DOCUMENT B

DETAILED PROPOSAL

Mood Anxiety and Personality Clinical Academic Group

A proposal for the reconfiguration of psychological therapy services in Lambeth, Southwark and Lewisham

Version and history: Based on paper reviewed by the working group on 7.11.11 and presented at staff workshop 14.11; updated by Jonathan Bindman 26.1.12 to support scrutiny briefing; this version is informed by staff consultation responses but is not part of the formal response.

Introduction

Current Services

Psychological therapies within the MAP CAG are provided in primary and secondary care in a range of settings. The IAPT services provide psychological therapies in primary care according to clear protocols, are currently being re-tendered by the PCT, and do not form part of this proposal.

In secondary care, psychological therapies may be provided by therapists, principally psychologists, working in borough based Community Mental Health Teams (CMHTs), or in specialised services which may treat patients of more than one borough. Some of these services also treat patients referred from other boroughs, at tertiary level.

The specialised services considered in this paper which provide psychological therapies to patients of Lambeth, Southwark and Lewisham are: the St. Thomas's Psychotherapy Service (SPS) in Lambeth, the Co-ordinated Psychological Therapy Service (CPTS) in Southwark, and the Traumatic Stress Service (TSS) and the Maudsley Psychotherapy Service (MPS), which serve patients of all boroughs. In addition, psychologists working in secondary care are included, whether working entirely within CMHTs (as in Southwark and Lambeth), or serving CMHT clients from a separate base in the Lewisham Psychological Therapy Service (LPTS).

The Centre for Anxiety Disorders and Trauma (CADAT) delivers psychological treatments to primary, secondary and tertiary care. It has been subject to a review concurrent with this proposal, and the treatments it provides in secondary care are also considered here.

The day services for patients of Lambeth, Southwark and Lewisham, the Cawley Centre and the Intensive psychological treatment Service (IPTS) are excluded from this proposal, as are inpatient services which may be offered to patients on psychological therapy pathways.

Case for Change

Discussions with commissioners in the three boroughs over a long period of time have indicated a desire for change, though with local differences detailed below. Commissioners in all boroughs have invested substantially in IAPT services which have delivered a large expansion in evidence based psychological therapies delivered in primary care in the last two to three years. A common theme of these discussions is that while they accept that many of the patients seen in secondary care present a level of clinical complexity which makes treatment in IAPT unsuitable, they anticipate at least a modest shift of resources from secondary to primary care. At present, referral routes between primary care and IAPT are largely independent from referral routes to secondary care, and there is no clear numerical evidence of a shift in demand between them. However, at the request of commissioners the previously established joint panels of commissioners and clinical staff have extended their remit to review referrals to MPS in both Lambeth and Southwark, and have identified a minority of cases as suitable for management in primary care.

The delivery of outcome measures and evidence based treatments is also a common theme of discussions, given that IAPT is set up to deliver these in a highly structured manner, and produces clear evidence of benefit for patients. For various reasons both the research evidence and the delivery of local outcome measures in secondary care psychological therapy services tends to be less satisfactory than in IAPT and commissioners have expressed concern about this.

The CAG business plan in 2011/12 planned to identify £250K efficiency savings through a review of psychotherapy services delivered in Lambeth and Southwark. This review focused on Maudsley Psychotherapy Services and St Thomas's Psychotherapy. The review highlighted the difficulty in managing services together when they are subject to different funding streams (currently a mix of block and cost per case), and the consequence that reducing staffing reduces cost per case income. The results suggested that it would be difficult to deliver significant savings through small scale change, and might lead to fragmented, poorer quality services. The planned savings were not achieved, and it is clear that the efficiency savings which are required in current business plans will be best achieved through service redesign, rather than mere reduction in activity which is likely to result in frustrated demand and poor patient and commissioner experience.

Commissioner intentions

<u>Lambeth</u>

Lambeth PCT gave six months notice to Maudsley psychotherapy services in April 2011 (ending 30th September 2011) of their intention to decommission the service.

During this time, all referrals to MPS have been triaged through Lambeth IAPT, followed by review at the specialist outpatient panel. Lambeth commissioners signalled their intention in early 2011 to undertake a strategic review of psychological therapy services led by Sarah Corlett, but during the year continued informal discussions with us, and indicated support for the principles in this proposal as it was developed by our working group. Despite expiry of the notice period, current arrangements continue. The discussions with members of the Business Support Unit and with GP leads have suggested a willingness to continue commissioning from SLAM but an intention to disinvest by around 10% of current total spend over 3 years, which as above they link to the development of primary care psychological therapies. There is also an understanding of the necessity for us to meet CIP targets of at least 12% over 3 years, and of the need for commissioners to share the responsibility for managing demand effectively (though not necessarily through current panel arrangements), and a desire for a model of secondary psychological therapy provision which offers a clear pathway to primary care referrers and provides measures of outcome.

Southwark.

Southwark also intend to review and restructure psychological therapy services. Direct discussions with them suggest a similar situation to that in Lambeth, with a desire to disinvest by 10% over 3 years, and a similar willingness to commission a model offering a clear pathway into secondary psychological therapy. IAPT is not being re-tendered but is subject to a review process involving current providers including SLAM.

Lewisham

Lewisham commissioners have expressed interest for some time in developing local psychological therapy services, and recognise that their current model of services is different from Lambeth and Southwark, with more limited provision within the borough and patients being treated at MPS on a cost per case basis. Currently they access all dynamic therapy from MPS. They recognise our need to achieve CIP targets, and welcome the proposal to develop a borough based service, but have indicated that, given that they recognise that secondary services are less developed than in other boroughs, they are not seeking to disinvest.

Move to PbR.

PbR HoNOS clustering has indicated that the majority of work delivered by MPS and TSS falls within the parameters of usual local secondary psychotherapy services. This makes it unlikely that the levels of tariff achieved through the current cost per case arrangement can be maintained once PbR is fully implemented. The apparent discrepancy in costs between MPS and SPS has been a source of concern to commissioners for some time (despite the unavailability of directly comparable costs which include estate costs) and application of a PbR tariff will make this unsustainable.

Pathway development

High level care pathways for anxiety, depression and personality disorder have been developed and agreed. Clinical protocols for diagnostic groups (Maps of Medicine) have also been developed and signed off by the MAP CAG Executive. The next steps anticipated in the process are to confirm how the interventions recommended by the pathways are accessed within each borough. Though it appears to us that the therapeutic modalities recommended by NICE are available at least to some extent in all boroughs, referral pathways are complex (in effect, any referrer whether in primary or secondary care can refer to any service in the borough or to any cost per case service) and we cannot be sure at present that people actually receive the services recommended by the pathways. Considerable local knowledge is required to refer people to the most appropriate service and this is not always present even at CMHT level, requiring the panel to redirect referrals between services (particularly between the TSS, CADAT and MPS, where accurate referral requires clinical knowledge; referrals to other services e.g. between MPS and SPS are divided by the GP practice of origin though the panel may redirect occasional referrals between them for specific reasons). The PCT has data to suggest that referral patterns from primary care are highly variable between practices. Development of the integrated services in this proposal will support delivery of the pathways.

The CAG commitment to clarity of pathway and outcomes is shared by commissioners who require clarity as to:

- which clients are served by each pathway
- what is provided
- what outcomes can be expected
- how it is accessed

At present, there is the potential for duplication of services, whether by condition (for example services for trauma being provided by CADAT and TSS (and also by MPS and CMHTs where the trauma involves early abuse) or by modality (for example CBT for various conditions being provided by CMHT psychologists, and also at SPS and at MPS). As a result, the pathways whereby people assessed as requiring particular treatments access those treatments are not transparent, to referrers or commissioners.

CADAT

There are large cost pressures across Lambeth and Southwark IAPT services, which fund a significant element of CADAT. Also, Lambeth IAPT have been given notice on their contract and are now planning to bid competitively for the re-tender. Southwark psychological therapies services are also under review and a review is anticipated in Lewisham which will affect CADATs income. National funding is becoming increasingly difficult to secure, partly due to the success of the national IAPT initiative but also due to the economic downturn, and research and development money is not predicted to increase. As a result, it has been necessary to review the CADAT service. While that review does not form part of this proposal, it was agreed that the two reviews should be carried out concurrently; firstly to ensure that any CADAT staff affected by the review should have the opportunity to apply for a post in the new psychological therapies service, and secondly because although CADAT is

located within primary care, some of its current activities overlap with secondary care.
.

The proposed model

Development Process

The CAG executive agreed at a planning meeting 21st July 2011 to develop plans to establish integrated psychological therapy provision within each local borough (excluding Croydon who already have an integrated service). Integrated, in this context, means that all treatments for psychological therapies are provided by a single multi-modality team with a single point of access.

This proposal drew upon previous discussions within the CAG Executive, and a document describing a vision for psychological treatment within the CAG prepared by the Professional Heads of Psychology in discussion with colleagues.

Following the meeting of 21st July, terms of reference were drawn up and agreed by the CAG Executive for a series of four meetings (later extended to five) of a group of representatives of the Executive and professional heads, chaired by the Clinical Director, to discuss and develop the proposal. The group acted in an advisory capacity, and this proposal is made by members of the CAG Executive with managerial responsibility for the affected services, for ratification by the CAG Executive.

The proposal was presented to all staff of the affected services at a workshop on 14th November 2011, was agreed by the Trust Board on 21st November, and formed the basis of a staff consultation document which was consulted on between 9th December and 16th January. Many responses were received and have been analysed, and the CAG Executive has agreed a number of changes which form the basis of a formal response, which remains in draft pending further discussions with stakeholders.

Service Model

An integrated psychological therapies team (IPTT) will be developed in each Borough. (The use of the term team rather than service will minimise confusion with the existing Intensive Psychological Therapy Service (IPTS) at Guy's Hospital). As above, integrated in this context, means that all treatments for psychological therapies are provided by a single multi-modality team with a single point of access.

The borough IPTT will provide all specialist psychotherapies required by NICE guidelines for people with anxiety, depression, personality disorder, and post-traumatic stress disorder (PTSD), as represented in the CAG condition specific pathways. These are listed in table 1. In addition, other modalities of therapy may be provided as part of clinical studies, on the basis of evidence other than that already included in NICE guidelines, or for other specific purposes, where agreed by the managers of the service and by commissioners. For example we note the development of Young's Schema Therapy at MPS but have not included it in our list of required pathways. We also note that some staff have skills in Dialectical Behaviour Therapy (DBT) but we are currently developing this as part of the stabilisation phase of the

Engagement, Assessment and Stabilisation (EAS) pathway for borderline personality in the CMHTs.

Table 1: Modalities of psychological therapy required by CAG pathways

Individual Treatments

Cognitive Analytic Therapy (CAT)
Psychodynamic therapy
Cognitive Behavioural Therapy (CBT)
Trauma specific CBT
Eye movement desensitisation and reprocessing (EMDR)

Group Treatments

Group psychodynamic therapy
Family and couple therapy

Referral routes and criteria

Referrals to the IPTT may come from GPs, IAPT, and MAP Assessment and Treatment (A&T) Teams, and will go through a single point of access in each borough. The point of access will allow for allocation to an appropriate therapy where indicated, or (if referred by a source external to SLAM and not already assessed by A&T) will allow for diversion to the Engagement, Assessment and Stabilisation (EAS) pathway within A&T or to IAPT. The principles of stepped care, as set out in NICE Guidance for depression (and the principle extended to other conditions where feasible) will be followed, with patients allocated to short term primary care psychological treatment or other alternatives outside SLAM where possible, and to more intensive treatments as appropriate in a stepped fashion.

It is proposed that, as the model of service will be highly transparent to referrers and commissioners, and allocation to treatment will be by a clear process and on the basis of clear pathways linking need to interventions required. The current (interim) system of allocation to MPS via the Lambeth specialist outpatient panel will not be necessary.

The criteria for acceptance for psychological therapy will be that the person meets the diagnostic criteria set out in the MAP CAG condition specific pathways, and meets threshold criteria for severity which will be agreed by the allocation process, having regard to the need to manage demand for services within the borough.

The referral pathway will be actively managed, using metrics such as the number and sources of referrals, time to allocation, and pathways to which they are allocated. A referral management group will be needed. This group will maintain an overview of all referral activity. In particular the group will ensure that the referral allocation system is managed effectively and resolve quickly any pathway disputes that may arise.

The group will comprise the Clinical Service Lead, CMHT A&T managers, a representative consultant psychiatrist, the Lead Psychological Therapist from IPTT, and the IAPT Lead.

The group will monitor the process of allocation, and may also carry out allocations directly, by attending an allocation meeting. However, other methods of working can be considered including delegation of the responsibility for allocation to subgroups, or dividing allocation geographically as convenient.

Allocation to IPTT may be direct where sufficient evidence of the criteria for treatment is available. In other cases it may follow assessment by A&T or a joint assessment between A&T and IPTT. Wherever possible, patients should not receive multiple or duplicate assessments. MAP CMHT assessment services will work to a standardised assessment, and IPTT services will develop a generic assessment process which will support all staff within secondary care to assess sufficiently to allow accurate and efficient allocation to the correct pathway.

Relationship with MAP A&T teams and the system of care within the Borough

Consideration was given in the development process to the possibility that the provision of psychological therapies could be fully embedded within A&T teams. This was rejected on the grounds that this would provide insufficient critical mass for the necessary processes of leadership, supervision and support of honorary staff, and that it was not feasible given the current size and location of MAP A&T teams. The IPTT is therefore proposed as a separate team in each borough.

However, the new IPTTs will work more closely with the MAP A&T teams than in the current model. Closer working between A&T and the IPTT than is currently possible between A&T and existing psychotherapy services will be facilitated by the common allocation process, by the borough focus of the new IPTT, and by the smaller numbers of A&T teams than previously (in Lambeth and Southwark). Other methods of developing closer working will also be encouraged, such as the provision of case discussions, supervision and training to A&T staff by IPTT staff. Co-location would of course also facilitate communication and liaison but may not be feasible and will be the subject of a separate review of accommodation for the new IPTT services.

Communication with IAPT will also be facilitated by their participation in common allocation processes for secondary care psychological therapies, as well as the supervisory and training links and joint working developed by CADAT which will be continued within IPTTs.

The role of psychologists currently delivering psychological therapies within CMHTs has been discussed in detail during the development process for this proposal. It is proposed that they join the new IPTT, and may benefit from the support of colleagues and have greater opportunities to participate in supervision and training within a larger psychological treatment service. However, the value of their current close working relationship with the CMHTs (not only in Southwark and Lambeth where they are currently fully integrated into CMHTs, but in Lewisham where they work closely with CMHTs from the centralised LPTS) is recognised. It is suggested that

they should remain co-located with CMHTs for much of the working week and should have a clear role working across and linking the IPTT and A&T teams.

The appended diagram (figure 1) shows areas of overlap between the work of the IPTT and the MAP A&T teams.

Overlap 'A' Assessment and Primary care liaison;

A psychological therapist from IPT will work jointly with the CMHT Team Manager, Consultant and IAPT lead on reviewing referrals into the team.

Referrals may be passed directly to the IPT for treatment allocation or may require a psychological therapist to take part in a joint initial assessment in the CMHT.

Psychological Therapists from IPT will also take part in the consultancy / link work arrangements put in place with local primary care practices.

Overlap 'B' Work with complex / care co ordinated clients;

IPT therapists will deliver psychological treatment or assist with the clinical management of complex patients cared for within the MAP CMHT.

Much of the work will be directed towards patients under care co ordination. The input may be delivery of specific interventions, joint therapeutic work with care co coordinator or training and supervision of care co coordinator in delivering therapy.

Funding and activity

It is anticipated that the new service will replace both existing block funded borough psychological therapy provision and cost per case services delivering standard treatment to local LSL residents. The service specification and activity of the new services will be negotiated with the local Primary Care Business Units. This will be agreed within a negotiated financial envelope designed to deliver local PCT disinvestment targets, as well as internal Trust efficiency savings.

The funding mechanism will be determined in due course by the operation of PbR tariffs but it is assumed that in the financial year 2012/13 the funding envelope will be agreed with PCTs in the form of a block, though with shadow tariffs and provision of cluster data as required.

Activity will be agreed with the PCT, reduced to reflect the level of proposed disinvestment. Activity will be reported as numbers of assessments, numbers of individual treatments provided, and numbers of group treatments provided. Assessments and treatments carried out by psychologists currently located within the CMHTs will in future form part of the IPTT activity. It is not possible, based on existing data, to suggest what activity levels will be for specific modalities of therapy and it is proposed that the team leaders of the IPTTs, working with the CAG managers, should be able to adjust the delivery of levels of particular modalities in response to local need.

Cost per case services and the Traumatic Stress Service

A small specialist/tertiary outpatient service will continue to operate on a cost per case basis. Based on existing demand, the principal focus of this will be to deliver care options for trauma for patients from outside LSL. While it is proposed that the Traumatic Stress Service should no longer exist as a separate service, the trauma care pathway for local residents being delivered by borough IPTTs, the name Traumatic Stress Service will be transferred to an outpatient service hosted within a borough IPTT, most likely to be the Southwark IPTT. This and any other cost per case service will need to be based on a clear business case and will need to demonstrate sufficient income and indications of future demand to cover trading costs.

CADAT

CADAT will more clearly focus on those areas where it uniquely contributes to MAP CAG and KHP: research, and education and training. CADAT will maintain its existing specialist contracts (NSCT, National including named patient). It will continue to generate income through research and training / supervision. It will look to expand both these streams in the future if possible, including more training and supervision external to SLAM.

Management of demand

Demand for cost per case psychotherapy has risen in recent years, and although the block funded services have generally been effective in managing demand without excessive waiting lists, demand tends to exceed the availability of services. The reasons for rising demand are necessarily somewhat speculative, though seem to be based more on a broad cultural change in attitudes to psychological therapy generally than to measurable indicators of need, and we have no firm data to project future demand. We have speculated about the impact of the recession on demand for psychological therapies, but noted that rising trends in demand predate 2008, and may be driven by the great increase in supply of primary care psychological therapies, which unlocks pent up demand, as well as cultural factors. Given that most people referred to secondary psychological therapies have long standing issues often related to early trauma, it seems probable that the impact of more immediate stressors such as unemployment will be reflected in increased demand for IAPT services rather than in secondary care.

It is accepted that the PCT and GP commissioners share the responsibility for managing demand arising from primary care, and they will need to do so by ensuring alternatives to treatment are explored, stepped care is available and used effectively in primary care, and appropriate thresholds are applied to referrals into secondary care. However, we will support this process. An experienced psychological therapist from the IPTT will work with the MAP Community team on delivering clinical consultancy to primary care practices. The aim of such consultancy will be to support GPs to manage patients in the community as well as managing demand into secondary services. IPT therapists will provide a consultancy focus for 'complex common patients' (a term used in primary care which encompasses people with complex

presentations who may have mood or personality disorders underlying social problems and physical health presentations).

Within secondary care we will seek to manage demand effectively by maintaining appropriate, transparent thresholds for care using the multi-disciplinary allocation process. The involvement of senior, experienced staff in allocations and assessments is likely to improve consistency.

We will also maximise the efficiency of the service by ensuring that all staff are aware of reasonable expectations for the proportion of their time to be spent in face to face patient contacts, by using stepped care effectively to ensure that treatments are offered at the minimum length likely to be effective, and group treatments are offered wherever appropriate.

Waiting lists are not an effective form of demand management and will be avoided as far as possible by seeking to manage demand at the point of allocation. However, some fluctuation in waiting times is likely. Where this reflects failure to manage demand from primary care, this will be discussed with commissioners. If appropriate we could increase capacity of psychotherapy quickly by using a 'bank' of sessional therapists which will be developed with the support of the existing NHS Professionals staff bank. Psychotherapists working patterns at present (many working part time for our services and also working in private practice or for other providers) make it likely that sessional time can be purchased flexibly.

Staffing and Leadership

The current services are staffed by medical psychotherapists, adult psychotherapists, and clinical psychologists. All see patients for individual or group psychotherapy of one or more of the types described in table 1, and to that extent their roles may overlap. However, their training and skills differ in important ways which contribute to the overall effectiveness of the service, and the IPTTs will therefore include staff of each of these three types. The types of therapy to be delivered in the new service will not be defined by professional background, and it will be for the Lead Psychological Therapist to deploy resources within the IPTT according to the individual skills of the staff appointed.

A Lead Psychological Therapist will be appointed to each borough IPTT, and may come from any professional background. A skills hierarchy will be developed that allows for senior clinical input into complex assessments, clinical leadership, primary care consultation and for supervision of junior staff.

All staff will have capacity / activity based job plans that will identify numbers of assessment and treatments to be undertaken in each period in addition to non patient facing activity such as GP consultation, supervision and co-working with care co-coordinators.

Consideration has been given to the ratio of staffing at different grades. Efficiency in mental health services usually requires that a pyramidal structure is adopted in which larger numbers of staff at lower bands deliver treatments to less complex cases.

However, in the case of psychological therapy services it is noted that between 45 and 85% of treatments in current services are delivered by honorary staff who are unpaid and who carry out their work in exchange for high quality supervision and training carried out by experienced staff. The proposed services will continue to use this model of service delivery, and the staffing structure therefore reflects the need for sufficient senior staff to provide supervision and training.

Central Functions

The current structure of services has the advantage that certain activities can be delivered efficiently from centralised services in ways which will be complicated by the move to three borough based IPTTs.

Considering all activities of the current services, those which can straightforwardly be devolved to local IPTTs include individual and group therapy, mentalisation (if offered), and family and couple therapy. CAT, currently only offered at St.Thomas's and CPTS, should be delivered by each IPTT.

Other functions will not be offered in each borough IPTT but can be hosted by one IPTT and made available to patients of other boroughs. These include the Young people's service, the CSA group, and the Vauxhall City Farm project. As described above, cost per case outpatient clinics can also be hosted by a local IPTT.

However, other functions would benefit from a single co-ordinating structure across all IPTTs. These include:

- co-ordination and delivery of medical teaching, which is structured around a Wednesday programme delivered at the Maudsley Hospital.
- A centrally co-ordinated Maudsley brand psychological therapies training drawing in staff from boroughs as necessary
- Services delivered by small numbers of staff to small numbers of patients which will be unhelpfully fragmented or undeliverable in three separate services, including perinatal treatment, mindfulness based cognitive therapy (MBCT), CBT for complex cases (Young's Schema Therapy)

It is proposed that these will be co-ordinated by the Trust Head of Psychotherapy, supported by other staff, who will be located within an IPTT but will have designated sessions within their job plans to deliver pan-borough services.

Risks and mitigations

Clinical risks arising from transition

Transition to new services may give rise to clinical risks. These relate to the need to contain staff distress and anxiety at the change in order that safe and effective therapy

can be maintained, and also the risk of disruption to the therapeutic contract as a result of the change in staff roles.

Staff containment will be facilitated by clear communication about the changes, and support from the current leadership of services during the consultation period, followed by prompt appointment of clinical leaders within the new structures.

Patients of the current services have been offered periods of treatment which extend beyond the period of the restructure, raising the question of how therapy can be continued at a time when therapists may be at risk of displacement, redeployment or redundancy. Given that the new services will be delivering approximately 90% of the activity levels of the current services, it is unnecessary to suspend allocation for the period of transition, particularly as this would give rise to additional clinical and financial risks. Where staff are moved to new service structures or redeployed within the organisation, it should be possible to release individuals from their new roles over a transitional period to maintain the commitment to individuals in therapy that their therapy will be completed as planned. In the event that staff do not remain within the organisation, the impact will need to be considered on a case-by-case basis, with options including continuation of therapy by the staff member retaining an honorary contract, shortening the period of therapy by agreement, or the offer of an alternative therapy or therapist. Allocation of a care co-ordinator from a CMHT may maintain continuity and mitigate risk for some individuals.

Dr Jonathan Bindman
Consultant Psychiatrist Lambeth Assessment and Treatment Team (Brixton)
Clinical Director Mood Anxiety and Personality

Figure 1: Diagram of model showing overlaps