

BOARD MEETING

28 July 2016

Paper Title:	Psychological Therapies Update
Section:	Private
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Agenda Item:	12
Presented For:	Assurance

1.0 Purpose of this Report:

The purpose of this paper is to update the Trust Board about ongoing challenges around access to psychological therapies (particularly Steps 4&5 services). This paper refers to access in Adult services. The paper describes the ongoing mitigations in place to support these challenges. It also updates the Board on capacity and demand analysis work being undertaken in the Trust's Psychological Therapies services.

This paper follows a deep dive into (Steps 4&5) Psychological Therapies presented at the Trust-wide Quality and Safety Committee (March 2016).

The paper briefs the Board on

- Current risk management and mitigation around demand for services
- Ongoing capacity and demand analysis work within psychological therapies.

2.0 Summary of Key Points

- Sizeable waiting lists and lengthy waiting times for psychological therapy (Steps 4&5)
- Update on Improving Access to Psychological Therapies Services (IAPT - Steps 1-3)
- Summary of Capacity and Demand analysis work (Steps 1-5)

3.0 Board Consideration

The Board are asked to acknowledge the current challenges around access to psychological therapy services, the current mitigations in place to support management of these challenges and the expected outputs of the ongoing deep dive capacity and demand analysis work.

4.0 Financial Implications

Dependent on the findings of the project there may be implications for further investment. This would relate to any outcome which identifies the service is under commissioned and requires additional resource.

5.0 Legal Implications

None

6.0 Assurance

	Assurance provided?
Board Assurance Framework	No
CQC Themes (see below)	Yes
Monitor Risk Assessment Framework	No
Other (please specify):	

This paper provides assurance in relation to the following CQC Themes:

Safe:	People who use our services are protected from abuse and avoidable harm
Caring:	Staff involve people who use our services and treat them with compassion, kindness, dignity and respect
Responsive:	Services are organised to meet the needs of people who use our services
Effective:	Care, treatment and support achieves good outcomes, helps to maintain quality of life people who use our services and is based on the best available evidence.
Well led:	The leadership, management and governance of the organisation make sure it's providing high-quality care that is based around individual needs, encourages learning and innovation, and promotes an open and fair culture.

Assurance re CQC Themes

CQC themes have been considered and the areas pertinent to this work are the domains of safety, effectiveness and responsiveness. Particular CQC key lines of enquiry would be Safe S4 (clinical risk assessment), Effective E4 (staff working together), E5 (staff having relevant information to work effectively), Responsive R1 (care to be planned), R3 (care to be timely), and R4 (responsive to concerns and complaints). Given that much of the work has been triggered by concerns over waiting times the CQC "Responsive" domain will be an important focus

7.0 Previous Meetings/Committees Where the Report Has Been Considered:

Highlight whether the paper has been discussed at any of the following meetings by placing a tick in the relevant box(es):

Audit Committee	<input type="checkbox"/>	Service Governance Committee	<input type="checkbox"/>	Remuneration Committee	<input type="checkbox"/>	Resources Committee	<input type="checkbox"/>
Executive Management team	<input type="checkbox"/>	Directors' Meeting	<input type="checkbox"/>	Chair of Committees' Meeting	<input type="checkbox"/>	MH Legislation Committee	<input type="checkbox"/>

8.0 Risk Issues Identified for Discussion

The risk being addressed by the ongoing work is that of lack of timely access to services due to lengthy waiting lists for psychological therapy.

9.0 Links to Strategic Drivers

Patient Experience	Quality	Value for Money	Relationships
Brief reference in each section about how this paper affects our Vision and Transformation agenda.	No Health without Mental Health- improve outcomes for people with mental health problems through high quality services that are equally accessible to all	Five Year Forward View- More accurate recording and widespread linking of patient-level activity, cost and quality data will make it easier for providers to manage their services for patients effectively and efficiently and also improve the payment system in patients' interests.	

10.0 Publication under Freedom of Information Act

- This paper is exempt from publication under Section 43 of the Freedom of Information Act, as it contains information which is commercially sensitive.

11.0 Recommendations:

The Board are asked to acknowledge the current challenges around access to psychological therapy services, the current mitigations in place to support management of these challenges and the expected outputs of the ongoing deep dive capacity and demand analysis work.

Psychological Therapies Hub

1.0 Background & context

1.1 The Psychological Therapies Hub (PTH)

On Friday 18th March 2016 the Psychological Therapies Hub Deep Dive was presented at the Trust-wide Quality and Safety Committee. This presentation discussed previous re-design of the psychological therapies service with the creation of the Psychological Therapies Hub (implemented FY15/16).

The previous re-design was mainly a design which addressed the “form” of the service. As demand for services has risen it is now necessary to consider further re-design of services, the main focus of which is to scrutinise the “function” of the services in more depth.

The significant challenge faced by the Psychological therapies hub is the length of time service users are waiting to commence therapy (steps 4&5).

Data from June 2015 demonstrated excessively long waiting times for access to steps 4&5 psychological therapy, the range being between 4 months and 27 months with an average wait of 16 months.

Increasing referrals, both via direct referral to steps 4&5 and also via upward triage from IAPT services (steps 1-3), has potential to worsen the current lengthy waits.

1.2 Current Mitigations and Risk Management

1.21 Centralisation of waiting lists

The referral pathway and waiting list for steps 4&5 psychological therapy has been centralised. This provides transparency around how many referrals are received, how they are being managed and the actual overall waiting times. Essentially it allowed the implementation of a level of governance of waiting lists which had not previously been in place. This mitigates risk by ensuring that there is only one central list which is easier to monitor and enables staff to better prioritise urgent cases if extra information is received.

1.22 Multidisciplinary Screening and Case Discussion

As part of this process multi-disciplinary screening and case discussion was introduced. The purpose of this is to give consideration to the most appropriate onward referral pathway for individual referrals so that we can ‘target’ people to the least intrusive, shortest available therapy option and methodology. This also supports triage to ensure that patients with higher levels of need are prioritised. It mitigates risk by reducing the chance of people being passed from therapist to therapist and increasing the chance of “right treatment, as soon as possible”.

1.23 Introduction of Waiting list Group work

The development and introduction of waiting list group work (in addition to groups which already operated in the Helios Centre) has progressed. Group work is now offered to people who have been placed onto waiting lists for individual therapy (following initial assessment).

Group work focuses on improving people's coping strategies via provision of peer support and peer challenge elements of therapy, both of which can assist maintenance of wellbeing and / or promote efficacy of therapy.

This additional Group work also mitigates risk of lack of access by supporting the better use of limited service capacity.

Brief Intervention psychological therapy delivered via group work for people on waiting lists can help to reduce reliance on crisis based services e.g. First Response, Intensive Home Treatment Team and inpatient admissions. This can be via supporting individuals to undertake preparatory work prior to them entering more individualised intensive and longer term therapy programmes.

Additionally, during this preparatory period signposting to other support services e.g. MIND, BAMHAG, Benefits Advice services, Carers Hub can also be assistive in supporting stability and wellbeing for individuals and their carers whilst they await more intensive courses of therapy.

In short, the waiting list group work mitigates risk by ensuring that people receive some level of service while waiting for individual therapy and therefore they are not left receiving no support. It also provides further opportunity for the service to monitor ongoing clinical risk.

1.24 Monitoring People on the Waiting List

The hub has already reviewed the people on the waiting list to establish which people receive ongoing support and monitoring from other BDCFT secondary care services e.g. CMHTs.

1.3 Capacity and Demand Analysis Work

Since the deep dive presentation a steering group has been established to further consider the capacity and demand challenges of the services. It is led by Allison Bingham.

The steering group have commenced a Capacity and Demand Analysis work to analyse the current situation regarding capacity and demand within the services (particularly Steps 4&5).

The steering group has representation from clinicians, Head of Psychological Therapies, management from all levels of therapy services, project management support, performance/IT support and service user representation.

The steering group meets monthly with ongoing work and meetings as required between meetings.

The project seeks to provide clarity on the following 3 questions:-

Is the psychological therapies waiting list a result of:-

1. Under-commissioning and, if yes, to what degree?
2. Lack of throughput – are there culture and practise issues which result in lack of throughput?

3. Is it a combination of the two factors above? If so what split?

Possible outputs of this work may be as follows:-

- A case for additional CCG investment based on evidenced under commissioning of the current service.
- A case for additional CCG investment based on projected increases in demand
- Implementation of additional system and process improvements to optimise deployment of available capacity and to realise more timely access to services (Steps 1-5).

It is also plausible that a combined output of the above measures is appropriate (e.g. some additional CCG investment required to meet current/future demand alongside different standard operating procedures within services).

2.0 A System-wide Approach (Stepped Care)

Although the deep dive for the Q&S committee and the current capacity and demand analysis work have an apparent focus on the Psychological Therapies Hub, the project has adopted a system wide approach.

A key issue to highlight is that the hub service operates alongside other adult mental health psychological therapy services, notably the Trust's IAPT teams (Steps 1-3).

This is an important issue because demand for the hub service is partly determined by the type of work taken on (or not taken on) by the IAPT service. This model of working is known as "Stepped Care" model and most NICE guidance for mental health difficulties has "Stepped Care" recommendations.

As a broad principle primary care services (such as IAPT services) provide services at Steps 1, 2 and 3, while secondary and tertiary level services (such as the Psychological therapies hub) tend to provide services at Steps 4 and 5.

This means that the threshold between service delivery at Steps 3 and 4 is highly significant in determining the level of demand for services. Services at Steps 4 and 5 are more intensive, longer term, usually multidisciplinary and tend to focus on people whose difficulties are multiple and more complex. Individuals at Steps 4&5 level of need present higher clinical risk.

The Psychological Therapies Hub is developing new ways of working in line and in partnership with IAPT services.

A current priority is the need to address parallel referral and triaging systems for both IAPT and Steps 4&5 Hub services to ensure that all referrals for psychological therapy, irrespective of level of need, enter only one system and that the entry point is at the lowest level of need where after patients are upward triaged through the steps 1-5 level of need.

Colleagues and service leads from the IAPT services are part of the capacity and demand analysis work which will also consider streamlining of processes and elimination of duplication.

Any further re-design recommendations and associated unification of systems and processes of both services will be undertaken on a partnership basis.

3.0 The Improving Access to Psychological Therapy Service (IAPT)

Bradford Improving Access to Psychological Therapies (IAPT) is a mental health service based on the national IAPT model. IAPT is an NHS programme of talking therapy treatments recommended by the National Institute for Health and Clinical Excellence (NICE) which support frontline mental health services in treating depression and anxiety disorders. Psychological therapies have been shown to be an effective treatment for people with common mental health problems, such as depression and anxiety disorders.

NICE recommends a stepped care approach, in which the first line treatment is the one that offers a reasonable chance of success, whilst being the least intrusive. People can then be stepped up to a more intensive treatment if required. The Trust IAPT service operates a 'stepped care model', covering steps 2 and 3. Step 1 refers to mental health care and treatment delivered by General Practitioners.

Step 2 is 'low intensity therapy', appropriate for people with mild anxiety and depression. Delivered by Psychological Wellbeing Practitioners (PWP – band 5) treatments are up to 6 sessions and include manualised Cognitive Behavioural Therapy (CBT) delivered in group and individually face-to-face or via telephone.

Step 3 is 'high intensity therapy', appropriate for people with moderate anxiety and depression. Delivered by Cognitive Behaviour Therapists (CBT – band 7) treatments are up to 12 sessions and delivered individually face-to-face.

Secondary care and tertiary services such as the trust's Psychological Therapies Hub would be described in this model as steps 4 and 5 respectively.

Originally developed as a Primary Care Mental Health Service (PCMH) by Bradford & Airedale Community Health Services (BACHS) the service worked with a broader range of severity, treatments and therapy modalities. Since the introduction of IAPT the service has been moving towards increasing IAPT adherence due to Key Performance Indicators (KPI's) required by NHS England. There are three KPI's that are closely scrutinised:

3.1 Numbers entering therapy

Defined once someone has attended two or more appointments, IAPT must achieve 15% of prevalence. Estimated to be 76k of local population, this equates to 950 people entering therapy per month across the year.

3.2 Recovery Rate

50% of those people that enter therapy must show recovery. Recovery is indicated when someone scores below the threshold of nationally prescribed clinical measures, for example a score of 9 on PHQ9 (depression measure). The initial score at start of therapy must be above 9; those below nine should not be accepted into therapy. A score above 20 indicates that the person has difficulties that are severe and therefore require treatment at steps above IAPT. These thresholds are set out in national IAPT guidance and commissioning specifications.

3.3 Waiting Time

From referral received to first therapy session, 75% must be seen within 6 weeks and 95% within 18 weeks.

Each of the three KPI's impacts the other; for example, increasing referrals (demand) in order to increase numbers entering therapy can lead to longer waits without additional capacity. It may also reduce recovery rate, if people with scores below 9 or above 20 are accepted into therapy.

Greater adherence to the nationally mandated IAPT thresholds has moved forward due to 2014/15 financial penalties that the Trust incurred as a result of under performance against the three main KPI's. In order to improve performance, the service is now aligning itself to the IAPT thresholds rather than its historical thresholds as a PCMH. Consequently, the IAPT service is now more likely to "step up" referrals suitable for Step4/5 rather than keep them as in the past. Hence there is increased demand at the step 4/5 and potential for increased waiting times as service users with more complex difficulties are stepped up from IAPT. Led by the Psychological Therapies Hub, the IAPT service is participating in a capacity/demand analysis of step 4/5 referrals.

Staff delivering step 4 therapy work within the Community Mental Health Teams (CMHTs) are line managed by the IAPT Service; an arrangement established following the transformation project when the Psychological Therapies Hub and IAPT operated as a single service. These arrangements are currently being reviewed, as both step 4/5 referrals are managed by the Psychological Therapies Hub. The work at step 4 is more closely aligned to that at step 5 rather than the IAPT steps, due to the more complex nature of the therapies offered. The hub determine the threshold between step 4 and 5 through a referral screening process (impacting demand), whilst IAPT are responsible for management of staffing at step 4 (impacting capacity).

4.0 IAPT Service Developments

The service is undertaking a comprehensive programme of transformation. Key areas of work include:

Development of a 'lead provider' contract with Voluntary Care Services

This will allow IAPT work to be delivered by a range of providers through subcontracting; increasing flexibility, value for money and choice for service users. It will allow development of services specifically for hard to reach groups.

4.1 Introduction of The Wellbeing College

Adopting an educational culture and language reduces stigma and increases scope of offer; wellbeing, recovery, treatment.

A range of psychological interventions with differing clinical governance requirements can function together within one network.

Several providers can operate together within a single coherent pathway that is simplified for service users through a 'prospectus'.

Enables providers to incorporate their existing provision and develop this over time as they choose.

Introducing self-referral via telephone/email will incorporate immediate assessment and enrolment through a single access point.

4.2 Implementation of a new IT system (PCMIS)

A significant issue for the service in achieving the IAPT KPI's has been data quality on SystemOne. SystemOne does not support accurate mapping of data to the national Health and Social Care Information Centre (HSCIC). The service has now migrated to PCMIS which provides assurance of accurate reporting of our KPI's and enables additional functionality such as online self-referral and online therapy.

The migration of data from SystemOne to PCMIS has required a period of data cleansing, correcting errors created through the migration process. As a result, accurate/complete reporting is expected from late July 2016. However, current reports already indicate an improvement in recovery rate across the service with all teams now above the recovery target of 50%. This is due to improved completion of data items as a result of the PCMIS system configuration requiring and reminding staff to complete data.

4.3 Relocation of office accommodation and delivery of clinical sessions

Moving away from delivering treatment in clinical settings will support the move to a non-stigmatised service model and encourage earlier engagement and intervention.

4.4 Proposal

- Support is being given to this project as it is necessary to evaluate the PTH service in relation to why there is such a lengthy wait for people to access therapy.
- The project will allow us to understand some or all of the contributions to the long waiting list and provide an opportunity for any required change to be identified.
- The data analysis support attached to the project will help us understand current blocks in the flow between referral and discharge and also to gain an accurate view of the clinical and non-clinical activity within the service.
- The project outcomes will support decision making in terms of improving quality within the service.
- Analysis so far has highlighted gaps in recording of data and providing evidence of the work being done.
- The overall project will support future planning for PTH in terms of improving the service users experience throughout their journey, reducing clinical risk, increasing productivity and ensuring the service is well placed within a competitive market.

5.0 Communication and Involvement via the Capacity and Demand Analysis Work

The full team from Psychological therapies hub were briefed about the capacity and demand analysis work in early May 2016 with a full explanation of rationale behind it, what we hope to achieve and the commitment expected from the teams in support of the ongoing work and any outcomes identified as a result.

They have also had communication around the next steps and plans in place so that everyone is informed and up to date with progress.

Full communications will continue via the PTH team meetings and e mail communications as required. The project is also discussed in the Psychological Therapies Council which addresses professional governance issues.

A broad range of staff from the PTH team have been asked to be part of the ongoing work. Thought has been given to ensuring an effective cross representation within the group (e.g. new staff, long established staff).

Service user representation will also be incorporated into any further re-design.

There is expertise in the form of a data analyst and project management support.

6.0 Financial Implications

Dependent on the findings of the project there may be implications for further investment. This would relate to any outcome which identifies the service is under commissioned and requires additional resource.

7.0 Risk Implications

The risk being addressed by the ongoing work is that of lack of access to services.

8.0 Communication and Involvement

Relevant stakeholders are involved in the ongoing work.
Outward communication will be decided and monitored by the steering group

9.0 Monitoring and review

This project will be monitored by the steering group and via the relevant Quality and Safety forums.

10.0 Timescales/Milestones

- The timescale for the ongoing deep dive work is 6 months
- The project commenced in May 2016 with Allison Bingham and Bev Knaggs attending the Psychological Therapies Hub meeting on 18th May 2016 when psychological therapies staff were briefed
- Analysis of both quantitative and qualitative data commenced in May 2016 and regular meetings are taking place between Allison Bingham and Sheraz Ul-Islam (Data Analyst).

- The Steering Group is meeting monthly.
- Completion of the project's data analysis phase is currently estimated to be October 2016. However, this may change as initial data analysis is surfacing significant issues which require more in-depth analysis and research than anticipated at the outset. These include lack of assessment allocation slots, length of time in therapy, duplication between IAPT and the Hub and the absence of standardisation of therapy.
- The findings are estimated to be reported November 2016 (this timescale may change, dependent on preceding bullet point).

11.0 Recommendations

The Board are asked to acknowledge the current challenges around access to psychological therapy services, the current mitigations in place to support management of these challenges and the expected outputs of the ongoing deep dive capacity and demand analysis work.