Development Centre
01904 717260
www.neyh.csip.org.uk

North West Development Centre
0161 351 4920
www.northwest.csip.org.uk

East Midlands Development Centre
01623 812930
www.eastmidlands.csip.org.uk

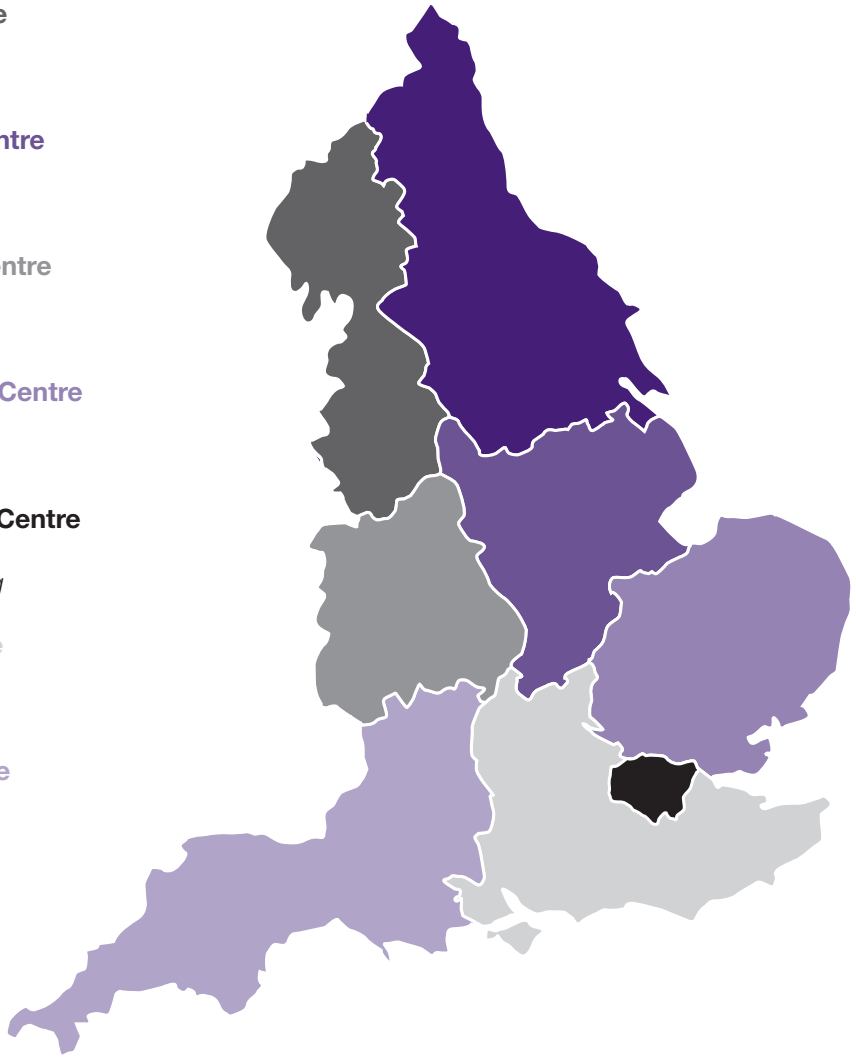
West Midlands Development Centre
0121 6784849
www.westmidlands.csip.org.uk

Eastern Regional Development Centre
01206 287593
www.eastern.csip.org.uk

London Regional Development Centre
0207 307 2431
www.londondevelopmentcentre.org

South East Development Centre
01256 376394
www.southeast.csip.org.uk

South West Development Centre
01278 432002
www.southwest.csip.org.uk



Local implementation will also be supported by these following resources:

Directory of Service Improvement

CSIP has created an online directory of service improvement that brings together the wealth of tools and techniques CSIP uses to support health care professionals, people that use services and the people that support them, as they work in partnership to improve local services. It brings together information on methodologies, networks, exercises, icebreakers, and energisers, which are supported by real life examples. The directory can be explored and utilized to improve services and make High Impact Changes. It helps answer questions like:

- Where should we start with service improvement?
- Who should we involve?
- What sort of tools or techniques could help us? And
- How will we know if things have got better?

To access the regularly updated directory, visit *www.csip.org.uk/serviceimprovementdirectory*

Integrated service improvement programme

The ISIP Road Map for Transformational Change provides guidance on the process of change and sign posts to tools and techniques. The web site also contains the ISIP stepped guidance to assist in planning and delivery of benefits led service improvement. *www.isip.nhs.uk*

Each strategic health authority has an ISIP lead who can provide you with information and support in using the ISIP methodology to support planning and delivery of service improvement.

Service improvement competencies

The Mental Health National Occupational Standards (NOS) state the competencies describing good practice in the delivery of mental health services and are mapped against the NHS Knowledge and Skills Framework.

The NOS can inform decision making in a range of areas including service and role redesign. Interactive tools and resources available to help individuals and organisations develop and measure performance outcomes include the skills required to provide service improvement interventions. These can be accessed through Skills for Health *www.skillsforhealth.org.uk/mentalhealth*

Literature and context review to the 10 High Impact Changes

High Impact Change 1

Treat home based care and support as the norm for the delivery of mental health services

Crisis resolution teams are intended to augment existing services, not replace them (Johnson et al 2005). But it is important to note that the evidence suggests that inpatient admissions (and costs) only reduce for crisis resolution teams if accompanied by a staged reduction in inpatient beds (Ford et al 2001). Pressures to maintain bed numbers might therefore affect the ability of crisis resolution teams to reduce admissions and costs; because if beds are available, they can always be filled (Lawton-Smith 2004).

Plus...

Glover et al (in press) 2005 have carried out a naturalistic observational study of the recent implementation of home treatment services in the UK. They found that crisis resolution teams were more effective in reducing admissions for women and older working age adults, and also when the teams had been established longer. Although expressed differently, this is similar to the finding of Burns et al (2001) that those home treatment services that reduced hospitalisation were more sustainable. In other words, the longer the team is established, the more likely it is it will reduce admissions – and if it reduces admissions, the more likely it is that the team will be sustainable.

Evidence of impact of home-based care across the full range of mental health services needs to be developed or more effectively captured in light of the gaps identified within the evidence base. Particularly the impact of older people's community services, personality disorder services, CAMHS and adult mental health.

However the message for service improvers is clear: give teams time to establish and ensure the whole system is geared up to reduce admissions – this includes making some reduction in the number of hospital beds.

Plus...

Community-oriented services for children and young people tend to be delivered by many agencies, notably education, social services, youth justice services as well as health. In a study of children identified by services as having "concerning" mental health problems, Clark et al (2005) found that 55 of the 60 participants in the study had a diagnosable mental health problem, with over half having more than one psychiatric disorder. Yet at one year follow up, 50% of the children had had no contact with mental health services at all and mental health services accounted for only 5% of the total service costs.

High levels of need were identified at baseline by the Health of the Nation Outcome Scale for Children and Adolescents and the Salford Needs Assessment Schedule for Adolescents, and these persisted over time (although this does mask wide variation, with some young people getting better and some getting worse).

The authors concluded that there was a need for a more formal needs assessment for children to ensure resources are targeted appropriately, and a shared perspective on child mental health between the various agencies potentially involved.

Kaplan (2002) described an evaluation of a multidisciplinary community mental health team for adolescents, although, notably, the team did not contain nurses. The team provided assessment, outreach and a range of interventions. Waiting times were reasonable, with over 50% of first appointments provided within two weeks of "case assignment".

Two-thirds of clients had fewer than 8 sessions and outcomes at discharge showed significant improvements in global functioning and in the original referral problem; there was also a reduction in deliberate self-harm. A small sample of adolescent users and parents provided satisfaction ratings, with the large majority rating the service highly.

Finally, the evaluators estimated cost savings based on likely out of borough (ECR) admissions prevented by the team. They found that the team prevented ECR admissions for between 6 and 9 patients, saving an average of £22,500 per patient based on a 3 month stay.

High Impact Change 2

Improve the flow of service users and carers across health and social care by improving access to screening and assessment

A large-scale American study, found that people who were given their future out-patient appointment time on the same day as their initial contact, were significantly less likely to miss the appointment, than those who had to wait to receive their appointment (Gallucci et al 2005).

The longer patients had to wait to receive notice of their appointment, the more likely they would miss the actual appointment. For people who received their appointment time on the same day, the did not attend (DNA) rate was 12%; for people who received their appointment the following day, the DNA rate increased to 23%, and for people who waited 7 days, the DNA rate was 42%. After that the rate levelled out.

The conclusion is that the first appointment time needs to be given to the service user as soon as possible following the initial contact, preferably on the same day.

Another approach was used in a psychology service where, with only three psychologists, waiting lists were excessively long (Woodhouse 2005). Referrals were audited against factors predictive of positive outcomes (Carr 1999, cited by Woodhouse 2005).

It emerged that the cases being prioritised were those where the referral letter described predictors of negative outcome. In other words, prioritised cases were those least likely to respond to treatment. The referral and assessment system was changed with a view to improving efficiency, using an opt-in approach to appointments and adapting waiting list prioritisation to reflect characteristics predicting a good outcome. The author compared findings in the year preceding the introduction of the new system with the first year of the new system. Opt-in rates stabilised at 70%, and non-attendance reduced significantly.

Following introduction of the opt-in appointment system, average wait for a first appointment dropped from 58 weeks to 45 weeks. A year after the introduction of the revised prioritisation criteria, the average waiting time reduced to 19 weeks, and by the following year had stabilised at 13 weeks. The results were statistically significant.

A Cochrane review (Reda and Makhoul 2001) looked at studies into improving attendance. They found only three relevant trials, all American. However, they did conclude that a simple prompt close to the appointment time may encourage attendance, and a simple orientation type letter the day before the appointment may be more effective, and more cost-effective, than a telephone prompt.

High Impact Change 3

Manage variation in service user discharge processes

A recent toolkit issued by NIMHE/CSIP (CSIP 2005) emphasises the role of day services in supporting recovery through employment and meaningful daytime activity, and also as an alternative to hospitalisation in a crisis. The toolkit cites research that suggests effective day services can facilitate early discharge and reduce inpatient admissions by up to 23%.

In a methodical review of the literature on delayed discharges, Glasby & Lester (2004) found that delayed discharges are multi-factorial in nature, with a wide range of community and other services required to enable timely and effective discharges to take place. These include housing options, day care, secure services and community support.

Moore & Wolf (1999) also held this view: acute inpatient care is part of a spectrum of care and a range of care options for different levels of need and different kinds of problem needs to be in place in order to avoid costly delays in discharge.

High Impact Change 4

Manage variation in access to all mental health services

Many older people are referred via general hospital physicians; therefore there have been initiatives to improve general hospital psychiatric liaison (Draper 2000).

For example, the introduction of a psychiatric consultation liaison nursing service for older people in one general hospital, resulted in increased referrals and decreased waiting times for a psychiatric consultation (down from a mean of 18 days to 6 days wait (Collinson & Benbow 1998).

There is mounting evidence of variations in access, treatment, experience and outcomes for different social, cultural and economic groups in relation to mental health services.

For example, black people and homeless people are less likely to enter mental health services via primary care (Bhugra et al 2004, Holland 1996); black people are more likely to be detained under the Mental Health Act and have more complex pathways into psychiatric care (Bhui et al 2003)]; Asian people are less likely to have their mental health condition recognised in primary care (Commander et al 2004); women report poor experiences in mental health

inpatient units (Ford et al 1998); deaf people have longer lengths of stay (Appleford 2003).However, there is very little robust evidence of service models that could address these issues effectively. What seems like common sense may not make the difference needed. For example, single sex units have been advocated as important for women to feel safer but Mezey's study found that women in single sex secure units felt as intimidated as those in mixed sex secure units, although they were in fact less vulnerable to actual attack (Mezey et al 2005).

Similarly, tools aimed at facilitating better understanding and implementation of culturally-sensitive services (eg Sathyamoorthy et al 2001) have not been systematically or scientifically evaluated (McKenzie 2002).

Where there have been controlled trials, samples are small and tend to compare results between two groups from the same client group, so it is not clear whether the outcomes would have been achieved with different client groups (see for example, Jacob et al 2002). Similarly, individual initiatives, such as services designed specifically for women, have sometimes been evaluated but not scientifically (generally without controls).

Many initiatives are in place, best described as projects, often delivered in the voluntary sector, and which can provide lessons for service developers. For a review of projects for minority ethnic communities in England, see Fernando (2005).

Direct Payments

Direct payments can enable people to have choice and control over the meeting of their social care needs, and this can be at less cost than their former use of provided services. Direct payments require the redistribution of resources to some extent away from provided services, as they are the alternative to these services and there is no additional money to finance this choice. Where they have enabled people to reduce hospital admissions, for example, they present a 'whole system' saving which needs to be balanced with the local authority's sole responsibility to make the direct payments.

High Impact Change 5

Avoid unnecessary contact and provide necessary contact in the right care setting

Assertive outreach teams have been found to result in reduction in hospital days, particularly if properly focused on the care of people with a history of heavy use of inpatient facilities (Commander et al 2005) and when users are engaged with the service (Meaden et al 2004).

They have been found to be as effective as other case management models in relation to quality of life, symptoms and social functioning outcomes, are liked by service users and families and may be cost-effective (Burns & Santos 1995).

Increased community contacts and engagement with severely mentally ill service users are seen as positive aspects of delivering assertive outreach and case management services, probably helping to avoid hospital admission (see for example, Marshall & Lockwood 2004). In a multi-method study, Freeman et al (2002) found that assertive outreach had the strongest evidence base in relation to promoting continuity of contact over time, resulting in improved outcomes and costs.

Most evidence points to sticking to the Assertive Outreach model in order to achieve successful outcomes. McGrew et al (1994) found that programs with higher fidelity were more effective in reducing hospital use. In a recent meta-analysis of 34 ACT studies, Latimer (1999) found high-fidelity programs showed 23% greater reduction in hospital days compared with lower fidelity programs at one year follow up.

High Impact Change 6

Increase the reliability of interventions by designing care based on what is known to work and that service users inform and influence

A recent Cochrane systematic review (Joy et al 2004) reported that CR teams sometimes help to avoid repeat admissions, reduce family burden, are preferred by patients and families, are as effective as hospital-based systems and are more cost effective.

Johnson et al (2005) 2005 conducted an RCT of a crisis resolution team compared with usual services. They reported a significant reduction in hospital admissions in the experimental team; their experimental group had a mean of 6.4 bed days compared with 17.4 in the control group. Looking at effects on the wider system, the authors reviewed local admission rates generally. They found that in the 12 months before the introduction of the Crisis Resolution team, there were 340 admissions in their locality. In the 12 months after the trial, when the crisis resolution team was fully functioning (explicitly when it was involved in all decisions to admit) this had reduced to 237 admissions.

Increased community contacts and engagement with severely mentally ill service users are seen as positive aspects of delivering assertive outreach and case management services, probably helping to avoid hospital admission (see for example, Marshall & Lockwood 2001). In a multi-method study, Freeman et al (2002) found that the assertive outreach model had the strongest evidence base in relation to promoting continuity of contact over time, resulting in improved outcomes and costs.

Rosenheck & Dennis (2001) found that homeless clients who have severe mental illness can be selectively discharged or transferred to other services without subsequent loss of gains in mental health outcomes, substance abuse, housing, or employment. However, most evidence points to sticking to the assertive outreach model in order to achieve successful outcomes. McGrew et al (1994) found that programs with higher fidelity to the model were more effective in reducing hospital use. In a recent meta-analysis of 34 ACT studies, Latimer (1999) found high-fidelity programs showed 23% greater reduction in hospital days compared with lower fidelity programs at one year follow up.

Direct payments enable people to meet their needs in personal, creative and innovative ways. The 'service' a person receives is designed by them and managed by them, with support to achieve this provided to the level which they require. Heslop (2001) accounts her experience:

"I am one of the small number of mental health service users who receive direct payments. I am directly supported in using the scheme by an advisor from ILSA (Integrated Living Scheme Advice and Support Service), part of the West of England, Centre for Inclusive Living (WECIL) (See Mark, 1998). But the use of direct payments has certainly meant that the services and support I receive are truly user-centred, user-led and match my own particular needs.

With the money that I receive from Social Services each month (reviewed on a 6 monthly basis) I employ 2 Personal Assistants (Pas), one to work a certain number of hours/nights each week and the other on a "back-up" basis to cover more urgent situations when support is needed. The actual hours of work are flexible, and generally planned a week in advance according to what my plans for the week are. So, for example, if I have a therapy session, hospital appointment or merely a difficult day at work in prospect, we will prioritise cover for those particular days. My allocation of direct payments money will also cover any necessary administration costs that I incur, such as providing Employers Liability Insurance, paying tax and National Insurance Contributions, paying for someone to take charge of payroll issues, or paying recruitment costs. Overall control of the money is in my hands, via a separate bank account, although there are strict record keeping and reporting regulations that must be adhered to and are regularly monitored.

The freedom that direct payment gives me is immeasurable.

- First and foremost it gives me control. I don't have to rely on a series of relatively inflexible community care workers, or even the rather more preferable option of independent, yet "untried and tested" (to me) independent advocates. I employ staff of my own choosing, who are available when I need them most. They follow my wishes and are not bound to distant, rigid policies to which I have had no input. And they help me with the areas of life that I see as priorities for me, at that particular time, rather than being restricted in the tasks that they can do.

- Secondly, it provides me with the support and confidence to live my life as I wish to live it, rather than being constrained by fear, lack of confidence and low self-esteem. I now live in my own home, hold down regular employment and have friends who do not need to worry about also being my "carers". I go out independently, do voluntary work with people with mental and emotional support needs, and have learned how to trust, albeit a cat!

- Third, it acts as a form of mental health promotion and maintenance, rather than being part of all too familiar "crisis intervention" process, which, in my experience, has come too late to be a very positive or empowering form of help.

Yet for all the very positive aspects of receiving direct payments there are also difficulties that it would be unfair not to address.

- First, when feeling fragile and vulnerable, the whole issue of recruitment and selection of PA's can seem overwhelming and exposing. It is hard enough to ask for help (from friends or professionals) at the best of times, but to advertise for help and expose oneself to questions (however well meaning they maybe) about your own support needs can be particularly difficult.

- Secondly, when I am particularly distressed, for example, or placing myself in danger, my PA's may, at times, need to override my wishes, which may create a difficult tension. My solution to this has been to plan out, with each PA at the start of their employment what we should do on these occasions and each of my PA's has ready access to an information file that includes: things to do to help me when I maybe distressed, advice about what to do in a crisis situation, (including what to pack should I need to go into hospital!), who I would prefer to be contacted on what occasions and their contact details.

- Thirdly, one has to be organised in rather exacting ways! Employees timesheets need to be submitted in order that they can be paid on time, receipts for expenditure need to be kept and filed, regular returns need to be completed and monthly needs assessments reviewed.

Nevertheless, for all the pitfalls and potential difficulties, the Direct Payments Scheme has given me a life that I could not envisaged five years ago. It CAN work very effectively with mental health service users, and the assumption that people could not cope because of their diagnostic label needs challenging. I hope that other mental health service users will have the same opportunities as me to use a truly user-centred and user-led option. It is high time that we demanded it as one of a range of all too limited, or non-existent choices that are currently available" (p8-9)

High Impact Change 7

Apply a systematic approach to enable the recovery of people with long term conditions

In the Cochrane review of day services, Marshall et al (2001) compared prevocational training (PVT) with Supported Employment (also known as Individual Placement & Support or IPS). PVT offers a period of training for employment whilst Supported Employment places and supports people with severe mental illness in ordinary jobs in a competitive market. The review found that Supported Employment was significantly more effective in terms of numbers in competitive employment; clients earned more and worked more hours.

Similarly, in an authoritative book on recovery, Schneider reviewed US and UK evidence into vocational rehabilitation interventions and their outcomes (Schneider 2005). She found no conclusive evidence that sheltered workshops are effective in helping people into work, and indeed might be detrimental.

She also found that education and training initiatives that actively focus on work (not social skills) were effective and that conventional prevocational training was less effective than supported individual placements (Individual Placement and Support/Supported Employment) in achieving employment outcomes. She argues that:

"IPS has such unparalleled evidence in its favour [for its effectiveness in enabling people to get real jobs with real wages, even service users who experience multiple disadvantages in addition to their mental health problems] that it is now known as evidence-based supported employment" (pp. 43).

It is important to note that supported employment is not just about employment for its own sake. In a study of supported employment, Becker et al (1996) found that 81% of service users in a SE scheme expressed job preferences that were realistic and stable. People who were in job placements that reflected their preferences were more satisfied.

High Impact Change 8

Improve service user flow by removing queues

Hamilton et al (2002) reported a triage approach in the form of a brief psychiatric screening clinic for first attendees referred from primary care. Sixty patients were allocated the screening clinic for a 20 minute appointment compared with a traditional hour-long assessment.

Twenty nine (48%) did not attend (compared with 21% DNA for all patients) but because the allocated appointment was only 20 minutes, this actually saved more than 19 hours over a year. The 31 people who did attend were seen in 10 hours and 20 minutes, saving a further 20 hours and 40 minutes. The overall saving to clinician time was more than 40 hours in one year. At 6-month follow up, no patients required admission or assessment following self-harm.

A recent survey found that in 49% of trusts, waiting times for a first appointment were 1-5 months, but in 18% of trusts, they were 6 months or more (Kerfoot et al 2004).

A number of solutions have been tested, including a well-received brief consultation approach (Heywood et al 2003) and triage clinics (Parkin et al 2003). In the latter study, a triage clinic was implemented in light of excessive waiting lists and high dissatisfaction amongst users and clinicians with the length of the wait.

The aim of the triage was to assess the need for specialist CAMHS intervention, mainly with referrals from primary care. In the study, 92 non-urgent referrals were offered triage in an outpatient clinic. Median waiting time was 61 days, with 95% offered an appointment within three months. DNA rates were reduced by a third and a quarter of those seen could be discharged at the end of the triage appointment. Users and physicians were mainly satisfied with the new system. The authors stressed the importance of competent and committed administrative staff as a critical success factor for the project.

Another approach was used in a psychology service where, with only three psychologists, waiting lists were excessively long (Woodhouse 2005). Referrals were audited against factors predictive of positive outcomes (Carr 1999, cited by Woodhouse 2005).

It emerged that the cases being prioritised were those where the referral letter described predictors of negative outcome. In other words, prioritised cases were those least likely to respond to treatment.

The referral and assessment system was changed with a view to improving efficiency, using an opt-in approach to appointments and adapting waiting list prioritisation to reflect characteristics predicting a good outcome.

The author compared findings in the year preceding the introduction of the new system with the first year of the new system. Opt-in rates stabilised at 70%, and non-attendance reduced significantly. Following introduction of the opt-in appointment system, average wait for a first appointment dropped from 58 weeks to 45 weeks.

A year after the introduction of the revised prioritisation criteria, the average waiting time reduced to 19 weeks, and by the following year had stabilised at 13 weeks. The results were statistically significant.

A number of studies have looked into the feasibility of delivering services in imaginative ways that reduce reliance on practitioners, especially those in short supply but great demand.

CBT is one such area of high demand. Lovell & Richards (2000) critically review the evidence for improving access to CBT services via multiple access points. They note that the number of CBT practitioners is nowhere near enough to treat the vast numbers of people with disorders that CBT can treat effectively. They also point to evidence that delivery of CBT services based on traditional outpatient clinics is unhelpful for three main reasons: 1) up to 25% of patients do not attend initial appointments (Zegleman 1988, cited by Lovell & Richards 2000); 2) session duration is based on convenience not evidence 3) open ended sessions not necessarily more effective than limited number of sessions (Barkham et al 1996, cited by Lovell & Richards 2000).

The authors argue that:1) studies increasingly suggest there is little difference in effectiveness between simpler behavioural and more complex cognitive treatments for a range of disorders 2) there is evidence for delivering brief CBT interventions through alternative delivery systems (including telephone and computer) that traditionally would have been treated using frequent, prolonged face-to-face sessions (numerous studies cited).

They suggest therefore that three major changes are made in CBT delivery: 1) less intensive treatments should be the first choice for the majority of clients 2) more intensive packages of care should be provided for patients at serious risk, with more complex needs or who have had an unsuccessful brief treatment regime 3) therapist assisted multi strand or complex therapies should be used where the previous stages have been unsuccessful – but only where clients have been unable to benefit from simpler approaches. They argue in summary that equitable CBT can only be delivered if systems are in place to maximise patient access, minimize initial therapist contact and abandon exclusive reliance on traditional delivery systems.

Results of alternative modes of delivering treatment are mixed but mostly promising. A systematic review of the effectiveness of computerised CBT (CCBT) packages, for example, was carried out for a Health Technology Assessment (Kaltenthaler 2002). The review looked at 13 papers but none of them reviewed the cost-effectiveness of CCBT; therefore the authors also reviewed four sponsor submissions.

The authors found some evidence that CCBT was as effective as CBT delivered by a therapist, and more effective than usual treatment, for people who were depressed, anxious or phobic in primary care populations. Where data were available, they found that CCBT reduces therapist time and can be of use where access to a CBT therapist is limited.

They conclude that CCBT may be a useful component of stepped-care approach, offered as one of the first options to patients presenting in primary care. In terms of cost-effectiveness the authors' findings were limited and they urged caution in interpretation. Notwithstanding this note of caution, they found that the cost of implementing reasonably effective CCBT packages ranged from £21,691 - £25,192 for the first year, depending on the practitioner involved (priced at the time of publication).

In support of this approach, a very recent trial evaluated the use of computer assisted therapy for major depression (Wright et al 2005). The authors found that a multi-media computer-assisted form of CBT for depression was as effective as standard CBT. Service users improved in terms of clinical outcomes and drop-out rates were low, although the sample was small.

High Impact Change 9

Optimise service users and carers flow through the service using an integrated care pathway approach

An example of using care pathways to audit and investigate patterns of care is reported by Commander et al (2004). The authors compared the pathways of white and Asian people with depression and anxiety to throw light on areas of strength and weakness within the system and any differences in how the system operated for these patient groups.

The other use of the term care pathways (sometimes referred to as integrated care pathways) refers to a systematic approach to delivering care. The aim is to provide a rational system for patient care especially in cases where care is complex, crosses organisational boundaries and/or requires input from a number of different professionals. Evidence for the use of care pathways in mental health in the UK is limited and mainly descriptive. Jones (2000) reported the evaluation of an attempt to introduce care pathways for people diagnosed with schizophrenia; the author found that lack of staff engagement and pressure on the service generally prevented the approach from being implemented.

However, the same author argued later that a care pathway may bring other benefits, such as standardized care and a greater control over the delivery of care (Jones 2001). Brett & Schofield (2002) describe a care pathway approach for older mentally ill people which has apparently resulted in improved, more consistent care that users and carers appreciate, but the evidence is anecdotal.

Browning & Hollingberry (2000) describe developing care pathways for eating disorders, acute mental health admissions and acute psychosis over three years. They report that the process increased awareness of best practice and evidence-based care throughout the team. Additionally, service users and carers were more aware of what to expect. A recent paper reported interesting findings from a Scottish implementation of integrated care pathways (ICPs) in community teams in Scotland (Rees et al 2004).

The aim was to enhance joint working across health and social care, reduce duplication and standardise quality of care within the region. Whilst staff responded positively to the idea of the ICP, the researchers found that in practice they were not implementing it. The authors concluded that operational procedures such as ICP cannot overcome problems at strategic and organisational levels.

There is growing recognition that people presenting with psychotic symptoms for the first time need specialized treatment. However there is recognition that early intervention (EI) will never be delivered by specialist EI services alone. Its achievement hinges on changing the care pathway of this young client group and their families by more integrated working between primary, specialist and community agencies.

EI Service implementation in the UK is still in progress and evidence of their effectiveness is therefore limited.

Rationale for EI: Typically those experiencing a first episode of psychosis can expect one to two years delay from onset to engagement and treatment in specialist care, by which time over 50% require use of the Mental Health Act and approaching 80% can become hospitalised (Johnstone, E et al 1986). In a review of the evidence, Birchwood et al (1998) argue that deterioration in mental health occurs most aggressively in the first 2-3 years, representing a 'critical period' for concentrating treatment efforts which maximise the potential for recovery and prevent relapse. From this has derived a fundamental treatment objective, namely to reduce Duration of Untreated Psychosis (DUP).

From this has arisen a justification for therapeutic optimism in EI translated into various treatment strategies; new medication regimens; psycho-education of patients and families; social interventions to support access to education; employment and housing.

Evidence base for EI treatment: There is increasing evidence to suggest that EI may reduce the harmful consequences of psychotic disorders (Ho et al 2003) and as such, EI services work closely to a recovery model.

A recent systematic appraisal of the evidence for early intervention work was published in the Cochrane Database (Marshall & Lockwood 2006), and is in the process of being updated. The reviewers analysed the research on duration of untreated psychosis and its relationship to outcomes for clients and found strong evidence that the longer the period of DUP the worse the outcomes for clients.

The evidence for intervening early to prevent psychosis was found to be fair with some promising preliminary findings. There is encouraging evidence of the impact of EI teams, for example in terms of reducing bed stays and in improved mental states.

This review looked at a number of randomised controlled trials of EI, published or in the process of reporting. A relatively recent trial from the Early

Psychosis Prevention and Intervention Centre (EPPIC) in Melbourne compared outcomes for people with an early psychosis who were assigned to specialist EPPIC care or standard care (Yung et al 2003). The standard care group had longer duration of untreated psychosis, were more likely to be admitted and use of the police in the admission process was higher compared with the EPPIC group. Again from EPPIC, the Personal Assessment and Crises Evaluation (PACE) trial looked at the effectiveness of treating young people identified as being at ultra high risk of developing psychosis.

The PACE study showed that it is possible to delay and potentially avert progression to full diagnostic threshold for psychotic disorder from 35% to 10% in a sample of 59 in 'ultra high-risk' individuals using low dose neuroleptics and CBT.i Subsequently, Morrison et al demonstrated that almost the same conversion rate to psychosis (i.e. 12%) could also be achieved with CBT alone using the PACE criteria.

The TIPS project evaluated community education about psychosis in an epidemiological 'case-control' study in Norway, finding a reduction in DUP and a concomitant reduction in psychosis symptoms at onset of treatment and 3 months follow-up.

Three RCTs have focused on providing intensive assertive outreach-based care to young people (16-30yrs) during the 'critical period'. The OPUS study in Denmark found advantages in terms of readmission, symptoms and quality of life for integrated, sustained treatment over treatment as usual.

In the UK, the Lambeth Early Onset (LEO) study evaluated the effectiveness of an early intervention service which is compliant with the 2001 Policy Implementation Guide recommendations. A team delivering specialised care for patients with early psychosis has been found to be superior to standard care for maintaining contact with services and reducing readmissions to hospital (Craig et al 2004).

The Croydon Outreach & Assertive Support Team (COAST) found disappointing results. Trends in bed use and quality of life were better for COAST service users compared with service users receiving treatment as usual, but differences were not statistically significant (Kuipers et al 2003).

High Impact Change 10

Redesign and extend roles in line with efficient service user and carer pathways to attract and retain an effective workforce

Challis et al (2004) reported a randomised controlled trial to test the value of employing a specialist clinician to assess older people before entering a care home. The authors found that the assessment uncovered mental health problems that had formerly not been recognised, and that outcomes improved. There were significantly fewer days spent in nursing home care and significantly fewer visits to A&E for those in the intervention group. NHS costs were significantly lower for the intervention group, even taking into account the additional cost of the clinician's assessment.

According to a recent survey, a fifth of trusts had outpatient CAMHS clinics within primary care settings and one third of CAMHS services had developed primary mental health worker posts (Bradley et al 2003). A recent study did find that introducing primary health workers created a more efficient CAMHS service (Whitworth and Ball 2004). Non-attendance rates decreased (from 45% to 9%), attendance increased (55% to 78%), and patterns of referrals to secondary care were altered so that Tier 2/3 work was more likely to be focused on appropriate cases.

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References

Appleford, J. (2003) Clinical activity within a specialist mental health service for deaf people: Comparison with a general psychiatric service. Psychiatric-Bulletin. Vol 27(10) Oct 2003, 375-377.

Becker DR, Drake R E, Farabaugh A, Bond G (1996) Job preferences of clients with severe psychiatric disorders participating in supported employment programs. Psychiatric Services. Nov;47(11):1223-6.

Bhugra D, Harding C, Lippett R (2004) Pathways into care and satisfaction with primary care for black patients in South London. Journal of Mental Health. Vol 13(2) Apr 171-183

Bhui K, Stansfield, S, Hull S, Priebe S et al (2003) Ethnic variations in pathways to and use of specialist mental health services in UK: Systematic review. British Journal of Psychiatry. Vol 182(2) Feb 2003, 105-116.

Birchwood M, Todd P, Jackson C (1998) Early intervention in psychosis: The critical period hypothesis. British Journal of Psychiatry. Vol 172(Suppl 33) Jun 53-59.

Bradley S, Kramer T, Garralda M, Bower P et al (2003). Child and adolescent mental health interface work with primary services: A survey of NHS provider trusts. Child & Adolescent Mental health Vol 8(4) 170-176

Brett W & Schofield J (2002) Integrated care pathways for patients with complex needs. Nursing Standard; Jul 31-Aug 6, 16, 46; 36-40

Browning R & Hollingberry T (2000) Mental health: for Good measure. Health Serv J. Oct 5;110(5725):34-5

Burns B J & Santos A B (1995) Assertive community treatment: an update of randomized trials. Psychiatric Services Jul; 46(7): 669-75

Burns T, Knapp M, Catty J et al (2001) Home treatment for mental health problems: a systematic review. Health Technology Assessment Vol. 5: No. 15

Carr, A. (1999). Handbook of child and adolescent clinical psychology: A contextual approach. London: Routledge. (cited by Woodhouse 2005)

Challis D, Clarkson P, Williamson J, Hughes J et al (2004) The value of specialist clinical assessment of older people prior to entry to care homes. Age and Ageing 33: 25–34

Clark A, O'Malley A, Woodham A, Barrett B & Byford S (2005) Children with Complex Mental Health Problems: Needs, Costs and Predictors over One Year Child and Adolescent Mental Health Volume 10, No. 4, 170–178

Collinson Y & Benbow S (1998) The Role Of An Old Age Psychiatry Consultation Liaison Nurse. International Journal Of Geriatric Psychiatry 13: 159-163.

Commander MJ, Odell SM, Surtees PG, Sashidharan SP (2004) Care pathways for south Asian and white people with depressive and anxiety disorders in the community. Social Psychiatry and Psychiatric Epidemiology. Apr;39(4):259-64.

Commander M, Sashidharan S, Rana T and Ratnayake T (2005) North Birmingham assertive outreach evaluation: Patient characteristics and clinical outcomes. Social Psychiatry and Psychiatric Epidemiology. 40(12) 988 - 993

Craig T, Garety P, Power P, Rahaman N et al (2004) The Lambeth Early Onset (LEO) Team: randomized controlled trial of the effectiveness of specialist care for early psychosis. BMJ 329;1067-1072

CSIP (with the Mental Health Foundation) (2005) Redesigning mental health day services: A modernisation toolkit for London. London: DH.

CSIP/NIMHE (2005) The Ten High Impact Changes for Service Improvement and Delivery: Making them relevant for mental health – A Discussion Document. CSIP/NIMHE (unpublished discussion paper)

DH Workforce Directorate (2005). A national framework to support local workforce strategy development: A guide for HR directors in the NHS and social care. London: DH (Available from *www.dh.gov.uk*)

Department of Health (2006). Our health, our care, our say: a new direction for community services. London: DH. (Available from *www.dh.gov.uk*)

Department of Health (2001). National service framework for older people. London: DH (Available from *www.dh.gov.uk*)

Draper (2000) The Effectiveness of Old Age Psychiatry services International Journal of Geriatric Psychiatry Aug;15(8):687-703.

Fernando S (2005) Multicultural mental health services: projects for minority ethnic communities in England. 42 (3) 420-436.

Ford R, Durcan G, Warner L, Hardy P and Muijen M (1998) One day survey by the Mental Health Act Commission of acute adult psychiatric inpatient wards in England and Wales British Medical Journal. 317;1279-1283

Ford R, Minghella E, Chalmers C, Hoult J et al (2001) Cost consequences of home-based and in-patient-based acute psychiatric treatment: Results of an implementation study. Journal of Mental Health. 10(4) Aug 2001, 467-476

Freeman G, Weaver T, Low J et al (2002) Promoting Continuity of Care for People with Severe Mental Illness whose needs span primary, secondary and social care: A multi-method investigation of relevant mechanisms and contexts. NCCSDO

Gallucci G, Swartz W, Hackerman F (2005) Impact of the wait for an initial appointment on the rate of kept appointments at a mental health center. Psychiatric Services. Mar;56(3):344-6.

Glover G Arts G & Babu K (in press) Crisis resolution/home treatment teams and psychiatric admission rates in England.

Hamilton R, Gordon P and Naji S (2002) Service innovation: the first year of a brief psychiatric screening clinic in primary care. Psychiatric Bulletin 26 218-221

Heslop, P (2001) Direct Payments for people with mental health support needs. The Advocate, 8-9

Heywood S, Stancombe J, Street E et al (2003) A Brief Consultation and Advisory Approach for use in Child and Adolescent Mental Health Services: A Pilot Study. Clinical Child Psychology and Psychiatry, Vol. 8, No. 4, 503-512

Ho B-C, Alicata D,Ward J, Moser DJ, O'Leary DS, Arndt S, Andreasen NC (2003) Untreated initial psychosis: Relation to cognitive deficits and brain morphology in first-episode schizophrenia. American Journal of Psychiatry 160:142–148

Holland AC (1996). The mental health of single homeless people in Northampton hostels. 110(5):299-303

ISIP (2005). Delivering quality and value: the ISIP guide to strategy and benefits.

Jacob K, Bhugra D & Mann AG (2002) A randomised controlled trial of an educational intervention for depression among Asian women in primary care in the United Kingdom. International Journal of Social Psychiatry; 48(2); 139-48

Johnstone, E.C., Crow, T.J., Johnstone, A.L. and Macmillan, J.F. (1986) The Northwick Park Study of first episode, schizophrenia: I. Presentation of the illness and problems relating to admission. British J of Psychiatry; 148: 115 - 120.

Johnson S, Nolan F, Pilling S, Sandor A, Hoult J, McKenzie N, White IR, Thompson M, Bebbington P (2005) Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. BMJ. Sep 17;331(7517):599.

Jones A (2000) Implementation of hospital care pathways for patients with Schizophrenia. Journal of Nursing Management, Jul; 8(4): 215-25

Jones A (2001) Hospital care pathways for patients with schizophrenia. J Clin Nurs. Jan;10(1):58-69

Kalthenthaler E, Shackley P, Stevens K, Beverley C et al (2002) A systematic review and economic evaluation of computerised cognitive behaviour therapy for depression and anxiety Health Technology Asessment.;6(22):1-89.

Kaplan A & the SAFE team (2002). From a Short-Life Project to a Mainstream Service: Convincing Commissioners to Fund a Community Adolescent Mental Health Team. Child & Adolescent Mental Health Vol7, No. 3, 114–120

Kerfoot M, Panayiotopoulos C & Harrington R (2004) Social Services and CAMHS: A National Survey Child and Adolescent Mental Health Vol 9, No. 4, 162–167

Latimer E A (1999) Economic impacts of assertive community treatment: a review of the literature. Can J Psychiatry. Jun;44(5):443-54.

Lawton-Smith S (2004) Out for the count. Health Service Journal. p29. 15 July

Lester H, Tritter JQ, Sorohan H (2004) Managing crisis: the role of primary care for people with serious mental illness. 36(1):28-34

Lovell K & Richards D (2000). Multiple Access Points and Levels of Entry (MAPLE): ensuring choice, accessibility and equity for CBT services. Behav Cognit Psychother 28: 379-391.

Marshall M, Lockwood A The Cochrane Database of Systematic Reviews 2006 Issue 2 Copyright © 2006 The Cochrane Collaboration. Published by John Wiley & Sons, Ltd.

Marshall M, Lockwood A (2004) Assertive community treatment for people with severe mental disorders (Cochrane Review). In: The Cochrane Library, Issue 3, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Marshall M, Crowther R, Almaraz-Serrano AM, Tyrer P (2001). Day hospital versus out-patient care for psychiatric disorders. The Cochrane Database of Systematic Reviews: Reviews. Issue 2 John Wiley & Sons, Ltd Chichester, UK DOI: 10.1002/14651858.CD003240

McGovern D, Hemmings P, Cope R. Long-term follow-up of young Afro-Caribbean Britons and White Britons with a first admission diagnosis of schizophrenia. Social Psychiatry and Psychiatric Epidemiology 1994; 29: 8-19

McGrew J H, Bond G R, Dietzen L, Salyers M (1994) Measuring the fidelity of implementation of a mental health program model. J Consult Clin Psychol. Aug;62(4):670-8.

McKenzie K (2002) A cultural sensitivity audit tool (review).

Meaden A, Nithsdale V, Rose C. Smith J &Jones C (2004) Is engagement associated with outcome in assertive outreach? Journal of Mental Health 2004 13(4): 415-24

Mezey G, Hassell Y & Bartlett A (2005) Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions British Journal of Psychiatry Dec;187:579-82

Moore C & Wolf J (1999) Open and shut case. Health Service Journal. Jun 24;109(5660):20-2

Morrison AP, French P, Walford L, et al. Cognitive therapy for the prevention of psychosis in people at ultra-high risk: randomized controlled trial. Br J Psychiatr 2004;185: 291-7.

Mortensen PB Suicide among schizophrenic patients: Occurrence and risk factors Clinical Neuropharmacology 18: S1-S8 Suppl. 3 1995

National Institute for Clinical Excellence (2001) Technology Appraisal Guidance - No.19. Guidance on the Use of Donepezil, Rivastigmine and Galantamine for the Treatment of Alzheimer's Disease. London: NICE.

NHS Modernisation Agency (2004). 10 High Impact Changes for service improvement and delivery: a guide for NHS leaders. London: DH (Available from *www.dh.gov.uk*)

NHS Modernisation Agency (2005). Improvement Leaders' Guides. London: DH (Available from *www.modern.nhs.uk*)

Parkin A, Frake C & Davison I (2003) A Triage Clinic in a Child and Adolescent Mental Health Service. Child and Adolescent Mental Health. Volume 8 Issue 4 177

Reda S and Makhoul S (2001) Prompts to encourage appointment attendance for people with serious mental illness. Cochrane Database Systematic Reviews. (2) CD002085

Rees G, Huby G, McDade L & McKechnie L (2004) Joint working in community mental health teams: implementation of an integrated care pathway. Health and Social Care in the Community 12 (6), 527–536

Sathyamoorthy G, Minghella E, Ford R et al (2001) Cultural Sensitivity Audit Tool for Mental Health Services. London: Sainsbury Centre for Mental Health.

Schneider, J (2005). Getting back to work: what do we know about what works? In Grove, B., Secker, J. and Seebohm, P (Eds.) New Thinking about Mental Health and Employment. Radcliffe Publishing Limited, Oxford. Pp. 37-49.

Whitworth D and Ball C (2004) The Impact of Primary Mental Health Workers on Referrals to CAMHS. Child and Adolescent Mental Health.9, No. 4, 177–179

Wiersma D, Nienhuis FJ, Slooff CJ and Giel R. Natural course of schizophrenic disorders: A 15 year follow-up of a dutch incidence cohort. Schizophrenia Bulletin 1998; 24:75-85

Woodhouse A E (2005) Reducing Waiting Times: Using an Opt-In System and Changing Prioritisation Criteria, Child and Adolescent Mental Health

Wright J H, Wright A S, Albano A; Basco M R et al (2005) Computer-Assisted Cognitive Therapy for Depression: Maintaining Efficacy whilst reducing therapist time. American Journal of Psychiatry; 2005; 162, 6. 1158 -1665

Yung AR, Organ BA, Harris MG (2003) Management of early psychosis in a generic adult mental health service Australian and New Zealand Journal of Psychiatry, Aug; 37(4): 429-36

Zegleman, F E. (1988). Psychiatric clinics in different settings default rates. Health Bulletin, 46, 286–290 cited by Lovell & Richards (2000)

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Document Purpose	Best Practice Guidance		
ROCR Ref:		**Gateway Ref:**	6583
Title	10 High Impact Changes for Mental Health Services		
Author	Care Services Improvement Partnership		
Publication Date	20 Jun 2006		
Target Audience	PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Directors of HR, Directors of Finance		
Circulation List	Communications Leads, Ds of Social Services, Voluntary Organisations		
Description	The Care Services Improvement Partnership (CSIP) has produced a specific guide on the 10 high impact changes for mental health services. This guide explains the intention of each high impact change and is underpinned by evidence collated from the range of mental health services across the country.		
Cross Ref	10 High Impact Changes for Service Improvement & Delivery. NHS Modernisation Agency (2004)		
Superseded Docs	N/A		
Action Required	N/A		
Timing	**N/A**		
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