B11 Psychological Therapies Performance

1. Introduction

NHS Dumfries and Galloway has been unable to achieve the psychological therapies heat target since its introduction in 2014. This paper outlines the current challenges and the strategies being employed to tackle the challenges.

2. Recommendations

1.1 *For HSCMT to note the challenges faced by the Psychology Department*
1.2 *For HSCMT to note the current strategies to tackle these challenges*

3. Background

The Psychology Department has an ongoing shortfall in the service's capacity to respond to the demand for psychological therapies within the HEAT standard of eighteen weeks, (B11 Psychological Therapies Waiting Times, see quarterly IJB performance reports)

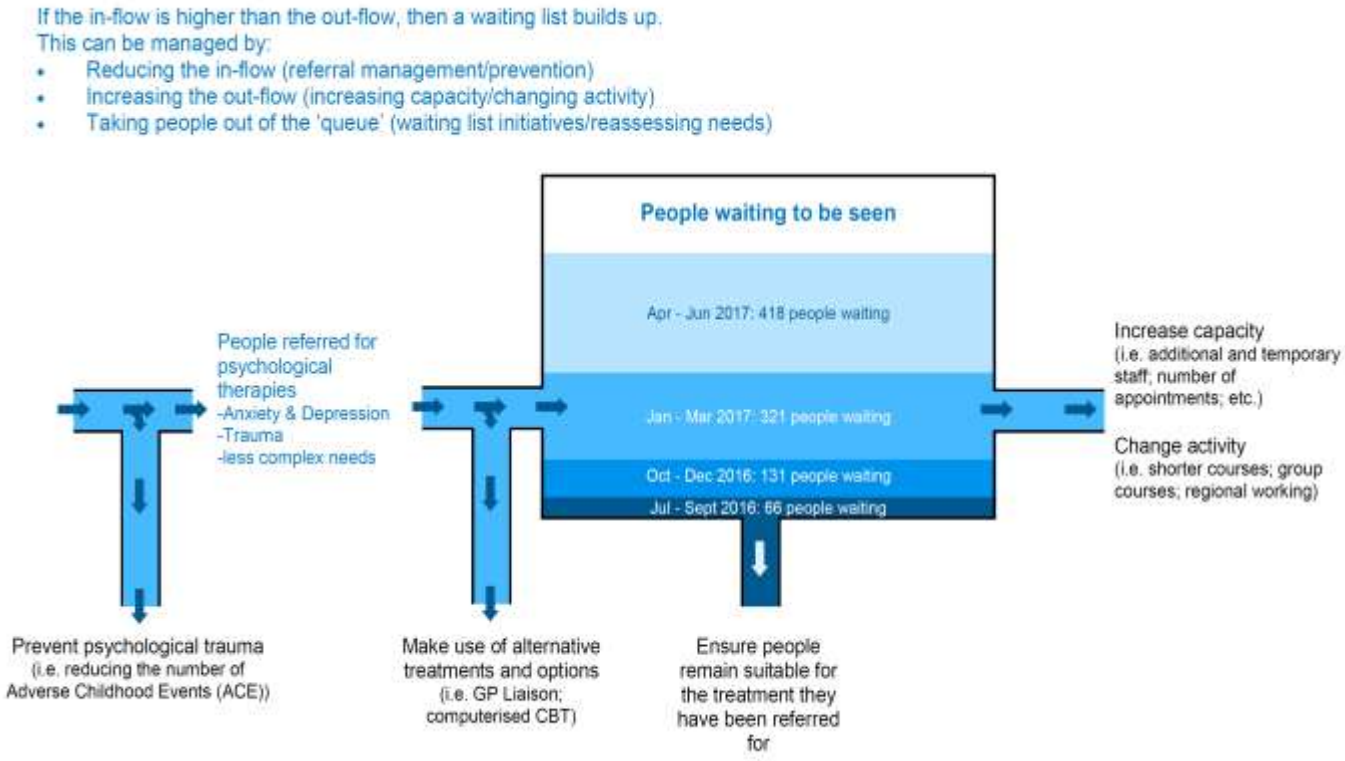
Compliance with the HEAT standard remains below the expected standard. Since December 2014, the average compliance is 69% and currently sits at 71%, (the target being 90%). This equates to approximately 150 people a month experiencing waits over 18 weeks.

The demand for psychological therapies has consistently outstripped the service's capacity to respond in a satisfactory and timely manner despite previous increases in staffing. The introduction of the HEAT standard in 2014 led to comprehensive revision of our work to ensure that management of the demand is as effective as possible. Despite this, referral rates remain high. This demand has been consistently higher than the national average and is currently nearly twice the Scotland average referral rate. NHS Dumfries and Galloway has referral rates three times some of the other equivalent mainland boards.

4. Main Body of the report

There are different approaches to managing services where the queue has become challenging. These include demand management, increasing capacity and changing levels of activity (e.g. offering shorter courses of treatment).

Demand and Capacity Management



Demand management

There are approaches to reduce demand for the service, which entail diverting people to more appropriate pathways, challenging referral thresholds and clarifying the service offered so people make informed referral requests.

Three strategies currently being progressed are:

- Primary Care Psychology Liaison Service
- Formulating the challenges of frequent attenders to Primary Care
- Computerised CBT (cCBT**)**

To manage the demand prior to referral, we have used the Scottish Government money to trial a number of intiatives

Primary Care Psychology Liaison Service - Enhancement of primary care capacity to deliver moderate intensity, evidence-based psychological interventions

General Practitioners often cite their biggest challenge is patients who attend their surgery with psychological difficulties who are unlikely to make effective use of existing psychological therapies provision. We know from our own data that those

who complete psychological interventions have better outcomes but traditional models of therapy do not suit everyone.

GPs have identified the need for psychological practitioners, based in primary care, who can actively guide and facilitate people with moderate psychological difficulties. These clients, who often do not meet the referral criteria for existing services could also be directed to a wider variety of mental health-enhancing activities or 3rd sector resources.

The new Mental Health Strategy outlines work with primary care as an important aspect of mental health care and boards are expected to be demonstrating the use of resources linked to primary care by 2018/19.

We are currently trialling a service within 2 GP practices who have are keen to have a mental health service in primary care to complement existing community support workers. The psychological therapist oversees all initial psychological assessment and formulation of mental health difficulties. Where appropriate, they would create an intervention plan which would identify need for mental-health enhancing resources online or in the local community supported by support workers. The assistant psychologists would deliver the intervention plans and work closely with GP staff.

Impact

Over the past 5 years, on average, 228 people fail to opt-in to the service and a further 316 people failed to attend their first appointment. This indicates that referral to our service may be not be the client's priority at that time. Whilst these numbers are reducing, work at primary care would reduce these numbers further. This would also be entirely in keeping with the new Mental Health Strategy.

Anecdotally, there has been a significant reduction in the referrals in one locality following the introduction of the Liaison Service. However, this is very early days and further evaluation and analysis is needed.

Outcomes:

- Evaluated trial of response to unmet psychological need for people whose difficulties cannot be met by existing mental health services.
- Reduction in number of inappropriate referrals to psychology, as well as a reduction in the number of people who drop out prematurely from talking therapy.
- Early interventions that prevent psychological distress culminating in unnecessary referrals to other secondary mental health services.

Formulating the challenges of frequent attenders to Primary Care

Frequent attenders at primary care with mental health difficulties are a challenge for the already stretched services and staff. The priority is to ensure they receive the care that they need without compromising the care of others in equal need. Frequent attenders often present to different staff members prompting an inconsistent and variable response to their needs. In addition, this leads to increased referrals to psychology and other secondary mental health services, for individual therapy.

This proposal includes the application of well evaluated work in the Emergency Department in DGRI and the Galloway Community Hospital. This work has involved creating a shared understanding of an individual's needs by using a psychological formulation. It also includes a shared action plan for future presentations. We now want to utilise this model and offer the same psychological perspective on the reasons people may frequently attend and use GP services. This would be trialled in the large Dumfries GP practices, who are high referrers to Psychology and have high levels of frequent attenders for psychological difficulties.

In addition, the postholder would also work with the GP practices to scope demand and the reasons for high demand as well as to look at the impact of their service users presentations on referral rates to Psychology.

Impact

Our two highest referring practices refer approximately 70 clients a month. This is a significant amount of clinical and administrative time for GPs. A proportion of these are clients who have been referred numerous times with limited success. GPs time is taken up with seeing clients frequently often referring for unnecessary tests and interventions.

Outcomes

- Reduction in unnecessary assessments or interventions.
- Improve understanding of reasons why people frequently attend GP services
- Improve consistency of management
- Scope demand and reasons for variance in referral rates by GP to inform future service plans.
- Reduce workload for GP practice staff.
- Improve patient experience

Computerised CBT (cCBT)

A recent European study has identified that cCBT is an effective way for clients to access evidenced-based psychological therapies utilising new technologies. A number of health boards are now using cCBT and are reporting it to be of benefit. The trial included people with mild to moderate difficulties who reported having chronic psychological difficulties. cCBT is included in the new Mental Health Strategy currently out for consultation and it is expected that Boards will be offering access to cCBT by the end of the 2017/18. cCBT is an eight session model and would add to our existing tiered model of service delivery, offering psychological therapy between the existing services of Self-Help service and psychology therapists.

Impact

Since starting to accept referrals from May 2016, nearly 100 people have already been referred. Whilst it is anticipated that cCBT will generate referrals that would not previously have been referred, directing even 30-50 people a month to cCBT would make a significant impact on waiting times and access for those who need psychological interventions.

Outcomes:

- Resource for GPs for people with mild to moderate psychological difficulties which allows access to guided CBT in home and community settings.
- Waiting times for psychological interventions are reduced.
- Those who go on to need further psychological therapy are more likely to make good use of the intervention as they have been socialised therapy already.
- People who use cCBT enhance their capacity to cope with psychological difficulty as evidence by outcomes from national research.

Increasing Capacity:

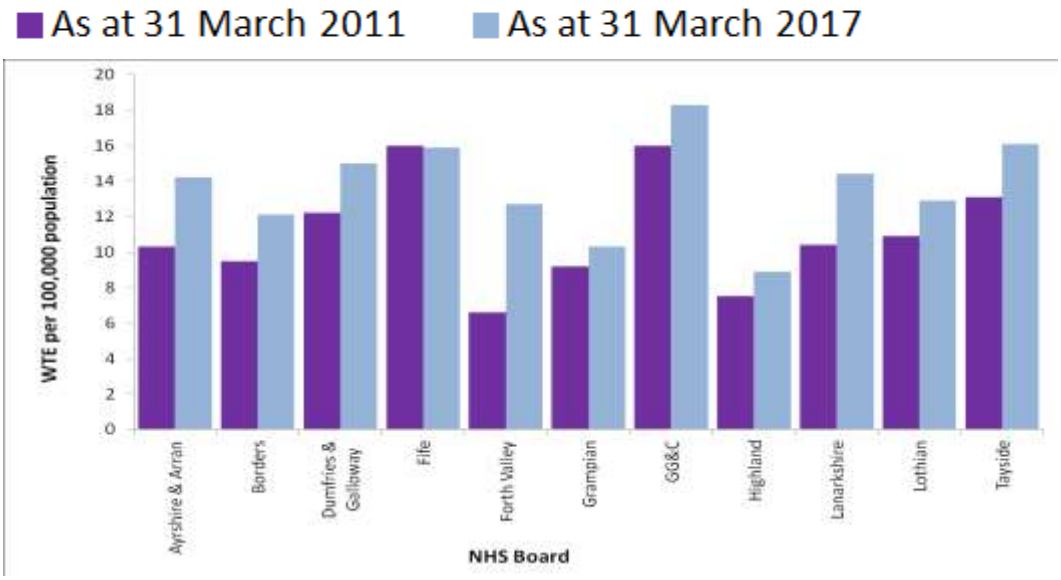
There are several approaches to increasing the capacity of the workforce:

- one is to recruit additional staff,
- another is to employ locum staff from an appropriate agency
- another is to transfer care of some people on the waiting list to other providers such as other health boards or third sector organisations (waiting list initiatives)

The current workforce is running under capacity due to unfilled clinical psychologist vacancies and having staff on long term leave. Recruiting to cover long-term leave is not feasible. There are no suitably qualified clinical psychologists living within commuting distance of our service who do not already work for us. Staff usually relocate to Dumfries and Galloway and usually only for permanent posts. Recruitment of psychologists to short-term posts has never been successful.

We have endeavoured to increase our workforce using skill mix; nurses, psychological therapists. However, the demographic and need of those waiting requires the skills and expertise of a clinical psychologist. Those waiting are experiencing high levels of complex trauma (More here from Toby) and this requires high intensity, psychological interventions that can only be offered safely by experienced clinical psychologists.

Due to the demographic of our workforce, many have caring responsibilities and therefore request to reduce their hours on a permanent basis. These small part-time hours have not been utilised as there are no part-time staff who want to work additional hours. However, we now have sufficient hours to make up 1 wte equivalent post from these hours alone, and this has just been advertised. Other clinical psychologists' posts are being advertised but have not been successfully recruited to, to date.



Vacancies across Scotland are currently 57 wte with 28 of these being replacement posts. Due to the recent mental health funding announced by the Scottish Government a number of health boards have advertised a large number of new jobs and last quarter there were 26 wte new vacancies advertised across Scotland. Therefore there is competition from other boards for new staff.

Current recruitment plan

We are currently exploring whether locums may be a way to fill vacancies on a temporary basis. However, unlike general medicine, staff need to see a patient fortnightly for 4-6 months to complete treatment, with a caseload of 30-40 clients at any one time. In order for a locum to be of benefit, we would need to appoint one for a minimum of 6-9 months for them to complete treatments and to be of benefit to the service.

We have staff returning from long term leave who are being deployed in localities with the longest waits and highest vacancies. We have also moved staff to cover areas of greatest need.

Transfer care of some people on the waiting list to other providers such as other health boards or third sector organisations.

Other health boards are in similar positions to us in terms of demand and/or capacity and are unlikely to be able to absorb additional demand at this stage. However discussions with neighbouring health boards are scheduled for later in the year.

There are few third sector agencies who are able to offer psychological therapies to the level needed to meet the needs of those waiting in our service. Those with less complex difficulties are seen within our Self-Help service which has no waiting time. Psychology work with the Third Sector in the following ways:

- Psychology is working closely with Support in Mind in relation to cCBT. Support in Mind is providing venues and computer access for clients who either don't have access at home or don't wish to do so. We are working on

how clients can also access the additional services that Support in Mind also have to offer.

- We have links with other third sector agencies such as Carers Centre, Women's Aid and Relationship Scotland. Psychology have encouraged General Practitioners to consider referral to the Third Sector before considering a psychology referral. GPs cite a number of concerns about referring the Third Sector. They do not feel they have enough knowledge of these services as the criteria or pathway change frequently and GPs do not feel able to keep up to date with this. They also cite concerns about the governance and safety, governance and quality assurance of services and they do not have the time to explore this in more detail. GPs would rather refer to Psychology and for us to see and signpost on if appropriate. We do advise GPs to re-direct referrals, where more appropriate services are in place and we have good working relationships with such as Women's Aid or Carer's Centre. Psychology would not be comfortable referring onto an external agency without having assessed the person first, but this could mean a substantial wait.

Changing the levels of activity:

Another approach to managing the challenging number of people waiting for treatment is to handle the activity in different ways, for instance:

- capping the number of sessions each person attends
- engaging with people on the waiting list to ensure they are willing to undertake the treatment being offered
- changing the model to more group work

We have capped the number of sessions that people are offered in line with the best evidence. Evidence suggests that the most therapeutic gain is achieved at session 6-8. However, cases are reviewed on an individual basis and further sessions are offered if clinically indicated. Ending therapy prematurely leads to re-referral in a number of cases.

Clients are opted-in to adult mental health service at various time points. Whilst opt-ins help to check that people are still in need, the over-use of opt-in can lead to client dissatisfaction. Despite regular opt-in the non-attendance rate to first appointment is unacceptably high. Further work is ongoing looking at technology solutions to our opt-in system using Florence. This would reduce the administrative processes used in the current opt-in system but may be more acceptable to clients and reduce dissatisfaction.

Staff are trialling a number of group-based interventions targeted at specific groups who make up a proportion of the waiting list. Those with trauma histories and those with 3 or more episodes of depressions are referred to a group relevant to their respective issues. Those with trauma are still likely to need individual therapy but are more likely to attend and make good use of the therapy offered. Early results for the depression

groups, show that the majority do not require further treatment. However, caution is needed for rolling-out groups. The setting up of groups is labour intensive and the correct group mix is hard to achieve in very rural parts of the region. Therefore groups may not be suitable for all localities.

Further work

We are continuing to work with our data analyst from ISD and Health Intelligence to explore our data in more detail. We are currently looking at locality specific data in relation to our non-attendance rates and re-referral rates.

We have a non-attendance policy that those referred are made aware of at referral and again when first appointment is sent out. Our non-attendance rate for first appointment is higher than we would like (20%) and the drop-out rate by session 3 is high (35-50%). Some localities have a high re-referral rate, probably caused by previous non-attendance or drop out. We are working with our referrers to ensure the right clients are referred at the right time to ensure they can make best use of the referral when its made.

SECTION 2: COMPLIANCE WITH GOVERNANCE STANDARDS

5. Resource Implications

5.1. See main body of the paper. No current cost pressure anticipated as use of locums and recruitment is within budget.

6. Impact on Integration Joint Board Outcomes, Priorities and Policy

The risk of not meeting the B11 Psychological Therapies Heat Standard is that this put the Intergrated Joint Board under pressure from the Scottish Government

7. Legal & Risk Implications

7.1. Currently there are risks in the length of time that service users are waiting to be seen. There is a chance that clients may become more unwell whilst waiting which may lead to an increase in suicidality and risk-taking behaviour.

8. Consultation

8.1. Not required at this stage

9. Equality and Human Rights Impact Assessment

9.1. Not required at this stage

10. Glossary

12.1 HEAT – Health improvement, Efficiency, Access to services and Treatment
CBT – Cognitive Behavioural Therapy
WTE – whole time equivalent