Early Intervention in Psychosis

Update from national mental health team

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We are now one year on from the introduction of the early intervention in psychosis standard. This is an opportunity to review what has worked well and what are the ongoing challenges for teams and commissioners.

1. Why do we have an early intervention in psychosis standard?
2. What improvements have we seen in access to care in 2016/17?
3. What achievements have been made to improve delivery of NICE concordant care in 2016/17?
4. What are key areas of development for 2017/18?
5. What are the national team focusing on in 2017/18?
6. What can commissioners and providers do in 2017/18?
The EIP access and waiting time standard requires that, from 1 April 2016, more than 50% of people experiencing first episode psychosis commence treatment with a NICE-recommended package of care within two weeks of referral. There are therefore two conditions for the standard to be met:

- a maximum wait of two weeks from referral, and
- treatment delivered in accordance with NICE guidance.

**From the Lost Generation Report (Rethink)**

"After more than a decade of progress and success, EIP care is effectively disappearing in some areas of the country”

**Why early intervention in psychosis?**

“It was much more of a holistic approach than previous support I’d received. They talked to me about my physical health, as well my mental health, and made sure I was looking after myself.”

“With the continued support of EIP across three years I feel like ‘me’ again... I am very ambitious in my career, working full time for the last 2.5 years and am enjoying being a first time mum to my 10-month old baby.”
One year on, the EIP standard is a priority for the NHS
- NHS Operational Planning and Contracting Guidance 2017-2019
- CCG Improvement and Assessment Framework
- NHS Improvement Single Oversight Framework
- Care Quality Commission Monitoring Framework.

Increased investment by commissioners
- Many teams have seen increased investment to meet the 50% RTT standard.
- The CCG Finance Tracker provides another level of transparency on this

Increased transparency at national, regional and local level
- Unify2 data collection intended to bridge the gap in coverage until data flowing through the MHSDS is considered to be complete and robust.
- Data and understanding at detail we have never had before.

So, what progress in improving timely access to EIP services has the Unify data shown us?

The numbers of patients who started treatment and incomplete pathways are likely to be under reported. This may also result in the percentage achievement against the standard being artificially inflated. These issues mean that individual months of data should be treated with a degree of caution at this stage.
The standard has seen an increase in the number of people starting treatment with a specialist EIP team

- From the start of data collection, the number of people with a first episode of psychosis starting treatment with a specialist EIP team per month has risen from 886 people in December 2015 to 1,205 people in November 2016.
- Since the EIP standard was introduced in April 2016, 9,597 people have started treatment with a specialist EIP team.

Source: NHS England, Unify collection
Not only are more people being seen, but they are accessing care much quicker

- The RTT component of the standard (50% of people starting treatment within 2 weeks) has been met since the introduction of the standard.
- Since April 2016, performance has risen from 65% to 77.6% in November 2016.

Source: NHS England, Unify collection
In November 2016, people that start treatment had a median waiting time of 1.3 weeks compared to 1.63 weeks in December 2015 when data collection started.

In December 2015, 523 started treatment with an EIP team within 2 weeks. This has increased to 935 in November 2016.

And those that have started treatment since April 2016 are waiting considerably less time.
But what about those that are yet to start treatment each month? We know more work needs to be done, but we are seeing a reduction in how long those people are waiting….

• In December 2015, of those people each month that were still waiting to start treatment only 24% had been waiting less than 2 weeks. In November 2016 that has improved to 50% of people waiting less than 2 weeks.
Investment has seen increased training of staff

• Health Education England invested £6m in training during 15/16. This programme has already delivered:
  • 542 people with family intervention training (including 14 trained trainers)
  • 124 people provided with top-up CBTp training
  • 80 people trained as CBTp supervisors.
• Furthermore, it is on track to deliver:
  • 1 year CBTp top up training for 170 people (by March 2017)
  • CBTp post-graduate diplomas for 116 people (by March 2018).

Again, we have greater transparency at all levels

• Until the MHSDS is robust to measure interventions and outcomes data, we have the CCQI self-assessment.
• Teams have not been scored for this first indicative year of the self-assessment.
• The 2016/17 will provide a baseline for teams to work with commissioners to identify areas for improvement and to help prioritise investment and drive care quality.
What are key areas of development for 2017/18?

1. Increasing access for over 35s and people with ARMS
2. Continued development of the workforce
3. Improving MHSDS data completeness and quality

What do we need to do to make this happen?

- CCG Finance Tracker to provide finance information we have never had before.
- CCQI self-assessment to provide transparency on gaps in provision and where delivery of NICE recommended care is strongest
- Continued funding and energy in regions for supporting mental health improvement.
- Clinical leadership has been key to delivery of the standard and must continue
- Continued work at all levels to improve quality of data for the MHSDS.
- Continued focus to improve interventions and outcomes reporting.
What are the national team focusing on in 2017/18?

Supporting regions, providers and commissioners
- Linking clinical leads, commissioners and ramping up the sharing best practice
- The IST to continue to support DCO assurance teams and CNs on improving data quality
- Launch of NHSI improvement offer

Improving data quality
- NHS Digital to begin reporting monthly on all clock stops with and without a specialist EIP team.
- NHS England in partnership with NHS Digital to develop guidance on how SNOMED will be used to monitor the quality of care.
- Regional and national performance reports to be updated to include MHSDS data and incomplete pathway data.
- NHS England working to transition from UNIFY so that the MHSDS becomes the source of RTT performance data during 2017.

2017/18 CCQI assessment of NICE-concordance process
- Opportunity to review self-assessment process
- 2017/18 onwards there will be a cost attached to the self-assessment that providers and commissioners will be expected to meet. Working with CQC to consider how it may be possible to reduce burden elsewhere.
What are the national team focusing on in 2017/18?

Monitoring investment

- Initial investment in 2015/16 of £40m through the tariff
- Additional investment made available to CCGs from 2017/18

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**Objective**

| % of people receiving treatment in 2 weeks | 50% | 50% | 53% | 56% | 60% |
| All services complete baseline self-assessment | All services graded at level 2 by year end | All services graded at level 3 by year end | 25% of services graded at least level 3 by year end | 50% of services graded at least level 3 by year end | 60% of services graded at least level 3 by year end |

Contracting and regulation opportunities

- NHS Operational Planning and Contracting Guidance 2017-2019
- CCG Improvement and Assessment Framework
- NHS Improvement Single Oversight Framework
- Care Quality Commission Insight Framework

Other opportunities

- Mental Health Dashboard finance information
- Payment model development
- Physical health CQUIN 2017-2019
- Physical health and Individual Placement and Support funding
The self-assessment data provides a fantastic opportunity for commissioners and providers to work together to:

1. Identify priority areas for development and ensure that the new investment made available is targeted effectively.

2. Identify workforce development needs and ensure that these are discussed with provider and regional workforce development leads.

3. Identify opportunities for peer-to-peer learning. What can you share? What can you learn?

4. Track improvement against this baseline – increasingly making use of data entered into electronic care record systems and making use of team-level feedback (e.g. as in Berkshire)
Any questions?