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NHS Foundation Trust

It's more than me! Supporting service users and their networks of support during an acute admission

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as one

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Welcoming Kind Positive Respectful Professional

Overview:

- Introduction to the project
- Results
- Discussion
- Conclusion & recommendations

Introduction:

- MH policies and guidelines recommend some form of family involvement
- Triangle of Care (2013) – therapeutic alliance between service users, professionals and carers so as to promote and sustain service user's health and well-being
- Generally poor implementation rates of this
- Particularly lacking within the inpatient context
- Upon discharge people will often return to family settings where informal care is given
- This project attempts to bridge the gap

From idea to reality

- Initial working party group:
  - Consultant Clinical Psychology Lead
  - Acute Clinical Psychologist (experience of previous such work)
  - Trusts Inclusion and Engagement Team Leader (representative of service users/carers views)

The Model:

- Reflective Team Approach (Tom Andersen, 1993) – adapted version (used previously, pragmatically)
- Delivery team -
  - Acute Clinical Psychologist – lead facilitator of the meetings
  - Chaplain (Spiritual Care Services) – reflecting team (counselling background)
  - Assistant Psychologist – to be recruited to support implementation and other administrative aspects of the project

Project plan:

- Small scale pilot study in one of our acute treatment wards
- To offer meetings to service users and their families (networks of support)
- To allow for sense/meaning making of the hospital admission including precipitating events
- Therapeutic focus/affects
- Inclusion/exclusion criteria – to have a family/significant others in your life

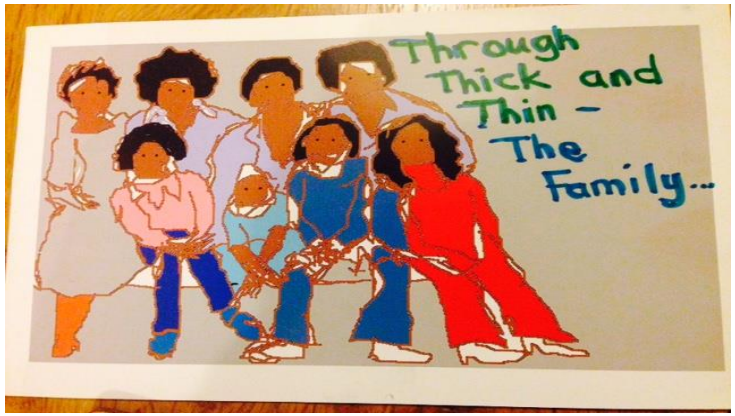
Outcomes:

- To the service user – satisfaction and recovery: measured via satisfaction and well-being measures
- To the family – satisfaction: measured via satisfaction measures
- To the services – length of stays, satisfaction, complaints and compliments: measured via sourcing routinely collected service level data

The process:

- A bid for funds for the project submitted and accepted by the Trusts Innovation and Improvement Panel
- Funds attained for the following:
  - Recruitment of an AP to support project implementation
  - Back fill costs for the chaplain to serve as reflecting team member
  - Training for staff upon carer awareness prior to the formal start of the project.
- AP soon recruited (fixed term contract – 3 days a week over 10 months)
- Promotional posters and leaflets (utlising SU art) produced and distributed
- Staff training upon “carer’s awareness” delivered jointly by the Trust and local carers organisation
- Regular weekly session set up during which two family meetings of 90 minutes duration were offered.
- Meetings only to occur if both the lead therapist and chaplain as reflecting team member were present
- Assistant would set up the meeting and maintain a study database
- A maximum of three meetings offered to any one family (ensure equitable provision)
- Database set up to log all SU’s admitted (this included those not involved in the project) and related data
- Project duration September 2018 – March 2019

Poster for the meetings:



Introducing Family Meetings

Admission to a mental health unit can be difficult, not only for individuals but also for those who care for them.

As a family/carer network, would you find it helpful to talk through what has happened and how you have been feeling?

We are a team of workers from our psychological therapies and the spiritual care service who have training and experience of working with individuals who are struggling through difficult experiences. We offer Family Meetings to all those admitted to XXXX with their families or support networks.

Ask your named nurse or any other clinician for more information and how to get in touch.

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Meetings format:

- AP meets and ensures completion of pre-meeting measures
- Lead facilitator – oversees introductions and discusses format of the meetings, i.e. that they will initially lead the meeting with reflecting team colleagues silently listening in
- 45 minute initial discussion exploring the problem definition and meaning/understanding including of the admission process
- Chaplain and AP (reflecting team members) invited to join in share observations/comments followed by a collective conversation until the meeting close after approximately 45 minutes
- AP then facilitates completion of post-meeting measures
- EPR entry would be made – all informed
- Letter summarising the meeting sent to all participants following final meeting

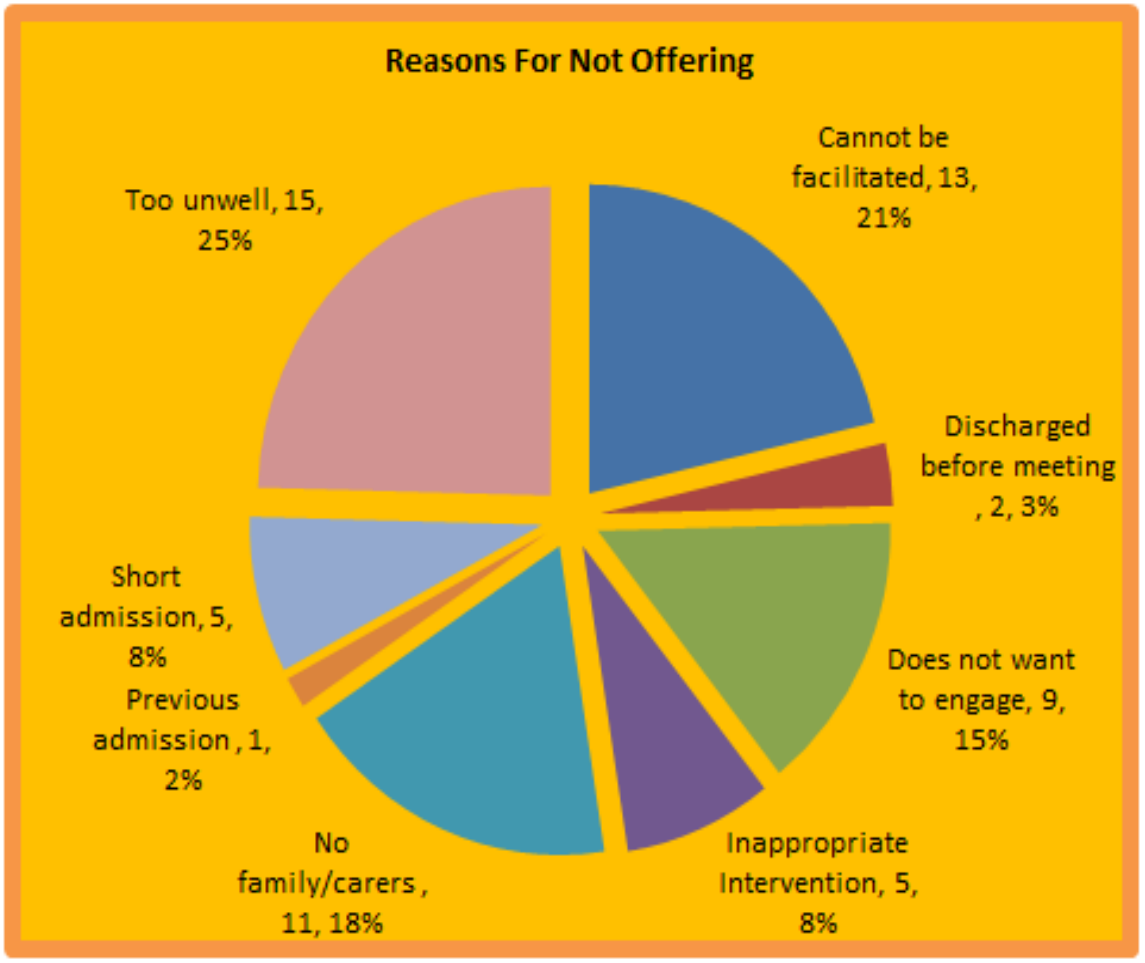
Measures/data:

- Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWS) – measure of wellbeing completed by SU only pre and post meetings
- Score-15 – family functioning measure. Completed pre-meetings only – baseline measure only
- Session Evaluation – 3 item questionnaire to rate the meeting. Completed after each meeting
- Family Feedback Questionnaire – rating overall family meeting experience. Completed at termination of meetings.
- Retrospective follow up evaluation – sent to all participants of the meetings via post to attain additional feedback
- Staff evaluation – collected via team meeting, 1:1 meetings and a distributed questionnaire
- Service level data – average length of stays pre, during and post project period (Trust's Data & Performance Team) and number of compliments and complaints pre and during project period (Trust's Complaints Team)

Results:

- Participation – open to all (who have family/significant others).
- AP database = 110 admissions during project period. External verification data from Data and performance team = 202 admission. Significant proportion of 45.5% of admissions therefore missed. Reasons include:
  - AP worked on part time basis - miss admissions during non working days and leave periods
  - Not recording March 2019 admissions – wrap of project
- Of 110 admissions 55.5% (n=61) not offered a meeting

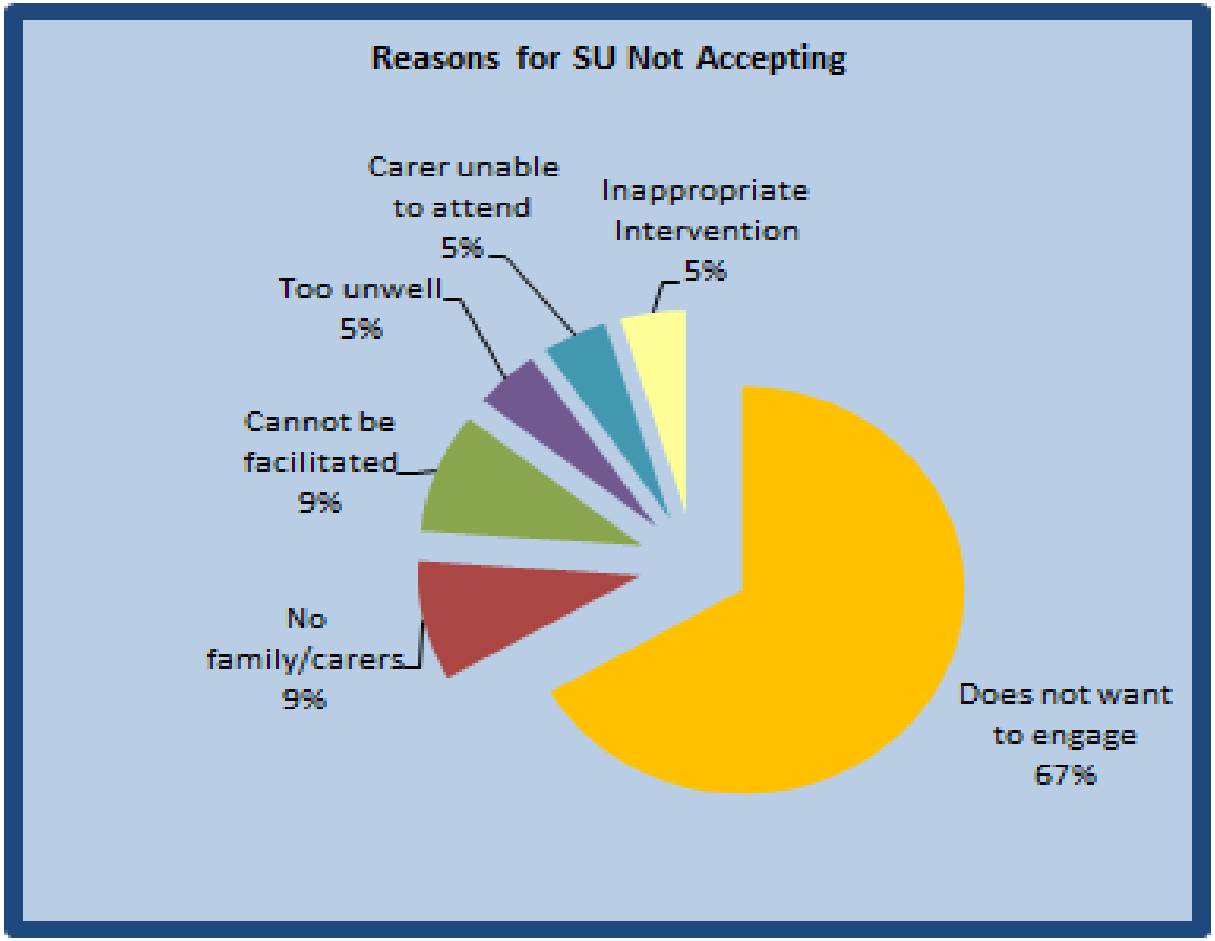
Not offered a meeting:



Results:

- 44.5% (n=49) offered, 42.9% (n=21) did not participate in the meetings

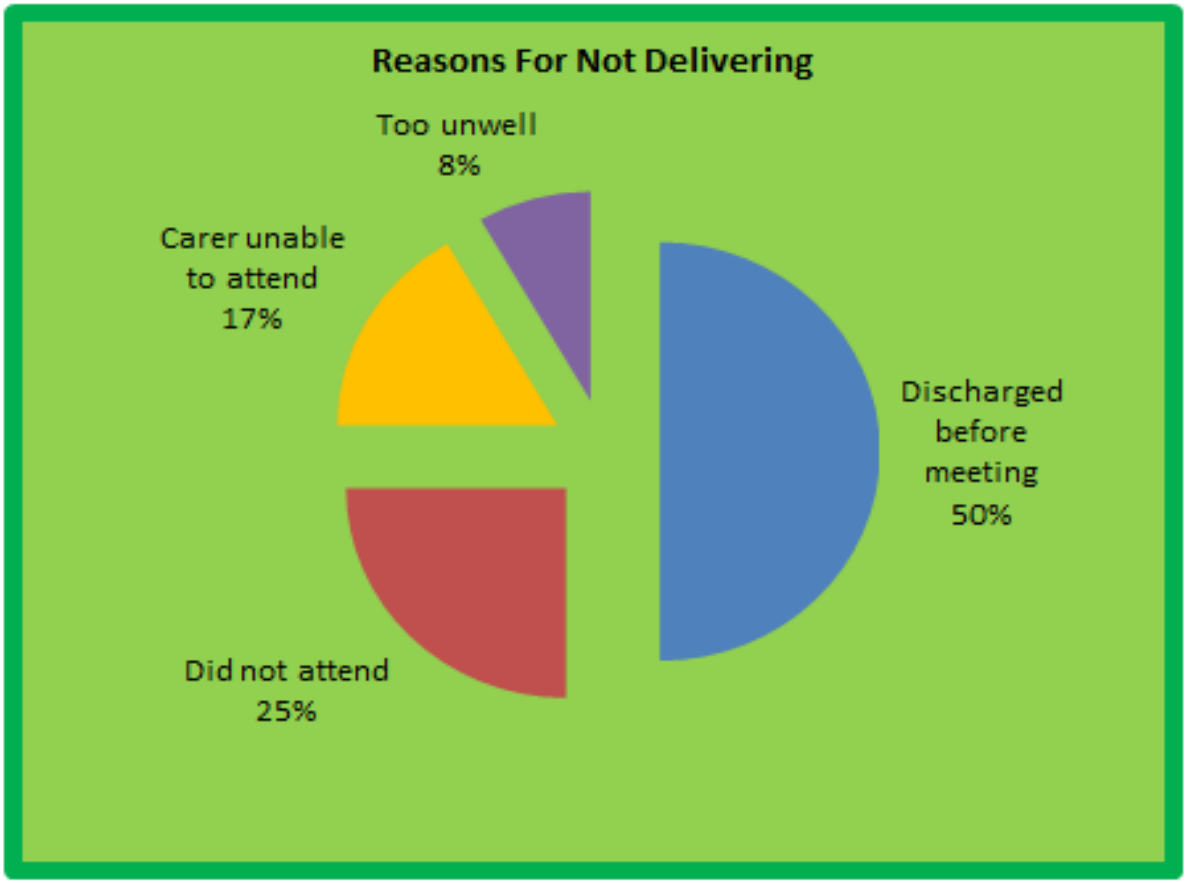
Reasons for non-participation:



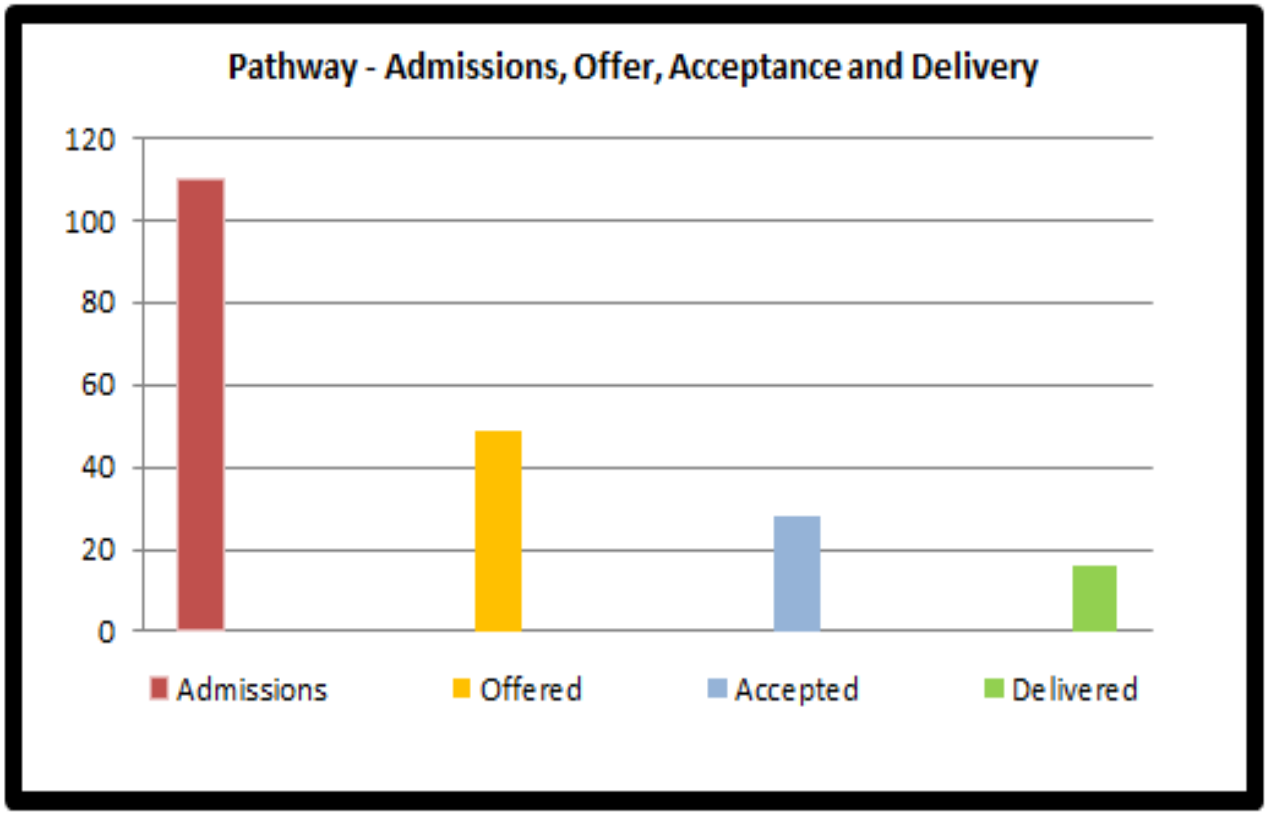
Results:

- 28 service users accepting a meeting, meetings subsequently facilitated for 57.1% (n=16)

Reasons for non facilitation of meetings:



Take up rates of the meetings:



Participants/attendees:

Relationship	N
Parents	18
Siblings	2
Partners	5
Other family members	1

Participant's demographics

N(16)		
Gender	Male	10
	Female	6
Age	18-30	6
	31-45	5
	46-65	5
Ethnicity	White British	9
	White Other	2
	British Asian	4
	Black British	1
Diagnosis	Depression	3
	Psychosis/Schizophrenia	7
	Bipolar	2
	Anxiety	1
	OCD	1
	Personality Disorders	1
	Other	1

Participant's demographics

- In line with NHS benchmarking figures in terms of diagnosis
- In line with Mental Health Act Statistics Annual Figures (2017-2018) in terms of mostly male, aged 18-34 years.
- Difference – ethnicity – mostly white group (reflect local population of Hertfordshire – mainly White & referral to and uptake of therapy)

Meetings offer:

Number of meetings	Access rate
1	38% (n=6)
2	43% (n=7)
3	19% (n=3)

SWEMWS (Wellbeing):

- Lots of missing data
- Meaningful comparisons about mood improvement across meetings could not be usefully made

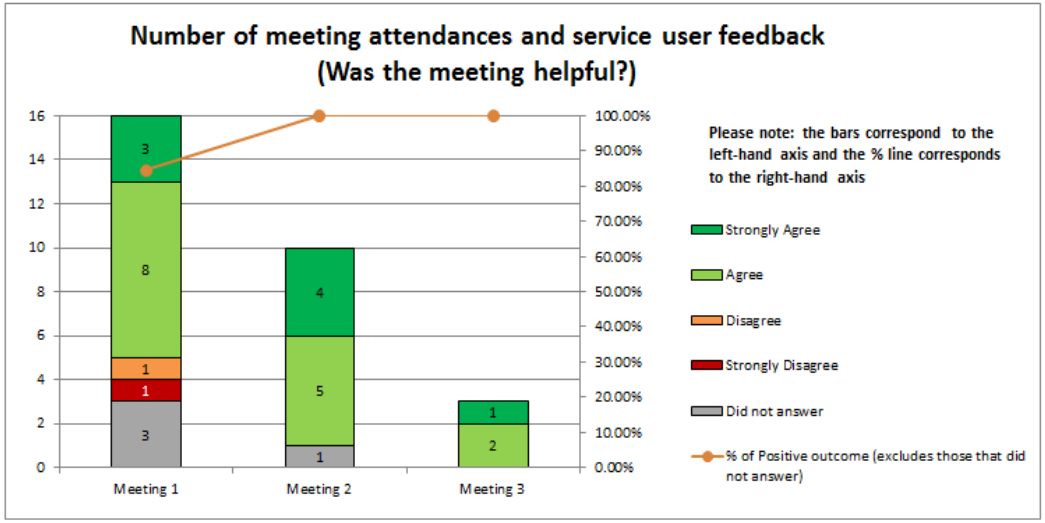
Score-15 (Family functioning):

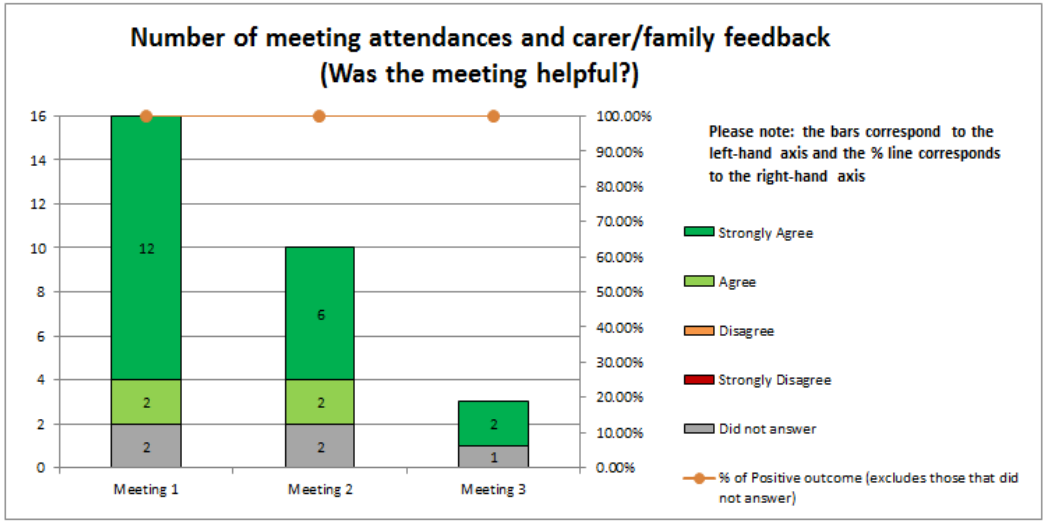
- Measures three areas of family functioning i.e.:
  - Strengths and adaptability
  - Overwhelmed by difficulties
  - Disrupted communication
- Service user scores showed they found their families to be more challenging than their family members did particularly in terms of “disrupted communication”

Session evaluation:

- Following first meeting 85% of SUs “agreed” or “strongly agreed” that the meeting had been helpful
- Attendees for second or third meeting 100% SUs agreed meeting had been helpful
- 100% carers/families “agreed” or “strongly agreed” meeting had been helpful following one or more meetings

Session evaluation:





Family Feedback Questionnaire:

- Scores ranged for 12-60 (12 = positive evaluation; 60 = negative evaluation)
- Overall average score = 22.3
- Overall meetings well received by both SUs and families

Retrospective follow up evaluation:

- Low response rate of 18% (n=3)
- All reported on reflection they found the meetings to be helpful
- All reported least helpful aspect was the limit in meeting offer, not able to explore issues in as much depth as they would like
- All reported more meetings should be offered
- Two reported summary letter as being helpful

Thematic Analysis:

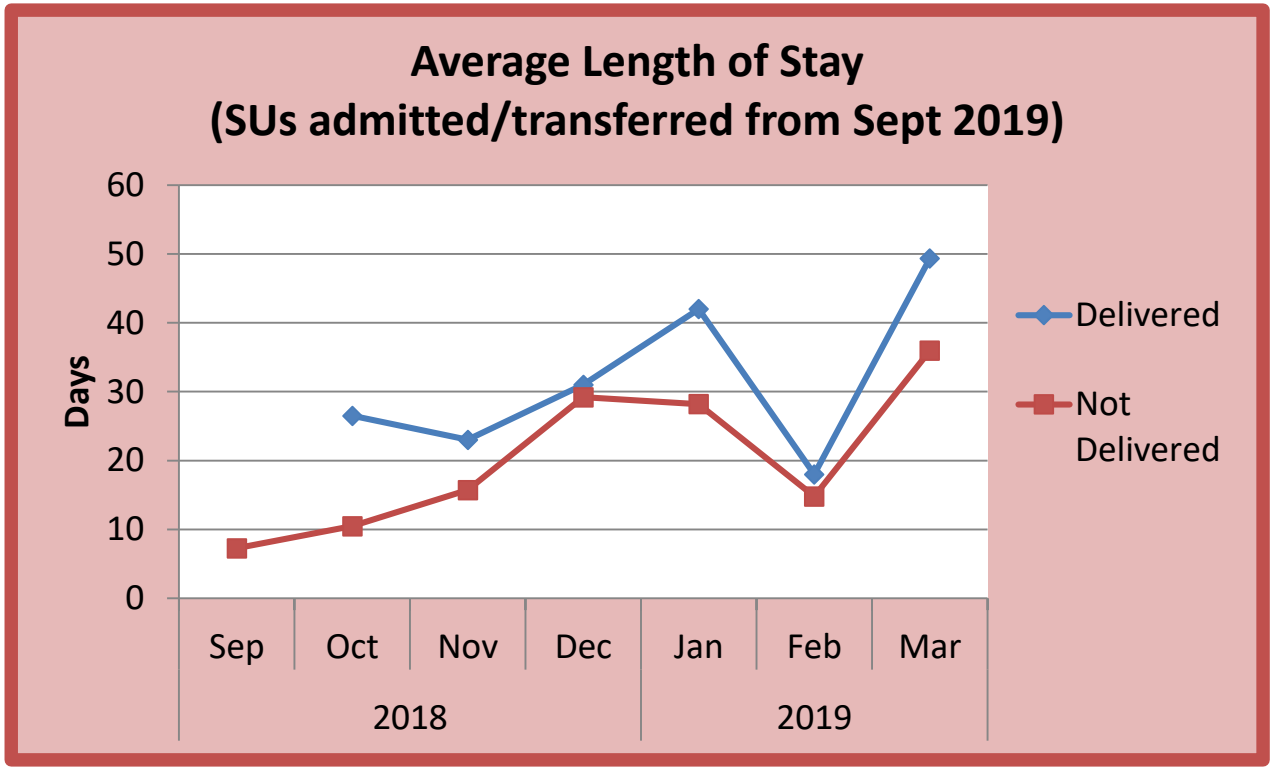
- Analysis of qualitative information/ feedback (23 comments)
- Themes include:
  - *Constructive meetings* (e.g. “The meeting has been productive, needed and helpful”)
  - *Hope* (e.g. “The empathy, emotional intelligence, courtesy, consideration and fulsome support gives us hope for X’s recovery”)
  - *Service offer* (e.g. “It is a good way to discuss issues in a formal setting”)
  - *Family dynamics* (e.g. “We appreciate the opportunity to talk through our situation in preparation for reuniting the family”)

Staff evaluation:

- 4 questionnaires returned
- Comments also collated from team meetings and some 1:1 meetings
- Collated comments from staff were favourable
- Staff keen for the project to continue and become a regular offer on the wards

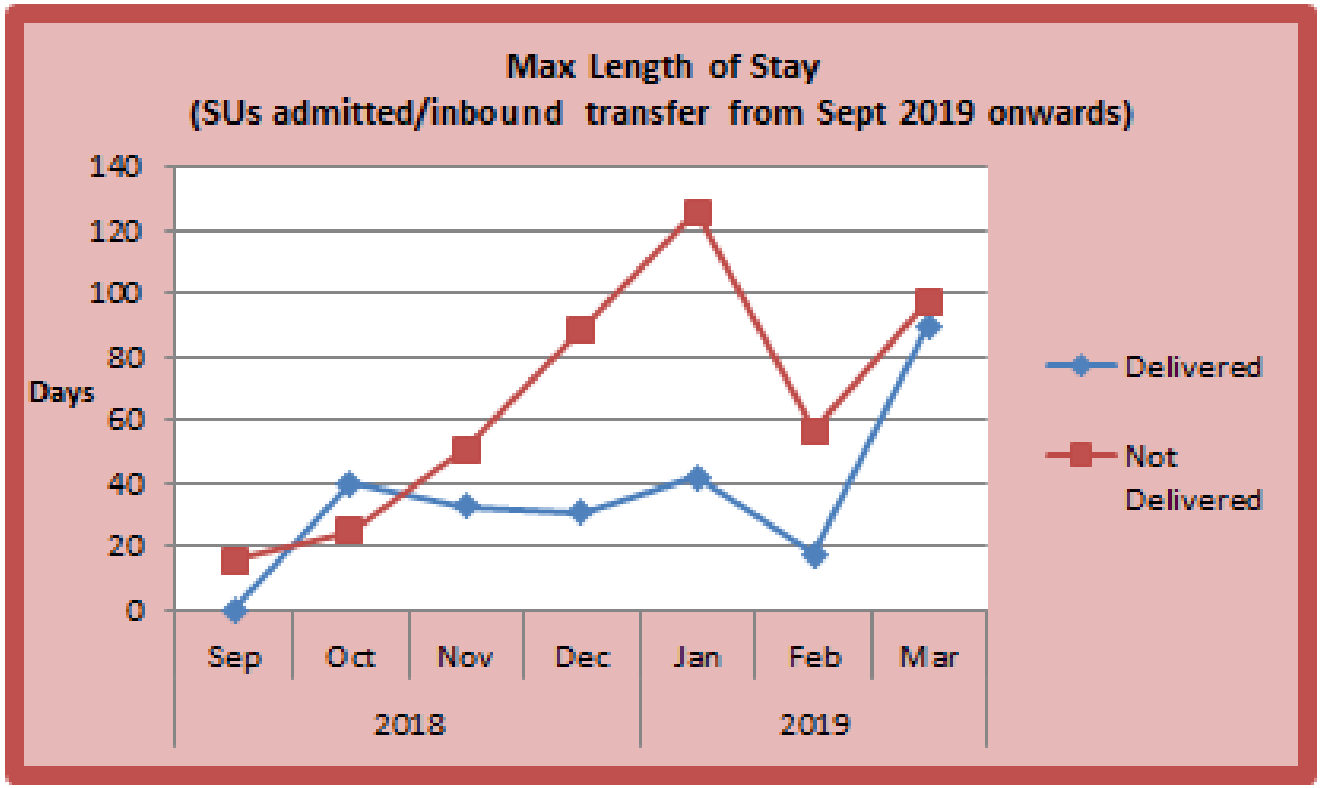
Service level data:

- Average length of stay



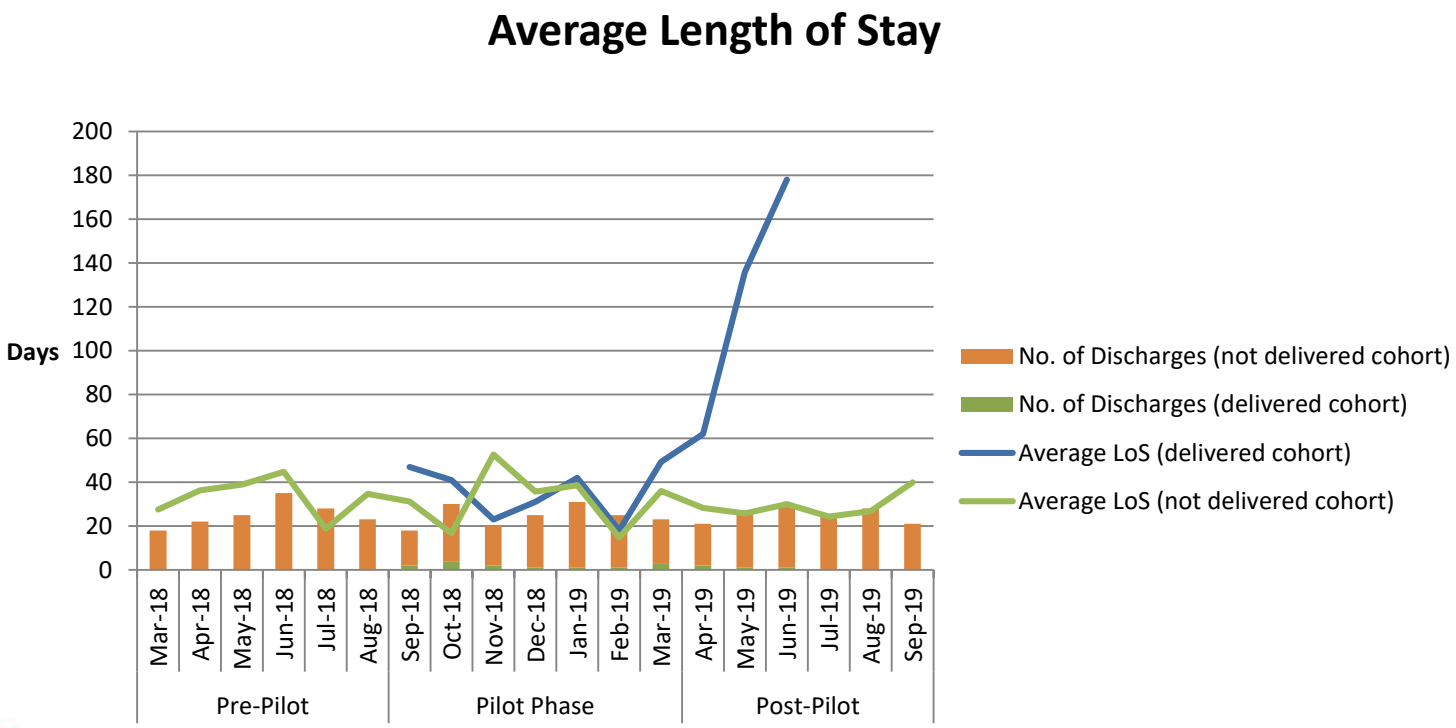
Service level data:

- Maximum length of stay



Service level data:

- Average length of stay pre, during and post study comparing project participants and non-project participants



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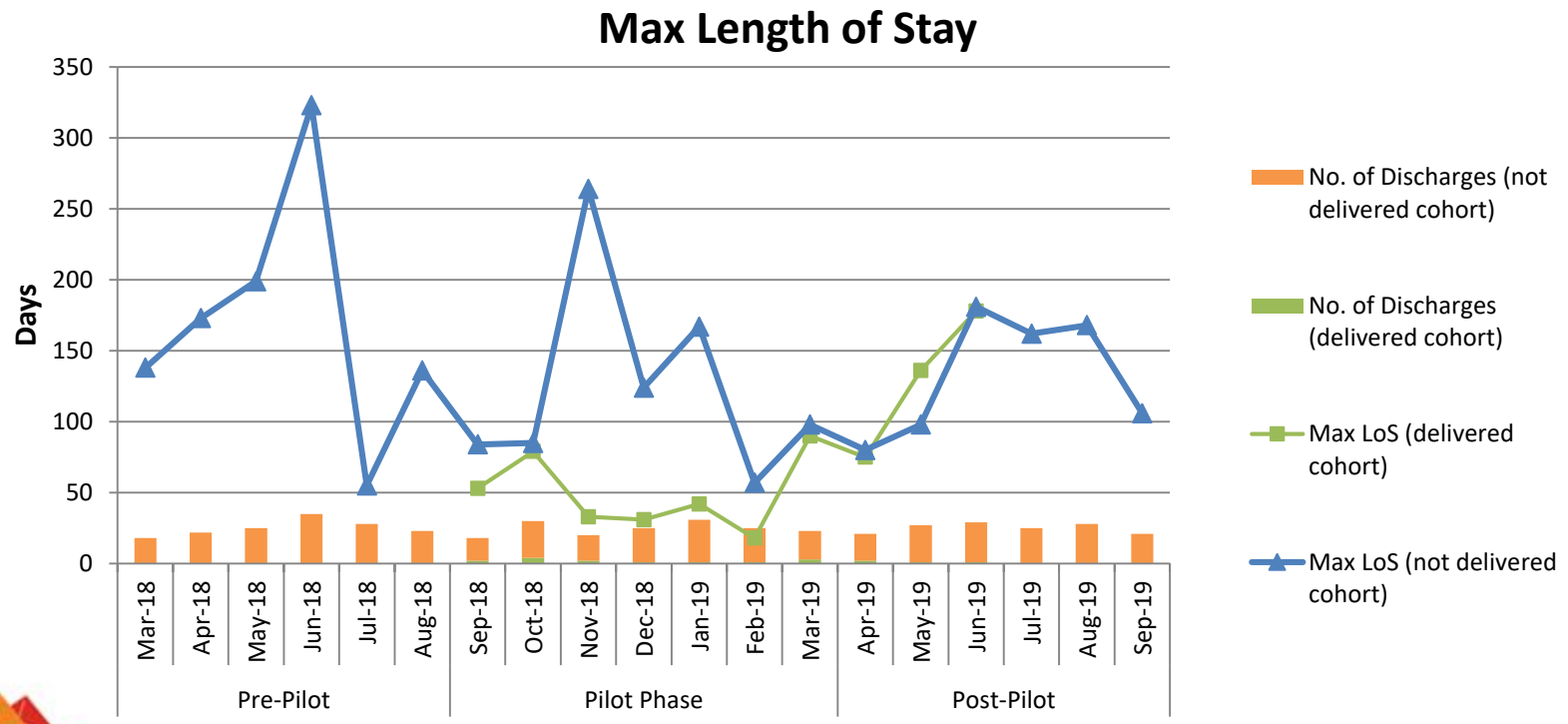

Service level data:

- Small number of participants, anomalies will impact upon average length of stay data
- Maximum length of stay data therefore sourced
- Maximum length of stays lower for project participants as compared to non project participants

Service level data:

- Complaints, PALs contacts & number of complaints

	Pre-project period (February 18 – August 18)	Project period (September 2018 – March 2018)
Number of complaints	5	3
PALs contacts	15	6
Number of compliments	2	1

Service level data:

- Promising reduction (complaints and PALS contact) in all figures from pre to during project period
- None however specifically mention the pilot study
- Coincidental reduction – not related to the project?
- Recommendations:
  - Identify if (how many) comments made by project participants or not
  - Source post project figures – further comparison
  - Continue to monitor on further implementation of project to see if change sustained

Discussion

- Positive initiative in terms of satisfaction from SUs, families and staff
- Enough to support further roll out/scaling up – larger scale implementation across acute care services
- Challenges – preclude further update of the project including:
  - Service user issues
  - Service delivery issues

Discussion:

- SU issues – too unwell: unwellness therefore became an exclusion criteria (potentially contentious)
- Service delivery issues – limited, rigid service offer (one fixed morning a week) which SUs and their families often could not accommodate
- Not know reasons for why significant amounts of people declined – worthy of further clarification

Discussion:

- Limited useful data from SWEMWS & Score-15
- Retain SWEMWS (ensuring full completion)
- Consider ceasing Score-15 (unless used as post meeting measure too – extension/change of contact)
- Promising findings from service level data
- Further exploration indicated
- Participants already likely have an advantage through their having significant others (family) in their lives
- Review meeting of project lead members at meetings formal end to review and plan further

Conclusion & recommendations:

- Meetings to continue, be scaled up and extended (given overall positive evaluations) across the acute care pathway and beyond
- Meetings continue to offer a reflective approach to allow for the enriching of conversations and to support the lead facilitator role
- Meetings continue to be facilitated by skilled therapist (likely psychologist) – complexity of meetings
- Reflecting team be open up to MDT members and not remain with the spiritual care team
- Skills of listening and observation key
- Opening up the role will allow for an increased & flexible response including for across the week
- Training to be delivered to newly recruited reflecting team members jointly by psychology and spiritual care team

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Thank you!

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