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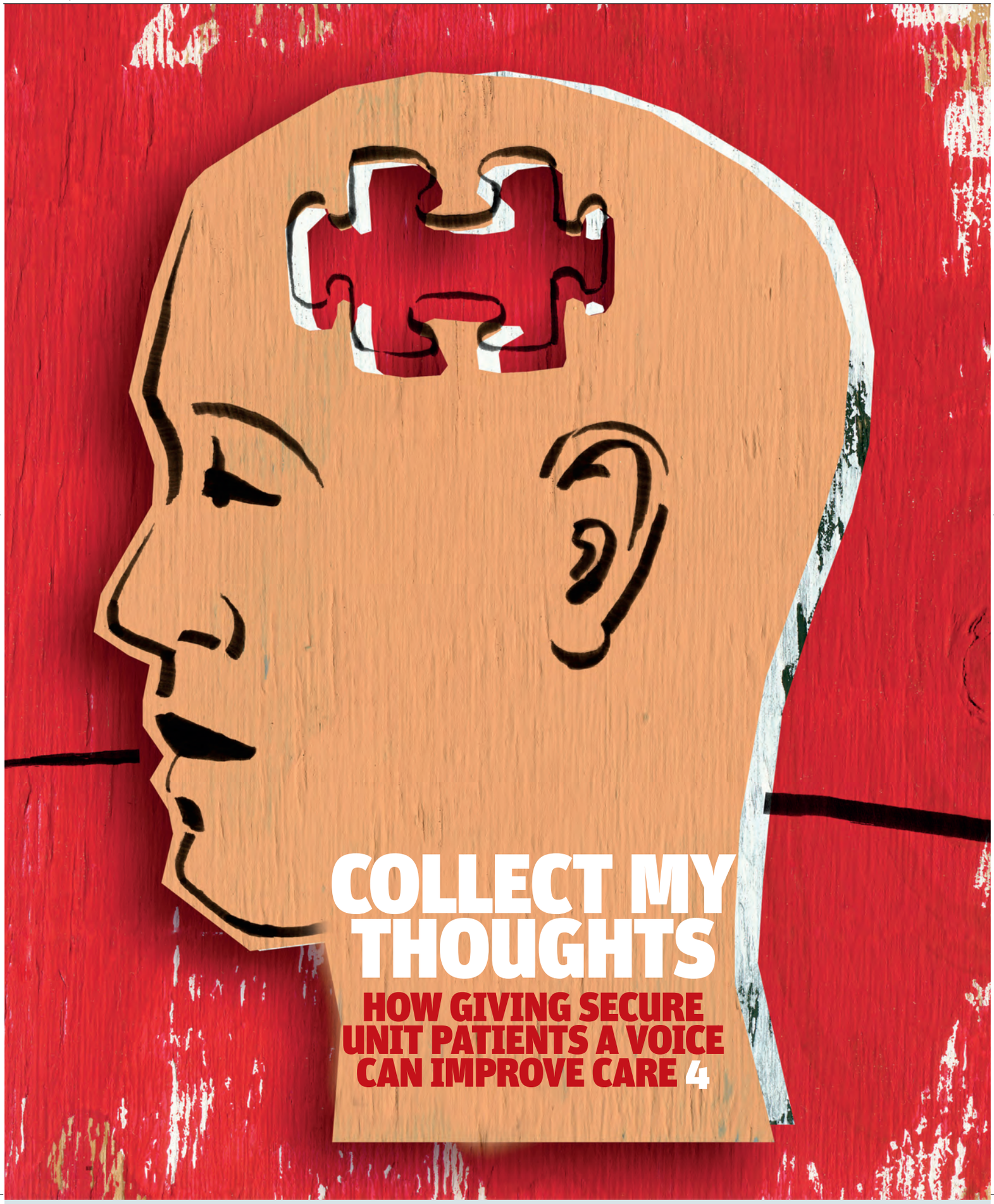

COLLECT MY THOUGHTS

HOW GIVING SECURE UNIT PATIENTS A VOICE CAN IMPROVE CARE 4

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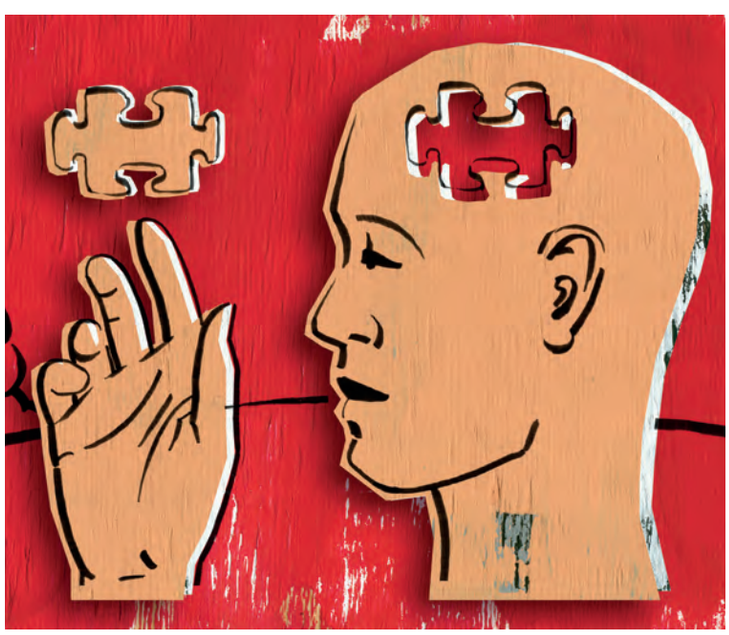
Alison Moore

SERVICE REDESIGN

Managing the moves of patients in secure and locked units to less secure environments and, hopefully, more independent lives can be a challenge. Integrated pathways, where staff at each step work together and share information, can make the process smoother, ensure patient needs are met within the least restrictive setting, avoid assessments being needlessly repeated and, ultimately, improve the patient experience and cut costs. Page 2



EXTERNAL PROVIDERS

Pressure on budgets is threatening mental health services at the very specialist, and expensive, end of the spectrum. But the head of the nation's largest third sector provider of NHS-funded care argues that the highly specialist services his organisation provides are the cheapest option in the long run, leading to shorter lengths of stay and better outcomes. Page 6

SHARED CARE

People with serious mental illness typically die 15-25 years earlier than the rest of the population – so looking after physical as well as mental health will be a vital task for GPs as they take a bigger role in tackling schizophrenia and other mental health conditions. GPs will also need support to take on more tasks traditionally done in hospitals – such as prescribing and monitoring antipsychotic drugs. Page 10

JOY CHAMBERLAIN ON PATHWAYS

IN ASSOCIATION WITH PARTNERSHIPS IN CARE

Partnerships in care
Changing lives for the better

Partnerships in Care (PiC) is the largest independent provider of secure and step-down facilities across the UK, with 1,200 beds across 23 hospitals. We have over 25 years of experience in providing specialist care focusing on:

- **enhanced medium secure, medium secure, low secure, locked rehabilitation, open rehabilitation and community housing to support patients' safe and positive re-integration into the community;**
- **individually tailored measurable and evidence-based treatment programmes with clearly specified goals and timescales;**
- **forensic specialisation with focus on risk reduction, relapse prevention and independent living skills; and**
- **care pathways which ensure patients are supported in the most appropriate environment whilst maintaining a seamless and progressive treatment plan.**

Increasingly, over the last five years, PiC has focused on extending care pathways into locked and open rehabilitation units. Patients can enter a PiC pathway at any point from a PiC unit, or from other services. Some of our more recently extended care pathways have included:

- **five new semi-independent flats as a step-down opportunity for patients at our locked rehabilitation service Abbey House, in Worcestershire;**
- **a locked rehabilitation service in South Wales at Aderyn (see case study) for our medium and low secure pathway at Llanarth Court;**
- **a locked rehabilitation service and open rehabilitation flats at Pelham Woods, Dorking, as a step down for female patients for medium and low secure females at The Dene, Hassocks;**
- **a new locked rehabilitation hospital for women at Annesley House, Nottinghamshire, which enables patients to step down further after their medium secure and low secure care pathway from nearby Calverton Hill and Annesley House.**

We place great importance on treatment outcomes. We support every patient to take optimal responsibility for their progress and the milestones which form the core of the care pathway plan. The My Shared Pathway national initiative has been an important step forward for services to ensure patients have more responsibility and choice in treatment. One of the case studies overleaf details how units can consider new ways of working as a result of this initiative to reduce the length of stay.

Clear care pathways communicated at the outset help patients to be aware of likely future steps from an early stage of their time with us. It is encouraging for patients to visualise and also visit their next stepping stone into the community. However, new services and ways of working must be supported by robust data and analysis to help ensure patient progression continues to improve.

Joy Chamberlain is group chief executive of Partnerships in Care
www.partnershipsincare.co.uk

SERVICE REDESIGN

BEYOND BOUNDARIES

Pioneers of 'seamless' pathways for patients in secure units – without repeated assessments – believe they offer the best chance of recovery. By Alison Moore

Getting care right for patients in secure and locked units is a key test for mental health providers and commissioners. This type of care is typically expensive – especially in medium secure units – and average length of stay can be long.

So ensuring that patients get the best chance of recovery and can be moved along a pathway which leads to them living in a less secure environment, where appropriate, offers both cost savings and better outcomes for the patient.

But providing this sort of pathway can be a challenge. A report by the Centre for Mental Health (*Pathways to unlocking secure mental health services*) highlighted issues around the shortage of appropriate step-down accommodation and the need for a more recovery-focused approach.

Part of the answer to this is providing an integrated pathway to help patients manage what can be a difficult transition from one care setting to another and allow ongoing treatment to continue.

Phil Walsh, care pathways adviser with the specialised commissioning group covering the Midlands and East, says it is vital to provide an appropriate package of care to meet patients needs in the right place at the right time. "Integrated care pathways bring together the team and the patient to discuss how this can happen," he adds. Commissioners are working to ensure individual patient needs are met within the least restrictive setting and that moves between different levels don't lead to ongoing treatment and assessments being repeated.

There is no universal pathway for patients in a medium secure unit: some will be there for a long time while others will be able to move swiftly into first low secure units, then possibly locked rehabilitation units and finally into some sort of supported accommodation in the community.

A few patients will be able to do this while remaining under the care of the same organisation, which allows for an easier flow of information between those caring for the patient and "seamless" care which will feel smoother for the patient. Some organisations, such as independent sector provider Partnerships in Care, provide a range of facilities for patients being stepped down, sometimes on the same site.

"My philosophy is to try to reduce these seams. Providing a comprehensive pathway means you can have one team going across the pathway," says Partnerships in Care medical director Dr Quazi Haque. "Where patients are encountering multiple repeated assessments at these transition points consistency of care is important ... patients really appreciate that. Continuity of care is often an operational sacrifice to ensure that care pathways fit an overall service model. This can be an error. In my view, patients, carers and clinicians often demonstrate the value of continuity across the whole pathway.

'Cause and effect are much easier to understand. We can understand where things are going well and where they are not'

"We have aligned our pathways to encourage our workforce, partners and customers to engage in an environment where innovation is supported and, just as importantly, effectively implemented."

Historically, much low and medium secure provision has been in the independent sector but often people have come out with few options on where to go next. Some have returned to their home communities with varying levels of support.

CASE STUDIES OVERLEAF ▶

ALAMY

But sometimes the lack of appropriate placements has meant that stays in low secure units have been extended.

"There's an initiative from commissioners to try to find the least restrictive, most cost effective ways of dealing with people entering a secure environment," says Dr Haque. "But if you just provide hospital based services you are going to reach an end point. We are trying to find solutions.

"Now we are providing whole episodes of care and cause and effect are much easier to understand. We can understand where things are going well and where they are not."

One encouraging development is the new academic health science networks, he says: Partnerships in Care has joined one of these and is hopeful that shared learning between all sides can lead to quicker adoption of innovation and best practice.

Many commissioners will be keen to see patients returned to be treated in their home area. But Dr Haque argues that it is a complex picture – in many cases it is in patients' interests to return home as soon as possible, while others may be better served elsewhere. Mr Walsh says, while commissioners continue to work with providers to bring new services closer to home, "our priority will always be for the patient to have the best possible treatment".

But providing the physical building to deliver a care pathway is only one part of the picture. It also needs clinicians to develop a programme of appropriate, personalised interventions which the patient is engaged with and will therefore aid recovery.

My Shared Pathway was a national pilot linked to the QIPP agenda and focused on recovery and identifying outcomes and aims, working closely with patients. One key element was sharing of information.

It was piloted by many independent and NHS providers, and is now being mainstreamed. Several Partnerships in Care services were among the pilot sites and the emphasis on patient involvement and setting out goals and outcomes has continued.

A service user who was recently discharged from Partnerships in Care's Kneesworth House believes he benefited from the My Shared Pathway approach adopted towards the end of his treatment and is an enthusiast for it, sitting as a service user representative on the national My Shared Pathway steering group.

"My Shared Pathway tried to hear what services users were saying about their care. People have much less control over their lives because they are in a secure environment but feel that it could be delivered in a much more recovery-oriented and outcomes-focused way," he says.

For example, he was able to chair his own care programme approach meetings. Patients are able to ensure that the CPA is framed in language they understand and are involved in their own risk assessments.

The former service user now lives in supported accommodation but has continued in his representative role; he hopes to move to his own accommodation and towards employment.

But he points out there remain issues for patients moving from secure care to supported accommodation. The two settings are funded by different bodies and there can be delays in getting placements – especially for those who are not returning to their home areas. This can delay discharge from the more expensive secure setting and is frustrating for patients ready to move on. ●

Partnerships in care
Changing lives for the better

SERVICE IMPROVEMENT: CASE STUDIES

SAY YOUR PIECE

How the thoughts and feelings of users have become a central influence on care in forward thinking secure mental health units

ADERYN UNIT, MONMOUTHSHIRE

Leaving secure accommodation is probably one of the most difficult transitional steps for mental health service users.

Those responsible for their care need to know that they are able to move into a less protected environment without undue risks to themselves or the wider community while service users need to have developed the skills to live semi independently.

Some will be ready to move to a supported community setting or even back home but for many others this may be too big a leap. Aderyn, a locked rehabilitation setting developed by Partnerships in Care back in 2006, offers 17 beds for men coming out of a secure setting. It is set in a rural area of Monmouthshire but close to Llanarth Court, a much larger unit offering a range of services including low and medium secure.

Since it was opened, Aderyn has had 45 admissions with 17 people being discharged in the last 18 months. Most of those admitted are sectioned under the Mental Health Act, either in cases involving the courts or as "civil" cases.

While in Aderyn – the word means "bird" in Welsh – service users can access psychiatrists and psychologists as well as occupational therapists and mental health nurses. There is a strong emphasis on rehabilitation – for example, patients have been involved in gardening projects in the extensive grounds. The work done to transform one area has recently won a national award. Acquiring new skills and retaining old ones are seen as an important part of the pathway towards rehabilitation.

And service users are taking small steps towards independence – perhaps using a local gym, shopping for food for themselves, or making bus journeys. They may be able to make visits home to their families or take part in sporting events.

This "halfway house" approach enables service users to move towards independence while still being supported. "We have a whole pathway from medium to low secure to locked rehabilitation to self supported and we can demonstrate that we have helped patients move on to the community," says Dr Phil Huckle, regional director executive and clinical director for Partnerships in Care in Wales and the West.

The emphasis is very much on working with service users to encourage them to move forward in their treatment. They are encouraged to set regular achievable goals for themselves and to talk about how they are feeling on a daily basis.

Giving users a voice

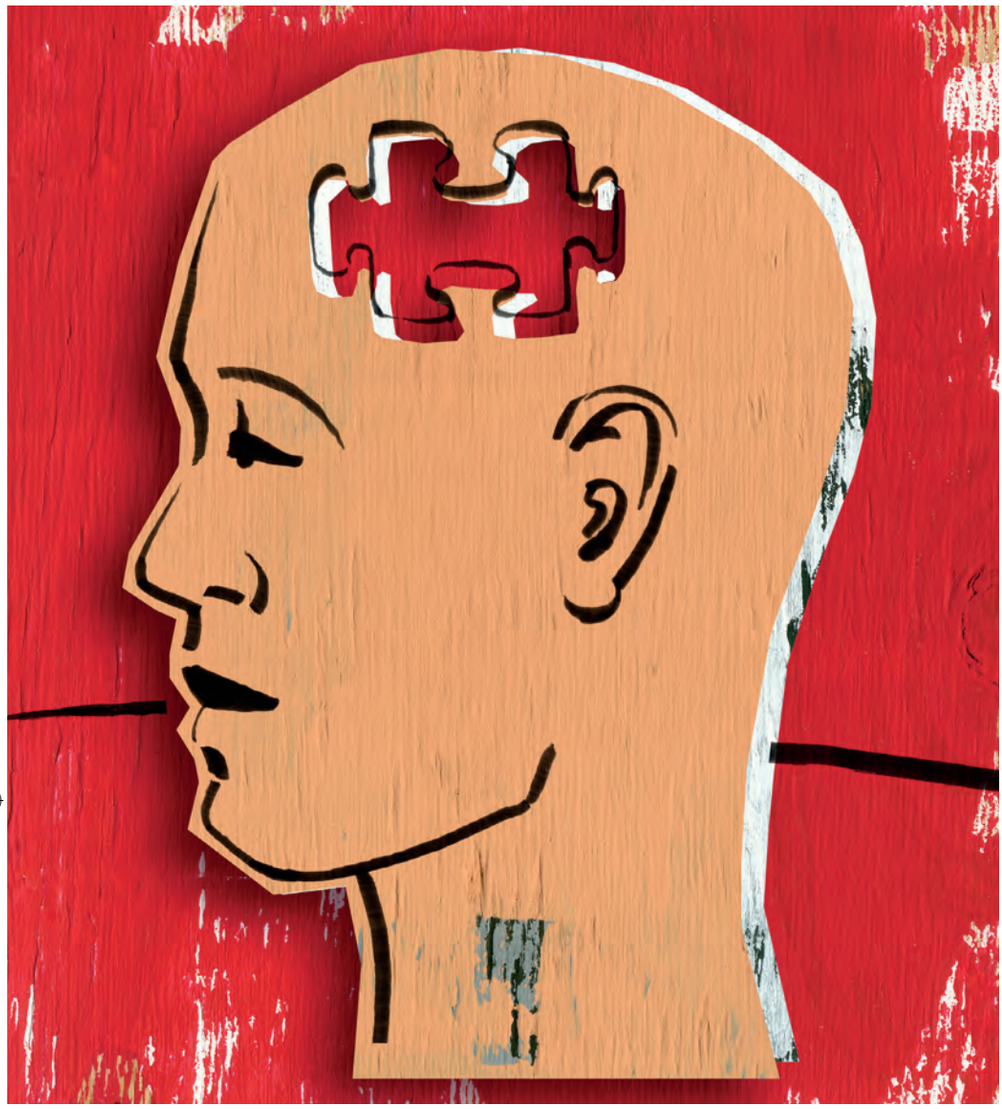
But crucially the patients are reminded they are on a pathway away from the institutional nature of secure accommodation. "They are more like residents than patients," says Dr Huckle. "There's independent research showing that having a resource like Aderyn means that people will spent three or four months less in secure units."

As costs generally decrease as service users move from a secure environment to living independently, that is good news for commissioners as well as those being treated. It also chimes with the requirements of the Mental Health Act that they should be kept at the lowest level of security that is appropriate for their particular needs.

Service users have a voice in how they are treated: in one of Partnership in Care's other sites, Abbey House, they have decided they wanted ward rounds to be done "by appointment" and have chosen to be called residents rather than patients. They also use advocates, supplied by Rethink. "They feel more empowered," says Dr Huckle.

There is a separate two bedroom cottage on the Aderyn site which is yet another step towards independent living. It is semi-supported with residents able to access the mental health team but largely looking after themselves. They have to take responsibility for everyday tasks such as doing the washing and cleaning, and also budgeting.

Dr Huckle says Aderyn is not a solution for everyone and some patients can be safely moved straight to a hostel or accommodation in the community when they leave low secure units. "But this allows some patients to progress in a step-by-step fashion," he says.



ALAMY

‘A resource like Aderyn means that people will spend three or four months less in secure units’

HAZELWOOD HOUSE, DERBYSHIRE

The NHS has a professed aim of involving patients in their care – “no decision about me without me” – believing it makes healthcare more effective and patients are more likely to comply with treatments and medication if they are involved in the decision.

But how can this approach be translated into improving outcomes for those in locked or secure units? While their circumstances are very different, there are ways of engaging them in their care which can lead to more insight into their condition and hopefully enhanced recovery.

“My Shared Pathway” was a national initiative that piloted a new approach to rehabilitation in 50 sites including learning disability, secure units and brain injury services. During the six months of the pilot there were a number of national workshops where both patients and staff could come together to discuss how things were working.

Partnerships in Care were one of the independent sector providers taking part and the approach was used at its low secure learning disability unit for men in Derbyshire, Hazelwood House.

The specialist nature of the care meant that some materials used in the pilot had to be adapted – for example, workbooks were produced in an easy read version by the national network to meet the needs of the service users. The use of these has been continued past the pilot phase and is now embedded in the unit’s approach.

“This is about a resource to aid the change in culture – to change the whole way we work with patients,” says Denise Banks, Partnerships in Care low secure services manager in the Midlands.

The approach involves patients working through a series of questions. Where am I? Where do I want to get to? How do I get there? And how am I doing? These aim to encourage both progress and insight, and draw on contributions from both service users and those caring for them.

Transition from one service to another was recognised as a particularly challenging time for many of them. Service users were invited to contribute to a “tree” to show how the process of moving from one unit to another felt. They write feelings on “fallen leaves” which are placed at the base of the tree. The trunk represents all the therapeutic work which they engage in and leaves at the top of the tree are their positive feelings.

Users also produced a photo album showing special events at the service such as Christmas. And existing inpatients have been going out with the assessment team and sharing information about how it feels to come into the unit with those being considered for transfer.

“If patients’ anxieties are reduced, they are more likely to engage in therapy, they move through the therapy programme more quickly and they may be discharged earlier,” says Ms Banks. “It was very helpful to get patients to understand how useful it is for them to be involved in their care.”

But some of this approach has wider ramifications. Those who are selected for a buddy scheme have to go through an interview process – a lot like a job interview.

The philosophy of the units has been very much around service user involvement. Ms Banks says this can contribute to reduced anxiety and a sense of ownership which can aid recovery. “The project has come with quite a lot of pre-planning to look at how patients can be involved in the secure pathway – from admission into medium secure, and through treatment and recovery into rehabilitation,” she says. Transition points are particularly important and are perhaps where things can go wrong.

“We have moved a long way from doing things to patients and focusing purely on the medical model to listening to patients and what they want, and responding to that.”

So what are the outcomes of this more patient-focused approach? Ms Banks says average stay in Hazelwood House has reduced. Previously service users would typically be there for 18 months to two years but recently throughput has been much quicker. Users are also becoming more confident. One was in a medium secure unit two years ago and was “basically lost” she says: after involvement in the pilot he is now doing presentations to both service users and staff. ●

PHILIP SUGARMAN ON SPECIALIST CARE

The Department of Health acknowledges that mental ill health is the largest single cause of disability. Estimates place the ongoing annual cost to the country as more than £75bn each year.

Yet this year funding for NHS mental health services fell by £150m. It would be fantastic if this were simply because earlier and more effective interventions in the community are taking effect. While these innovations are undoubtedly helping many people, it is concerning that some of society's most vulnerable people are exposed to greater reduction in support than people with other health needs.

There is a vital role for specialist mental healthcare services to address needs that are very specific and complex, which cannot be met adequately in local services. Where specialist care is not provided, the consequence often is adverse outcomes, multiple "revolving door" admissions to hospital, severe substance misuse, homelessness, and offending behaviour.

In a community unable to offer the support needed, harm to the individual, their family, friends and neighbours soon involves very expensive emergency services and the already overburdened criminal justice system.

Early diagnosis and expert multidisciplinary care are the best way to support people along the pathway to recovery. Their quality of life and prospects for health and social stability are greatly improved, with greatly reduced short and long term costs to society.

Our charity, St Andrew's Healthcare, has worked with the NHS since its foundation to address these complex needs. The charity now provides an unparalleled range of national and regional services bringing recovery pathways closer to service users' homes.

In mental health and learning disability our national specialist adolescent and women's services are the largest in the country, while our pioneering National Brain Injury Centre has specialist facilities for men, women and young people. We are also the UK's leading provider of secure care for older people and for autism.

As a national teaching hospital, partnering several universities including King's College London Institute of Psychiatry, we give academic clinicians the chance to discover what works through research. We share what we have learnt by large-scale publication, by training healthcare leaders of the future, and by providing cutting edge specialist services and inspiring others to do the same.

As a charity we invest for the long term in research and training, and in new and improved services and facilities. We believe charitable provision of specialist care, in national centres of excellence, is an effective and viable model for mental healthcare provision which focuses on the best possible outcomes.

Professor Philip Sugarman is chief executive officer of St Andrew's Healthcare

www.stah.org

IN ASSOCIATION WITH ST ANDREW'S HEALTHCARE

St Andrew's HEALTHCARE

EXTERNAL PROVIDERS

GENERAL ANXIETY

Cuts that push patients out of specialist units would be a false economy, says the head of the nation's largest third sector supplier of NHS-funded care. By Alison Moore

Mental health has historically been seen as the poor relation in healthcare with limited resources and even less attention. The last decade has seen that change with increased money and the development of high quality specialist services both within and outside the NHS.

But now a leading figure in specialist mental health provision has warned those gains could be starting to stall. Professor Philip Sugarman, chief executive of St Andrew's Healthcare, points out the funding for mental health has actually fallen recently, despite promises that NHS funding overall would be protected by the government.

"At a time of limited NHS funding there is a focus on measurable issues like waiting times for surgery," he says. And he warns that reductions in the number of people admitted to specialist mental health services could mean that they remain in settings which are not able to provide the best care for them, including prisons.

So there are challenges for private and charity sector providers. Professor Sugarman argues that the services St Andrew's provides at the very specialist, and expensive, end of the spectrum are the cheapest option in the long run. "These very effective services work out better for everyone – service users in highly specialist services have shorter lengths of stay and better outcomes," he says.

"If someone arrives in a placement - and it is not as specialist as it needs to be for them – the weekly rate may be cheaper but the consequence is that they will spend longer there when they could otherwise have moved onto more independent living.

"The solution is shorter stays but very specialist care and then moving on into the care of specialist community teams. Our real ambition for our service users is that they get effective specialist care all the way down the pathway."

But service limitations mean that service users may be unable to move on when they are clinically ready to or can only access a generic service further down the line, rather than one best suited to their needs. While catchment-based generic community mental health services are important, he argues that there is also a need for more specialist teams within mental health trusts to support people closer to home so that they don't fall between the gaps.

St Andrew's tries to ensure there is clinician-to-clinician contact as a service user moves out of its care, with an agreed transfer plan.

"That can work very well but sometimes we find problems," he says. "Sometimes there is not a specialist team locally or there is dispute over who is responsible. That can mean that people move on later."

And he warns that sometimes people who are moved into a generic service can end up being re-admitted because their needs can't be met.

Part of the solution to this is around how services are commissioned. "What we really like are commissioners who are well trained and supported and have expertise. Whenever we have an NHS reconfiguration that tends to fall down a bit. It takes a while for the teams to get up to speed again," he says. "CCGs should aim to have in place the most knowledgeable team they can from the start."

'The procurement cost per bed of St Andrew's biggest recent development was half that of NHS equivalents'

But greater involvement of clinicians in commissioning is something he has wanted to see for a long time, he adds.

Much highly specialist commissioning

CASE STUDIES OVERLEAF ▶

will be led by the NHS Commissioning Board but it will need to provide a framework to enable CCGs to continue work right down the pathway, he says. This will be a massive task.

"Everyone is rightly concerned about whether, in all the changes, the NCB will get it right for every single specialism first time round. An effective national strategy is sorely needed in many specialist areas, such as brain injury and mental health care for young offenders.

"In the new system the NCB will look to have responsibility to make sure local commissioning works well, If the NCB succeeds, it may be able to join up that care pathway so people can move up and down the system smoothly. But it is an open question whether the NCB can achieve that to the extent needed."

He believes the charitable sector could provide more care going forward – and this not-for-profit model is not far removed from that of increasingly autonomous foundation trusts. St Andrew's is already the largest third sector supplier of NHS-funded healthcare in the country.

And third sector organisations have had to make their contribution to improving quality and achieving cost savings, just as NHS ones have. Providing the most effective treatment in the shortest appropriate length of stay is part of that. "We have had to boost therapeutic input while we control our costs," he says. This has ranged from reducing staff sickness by half over the last five years to ensuring procurement is done efficiently. The procurement cost per bed of St Andrew's biggest recent development – William Wake House in Northampton – was half that of NHS equivalents, he says.

Its new facilities have also been at the forefront of developing innovative care services which fill "niches" identified at a national or regional level, such as a new service for adolescents with a combination of head injuries and challenging behaviour, and a secure service for the profoundly deaf.

And part of that innovation will be greater involvement in training healthcare professionals (see case study, overleaf). Traditionally, training has been largely restricted to the NHS but Professor Sugarman says the advent of Health Education England is leading to changes. St Andrew's is now the first teaching hospital outside the NHS, formally partnered with a number of universities and working with the NHS to offer opportunities to both students and more senior clinicians. Two doctors in advanced training who joined recently felt they would benefit from working in St Andrew's specialist units which they would not be able to experience in the NHS.

Professor Sugarman says the benefits run both ways: "It works wonderfully for us to see a lot of young trainee doctors coming in. They help keep us up to date, they are very enthusiastic and are very good with the service users," he says. He says the situation is now at a watershed and the charity has become a substantive national teaching hospital with a reputation for expertise. This is helping ensure the flow of staff in training become the norm as they follow NHS patients between highly specialised and more local services. ●

EXTERNAL PROVIDERS: CASE STUDIES

SPECIAL CASES

How niche care can offer benefits both to patients who get a service that precisely meets their needs and to trainee doctors who can enrich their experience

ADOLESCENT BRAIN INJURY UNIT

People who suffer brain injury often make a good physical recovery but then go on to suffer from other problems.

They may develop challenging behaviour which means they are verbally and physically aggressive to those around them – including healthcare staff – and lose their inhibitions, behaving inappropriately. This can make it difficult to get them to accept therapy of various kinds and can be difficult for healthcare workers to deal with.

In the last 30 or 40 years, great strides have been made in recognising this behaviour is linked to the original brain injury, and offering specialist services to aid rehabilitation. St Andrew's Healthcare set up the world's first specialist unit to treat people with both brain injury and challenging behaviour in 1979 – it's now the national brain injury centre and has expanded from 16 beds to 108.

Now it has set up a similar unit which is the first in the country to treat adolescents presenting with the same issues. The chances of suffering head injuries peak in adolescence and then decline until much later in life. Many adolescent head injuries are the result of being involved in car accidents or fights, often involving alcohol or drugs; the areas of the brain most likely to be damaged in this are unfortunately the ones which influence relationships and related behaviour.

Such problematic behaviour can often seem intractable but Professor Nick Alderman, the specialty lead for the centre, says lots can be done to help them – preferably as early as possible after injury. "The earlier we can get this to people the more we can do for them. Leaving people without rehabilitation is not a good idea," he says. The adult unit often sees patients five years or more after their initial accident when their behaviour has become more challenging and they have been referred back into local services, often with a stay in a psychiatric hospital.

Early rehabilitation is important to stop the challenging behaviour becoming embedded and leading to further problems. Professor Alderman, a neuropsychologist, says there is research to suggest many people who end up in prison have suffered a head injury at some point – in one study in Texas 80 per cent of inmates had, and in another in the UK 60 per cent had. "There is a link emerging from head injuries to offending," he says. "It seemed right for us to develop a service aimed specifically at adolescents with brain injuries. We knew there were many young people out there with head injuries and no existing services for those who also had challenging behaviour. It might stop them going down a slippery slope."

The first step is a very detailed assessment period involving specialists from many different disciplines. After more than 30 years with an adult service, St Andrew's has been able to use the expertise from there to develop services for youngsters.

Then a decision has to be made on whether the adolescent will benefit from what is on offer to tackle their challenging behaviour. Much of this therapy is based on rewarding good and appropriate behaviour and playing down the more challenging aspects to encourage participation in therapeutic work. "We try to provide an enriching social environment that rewards people for appropriate behaviour," says Professor Alderman. This can lead to a significant turnaround but it can take time. Adolescents are looked after in a 12-bedded mixed sex unit which opened just over a year ago and takes teenagers from 13 upwards.

Recent advances in understanding of the adult brain have shown that other parts can take over some of the functions of areas damaged by injury – a phenomenon known as plasticity. What is less certain is whether this may be of even more importance in the developing adolescent brain.

In the long run the care offered at St Andrew's can be cost-effective as it is more likely to work with this particular group. "Ordinary" rehabilitation may have little effect as the user may disengage. And, with a link with offending, there could be other savings within the public sector.

And it is important that there is an onward care pathway for adult and adolescent patients on discharge, if needed. Although services have improved over the last few years in many areas, it is far from uniform. "The need is still greater than the provision," says Professor Alderman.

Where to? Highly specialist units can offer care not available in the mainstream NHS

‘Many people in prison have suffered a head injury at some point – in one study in Texas 80 per cent of inmates had’

Professor Alderman points out there can be a balance between specialist care and distance: although St Andrew’s is fairly central, at least for English patients, in Northampton, there can be long journeys for families to see their adolescents. Ultimately the learning from this unit could lead to others being set up around the country.

TRAINING OUTSIDE THE NHS

As the NHS has opened its service up to more competition the possibility that staff may no longer be trained entirely in the NHS has begun to seem less fanciful.

And psychiatry, with its history of involvement of the independent and charitable sector, would seem to offer many opportunities for innovative training. Some specialist services are clustered in the independent sector, so training for them can be quite difficult in NHS organisations.

Two higher trainees in psychiatry are beginning to break this mould. Tim Millward and Marlene Kelbrick are spending two years based at St Andrew’s in Northampton, as clinical leadership fellows, and at the main NHS provider in the county, Northamptonshire Healthcare. This year Dr Millward will spend half the time in each organisation, while Dr Kelbrick is based solely in St Andrew’s; next year this position will reverse. Dr Millward and Dr Kelbrick also have out of hours duties in the NHS.

The pair will also spend two days a fortnight for part of that time working on a masters degree from the University of Leicester on how healthcare research can be implemented in services.

Dr Millward, who is in his sixth year of specialty training, said that St Andrew’s had been very keen to get involved in training but the scheme had taken a year or so to set up because of the impact on the NHS provider of effectively losing a trainee.

“It’s very unusual to be training in a non-NHS environment,” he says. “There are a lot of very talented psychiatrists who were keen to be involved in education but were locked out because they were not in the NHS.”

Since starting at St Andrew’s four months ago, he has noticed a different ethos to his previous NHS employers. St Andrew’s is a charity but needs to have a fairly business like approach in what is a very competitive environment. “There are great facilities here and things tend to get done quite quickly when someone says it should be done. People seem to really like working for the organisation, It makes you feel enthusiastic about it as well,” he says. The research department is very close knit and the director of medical training is very accessible. And it is a much smaller organisation than an NHS mental health trust, which also tend to operate from a multitude of sites.

But one of the key attractions is the different experiences the trainees can have. Dr Kelbrick will be working with patients with developmental disorders which is quite specialist and Dr Millward is to spend some time working in women’s forensic psychiatry.

“In some ways you get more options working here,” he says. “It’s a really special opportunity. It gives you a different perspective on healthcare and healthcare delivery.” The opportunity to get a range of experience in both the NHS and in some of the more specialist services in the independent sector could also stand trainees in good stead as they apply for consultants’ posts, he says.

St Andrew’s already takes nursing and other healthcare students from nine universities for placements, offering around 400 placements a year, and has a summer school in psychiatry for undergraduates from UK universities. It has devised a range of courses, working with its local university in Northampton, to offer training to employees at different points of their career. These courses are devised and delivered by the charity but quality assured by the university.

This means some will be able to progress from roles which require few qualifications to more advanced ones. The courses are also tailored to the charity’s needs. “We want to make sure that we are a teaching hospital which has great medical education and also reflects this ethos for other staff,” says Clare Allen, St Andrew’s human resources director. Staff have the chance to get, say, a foundation degree or take more advanced specialist courses. Increasingly, the organisation is taking a multidisciplinary approach to training, with staff from different professional backgrounds learning together.

And Ged Rogers, clinical education manager, points out offering these opportunities is not just good for the individual, they help the organisation retain experienced staff and the skills acquired will improve the delivery of care. ●

ALAMY

MARTIN PRICE ON RAISING THE BAR

IN ASSOCIATION WITH JANSSEN

Janssen
PHARMACEUTICAL COMPANIES OF Johnson & Johnson

Central to our credo at Janssen is a pledge to put the needs and wellbeing of the people we serve first. Nowhere is that need any greater than in people with serious mental illness, such as schizophrenia and bipolar disorder, who still die up to 20 years younger than their peers in the UK.

The coalition government's 2011 mental health strategy, *No health without mental health* set out a clear vision of how to improve the lives of people living with mental ill health, with an aim of achieving parity with physical illness or injury. However, its implementation comes at a time of huge reform of the NHS, as the Health and Social Care Act is implemented. The introduction of GP-led clinical commissioning groups, the establishment of local authority health and wellbeing boards and the formation of Healthwatch England under the mandate of the Care Quality Commission to represent the views of patients, will all influence local mental health policy.

This period of change is both a challenge for those responsible for turning the vision of *No health without mental health* into a reality, but also provides a huge opportunity to improve the lives of patients devastated by mental illness and to set a new standard for mental health

'This period of change provides a huge opportunity to improve'

service provision with patients at the core.

This is especially important in areas such as schizophrenia, where the long term human and economic cost are tremendous, and where we know it is imperative patients feel in control and are well supported to stay well.

At Janssen we believe the best way of supporting patients is to work in partnership with clinical, policy and patient stakeholders to raise the bar in service. Some of the projects we are supporting include: a pilot adherence project with the South Essex Partnership University Foundation Trust; Schizophrenia24x7, a website with information and tools to support anyone affected by schizophrenia (www.schizophrenia24x7.co.uk); PsyAcademy, a central resource providing educational courses and interactive digital tools for psychiatric professionals and Reach4Resource, a nurse education programme.

The foundations of Janssen were built on improving the lives of people with serious mental illness and although great strides have been made we cannot afford to be complacent. We need to work together to ensure that we use the opportunity current NHS changes present to set a benchmark in mental health care, and ultimately create a better future for patients.

Martin Price is external affairs director at Janssen
www.janssen.co.uk

SHARED CARE

FAIR SHARE

Giving primary care professionals a bigger part in holistic care of those with serious mental illness can deliver a better deal for patients. By Alison Moore

Schizophrenia is probably the most feared and misunderstood serious mental illness. Improved treatments and better care pathways are helping people live with the disease but there is still a long way to go to ensure that all patients benefit as much as possible.

Over the years the focus of treatment for people with schizophrenia has moved from a very medical model aimed at combating symptoms to a more holistic approach, aimed at improving their psychosocial functioning. But that shift is far from complete and there are concerns that not enough is being done to ensure patients benefit, despite the government strategy outlined in *No health without mental health*.

Andrew McCulloch, chief executive of the Mental Health Foundation, says: "There are a lot of new interventions which are not really being utilised such as cognitive behavioural therapy and family therapy." The advances of the last decade have stalled or are even going backwards, he suggests.

Paddy Cooney, interim director of the Mental Health Network, says the way ahead has to be a service where health professionals work with patients and listen to their concerns. But wider issues also have to be considered – homelessness, unemployment and relationship problems will all impact on how they are feeling. "The best service will always be the one which sees the service user in that context," he says.

For health professionals involved in treating people with schizophrenia, there are many challenges, not least the need to look at recovery pathways rather than just dealing with a crisis. Dr McCulloch advocates a "longitudinal" approach which looks beyond the episodic care which can dominate schizophrenia care.

Many people will live with schizophrenia for a very long time, he says, and when they do need to be admitted to hospital that experience can be very negative. Early diagnosis and treatment will be key to improving care, he says.

He is dubious whether clinical commissioning groups will do this any better than PCTs but suggests that health and wellbeing boards may provide a useful forum and will raise issues such as housing as well as health.

"The other thing we can do is to task NHS providers with producing a more recovery-based approach. We do have a good national policy on mental illness but it is a question of the commissioning board taking it on," Dr McCulloch adds.

Developing shared care has been a challenge in many areas although there have been success stories where GPs have successfully taken on the care of stable patients. Compliance with medication remains an issue, regardless of where people get their care. Many may have disorganised, chaotic lifestyles. Research suggests just over half are not totally compliant, which can expose them to the risk of deterioration and relapse.

Improving compliance has to involve working with the service user to understand why they are not taking their medication and ensure they are aware of the possible consequences. Mr Cooney suggests that a quick response to problems with medication such as side effects is important: anyone suffering side effects doesn't want to be told to press on for three or six months without relief.

And he points out there are new ways of getting information about how service users are coping. For example, a smartphone app developed in Manchester enables them to record how they are feeling each day by giving answers to "prompt" questions. This data can be made available to the team treating them to track their mental state and to provide an agenda for the next consultation.

CASE STUDIES OVERLEAF ▶

ALAMY

Dr McCulloch says there is a balance of pros and cons with medication. Although it remains very important for many sufferers, the side effects can be severe and require sensible management and balance. "It is about being transparent and giving information," he says.

Mental health is not the only issue for those with serious mental illnesses. Their physical health can also be impacted: for example, patients with schizophrenia can be at higher risk of cardiovascular disease.

Sheila Hardy, a nurse consultant in mental health, says that people with serious mental illness will die 15-25 years earlier than the general population. Physical health checks, carried out in primary care, are one way to identify patients at risk and move them towards a healthier lifestyle.

Yet provision for patients whose care moves from secondary to primary care is very patchy. Ms Hardy felt that one barrier might be that practices were reluctant to set up health check clinics because they were inexperienced in dealing with this. She set up a practice nurse training course which she would deliver in practices, free of charge – but found practices were reluctant to release nurses for it. She has now set up a website to help nurses which has a range of tools and downloadable resources.

'Patients with schizophrenia can be at higher risk of cardiovascular disease'

One of the issues can be that psychiatrists are not experts in physical health and GPs are not experts in mental health so who is best placed to monitor the service user?

Dr Niraj Ahuja, consultant psychiatrist at Northumberland Tyne and Wear Foundation Trust works closely with GPs to ensure that people don't fall between the gaps and their physical as well as their mental health is monitored. "It is about building relationships," he says. "I see shared care guidelines not as rigid but more flexible – sometimes you pick up the phone and have a chat."

So what of the future? Mr Cooney says that there is growing evidence of the importance of early intervention. To identify those developing schizophrenia will mean working with adolescents and creating an atmosphere in which they or those around them can raise troubling symptoms.

"You have to get really close to young people," he says. "If you set up an early intervention in psychosis service in the middle of a psychiatric hospital they are not going to come."

And Dr McCulloch adds: "This is a very important group of people. The credibility of the system requires them to be well managed. It is a win-win for everyone to do it right and it is not necessarily more expensive than the wrong thing." ●

SHARED CARE: CASE STUDIES

DOSE OF CONFIDENCE

How trusts are supporting GPs who may be nervous about taking on responsibility for prescribing powerful antipsychotic drugs

LEICESTERSHIRE PARTNERSHIP TRUST

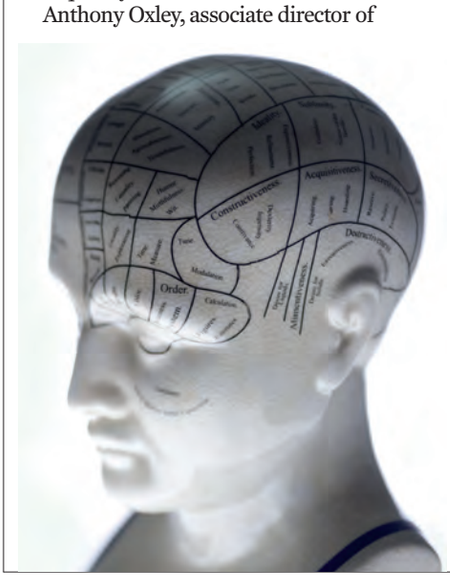
Shared care requires all partners to sign up to a joint approach to ensure service users can be treated in the most appropriate setting.

So it is important that GPs – who can sometimes feel concerned about prescribing anti-psychotic medication – are involved in the process of setting up protocols and don't feel that additional work is being forced upon them without requisite support.

The involvement of GPs was crucial in setting up a successful shared care scheme in Leicestershire under which people who had been newly diagnosed with schizophrenia are initially treated in secondary care, where they are started on medication, monitored and stabilised, after which many are then able to be transferred back to their GP's care.

This meant that GPs had to be confident in prescribing anti-psychotics as ongoing medication but also needed to be able to access support and advice from secondary care quickly.

Anthony Oxley, associate director of medicines management at the Leicestershire Partnership Trust, says service users on one particular medicine can't have their care shared in this way – it is particularly complex and can only be prescribed in secondary care – but most will be cared for by their GP.



A major challenge in setting up shared care arrangements is that GPs can sometimes feel ill-equipped to look after patients with schizophrenia and worry that their knowledge of the medicines, side effects and the disease itself is not sufficient.

Support from the secondary care sector is vital. Mr Oxley says: "What we don't want are people floundering around feeling they don't know what they are doing.

"It is about putting enough support into the system to make primary care clinicians feel comfortable to take on these patients. If the patient deteriorates the shared care agreement tells the clinician what to do and offers them help." This might be a quick referral for an outpatient appointment or simply the ability to phone a consultant for advice.

If a GP has concerns about prescribing a particular treatment because they are unfamiliar with it, pharmaceutical companies are keen to help, says Mr Oxley. Many of the medicines involved are relatively new and are on patent so companies will be willing to help with, for example, teaching administration techniques. Primary care pharmaceutical advisers are another source of help.

But Mr Oxley sympathises with GPs in these situations. "If I was asked to prescribe a drug I had not come across before, I would want to know that I understood it before I prescribed it for the first time. The shared care agreement is also reviewed so particular problems affecting a number of GPs can be addressed then so that treatment options are not 'pickled in aspic'," he says.

So what are the advantages for people with schizophrenia? Part of it, suggests Mr Oxley, is around normalisation of care. Rather than visiting a mental health unit every three months or so for a repeat prescription the patient just has to visit their local surgery.

Their GP will also have a holistic overview of their care and will know what other medications they are on, making it less likely that they will end up with drug interactions (lack of information about other prescribed drugs is often an issue when people attend secondary care as the consultant may not have access to their medical records and may have to rely on the service user's recollection).

It also upskills GPs – the more they deal with people on anti-psychotics the more confident they are likely to be in prescribing for and managing others.

From a secondary care perspective it means consultants' time can be concentrated on the people who need their specialist knowledge most – the newly diagnosed or those who are having difficulties – rather than those who are well-managed and stable.

But the system relies on everyone playing by the rules: psychiatrists only discharging service users to shared care when they have been properly stabilised and GPs being

honest about their concerns and why they may not want to take on a particular patient who meets the criteria for shared care.

"I have been very insistent with the strategy group [the Leicestershire Medicines Strategy Group which drew up the shared care arrangements] that we all have to commit to these roles," Mr Oxley says.

And the success of the shared care arrangement is evident: CCGs seem keen to continue it once they take over the reins.

LINCOLNSHIRE PARTNERSHIP TRUST

The mental health trust in Lincolnshire has worked to ensure that suitable schizophrenia sufferers can be treated in primary care and that GPs feel confident in prescribing for them.

Shiraz Haider, chief pharmacist at the Lincolnshire Partnership Foundation Trust, has had a number of workstreams looking at shared care. These have allowed the trust and GPs to address areas such as referral pathways, prescribing and monitoring of patients.

'GPs will know what other medications they are on, making it less likely that they will end up with drug interactions'

People with schizophrenia are always formally diagnosed in secondary care, often after a concerned GP has referred them. But in Lincolnshire this does not necessarily mean they have to travel to a hospital for the appointment – community psychiatric teams may be able to do it closer to home.

But what happens next varies across the county. In some cases, GPs feel confident in initiating prescribing of medicines for schizophrenia and will do this, monitor their patient and continue prescribing in the surgery.

Others will feel they need some support from secondary care clinicians before prescribing: this can be as simple as a phone call to a consultant to seek advice or getting a consultant's letter confirming what they should prescribe.

And in a few cases GPs will not feel sufficiently confident to prescribe, although they may be happy to continue with prescribing which has been initiated in secondary care and continues unchanged.

There are also slightly different approaches between the two PCTs in the county: in one, GPs will prescribe depot injectable medications for schizophrenia, in the other they won't and it has to be done in secondary care. Patients who need oral medication and are relatively stable can generally be cared for in primary care, although some GPs are more comfortable than others with this.

But it is also important to think about what is best for the individual and ensure they get the best overall care.

And as part of this, Mr Haider is looking at developing prescribing guidance for GPs. This is meant to help them and to give them more information which can help avoid common problems.

While cost is important, Mr Haider is keen that GPs look at the whole cost of using a particular medicine, not just the initial acquisition cost. Some GPs want to use first generation generic medicines which may not be the most appropriate choice for that particular patient. A treatment which produces significant side effects can also discourage compliance. As patients react very differently to medicines for schizophrenia, there is no one solution and he points out patient choice is also a factor.

Mr Haider's solution is to get GPs to look at the bigger picture around the use of treatments; relapse rates, for example, are important in affecting the overall cost. A treatment which is cheap on paper may not be cheap for the NHS as a whole if the service user is more likely to relapse on it, requiring expensive stays in hospital or secondary care input. "We have been successful in educating GPs to look not just at the acquisition cost of the prescription but at the outcomes," he says.

Changing GPs' attitudes to medicines and to build their confidence around prescribing takes time. Mr Haider often does practice visits to have one-to-one discussions, as well as organising workshops.

Who pays for medicines is another issue – and an important one for both the trusts and the emerging CCGs. Prescribing in secondary care keeps GP spend lower but may not be the right solution for the health economy, especially if expensive consultant time is taken up with relatively routine prescribing. But by communicating with and meeting with GPs, Mr Haider has managed to overcome many of these issues and ensure that both quality of care and cost are considered. ●

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