



Sheffield Care Trust

Mental Health and Wellbeing



**Sheffield Crisis Assessment and
Home Treatment Service**

**Enhancing Pathway into Care (EPIC) Project
For Pakistani Service Users**

**Audit Report of CAHT - PMC
Enhanced Pathway**

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1. Introduction

1.1 The Sheffield Enhancing Pathways Into Care Project

One of the Government's key targets for Mental Health services was the establishment of 335 crisis resolution / home treatment teams by Dec 2004. These teams act as the gatekeepers to acute psychiatric services and aim to provide home treatment for people in crisis, as far as possible, as well as supporting early discharge for those admitted into inpatient beds.

The available national evidence suggests that by the time many Black and Minority Ethnic (BME) communities access secondary mental health services it is usually in "crisis"¹, which in turn creates a profound impact on their families and experience great difficulties in reintegrating back into their communities with any sense of dignity. The South Yorkshire FIS wishes to support a project that aims to develop pathways for people in crisis. The pathways have been selected based upon the national evidence of the experiences of black and ethnic minority communities within mental health services. The Sheffield Crisis Assessment and Home Treatment (CAHT) service is therefore working to Enhance Pathways into Care (EPIC) for a specific Black and Ethnic Minority Group (those from a Pakistani background).

The Sheffield EPIC project proposes to use a Community Development (CD) model in order to enhance services for Pakistani communities. The strength of the CD approach recognises the belief that people know best about their own needs and requirements and that they have the knowledge, abilities and experiences which should be utilised. However, the responsibility for policy development and practice cannot be the individual responsibility of the Pakistani communities; it requires a multi-agency approach with effective partnership arrangements. This involves building on the strengths, creativity and an experience of the community in a manner, which does not exploit or oppress them.

The 2001 Census identifies that Pakistani people form a large representation amongst the BME communities in Sheffield, who continue to be disproportionately located within deprived areas of the City. Whilst their representation within mental health services is also disproportionately high, there has been very little engagement and service development for this community by the statutory mental health services in Sheffield. This is also the case across South Yorkshire.

¹ Fernando, S (1991) Mental Health Race and Culture. Macmillan in Association with Mind publications

1.2 Aims for the Sheffield EPIC Project

1. The Sheffield EPIC project will aim to improve access to crisis services/ home treatment for the Pakistani community in line with national targets. The CAHT team is seeking to build capacity to provide support where mental health needs of Pakistani service users have been identified within CAHT. The CAHT recognizes that the current paradigms of practice and service development have not engaged with this local community sufficiently and since their current pathways into mental health services is when experiencing a crisis; it would appear that this is a valid pathway to focus upon.

The CAHT is a newly established crisis resolution and home treatment service working in two teams in the North and South of Sheffield. This project will work across both teams

2. The pathway that we seek to improve is in the early stages of collaboration between the Crisis Assessment and Home treatment team and the Pakistani Muslim Centre.

The team is seeking to build on capacity where mental health needs of Pakistani service users are identified during a crisis episode. The current shortage of prescribed social activities and lack of respite for carers increases the risks of admissions into hospital in many cases under compulsory detentions under the Mental Health Act (1983).

The CAHT recognise that the current paradigms of practice and service development have not engaged with the local communities sufficiently, (particularly when examining explanatory models of health and illness). The partnership will seek to improve knowledge and find creative ways in promoting access to these pathways, which will be more meaningful for the communities.

The vision of this project is to establish models of good practice, which addresses in a culturally congruent and holistic way the specific health and related social care needs of Pakistani service users in Sheffield. We anticipate that this project will foster the sharing of good practice across South Yorkshire.

At a later stage, the project would envisage that the PMC through established networks with Sheffield Care Trust, FIS support would find additional pathways to explore. Priorities will be given to the early detection of mental health problems, forge partnerships with the Early Intervention Services, In-reach through advocacy support into the in-patient wards.

These priorities support the Government's policy on new developments in mental health care.

3. Outcome measures will be:

- To ensure that user led and user focused services are recognized and integrated into the mainstream.
- To promote a culture where carers are included in care packages and that a community language should not be a barrier in having a voice. This can be promoted through collective action.
- To reduce the rates of in-patient admissions from the Pakistani community by offering alternatives i.e. prescribed social activity.
- To improve data sets and value based evidence to support further pathways through good practices identified by the audit.
- To improve relationships and respect between statutory services and the Pakistani community.
- To share as a model of good practice across South Yorkshire and nationally.

The main goal of the project is to develop enhanced packages of care for the Pakistani Community.

1.3 Outcomes for the Sheffield EPIC Project

Compare existing Crisis and Home Treatment (CAHT) packages and what has been developed after the EPIC.

Collect baseline and outcome data after nine months of the project life and focus upon the key features.

Sheffield EPIC wants to observe/collate:

- i. A decrease in compulsory detention for the Pakistani community
- ii. Decrease in Inpatient care for the Pakistani community
- iii. Increase in early discharge rates (this is to be defined as the average length of stay) for the Pakistani community
- iv. Appropriate percentages of Pakistani people accessing secondary care in non emergency community mental health services (consider the local data in the relevant areas and compare the percentage in contact with statutory services).
- v. Explorative data regarding the subjective views of PMC users with regards to stigma, suspicion, mistrust, capacity, interpreting/translation.
- vi. The development of advocacy services and representation in Care Trust Council.
- vii. A focus on economic circumstances of service users within the Pakistani Muslim Centre i.e. signposting etc.
- viii. An improvement in existing collaboration between Sheffield Care Trust and the Pakistani Muslim Centre

- ix. An improvement in the limited knowledge of the CAHT team on matters of 'Race' and culture in mental health.
- x. An increase in the assessments of social care needs of service users from PMC who also use secondary mental health services.
- xi. An increase in the facilitation of respite care for both service users from the Pakistani community and their carers.
- xii. The emergence of pathways of care that are timely and appropriate for the Pakistani community i.e. Early Intervention Services, Psychological Services

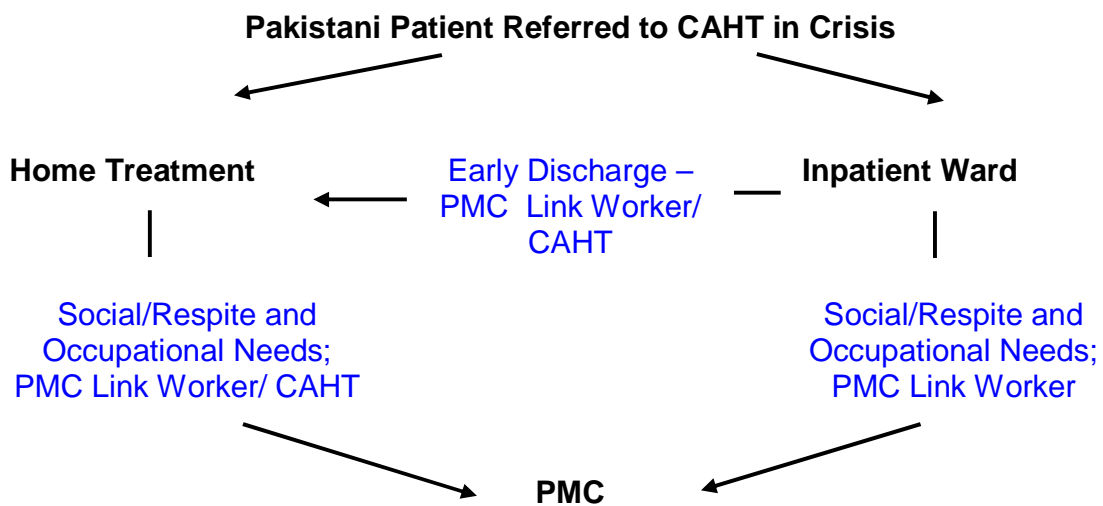
2. The Current Audit

The focus of this audit report is to provide baseline data upon standards of care within CAHT across a 2 year period that enables comparison for the enhanced pathway developed/delivered through the initiation of the EPIC project.

The audit is focused on a highly specific component of the broader EPIC project – namely improvements in the clinical pathway between CAHT and the PMC. This audit project does not encompass the broader aims of the project and does not report upon impact in terms of broader vision for impact on CAHT service delivery (i.e. enhancing the pathway of care for patients from a Pakistani background as delivered internal to CAHT). This point will be further discussed though the method and results section.

The pathway of focus for this audit is diagrammatically represented below:

Diagram 1: Sheffield EPIC – Intervention Pathway



3. Method

3.1 Design

This audit report studies two 'discrete' time periods in CAHT and inpatient service delivery - presenting data from 2005 and comparing this to 2006. These two time periods can be roughly conceptualised as representing periods prior to EPIC (2005) and active project development (2006). Whilst, the 2006 period falls short of full implementation, it still represents an impactful stage of preparation where engagement of stakeholders, refinement and development of project purpose were all actively occurring both within and outside CAHT. The audit is therefore largely retrospective in design.

3.1.1 Further Commentary on Processes and Timing of Implementation Stages

It is worthwhile at this point making some general and specific comments about the background processes that may or may not impact/confound the reported data. Broadly, issues to consider would include;

- The CAHT began service delivery in **2005** and this presents an intense period of learning and development for the service as a whole. Illustrative of how much development and basic learning the CAHT service was subject to at this time includes the fact that An Operational Policy was not in place until April 2005, the configuration of the service into a North and South Team was not fully operational until October 2005 and basic clinical procedures and documentation was not stable until at least summer 05. In terms of EPIC, the proposal had been submitted and accepted at the very late end of 2005 and had chiefly been discussed within the senior staff team.
- In **2006** the team had more stable function in terms of team identity, operational procedures and policies. However, the service had limited consolidation time as it began to tackle conceptually and procedurally the challenge of facilitating early discharge to increase positive impact upon acute inpatient and strengthen links with community mental health teams. By the end of 2006 the service was developing increased consensus in terms of vision, purpose and targets but these were subject to continuing critical review due to external pressures. In terms of EPIC the scope and breadth of the project had lead to poor delivery of vision and implementation within CAHT. In the late summer critical review of the scope and breadth lead to a single senior clinician taking project management with resulting specificity and focus of the CAHT-PMC link as the initial phase for implementation/change. Internal to CAHT specific workers were recruited to an EPIC project group, again focusing on methods of enacting the CAHT-PMC link as the method of intervention. The PMC link worker was finally recruited and in post by November 2006 and began regular visits to the service and received clinical induction and supervision from the CAHT Clinical Psychologist. A procedure for monitoring, identifying and devising

care plans was drafted and in operation by December 2006. However, full implementation of the CAHT-PMC (i.e. launch with the broader CAHT team) was yet to occur.

Therefore the data presented represents 2 time periods, 2005 where EPIC did not exist except in the minds of a few lead clinicians and managers, and, 2006 where a process of engagement and dissemination began to make EPIC more than a concept within the CAHT service, but with continuing limits to its transparency and inclusiveness across the staff group.

3.2 Measures

3.2.1 CAHT and Inpatient Activity by BEM and related Demographics

This report draws upon results from the broader CAHT audit strategy that was designed at service inception (and prior to consideration and initiation of the EPIC project). The CAHT audit program already had core purpose of facilitating examination of issues of equity and access. Therefore, we are able to report detailed activity and demographics relating to the issue of access for BEM groups (including Pakistani service users) both within CAHT and on the inpatient wards. The majority of this data was uploaded into a statistical database package from the Sheffield 'INSIGHT' clinical information system and relied on staff accurately recording clinical activity and a good working relationship with the information department.

3.2.2 Development of Project Specific Audit Tools

Early in the EPIC project life (within 3 months) a number of audit tools were developed. The audit was focused upon quantitative methods, as these matched better the resources and capacity of the EPIC team working within CAHT. The tools were developed within the ethos of the project and were targeted to monitor standards of delivered care at two different stages and with differential key audit questions (see Table 1 below). Two checklists were developed to facilitate audit of care pathways within CAHT. The checklists provide a simple view of the administrative and clinical care components delivered to patients and families. The checklists were based upon audit of the written notes and therefore are as much an audit of documentation standards as they are the quality of care provided. This latter point will be picked up upon further within the results section.

Table 1: To provide an overview of the key audit questions, developed tools and tool function for the EPIC audit

Key Audit Question	Are there differences in the existing delivery of care between White UK and BEM groups?
Developed Tool	'Standards of Care Checklist'
Purpose/Focus of Tool	A checklist used to audit and provide a baseline of documentation and clinical procedures that most patients would be expected to be in receipt of (see Appendix 1). The standard care checklist enables clinical and administrative variations to be notated as variance, hoping

	<p>this would build our understanding of consistent 'discrepancies' between what we think should happen in a patients CAHT care pathway and what actually does happen. The recording of variance also enables the potential identification of systematic resource failures (i.e. women consistently refuse a medical because we cannot offer flexibility in gender of examining doctor).</p> <p>The standard care audit checklist enables us to examine practice, prior to the initiation of the EPIC project and highlight any differential practice across different ethnic groups.</p>
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Key Audit Question	At fullest implementation of EPIC within CAHT there would be improvements in the cultural sensitivity, appropriateness and specificity of delivered interventions both within CAHT and in the CAHT-PMC link
Developed Tool	'Enhanced Standards of Care Checklist'
Purpose/Focus of Tool	<p>The second checklist takes the standard care and interrogates it from a culturally sensitive perspective (see Appendix 2). In a sense this checklist anticipates and visions what we would hope individuals from a Pakistani background would receive if we had greater awareness, sensitivity and responsiveness to issues of ethnicity and culture. This is then transformed into an enhanced 'culturally appropriate' audit checklist that captures clinical and administrative activity (and variance) specifically for those from a Pakistani background. The culturally appropriate pathway continues to map onto the standard pathway and enables comparison for improvements but also records improvement sin care delivered.</p> <p>This checklist is intended to be implemented prospectively once the formal launch of EPIC and reciprocal training from CAHT and PMC has occurred. It is therefore a representation of impact once vision is delivered.</p>

The current report summarises the results from the retrospective standard care checklist audit that was completed at two time points. The Enhanced Standards of Care Checklist was not used, as full project implementation was not achieved during the life the project.

3.3 Sample

3.3.1 Sample - CAHT and Inpatient Activity by BEM and related Demographics

Two databases were utilized for activity reporting, these were the standard databases used to monitor activity, impact and access within the broader CAHT audit strategy. The first database yielded detailed information relating to CAHT activity (i.e. length of episode, nature of clinical contact, number of contacts, repeat episodes and demographic data). The second database yielded information relating to inpatient services (i.e. length of stay, admission rates, repeat admission and demographic data). The databases were derived from the clinical information system used within Sheffield Care Trust and through collaboration with our Information Department. Within each database, there is some missing data relating to ethnicity and these cases are excluded for the purposes of simplicity within this report.

3.3.2 Sample - 'Standards of Care' Audit Checklist

The 'standards of care' audit checklist was used to retrospectively interrogate notes with differential samples across time periods;

2005 - Three sample groups from the Home Treatment population were identified for comparison of checklist standards between different ethnic groups;

- White UK
- Asian/Asian British Pakistani
- Black/Black British Caribbean

This enabled comparison of potential differences of White UK compared to BEM's, but also Pakistani service users as compared to another Black and Ethnic Minority group. For the White UK group a random sample of patient identification numbers was drawn from the database. For the two BEM groups the sample represents every case-note file that could be found for the CAHT BEM service user population. For both BEM groups some files were not accessible at the time of the audit.

2006 - A single sample was selected and specific comparisons to CAHT-PMC pathway made to 2005 data

- Asian/Asian British Pakistani

The sample represents every file that could be found for the CAHT Pakistani service user population, however, some files were not accessible at the time of the audit.

3.3 Analysis

All of the Excel databases were imported into a powerful statistical analysis package called SPSS (Statistical Package for the Social Sciences) which enabled maximum flexibility in exploring patterns and associations within the different data sets. The audit checklist data was written into SPSS from the outset. SPSS also facilitates the merging of different data sets.

4. Results

4.1 Background - Demographics

Sheffield City Council (2003), in a census topic-report focused upon ethnicity, drew out the following headlines, that are pertinent to consider in relation to the current project;

- The minority ethnic population in Sheffield has increased by 80 percent since the 1991 Census to around 45,000 people
- The Indian community in the city appears to have more than doubled
- The largest minority ethnic group in Sheffield is the Pakistani group at almost 16,000 people, or 3 percent of the total population
- Around half of the people in black and minority ethnic groups were born in the UK
- The Pakistani, Bangladeshi and Mixed ethnic groups have a high incidence of long-term limiting illness when taking into account the age distribution
- Unemployment rates are generally higher for black and minority ethnic groups; the Indian and Chinese groups are the exception
- Most of the BME groups tend to be generally better qualified than the majority White British population

The report also states;

“The 2001 census records a total population for Sheffield of 513,234. Of this total 91.2% are classified as White. This leaves a total of 45,017 people of black or minority ethnic origin, 8.8% of the total population. Inclusion of Irish and Other (non British) White people adds a further 10,489 people bringing the total percentage to 10.9%.”

Sheffield City Council (2003)

It is now widely acknowledged that significant health inequalities exist for people from a Black and Ethnicity Minority group. It is understood that there are differential rates of access according to type of mental health provision, with increased rates of admission for many BEM groups. The Healthcare Commission (2005) found that, in a ‘snap-shot survey’ of psychiatric inpatient services, whilst

79% of inpatients were White British, 19% were from Black and minority ethnic groups. This contrasts with the national proportional rates for ethnic origin were White British is 91% and BEMs is 9%. However, within the survey it was found that for Pakistani inpatients the proportional rate was lower as compared to the national average. For Sheffield, the survey found 84.8% of inpatients were White British and 15.2% were from a BEM group and 2.7% were from a Pakistani background. Few other studies in the area of ethnicity sufficiently partition ethnic origin to enable examination of detail for the diverse sub-groups comprising what is commonly reported as a BEM group.

As CAHT is effectively a community service, but one that provides a crisis response and an alternative to hospital, it was important to understand if CAHT had differential rates of access as compared to the inpatient services and to the population rates for Sheffield area.

Table 2; To show summary demographic data for Sheffield, Sheffield CAHT and Inpatient Services relating to BEM groups

Time Period	2001 Census - Sheffield	CAHT Total Episodes (including consultation only)	Crisis Assessment	Crisis Assessment leading to Home Treatment Episode	Sheffield Inpatient Admission Rate
2005-2006					
Ethnicity					
White British	89.1%	83% (5406)	83.8% (3153)	83% (828)	78.5% (1318)
Black and Ethnic Minorities	10.9%	17% (1110)	16.2% (611)	17% (170)	21.5% (361)
British Asian/Asian Pakistani partitioned out from BEM Group	3%	2.9% (191)	2.5% (95)	3.6% (36)	3.9% (65)

There was a marginal increase in referral rate of British Asian/Asian Pakistanis' to the CAHT service between 2005 and 2006. There were no significant changes in inpatient admission rate between 2005 and 2006 across the ethnic groups reported. Further detail relating to pathway and clinical and social demographics is provided further on within the results section for both Sheffield inpatient and CAHT services.

The CAHT service is currently analyzing and interpreting deprivation data relating to service access and ethnicity, whilst this data is not available for this report, it will hopefully be made accessible through journal publication in the near future.

4.2 Background – Sheffield CAHT Clinical Outcomes by Ethnicity

As previously discussed, the audit of the EPIC project was facilitated by a robust audit program that was already in place and already had an explicit focus upon inequalities in access and provision. As part of this overall audit programme clinical outcomes had been monitored in 2005 and this data was analyzed by ethnicity.

Two measures had been utilized and these are summarized as follows along with details of the sampling procedure;

Brief Psychiatric Rating Scale – Expanded (BPRS-E)

The Brief Psychiatric Rating Scale (BPRS) is an 18 item scale developed by Overall and Gorham (1962) designed to measure severity of psychiatric symptomology across a range of conditions and to evaluate response to treatment over time. The BPRS has been modified over time to increase not only inter-rater reliability but also clinical validity. The most up to date instrument is called the BPRS-Expanded (BPRS-E) that has 24 items, including rater observations of behaviour (Ventura et al, 1993; Lুকoff et al, 1986). Each of the 24 items is rated on a scale from ‘not present’ (0) to ‘extremely severe’ (7).

The BPRS-E has good reliability and validity and is well established within the clinical research literature as a useful measure of outcome. The BPRS-E is not an interview tool or formal assessment guide, although it may highlight areas for further assessment. The BPRS-E is rated on the basis of prior psychiatric interview and other collateral information.

Advantages and Disadvantages

The BPRS-E has advantages in that, with training, it is a cost effective measure with which to monitor outcome i.e. that it can be rated without additional time-consuming interviews and has been widely used in comparative services. It has minimal intrusiveness to patients i.e. they are not submitted to additional clinical investigation in order to provide a rating. The BPRS-E has good clinical sensitivity and is likely to detect significant clinical changes over time. However, the BPRS-E focuses exclusively on symptomology and tells us little or nothing about social functioning and impact of symptoms on quality of life e.g. although it may tell us about severity of anxiety it does not tell us what functional social supports the person has in place that may mediate the impact of these symptoms. A further disadvantage is due to the fact that the BPRS-E is a collateral tool it does not involve the patient and is an objective account by clinicians that does not provide room for subjective accounts on the part of the patient.

Health of the Nation Outcome Scale (HoNOS)

The development of HoNOS was commissioned by the Department of Health and was specifically designed to become a standardized assessment tool for use across all NHS mental health services (see Wing et al, 1996). The HoNOS is a 12-item questionnaire designed to measure level of functioning across a range of areas

including; psychiatric, psychological, behavioural and, importantly, social and leisure. Each of the twelve common 'problem areas is rated on a scale of 'no problem' (0) to 'severe or very severe problem' (4). HoNOS is part of the Minimum Mental Health Data Set that has become mandatory in March 2003. The HoNOS is not an interview tool or formal assessment guide, although it may highlight areas for further assessment. The HoNOS is rated on the basis of prior psychiatric interview and other collateral information.

Advantages and Disadvantages

The HoNOS is a good measure to use in conjunction with the BPRS-E as it includes rating of social and interpersonal functioning. Again, it is a cost effective measure with which to monitor outcome i.e. that it can be rated without additional time-consuming interviews and has been widely used in comparative services. It has minimal intrusiveness to patients i.e. they are not submitted to additional clinical investigation in order to provide a rating. However, the HoNOS is a global measure and this means it can have poor sensitivity to clinical improvements. In the same way as the BPRS-E, the HoNOS is a collateral tool and does not involve the patient and is subject to the same criticisms as a result.

Administration and Sampling

The CTRS was administered as a routine clinical tool at every assessment; this tool was rated by the assessor at the point of assessment. For the BPRS-E and HoNOS a single person, the CAHT Psychology Assistant, made all of the ratings. The rater had been trained in using a variety of psychiatric assessment tools and co-ratings of example cases had been undertaken as a small group activity. The rater did not conduct the interviews upon which the ratings were based but made a collateral assessment based upon the notes and through discussion with key colleagues involved with the direct assessment, as appropriate.

The results reported here are based upon the time 1st April 2005 to 30th September 2005. There were **123 patients** for whom data on the CTRS, HoNOS and BRPS was collected.

The results reported here are based upon the time period 1st April 2005 to 30th September 2005. The clinical outcomes data was examined to explore whether particular demographic characteristics were associated with different patterns of change as measured by the difference between assessment and discharge scores on both the HoNOS and BPRS-E. Across all groups the mean difference score indicated significant improvements in clinical (and in the case of HoNOS, social) improvements. The mean difference scores for ethnicity would indicate that the sampled Black and Ethnic Minority community have greater improvements in functioning (as measured by the HoNOS) and symptomology (as measured by the BPRS-E) as compared to the White UK sample. The findings are reported in table 3 below;

Table 3: To show Clinical Outcomes for a sample¹ of the Sheffield CAHT population by BEM groupings

Demographic	HoNOS Difference Score (Assessment – Discharge)	BPRS Difference Score (Assessment – Discharge)
	Mean (StD)	Mean (StD)
Ethnicity		
White UK (n=87)	5.9 (5.7)	9.3 (9.6)
Black and Ethnic Minorities (n=29)	7.8 (7.5)	12.8 (13.4)
British Asian/Asian Pakistani partitioned out from BEM Group (n=7)	8.14 (8.2)	10.17 (14.6)

¹ _The results reported here are based upon the time period 1st April to 30th September 2005.

This improvement is even greater for the Pakistani group within the clinical outcomes sample (see Table 3 above). For both the HoNOS and BPRSE-E difference scores those people classed as employed have greater improvements in both functioning and symptomology. It is therefore notable that the significantly elevated rates of improvement for those of Pakistani origin are despite the fact that they have a very low rate of employment (2.1% Pakistani origin employed as compared to 14.8% for other BEM groups and 19.8% for White UK – across the entire CAHT 2 year population).

4.3 CAHT and Inpatient Activity

4.3.1 Qualitative Account of Project from PMC Link Worker - Nayla Mahmood

“Mental Health and Emotional Well-Being

Working on the Inpatient Wards

My work covers the four mental health wards within Sheffield. These are Stanage and Burbage wards at the Michael Carlisle centre in Netheredge, and Rowan and Maple wards at the Northern General Hospital. I have worked alongside staff on the inpatient wards that has enabled me to gain an understanding of the roles and job specifications. This has been achieved by visiting the wards on a weekly basis and interaction and discussion with different staff on the ward. I provide attendance at weekly meetings where the consultant psychiatrist, nurses, care-coordinators, pharmacist, medical students as well as other staff from mainstream settings meet. The meetings allow the staff to discuss patient's progress and any concerns or problems are discussed. This allows all people, both professionals and non-professionals, who have contact with the patient to raise any concerns and issues they may have regarding the patient. This also provides an open and transparent platform for discussion with key focus on the patient and their level of need, both present and anticipated for the future, on discharge from the ward.

Building a key relationship with staff on the wards

The ward staff are beginning to show an interest in my role as well as EPIC and the PMC. They are willing to liaise and work together where appropriate. This allows me to give advice on BME concerns and patient issues, as well as family issues from a cultural and religious perspective. It allows the staff to learn about the Pakistani culture such as halal food, intermingling of the sexes, praying 5 times etc. It allows input into the ward and learning by the staff as well as accommodating needs of BME individuals and their families whilst they are staying on the wards. It makes staff more aware and sensitive of these needs and they should be able to apply this learning to enhance the care of new patients who may enter the wards at later times.

Working with patients, carers and other family members

I have also met with the patients admitted on the wards, and with their families who are visiting them on the wards. On talking to them I have obtained basic information from them, and tried to identify any unmet needs. I have worked alongside Dr Hassan Daudjee to design a tool to collect basic data from the patient, this is still being revised. I have also addressed concerns they have whether whilst on the ward or financial, housing or employment issues they have in their personal lives. Where appropriate I have discussed these issues with the care-coordinator after obtaining patient consent to do this. In cases where the patients do not have care-coordinators I have discussed this with the ward staff and emphasised the urgency of allocating the patient a care co-ordinator. I have also signposted both patients and

their families to appropriate departments such as the Department of Social Security in reference to benefits, the jobcentre for work and colleges etc.

I have reassured patient's families that their loved ones are being cared for in a secure and professional environment. I feel Asian/Pakistani parents have a lot of concerns and fears about treatment on inpatient wards, in particular where the patient is a female member of the family. In such cases I found members of the family staying with the patient 24 hours a day, despite reassurances from ward staff and myself. Here the cultural aspect is so strong that girls are not left by themselves in any case, mothers will stay with them despite hassle and inconvenience to them by doing this. In such cases we need to value the family's wishes and concerns and try the best to accommodate the needs of the individual family. In such cases where it has been appropriate, "Home Treatment" has been discussed with staff and the family, and early discharges made to the Crisis and Home Assessment Team (CAHT).

On talking to patients on wards I have found many of them having a common background. A lot of the patients were married but separated, they were presently experiencing marital problems with their spouse and this was causing them a lot of anxiety whilst on the wards. They had children but with no access at present or very limited access due to the separation and the separate living arrangements of both partners. They further would express their desire to attempt reconciliation and to get back together in a blissful marriage.

Due to the sensitive nature of the issue and not having the other partner's side of the story, I tried to remain neutral to the patient. I acted as a listener to them allowing them to pour out their concerns and work through these themselves. I would only emphasize what they would say by quoting their words at times, allowing them to see things from a variety of angles and not necessarily one way. I feel this allowed them to look at a situation in an unbiased way and attempt to realistically tackle and work through it in a systematic way. A few patients who remained on the wards for a long period of time would stop and talk to me when I visited the wards. They would discuss how they were doing and what things were going well, as well as concerns they may have. They felt they could both trust and confide in me as I had initially taken time out to talk to them about them.

Staffs on the wards have a very difficult yet rewarding job, I feel they are excellent in their roles and often exceed their job descriptions to go that extra mile with their patients. The wards work by collaborative working of all ward staff in a professional and sensitive manner. All staff are equally important and serve a paramount role, the wards would not function as well as they do if the staff were not liaising, networking and valuing each others expertise and opinions. I have become a recognised face on the wards as I am accessing them weekly. Staff are learning about the EPIC project as well as BME patients having at times different needs culturally and religiously in comparison to other patients. Basic human needs are always the same whether you are White Caucasian, African-Caribbean or South Asian or any other ethnicity. Slight deviations occur when patients have slightly different needs

which need accommodating such as special dietary requirements, need for separate prayer facilities etc. Staff will approach me and ask questions about patients and their behaviour or requests, they will require an explanation in religious and cultural context. We will then discuss ways to deal with the situation without causing distress to the patient and causing inconvenience to staff. Issues which have popped up are usually about halal food, praying and ablution as well as recently the need to take shoes off prior to entering a room.

Networking with other resourceful centres

I have also met the Occupational Therapy department and discussed ways we can work together to learn from each other. The department has requested information about Asian recipes, halal food and spices, as well as the need to engage more Asian men in cooking. I have explained the typical extended families where the mother, grandmother, wives and sisters are the main cooks in the house as well as attending to other household chores. The culture did not believe in men cooking, and because many families have always cooked and cleaned for the men the differences in roles in the sexes are deeply embedded in everyone. There are however exceptions and some families, especially the new generation, are engaging the male members in cooking activities. This will take time to combat and develop as, in many families, their views are stringent and they will not allow male members to cook, they do not see a need for this with female members seen as fulfilling this role. However I feel with a rise of male patients on wards they are recognising a need to learn the basic culinary skills as a means of survival and necessity if not one of enjoyment and skill development. I have spoken to male patients on the ward who on discharge from hospital rely mainly on take aways and food from mum or sisters. I feel this is inadequate and have discussed with them the need to cook basic meals as takeaways are not the best nutritionally. They have been uninterested and do not feel there is a problem with the way things are at present. I feel this is an issue which should be tackled gradually in an appropriate manner.

I have also met the Sheffield Mental health Citizens Advice Bureau (SMH CAB), and learnt about their role as well as briefed them on my role. I was given leaflets and advised on ways they could help patients in a variety of good ways.

Working with the Crisis and Home Assessment Team (CAHT)

My work with the Crisis and Home Assessment Team (CAHT), has allowed me to closely shadow Dr Jo Nicholson (Clinical Psychologist) and appreciate her role individually, as well as collectively alongside her colleagues. I have met consultants, Support time recovery workers (STRs), team managers, nurses, Occupational therapists and many other professionals within CAHT. I have learnt to grasp each role and learn how the team work together to fulfil their function and purpose.

Dr Jo and I have developed a procedure where I check the boards for the North and south team on a weekly basis:-

- 1) I identify any Pakistani patients on the boards

2) I check the patient files to identify the recorded ethnicity

3) Where a patient is identified I will talk to appropriate staff and read the file to get an accurate account of the needs and patient and family history.

If staff and Dr Jo Nicholson feel the patient can benefit from the Pakistani Muslim Centre (PMC)² a number of actions may follow;

- leave a note on the file prompting staff to discuss the PMC, arrange visit to the PMC or record a declined PMC from the individual and the family
- Or, if the patient is being given a home visit the staff who are visiting will verbally discuss and record the above, here we will talk to the staff face to face and advise instead of leaving a note in the file.

The note in the file is for cases where there is no home visit arranged on the day the boards are being reviewed. All responses are appropriately documented on the individuals file so they can be reviewed later if necessary.

I have also had the good fortune of accompanying Dr Jo Nicholson on home visits to see individuals, this has included White Caucasian and other ethnic groups as well as South Asian individuals. This has allowed me to learn about her role and how she uses skilful questions and scenarios to gain an insight into the individual, their past, present and any future intentions or ideas and beliefs they may hold. It allows me to watch explorative techniques as well as therapeutic and psychological assessing of individuals in their own homes. It is very challenging as, at times, the individual is in a distressed and uncommunicative state and getting information from them is very difficult. It is more difficult as you are visiting a family home which often has other family members present with their own concerns and issues both in relation to the individual you are visiting and their personal problems. To obtain correct and useful information in a professional and sensitive manner without getting side tracked is a brilliant skill, which no doubt has to be learnt and developed over time.

This part of the work has allowed me to look at the other side and learn about the differences and similarities in the CAHT and inpatient wards. The challenges and problems are different due to the fact patients are on a ward and they have an environment designed for patients like them. Staff are always on hand around the same vicinity and can observe and tackle problems straight away as they happen to deal with them. CAHT, although working in a team, get accounts of the patient after home visits or individual visits to the CAHT site, or liaison with other staff who have recently seen the individual. There can be a time delay in obtaining information and then acting upon this.

² There are a number of reasons why the patient may not be included – prior refusal, need for improvement in mental state prior to introduction of PMC idea, out-of-area treatment, high risk to others. In some cases it is the carer who is the target for PMC link worker rather than the patient (who may have a very chaotic and unstable lifestyle and is not amenable to PMC link).

However CAHT allows individuals to be treated in the comfort of their own home surroundings where often the family system acts as a support factor to promote their recovery. It also tackles fears of having to be hospitalised and alleviates these concerns. At times individuals who are not benefiting, or deteriorate to such an extent that the team feel it is better, they will get referred onto the inpatient wards. Similarly at times the inpatients will be referred to CAHT where it is felt by staff it will be more beneficial to them or the family. The inpatient and CAHT service are excellent in their provisions to individuals, patients and their families. They seek to tackle patient's symptoms psychologically, somatically, personally and socially in the best manner possible. They monitor the patient's medication and progress and ensure the best treatment is given to promote recovery. They ensure appropriate services are accessed on discharge and they work collaboratively with other individuals and groups to ensure continuation in recovery on leaving services, as well as easy integration to the community.

Developments and linking with the Pakistani Muslim Centre (PMC)

All of the patients and families I work with are given information about the PMC and the facilities on offer. Staff who work with the patients are also given this information as it is not always appropriate to talk directly with the patient and the families. When it is felt the patient is well enough to comprehend and take in this information it is then deemed appropriate to introduce the PMC idea. Where patients are too unwell their progress is monitored and the PMC will be introduced later on, each patient is different as is the work that is done with them hence individually tailored to accommodate their needs and well being. I have also been working with carers to offer them respite and time away from the person being cared for.

I am working alongside the consultant Nurse Ms Rashna Hackett to set up a sukhoon clinic at the PMC. This will be a drop in clinic for women to use and discuss and problems or ask questions about mental health and health in general as well. It is anticipated these sessions will commence at the end of March or first week of April. Mr Irshad Akbar has also provided a room to be developed and used for this purpose.

I have arranged introductory visits to the PMC for patients who were interested in using the Gym and joining classes currently on offer. I have been visiting patients at home as sometimes they are not well enough or confident enough to want to go outside. I work with them at home to develop self-esteem and confidence, slowly taking them out on short visits. It is anticipated eventually they will be well enough to come to the PMC and make use of their resources.

Other developments

We are working to develop services at the PMC and are organising a Women's health day to promote awareness of health issues, which will include mental health as well. I will be developing the Sukhoon Clinic support group. My co-worker Mr Matloub Husayn-Ali-Khan is currently doing good work with the male patients. He is also hoping to develop support for the male group in a capacity which he feels most appropriate to their requirements.

The EPIC project won an award at the Delivering Race Equality (DRE) Conference in Coventry last week. This has been very welcomed and gives encouraging feedback about the impact of the project and the good work by all involved with the project. It also allows a foundation to develop this project and others to assist the Pakistani community, and even expand to other BME groups by learning and applying findings from this project to others in the future."

4.3.1 Pathway Data from PMC Link Worker

Table 4 and Table 5 show data from October 2006-February 2007 that has been collected by the PMC Link Worker:

Table 4: To show contact/activity data for the PMC Link Worker

<i>PMC Link Worker Type of contact/intervention October 2006 – February 2007</i>	<i>Number of patients</i>
Patients identified for early discharge from wards to CAHT	3
Patients given home visits to offer respite to carers	2
Interest from other voluntary organisations since EPIC	3
Interest from other statutory organisations since EPIC	2

Table 5: To show further data relating to Link Worker Activity

Date	Patient identified on ward (visit to PMC)	Patient identified in CAHT (visit to PMC)	Service user visited at home (visit to PMC)
October 2006	0	0	0
November 2006	7 (*3)	1	0
December 2006	2	2(*1)	0
January 2007	5(*1)	2	0
February 2007	8 (*1)	3	2(*1)
March 2007	6 (*1)	1	3(*2)

* Patient who visited the PMC, either for a single visit or more visits.

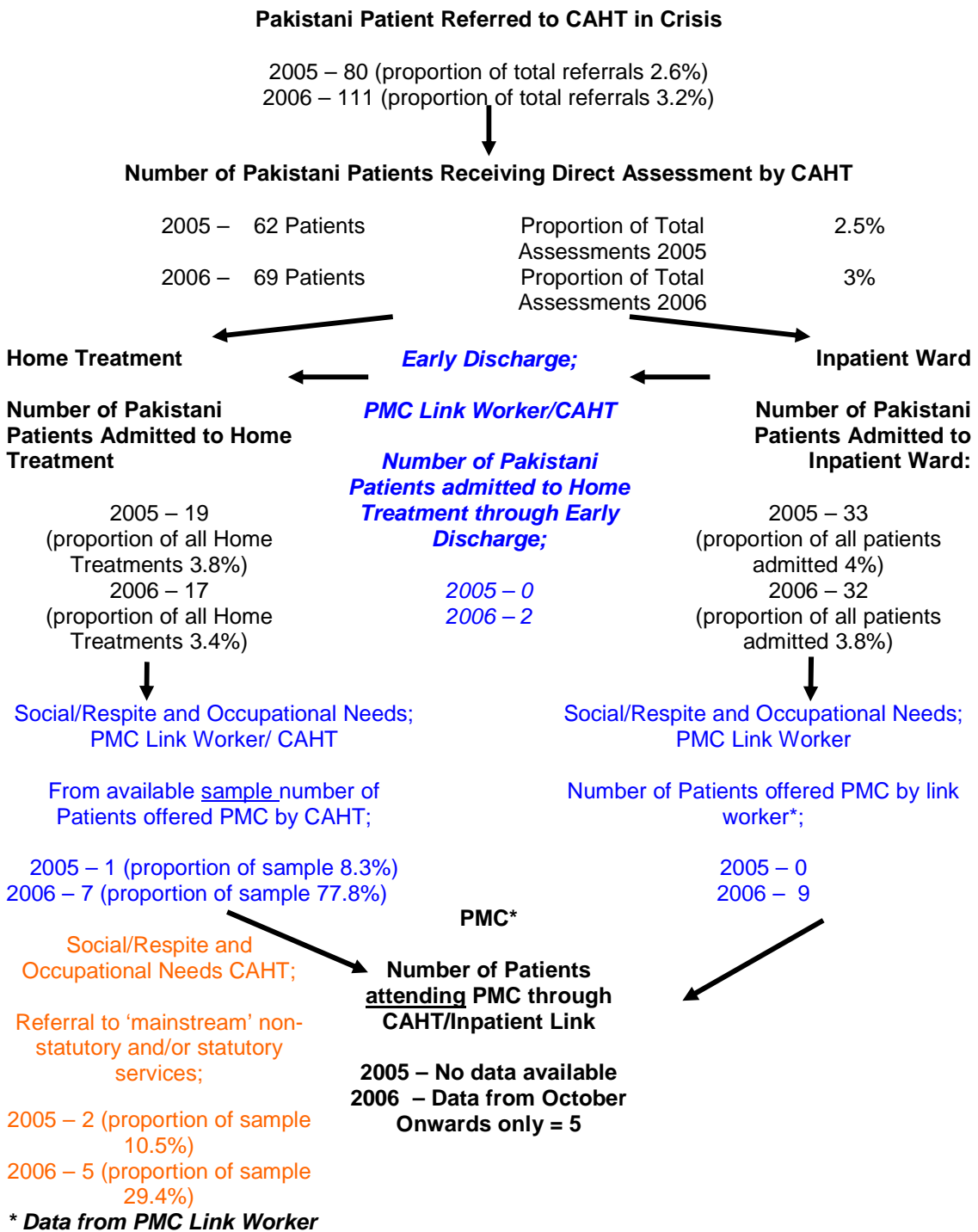
Other notes relating to table 5 above, provided by the PMC Link Worker;

- Where patients were identified on the ward first and later at CAHT they have only been included on the ward list once. Bear in mind patients were in contact whilst on the wards long term, this usually was longer than the single month where they were first admitted on the wards.
- Service users visited at home were patients referred by St Anne's day service, CAHT and lastly by the Clinical Psychologist Service

4.3.3 Pathway Data – from Internal CAHT Audit and Review of Inpatient Data

Diagram 2, below, shows summary data for the EPIC intervention.

Diagram 2: Pathway by Year for Pakistani Patients



4.4 'Standards of Care' Audit Checklist

At the point of analysis it became clear that, particularly with such small n's, comparison of pathway between groups using the tool devised did not yield useful information. Analysis revealed huge discrepancies in the standard of note keeping from individual 'case' to individual 'case – but no discernable trends by group were observed and the amount of variability case by case meant the audit tool served best to illustrate problems in quality of note keeping across the board rather than the tool having utility for the task in hand – i.e. to discern potential differences in quality in processes and procedures of care for specific groups.

As the project was subject to a developmental process of refinement (i.e. increasing clarity regarding the focus and specificity of intervention), that was not mirrored by changes in the audit tools, the audit tool was found to have limited utility for the emerging purpose of the EPIC project. Therefore, within this report the detailed findings of notation compliance to the standard checklist are not reported here – as they simply present unnecessary 'noise' that does not reflect core purpose of the project aims. All the useful data has already been presented within Table 1 above.

4.5 Inpatient Demographics

As previously discussed, nationally the rates of admission for particular BEM communities are elevated as compared to the proportional population data. However, nationally the rates of admission for Pakistani are lower than the national population proportions (Health Care Commission, 2005).

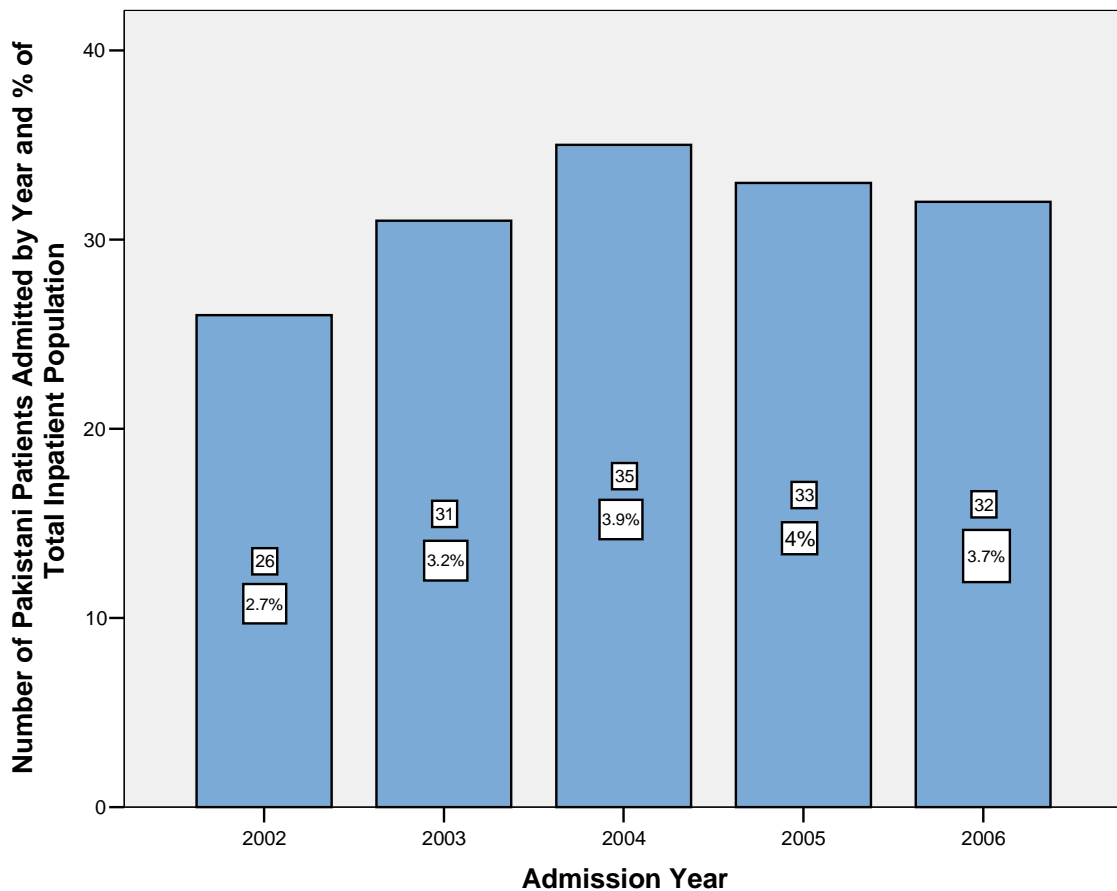
The Healthcare Commission (2005) found that, in a 'snap-shot survey' of psychiatric inpatient services, whilst 79% of inpatients were White British, 19% were from Black and minority ethnic groups. This contrasts with the national proportional rates for ethnic origin were White British is 91% and BEMs is 9%. However, within the survey it was found that for Pakistani inpatients the proportional rate was lower as compared to the national average. For Sheffield, the survey found 84.8% of inpatients were White British and 15.2% were from a BEM group and 2.7% were from a Pakistani background.

Summary data relating to inpatient for Pakistani service users are presented in Table 6 and Graph 1 below.

Table 6: To show inpatient data by BEM groupings

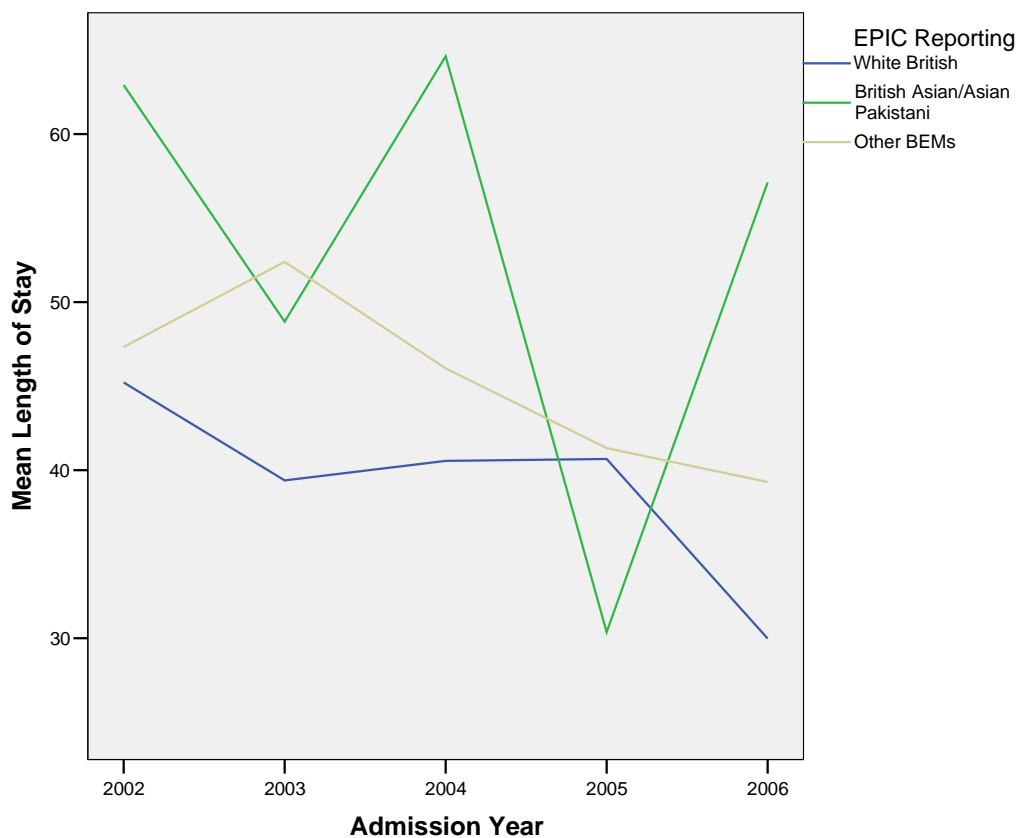
	2001 Census – Population by Ethnicity Sheffield	Sheffield Inpatient Admission Rate 2005-2006	National Count Me In Survey - 2005	Sheffield Count Me In Survey - 2005
Ethnicity White British	89.1%	78.5% (1318)	79% (26762)	84.8% (251)
Black and Ethnic Minorities	10.9%	21.5% (361)	19% (6576)	15.2% (45)
British Asian/Asian Pakistani partitioned out from BEM Group	3%	3.9% (65)	1% (325)	2.7% (8)

Graph 1; To show numbers and proportional percentages of admissions to the acute inpatient setting for Pakistani patients across a 5 year period



A further measure of outcome for EPIC, relating to the inpatient dataset, was length of stay, which was intended to be a measure of success for the CAHT Early Discharge program. The average lengths of stay by ethnic group across 2002-2006 are presented in Table 7, below. From Table 7 we can see a larger degree of variability and an overall longer length of stay for the Pakistani group, as compared to the other ethnic groups. All groups, however, would show an overall trend (smoothing variability) for reduction in length of stay across the 5 year period. It should also be noted that as these lengths of stay include admissions to substance misuse beds, academic and learning disability beds interpretation is difficult without further investigation that is beyond the resources of this project.

Table 7: To show average length of stay by ethnic group



The Sheffield CAHT audit also has data relating to diagnostic group by ethnicity. However, this data set is unwieldy to present within this particular report but, again, will be hopefully submitted for publication in the near future. Unfortunately, the information relating to compulsory detention from the Sheffield clinical information database, was found to be unreliable and this data was therefore not available within the given resources.

5. Discussion

Clinical and Social Demographics

The largest ethnic minority group in Sheffield is the Pakistani group comprising 3% of the total population. Whilst the Pakistani group is found to have a high incidence of long-term limiting illness, nationally the Pakistani group is found to have low admission rates both proportionally to national averages and as compared to other BEM groups. From the national 'Count Me in' Survey Sheffield reported that 2.7% of the overall admitted population on a single-day was Pakistani. The admission rate for the Pakistani group across 2005-2006 was 3.9%, with 3.6% of all home treatment episodes being from the Pakistani group. The access rates to the CAHT for the Pakistani group is a proportional elevation compared to the base population rate that is observed across all BEM groups and being comparable to the inpatient rates indicates the service provides equitable access to BEM communities suffering acute crisis.

The Sheffield CAHT service shows good clinical and social outcomes for the majority of service users but has greater rates of improvements for those from a BEM group. When Pakistani service users were partitioned from the clinical outcomes sample they showed enhanced improvement rates as compared to other BEM groups (as a single category).

The CAHT service is currently analyzing and interpreting deprivation data relating to service access and ethnicity, whilst this data is not available for this report, it will hopefully be made accessible through journal publication in the near future.

CAHT and Inpatient Activity

The PMC Link Worker provides a descriptive account that shows the richness learning, collaboration and reciprocal contributions across the course of the project. The quantitative data provided by this worker also illustrates the rolling momentum, across a relatively short period of time. Such work will necessarily be developmental and accumulative and the most important contributor will be the continuing enthusiasm and support of staff in a cyclical program of support and (re) invigoration.

The pathway data from CAHT and inpatient services shows that whilst there are minimal fluctuations in access rates to both services the Early Discharge flow, and the flow to PMC is significantly improved. Whilst the numbers are small, the dramatic difference to quality of life and function that can be afforded by community support and access cannot be underestimated. Reduction in isolation, increase in opportunity and access can all make a critical difference in the individual pathway to recovery. Further, there were marked improvements in 2006 in access for CAHT Pakistani service users to statutory day services and alternative non-statutory services (usually when refusing PMC – 71% refused PMC offer - and then being offered a mainstream alternative). Therefore, the EPIC project had served to highlight and put the social and occupational and

needs of this vulnerable group high onto the agenda of staff working within the CAHT service, facilitating referral onwards to community based support services.

Standards of Care Audit Checklist

A major finding of the audit project was the fact that the audit tools developed did not match the developmental task of refining and defining the project scope as enacted within and between the CAHT service and the PMC. Much of the data gathered from the audit tool employed that was (supposedly) specific to the CAHT-PMC pathway was redundant and is simply not reported here. The audit tool had good utility/fidelity as a tool to audit quality of record keeping and clinical notation but in terms of specificity was cumbersome and had poor utility to measure potential improvements in the CAHT-PMC pathway. Particularly, the measure employed had poor utility to measure improvements in clinical detail (and hence quality) of the pathway for the individuals receiving Home Treatment care and their access to the PMC.

Generally, the observation from this audit must be that improvements in documentation need to occur across all patient groups. In the process of gathering the information from the notes, it was frustrating to see important care elements being delivered (as gleaned from the daily records) but not documented within the care plan itself. It was also frustrating to recall and be aware of important clinical interventions being conducted (especially psycho-education to the patient and/or carer) but this not being clearly documented within the notes.

Inpatient Demographics

Aside from the inpatient data already commented upon trends for length of stay were presented. The results were difficult to interpret, especially considering the data included admissions to substance misuse beds, academic and learning disability beds and further analysis was beyond the resources of the current EPIC team. The broader Sheffield CAHT audit programme also has data relating to diagnostic group by ethnicity. However, this data set was too unwieldy to present within this particular report but, again, will be hopefully submitted for publication in the near future. Unfortunately, the information relating to compulsory detention from the Sheffield clinical information database, was found to be unreliable and this data was therefore not available within the given resources.

Recommendations/Process Reflections

The findings of this audit project cannot be interpreted in isolation from the process of developing a robust EPIC focused intervention within/between CAHT and PMC. Therefore within these recommendations, process reflections must necessarily be discussed and highlighted.

- The CAHT service already had a commitment to equity issues (as reflected in readiness of existing audit strategy that could monitor

outcomes specific to EPIC project). This is an important point to consider because in terms of pragmatics the EPIC audit integrated well to existing deployment of resources (i.e. existing commitments) and process (i.e. the hearts and minds of senior clinicians and managers were readily orientated to the EPIC initiative and this facilitated a willingness and embracing of the project, without which, it may have taken even longer to get off the ground)

- Developing audit tools (specifically the 'Standards of Care Checklist') early gave us a framework, but they had limited utility in measuring meaningful outcomes across the developmental life of the project. The main message relating to the checklist measure is - don't bother using tool unless you want to audit quality of note keeping!
- New audit tools with good specificity to measure quality of the CAHT-PMC link are in development currently and improvements to facilitate audit are already in place (i.e. audit will be facilitated through Standardized Care Plans that record initiation and outcome of the CAHT-PMC link)
- Resources anticipated that a quantitative tool would be the best management strategy in maximizing information within limited resource capacity – but the audit was still extremely time consuming because it involved detailed case-note reviews. With the benefit of experience and hindsight we would have had a better data set, for the same resource expenditure, if we had used a qualitative method
- Within BEM focused studies, with quantitative data, small numbers tend to confound comparisons– this is a constant issue
- There are achievements we would want to highlight here that are not captured by simply reporting the quality/improvements in PMC-CAHT link – i.e. even though the checklist audit tool had poor utility, through dissemination of the tool, presentation of audit strategy across the Trust debate was stimulated and other workers developed a very effective tool (based on the checklist idea) that has been successfully implemented in the inpatient area (see Appendix 3)