NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
26 September 2019

Subject:	**Scottish Government Waiting Times Standard for Psychological Therapies**
Purpose:	To provide an update on the improvement plans, trajectories and progress against the Scottish Government waiting times standard for Psychological Therapies
Recommendation:	IJB to have knowledge of and to support the improvement plans

Glossary of Terms	
NHS A&A	NHS Ayrshire and Arran
SG	Scottish Government
HSCP	Health & Social Care Parntership
MHS	Mental Health Services
PS	Psychological Services
CAMHS	Child and Adolescent Mental Health Services
AMH	Adult Mental Health
V1P	Veterans First Point
cCBT	Computerised Cognitive Behavioural Therapy
PIG&T	Psychological Interventions Governance & Training Group
ISD	Information Services Division

1.	**EXECUTIVE SUMMARY**
1.1	The Mental Health Strategy 2017 – 27 has a key focus on prevention, early intervention and improved access to mental health services, including psychological therapies. The strategy reflects Scottish Ministers expectations that mental health is a priority and that significant improvements are made to the quality and delivery of services. While the Mental Health Strategy recognises that improvements have been made in access to psychological therapies, there is acknowledgment that demand is increasing and waiting times remain higher than the 18 week referral to treatment standard across many service areas.
1.2	Locally, this funding has enabled fixed term posts across priority service areas to be made permanent improving recruitment, retention and stability in the dedicated workforce available to deliver psychological therapies.
1.3	To increase parity with Acute services and to improve understanding of the improvement work and challenges in achieving the standard, SG included the waiting times standard for access to psychological therapies in the Health Boards 2019 Annual Operating Plan. Improvement plans were developed and approved in April 2019, detailing ongoing service improvement work and proposals to achieve waiting time compliance by December 2020.

1.4	The standard is that 90% of patients will commence psychological therapy within 18 weeks from referral. This standard relates to all levels of psychological therapy provided by the wider workforce and is broader than the specialist level work provided by the Psychological Service. The improvement plans are linked to waiting times trajectories through to December 2020. SG has recently requested that the plans and trajectories be extended until March 2021.
1.5	Local compliance against the standard is currently at 75% (July 2019). While this aggregated level of compliance for all services remains below the standard, there is considerable variation in waiting times across our services, with some services consistently achieving the standard, some varying around the 18 week standard, and others well below the standard. The major breaches are within the Child and Adult Mental Health Community services and some Physical Health Psychological Specialties.
1.6	Additional data highlights progress in increased activity, reduction in total numbers of people waiting and reduction in numbers of people waiting over 18 weeks. One area of notable success is the impact of the local computerised Cognitive Behavioural Therapy service which has been utilised well above projections and is positively contributing to the number of people having immediate access to an evidence based psychological approach.
2.	**BACKGROUND**
2.1	Psychological Services is a pan-Ayrshire specialist service comprising a professional skill-mix of Psychologists, Psychological Therapists and Graduate Assistant Psychologists - approximately 70 whole time equivalents. The service provides specialist psychological assessment and treatment to all ages of the population from birth (neonatal unit) to death (palliative care psychology). Services are provided in both acute and mental health settings. Training, supervision and consultancy is provided to the wider health and social care workforce.
2.2	Some of the services are provided by single or small numbers of clinicians and are vulnerable to periods of leave. Even where waiting times standards are being met, there is recognised unmet need.
2.3	Currently, the local monthly waiting times report to SG reflects the waiting time to access treatment from specialist level Psychologists and Psychological Therapists. However, there are staff within the wider workforce, primarily Nursing and Allied Health Professionals, who have received training in psychological interventions and are delivering psychological work as part of their generic role. Through ongoing work to improve our data systems, we will be better placed to capture this activity and report a more accurate account of all dedicated psychological work being provided locally. This will enable more accurate workforce planning based on knowledge of demand and capacity for all levels of psychological work.
3.	**PROPOSALS**
3.1	As noted in a previous 2018 paper to the IJB's "Findings and Recommendations from Review of Pan-Ayrshire Psychological Services", several key findings and proposals remain relevant to achieving compliance with the SG waiting times standard:

	• A whole Mental Health system approach is required for transformational change to occur and to ensure the MHS, including Psychological Therapy provision, is fit for current and anticipated future demand. • PS cannot make the required changes independent of the wider teams in which they deliver. In addition, the small and specialist PS alone cannot and should not meet the population demand for psychological input. There is a requirement for increased dedicated psychological input from the wider staff team, particularly to increase capacity for low intensity psychological work. • Development of new ways of working needs to be realised through Psychology's key involvement and leadership in service re-design work being undertaken across the three Partnerships. • There is a need for accessible and accurate service data to enable understanding of demand and capacity, to ensure efficiency in the utilisation of staff time and to enable more accurate workforce planning.
3.2	SG improvement plans and trajectories to deliver on the waiting times standard were developed and approved in April 2019 and are outlined in Appendix 1. These plans include a single aggregated waiting time compliance trajectory for all services reporting on the standard as well as detailed plans and trajectories for those services consistently breaching the standard.
3.3	These plans do not include the services which are consistently achieving the standard – cCBT, Learning Disabilities, Forensic/Low Secure and Addictions. Although Older Adults is achieving the waiting times compliance, an improvement plan is included to retain a focus on this service which has a small resource, including two fixed term posts until March 2020, is vulnerable to periods of staff leave, and anticipates increased demand for both specialist neuropsychological assessment (dementia) and therapeutic work.
4.	**PROGRESS UPDATE**
4.1	Current (July 2019) compliance against the standard is 75%. Although the level of compliance is falling below the 90% standard, it is consistent with trajectories. A review of wider data, as outlined in Appendix 2, highlights a slight reduction in total numbers of people waiting and a significant reduction in numbers of people waiting over 18 weeks. For example, 575 people were waiting more than 18 weeks in April 2019, reducing to 368 people waiting more than 18 weeks in July 2019. This gradual progress is in the context of a challenging period of loss in workforce related to vacancies and maternity leave.
4.2	The focus on a wider data set is essential to monitoring progress given the limitations of the level of compliance as a measure of change. It is important to note that as we appoint to a number of vacant and new posts, these new staff will increase activity across the service, focused on the longest waits, which is likely to drive the aggregated compliance down given the method of calculating level of compliance (of the number of patients seen in any month, the percentage seen within 18 weeks). This is recognised by SG and requires us to report on a wider data set that reflects progress in activity, longest waits and numbers of people waiting more than 18 weeks.
4.3	While recognising that inconsistencies in what Health Boards report to SG make it difficult to meaningfully compare performance, the recently published ISD data (September 2019) on national waiting times for psychological therapies highlights only one Health Board achieving the standard and three reporting slightly higher levels of compliance than NHS A&A. NHS A&A's level of compliance is achieved in the context of having a relatively low dedicated Psychology and Psychological Therapy resource.

	The most recent ISD workforce data (April – June 2019) reports NHS A&A as having 69 whole time equivalents, with the similar sized Health Boards of Fife and Tayside reporting 97 and 94 whole time equivalents respectively. Only three Health Boards were reported to have a lower resource (whole time equivalent per 100,000 population).
4.4	Since April, there has been development in recruitment as well as improvement work. Some of this progress and limitations is summarised below with a focus on the AMH Community and Child Services: <u>AMH Community</u> • Recruitment. There has been recent approval to recruit to a number of fixed term posts on a permanent basis. The Adult service has increased its specialist Psychology capacity by 2.4wte (North and East) with recent agreement to make permanent one of three fixed term Cognitive Behaviour Therapy posts (North). This permanent resource, together with a smaller increase in capacity through waiting list initiatives, will provide an increased stable workforce tailored to current demand, enabling increased throughput and targeting of longest waits.
	• Training and increasing capacity within the wider workforce. A pan-Ayrshire multidisciplinary Psychological Interventions Governance and Training Group for Adult services has successfully commenced. This group will provide a strategic focus to the development of a psychological training and supervision plan to ensure training is linked to service need, leads to protected time for delivery of psychological work and provides clarity on the resource available for the different intensity levels of psychological work. Initial work to map local capacity for psychological interventions/therapies has already identified psychological work being undertaken by the wider workforce that is not currently captured within the SG report and which may positively impact on compliance against the waiting times standard. The outputs of this group, including capacity and compliance, will be communicated through formal governance structures.
	• Therapeutic and service developments. To meet the changing referral demands, such as the increase in complex trauma, interpersonal difficulties and emotional instability, new developments in therapeutic options are being developed. Transdiagnostic emotional regulation groups have commenced in the East Adult Community service and are due to commence in the South, providing an efficient and effective approach for a complex patient group. To increase access to our digital based therapeutic option of computerised CBT for mild to moderate anxiety and low mood, marketing and training visits have been delivered, with future dates confirmed, to all GPs in Ayrshire and Arran. A review of referral criteria for specialist assessment and therapeutic work of the Psychology resource is about to commence.
	• Improved data systems. A pan-Ayrshire group has been established to map requirements of data reporting, utilising existing data systems of Trakcare/PMS, which will lead to more functional access to live data and subsequent accurate and timely reporting against the waiting times standards. This has coincided with an increase in data collation, reporting and case management across all Adult Psychological Specialties.

	• Limiting factors to progress. The service continues to have difficulty in recruiting to fixed term posts to cover the loss of capacity through maternity leave and where this loss of capacity may be the only dedicated or substantive Psychology provision to a service. To mitigate against this and increase likelihood of recruiting, the service is considering the options of reconfiguring these posts, including different bandings and clustering with other available posts. Funding for Stress Control classes has not been secured. Despite interest from Public Health colleagues, lack of budget has prevented taking this proposal forward in partnership with Public Health. Consideration is being given to the development of a "no cost" intervention within Psychological Services for community access.
	<u>Child Services</u>
	• Recruitment. Within Community Paediatrics and CAMHS, the two SG funded fixed term Clinical Psychology posts have been made permanent. In addition, a combination of core budget and CAMHS Taskforce funding will increase permanent Psychology provision by an additional four posts, supported by two fixed term Assistant Psychology posts. These post-holders will be in post early 2020 and will focus on early intervention, whole system work and neurodevelopmental assessment. The new structure for neurodevelopment multi-disciplinary teams of Psychology, Speech and Language, Nursing and Administration has been outlined, with likely implementation of this new model in December 2019. This will reduce the substantial backlog for assessment rapidly and will have a positive impact on waiting times for psychological interventions.
	• Therapeutic and service developments. Within Community Paediatrics, a single-session group-based intervention for parents of children with behaviour that challenges (one of the primary referral reasons) has been developed and will be piloted shortly. This group will improve clinical care by offering practical strategies to consider and apply at an early stage of contact with the service, will reduce individual clinician time for each case, and will provide peer-support via group intervention. Referral criteria for accessing Clinical Psychology have been written and are currently being reviewed by other services for comment. A detailed audit of clinical activity in relation to neurodevelopmental assessment has been completed and has identified potential areas where support from other disciplines may reduce the need and number of referrals for a more comprehensive specialist neurodevelopmental assessment.
	• Within CAMHS, a staged plan for addressing neurodevelopmental assessment has been developed which will address both short-term waiting issues and longer-term sustainability. Further specialist training in autism diagnostic assessments has been completed by all existing Clinical Psychologists to improve competence and efficiency in undertaking diagnostic assessments.
	• Improved data systems. Within CAMHS, the external company Benson Wintere has recently moved to developing the second phase of a live scenario data model which will enable demand capacity analysis on the whole team working and more accurate workforce planning;

	• Limiting factors to progress. Consistent with the Adult service, the Child service has failed to recruit to a fixed term post to cover the loss of capacity through maternity leave. To mitigate against this and increase likelihood of recruiting, a reconfigured post is being re-advertised and consideration will be given to a different skill-mix and banding if there is a failure to recruit on a second attempt. In addition to maternity leave, there has been a further two recent vacancies created by staff leaving the Child service with an associated loss of specialist expertise, training and supervision capacity and clinical activity. These losses will reduce the positive impact of the additional resource given the recruitment process and time taken to re-appoint.
4.5	**Anticipated Outcomes**
	Improvement plans, including increased resource, will reduce the longest waits and improve waiting times Development of a strategic plan for psychological training and supervision based on the needs of the teams with more explicit knowledge of what resource is available and required for delivery of the different levels of psychological work. Workforce plan to reflect current and projected workforce requirements. Improved access to service performance data to inform on demand capacity analyses and clinical outcomes.
4.6	**Measuring Impact**
	Impact will be monitored through the Corporate Management Team, Access Performance Governance Group, MHS Waiting Times Group and the monthly communication with SG.
5.	**IMPLICATIONS**
5.1	Re-design of services to embed psychological therapies provision as a core function of the team with dedicated resource.

Financial:	The Mental Health Outcomes Framework funding has enabled recruitment on a permanent basis to six posts initially funded through fixed term SG funding to Increase access to Psychological Therapies and three posts funded through fixed term CAMHS Taskforce. There remain four NES funded fixed term posts (March 2020) working across CAMHS early intervention, Adult Community and Older Adult for which no permanent funding has been identified at present. In addition, no permanent funding has been identified for the local Veterans First Point service which provides a holistic service, including quick access to psychological therapies, for people who typically have not engaged well with mainstream services.
Human Resources:	Training and supervision of the wider workforce and workforce planning.
Legal:	None
Equality:	None

Children and Young People	The planned improvements with our CAMHS service will improve outcomes for Children & Young People.
Environmental & Sustainability:	None
Key Priorities:	In alignment with the Partnership strategy and integration of services.
Risk Implications:	The improvement plans and ability to achieve and sustain the waiting times standard are heavily dependent on increasing resource, both at specialist level and in the wider workforce. The positive impact of additional and permanently funded posts will be reduced through a number of recent vacancies, an increase in maternity leave, the difficulty recruiting to fixed term cover posts, and the time inherent within the recruitment process. ISD workforce data shows an overall reduction in whole time equivalent resource of specialist Psychologists and Psychologist Therapists in NHS A&A over recent years which is relatively low when benchmarked against other Health Boards. Recent additional investment and opportunity to recruit on a recurring basis will improve available resource but the full impact will not be realised until 2020 when posts are appointed to. Capacity issues within the wider workforce of Nursing and Allied Health Professionals will limit the dedicated time they can provide to delivery of psychological work as part of their generic role
Community Benefits:	Not applicable

Direction Required to Council, Health Board or Both	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

6.	**CONSULTATION**
6.1	Ongoing consultation through the pan Ayrshire MHS Strategic Planning and Change Project Programme Board, the pan Ayrshire MHS and North HSCP Clinical Care and Governance Groups, the North MHS and HSCP Senior Management and Professional Leads Team, and Acute Clinical Directors and General Manager.
7.	**CONCLUSION**
7.1	The SG improvement plans and trajectories for the 18 week referral to treatment waiting time standard reflect the combined need for service improvement work, improved data systems, additional resource in service areas where capacity is low relative to current and projected demand, and increased input from existing wider team staff in the provision of psychological work.

7.2	The plans, progress and limitations in achieving the trajectories are being reviewed through a pan Ayrshire multi-disciplinary MHS waiting times group. This reflects that the standard is for access to all levels of evidence based psychological therapies, not only specialist Psychology provision, and requires whole service ownership to achieve and sustain the standard. Progress is being reported through the Pentana system to the Corporate Management Team, Performance Governance Groups and regular telecommunication with SG.
7.3	In the context of recent vacancies and maternity leave, the full impact of additional permanent resource and improvement work will not be realised until early 2020. Despite the current challenges from loss of workforce, data reports highlight a stable level of compliance since the introduction of the plans in April 2019 (currently 75% compliant against the 90% standard) but a slight reduction in total numbers of people waiting and a significant reduction in numbers of people waiting longer than 18 weeks.

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NHS Ayrshire and Arran Psychological Therapies
Mental Health Directorate, AOP Template, April 2019

Ayrshire & Arran Psychological Therapies

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	77%	79%	79%	80%	84%	87%	90%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
June 2019	1. Create business case for roll out of community based CBT/Stress group to support stepped/matched care model (AMH/OA/Spec) 2. Create written referral criteria	Zero initially, Small (1-5%)	Public Health case, so discussion regarding projected five figure cost	Requires funding agreement, new ways of working, and links with GP partners and venues, in addition to potential recruitment and staffing from within stretched resources. Links with new MHP role required to be explicit.	Dependant on success of business case. Requirement for additional funding not guaranteed given organisational finances. Could be designed by existing staff, but significant time lag if so and requirement for pilot. Off the shelf resource available but cost associated, alongside training requirements. Other boards run the same model and are breaching/explicit pathways/recording required.

	and operational policy for whole service (All)	Medium (1-5%)	From within existing budget	Requires communication with referrers and partners. Agreement on gaps in service, limits of responsibility and requirements for consistency of implementation across 3 partnerships	Increased load on senior staff, delegation will mitigate. Limited consultation will result in negative view of Psychological Therapies. Senior leadership support required from board.
	3. PMS/Trakcare mapping commences (AMH/OA/Spec)	Small (1-5%)	From within existing budget	Key links made with digital health/Business Intelligence. Discussion with administrative management and specialties. Links with BI team are key	Increased anxiety within staffing, education required and supportive training.
	4. SBAR for life span neurodevelopmental service (All)	Large (20-30%)	New funding required	Board level decision.	Possible dilution of service due to upfront cost/clear health economic benefits and positive impact on wait times to be evidenced to senior management
	5. Establishing Psychological Therapies Training Group (AMH/OA/Spec)	Medium (15%)	From within existing budget	Links with NES PTTC role providing oversight of all training and delivery of supervision of psychological interventions across all discipline. Nurse consultant, AHP Lead, Clinical Leaders and Psychology Head of Specialty need buy in.	Requirement for consistency of roll out of Psychological Interventions across all disciplines will impact on perceived core business, need for senior leadership to reinforce centrality of psychological interventions to core business

	6. Use of Waiting List Initiatives in all specialities from within current staffing (All)	Small (1-5%)	From Underspend	Staff buy in and admin management for additional work.	Historically has been difficult to recruit staff/open to CAAPs for enhanced rate.
	7. Increased resource in specific areas where historical backlog is significant	Medium (20%)	Additional Resource required	Clinical space capacity in host specialty alongside administrative capacity would need examined. Additional resource would need approved by Head of Mental Health	All risks associated with clinical roles in terms of potential maternity leave etc.
September 2019	1. Roll out Trauma Training for all Mental Health Disciplines (All)	Small (1-5%)	From within existing resource (potential for reduction in clinical capacity for trainers)	Needs senior leaders to free time for inpatient/community staff to attend. Psychology staff to deliver.	Resistance from services who already assume they are trauma informed, make explicit collaborative nature of the work and seek senior leadership validation.
	2. Introduction of Manualised DBT/ER group based intervention for Transdiagnostic presentations delivered by nursing/AHP in line with potential Emotional Intensity Pathway(AMH/OA/Spec)	Small (1-5%)	Depends on package (free-four figures)	Requires Pilot over summer months, with CPN/OT observations and training from within psychology or externally funded	Risks detailed above. Increased load on psychology up front. Local issues regarding accommodation and referral streams.
	3. Training and Marketing provided to all A&A GPs for Ccbt (AMH/OA/Spec)	Small (1-5%)	From within existing budget	New national package released in May 2019, coordinator has good links with national program and will link with Head of Adult to engage practices not covered already	Need for GP buy-in/strong marketing package and historic data.

December 2019	1. Introduction of formal case management across Psychological Therapy specialties using PMS/Trakcare (All)	Small (1-5%)	From within existing budget	Staff awareness raising	Increased perceived stress on staff/clear positive, non-punitive reasons for same provided
	2. Use of data to address capacity shortfall/staffing issues (All)	Small (1-5%)	From within existing budget	Business intelligence to provide platform for real-time data analysis by senior clinicians and management. Increased ability to communicate demand and capacity and quicker awareness of gaps or demand issues within services.	None noted
	3. Recruitment of Multiple Peripatetic Staff across specialties (All)	Small (1-5%)	From underspend due to predicted maternity leave	Permanent role established from temporary funding through underspend, requires Head of Mental Health Sign Off. HR support for new job descriptions	Risks and mitigations in line with all recruitment issues
March 2020	1. Recording of psychological interventions delivered by AHP/Nursing that meet LDP criteria (Whole)	Small (1-5%)	None	Contingent on success of roll out of PMS/Trakcare and Psychological Training Group and Partnership leader buy in	Noted above
	2. Delivery of High Volume community based CBT/Stress classes and Clinical Health Psychology Group (AMH/OA/Spec)	Small (1-5%)	As above	As above	As Above

	3. Recording of above data against LDP Criteria	Medium (20%)	As above	Agreement from SG that intervention is reportable	SG require sign off, may deem to be too low level to meet LDP standard, use exemplars from other boards
June 2020	1. Development of TEC to support delivery of psychological therapies (All)	Small (1-5%)	Funding streams through SG and from Digital Services, but likely will require further investment	Requirement for organisational compliance, use of App based resources requires significant oversight	Limited control of access to resources/Ccbt model, well established within A&A.
September 2020	1. Recruitment and commencement of Specialist Perinatal Mental Health Team (All)	Small (1-5%)	SG funding and business case ongoing as of May 2019	Positive impact on LDP from within adult and CAMHS services	Internal recruitment could see existing staff vacate current role for new posts.
December 2020	Continue with above actions and redraft in line with LDP				

CAMHS Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	28%	28%	50%	60%	65%	70 %	80%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
Sept 2019	1. Introduction of individual caseload management via caseload review tool and outcome measures to increase throughput of cases	Medium (5-10%)	From within existing sources	Pressure from other services/ disciplines to maintain caseload. Support for clinical staff to discharge patients.	Limited number of experienced supervisors to oversee caseload management will be mitigated by advanced planning of staffing and detailed job planning. Increased risk to patients and organisation in situations where individuals are discharged and subsequently experience harm. Mitigated by agreed risk assessment and management procedures across CAMHS service.
	2. Psychology waiting list management through 16 week opt-in letters to reduce DNA rates and unnecessary appointments	Medium (5 – 15%)	Additional admin requirement for sending letters and monitoring responses	Availability of administrative support.	Failure to respond from patients/ families may be due to literacy or other difficulties. Increased risk to patients and organisation in situations where individuals are discharged and subsequently

					experience harm. Mitigated by agreed risk assessment and management procedures across CAMHS service. Risk mitigated by letter to families to inform of discharge and correspondence with referring agencies to inform of lack of response leading to discharge from service. Potential for lag in administration, if no additional resources. Need for service managers/ leads to be fully aware and in agreement with process to avoid confusion within teams. Mitigated by process being approved within CAMHS Clinical Governance Group and circulation of information round all team members.
	3. Clarity on DNA processes, shared across CAMHS and agreed with wider A&A mental health governance	Small (< 5%)	From within existing resources	Agreement across CAMHS and NHS A&A mental health services	Failure to attend may be due to factors other than appointment not required (e.g., literacy difficulties or social circumstances). Risks and mitigation processes as (2) above.
	4. Development of clear criteria for Psychology waiting list	Small (5 – 10%)	From within existing resources	Agreement across CAMHS	Restrictions on service provided to C&YP. Mitigated by agreement across CAMHS and identification of gaps in service provision that might be filled by developments of appropriate alternatives. Flexibility of criteria via discussions

	5. Recruitment to fixed-term 0.5 WTE 8A Clinical Psychology post focused on neurodevelopmental, which will have positive impact in reducing pressure on psychological therapy provision	Small (5 – 10%)	Funding from SG CAMHS Taskforce	Agreement with CAMHS management	Failure to recruit to fixed-term post. Mitigated by advertisement as soon as possible and/ or configuration of full-time post by combining with other specialties
	6. Recruitment to 1.0 WTE 8A Clinical Psychology and 1.0 WTE CAAP posts to support development, implementation and evaluation of 'whole CAMHS' model	Medium (10%)	Funding from SG CAMHS Taskforce	Agreement with CAMHS management	Failure to recruit to fixed-term post. Mitigated by advertisement as soon as possible and/ or configuration of full-time post by combining with other specialties
Dec 2019	1. Development of matched-care model of psychological interventions, with structured assessment processes to identify needs and a range of low-intensity interventions available to meet the needs of C&YP. Developed with other members of CAMHS MDT and partner agencies.	Medium (15%)	Group development time, CAMHS training plan to identify service needs, training for staff involved in groups, availability of physical resources for groups, administrative support for groups	Agreement with CAMHS management for involvement of MDT in psychological interventions. Involvement with partner agencies in provision of interventions within community settings (e.g., Education), Support of CAMHS to develop groups, availability of training.	Lack of capacity within CAMHS teams to support interventions. Attrition rate associated with group interventions; clear re-engagement pathways. Limited effect upon need for individual interventions. Mitigated by quality training and delivery of groups from evidence-based programmes. Agreement and support via CAMHS Clinical Governance Group.
	2. Therapy specific waiting lists (e.g., IPT, CBT)	Small (5%)	Administrative support required	Agreement across CAMHS to develop these. Benefit if linked to CAMHS training priorities and skill-mix.	Easier identification of specific demand for service and highlight opportunities for group work and joint-working between disciplines. Improved ability to identify ring fenced time from clinicians. Greater ability to identify training needs. Risk of fragmentation of service mitigated by co-operation

					between CAMHS disciplines and link to CAMHS training priorities and skill-mix.
	3. Development of new neurodevelopmental service outwith CAMHS (see detail in CAMHS section of Improvement Plans). This will significantly reduce proportion of clinical time dedicated to neurodevelopmental assessment and follow-up	Large (15%)	Significant financial investment in staffing for new pathway. Need to re-allocate/ define resources from several disciplines	Financial investment from Partnership. Full engagement from NHS and partner agency services within A&A	Lack of financial investment. Risk mitigated by business plan and application for funding supported by senior management. Lack of engagement from services and agencies mitigated by involvement in implementation of pathway and recruitment of staff invested in its success.
	4. Planned Maternity Leave 0.6 8B Clinical Psychologist	Large negative (15%)	Small increase in underspend. May required additional administrative support and fixed-term monies.		Significant loss of capacity within team, including specialist service within CAMHS; significant loss of capacity in supervision and line-management. Increased pressure on administrative staff responding to waiting list queries. Increased pressure on team leaders and psychology leads in managing waiting lists and responding to queries. Mitigated by early advertisement of fixed-term post from underspend or potential for additional hours on an 'acting up' basis from existing staff team.
	5. Failure to reappoint to 0.7 8A clinical psychology post recently vacated	Large negative (10%)	Increase in underspend.		Significant loss of capacity within team, including neurodevelopmental service within CAMHS; significant loss of capacity in supervision.

					Additional pressures on admin, team leaders and psychology leads. Mitigated by recruitment to post.
Mar 2020	6. Development of CarePartner and PMS/ Trakcare to support caseload management through necessary reportable features.	Small (1%)	Funding required for electronic systems teams	Availability of electronic systems staff to support development and potential for change in existing systems	Carepartner does not assist us with case load management. The work list needs to be reportable and activity associated with the user should also be reportable. Discipline discharge is also required.
June 2020	1. Failure to appoint to 1.0 Band 5 Assistant Psychologist post at end of SG fixed-term (March 2020) funding	Medium (10%)	Nil	Requirement for other clinical staff to absorb workload, with time spent on duties that could be fulfilled by Assistant Psychologist. Increased pressure on administrative staff responding to waiting list queries. Increased pressure on team leaders and psychology leads in managing waiting lists and responding to queries.	Loss of capacity across teams, including aspects of neurodevelopmental service within CAMHS. Mitigated by provision of permanent post and recruitment to this.

Medical Paediatric Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	100%	100%	100%	85%	100%	100%	100%	100%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
March 2019	1. Recruit 0.6wte temp 8b by rebanding existing 8a staff member to cover leadership role of career break staff member	Small (1-5%)	From within existing sources	Provide leadership within the psychology team and wider medical paediatric service. Provide stability and increase staff morale.	Recruitment process can be lengthy leading to delay in appointment.
	2. Recruit 0.6wte temp 8a to cover clinical role of career break	Medium (5-15%)	From within existing sources	Dependant of HR and organisational process.	Recruitment process can be lengthy leading to delay in appointment. Short-term contracts can be unattractive and appointees often leave prior to end of contract. Impact on standard will not be realised until staff member in post – likely to be Sept 2019.
June 2019	1. Continue to deliver service as current.				

September 2019	1. Continue to deliver service as current.				
December 2019	1. Planned maternity leave 0.6wte 8a Clinical Psychologist	Large Negative (15-30%)	Small increase in underspend if contract of temp staff not extended.	Possibility to extend contract of temp staff depends of them still being in post and willing to consider extension.	Significant loss of capacity within team. Short term post to be advertised from underspend, Possibility to extend contract of appointed temp staff.
	2. Return of 0.6wte 8b psychologist	Large (15-30%)	From within existing sources	Increase in capacity and through-put. Increase clinical expertise within department with return of senior staff.	
Mar 2020-Dec 2020	1. Continue to deliver service as current				

Physical Health Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	**Mar 2019**	**Jun 2019**	**Sep 2019**	**Dec 2019**	**Mar 2020**	**Jun 2020**	**Sep 2020**	**Dec 2020**
Performance against the LDP standard (%)	95%	69%	**67%**	75%	79%	83%	83%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

March 2019	1. Chronic pain business case – prepare and submit business case for additional resource to Board.	None until agreed and finance released.		Preparatory work for business case being done by existing clinical staff. Bid dependant on multidisciplinary input.	Bid may not be successful or may not be successful in its entirety.
	2. Waiting list initiative – chronic pain service	Medium (5-15%)	Central budget underspend	Increase in capacity and throughput, dependent on availability and willingness of staffing and supervision/admin.	Increased load on existing staff, out with working hours, potential for admin lag. Need for managers to be fully aware of process
	3. Opt-in specialities that breach standard.	Small (1-5%)	From within existing sources	Additional load on admin.	
	4. Make vetting process in General medical speciality more rigorous	Small (1-5%)	From within existing sources	Dependant on information from referrers from non-mental health speciality.	Time spent by clinicians seeking further information could impact on their clinical capability. Suitable patients may get vetted out due to poor provision of information rather than inappropriateness for service.

June 2019	1. Chronic pain business case – awaiting outcome of business case 2. Extend waiting list initiative to general medical speciality	 Medium (5-15%)	 Central budget underspend	Board process. Increase in capacity and throughput, dependent on availability and willingness of staffing and supervision/admin.	Dependant of success of business case. This service has experience 100% increase in referrals in the last 4 years with no additional resource. A waiting list initiative will only act to temporarily reduce waits without long-term sustainability of reduced waits.
September 2019	1. Chronic pain business case – advertise post(s)	None	From within existing resource	Dependant on HR and recruitment process timescales.	Dependant of success of business case.
December 2019	1. Chronic pain business case - recruit	Large (15-30%)		Increase in capacity and throughput. Dependant on HR and recruitment process timescales.	Dependant of success of business case.

Community Paediatric Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	0%*Compliance is more typically around 30%, hence the starting base for these figures is low.	25%	35%	35%	60%	70%	80%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
Sept 2019	1. Clarity on criteria for Psychology waiting list	Small (5 – 10%)	From within existing resources	Agreement across Community Paediatric and consultation with CAMHS service.	Tighter focus on service provision to identified population.. Mitigated by identification of gaps in service that might be filled by appropriate service and community based resources e.g. OSS.
	2. Introduction of individual caseload management via caseload review tool and outcome measures to increase throughput of cases	Medium (10%)	From within existing resources	Pressure from other services/ disciplines to maintain caseload. Support for clinical staff to discharge patients.	Limited number of experienced supervisors to oversee caseload management. Increased risk to patients and organisation in situations where individuals are discharged and subsequently experience harm. Mitigated by

					agreed risk assessment and management procedures within the service.
	3. Start of Assistant psychologist in fixed term post. Release up to 8 sessions of qualified Clinical Psychologist time in undertaking observations, completing focal pieces of clinical work and preparing resources.	Medium (5-15%)	From within existing resources		Fixed term until March 2020. If post is not continued likely to lose current post-holder prior to end of contract with loss of capacity from qualified staff once more.
	4. Loss of staff member	Large negative (15-30%)	Increase in underspend		Requirement for other clinical staff to absorb workload. Increased pressure on administrative staff responding to waiting list queries. Increased pressure on psychology lead in managing waiting lists and responding to queries
	5. Failure to make current 8A fixed–term Scottish government post permanent	Large negative (15-30%)	Increase in underspend		Current post-holder likely to leave within 2-3 months if post not confirmed as permanent. Unlikely would be able to recruit to remainder of term – to march 2020. Requirement for other clinical staff to absorb workload. Increased pressure on administrative staff responding to waiting list queries. Increased pressure on psychology lead in managing waiting lists and responding to queries.

Dec 2019	1. Development of workshops on introduction to psychological work and behavioural principles. To be offered to families prior to beginning 1:1 work. Brief intervention for those requiring minimal input and to increase engagement and efficacy of 1:1 treatment. 2. Development of new neurodevelopmental service outwith Community Paediatrics (see detail in CAMHS section of Improvement Plans; new service will support children who might otherwise have accessed CAMHS or Community Paeds). This will significantly reduce proportion of clinical time dedicated to neurodevelopmental assessment and follow-up.	Medium (5 - 15%) Large (35%)	From within existing resources. Group development time, availability of physical resources for groups, administrative support for groups Significant financial investment in staffing for new pathway. Need to re-allocate/ define resources from several disciplines	Support of other disciplines/ agencies in supporting this approach Financial investment from Partnership. Full engagement from NHS and partner agency services within A&A	Attrition rate associated with group interventions; clear re-engagement pathways. Limited effect upon need for individual interventions. Mitigated by quality training and delivery of groups from evidence-based programmes. Lack of financial investment. Risk mitigated by business plan and application for funding supported by senior management. Lack of engagement from services and agencies mitigated by involvement in implementation of pathway and recruitment of staff invested in its success.
Mar 2020	1. Development of groups based on STEPPS program for selected groups of parents prior to engage in psychological work on behavioural and emotional regulation difficulties for their children	Medium (5 - 15%)	Potential additional cost attached to training to use this model) OR From within existing resources. Group development time, training for staff involved in groups, availability of physical resources for groups, administrative support for groups	Work with staff within AMH Psychology to develop an appropriate model.	Attrition rate associated with group interventions; clear re-engagement pathways. Limited effect upon need for individual interventions. Mitigated by quality training and delivery of groups from evidence-based programmes.

Older Adult Psychology Service

1. The LDP Standard for Older Adult Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	99%	99%	99%	99%	99%	99%	99%	99%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
March 2019	1. Inpatient pilot – dedicated clinical sessions allocated to two clinicians	Medium (5-15%)	From within existing sources	Increased administrative load.	Short-term reduction in community case load monitored in weekly meetings
	2. Introduction of case management – revised job plans	Medium (5-15%)	From with existing sources	Increased adherence to appropriate case numbers	Lowering of staff morale; Increased communication and transparency regarding intention and aim. Vulnerability to change due to other service developments.
	3. Assistant Psychologist (1.0WTE) providing clinical and administrative support - ongoing	Medium (5-15%)	From Scottish Government underspend to March 2020(dropped 0.3WTE)		Supervision requirements for non-qualified staff member (weekly with 8A Clinical Psychologist); however, mitigates risks for working unsafely etc.
	4. Capability Pathway 1.0WTE 8a Clinical Psychologist	Large Negative (15-30%)	NES temporary funding		Weekly meetings to review waiting list regarding risks of

	(0.2WTE Clinical Psychologist 8B)				breaching to be able to respond timeously if required.
	5. Regular attendance at CMHTE referral meetings – consultation	Small (1-5%)	From within existing sources		Inequitable resource allocated to different areas – Assistant Psychologist allocated one meeting to facilitate communication.
	6. Weekly vetting meetings	Small (1-5%)	From within existing sources		
June 2019	1. CBT teaching and coaching groups to Elderly Mental Health (main referrers)	Small (1-5%)	From within existing sources	CBT resource in EMH lower since 2018 due to retiral of 1.0 WTE CBT therapist in EMH. Two 0.2WTE CBT therapists employed this year, supervised by 8B Clinical Psychologist (group supervision).	Attendance at offered CBT groups dependent on staff not managed by OAPS. Managed by agreeing dedicated time from EMH Line Managers and feeding back attendance. Ongoing evaluation from and of group members and responding to feedback.
	2. Inpatient pilot end – develop inpatient referral criteria	Small (1-5%)	From within existing sources		Inpatient service manager resistance – managed via liaison with appropriate leads regarding criteria.
	3. Stress & Distress informed practice teaching	Small (1-5%)	From within existing sources		
	4. Planned Maternity Leave 0.7WTE 8a Clinical Psychologist	Large Negative (15-30%)		See below. Inpatient criteria will absorb Psychiatric Liaison cases with no dedicated time allocated. Both	Significant loss of capacity within team. Proposed bid for 0.5 WTE 8A has been submitted.

				Consultant Psychiatrists in EMH-Liaison team will not be available as of this time period (one due to leaving post and the other on maternity leave) which may impact on referrals.	
Sept 2019	1. Assistant Psychologist (1.0WTE) providing clinical and administrative support – ongoing as above 2. Regular attendance at CMHTE referral meetings – consultation, - ongoing as above 3. Weekly vetting meetings – ongoing as above				
Dec 2019	1. Assistant Psychologist (1.0WTE) providing clinical and administrative support – ongoing as above 2. Regular attendance at CMHTE referral meetings – consultation, - ongoing as above 3. Weekly vetting meetings – ongoing as above				
Mar 2020	1. Temporary funding for posts ends (2.0 WTE – 1.7WTE				Significant loss of capacity within team. Proposed bid for 0.5 WTE

	Clinical Psychologists and 1.0 Assistant Psychologist)				8A and Clinical Nurse Specialist has been submitted.
Jun 2020	See all previous ongoing actions				
Sep 2020	See all previous ongoing actions				
Dec 2020	See all previous ongoing actions				

Neuropsychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Neuropsychology	95%	95%	95%	80%	84%	90%	90%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
March 2019	2. Clinically Urgent patients (diagnostic) are prioritised as is ward work. 3. Employment of 0.8 wte clinical psychologist 4. Opt in initiative for wait list	Small (0%) Small (1-5%) Small (1_5%)	From within existing sources From with existing sources From existing sources		Administrative load to activate the opt in for the waiting list – potential to redistribute some the task within the admin team. . New member of staff – need to ensure they do not become overloaded too quickly with the volume of clinical work. Department induction and supervision to be in place and functioning well in advance of taking on cases Board employment of locum neurologist likely to increase referral rate to acute neuropsychology, especially for diagnostic work. Close monitoring and distribution of referral criteria to locum service via the medical clinical lead will be required. Job planning for consultant clinical psychologist will result in a change of remit but will not

					increase clinical capacity for acute neuropsychology but will for neurorehab.
June 2019	1. Introduction of NES education group	Medium (5-10%)	From within existing sources	New psychologist will need to familiarise self with education materials and process for onward referral. Administration load required to activate and the group	Protection of clinical time to allow for this process which will initially affect clinical capacity
	2. Increased capacity from new 0.8 wte clinical psychologist	Medium (5-15%)	From existing resources	Access to clinical space not within our control within the acute sector	Utilise current vacant space due to maternity leave – project clinical need and communicate with acute sector to enable increased clinical space
Sept 2019	1. Return of 1.0wte Clinical Psychologist from maternity leave	Large (20%)	From existing resources		Increase in breaches due to routine cases being engaged more frequently and backlog being reduced.
	2. Introduction of mood well being group for neurological conditions	Med (10%)	From existing resources	Administrative load to start the group Importance of data collection to evaluate the clinical impact of the group to	Bedding in the distress thermometer into PD clinics to ensure correct patients are referred to the group and or service – promote education into the acute teams to familiar themselves with the stepped care model of psychological care for their patient populations.
December 2020	Continue with the above actions	Medium			

North AMH Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
	60%	60%	55%	65%	70%	75%	85%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
June 2019	1. Advertise for 1.0 WTE Psychologist	nil	Funding from existing budget	Post was planned as additional resource but will be covering for maternity leave for 1st year (see Sept 19).	
September 2019	1. Participate in redesign of community mental health services in North- merge CBT waiting lists.	Large Negative (15-30%)	From existing resources	This action is contingent on progress with wider service re-modelling. Combined numbers of merged CBT list will be around 130. New model of care has potential to increase demand on Psychology team further in short term, particularly through lack of capacity	Decreased morale among CAAPs, clinical nurse specialists who will see waiting times increase. Need to review core business of service. In long term with partner buy-in, service should have increased control over waiting list and referral stream. Opportunity to look at ways to address high levels of re-referrals from within

				among nurses to provide psychological interventions.Disruption to service as staff are relocated.	CMHS to psychology = 33.3% est. Changes made incrementally= hard to predict.
	2. Planned Maternity Leave 1.0 8a Clinical Psychologist	Large Negative (15-30%)	Small increase in underspend		Significant loss of capacity within team; limited cover from WL clinics. Loss of supervision/consultation resource to in-patient service for North patients at Woodland view. There will be only 0.8 WTE clinical psychologist available for cognitive testing until next quarter) and supervision of Clinical psychology trainees.
	3. Waiting List Reduction Clinics	Medium (5-15%)	Central budget underspend	Increase in capacity and throughput, dependent on availability of staffing and supervision/admin. Dependent on negotiating funding for increased admin support	Possible that there will be limited interest (as before). For those who do come forward there will be increased workload which could impact on stress levels. Potential for admin lag due to increased demand.
	4. Review counselling waiting list	Small (1-5%)	From existing resources	Patients might be transferred to other waiting lists, so that numbers will not decrease overall, although suitability might be matched better.	Potential impact on morale of staff from reviewing vetting decisions.
December 2019	1. Return of 1.0wte Clinical Associate from maternity leave	Small (1-5%)	From existing resources	Mat leave ends around October (tbc). Temporary contract due to end in	Liaise with managers to look for permanent funding

				March	
	2. Participate in redesign of community mental health services in North: Changes made incrementally from previous period	nil		This action is contingent on progress with wider service re-modelling. There may be ongoing disruption to service..	Decreased morale and increased stress through process of change will need managed.
	3. Design transdiagnostic therapy group for patients transitioning from PCMHT to new model of care	nil	From within existing sources	Group needs to be developed according to evidence based practice to fit with overall model of care. This will require considerable input from Psychology staff and admin to manage wait.	This will initially lead to increase wait in averaged trajectory as staff need to free up capacity but a small benefit should become more apparent over time.
	4. Possible sharing of 0.2 WTE Clinical Associate based in East CMHT	Small (1-5%)	From within (East) existing source	Depends on demand-capacity in East team	
	5. New 1.0 wte Psychologist commences post in CMHT.	Large (8-10%)	From within existing sources	Available clinic space to meet expected clinical capacity for this post-holder. Admin support to enable timely uptake and throughput of cases.	Regular line management meetings at outset and supervision established to support new staff member reduce capacity of consultant psychologist. Lack of experience requires planned CPD over 1-2 years to skill up to manage complexity.
March 2020	1 Increase frequency of mindfulness stress reduction groups	Small (1-5%)	From within existing sources	Anticipated that when service redesign is settled we could make more use	Increased demand on CAAP facilitator who will also be trying to address long CBT waiting list

	2 Start transdiagnostic therapy group for patients transitioning from PCMHT to new model of care	Small (1-5%)	From within existing sources	of mindfulness groups across Psychology service.	(see Sept 19). Might need to look for co-facilitator
June 2020	Dependent on outcome of above actions and new model of CMHS				
September 2020	Return of 1.0wte Principal Psychologist from maternity leave	Medium (10%)	From existing resources	Mat leave ends around August 2020. This will allow us to make use of full establishment of Psychology staff	Psychologist may request reduction in hours on return to 0.8 WTE
December 2020	North Community will have completed redesign of service and will be functioning with full establishment of staff plus new recruits embedded				

South AMH Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
Performance against the LDP standard (%)	76%	84%	72%	74%	85%	86%	88%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
June 2019	1. New 1.0 wte Psychologist commences post in CMHT.	Medium (8-10%)	From within existing sources	Available clinic space to meet expected clinical capacity for this post-holder. Admin support to enable timely uptake and throughput of cases. CPD opportunities required to establish full capacity to manage complexity of caseload expected in CMHT Psychology.	Early liaison with stakeholders re post-holder. Establish balanced caseload ready for post-holder. Timely department induction. Job Plan outlined on commencement of post. Regular line management meetings at outset and supervision established to support new staff member. Lack of experience requires planned CPD over 1-2 years to skill up to manage complexity.
Sept 2019	1. 1.0 wte Experienced CAAP leaves PCMHT service middle of September. 2. Timely recruitment process	Large Negative (--17-20%)	From within existing sources.		Increase in CBT WL expected due to reduced capacity.

	commenced to replace 1.0 wte CAAP.	Negligible	From within existing sources	Time taken for scrutiny panel process. Timely liaison from recruitment/HR.	Timely completion/submission of recruitment paperwork. Monitor CBT WL with staff and utilise extra capacity within the speciality where appropriate.
	3. Manage capacity: Reduce CBT WL from 2 to 1 across Psychological Specialty. 4. Manage demand: Introduce CBT assessment clinics.	Medium (5-7%)	From within existing resource	Admin support required to facilitate and manage changes to CBT list/clinics (i.e. streamline systems/processes, manage assessment clinics, etc). Reduction in admin processes/demand once bedded in. Increased throughput and sign-posting.	Admin capacity. Navigating systems-Admin managing patients on 1 CBT list who will be on different databases (pcmht v cmht) with different centres of care/teams, until such time as wider service re-modelling occurs. Clarity for admin and clinicians will be provided from process mapping work. Clinicians will need support in CBT assessment clinics from senior staff regarding appropriate sign-posting.
	5. Principal Psychologist leads on recruitment and facilitation of 10 week Survive and Thrive course as part of complex trauma pathway, delivered with an MDT colleague.	Small (1-3%)	From within existing resource	Temporary reduction in capacity for psychologist (0.5 wte per week for 10 weeks). Psychologist is required to lead on this from a governance perspective.	Lack of appropriate cases from within psychological specialty. Plan recruitment in advance. Requested further national (& local) NES S&T training opportunities given good outcomes.
	6. Consultant Psychologist provides clinical supervision for 10 week Survive and Thrive course (1 hr fortnightly).	Small (0.5%)	From within existing resource.	MDT colleagues available to co-facilitate. Availability of NES S&T training to skill up other psychologists to share facilitation role. Awareness in team of selection	Clinical Outcomes analysed over consecutive groups to ensure effectiveness of treatment/mitigate risks.

				criteria/appropriate cases. Requires admin burden is shared with MDT colleague/co-facilitator.	
	7. Refine demand: Conduct review of suitability criteria for Psychological Specialty with stakeholders in MH service in South Ayrshire in preparation of re-modelling work.	Small (1-3%)	From within existing resource.	Service manager, Team Lead and wider MH staff engagement in the process. Increases awareness in stakeholders/referrers & reduces inappropriate referrals.	Lack of training and understanding of psychological interventions, matched/stepped care model and demands elsewhere, lead to potential disagreement. Requires communication and feedback with referrers. Requires consistent response to referrals and strong leadership.
	8. Refine demand: Share local framework with wider team regarding availability of high volume (HV) and low intensity (LI) interventions available as part of the stepped/matched care approach.	Small (1-3%)	From within existing resource	Consensus agreement with Senior manager, Team Leads and staff regarding roles and provision of psychological interventions at different levels of intensity. Requires local strategy relating to training and implementation of LI and HV for wider MH workforce in LI and HV psychological interventions.	Resistance and low morale in wider workforce re evidence base for psychological interventions and governance role, in light of competing demands & resources. Requires Integrated strategy around psychological interventions and forums/opportunities for senior staff to discuss/lead. Challenges to implementation of training and reduced governance of LI/HV interventions results in lack of delivery at this level and inappropriate referral on to the Psychological Specialty.

Dec 2019	1. Principal Clinical Psychologist reduces direct clinical capacity by 0.5-1.0 wte to provide 10 month placement for AMH Trainee Clinical Psychologist.	Medium Negative (- 5-8%)	From within existing resource	Liaison with stakeholders Admin support required. Clinic space available	Reduction in capacity and throughput of cases for Psychologist. Placement/competency difficulties resulting in increased demand on supervisors time (i.e., increased level of observations/recordings & liaison with stakeholders).
	2. Establish new PATS Model for South Ayrshire Psychological Specialty.	Medium (5-7%)	From within existing resource.	This action is contingent on progress with wider service re-modelling. Enables more flexible and effective use of psychology resource. Streamlines process. Administrative support/capacity required to facilitate changes with systems and processes. Once bedded in should result in reduction of admin tasks. Requires buy in from stakeholders and support from Senior Managers and TL's. Improves performance management ability. Provides psychological specialty staff with clarity of role. Increases capacity for some staff by removing unnecessary team related tasks.	Could be delayed-Contingent upon wider service re-modelling. Process mapping will provide clarity regarding processes for staff. Changes made incrementally. Regular communication with staff in both PCMHT and CMHT at business meetings. Re-modelling work done in a collaborative manner in partnership.

		Small (1-3%)			
	3. Two Principal Clinical Psychologists deliver 18 week Compassion Focussed Therapy Group (part of complex trauma pathway).		From within existing resource.	Requires reduction in capacity of 2 Psychologists in order to recruit to and deliver the group effectively. Dependent upon available cases on the psychology waiting list.	High attrition from group. Clear engagement policy Suitable cases may not come from within existing psychology WL (i.e., new demand). Clinical outcomes/qualitative feedback monitored to mitigate risks of delivery.
	4. Tighten referral requirements (i.e. stated clinical rationale) for intra-team referrals.	Small (1-2%)	From within existing resource	Require communication and engagement with MDT colleagues on this matter. Requires support from Team Lead.	Risk of referrals not accepted without adequate info/meeting new requirements. This will be raised at consecutive business meetings. MDT colleagues invited to attend psychological specialty referral meeting to discuss cases and increase awareness of expected referral practice.
March 2020	1. Recruitment: CAAP (1.0 wte) has commenced post and taken up full caseload.	Large (10%)	From existing resource.	Available clinic space to meet expected clinical capacity for this post-holder. Admin support to enable timely uptake and throughput of cases. CPD opportunities required to establish full capacity.	Early liaison with stakeholders re post-holder. Establish balanced caseload ready for post-holder. Timely department induction. Job Plan outlined on commencement of post. Regular line management meetings at outset and supervision established to support new staff member. Lack of experience requires planned CPD over 1-2 years to skill up to level required.

	2. Principal Psychologist leads on recruitment and facilitation of 10 week Survive and Thrive course for complex trauma, delivered with an MDT colleague.	Small (1-3%)	From existing resource.	As Above	As above
	3. Consultant Psychologist provides clinical supervision for 10 week Survive and Thrive course (1 hr fortnightly).	Small (0.5%)	From existing resource	As Above	As Above
June 2020	1. Audit patient attendance rates & implementation of psychological specialty attendance policy.	Small (1-3%)	From existing resource	Increased focus on this in clinical supervision, reinforced via line management. Communication with staff and engagement by staff.	Anxiety in staff. /fear of complaints. Support staff in making difficult decisions/having difficult conversations. Keep on the agenda of business meeting.
Sept 2020	1. Principal Psychologist leads on recruitment and facilitation of 10 week Survive and Thrive course for complex trauma, delivered with MDT colleagues.	Small (1-3%)	From existing resource	As Above	As Above
	2. Consultant Psychologist provides clinical supervision for 10 week Survive and Thrive course (1 hr fortnightly).	Small (0.5%)	From existing resource	As Above	As Above
	3. A CAAP shadows above activity with a view to leading on similar intervention for	Small negative (- 3-5%)	From existing resource	Requires temporary reduction in CAAP capacity (0.5 wte per	Small increase in CBT WL length. Increase in CAAP knowledge. Development of novel initiative for

	milder trauma/PTSD population.			week).	milder trauma population going forward. Meeting local demand mitigates risk.
Dec 2020	1. Clinical Psychologist leads on delivery of 18 week Compassion Focussed Therapy Group (part of complex trauma pathway) & in new PAT model a CAAP is introduced as co-facilitator.	Small 1-3%	From existing resource	Reduction in capacity for CAAP & Psychologist. CAAP will require CFT CPD/training. Requires existing cases on Psychology WL. Requires admin support to arrange screening appointments.	Introducing a CAAP as co-facilitator frees up a psychologist for highly specialist level intervention whilst retaining appropriate governance levels for the CFT group (1 Psychologist will continue to lead). Small increase in CBT WL length due to temporary reduction in CAAP capacity.
	2. Principal Clinical Psychologist reduces direct clinical capacity by 0.5-1.0 wte to facilitate supervision of AMH Trainee Clinical Psychologist.	Medium Negative (5-8%)	From existing resource	As Above	As Above

East AMH Psychology Service

1. The LDP Standard for Psychological Therapies is for at least 90% of people to start treatment within 18 weeks of referral. **Please complete the table with your trajectory for meeting the standard by, or before, December 2020.**

Quarter ending	Mar 2019	Jun 2019	Sep 2019	Dec 2019	Mar 2020	Jun 2020	Sep 2020	Dec 2020
	25%	17%	37%	42%	47%	60%	75%	90%

2. **Please describe the actions that will be taken each quarter to deliver the above trajectory, the expected impact of these actions on progress towards the standard, and any associated dependencies and risks.** Actions might include for e.g.: recruitment of specific staff; waiting list initiatives; improvement work to improve processes; wider system change; etc. An example is included in the table below.

Quarter ending	Action(s)	Forecast impact on standard	Funding – source and amount	Interdependencies (i.e. between performance, funding, workforce, partners)	Risks and steps to mitigate
March 2019	• Change to model of delivery of Psychological Specialty AMH delivering care to patients in acute MH inpatient wards. East now have commitment to offer 1 session per week.	Small negative (1-3%)	Existing resource	Stakeholders wish further discussions about model of delivery this may or may not have impact on demand capacity.	Internal management of demand has reduced referral rates in collaboration with partners and stakeholders. Changes in staffing within other disciplines may impact on this.
	• Commencement of two (2 wte) fixed term (until end March 2020) Clinical Associates in Applied Psychology. Commitment that one of CAAP will have a one ring fenced day per week (including admin, patient work) from September 19 to March 20	Medium positive (5-15%)	Temporary fixed term NES funded posts		Newly qualified staffing requiring investment in increased supervision for senior staff Risk of temporary posts that either or both will secure other posts (have planned permanent CAAP post in South due for advert).

	• To ensure equity of access to high intensity Cognitive Behavioural Therapy merged two treatment waiting lists one hosted in PCMHT for treatment delivered by CAAP (1.5 wte permanent clinicians & longest wait 75 weeks RTT) and other hosted in CMHT for treatment delivered by CNS in CBT (0.7 wte & longest wait 60 weeks RTT). By end of the merger 59 patients were on the waiting list (patients who had been offered appointments in April and May were not counted in this number).	Small positive (1-3%)	From existing resource	Required joint working and significant support from admin colleagues.	Patients that previously waited solely on 0.7 wte clinician now have opportunity to be seen by additional clinicians. Large waiting times means this will only have an impact for the sake on compliance on those patients meeting criteria for priority.
	• Ongoing commitment from Consultant Clinical Psychologist to contributing to the PCMHT/CMHT review. Through multidisciplinary subgroup lead on generating proposal to assist managing waiting times.	Medium negative (-5-15%)	From existing resource	East Partnership senior managers presented one alternative proposal & generating another. Review undertaken for one year still no shared vision on service improvements/redesign.	Subgroup proposal noted (information gathered as evidence) that CPN in CMHT are not delivering low intensity psychological interventions and that they have limited capacity among their other core duties to deliver psychologically informed work. Risk is that Psychological Specialty are receiving greater volume of referrals ; also that the dose (number of sessions required) from the Psychological Specialty clinicians is greater given that the greater scope of psychological work needs to be covered. Also risk that as role of CPN in delivering psychologically informed interventions such as

					safety and symptom stabilisation is not established that there will be miscommunication and deterioration in working relationships between CPN and other clinicians. When review is complete it is planned that all Psychological Specialty clinicians will be hosted by only one functional team – this will have potential impact on where receive admin & on administrative base for clinicians.
	• 0.8 wte 8b Clinical Psychologist commenced maternity leave	Medium negative (-5-15%)	From existing resource		Leading up to maternity leave has not been in a position to commence new treatment cases leading to increasing waiting times. Specialty now only has 1.4 wte. Planning for this the part-time Consultant Clinical Psychologist took on clinical supervision of first year Trainee Clinical Psychologist (12.5% of their overall capacity) & also absorbed line management of Trainee Clinical Psychologist & supervision of Clinical Psychologist this has had a significant negative impact on capacity to offer treatment appointments. Increased demands on remaining clinicians potential to lead to admin backlog.
June 2019	May • Identified pattern within EAPCMHT of under vetting	Medium negative (-5-	From existing resource		If patients are suitable for counsellor then they are likely to

	referrals for consideration by counsellors. Carrying out review of referrals into Self Help Worker treatment waiting list (current longest wait RTT 34 weeks) early indication that significant percentage will be suitable for an assessment with counsellor.	15%)			have already waited for in excess of 18 weeks RTT. Will use the information from this review (and a previous one) to assist the Primary Care Practitioners whom vet to improve identification of suitable cases, to improve patient pathway.
	June • Two permanent part-time (collectively 1.5 wte) 8a Clinical Psychologists commencing.	Small negative (-1-5%)	From existing resource	Available clinic space to meet expected clinical capacity for this post-holder. Admin support to enable timely uptake and throughput of cases. CPD opportunities required to establish full capacity.	Will have a positive impact on the patient numbers waiting, however, given the significant wait times main impact will have on assisting compliance is that can take on any priority referrals more quickly as more capacity. Indeed potentially overall may have a negative impact on compliance given that there will be a significant volume of patients waiting over 18 weeks being taken off the waiting list.
	• Two fixed term CAAP continuing to develop their caseload	Medium positive (5%)			
September 2019	• 2 fixed term CAAP will be position to refresh a percentage of their caseload. • Additional 8a role to address backlog	High positive (20%) Medium (15%)	Dependent on additional resource	Requires Head of Mental Health approval	Anticipated that after 5 months there will be movement and volume of additional patients commencing treatment. Risk of further periods of absence from within the HI CBT which would have negatively impact on

					capacity.
December 2019	• Return of 0.7wte Clinical Psychologist from maternity leave. • Nearing end of fixed term CAAP (2.0wte) contract. Compile evidence of impact to date on waiting times and compliance.	Small positive (1-5%)	From existing resources	Mat leave ends around December (tbc).	Will have a positive impact on the patient numbers waiting, however, given the significant wait times main impact will have on assisting compliance is that can take on any priority referrals more quickly as more capacity. Liaise with managers to look for opportunities to secure permanent funding. Needs to be consideration of impact additional clinical resource will have on admin colleagues. Prior to fixed term CAAP commencing was considerable negotiation over this issue.
March 2020	• Return of 0.8wte 8b Clinical Psychologist from maternity leave	Medium positive (5-15%)	From within existing sources	Mat leave ends around February (tbc). Anticipate that there will be pressure on providing adequate admin when at full establishment (already in discussion with Admin manager about this).	Anticipated that since June will have had 2.2 wte Clinical Psychologist resource more than currently, so being back to original full establishment of Psychologists creates opportunity to make significant improvement to patient numbers waiting and the wait times. Noted as small rather than medium as 8b has additional duties to clinical duties e.g. line manging Trainee Clinical Psychologist. Risk of further

	• Current planned end End of fixed term CAAP contracts	Medium negative (5-15%)			periods of absence from within the Psychologists which would have negatively impact on capacity.
June 2020	Audit patient attendance rates & implementation of psychological specialty attendance policy.	Small (1-3%)	From existing resource	Increased focus on this in clinical supervision, reinforced via line management. Communication with staff and engagement by staff. Looking at other models for example in acute services.	Anxiety in staff. /fear of complaints. Support staff in making difficult decisions/having difficult conversations. Keep on the agenda of business meeting.
September 2020	Continue discussions with admin manager regarding having access to dictation	Small (1-3%)	Need additional capacity in admin resource	Only able to acquire dictation when medically required by a clinician during a temporary condition.	If continues to be no access to this facility then the burden of additional administrative tasks will fall on clinicians and have an impact on their capacity to see patients.
December 2020	Having full establishment of Clinical Psychologists (most for a period of 12 months)	High positive (10-20%)	From existing resource		Anticipated that after 12 months there will be movement and volume of additional patients commencing treatment. Risk of further periods of absence from within the Psychologists which would negatively impact on capacity.