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QI Network Newsletter

Mental Health, Psychology services and CAMHS

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National Clinical Director of Healthcare Quality & Strategy REH visit

(Jason Leitch)

On the 12th October 2017 I arrived at the Royal Edinburgh Hospital and met a Scottish Quality & Safety Fellow who I thought was going to show me an excellent quality improvement project.

What I actually experienced was a hospital-wide, systematic approach to improving processes and outcomes for patients, families and carers using quality improvement methods across the hospital.

I met multi-disciplinary teams who had co-designed quality improvement projects based on priorities across a broad range of mental and physical health challenges. For example, I didn't expect to meet an Occupational Therapist leading an improvement project which included innovative health interventions such as bike maintenance, cycling around the Royal Edinburgh grounds, a weekly walking group with a café stop – all to improve rehabilitation for psychiatric patients.

The most impressive thing about my visit was in fact quite a geeky reflection on my part – it was the systematic nature of the approach to change. The application of quality improvement methods at scale is, of course, a series of micro system projects which succeed best when they are linked to a common purpose, a capacity and capability plan and people who genuinely care about making it better for patients and families. Geeky maybe, but very apparent at the Royal Edinburgh.

In my final meeting of the day, a trainee oral surgeon on his mental health rotation described a new initiative linking all of my worlds: quality improvement for oral hygiene in mental health inpatients. He was a lovely guy, he'd just started the project and in a few months he was plainly going to make a real difference to patients' oral health.

When I was kindly asked for my advice after my visit, my contribution is simplistic and three-fold:

1. Celebrate success. It seemed to me as is often the case, the teams and leaders hadn't fully appreciated what they were achieving. Systematic improvement is hard and often you need external eyes to shine a light on the progress that's being made.
2. Focus on the service user. My experience of mental health quality improvement is that it is better at involvement and engagement of patients and families than other sectors. It is unusual to find patients on improvement teams in acute care settings. This is not unusual in mental health. My experience suggests that service user involvement leads to better choice of outcomes and accelerated improvement.
3. Keep the faith. The literature calls this advice "relentless focus". Improvement is not only hard, it also takes longer than you first imagine. It requires stickability, courage and determination.

The systematic approach to change that I witnessed at The Royal Edinburgh is an example to others on this journey, and I have already shared my experiences from this visit to encourage and illustrate what it is possible to achieve. Thank you to everyone who made my day possible.

Want to know more?

WE ARE ON THE WEB!

Lothian Quality, Better Health, Better Care, Better Value, is the website dedicated to quality improvement and it is now up and running and can be found at https://qilothian.scot.nhs.uk

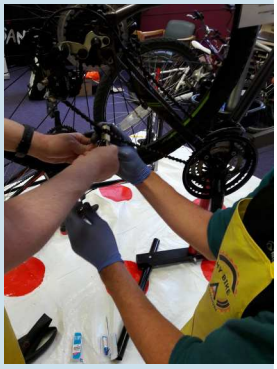
QI Training

If you are interested in training with QI Academy, please contact your local QI Lead:

- Jane Cheeseman
- Belinda Hacking
- Patricia Graham
- Cathy Richards

Promoting cycling and walking in psychiatric rehabilitation

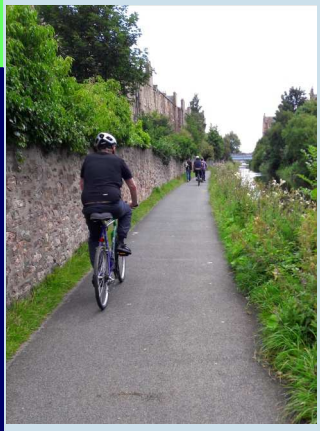
(Laura Dickson)



Occupational Therapists have an important role to play in health promotion within both rehabilitation and acute wards, and are well placed to influence how people's choices and routines can directly impact their physical and mental health (College of Occupational Therapists, 2006).

The benefits of regular low-impact exercise like walking and cycling are well documented, such as reducing the risks of coronary heart disease, stroke, cancer, obesity and Type 2 diabetes, as well as promoting mental wellbeing (NICE, 2012; Scottish Government, 2016).

Through partnership working with third-sector organisations including Scottish Association for Mental Health (SAMH) and My Adventure, Occupational Therapists at the Royal Edinburgh Hospital have created various health promotion groups on Myreside ward, which include a walking group and cycling group. There has been a demonstrated need and interest in cycling on the rehab wards for some time and this was brought together in a group format, giving patients the opportunity to learn skills around fixing bikes, practice safe cycling within the grounds and explore community resources.



Building on the success of the walking group and interest from patients who used to cycle, or had expressed an interest in cycling, the idea came about to rescue some abandoned bikes around the Royal Edinburgh site, and do them up with some assistance. This was facilitated by the support of Myreside nursing colleagues and help from cycling organisations My Adventure and Sustrans.

The group aimed to cover both basic bicycle maintenance skills, and guided 1-1 cycle rides around the hospital grounds, and then local cycle paths in a group once riders had demonstrated they could ride safely. The creation of the walking and cycling groups have led to increased patient participation in exercise and time spent outdoors, and reinforced the benefits of active travel to explore the local community. A further goal was to encourage individuals to set healthier goals that they can take forward with them on their move from hospital to the community setting.

Sharing Improvement Ideas across teams in CAMHS

Twelve months ago the national Mental Health Access Support Team ran a workshop for CAMHS team to support the service using the model for improvement to improve the clinical pathways for Autism Spectrum Disorder (ASD). On November 14th 2017 the teams gathered to share ideas for improvement that had been tested over the past year and welcomed the ADHD teams who had also been using the model for improvement CAMHS. Nine teams presented data from the assessment and post –diagnostic pathways for ASD and ADHD.

Presentations were delivered by teams who were at various stages with their QI journeys. One popular change idea had been tested by 4 teams of using of an allocated assessment information gathering meeting. Teams typically suggested that this meeting required specific paperwork to be completed and an allocated timeslot. Other common change ideas included letters to parents summarising the assessment pathway and storing resources electronically on shared drives for easy access.

The teams who were towards the end of their tests of change illustrated positive improvements to timeliness and consistency. For example the North Edinburgh ASD reported a gradual reduction in wait times for ADOS assessments despite a huge increase in demand, while West Lothian found that parental attendance to the large (35+ families) post-diagnosis parents groups was equivalent to attendance at the small (~9 families). Suggesting that working with the larger group may be of benefit in terms of service efficiency and improved access for parents.

At the end staff shared that they felt empowered by using the model for improvement their QI projects. Comments also included that staff were glad to be able to measure the impact their changes had on referrals and waiting times without the requirement of large datasets. Most of the staff who presented projects had also attended a QI coaching sessions earlier in the year. The impact of the coaching was assessed; following the coaching staff reported having a better understanding of QI and increase confidence about their projects. CAMHS are very grateful to the QI Academy and the MHAIST team for support, coaching and training.

Pass plans in Adult Acute Mental Health

(Eileen Clark)

As part of my role as Quality Improvement Nurse for Adult Mental Health (AMH) services I was asked to look the pass plans with the acute mental health wards.

Pass plans are used to plan and prescribe a patient's time off the ward and should be agreed with the patient and the multi-disciplinary team. All inpatients should have a clear plan in the front of their notes. This information should also match exactly to the information written on the Patient Status at a Glance (PSAG) board in the ward duty rooms.

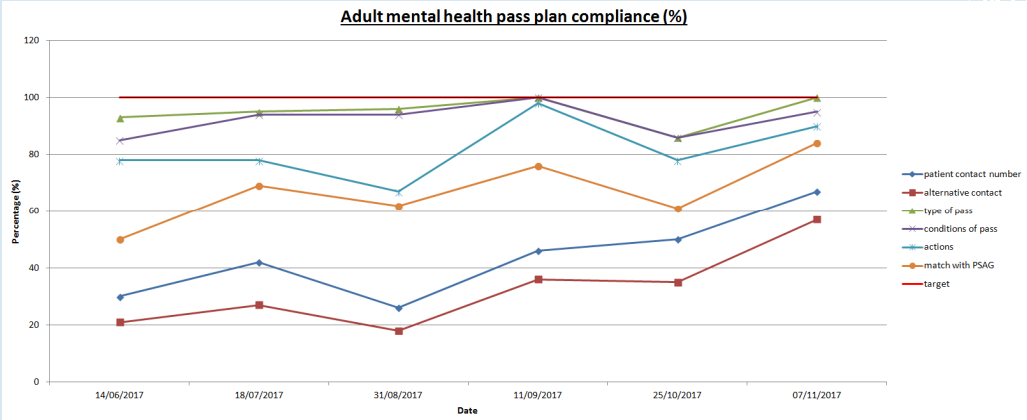
The aim and purpose of carrying out this piece of work was:

► To ensure that all pass plans were accurate and up to date for all adult acute wards at REH by end of September 2017.

► Clear plans are important to be in place if patients allowed out on pass or if patients that are potential risk to themselves or others go missing.

► Links with new missing patient policy.

I first started this audit in June 2017 and looked at the compliance rates of specific areas within the pass plan. These were the details which would be most important should someone go missing from hospital or fail to return from a pass. Contact details for the patient and details of what actions staff should take were audited.



Over the past 4 months there has been a gradual improvement in the completion of the pass plans. However there was a drop in compliance in August, this would appear to be due to the move of the adult wards to the new Royal Edinburgh Building. The improvement has been achieved by providing the wards with regular feedback in regards to their progress and providing them with evidence of their progress to display in the clinical areas. Monthly reports are sent to charge nurses and nurse managers and updates are also given at the monthly charge nurse meeting.

The imminent introduction of a new missing persons joint protocol between the Royal Edinburgh Adult Mental Health Inpatient Services and Police Scotland has led to the development of a revised pass plan which is being slowly introduced across AMH services.

REH Clinical Change Forum

Jane Cheeseman, Clinical Lead for QI in Mental Health opened the event by looking at where we are one year after starting on the QI journey. A tremendous amount has been achieved in this time and we are delighted with the enthusiasm and activity we see all around.

Mental Health is just one of the six current QI programmes in NHS Lothian and *Vicky Tallantire* presented the results of the recent evaluation of all the programmes.

Julie Burgmans, Leanne Galloway, Beccy Brown and Martine Mungall presented the findings from their project to improve access to neurodevelopmental assessment in CAMHS in East Lothian with early signposting and support.

Frances Aitken and *Frank Charleson* are senior charge nurses in Care of the Elderly wards at REH and they have changed the culture in their wards in a major way. As a result of this change adverse events and the need for constant observation have reduced to zero and the staff are happy to come to work.

Lesley Whitton reported on her project looking at waiting times to the Sexual Problems Clinic. Now there are only about 20 patients on the waiting list and most are seen within 18 weeks.

Belinda Hacking presented Quality Improvement in Pain Management, with a focus on changing culture. There was a high non-attendance rate at this service and the aim was to improve this and the experience of patients. Staff feel motivated to think how they can improve the service further, especially by working as a team.

Quality Improvement in West Lothian was the topic explored by *Hosakere Aditya*. One area being looked at has been unscheduled care; moving from a doctor-led model to nurse-led has released 1.5 wte of consultant time which is being turned towards reducing the waiting lists.

David Hall and *Johnathan Maclennan* from HIS closed the session with reiteration that people are at the heart of what we do and there is permission to try things differently. They gave a prompt about the need to spread the learning from all projects and to celebrate success. You can find out more at: https://qilothian.scot.nhs.uk/new-page-5

Use of metformin for antipsychotic-induced weight gain

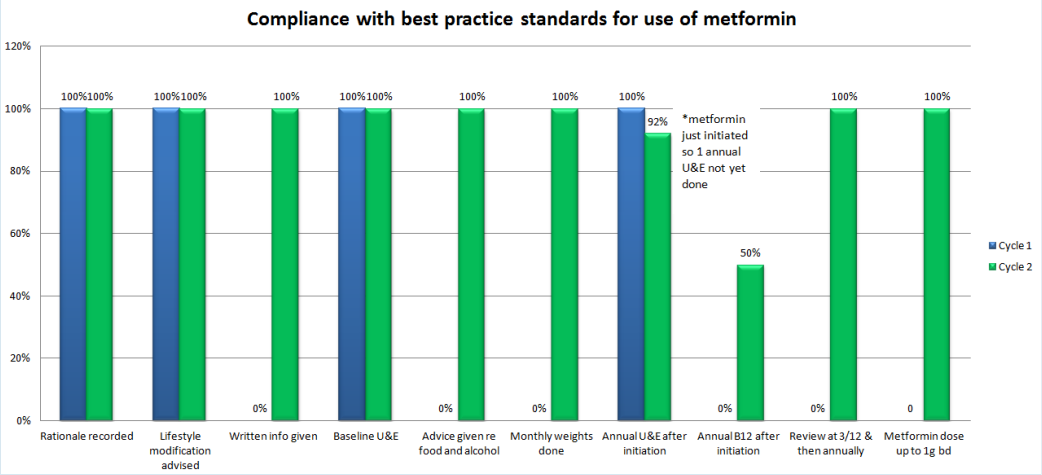
(Carla Schmoll)

Treatment with atypical antipsychotic medication is a significant contributor to weight gain and the metabolic syndrome and is associated with premature mortality. People with mental illness are three times more likely to develop diabetes, and twice as likely to die from heart disease. In the Scottish government's mental health strategy we are encouraged to address these health inequalities through local audit and further research.

In addition to lifestyle modification, metformin has emerged as the current most effective and safe treatment to reduce weight gain associated with antipsychotics, but remains an off-label use for this drug.

Standards exist, however, for safe use of metformin for antipsychotic-induced weight gain. From May 2015- June 2016 Dr Debbie Mountain, Rehabilitation Psychiatry consultant, and myself decided to conduct an audit to assess whether our use of metformin for this purpose complied with current best practice and then to design an intervention that ensured our future prescribing was safer and more appropriate.

We identified the standards relating to antipsychotics and weight gain by looking at NICE guideline 178, SIGN guideline 131, the Lester cardiometabolic health resource, the REH rehabilitation ward standards for monitoring of weight and a review article in *Progress in Neurology and Psychiatry* outlining best practice for use of metformin in this context, and extracted ten clear standards against which to measure our practice.



After cycle 1 we designed an intervention – a protocol for use in the rehabilitation department – to ensure each standard was addressed in prescription and monitoring of metformin. The results demonstrate the efficacy of the protocol and an improvement in our adherence to best practice.

Of note, results from cycle 1 also demonstrated that metformin had a positive impact on antipsychotic-induced weight gain 3 months after initiation, whilst results from cycle 2 suggest the benefit continues well beyond 3 months and, while fewer patients continue to lose weight, the number whose weight stabilizes appears to increase.
Of course other factors are not recorded or accounted for due to the nature of this work, but these findings merit further study.

Physical health monitoring of patients taking clozapine

(Ommar Ahmed Marianne Van-De-Lisle)

The aim of this project is to improve physical health monitoring of patients taking clozapine to meet national standards in at least 80% of patients by December 2017. The Mental Health Strategy 2012-15 committed the Scottish Government to develop a national standard for monitoring the physical health of people being treated with clozapine. An updated version of the standards was launched in February 2017.

Evidence confirms that risk of physical health illness e.g. diabetes, cardiovascular disease is higher among people with mental health illness as compared to general population. People with severe mental health illness have a shorter lifespan compared with general population and it is believed that the excess mortality is mainly due to poor physical health. The main contributory factors are thought to be lifestyle choices, side effects of psychotropic medication and disparities in health care access.

Previous audits of the national standards have been conducted in areas of the mental heath service in Lothian and action taken to improve monitoring, however, to date there has not been a service wide approach to this issue. This project will initially focus on the inpatient setting. Data will be collected across acute mental health wards for 10 patients who started clozapine prior to 1st April 2017. Once the data has been collected and analysed, a clozapine bundle would be developed to streamline current and any new paperwork required to meet the objectives of this national standard. New monitoring parameters and the clozapine bundle would be highlighted to medical, nursing and pharmacy staff to ensure adherence to national standards for physical health monitoring. The intention following the initial work will be to link with community and primary care teams to ensure that there is continuity of monitoring for this patient group, irrespective of setting.

Need a guidance on starting or running QI Project?

QI Clinics

Let your QI support team know and book your appointment: qi.mentalhealth@nhslothian.scot.nhs.uk

You can pick from any of the listed dates. There are two time slots per day 10am to 11am and 11am to 12am. Meeting room 4 at REB is booked for all these meetings throughout the year.

QI Clinic Dates:
12th January
9th February
9th March
6th April
4th May
1st June
29th June
27th July
24th August
21st September
19th October
16th November
14th December

Thank you!

Thank you for reading our newsletter. Next publication will be issued in April 2018.

Any suggestions for next newsletter and your feedback are most welcome.

Please email them to qi.mentalhealth@nhsloth

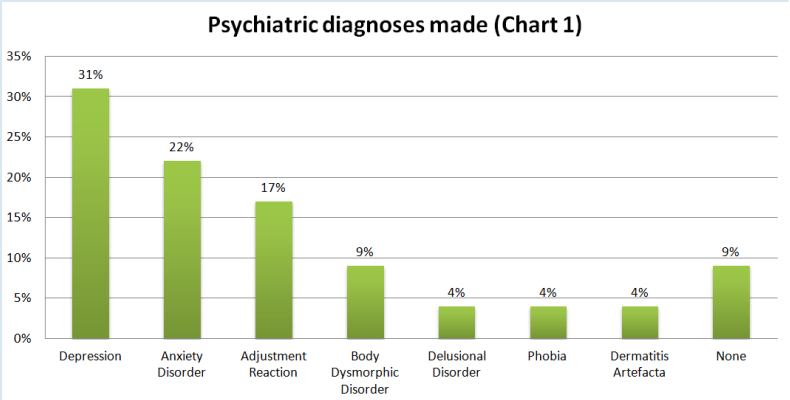
Psychodermatology

(Dr Catriona Howes, ST5 in Psychiatry
Dr Stephanie Ball, ST5 in Dermatology
Dr David McKay, Consultant Dermatologist
Dr Wojtek Wojcik, Consultant Psychiatrist)

It is well recognised that psychological factors often have an effect on skin disorders and that skin disorders can also affect one's mental health and wellbeing. Despite this and national recommendations from the British Association of Dermatologists, there was no dedicated Psychodermatology service provision for NHS Lothian. The NHS Lothian dermatology department has a catchment area of 850,000 patients, giving rise to around 33,000 new patient referrals a year. This figure is rising annually by about 3%. Given roughly one third of all skin conditions have associations with significant psychiatric co-morbidity, the lack of a structured psychodermatology clinic within the region has been increasingly apparent.

With this in mind, it was proposed that a psychodermatology service be established and jointly run by dermatology and psychiatry.

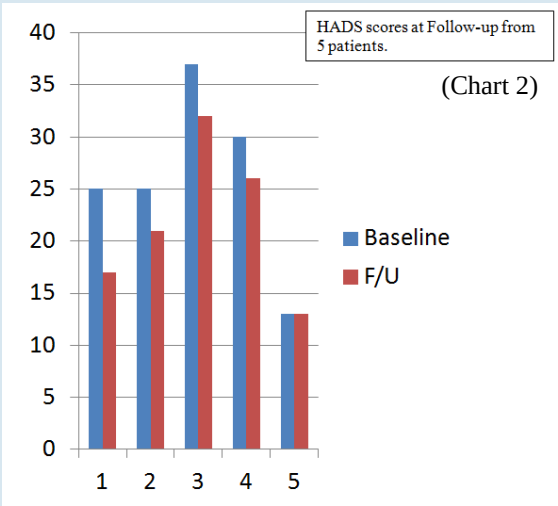
Firstly, a project team was formed comprising the clinical director of dermatology, Dr David McKay, a consultant liaison psychiatrist, Dr Wojtek Wojcik, and higher trainees in dermatology and psychiatry, Dr Stephanie Ball and Dr Catriona Howes respectively. The project aimed to offer an established, effective fortnightly joint clinic by January 2017.



In October 2016 trainees and consultants from the dermatology service in NHS Lothian were surveyed on their experience of managing patients with psychological needs. This survey revealed that most doctors had been managing patients alone, or where appropriate, making separate referrals to locality mental health services. Two thirds of doctors surveyed were not satisfied with this arrangement (mean satisfaction score of 2.5 out of 10), and half reported they had encountered difficulties referring patients for mental health support previously.

It was agreed that patients would be seen by Dr Howes and Dr Ball and supervised remotely by Dr Wojtek and Dr Mckay. Patients were to be seen in the dermatology out-patient department and given one hour slots for new appointments and 30 minutes for return appointments. Referrals would be accepted only from within the dermatology directorate and would be made via a simple A4 page form.

New patients were to be assessed via a thorough clinical interview as well as Dermatology Quality of Life Index forms and Hospital Anxiety Depression forms at each visit to assess objective response, particularly where therapy or medication has been started.



(Chart 2)

The clinic began in January 2017, and we have now accepted 28 referrals which have been overwhelmingly female (89%) and with a mean age of 47.7 years. The most common reason for referral has been concerns about mood and anxiety disorders. Following assessment, Chart1 shows the psychiatric diagnoses made.

We found very high scores on the HADS (Hospital Anxiety and Depression Scale) at baseline. We believe this reflects the high degree of distress psychodermatology patients endure. Chart 2 demonstrates modest improvements in these scores.

After the clinic had been running for six months, we decided to repeat our survey of consultants in the dermatology department. They reported a significant improvement in satisfaction levels, with a repeat mean satisfaction score of 9 out of 10. We have also begun to collect patient feedback, using the CARE (Compassion and Relational Empathy) questionnaire. This process remains incomplete, but the results have thus far been overwhelmingly positive, with particularly good evidence that patients felt "more in control" of their condition following psychodermatology input.