NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board Meeting

Thursday 16 November 2017 at 10.00 a.m.

Council Chambers, Cunninghame House

1. Apologies
Invite intimation of apologies for absence.

2. Declaration of Interest

3. Minutes / Action Note (Page 5)
The accuracy of the Minutes of the meeting held on 14 September 2017 will be confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973 (copy enclosed).

3.1 Matters Arising
Consider any matters arising from the minutes of the previous meeting.

Presentation

4. Café Solace

5. Director's Report (Page 17)
Submit report by Stephen Brown, Director (NAHSCP) on developments within the North Ayrshire Health and Social Care Partnership (copy enclosed).

6. Meeting Dates 2018 (Page 29)
Submit report by Angela Little, Committee Services Officer, on the draft timetable for meetings of the IJB and IJB PAC for 2018 (copy enclosed).

Finance

7. 2017/18 Financial Performance Update as at 30 September 2017 (Page 39)
Submit report by Eleanor Currie, Principal Manager – Finance, on on the projected financial outturn for the financial year 2017/18 as at 30 September 2017 (copy enclosed).

Quality and Performance

8. Chief Social Worker Officer Annual Report (Page 67)
Submit report by David MacRitchie, Chief Social Work Officer, on the Chief Social Work Officer Report 2016-17(copy enclosed).

9. Findings & Recommendations from Service Review of Pan Ayrshire Psychological Services (Page 103)
Submit report by Thelma Bowers, Head of Service (Mental Health), on progress of the Service Review of Pan Ayrshire Psychological Services (copy enclosed).

Strategy and Policy

10. HSCP Strategic Plan 2018-21 (1st Draft) (Page 377)
Submit report by Scott Bryan, Team Manager (Planning), on the current status of the development of the partnership's new three year strategic plan for the period April 2018 – March 2021 (copy enclosed).

Tendering

11. Peer support, recovery and employability support services for people with mental health problems in North Ayrshire (Page 381)
Submit report by Dale Meller, Senior Manager (Community Mental Health), on the peer support service specification prior to public procurement (copy enclosed).

12. Urgent Items
Any other items which the Chair considers to be urgent.

Integration Joint Board

Sederunt

Voting Members

Stephen McKenzie (Chair)	NHS Ayrshire & Arran
Councillor Robert Foster (Vice Chair)	North Ayrshire Council
Councillor Timothy Billings	North Ayrshire Council
Alistair McKie	NHS Ayrshire and Arran
Councillor Christina Larsen	North Ayrshire Council
Bob Martin	NHS Ayrshire and Arran
Dr. Janet McKay	NHS Ayrshire and Arran
Councillor John Sweeney	North Ayrshire Council

Professional Advisors

Stephen Brown	Interim Director North Ayrshire Health and Social Care
Margaret Hogg	Section 95 Officer/Head of Finance
Dr. Paul Kerr	Clinical Director
David MacRitchie	Chief Social Work Officer – North Ayrshire
Dr. Mark McGregor	Acute Services Representative
Alistair Reid	Lead Allied Health Professional Adviser
David Thomson	Lead Nurse/Mental Health Advisor
Vacant	GP Representative

Stakeholder Representatives

David Donaghey	Staff Representative – NHS Ayrshire and Arran
Louise McDaid	Staff Representative – North Ayrshire
Marie McWaters	Carers Representative
Sally Powell	Carers Representative
Fiona Thomson	Service User Representative
Nigel Wanless	Independent Sector Representative
Vicki Yuill	Third Sector Representative
Vacant	Service User Representative

North Ayrshire Health and Social Care Partnership
Minute of Integration Joint Board meeting held on
Thursday 14 September 2017
at 10.00 am, Council Chambers, Cunninghame House, Irvine

Present
Stephen McKenzie, NHS Ayrshire & Arran (Chair)
Councillor Robert Foster, North Ayrshire Council (Vice Chair)

Councillor Timothy Billings, North Ayrshire Council
Councillor Christina Larsen, North Ayrshire Council
Bob Martin, NHS Ayrshire & Arran
Dr Janet McKay, NHS Ayrshire & Arran
Alastair McKie, NHS Ayrshire & Arran

Stephen Brown, Interim Director North Ayrshire Health and Social Care (NAHSCP)
Margaret Hogg, Section 95 Officer/Head of Finance
Alistair Reid, Lead Allied Health Professional Adviser
David Thomson, Lead Nurse/Mental Health Advisor
Louise McDaid, Staff Representative – North Ayrshire Council
David Donaghey, Staff Representative – NHS Ayrshire and Arran
Fiona Thomson, Service User Representative
Nigel Wanless, Independent Sector Representative
Sally Powell, Carers Representative
Barbara Hastings, Third Sector Representative

In Attendance
David Rowlands, Head of Service (Health and Community Care)
Thelma Bowers, Head of Service (Mental Health)
Eleanor Currie, Principal Manager (Finance)
Donna McKee, Head of Service (Children, Families and Criminal Justice)
Isabel Marr, Senior Manager (Long Term Conditions)
Jan Philip,
Jan Thomson,
John Godwin, Senior Development Officer
Tom Henderson, Social Enterprise Manager
Karen Andrews, Team Manager (Governance)
Angela Little, Committee Services Officer
Euan Gray, Committee Services Support Officer

Also In Attendance
Pat Kenny, Deloitte
Councillor Anthea Dickson, North Ayrshire

Apologies for Absence
Councillor John Sweeney, North Ayrshire Council
Dr Paul Kerr, Clinical Director
Vicki Yuill, Third Sector Representatives
Marie McWaters, Carers Representative

1.	**Apologies** Apologies were noted.	
2.	**Declarations of Interest** In terms of Standing Order 7.2 and Section 5.14 of the Code of Conduct for Members of Devolved Public Bodies the following Members declared an interest:- Nigel Wanless – Item 7 - Financial Performance Update – on the basis of the effects on care home placements. Janet McKay – Item 16.1 – Hansel Alliance – on the basis of a family connection. In terms of Standing Order 7, the Board agreed that the Members did not require to leave the meeting and could take part in the discussion on these items.	
3.	**Minutes/Action Note** The accuracy of the Minutes of the meeting held on 17 August 2017 were confirmed and the Minutes signed in accordance with Paragraph 7 (1) of Schedule 7 of the Local Government (Scotland) Act 1973, subject to the following amendment:- 3. Declarations of Interest ~~Nigel Wanless – Item 9 – Care at Home Outsourced Service Provision – on the basis that he is a care home provider.~~ "Nigel Wanless – Item 6 – 2017/18 Financial Performance Update – on the basis that he is a care home provider".	
3.1	**Matters Arising from the Action Note** Public Partnership Forum – meetings have taken place and the review will be undertaken within 6 – 12 months. A nomination has been received for the IJB service user representative vacancy. F. Thomson will discuss the nomination with the Director. The Board agreed to agree to adopt the nomination for the Service User Representative vacancy.	F. Thomson/S. Brown.

	Chair of Locality Forums – Kilwinning Locality Forum appointed Robert Steel as Chair. The Board agreed, in terms of Standing Order 2.2 (k) to appoint Robert Steel, in his capacity as the Chair of the Kilwinning LPF, as a non-voting member of the IJB.	A. Little
4.	**Presentation: Palliative and End of Life Care** Isabel Marr, Senior Manager gave a presentation on Palliative and End of Life Care. The presentation provided information on:- • The strategic drivers – palliative and end of life strategy, palliative and end of life knowledge and skills framework and Scotland's National Dementia Strategy 2017-20; • North Ayrshire Approach – review models of care, Ward 2, Woodland View, Care Homes plus specialist bed in Abbotsford and Care at Home; • Identified need in North Ayrshire – training in palliative and end of life care across all sectors; • North Ayrshire palliative and end of life education group; • Palliative care; • End of life care; • Difference between palliative and end of life care; • Training plan that includes 3 levels:- - Informed; - Skilled; - Enhanced; • Timescales; and • Success. Members asked questions and were provided with further information in relation to:- • Training that will be offered to all care at home staff and potentially family carers; and • Palliative care training that is already provided to care at home staff and enthusiasm within the care sector for this training. Noted.	
5.	**Director's Report** Submitted report by Stephen Brown, Interim Director NAHSCP on developments within the North Ayrshire Health and Social Care Partnership. The report highlighted works underway in the following areas:- • Review of Integration Scheme;	

	• Budget update; • Childhood obesity; • Business support review; • Celebrating and recognising success – Rosemount Duke of Edinburgh and COSLA Excellence Awards; • Funky Films; • HSCP Syrian Refugee Co-ordinator; and • Change Programme Update. Members asked questions and were provided with further information in relation to:- • The continuation of the range of interventions and activities that has helped to reduce the levels of childhood obesity in North Ayrshire; and • Consultation that has taken place with stakeholders on the review of the Integration Scheme. Noted.	
6.	**Audited Annual Accounts** Submitted report by Margaret Hogg, Chief Finance Officer on Deloitte's final report to the Members of the Board and the Controller of Audit on the 2016/17 audit. A verbal update was provided by the external auditor, Pat Kenny, Deloitte. The IJB's accounts for the year to 31 March 2017 were submitted to Deloitte LPP in accordance with the agreed timetable. Deloitte have given an unqualified opinion that the 2016/17 financial statements give a true and fair view of the financial position and expenditure and income of the IJB for the year, concluding that the accounts have been properly prepared in accordance with relevant legislation, applicable accounting standards and other reporting requirements. No monetary adjustments have been identified and the IJB's position remains as reported to the IJB on 22 June 2107. The Board agreed to (a) note the findings of the 2016/17 audit as contained in the External Auditor's annual report at Appendix 1 to the report; (b) adopt the Action Plan as outlined in the annual report; and (c) approve the Annual Accounts for 2016/17 for signature.	
7.	**Financial Performance Update** Submitted report by Margaret Hogg, Chief Finance Officer on the financial position of the North Ayrshire Health and Social Care Partnership as at 31 July 2017. The detailed position against the full year budget of £222.962m was set out at Appendix A to the report. Appendix B detailed some savings at risk from delivery and included £1.684m of NHS savings shortfall still to be agreed. The forecasted net position, including the projected underspend of £0.222m was outlined in Appendix C. Appendix D	

	provided full details of £2.957m of mitigations. £1.557m of mitigations and the proposed use of £1.400m of the Challenge Fund, subject to approval by North Ayrshire Council, were outlined at Appendix E to the report. Members asked questions and were provided with further information in relation to:- • An overspend of £2.8m in the Set Aside Budget that is managed in-house by the Health Board, the impact of the proposed mitigation plan on bed occupancy in the Acute Hospital budget, that the IJB may need to meet an increased charge based on the increased activity and that the impact will not be known until budgets are set for 2018/19; • Improved care assessment processes that are now in place to ensure appropriate placements for individuals for the required length of time; • Option 2 that presents a plan to reduce the Challenge Fund by £1.4m; • A positive meeting that had taken place with the Cabinet Secretary where the financial position had been discussed, including plans to reduce the Challenge Fund by £1.4m and work to continue Phase 3 projects; • Work that is ongoing to deliver savings within the Prescribing budgets; and • Savings proposals that have been worked on with NHS to achieve the required savings. The Board agreed to (a) note the projected financial outturn for the year; (b) approve Option 2 as a mitigation plan to reduce the projected deficit to £2.368m; (c) grant authority to the Chief Officer to seek approval from the Council use £1.400m of the Challenge Fund monies to reduce the impact of mitigation on Council commissioned services in 2017/18; and (d) note the intention to bring a further report to the IJB in the near future in relation to the gap in budgets for services commissioned from Health.	
8.	**Cumbrae Review of Services – Integration and whole system change** Submitted report by David Rowland, Head of Service, Health & Community Care, on the outcome of the Cumbrae Review of Services which mapped current services and the needs of people on Cumbrae. Paper 1 to the report provided information on the service mapping that had been undertaken. Details of the public engagement sessions that had taken place were outlined in Paper 2. Paper 3 detailed feedback from the staff engagement session held on 10 July 2017, and a patient's perspective and experiences of services on Cumbrae were provided at Paper 4. The report outlined the proposed development of an integrated hub approach that will allow island partners to work together with Partnership services to meet the health and well-being needs of the population in the most effective way.	

	The Board agreed to (a) approve the HSCP scoping the development of a hub and associated multi-disciplinary team working; (b) endorse further work with the local community, NHS Ayrshire and Arran Estates and North Ayrshire Council Place Team to develop a fully costed plan for a hub; and (c) received a report on progress by 31 March 2018.	
9.	**Learning Disabilities Strategic Plan 2017-2019** Submitted report by Thelma Bowers on the development of the Learning Disability Strategic Plan. The Strategy was attached at Appendix 1 to the report and outlined:- • How we developed the plan; • Our vision, aims and values; • Context for our strategic plan; • What we need to do; • Our plan • The six priority themes; and • Monitoring progress. Members asked questions and were provided with further information in relation to:- • Consultation that had been undertaken with staff, workshops that are planned and the future involvement of the Staff Partnership Forum. The Board agreed to (a) support the Learning Disabilities Strategic Plan 2017/19; and (b) receive a update to a future meeting of the Board.	
10.	**Ensuring Alignment of Advice Services in North Ayrshire** Submitted report by David Rowland, Head of Service, Health & Community Care, on the delivery of fully aligned advice services across North Ayrshire and the future role and function of the directly managed and commissioned services. Appendix 1 to the report provided information on the provision by the Third and independent sectors. The detailed service specification for the proposed tender process was outlined at Appendix 2 to the report. Members asked questions and were provided with further information in relation to:- • Quarterly review meetings that are held with NACAS as part of the Service Level Agreement; • Other funding streams that NACAS had secured to provide specific advice services; • Tribunal services that are no longer provided by NACAS; • The involvement of NACAS in the tender specification and that they would not be precluded from tendering for advice services; • The legislative requirement to procure advice services;	

	• Reconfiguration of the Money Matters Team that would allow them to provide tribunal services. The Board agreed, Councillor Billings and Barbara Hastings dissenting, to (a) develop the capacity of the Money Matters Ream within the totality of the financial envelope available to the Partnership for advice services to secure an appropriate level of serviced, including in-person Tribunal Services for everyone who requires it in North Ayrshire; and (b) commission an appropriate, complementary range of advice services by requesting North Ayrshire Council to procure these through a tender process.	
11.	**North Ayrshire Social Enterprise Strategy** Submitted report by John Godwin, Service Development Officer, on the new North Ayrshire Social Enterprise Strategy (Appendix 1) and potential issues and opportunities for North Ayrshire Health and Social Care Partnership within this framework. The Board agreed to (a) note the report; and (b) the direction of travel of the new North Ayrshire Social Enterprise Strategy.	
12.	**Planning and Delivering Care and Treatment across the West of Scotland** Submitted report by John Burns, Regional Implementation Lead (West), which provided information on the development of Regional Delivery Plans, encompassing a whole-system approach to the delivery and health and social care for each of the three regions (North, East and West). The Board agreed (a) to approve the active involvement of the Chief Officer in the Regional Planning arrangements for the West of Scotland; and (b) that the Chief Officer provides regular updates in respect of progress as appropriate. ** The Chair, Stephen McKenzie, left the meeting at this point. Councillor Foster took the Chair for the remainder of the meeting.	
13.	**Service for Survivors of Childhood Rape and Sexual Abuse** Submitted report by Nicola Murphy, Senior Manager (Children, Families and Criminal Justice) on the requirement to undertake a collaborative tendering exercise to appoint a service provider to deliver a counselling service for survivors of childhood rape and sexual abuse. Members asked questions and were provided with further information in relation to:- • Efficiencies that would be realised as a result of the collaborative tender exercise with East Ayrshire and would not require an increase in current funding.	

	The Board agreed to approve North Ayrshire Council undertaking a tender exercise with East Ayrshire Council to appoint a service provider to deliver a counselling service for survivors of childhood rape and sexual abuse.	
14.	**Minutes of Strategic Planning Group** Submitted the Minutes of the Strategic Planning Group meeting held on 2 August 2017. Noted.	
15.	**Exclusion of the Public** The Board resolved in terms of Section 50(A)4 of the Local Government (Scotland) Act 1973, to exclude from the Meeting the press and the public for the following item of business on the grounds indicated in terms of Paragraphs 3 and 9 of Part 1 of Schedule 7A of the Act.	
15.1	**Hansel Alliance** Submitted report by Jan Thompson on services currently provided by Hansel Alliance, discussions that had taken place with Hansel in relation to the rates charged for these services and work that will be continue to review all service users who access residential and respite services provided by Hansel Alliance. Noted.	
	The meeting ended at 12.05pm	

North Ayrshire Integration Joint Board – Action Note

Updated following the meeting on 14 September 2017

No.	Agenda Item	Date of Meeting	Action	Status	Officer
1.	Volunteering Strategy	11/2/16	Agenda – prior to end 2016	now in receipt of a guidance letter from the Scottish Government and will continue to develop new volunteering strategy with guidance in mind. A first draft will be circulated in October/November for initial comment with a final draft being submitted to the IJB in December.	V. Yuill
2.	Public Partnership Forum	15/12/16	Director to liaise with Service User Representative to investigate matter 14/9/17 - IJB agreed to adopt the nomination for the service user representative	a meeting has now taken place with the Assistant Director of Nursing and Acute Care to agree a way forward. Hope to meet before the end of August with PPF Members regarding the structure of PPF and also to get a view on the review of Integration Scheme.	S. Brown

3.	Technology Enabled Care (TEC) and Innovation	22/6/17	A report on the financial plan will be presented to the August meeting	a report will now be submitted to the IJB to the October or November meeting to enable NHS scrutiny first.	Kathleen McGuire

4.	Presentation – Addiction Service Update	20/7/17	IJB Members to forward suggestions for learning areas		IJB Members

5.	Presentation: What's Important to Me	17/8/17	Shannon Morrison to be invited to meet informally with the IJB – possibly in the October holiday		Karen Andrews

Integration Joint Board
16th November 2017
Agenda Item 5

Subject:	**Director's Report**
Purpose:	To advise members of North Ayrshire Integration Joint Board (IJB) of developments within the North Ayrshire Health and Social Care Partnership (NAHSCP).
Recommendation:	That members of the IJB note progress made to date.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership

1. EXECUTIVE SUMMARY

1.1 This report informs members of the Integration Joint Board (IJB) of the work undertaken within the North Ayrshire Health and Social Care Partnership (NAHSCP) nationally, locally and Ayrshire wide.

2. CURRENT POSITION

National Developments

2.1 National Reference Group – Thematic Scrutiny of Adult Protection

On 19th September 2017 I attended the first meeting of the National Reference Group on the thematic scrutiny of adult protection.

2.2 Chief Officers/CSWA Meeting on Children's Services

On 29th September 2017, the Chief Officers across Scotland met with Iona Colvin, Chief Social Work Adviser, Scottish Government to discuss children's services.

2.3 Education and Skills Committee

North Ayrshire Health and Social Care Partnership, along with other local authorities, agencies and others, was asked by the Scottish Government to comment on the Children and Young People (Scotland) (Information Sharing) Bill and the Illustrative Code of Practice. The Partnership was then invited, by the Scottish Parliament, to give evidence (along with two other local authorities and Edinburgh University) at the Scottish Government Education and Skills Committee in Holyrood on Wednesday 27 September.

Andrew Keir, GIRFEC and Corporate Parenting Manager, represented the Partnership and was called upon to answer questions regarding the Named Person, Getting it Right for every Child and elements of the new Bill and the Code of Practice.

You can watch the session by following this link:
https://www.scottishparliament.tv/meeting/education-and-skills-committee-september-27-2017

Ayrshire Developments

2.4 Children and Young Persons Mental Health

On Monday 11th September 2017, a Children and Young Person's Mental Health Celebration was held in Kilmarnock. Over 170 delegates attended the event from across Ayrshire from health, social care, education, third sector, service users, parents and carers.

The event was opened by Willow, Bessan and Eilidh from Largs Academy – they spoke about their experience using the Wellness Recovery Action Planning (WRAP).

One of the highlights of the day was the presentation by Courtney Gemmell, a Scottish Youth Parliament Award winner, for her work for young people affected by mental health issues. Courtney told us about her own journey and how this was a driver to create the Mental Health Toolkit – launched at the event. This was followed by a teacher's perspective of CAMHS in North Ayrshire. The final presentation was from Dr Jennifer Halliday, NHS Healthcare Improvement, who emphasised that Ayrshire and Arran is leading the way in terms of multi-agency work in relation to Children and Young People's Mental Health and covered the importance of networking and sharing of good practice.

The feedback told us that the day was a great success. Many thanks to all presenters and attendees – effective working across agencies and teams is changing outcomes for local children and young people. If you'd like more information about the Mental Health Toolkit, please contact Donna Anderson danderson@north-ayrshire,gov.uk.

2.5 Woodland View Official Opening

Woodland View hospital was formally opened on 5th September 2017 by the Scottish Minister for Mental Health, Maureen Watt. The facility, which opened to patients last May has already revolutionised the way in which we support those with the most acute mental health needs. For those of you who have seen the facility, you will know that it is light years away from the traditional mental health in-patient facilities. Whilst our care of mental health patients has been changing and improving for many years, in many places across the country that care is still being provided in buildings that started life as 'asylums'. The environment at Woodland View therefore is a welcome, de-stigmatising departure from those types of facilities and we have already seen signs of improved outcomes for those supported and cared for there.

On the very same day that we opened the new hospital, however, a report was published highlighting waiting times for access to a range of mental health services across Scotland. Although we have made significant improvements in our waiting times to many services across Ayrshire and Arran, most notably our Child and Adolescent Mental Health Services, our waiting times around some of our psychological therapies are still far longer than they should be. The overwhelming message in all of this, therefore, is that improving services never stops.

North Ayrshire Developments

2.1 Health & Social Care Pressures

On 13th September 2017, Councillor Cullinane and I, met with Shona Robison, the Cabinet Secretary for Health. The meeting highlighted the pressures our Health and Social Care system is facing in North Ayrshire and the specific difficulties being experienced in relation to demand and tightening resources to meet that demand. It also allowed us to highlight some of the great work that is happening here locally and the investment that we have committed from the Challenge Fund to transform the way we work.

2.2 Care Experienced Young people – Council Tax Exemption

At North Ayrshire Council meeting on Wednesday, North Ayrshire unanimously agreed to seek the power to exempt care experienced young people from paying Council Tax. Care experienced young people often have little or no family support and therefore rely on their Corporate Parents to help give them the best start into adulthood that they can get. I believe North Ayrshire Council was the first in Scotland to call for the power to do this and the Scottish Government has now announced plans nationally to do this.

In addition, Council agreed to seek to become a Carer Positive Employer. This is in recognition of the invaluable job that carers undertake, often juggling (with great difficulty) their caring responsibilities with the demands of their job.

2.3 Children's Challenge Fund

The attached newsletter is the first in a regular update from the new Children's Challenge Team – we wish the new team lots of success with the new ways of working and their innovative approach to help children and young people who are looked after and accommodated achieve improved outcomes.

2.4 Child Protection and Safeguarding Team

We recently announced the establishment of a dedicated Child Protection and Safeguarding Team. The creation of this new and innovative team allows us to concentrate our joint efforts to ensure we continue to deliver a quality service that protects the most vulnerable children and families within our communities.

The Team, based at Cunninghame House, will be managed by Margaret Paterson, Team Manager, and will comprise of seven qualified social workers. The Team will respond to all new Child Protection Concerns/Investigations and Pre-Birth referrals.

2.5 NAHSCP Infographic

The Partnership has begun posting a regular weekly infograph on Twitter and other social media. This is designed to highlight the breadth and quality of the work that we do across North Ayrshire and contains a variety of interesting facts and data every week. Again, if you are not already on Twitter, join up and follow the Partnership tweets to access these. Equally, if you know of any work, or facts and figures that you think should feature on the infograph, contact Eleanor McCallum with details.

A copy of the latest infographs are attached at Appendix 2.

2.6 Celebrating Success……Again!

Ward 3 Woodland View, Irvine
The staff in Ward 3 in Woodland View, in conjunction with Onside Ayrshire, have won Scotland's Dementia Award 2017 for Best Innovation in Continuing Care. Congratulations to Stephanie McClymont and the entire team for winning such a prestigious award and, more importantly, providing first-rate care to patients.

Café Solace
On 5th October, the Recovery at Work team, who designed and deliver Café Solace, scooped the Gold at the national COSLA awards. If the Health and Social Care Partnership was given a choice of which category we could win an award in, it would be the one the team picked up last night – Tackling Inequalities and Improving Health. I cannot begin to articulate how proud I am of everyone involved in the project but most of all those service users who have transformed their own recovery journey by giving something back and building their own local communities.

Mental Health Pilot - Ayrshire Police Scotland Awards
On 12th October, Jacqueline Nisbet, who is a mental health nurse working within our Crisis Resolution Team, received a Police recognition award at the Police annual awards ceremony in Fullarton Connexions.

The award recognised Jacqueline's contribution to the development of a direct referral pathway from Police into community mental health services. This is used by Police when they identify people in distress or people with mental health problems through the course of their work. Jacqueline was seconded to Police Scotland in 2016 to undertake the scoping which informed the referral pathway. During this time she built up extremely positive and effective working relationships with Police colleagues – so much so that when she returned to the mental health service, she was presented with a flashing blue light!

Well done to Jacqueline for an excellent piece of partnership working and for achieving her recognition award.

Herald Society - Team of the Year

Our Money Matters Team scooped the Team of the Year Award at the Herald Society Awards held recently. This is national recognition of the work that the team does day in day out, representing people at tribunals, helping people navigate a complex benefits system and, ultimately, ensuring that citizens of North Ayrshire get the financial support they are entitled to. So a huge congratulations to them all.

Scottish Health Awards

And finally, congratulations to Elaine Kelso who was the winner of the Midwife Award at the Scottish Health Awards. This is another great achievement, recognising Elaine's dedication as the sole midwife based on Arran.

Care Experienced Young People Event
An event celebrating the achievements of our care experienced young people was held on Tuesday 24th October 2017 at Ayrshire College, Kilwinning Campus.

The Event which fell in National Care Leavers' Week was to celebrate the efforts made by Care Experienced Young People in pursuing education, training or employment.

2.7 Review of Integration Scheme

The first phase of reviewing our Integration Scheme that governs the work of the Health and Social Care Partnership is now complete. As most of you will be aware, both North and East Ayrshire Councils had agreed with the NHS Board to undertake a review of the Schemes to explore whether there was a need for change in order to further improve the delivery of health and social care locally.

A healthy number of survey responses were completed and almost two hundred people attended our stakeholder engagement events. The findings of the consultation highlighted some real positives. People told us that the North Ayrshire Health and Social Care Partnership has established an identity to which many increasingly relate. We heard also that we have built strong links with our stakeholders and local communities and delivered some innovative developments to begin the job of transforming how we deliver health and social care in North Ayrshire.

A number of issues were raised through the consultation that highlighted some of the challenges we face. Issues around lead partnership arrangements across the three Ayrshires, for example, and the potential for one IJB to make a decision that could impact negatively on another was highlighted as a significant issue. North Ayrshire Council considered the findings of the first phase review on Wednesday of this week and agreed the findings and recommendations. In summary, there is no clear case for changing the Integration Scheme at present. Indeed, there are elements within the existing scheme that have not been fully implemented. There are a number of issues which should be improved upon and these will require development over the next few months. Council further agreed to a report coming back once that work has been done.

3. IMPLICATIONS

Financial :	None
Human Resources :	None
Legal :	None
Equality :	None
Environmental & Sustainability :	None
Key Priorities :	N/A
Risk Implications :	N/A
Community Benefits :	N/A

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	

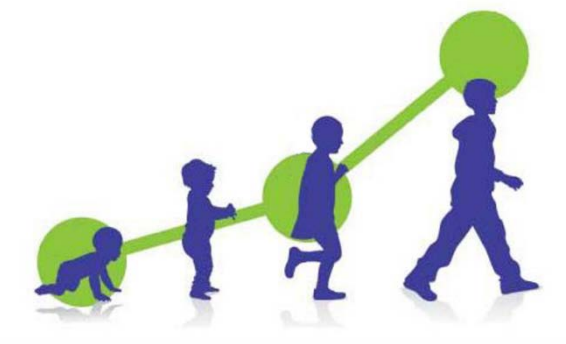
4. CONSULTATION

4.1 No specific consultation was required for this report. User and public involvement is key for the partnership and all significant proposals will be subject to an appropriate level of consultation.

5. CONCLUSION

5.1 Members of the IJB are asked to note the ongoing developments within the North Ayrshire Health and Social Care Partnership

For more information please contact Stephen Brown, Interim Director, NAHSCP on (01294) 317725 or sbrown@north-ayrshire.gcsx.gov.uk



CHILDREN AND FAMILIES Challenge Team

The Challenge Fund has enabled the Children and Families team in the Partnership to think creatively about ways to enhance the services we provide to young people who are looked after and accommodate, or at risk of becoming so.

We're working together with North Ayrshire Education & Youth Employment directorate. By combining our resources to greatest effect, we're able to make service changes for those who are most disadvantaged and have the poorest health, wellbeing and attainment outcomes. This opportunity will enable us to re-frame how we support looked after and accommodated young people and their families.

The Challenge Fund monies are available for **one year:** we have until September 2018 to show that 'thinking and doing differently' really can change children's outcomes.

What is The Challenge Team remit?

The team will work within the strategic priorities and promises of, Getting it Right for You: North Ayrshire Children's Service Plan, North Ayrshire Corporate Parenting Plan and North Ayrshire Health and Social Care Partnership's Strategic Plan.

The team has two remits:

1. Supporting children and young people who currently reside in external residential placements as well as those who are at risk of becoming so. This work will also involve supporting families.
2. Supporting children, young people and their families within Greenwood Academy and Elderbank Primary.

Meet the Challenge Team!

- **Social workers will oversee and case manage.**
  They will attend the relevant multi-agency meetings with all services, using GIRFEC principles and the Curriculum for Excellence. This approach should support a move towards better outcomes for looked after children.
- **Family care workers will support the family members in the family home.**
  They will work to develop routines for children and support parents to implement parenting structures. The family care worker will also support housekeeping, budgeting and any other relevant practical tasks that the family might want help with. Every family will have different needs – the family care worker will adapt their support accordingly.
- **Mentors will spend time with the children to build on self-confidence issues.**
  They will be positive role models in a pro-social modelling context and encourage children and young people to move towards better outcomes in educational achievement and social aspects of their lives.
- **Administrative support –** provided by a Clerical Assistant and Admin Assistant.

SOCIAL WORKERS
Julie Marshall (based at Rosemount)
Jennifer Cairney (based at Rosemount)
Andrew Morrison (based at Rosemount)
Michael Lavery (based Greenwood Academy)
Robyn Nimbley (based Greenwood Academy)
Julia Clannachan (based Greenwood Academy)

FAMILY CARE WORKERS (NURTURE)
Shannon Morrison
Ashley Fisher
Karen Crawford

MENTORS
Gillian Sommerville
Sarah Jane Gordon
Yasmin Chapman

REGISTERED NURSE
Ailsa Jack (based at Greenwood Academy)

ADMIN SUPPORT
Jennnifer Caldwell
Pauline Barr

PROJECT MANAGER
Kirsteen Lee (Children's Services Change Projects)

TEAM MANAGER
Martin McAdam

SENIOR MANAGER
Mark Inglis

The team is co-located and contactable at Rosemount (01294 213733) and Greenwood Academy (01294 215430).

Objectives and priorities – measuring success

- Children returning an area where there are familial and social networks
- Collaborative working between all services
- Fewer children moving from residential units to external placements
- Closer multi-agency working to identify individual children's needs
- Reducing external residential placements and costs by 20%
- Fewer children progressing through the care system
- Fewer children becoming accommodate away from home
- Higher attendance at school and improved educational attainment
- More children achieving positive destinations
- Children having more resilience, confidence and higher self esteem
- Improved health and wellbeing of children and their families
- Empowering families to develop resilience and family cohesion, along with partner services in a complementary capacity
- Enabling families to work towards positive support networks

Key messages

By creating a multidisciplinary team and drawing on specialist knowledge and expertise in a whole systems approach, desired positive outcomes can be achieved for our most vulnerable children.

Working in partnership with families, we will ensure right person, right time, right place with the needs of each individual child at the heart of everything we do.

Through evaluation and in consultation with children and their families, we will consider future models for our looked after and accommodated children and young people.

Reducing the number for expensive external placements will enable the Partnership to re-invest monies in early intervention services.

Children and Families Challenge Team is an additional resource to compliment existing services.

Contact MartinMcAdam@north-ayrshire.gcsx.gov.uk for more information.

North Ayrshire Health and Social Care Partnership

Stats and info of some weekly NAHSCP activities during week ending 20 October 2017

@NAHSCP

Café Solace volunteers

40 VOLUNTEERS INVOLVED SINCE MAY 2015

8 RETURNED TO FULL-TIME EMPLOYMENT

16 MOVED TO FURTHER EDUCATION

Ardrossan Kilbirnie Irvine

23,742 hours PROVIDED BY CARE AT HOME

30 PEOPLE LEFT HOSPITAL WITH CARE AT HOME IN PLACE

£12,872 FROM 3 APPEALS WON

INCOME GENERATION FOR VULNERABLE PEOPLE

This also happened ...

CHALLENGE POVERTY WEEK

Our health and social care teams include Money Matters because

- 7051 children in NA are living in poverty
- 17.3% people in NA are income deprived

... it doesn't grow on trees!

DESTITUTION PAYMENTS

14 PEOPLE PRESENTED

£773 TOTAL ASSISTANCE PAID

Integration Joint Board
16th November 2017
Agenda Item 6

Subject:	**Meeting Dates for 2018**
Purpose:	To advise members of the draft timetable for meetings of the IJB and IJB PAC for 2018.
Recommendation:	That the Board agree the dates for meetings of the Integration Joint Board and the Performance and Audit Committee.

Glossary of Terms	
IJB	Integration Joint Board
IJB PAC	Integration Joint Board Performance and Audit Committee
HSCP	Health and Social Care Partnership

1. EXECUTIVE SUMMARY

1.1 A schedule of meetings for the Integration Joint Board and the Performance and Audit Committee is required to be arranged for the forthcoming year.

2. CURRENT POSITION

2.1 Meetings of the Board have taken place on a monthly basis and it is proposed that this continues. When appropriate briefing sessions and workshops have utilised existing IJB meeting slots and it is proposed that this arrangement also continues.

2.2 The IJB Performance and Audit Committee meets on a quarterly basis, with a special meeting held in June, if required, to consider the annual accounts before there are presented to the IJB for approval.

2.3 The timetable has been created to accommodate budget and performance schedules. In an effort to avoid potential diary clashes, Council and NHS meetings have also been included in the draft meeting timetable. This has highlighted a few occasions when meetings of the IJB and PAC would clash with Council meetings. These dates have therefore been avoided and narrative inserted to explain the change to the usual date/time.

2.4 The key dates for the meetings of the IJB and IJB PAC are attached at Appendix 1 and 2 to the report. Appendix 3 to the report provides a calendar of Council, CPP, NHS Board, IJB and IJB PAC meetings.

2.5 Meetings of the IJB and IJB PAC will take place on the following dates:-

IJB	IJB PAC
18 January	8 March
15 February	14 June
15 March	6 September
19 April	6 December
24 May	
21 June	
19 July	
16 August	
13 September	
11 October	
15 November	
13 December	

3. IMPLICATIONS

Financial :	None
Human Resources :	None
Legal :	None
Equality :	None
Environmental & Sustainability :	None
Key Priorities :	N/A
Risk Implications :	N/A
Community Benefits :	N/A

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	

4. CONSULTATION

4.1 The following Members and Officers have been consulted on the draft timetable for meetings of the IJB and IJB PAC for 2018:-

IJB Chair
IJB Vice Chair
IJB PAC Chair
IJB PAC Vice Chair
Interim Director
Section 95 Officer

5. CONCLUSION

5.1 The agreement of the timetable for meetings in 2018 is required to allow for all necessary arrangements, such as room bookings, diary entries and report scheduling to be undertaken.

For more information please contact Angela Little, Committee Services Officer (01294 324132) or alittle@north-ayrshire.gov.uk

IJB meeting dates 2018

All Pre Agenda meetings at 9.30 a.m. **All Board meetings at 10.00 a.m.**	
Tuesday 19 December	Reports due with Social Services
Wednesday 20 December	Reports due with Committee Services
Thursday 21 December	Issue IJB Pre Agenda
Thursday 4 January	IJB Pre Agenda Meeting
Thursday 11 January	Issue IJB Agenda
Thursday 18 January	**IJB Meeting**
Tuesday 23 January	Reports due with Social Services
Wednesday 24 January	Reports due with Committee Services
Thursday 25 January	Issue IJB Pre Agenda
Thursday 1 February	**IJB Pre Agenda Meeting**
Thursday 8 February	Issue IJB Agenda
Thursday 15 February	**IJB Meeting**
Tuesday 20 February	Reports due with Social Services
Wednesday 21 February	Reports due with Committee Services
Thursday 22 February	Issue IJB Pre Agenda
Thursday 1 March	**IJB Pre Agenda Meeting**
Thursday 8 March	Issue IJB Agenda
Thursday 15 March	**IJB Meeting**
Tuesday 27 March	Reports due with Social Services
Wednesday 28 March	Reports due with Committee Services
Thursday 29 March	Issue IJB Pre Agenda
Thursday 5 April	**IJB Pre Agenda Meeting**
Thursday 12 April	Issue IJB Agenda
Thursday 19 April	**IJB Meeting**
Tuesday 1 May	Reports due with Social Services
Wednesday 2 May	Reports due with Committee Services
Thursday 3 May	Issue IJB Pre Agenda
Thursday 10 May	**IJB Pre Agenda Meeting**
Thursday 17 May	Issue IJB Agenda
Thursday 24 May	**IJB Meeting**
Tuesday 29 May	Reports due with Social Services
Wednesday 30 May	Reports due with Committee Services
Thursday 31 May	Issue IJB Pre Agenda
Thursday 7 June	**IJB Pre Agenda Meeting**
Thursday 14 June	Issue IJB Agenda
Thursday 21 June	**IJB Meeting**

Tuesday 26 June	Reports due with Social Services
Wednesday 27 June	Reports due with Committee Services
Thursday 28 June	Issue IJB Pre Agenda
Thursday 5 July	**IJB Pre Agenda Meeting**
Thursday 12 July	Issue IJB Agenda
Thursday 19 July	**IJB Meeting**
Tuesday 24 July	Reports due with Social Services
Wednesday 25 July	Reports due with Committee Services
Thursday 26 July	Issue IJB Pre Agenda
Thursday 2 August	**IJB Pre Agenda Meeting**
Thursday 9 August	Issue IJB Agenda
Thursday 16 August	**IJB Meeting**
Tuesday 21 August	Reports due with Social Services
Wednesday 22 August	Reports due with Committee Services
Thursday 23 August	Issue IJB Pre Agenda
Thursday 30 August	**IJB Pre Agenda Meeting**
Thursday 6 September	Issue IJB Agenda
Thursday 13 September	**IJB Meeting**
Tuesday 18 September	Reports due with Social Services
Wednesday 19 September	Reports due with Committee Services
Thursday 20 September	Issue IJB Pre Agenda
Thursday 27 September	**IJB Pre Agenda Meeting**
Thursday 4 October	Issue IJB Agenda
Thursday 11 October	**IJB Meeting**
Tuesday 23 October	Reports due with Social Services
Wednesday 24 October	Reports due with Committee Services
Thursday25 October	Issue IJB Pre Agenda
Thursday 1 November	**IJB Pre Agenda Meeting**
Thursday 8 November	Issue IJB Agenda
Thursday 15 November	**IJB Meeting**
Tuesday 20 November	Reports due with Social Services
Wednesday 21 November	Reports due with Committee Services
Thursday 22 November	Issue IJB Pre Agenda
28 November *(Moved due to clash with CPP Board Meeting)*	**IJB Pre Agenda Meeting**
Thursday 6 December	Issue IJB Agenda
Thursday 13 December	**IJB Meeting**

IJB Performance and Audit Committee – Meeting dates in 2018

All meetings at 10.00 a.m.

Monday 19 February	Reports due with Committee Services
Thursday 22 February	Issue Pre Agenda
Tuesday 27 February	**Pre Agenda**
Thursday 1 March	Issue Agenda
Thursday 8 March	**IJB PAC**
Monday 28 May	Reports due with Committee Services
Thursday 31 May	Issue Pre Agenda
Monday 4 June *(moved from 5/6/18 due to clash with Audit and Scrutiny Committee)*	**Pre Agenda**
Thursday 7 June	Issue Agenda
Thursday 14 June	**IJB PAC**
Monday 20 August	Reports due with Committee Services
Thursday 23 August	Issue Pre Agenda
Tuesday 28 August	**Pre Agenda**
Thursday 30 August	Issue Agenda
Thursday 6 September	**IJB PAC**
Monday 19 November	Reports due with Committee Services
Thursday 22 November	Issue Pre Agenda
Tuesday 27 November	**Pre Agenda**
Thursday 29 November	Issue Agenda
Thursday 6 December	**IJB PAC**

Appendix 3

Draft Committee Timetable Jan-Dec 2018 IJB, IJB PAC, CPP and NHS Board Meetings

Meeting Cycle 1

Wk Begin	Wk	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1 Jan					9.30 a.m. IJB Pre Agenda	
8 Jan	1			10.00 a.m. Licensing Committee		
15 Jan	2		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB	
22 Jan	3		*11.00 a.m. Audit & Scrutiny Pre-Agenda* 2.30 p.m. Cabinet			
29 Jan	4	9.15 am NHS Board	10.00 a.m. Audit & Scrutiny Ctte	10.00 a.m. Appeals Ctte (if required)	9.30 a.m. IJB Pre Agenda	*11.00 a.m. Ayrshire Shared Services Joint Ctte Pre-Agenda (TBC) (hosted by EAC)*
5 Feb	5		2.00 p.m. Police & Fire & Rescue Ctte	10.00 a.m. Licensing Committee		
12 Feb	6		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB	2.00 p.m. Ayrshire Shared Services Joint Ctte (TBC) (hosted by EAC)
19 Feb	7		2.30 p.m. Cabinet (Education)	10.00 a.m. Appeals Ctte (if required)		
26 Feb	8		10.00 a.m. IJB PAC Pre Agenda	2.00 p.m. Council	9.30 a.m. IJB Pre Agenda	

Meeting Cycle 2

Wk Begin	Wk	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
5 Mar	1			10.00 a.m. Licensing Committee	10.00 a.m. IJB PAC	
12 Mar	2		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB	*11.00 a.m. Ayrshire Shared Services Joint Ctte Pre-Agenda (TBC) (hosted by EAC)*
19 Mar	3		*11.00 a.m. Audit & Scrutiny Pre-Agenda* 2.30 p.m. Cabinet		CPP BOARD	
26 Mar	4	9.15am NHS Board	10.00 a.m. Audit & Scrutiny Ctte	10.00 a.m. Appeals Ctte (if required)		2.00 p.m. Ayrshire Shared Services Joint Ctte (TBC) (hosted by EAC)
2 April					9.30 a.m. IJB Pre Agenda	
9 April						
16 April	5			10.00 a.m. Licensing Committee	10.00 a.m. IJB	
23 April	6		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body		
30 April	7		2.30 p.m. Cabinet	10.00 a.m. Appeals Ctte (if required)		
7 May	8			2.00 p.m. Council	9.30 a.m. IJB Pre Agenda	

Meeting Cycle 3

Wk Begin	Wk	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
14 May	1		2.00 p.m. Police & Fire & Rescue Ctte	2.00 p.m. Licensing Committee		
21 May	2	NHS Board	*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB	
28 May	3		*11.00 a.m. Audit & Scrutiny Pre-Agenda* 2.30 p.m. Cabinet	10.00 a.m. Appeals Ctte (if required)	CPP BOARD	
4 June	4	10.00 a.m. IJB PAC Pre Agenda (moved from 5/6/18 due to clash with Audit and Scrutiny)	10.00 a.m. Audit & Scrutiny Committee	2.00 p.m. Licensing Committee	9.30 a.m. IJB Pre Agenda	*11.00 a.m. Ayrshire Shared Services Joint Ctte Pre-Agenda (TBC) (hosted by EAC)*
11 June	5		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB PAC	
18 June	6		2.30 p.m. Cabinet (Education)	10.00 a.m. Appeals Ctte (if required)	10.00 a.m. IJB	2.00 p.m. Ayrshire Shared Services Joint Ctte (TBC) (hosted by EAC)
25 June	7	NHS Board		2.00 p.m. Council		
2 July					9.30 a.m. IJB Pre Agenda	
9 July						
16 July					10.00 a.m. IJB	
23 July						
30 July					9.30 a.m. IJB Pre Agenda	
6 August						
13 August					10.00 a.m. IJB	

Meeting Cycle 4

20 August	1	NHS Board	2.00 p.m. Police & Fire & Rescue Ctte	10.00 a.m. Licensing Committee		*11.00 a.m. Ayrshire Shared Services Joint Ctte Pre-Agenda (TBC) (hosted by SAC)*
27 August	2		*10.00 a.m. IJB PAC Pre Agenda* *2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	9.30 a.m. IJB Pre Agenda	
3 September	3		2.30 p.m. Cabinet		10.00 a.m. IJB PAC	2.00 p.m. Ayrshire Shared Services Joint Ctte (TBC) (hosted by EAC)
10 September	4			10.00 a.m. Appeals Ctte (if required)	10.00 a.m. IJB	
17 September	5		*11.00 a.m. Audit & Scrutiny Pre-Agenda*	10.00 a.m. Licensing Committee	CPP BOARD	
24 September	6		10.00 a.m. Audit & Scrutiny Committee *2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	9.30 a.m. IJB Pre Agenda	
1 October	7		2.30 p.m. Cabinet (Education)	10.00 a.m. Appeals Ctte (if required)		
8 October	8	NHS Board		2.00 p.m. Council	10.00 a.m. IJB	
15 October						
22 October						*11.00 a.m. Ayrshire Shared Services Joint Ctte Pre-Agenda (TBC) (hosted by SAC)*

Meeting Cycle 5

29 October	1			10.a.m. Licensing Committee	9.30 a.m. IJB Pre Agenda	
5 November	2		*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body		2.00 p.m. Ayrshire Shared Services Joint Ctte (TBC) (hosted by EAC)
12 November	3		*11.00 a.m. Audit & Scrutiny Pre-Agenda* 2.30 p.m. Cabinet		10.00 a.m. IJB	
19 November	4		10.00 a.m. Audit & Scrutiny Ctte 2.00 p.m. Police & Fire & Rescue Ctte	10.00 a.m. Appeals Ctte (if required)		
26 November	5		10.00 a.m. IJB PAC Pre Agenda	10 a.m. Licensing Committee 2.00 p.m. IJB Pre Agenda (moved from 29/11/17 due to clash with CPP)	CPP BOARD	
3 December	6	NHS Board	*2.30p.m. Cabinet Pre-Agenda*	2.00 p.m. Planning Committee 2.15 p.m. Local Review Body	10.00 a.m. IJB PAC (moved from 29/11/18 due to clash with CPP)	
10 December	7		2.30 p.m. Cabinet	10.00 a.m. Appeals Ctte (if required)	10.00 a.m. IJB	
17 December	8			2.00 p.m. Council		
24 December						

To be added:-

Locality Partnerships (evenings)

Integration Joint Board
16 November 2017
Agenda Item 7

Subject:	**2017/18 Financial Performance Update as at 30 September 2017**
Purpose:	To provide an update on the projected financial outturn for the financial year 2017/18 as at 30 September 2017
Recommendation:	It is recommended that the IJB: (a) Notes the projected financial outturn for the year; (b) Approves the proposed mitigation actions included in Appendix E; (c) Approves the savings identified to date against the NHS target (Appendix F) and notes that this will be further refined as part of an update to the IJB in December; and (d) Note the Annual Financial Statement for 2017/18 included in Appendix H.

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
MH	Mental Health
CAMHS	Child & Adolescent Mental Health Services
BRAG	Blue, Red, Amber, Green
UNPACS	UNPACS, (UNPlanned ACtivities) - Extra Contractual Referrals

1. EXECUTIVE SUMMARY

1.1 This report provides an overview of the 2017/18 financial position of the North Ayrshire Health and Social Care Partnership as at 30 September 2017. This report reflects the projected expenditure and income and has been prepared in conjunction with relevant budget holders.

1.2 The projected outturn is £5.326m overspent for 2017/18 after applying the £1.4m of the challenge fund to support service delivery. The previously approved mitigation plan is attached at Appendix D and if delivered will reduce the deficit to £4.094m. Added to the £3.245m deficit brought forward from 2016/17 this could result in a projected closing deficit of £7.339m.

1.3 It is essential that the IJB operates within the budgets delegated and does not commission services which are higher than their delegated budgets

1.4 Given the latest projections further mitigations have been developed and are attached in Appendix E for the IJB's approval. If all approved this would reduce the deficit to £3.614m.

1.5 A review of NHS budgets have been undertaken and some underspends have been allocated to the NHS savings target, to assist the delivery of a balanced budget in 2017/18. This does not change the overall projection but ensures underspends are allocated against savings targets and supports budget management. These are included in Appendix F for the IJB's approval.

1.6 Further work will be undertaken to develop a mitigation plan and this will be reported to the IJB in December. It should be noted that with only four months remaining in the financial year it is unlikely that full mitigation can be put in place.

2. BACKGROUND

2.1 The period 4 report projected an overspend of £5.325m and requested approval from North Ayrshire Council to use £1.4m of the Challenge Fund to reduce the impact of mitigation on Council commissioned services in 2017/18. This was approved and has been allocated to care home placements £0.977m and LD care packages £0.423m. This reduced the period 4 projection to £3.925m. Since then the projected overspend has increased to £5.326m which is an adverse movement of £1.401m. This report provides an update on projections, to enable the IJB to consider the implications for services in 2017/18, including further mitigating actions to recover this overspend.

3. FINANCIAL PERFORMANCE

3.1 Against the full-year budget of £224.540m there is an overspend of £5.326m (2.4%). The following sections outline the significant variances in service expenditure compared to the approved budgets. Note that the main movements from the period 4 position after the Challenge Fund was applied (£3.925m) are explained. Appendix A provides the detailed position.

3.2 Health and Community Care Services

Against the full-year budget of £64.757m there is a projected underspend of £0.175m which is a favourable movement of £0.474m. The main reasons for the movement are:

- **Locality Services – projected underspend of £0.129m (favourable movement £0.206m)** which reflects additional income which has been secured from charges to users in line with the charging policy.

  Care home placements were waitlisted from period 2 to 5 to reduce the projected overspend. There are currently 855 placements being managed on a one for one basis until the year end and 84 people are being waitlisted for services

- **Community Care Service Delivery – projected underspend of £0.267m (favourable movement of £0.247m)**
  This is due to a reduction in the care at home commitment as previously assumed hours are not being purchased from the third and independent sector. One provider is currently under a moratorium which has reduced capacity within the sector.

3.3 **Mental Health Services**

Against the full-year budget of £71.115m there is a projected overspend of £1.853m (2.7%) which is an adverse movement of £1.443m. The main reasons for the movement are:

- **Learning Disability – projected overspend of £1.349m (adverse movement of £1.146m)** which mainly relates to care packages as a result of an out of authority charge for a care package which has been backdated for 5 years at a cost of £0.392m. After seeking legal advice we are obliged to pay this even though the service has only become aware of this charge in 2017/18. The number of packages has also increased by one package costing £0.130m and existing packages have increased by £0.112m. There will also be a non achievement in the LD savings of £0.300m despite packages being reviewed.

  All employee costs underspends were reviewed within the NHS element of the budget and have been transferred on a non recurring basis to achieve the whole system review saving. This includes £0.094m from LD services.

- **Community Mental Health – projected overspend of £0.375m (adverse movement of £0.221m)** which is mainly due to the allocation of £0.101m of savings for the whole system review of Mental Health which had been held under the Lead Partnership budget (NHS commissioned services) and the non achievement of £0.050m worth of savings. This resulted in employees budgets being reduced to reflect a saving which has been secured. The remaining budget overspend of £0.375m relates to care packages within Council commissioned services.

- **Addictions – projected overspend of £0.014m (adverse movement of £0.077m)** which is mainly due to the allocation of £0.094m of the savings for the whole system review of Mental Health which had been held under the Lead Partnership budget.

- **Lead Partnership –projected overspend of £0.215m (adverse movement of £0.099m).**

  a) Adult inpatients has a projected overspend of £0.671m (adverse movement of £0.206m) which relates to the phasing of the delivery of optimising bed capacity and income generation from other health board areas and additional supplementary staff in relation to increased constant observations. The level of constant observations has increased due to the complexity of current cases. The mitigation plan for mental health included improving the sickness rate and at period 6 it is 7% which is below the quarter 2 target of 8%.

  b) There is a projected non achieved saving of £0.028m (£0.247m favourable movement) following the allocation of this saving across Mental Health Services to secure the delivery of the majority of the saving linked to the whole system review of MH services.

  c) UNPACS – is projected to overspend by £0.105m (favourable movement of £0.071m) due to transfers to Woodland View.

d) CAMHS – is projected to be underspent by £0.003m (adverse movement of £0.0160m) due to £0.080m being proposed as a non-recurring saving and £0.080m being allocated to the savings for the whole system review of Mental Health which had been held under the Lead Partnership budget.

e) MH Admin – is projected to be underspent by £0.036m (adverse movement of £0.100m) due to £0.100m being proposed as a non-recurring saving.

3.4 **Children's Services and Criminal Justice Services**

Against the full-year budget of £34.412m there is a projected overspend of £1.751m (5.1%) which is an adverse movement of £0.682m. The main reasons for the movement are:

- **Looked After and Accommodated Children – projected overspend of £1.873m (adverse movement of £0.865m).**

  Residential Schools and Community Placements – projected overspend of £1.006m (adverse movement of £0.532m from P4). This is due to projected discharge dates for seven placements being later that previously projected at an additional cost of £0.165m, five new placements £0.260m and increases to existing placements of £0.116m.

  Residential Units Employee Costs – projected overspend of £0.226m (adverse movement of £0.266m) due to the non delivery of savings linked to the reconfiguration of Children Homes.

  Looked After Children Placements – projected overspend of £0.539m (adverse movement of £0.069m) due to an increase in the number of kinship and fostering xtra placements.

3.5 **Primary Care - Prescribing**

Against a full year budget of £47.575m primary care prescribing is projected to overspend by £0.597m (1.3%) which is an adverse movement of £0.193m. There were £2.046m of prescribing savings agreed as part of the 2017/18 budget and it is projected that £1.449m will be achieved and £0.597m not achieved. The partnership is continuing to work with primary care and pharmacy colleagues to identify options for bridging this gap.

3.6 **Management and Support Costs**

Against the full-year budget of £4.504m there is a projected overspend of £1.326m. This mainly relates to the NHS savings target of £1.684m which has still to be agreed and is coded to management and support costs pending allocation. There is also an unfunded post and a shortfall in the payroll turnover achieved within this section.

A review of NHS budgets has been undertaken and some underspends totalling £0.519m have been allocated to NHS savings on a non recurring basis, to assist the delivery of a balanced budget in 2017/18. This does not change the overall position but ensures underspends are allocated against savings targets and supports budget management. These are included in Appendix F for the IJB's approval.

3.7 **Change Programme**

Against the full-year budget of £2.516m there is a projected underspend of £0.497m of which £0.339m is being proposed as a non-recurring saving, leaving £0.158m of an underspend. This is reflected in the forecasted net position and is shown in Appendix C.

3.8 **Lead Partnerships**

North Ayrshire HSCP
Services managed under Lead Partnership arrangements by North Ayrshire Health and Social Care Partnership are projected to overspend by £0.182m in 2017/18. A recovery plan will be developed and reported to the December IJB for approval.

If full recovery is not feasible, there will be a requirement to request additional funding from the other partnerships.

South Ayrshire HSCP
Hosted Services are forecast to overspend by £0.7m. £0.6m of this is due to a decision not to proceed in full with reductions in Allied Health Professionals. This was originally part of the Cash Releasing Efficiency plan, and is under review as a result of the wider system impact. The Continence Service/Community Equipment Store forecast a £0.1m overspend.

If full recovery is not feasible, there will be a requirement to request additional funding from the other partnerships.

East Ayrshire HSCP
Primary Care services managed under Lead Partnership arrangements by East Ayrshire Health and Social Care Partnership are projected to marginally overspend in 2017/18 by £0.147m. This is largely due to additional payments to GP practices currently experiencing difficulty (mainly practices that the NHS Board is administering due to previous GPs handing back contracts), as well as delayed identification of recurring options to meet the approved Primary Care cash releasing efficiency target and is partially offset by anticipated savings in other lead services. This includes savings in Dental services due to vacant posts, as well as non-recurring slippage on the Primary Care Transformation Fund. Work is ongoing to finalise the PCTF slippage sum available to partially offset pressures. The GP practices in difficulty issue is extremely fluid and there is the potential for additional financial pressures over the remainder of the financial year. Any revision to this projected outturn position will be notified to the three Ayrshire Integration Joint Boards at the earliest opportunity.

Work is being progressed through the Strategic Commissioning for Sustainable Outcomes Programme Board to agree proposals to reduce costs and deliver savings, where possible, in order to achieve financial balance in 2017/18 and going forward, as part of the medium term financial plan. This plan and associated analysis of risks will require to be presented for consideration and approval to all three Ayrshire Integration Joint Boards.

If full recovery is not feasible, there will be a requirement to request additional funding from the other partnerships.

3.9 **Set Aside**

The Integration Scheme makes provision for the Set Aside Budget to be managed in-year by the Health Board with any recurring over or under spend being considered as part of the annual budget setting process.

In the first half of 2017/18 there is an overspend on Acute Services of £5.4m. This is forecast to be £11.4m by the end of the year. A large proportion of this relates to the Set Aside Budget.

84 additional and unfunded beds are open, 60 of which are at Crosshouse. These are to meet operational demand and directly affect expenditure levels, particularly in Nursing.

3.10 **Savings Update**

The 2017/18 budget included £6.226m of savings.

BRAG Status	**2017/18 Projected Position**
Red	2.706
Amber	0.943
Green	2.218
Blue	0.359
TOTAL	**6.226**

Some savings are at risk from delivery and this is reflected in the update provided within Appendix B. This includes the £1.165m (assumes the £0.519m being proposed is approved) of NHS savings shortfall still to be agreed.

There are £0.148m of amber savings and £0.230m of red savings which are assumed to be achieved in the projected outturn. If they are not achieved this will increase the projected overspend further.

£1.857m of amber and red savings (mainly care homes, prescribing saving, LD care packages and the redesign of children's units) are assumed not to be delivered in 2017/18. If these were delivered this would reduce the overspend currently projected.

3.11 Mitigation Plan

The IJB is currently forecasting an overspend of £5.326m, of which mitigation plans totalling £1.557m are in place. £1.232m of the £1.557m is projected to be delivered which leaves a balance of £4.094m still to be mitigated. As reported previously £1.684m of this relates to NHS savings not achieved. The partnership has worked closely with NHS Ayrshire & Arran colleagues to identify alternative savings. However, to date no new alternative have been identified.

NHS Ayrshire & Arran have confirmed that no further funding will be made available to the partnership. As a result a mitigation plan needs to be developed and will be reported to the IJB in December.

3.12 Annual Financial Statement

The Public Sector (Joint Working) (Scotland) Act 2014 (the Act) requires that each Integration Authority (Partnership) must publish an Annual Financial Statement on the resources that it plans to spend in implementing the Strategic Commissioning Plan. The 2017/18 Annual Financial Statement is shown in Appendix H.

4. Anticipated Outcomes

4.1 Approval of the mitigating plan will assist in ensuring the overspend is minimised. Further mitigation will continue to be worked on and the outcome reported to the December IJB.

5. Measuring Impact

5.1 Regular updates will be presented to the IJB throughout 2017/18.

6. IMPLICATIONS

Financial :	The financial implications are as outlined in the report. The projected outturn is £5.326m overspent for 2017/18 prior to mitigation and £4.094m if £1.232m of mitigating action in Appendix D is delivered. Added to the £3.245m deficit brought forward from 2016/17 this could result in a projected closing deficit of £7.339m. It is essential that the IJB operates within the budgets delegated and does not commission services which are higher than their delegated budgets. Given the latest projections further mitigations have been developed and are attached in Appendix E for the IJB's approval. If all approved this would reduce the deficit to £3.614m. A review of NHS budgets have been undertaken and some underspends have been allocated to the NHS savings target, to assist the delivery of a balanced budget in 2017/18. This does not change the overall projection but ensures underspends are allocated against savings targets and supports budget management. These are included in Appendix F for the IJB's approval. Further work will be undertaken to develop a mitigation plan and this will be reported to the IJB in December. It should be noted that with only four months remaining in the financial year it is unlikely that full mitigation can be put in place. Application of the Integration Scheme to the projected £4.976m overspend in 2017/18 would share the overspend as £2.903m for North Ayrshire Council and £2.423m for NHS Ayrshire & Arran.

Human Resources :	There are no Human Resource implications for staff employed by Partner bodies.
Legal :	There are no Legal implications
Equality :	There are no Equality implications
Environmental & Sustainability :	There are no Environmental & Sustainability implications
Key Priorities :	There are no Key Priorities implications.
Risk Implications :	The Impact of Budgetary Pressures on Service Users and associated control measures are recognised in the Strategic Risk Register. The approved mitigation plan detailed the risk associated with each proposal.
Community Benefits :	There are no Community Benefits

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	X

7. CONSULTATION

7.1 This report has been produced in consultation with relevant budget holders, the Partnership Senior Management Team and the Director of Finance for NHS Ayrshire and Arran and the Executive Director Finance and Corporate Support for North Ayrshire Council.

8. CONCLUSION

8.1 It is recommended that the IJB:
(a) Notes the projected financial outturn for the year;
(b) Approves the proposed mitigation actions included in Appendix E;
(c) Approves the savings identified to date against the NHS target (Appendix F) and notes that this will be further refined as part of an update to the IJB in December; and
(d) Note the Annual Financial Statement for 2017/18 included in Appendix H.

For more information please contact Eleanor Currie, Principal Manager – Finance on (01294) 317814 or Margaret Hogg, Chief Finance Officer on (01294) 314560.

2017/18 Budget Monitoring Report – Projected Objective Summary

Appendix A

Partnership Budget - Objective Summary	2017/18 Budget									2017/18		
	Council			Health			TOTAL					
	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Budget	Projected Outturn	Projected Over/ (Under) Spend Variance	Over/ (Under) Spend Variance at 4 Pre £1.4M Challenge Fund	Over/ (Under) Spend Variance at 4 Post £1.4M Challenge Fund	Movement in projected budget variance from Period 4
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
COMMUNITY CARE AND HEALTH	**54,233**	**53,779**	**(454)**	**10,524**	**10,803**	**279**	**64,757**	**64,582**	**(175)**	**1,276**	**299**	**(474)**
: Locality Services	26,129	25,958	(171)	3,441	3,483	42	29,570	29,441	(129)	1,054	77	(206)
: Community Care Service Delivery	25,571	25,304	(267)	0	0	0	25,571	25,304	(267)	(20)	(20)	(247)
: Rehabilitation and Reablement	744	792	48	1,837	2,097	260	2,581	2,889	308	284	284	24
: Long Term Conditions	1,342	1,335	(7)	2,962	2,946	(16)	4,304	4,281	(23)	(9)	(9)	(14)
: Integrated Island Services	447	390	(57)	2,284	2,277	(7)	2,731	2,667	(64)	(33)	(33)	(31)
MENTAL HEALTH SERVICES	**21,840**	**23,478**	**1,638**	**49,275**	**49,490**	**215**	**71,115**	**72,968**	**1,853**	**833**	**410**	**1,443**
: Learning Disabilities	17,198	18,447	1,249	373	373	0	17,571	18,820	1,249	626	203	1,046
: Commmunity Mental Health	3,808	4,183	375	1,743	1,743	0	5,551	5,926	375	154	154	221
: Addictions	834	848	14	1,077	1,077	0	1,911	1,925	14	(63)	(63)	77
: Lead Partnership Mental Health NHS Area Wide	0	0	0	46,082	46,297	215	46,082	46,297	215	116	116	99
CHIDREN'S SERVICES AND CRIMINAL JUSTICE	**29,957**	**31,720**	**1,763**	**4,455**	**4,443**	**(12)**	**34,412**	**36,163**	**1,751**	**1,069**	**1,069**	**682**
: Intervention Services	3,816	3,723	(93)	295	314	19	4,111	4,037	(74)	(90)	(90)	16
: Looked After & Accomodated Children	15,205	17,078	1,873	0	0	0	15,205	17,078	1,873	1,008	1,008	865
: Fieldwork	6,497	6,546	49	0	0	0	6,497	6,546	49	111	111	(62)
: CCSF	424	450	26	0	0	0	424	450	26	32	32	(6)
: Criminal Justice	2,902	2,902	0	0	0	0	2,902	2,902	0	0	0	0
: Early Years	311	246	(65)	1,738	1,740	2	2,049	1,986	(63)	52	52	(115)
: Policy & Practice	802	775	(27)	0	0	0	802	775	(27)	(5)	(5)	(22)
: Lead Partnership NHS Children's Services Area Wide	0	0	0	2,422	2,389	(33)	2,422	2,389	(33)	(39)	(39)	6
PRIMARY CARE	0	0	0	47,575	48,172	597	47,575	48,172	597	404	404	193
MANAGEMENT AND SUPPORT COSTS	4,544	4,667	123	(40)	1,163	1,203	4,504	5,830	1,326	1,829	1,829	(503)
CHANGE PROGRAMME		(158)	(158)	2,177	2,177	0	2,177	2,019	(158)	(222)	(222)	64
LEAD PARTNERSHIP AND SET ASIDE	0	0	0	0	132	132	0	132	132	136	136	(4)
TOTAL	**110,574**	**113,486**	**2,912**	**113,966**	**116,380**	**2,414**	**224,540**	**229,866**	**5,326**	**5,325**	**3,925**	**1,401**

2017/18 Savings Tracker

Appendix B

Service	Description	B / R / A / G	Budget Savings 2017/18	Saving assumed to be fully achieved in the projected outturn?	Update on progress to date and proposed action moving forward
Teams Around the Child	Children's unit - Service Redesign	Red	(327,000)	(23,000)	Residential Review underway with staff, to date 17 expressions of interest in VER with 6 applications received (4 VERS agreed and progressed June) one to one interviews underway with restructure models being devised
	Full Year Impact of Contract Savings	Green	(76,000)	Yes	Fully delivered.
	Roll out of SDS in children Services	Green	(17,000)	Yes	Not yet commenced but planned for later in 2017/18
Care for Older People & those with complex needs	Whole system review of NHS provided beds in care of elderly/elderly Mental Health and purchased nursing care beds. This will be predicated on the development of a tiered model of care that offers the opportunity to continue living for longer within a community setting, with support appropriate to individual needs. This represents a 7.9% saving	Amber	(496,000)	Yes	This saving has been made in 2017/18 but relied on the Challenge Fund investment. Assumes that admissions to care homes are being made on a one for one basis with 855 placements.
	Review and redesign day care for older people with a view to securing a more flexible, person centred approach that is aligned with other services to deliver greater efficiency in service provision.	Red	(50,000)	Assumed that this will not be achieved but is included in the projected overspend.	The necessary changes to Day Services are being progressed including reducing capacity and staffing to deliver this saving.
Delivery of the Mental Health Strategy	Mental Health Care Packages baseline budget adjustment based on historic underspends	Red	(60,000)	Assumed that this will not be achieved but is included in the projected overspend.	This saving will not be achieved as the historic underspends have been subsumed by additional demand.
	Integration of Teams Management and Support	Amber	(50,000)	Yes	Integration of CMHT/PCMHT dependent on release of accomodation. Review of LD structures in the last quarter of 2017/18 may bring further savings. MH teams integration options appraisal being considered by PSMT/accomodation group.

Service	Description	B / R / A / G Status	Budget Savings 2017/18		Update on progress to date and proposed action moving forward
Delivery of the Learning Disabilities Strategy	Learning disabilities - develop employability skills with a wide group of service users	Green	(60,000)	Yes	Review of workforce and employability schemes underway.
	Review of sleepover provision in LD	Red	(151,000)	Assumed that this will not be achieved but is included in the projected overspend.	Sleep over pilots implemented and Canary assessment tool purchased. Next steps to extend canary roll out and develop outline busines scase for development of a responder service. plan to look at Parkview (Key Housing to see if there is any scope to share staff and sleepovers). We have liaised with Moorpark and following an update from CLDT and Care Managers (after meeting with families) we plan to put assistive technology in place for three service users for a 6 week period. Current mapping of LD sleepovers, costings and areas and have identified 9 people who could transition to non sleepover provision but will require a bespoke response service and another 7 who with preparation over next year could transition from sleepover support with responder service in place.
	Introduction to SDS in LD	Red	(100,000)	Assumed that this will not be achieved but is included in the projected overspend.	LD strategy launched on 28.06.17 and implementaion phase of SDS development. Leadership capacity to accelerate change programme agreed with challenge fund.
	Savings in LD Community Packages	Red	(50,000)	Assumed that this will not be achieved but is included in the projected overspend.	Review of packages underway and ARG processes. Also commence initial work to implement CM2000 later in the year.
Management and Support Services	Review of Partnership business support functions	Amber	(75,000)	Yes	A full review of business support will be undetaken during 2017/18 with a view to achieving these savings.
	Review of Charging Policy	Blue	(100,000)	Yes	Complete but continue to monitor
	Review of Management and Support Across the Partnership	Red	(80,000)	Yes	Posts to be identified
	New ways of Working Across the Partnership	Red	(50,000)	Yes	Posts to be identified
	Review of Fleet Management and Catering Budgets across the Partnership	Blue	(22,000)	Yes	Complete but continue to monitor
	Workforce Modelling	Red	(100,000)	Yes	Posts to be identified
Teams Around the Child	Transfer of 12 external foster care placements to in-house carer provision, and a reduction of a further 4 external long term foster placements.	Blue	(91,520)	Yes	Complete
	Alignment and Rationalisation of Learning Development functions in Children Services	Blue	(50,000)	Yes	Complete
	A Review of Management and Support in Children Services	Blue	(65,000)	Yes	Complete
			GRAND TOTAL	**(2,070,520)**	

NHS Savings

Service	Description	B / R / A / G	Budget Savings 2017/18	Saving assumed to be fully achieved in the projected outturn?	Update on progress to date and proposed action moving forward
Mental Health	**Review of Psychology Services**	Green	(200,000)	Yes	Psychology service review complete. Recommendations being developed. Reporting to a future IJB. Release of HR capacity to support re-design of workforce has delayed progress.
Primary Care - Prescribing	**Prescribing Annual Review**	Green	(1,346,000)	Yes	Continue to monitor
Primary Care - Prescribing	**Prescribing Incentive Scheme**	Amber	(770,000)	Assumed that £596K will not be achieved but is included in the projected overspend.	Continue to engage with GPs including raising this at meetings that have with arranged with GPs.
Mental Health	**Phased Closure of House 4 at Arrol Park**	Amber	(125,000)	Yes	Refurb of unit to enable segregation of unit and transfer of workforce across the unit underway/reduction of beds. This will also enable the transition of an out of area patient pending a tier 4 supported accommodation solution being identified via capital bid. Business case developed.
Mental Health	**Substitute Prescribing** This proposal will result in a 1% reduction in substitute prescribing.	Blue	(30,000)	Yes	Complete
Proposed savings to be approved (IJB November 2017)		Green	(519,000)		
STILL TO BE IDENTIFIED		Red	(1,165,000)		
Total			**(4,155,000)**		

Change Programme

Appendix C

Integrated Care Fund Area of Spend	2017/18 Budget	2017/18 Projected Spend	Slippage	Comment
	£000's	£000's	£000's	
Funding Previously Agreed to 31/3/18	208	208	0	
Partnership Enablers	129	129	0	
Social Enterprise Development Opportunity	15	15	0	
Ideas and Innovation Fund	579	476	(103)	The Community Connectors will be funded by the Scottish Government for the second half of the year.
Reshaping Care for Older People Legacy	132	229	97	LOTS workers
Engagement and Locality Planning	123	86	(37)	
Teams around GPs	756	453	(303)	See and Treat Centre slippage
Change Team	824	720	(104)	
Low Level Mental Health	108	64	(44)	
Other	16	13	(3)	
TOTAL	**2,890**	**2,393**	**(497)**	
Less Proposed Non Recurring Savings			**339**	
REVISED UNDERSPEND			**(158)**	

Mitigation Actions - Previously Agreed

Appendix D

		Approved Plan £000's	Projected Position £000's
Savings delivered from Challenge Fund projects in 2017/18			
Phase 1	Challenge Fund - Review Physical Disabilities Caseload	117	117
	Challenge Fund - Pilot Step Up/Step Down Beds	100	40
	Challenge Fund - Develop Reablement and Assessment Capacity Within Care at Home	95	95
	Challenge Fund - Pilot a New Approach Sleepover Provision within Learning Disability	150	35
	Challenge Fund - Investment in Universal Early Years, School Based Approach and Reduction in Need for Residential School Placement	200	200
	Challenge Fund - Expansion of MAASH	30	30
	Challenge Fund - Pilot Sickness Absence Taskforce	50	-
	Sub Total	**742**	**517**
Phase 2	Challenge Fund - Right Intervention at the Right Time - Review of Threshold/Criteria	100	100
	Challenge Fund - Review and Development of Charging Policy	25	25
	Challenge Fund - Roll Out of Self Directed Support	75	75
	Challenge Fund - Pilot a See and Treat Service	50	50
	Sub Total	250	250
Challenge Fund Total		**992**	**767**

Other Agreed Mitigating Actions	Implications	£000's	£000's
Learning Disability - Review of Packages	The review of care packages is ongoing and required to ensure services are appropriately aligned to need. Changes to service provision should reflect new models of service delivery in alignment with the Learning Disability Strategy outcomes. There are risks identified in relation to the pace of change and development of alternative service delivery models and choices for service users to transition into (SDS, sleep over provision, supported accomodation, short breaks/respite). Changes to service delivery will be risk assessed to minimise impact. We will also introduce a clear escalation policy to ensure senior management approval for new care packages.	215	115

Mental Health - Review of Packages	The review of care packages is ongoing and required to ensure services are appropriately aligned to need. Changes to service provision should reflect new models of service delivery particularly in relation to development of new supported accomodation models. There are risks identified in relation to the pace of change and development of alternative service delivery models and choices for service users to transition into. There are minimal service choices available at this time with an undeveloped provider market. Changes to service delivery will be risk assessed to minimise impact. We will also introduce a clear escalation policy to ensure senior management approval for new care packages.	100	100
Spending Freeze on Non Essential Non Payroll Spend Not Linked to Care	The impact of this will be monitored and is likely to impact on training developments available to staff, funds available for consultation and engagement.	100	100
Reduction in Overtime Usage - Freeze in Non Essential Areas	The impact of this will be monitored.	100	100
Review of Management and Support Functions	This is being targeted in addition to savings which have been approved as part of the 2017/18 budget. This will impact on the support which can be offered to support transofrmational change and will require remaining resources to be prioritised.	50	50
Total Other Mitigating Action		**565**	**465**

Grand Total	**1,557**	**1,232**

Notes

(1) £515,000 will be targeted, with £300,000 contributing to previous year savings and £215,0000 contributing to the mitigation.

(2) All vacancies will continue to be subject to scrunity and will only be filled for essential posts which are required to be filled to deliver services which otherwise would be covered through overtime, agency or bank staff. This is required to meet current turnover targets

Proposed Mitigating Actions **Appendix E**

Proposed Mitigating Actions	**£000s**
1) Older people – equipment budget – waitlist new clients based on need	200
2) Care at home – delay recruit of 10 staff to April 2018	130
3) Children's services – additional savings to be secured from Challenge Fund projects.	150
Total Proposed Mitigation	**480**

Proposed NHS Savings **Appendix F**

Proposed Saving	**Implication**	**£000's**
1) CAMHS	All of the savings being proposed are from current areas of underspend. They are being proposed on a non recurring basis and will have no impact on service delivery in 2017/18.	80
2) Mental Health Admin		100
3) Change Programme - ICF		339
TOTAL SAVINGS PROPOSALS		**519**

Appendix G

BUDGET RECONCILATION

	Partner	Period	Permanent or Temporary	£	£
Initial Approved Budget	NAC	4		86,907	
Resource Transfer	NAC	4	P	22,378	
Transfer from Housing - Aids and Equipment	NAC	6	P	199	
Increase to OP Care Homes	NAC	6	T	977	
Increase to LD Community Packages	NAC	6	T	423	
Removal of Depreciation	NAC	6	P	(70)	
Net Resource transfer	NAC	6	P	(240)	
Period 6 reported budget - Council					**110,574**
Initial Approved Budget	NHS			136,230	
Resource Transfer	NHS	2	P	(22,138)	
Dean Funding for Junior Doctors	NHS	2	P	9	
ANP Post to East (from ORT funding)	NHS	3	P	(49)	
AHP post funded by ADP	NHS	3	T	(31)	
NES Junior Doctor reduction in funding	NHS	3	P	(13)	
Veterans/Carers Funding	NHS	4	T	210	
ANP Funding from North to South	NHS	4	P	(49)	
Arrol Park GP medical service transfer to PC	NHS	4	P	(13)	
FNP Budget adjustment to match allocation	NHS	4	T	(3)	
Dementia Specialist Nurse	NHS	6	P	29	
West of Scotland CAMHs (anticipated)	NHS	6	T	24	
Veterans/Carers Funding to NAC	NHS	6	T	(210)	
Reduction in ADP funding for NAC	NHS	6	T	(30)	
Period 6 reported budget - NHS					**113,966**
Total Partnership Budget					**224,540**

Annual Financial Statement 2017/18 **Appendix H**

	2017/18		
	Payment £m	**Set Aside £m**	**Total £m**
RESOURCE			
NORTH AYRSHIRE COUNCIL	88.437		**88.437**
NHS AYRSHIRE & ARRAN	136.103	23.400	**159.503**
TOTAL INCOME	**224.540**	**23.400**	**247.940**
EXPENDITURE			
COMMUNITY CARE AND HEALTH	64.757		64.757
MENTAL HEALTH SERVICES	71.295		71.295
CHIDREN'S SERVICES AND CRIMINAL JUSTICE	34.412		34.412
PRIMARY CARE	47.575		47.575
MANAGEMENT AND SUPPORT COSTS	3.985		3.985
CHANGE PROGRAMME	2.516		2.516
LEAD PARTNERSHIP AND SET ASIDE	0.000	23.400	23.400
TOTAL EXPENDITURE	**224.540**	**23.400**	**247.940**
SAVINGS TARGET	6.226		6.226
AGREED SAVINGS	5.061		5.061

EARMARKED RESERVES (DEFICIT BROUGHT FORWARD)			-3.245
GENERAL RESERVE			0
TOTAL RESERVES			-3.245

DIRECTION

From North Ayrshire Integration Joint Board

1.	**Reference Number**	16112017		
2.	**Date Direction Issued by IJB**	16 November 2017		
3.	**Date Direction takes effect**	16 November 2017		
4.	**Direction to**	**North Ayrshire Council**		Yes
		NHS Ayrshire & Arran		
		Both		
5.	**Does this direction supercede, amend or cancel a previous direction – if yes, include the reference numbers(s)**	**Yes**		
		No	No	
6.	**Functions covered by the direction**	Peer support, employability and recovery services to people with mental health problems in North Ayrshire as outlined in the report.		
7.	**Full text of direction**	North Ayrshire Council is directed to re-commission the peer support, employability and recovery service to the value of £279,887 per annum for 2 + 1 years as outlined in the report.		
8.	**Budget allocated by Integration Joint Board to carry out direction**	£279,887 per annum		
9.	**Performance Monitoring Arrangements**	The contracts forming part of this service will be managed in line with the Performance Management Framework for North Ayrshire HSCP and a monitoring officer will be appointed from the HSCP.		
10.	**Date of Review of Direction (if applicable)**	August 2018		

NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
16th November 2017
Agenda Item No. 8

Subject:	**Chief Social Work Officer Annual Report**
Purpose:	To provide the report of the Chief Social Work Officer to the Integration Joint Board (IJB) as required by the Scottish Government's Guidance.
Recommendation:	That the Integration Joint Board note and endorse the report set out at Appendix 1.

Glossary of Terms	
IJB	Integration Joint Board
CSWO	Chief Social Work Officer
SOLACE	Society of Local Authority Chief Executives
ADSW	Association of Directors of Social Work
SIMD	Scottish Index of Multiple Deprivation
HSCP	Health and Social Care Partnership

1. EXECUTIVE SUMMARY

1.1 There is a requirement for every Local Authority to appoint a professionally qualified Chief Social Work Officer (CSWO) and this is contained within Section 3 of the Social Work (Scotland) Act 1968 as amended by Section 45 of the Local Government etc. (Scotland) Act 1994.

1.2 In line with the legislation and guidance, the CSWO is required to prepare an annual report for the Council, on all statutory, governance and leadership functions of their CSWO role.

1.3 Given all social work and social care functions have been formally delegated to the Integrated Joint Board (IJB), it is vital that the Board is sighted on the CSWO annual report and is aware of the key issues.

1.4 This is the eighth annual report covering the period of April 2015 to March 2016. It is attached as Appendix 1.

2. BACKGROUND

2.1 In 2014, the Office of the Chief Social Work Adviser, following consultation with CSWOs across Scotland, SOLACE, the then ADSW and others, identified a more standardised approach to prepare the annual reports.

2.2 The report provides an overview by the CSWO of the partnership structures, robust governance arrangements and the performance of social services in the context of the demographic landscape of North Ayrshire and the delivery of Social Services. It looks more closely at the statutory functions of the service and the quality and workforce development within our services. The report is also forward looking, reviewing the preparation for key legislative changes that will impact on our delivery and reviewing the key challenges the service will be facing in the forthcoming year.

2.3 The report highlights the range of Social Work activity throughout the year and places that in the context of the socioeconomic challenges faced locally. Of particular note, the following three areas should be highlighted:

- The most recent SIMD figures (2016) show a worsening position in North Ayrshire in the domains of Income, Employment, Education and Housing. All of these domains are likely to impact on the demands for Social Work interventions and this appears to be borne out particularly in relation to increased Adult Protection activity, Mental Health, Disabilities and Destitution presentations. There are significant challenges due to a combination of the financial pressures, demographic change and the cost of implementing new legislation and policy.

- The Audit Scotland Report of 2016 on 'Social Work in Scotland' concluded that "*Current approaches to delivering Social Work Services will not be sustainable in the long term. There are risks that reducing costs further could affect the quality of services. Councils and Integration Joint Boards (IJBs) need to work with the Scottish Government, which sets the overall strategy for Social Work across Scotland, to make fundamental decisions about how they provide services in the future. They need to work more closely with service providers, people who use Social Work Services and carers to commission services in a way that makes best use of resources and expertise available locally. They also need to build communities' capacity to better support vulnerable people to live independently in their own homes and communities*".

- The new Health and Social Care Partnership (HSCP) structures create possibilities to take a whole system approach to delivery of services and the Social Work role and function within this environment will remain a vital one if these possibilities are to be realised. Throughout this annual report, examples are given of new and innovative approaches to delivery Social Work Services.

3. PROPOSALS

3.1 It is proposed that the IJB note and endorse the report set out as Appendix 1.

3.2 **Anticipated Outcomes**

That the IJB and the Scottish Government are made aware of the significant challenges facing Social Work Services in North Ayrshire.

3.3 **Measuring Impact**

Impact will be measured in terms of the direction and support to continue to transform the delivery of Social Work Services.

4. IMPLICATIONS

Current models of delivering Social Work services will change.

Financial :	There are none
Human Resources :	There are none
Legal :	There are none
Equality :	There are none
Environmental & Sustainability :	There are none
Key Priorities :	This report covers matters which contribute to the key priorities around vulnerable children and adults within the North Ayrshire IJB Strategic Plan.
Risk Implications :	There are risks that reducing costs further could affect the quality of services.
Community Benefits :	Anticipated greater community and service user involvement in the design, commissioning and reviewing of Social Work Services.

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	

5. CONSULTATION

5.1 Members of the Partnership Senior Management Team and Senior Managers across the partnership have been consulted on this report.

6. CONCLUSION

6.1 The CSWO Annual Report sets out, for Elected Members, the extent of the delivery of Social Services in North Ayrshire and summarises significant aspects of performance in relation to the statutory interventions carried out by the registered Social Worker and Care Services delivered on behalf of the Local Authority.

For more information please contact David MacRitchie, Chief Social Work Officer, on 01294 317781.

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

North Ayrshire Council
Chief Social Work Officer Report
2016-17

Delivering care together

Version: 4.02 draft

David MacRitchie

Chief Social Work Officer – North Ayrshire

30th September 2017

Contents

Introduction

In April 2015, Integration Joint Boards were established and Health and Social Care Partnerships (HSCPs) formed across Scotland. All Local Authority Social Work responsibilities were delegated by North Ayrshire Council to the North Ayrshire Integration Joint Board (IJB) which was fully established in 2015 by the Public Bodies (Joint Working) (Scotland) Act 2014 with responsibility for the strategic, operational and financial oversight of the North Ayrshire Health & Social Care Partnership (NAHSCP) .

The NAHSCP is one of the three Ayrshire partnerships formed with the NHS Ayrshire and Arran and has lead Partnership responsibility for Mental Health and Learning Disability Services as well as Child Health Services.

In 2015 NAHSCP published its first strategic plan, refreshed in 2016. Our vision and priorities were endorsed through extensive consultation with the public. They are aligned to that of the Council and those of the Single Outcome Agreement.

"All people who live in North Ayrshire are able to have a safe, healthy and active life "

North Ayrshire Health & Social Care Partnership Priorities

- **Tackling inequalities**
- **Engaging communities**
- **Bringing services together**
- **Prevention & early Intervention**
- **Improving mental health and well-being**

The partnership has an integrated management structure, with Heads of Service and Senior Managers having line management responsibility for both health and social work staff.

The year 2016/17 saw the secondment of our Chief Officer and Director to the post of Chief Social Work Advisor to the Scottish Government. The then CSWO, who had been in the role for three years and was Head of Service for Children and Families and Justice Services, was appointed as Interim Director and I, as his deputy CSWO, succeeded to this role on an interim basis. I am the Senior Manager for Justice Services. The appointment of CSWO is not delegated to the Integration Joint Board. The CSWO is one of the five statutory officers to the council, appointed by the Chief Executive, and gives professional governance, leadership and accountability for the delivery of safe and effective social work and social care services, both provided directly by the HSCP and those commissioned or purchased from the voluntary and private sectors. [1]

[1] Section 3 of the Social Work Scotland Act 1968 , as amended by Section 45 of the Local Government (Scotland)Act 1994

1. Key challenges, developments and improvements during 2016/17

The transformational change in the delivery of health and social care can in no small way be traced back to the seminal review report of Social Services in 2006, “Changing Lives”. The report highlighted the cross cutting nature of social services, supporting and protecting vulnerable individuals and improving the well-being of communities and people. Changing Lives influenced many other policy developments and legislation including the Public Services (Reform) (Scotland) Act 2010, Self -Directed (Support) (Scotland) Act 2013 and the Public Bodies (Joint working) (Scotland) Act 2014. Changing Lives and subsequent policies and legislation have highlighted that people who need health and social care support should be at the centre, able to exercise choice and control over the services they receive which are delivered efficiently, effectively, and seamlessly from the point of view of the user. The quality of those services requires to be assured externally and internally through appropriate governance and quality control.

This legislative backdrop sets the framework and expectations of the delivery of social work and health services. It sits alongside the current financial constraints on both Local Authority and Health Board funding, the UK Government’s ongoing austerity programme and significant changes in Welfare Reform.

In reviewing the content of this report, there are many areas where I can highlight the contribution and at times, leading role, of our social work teams in supporting the NAHSCP in taking forward a significant change agenda. These are:

- Service user engagement and involvement – with many examples of effectively working together on an individual and collective basis.
- Commitment to early intervention and prevention – with a range of initiatives across services that have been established by re-organisation of our workforce rather than separate funding.
- Motivation - to do things differently, and our readiness to work with partners to achieve better outcomes for the people who use our services.

The context that social work and social care currently operates within is challenging. Issues of austerity; public sector reform; higher demand for care and support; and increased expectation from the public about what that care and support can be. Audit Scotland stated in their 2016 report on social work, that social work services are not sustainable in their current form.

The significant challenges we are facing are:

- Financial constraints - impacting on the sustainability of current models of service delivery in the face of rising demand and complexity.
- Time and capacity - to establish sustainable and effective alternative models of care that require to be supported to achieve the desired outcomes.

Social work services are needed now perhaps more than ever. North Ayrshire Council, working with the Partnership, has established a Challenge Fund which will be accessed by the Partnership to undertake transformation projects in 2017/18. This fund will deliver significant investment targeted at transforming the way in which services are delivered in order to deliver savings. It will be used to pilot new models for delivery which will seek to provide innovative services for the local community, within a community setting, whilst also delivering a service which is financially sustainable moving forward.

Throughout this report I will give examples of how we are addressing the issues of demand and sustainability by evidencing our adoption of new and innovative ways to deliver services.

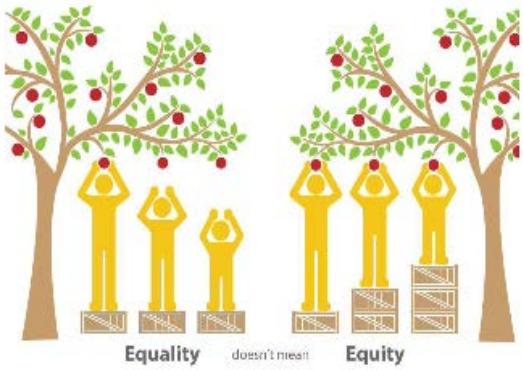
2. Partnership Structures/Governance Arrangements

North Ayrshire has a population of 135,890 living across a mix of town and rural communities on the mainland and two island communities, Arran and Cumbrae.

In North Ayrshire 39% of residents live in 20% of the most deprived areas of Scotland, the fourth highest incidence of deprivation in Scotland; a third of our children live in poverty, a situation second only to Glasgow. Deprivation is directly linked to a higher prevalence of complex individual problems such as mental ill health, increased drug and alcohol problems, criminality, lower life expectancy, illness in later life and poorer outcomes for children.

Fundamental to social work values is a commitment to address social injustice and we play an active role in strategic partnerships both of the Council and the Integration Joint Board to address both the cause and outcome of deprivation on people's lives. Local Authorities have a statutory responsibility to promote social welfare, and partnership working is key to providing high quality and effective support and services.

North Ayrshire Community Planning Partnership has published a strategy to 'tackle the root causes of poverty and address its impact to create a better life for local people'. The "Fair for All" Strategy makes clear the need for targeting support proportionately to provide equity of access to services and equality of opportunity. It reflects the Council ethos of continued partnership initiatives, for example, that between Social Work, Place, Economy and Communities and Police Scotland in the provision of school meals and activities during school holidays for children in North Ayrshire, free to those in receipt of benefits. This initiative is a first in Scotland, and is now being replicated in other local authorities.



The Children's Services Strategic Partnership has overseen the Improving Children's Outcomes agenda and is responsible for the strategic direction of children's services across

North Ayrshire. Our Children's Services Plan 2016-20 makes promises to the children of North Ayrshire and we are meeting those promises through partnership working and the development of supporting strategies and actions to realise the intended outcomes.

The **Corporate Parenting Strategy** places responsibility on partners for working together to meet the needs of Looked After Children and young people. The Leader of North Ayrshire Council signed the Care Leavers' Covenant which was witnessed by two Care Leavers in February 2017. The pledge is made that all our Looked After Children and young people's needs should be identified, assessed and met by breaking down barriers to support and services through Corporate Parents collaborating and working together. For this to happen a three year Corporate Parenting Plan has been developed and has been approved by Ayrshire and Arran Health Board, North Ayrshire Integration Joint Board the the North Ayrshire Cabinet. At the time of writing, the plan awaits final approval from the Community Planning Partnership. The plan sets out desired outcomes for our young people around their needs in relation to health, access to activities, education and training and employment.

Progress in delivering on this plan is evidenced by the outcomes of young people involved in our *Throughcare* Team. The team facilitated an agreement whereby five Local Authority Modern Apprenticeships were ring fenced for care leavers in 2017/18. This target was surpassed with the team supporting a further two care leavers to achieve appointment to these posts. An excellent initiative, aligned with Fair for All, and providing equity of opportunity to disadvantaged young people. In February 2017, Throughcare was awarded the first HSCP award of Team of the Year. This was in recognition of the efforts made to ensure that care leavers were well supported by ensuring that other services were made aware of, and fulfilled, their duties as Corporate Parents.

The **Positive Family Partnership Strategy 2016-20** has built on the previous strategy which realised positive outcomes from evidence based programmes delivered by the *Youth Support Team* such as the CEDAR programme (children experiencing domestic abuse), and our 2016 COSLA Bronze Award winning SNAP (Stop Now and Plan), a programme aimed at 8-11 year olds and their parents to improve children's resilience and their ability to deal with their emotions. All children involved in SNAP in 2016/17 maintained attendance at school, a significant achievement given the challenges they faced.

The **Alcohol and Drug Partnership (ADP)** has also realised initiatives delivered jointly with North Ayrshire Drug and Alcohol Recovery Service (NADARS). NADARS is an integrated health and social work team focusing on recovery. The ADP has promoted engagement, consultation and peer support ahead of the Community Empowerment legislation and has supported the training of service users in the role of peer researchers.

Within the partnerships described above, there are particular responsibilities which fall on statutory social work services in the exercise of individual and public protection and decisions taken or recommendations made can affect personal lives, individual rights and liberties.

I am an adviser to North Ayrshires Chief Officers Group for Public Protection and am a member of the Child and Adult Protection Committees. I am also a member of the Multi Agency Public Protection Arrangements (MAPPA) Strategic Oversight Group. In this way, a comprehensive overview is maintained of all issues relating to public protection and of risk management arrangements.

The Scottish Government's Publication "Recorded Crime in Scotland, 2015-2016" shows that between 2014-2015 and 2015-2016 North Ayrshire saw a 6% reduction in recorded crime, with East Ayrshire showing a 2% reduction and South Ayrshire a 4% reduction. The Scottish average reduction was 4%. Working together is seeing successful outcomes in North Ayrshire.

Justice social work services are long-versed in using an evidence based approach to risk assessment and management. They utilise accredited assessment tools such as the level of Service/Case Management Inventory (LS/CMI) to inform Court disposals and onward planning. In 2016, a standardised format of evaluating Risk of Serious Harm (ROSH), part of the LS/CMI, has also been utilised. The reason for this is that on 15th December 2015 Ministers commenced section 10(1) (e) of the Management of Offenders (Scotland) Act 2005 which took effect on 31st March 2016. This extended the scope of MAPPA to include other risk of serious harm offenders managed in the community, where the responsible authorities assess that a risk of serious harm to the public exists and which requires an active multi-agency response.

As CSWO, I have a direct line of accountability to the Chief Executive in North Ayrshire, meeting quarterly. I also appraise Elected Members and Senior Officers in the council on any issues, risk and developments within the service. This regular communication and information flow supports close working links with other local authority services and a consistent approach adopted by the Council to address cross-cutting issues.

As CSWO, I have a non-voting but advisory role to the IJB. The challenge presented is one of operating in an environment of cultural differences and experience of employing bodies. As integration progresses and teams develop together this should ameliorate this situation.

As CSWO I am charged with assuring that social work services meet national standards, comply with inspection, regulation and registration requirements and provide best value.

We must continue to ensure that there are appropriate arrangements in place for professional social work supervision outwith line management arrangements as health and social care teams are integrated. The landscape of governance and scrutiny is certainly more complex. Our Social Work Governance Board is now one of several governance groups in the HSCP which reports to the IJB. We are currently looking at the possibility of streamlining these arrangements and reducing the number of governance groups across the partnership.

3. Social Services Delivery Landscape

Social Services provision in North Ayrshire is a mix of in-house services and those commissioned from the Third and Independent Sectors. Over 2016/17, the HSCP Social Work Teams commissioned social care services from 217 different providers at a cost of £50M across the full range of service user groups. We have an established Quality Management Framework in place used to both support providers and ensure that any service delivery issues are addressed in an agreed and managed way.

The Third and Independent sectors in North Ayrshire have a well-established seat on the Integration Joint Board, and Strategic Planning Group which is involved in developing the HSCP Strategic Plan. We have a Providers Forum that was formed eight years ago by social services and has developed into a robust self-managed group. This forum is a further means to share market information, to communicate and consult regularly, share best practice and discuss opportunities for joint working across sectors.

However, the market for social care provision is also being adversely effected by the increasingly significant challenge presented by the ongoing financial constraints on public services and the UK government's austerity programme that continues to compound the difficulties already experienced by our service users. We shall see in the following section that the NAHSCP has considerable overspends to address in addition to savings targets to be made. As alluded to above, these financial issues are set against a backdrop of increasing demand for statutory services as the complexity of health and social care situations faced by people who need our services increases.

We are going through a very conflicting time as we strive to change the 'balance of care' from residential care to community care. Shifting to prevention and early intervention is difficult because resources are locked into service delivery meeting existing demands. The lasting benefits from any models of early intervention and prevention, that are already showing positive outcomes and have social value, will take time to materialise.

As resources are threatened due to budgetary demands we are having to review our eligibility criteria for social care services, focussing on high risk and substantial need. The Third Sector is pivotal to an early intervention and prevention approach that can mitigate many of the effects of poverty and deprivation on health and well-being. They have a largely local workforce with intimate knowledge of localities and are well placed to support groups and communities.

The Third and Independent Sectors have been afforded monies from the Integration Care Fund (ICF) over the past three years and have established some successful initiatives such as "**Food Train",** with a growing group of volunteers (28 at last count) who run grocery shopping and a delivery service to people aged 65 and over and have 128 customers. "**On Yer Bike"** is another successful community project running cycling outings and bike maintenance and has had over 300 participants.

However, as the demand and pressure for mainstream services grows, so the share of monies afforded to the Third and Independent Sectors from the ICF has fallen from £1.25M representing 43% of the fund to £0.686M or 23% of this budget.

It is clear that the Third and Independent Sectors are facing similar financial challenges and the uncertainties about funding do not sit easily with future planning to realise market opportunities. The market for services is set within the legislative context of the Self Directed Support (Scotland) Act 2013 (SDS). SDS aims to improve the lives of people with social care needs by empowering them to be equal partners in decisions about their care and support.

A recent Audit Scotland Report highlighted the 'poor uptake' of SDS across Scotland, some three years after the implementation of the Act, with the overwhelming number of service users still choosing the local authority to deliver their services. Our experience in promoting SDS is compromised both by a lack of choice within the market and a reluctance by service users to take responsibility to control their care. This is less evident in the uptake of alternative options noted by our Children with Disabilities Team, where parents of the child welcome such responsibility and engage well with the SDS process.

During the past year we have been negotiating with the Third and Independent Sector providers in relation to increased rates for their staff due to the living wage legislation. This has been supported by ourselves as a Fair Work Practices employer. However, there have been tensions in achieving agreement with some Independent providers. We have experienced particular difficulties in agreeing increased costs for 'rural' areas and huge difficulties in securing relatively small packages of care as our providers have to consider their economies of scale.

At times, changes in funding and difficulties in operations of a partner organisation has resulted in the withdrawal of services. This has inevitably had an impact on social work services who are required to fulfil statutory obligations to these service users. Two examples are given below:

- Money Matters during 2016/17 had significant demands on its service following the decision taken by North Ayrshire Citizens Advice Service to no longer provide an Appeals service to non HSCP clients. Money Matters, since September 2016, now represents both HSCP and non HSCP appellants at Social Security appeals. The team had to train additional advisers into the Welfare Rights Officer's role and review service delivery to enable this area of work to be prioritised. Since that time, the team have provided advice and representation at over 350 appeals and have achieved a 70% success rate so far. Plans for 2017/18 are in place to redress this situation so that Money Matters continues to focus on those most vulnerable and advice and representation services are also available to others in North Ayrshire.

- We had previously seen the impact of the financial difficulties on external Home Care Services in 2015 when five independent providers suddenly folded. We maintained service continuity through TUPE of staff to our own services. Over 2016/17 we evaluated how the service as a whole could be sustainable in the future and, working with our partner providers, we have identified that a change in the balance of provision is required such that a maximum balance would be 70% of home care services provided in-house and 30% by independent providers. In 2018 we will be establishing a framework tender to support this.

4. Resources

Financial information is part of our performance management framework, with regular reporting of financial performance to the Integration Joint Board (IJB). Strong financial planning and management underpins everything that we do to ensure that our limited resources are targeted to maximise the contribution to our objectives. The ability to plan based on the totality of resources across the health and care system to meet the needs of local people is one of the hallmarks of integrated care. In December 2016, the Scottish Government published the Health and Social Care Delivery Plan which sets out the programme for further enhancing health and social care services. Critical to this is shifting the balance of care and support from hospital to community care settings, and to individual homes when that is the best thing to do. This provides a clear impetus to the wider goal of 50% of the health budget being spent in the community by 2021.

Our annual accounts provide full detail of revenue expenditure 2016-17.

In summary, Partnership services experienced a continued growth in demand, particularly in Community Care services for older people and in Children and Families services. This has led to in-year overspends on commissioned services against the original approved 2016–17 funding. Unachieved savings also contributed to the overspend, particularly within Mental Health and Learning Disability Services.

A number of services experienced significant in-year budget pressures during 2016/17:

- ***Community Care and Health – Overspend of £1.318m –*** This overspend mainly relates to demand in Care Homes, Respite and Care at Home. Care at home experienced a 30% increase in demand and service users had to be placed on a waiting list.

- ***Mental Health Services – Overspend of £0.792m -*** This overspend is related to Community Packages and Direct Payments within Learning Disability services and reflects the current packages commissioned. Part of this overspend (£0.251m) is linked to the non-delivery of savings in 2016/17.

- ***Children and Families and Justice Services – Overspend of £1.262m -*** This overspend is mainly within Children's Services and reflects an increased requirement to place children within Residential Schools.

The partnership will continue to face high levels of demand for services, however, it is imperative that services are commissioned within the resources made available and this will be the highest priority during 2017/18.

We are undertaking reviews of our current models of care to establish more sustainable approaches to allow us to meet our statutory duties. This is evident in all service areas as follows:

4.1 Mental Health Services and Community Care

The Learning Disability Social Work team commissions care and support packages according to the level of need and complexity of the individual's situation. They have a service user group ranging from 494 to 526 over 2016/17. The team also provides Day Services to 90 service users in premises that are not flexible enough to accommodate changes in practice and models.

The Mental Health Social Work team works in the same way and have a service user group that has ranged between 183 and 229 over 2016/17. The increase in complexity of mental health problems presented to in patient and community services is reflected in the need for larger care packages of support to facilitate discharge from hospital.

For both learning disability and mental health services, the current model of support is largely being provided to service users in dispersed and individual tenancies with a significant number of these service users being assessed as needing responsive care, available on a 24/7 basis. The current model is overly intrusive in that carers are 'ever-present' in the person's home. This does not facilitate the desired personal outcomes for service users and it is also very costly.

The newly launched Learning Disability Strategy and the evolving Mental Health Strategy in North Ayrshire focusses on service users and carers being partners in arranging care and person centred planning focussed on outcomes and pursuing the maximisation of independence.

A small pilot project commenced during 2016/17 and worked with service users, carers and providers to assess whether a care support worker was required overnight and, if not required, to introduce a telecare option as appropriate. We worked closely with a seconded care at home manager to look closely at all telecare options and initiatives that have proved successful to other care groups.

We have met with significant concerns and resistance from family carers to change any aspect of support packages and it is clear that we need to engage further and highlight that this can be a safe and effective option.

In 2016/17 the opportunity to take forward the agenda to establish new models of care came unexpectedly when a large care home in Irvine came on the market. The footprint and, for its time, innovative design of the resource lent itself to development and refurbishment to realise many goals. The Tarryholme Drive Project will allow for:

- The development of a new Learning Disability Day Centre with strong community links and flexible use of space.
- A pathway for people recovering from acute mental health problems to rehabilitate out with a hospital setting leading to improved outcomes and avoiding the unintended negative consequence of long-term hospitalisation.
- A range of supported living options, 20 tenancies and a small care home for people with complex and significant learning disabilities.

Capital funding for the purchase and refurbishment of the site was supported by North Ayrshire Council and Ayrshire and Arran Health Board and demonstrates a joint commitment to establish new models of working. The refurbishment of the site will be complete by spring 2019.

However, to continue to meet current demand and the forecast increases, the models of care have to develop alongside alternative models of accommodation available to Community Care, Mental Health, Learning Disabilities and Children with Disabilities.

We have seen the success of a core supported housing model at Castlecraigs Court in Ardrossan. Thirteen housing tenancies for adults with learning disabilities and/or mental health problems who would otherwise require a care worker in their home on a 24/7 basis have this support provided by on-site care staff on both a planned and responsive basis. The residents enjoy greater independence, but have the benefit of accessible support. The cost of packages is practically half that of delivering this care and support in individual dispersed tenancies.

To this end we have been working in partnership with Housing to develop housing models which will see a programme of developments across North Ayrshire of extra care housing and core supported housing models. Sheltered care housing models, such as Vennel Court and Montgomery Court are being further planned as extra care, providing an opportunity to deliver a core model of 24/7 responsive care to adults who have physical disabilities as well as those termed ‘older people’. Delivery of these models is expected in 2020/21.

4.2 Children and Families and Justice Services

We continue to experience high incidences of children subject to legislation. We had 601 children and young people subject to a Compulsory Supervision Order, or Looked After during 2016/17. Of these, 389 were accommodated away from their parental home. We had 112 children who were placed on an order with a kinship carer. Impending implementation of further Welfare Reform changes presents yet another financial challenge to the Partnership and communities in North Ayrshire. Changes being implemented in November 2017 to universal credit will see the removal of amounts paid to kinship carers for a child if newly placed/ or when the claimant’s circumstances change. The resulting shortfall for a carer for one child is £63.94, a sum that the Local Authority would require to make up in allowances to prevent further financial hardship.

Mitigating these circumstances, we have continued to work to reduce the number of children who are accommodated in external, and more expensive, foster placements that are often out with the local authority and as such away from the child’s community. We have reduced numbers of external foster placements in 2016/17 from 30 to 13 with plans to reduce further next year. We have successfully increased our in-house foster parents to 100, to ensure that our young people are cared for close to their home communities. We had projected a demand for 122 foster placements, but the numbers of children requiring to be accommodated increased beyond our estimate and led to a rise in foster placements to 141. This increase in accommodated children has also resulted in an increased demand for residential school placements as well as placements in our own children’s homes, which were accommodating younger children and at times going over their registered numbers.

In 2017/18 we plan to use some of the Challenge Fund monies to develop a project utilising existing services to focus on robust care plans that will enable young people to return to the community from expensive and outwith area residential placements. In effect, the bespoke virtual team will wrap around the young person and facilitate a return to the local community.

Justice Social Work Services engage with approximately 450 service users at any given time. This past year has been a particularly challenging year for us in terms of our core Justice Services being able to respond to the needs of service users. In 2015/16 we saw an increase of 31% in the number of Community Payback Orders (CPO's) from the previous year. In the Scottish Government Justice Statistics for 2015/16, published in February 2017, it showed that North Ayrshire had the highest number of CPO's in Scotland per 10,000 population. There has been no increase in the budget to reflect this demand.

From the evidence above, it is clear that as we move into 2017/18, we need to continue to address proactively the funding challenges presented while, at the same time, providing quality services for the people of North Ayrshire.

5. Service Quality and Performance including delivery of statutory functions

The Annual Performance Report reflects the overall progress in meeting National Outcomes. As our strategic priorities are designed to further this progress I shall consider the performance of social work in achieving these priorities. The priorities are as follows:

5.1 Tackling Inequalities

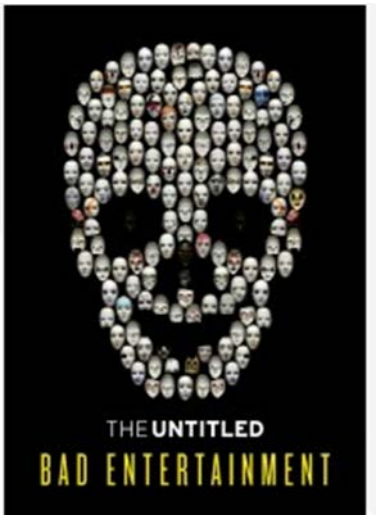
The demographics of North Ayrshire present additional challenges in contributing to the National Outcomes. It is no surprise that the incidence of people presenting to social work services for support from the most deprived areas represent the majority, 59% of the 5,757 individuals referred into our generic 'intake' team, Service Access, over 2016/17. Approximately 10% of these referrals were classified as destitution referrals requiring short term financial support or referral to food banks.

Examples from our social work teams in tackling inequalities in 2016/17 are:

1. **Money Matters -** the Money Matters team works across service boundaries and achieved £8.2m in Income Generation for North Ayrshire residents.

2. **Activity Agreement Programme** - established by our Rosemount Project working with looked after young people who are leaving school to help clarify and support future planning for them. The programme assisted 83.5 % of the young people referred to them to transition to a positive destination. These positive destinations included college

placements and full time employment, with one young person securing a Modern Apprentice place.



The Activity Agreement's "Bad Entertainment" exhibition was displayed at the National Portrait Gallery in Edinburgh from January 2016 until May 2016 and then presented locally at the Harbour Arts Centre in June 2016. Bad Entertainment opened to critical acclaim and started as an exploration for young people to use art to address their own lives and sketch out what kind of society could exist if the future was in their hands. Our partnership and work with the National Gallery continues to feature in our Activity Agreement Programmes with young people working on a conceptual skill project called "Art of the Future".

3. **Employability Project -** The Justice Social Work team are in the process of setting up an employability project linked to our Unpaid Work Service. One of the Council's priorities is to grow our economy, increasing employment and regenerating towns. This project is a key element of this, considering how to help those furthest from the labour market in the hardest to reach communities back to work. North Ayrshire Economic Development Team have secured funding from the European Social Fund to provide two Peer Mentor Employability Workers to support staff and service users in Unpaid Work. These posts will look at the employability prospects and signpost service users to better employment opportunities within North Ayrshire or surrounding areas. The Project has made links with local employers and Third Sector organisations to further its objectives.

5.2 Bringing Services Together

Our workforce is our major resource and the reconfiguration of teams has been geared towards the goals of moving towards a focus on early intervention and prevention and ensuring that intervention is by the right person, in the right place, at the right time and that it is doing the right thing.

Reconfiguration of teams and partnership working can both help realise the desired outcomes for service users and also ensure that social work resources are used efficiently and effectively. Some examples of this from across the services are given below:

1. **Multi Agency Assessment Screening Hub (MAASH)** - We have spoken in previous reports of the development of the Multi Agency Domestic Abuse and Response Team (MADART). This partnership model, working with police, housing, social workers and third sector organisations (Women's Aid and Assist) has undoubtedly helped better support victims of domestic abuse in a more effective and timeous way. The MADART team, alongside social work justice services (notably the Caledonia Programme working

with perpetrators of domestic violence) has been a major contributor to reducing levels of domestic abuse in North Ayrshire. The most recent Police Scotland figures relating to Domestic Violence in North Ayrshire demonstrate a 21.7% reduction on last year's figures. This is the third year in a row that the number of domestic abuse incidents in North Ayrshire has reduced after many years of continual rises.

A further development of this type of successful partnership model is evidenced in the establishment of MAASH (Multi-Agency Assessment and Screening Hub) during 2016/17 within which MADART now sits. MAASH deals with all concerns referred to and by the Police. North Ayrshire has higher numbers of children referred to the Scottish Children's Reporter Administration (SCRA) than other areas of Scotland at 2.3% of all children compared to 1.5% nationally. The highest number of referrals to SCRA were from the police, but by establishing MAASH, this has helped to reduce the number of police referrals to SCRA by 46% this year. MAASH screens and assesses referrals, and support is offered at the earliest time to avert situations escalating to the point where statutory intervention may be required. This kind of approach is in the best interests of families and also averts unnecessary work for our limited registered Social Worker resource.

We will be looking to expand the role of the Hub to include Adult Support and Protection referrals which similarly see a high incidence of referrals from our Police colleagues.

2. **Building Teams around the Child** -The latest census information showed the number of children (0-15yrs) in North Ayrshire as 24,283. A third of these children live in poverty. Evidence shows that negative experiences in the early years can result in poor social and health outcomes over the life span. There are strong links between childhood trauma and the adult onset of chronic disease, poor mental health and biomechanical coping mechanisms, such as drugs or alcohol misuse. The study of Adverse Childhood Experiences (ACEs) shows how adversity impacts on how people respond to stress, resilience and the ability to form lasting relationships.

Currently our social work Children and Families Teams are involved with 2626 individual young people, with 68% coming from an area of significant deprivation. The Children and Families (Disabilities) team caseload has increased over the years as has complexity of these disabilities.

We are establishing teams around children and families, based within our six identified localities. The locality model of the teams around Children and Families will ensure that children and families get the right support from the right person at the right time, and delivered within their own community. It is anticipated that the multi-disciplinary approach to Children and Families Services will include; teaching staff, educational psychologists, social workers, school nurses, health visitors, child and adolescent mental health specialists, and intervention specialist services. The HSCP continues to engage with the Tapestry Partnership, connecting schools with communities within the Three Towns locality and there is consideration of extending this approach to include the Kilwinning locality.

While in some localities these teams will be co-located, this will not always be the case due largely to logistical and accommodation issues. We will however develop Locality Resource Groups (LRG) in all six localities, to ensure that there is a locality approach to meeting the needs of Children and Families within their own communities. These forums

will be attended by some of the above named agencies as well as others who are identified as key participants and who will contribute to developing robust multi-disciplinary plans for children and their families.

We believe that this approach is required to enhance the existing partnerships that already are evident within local communities. The building upon existing professional relationships within a locality, utilises local knowledge and experience of that locality and will contribute towards better informed plans for children and families. This will put Children and Families Services at the heart of the Health and Social Care Partnership and utilise resources to maximum effect.

The locality team around children and families should ensure that it is more likely that services will be delivered by professionals whom children and their families are more familiar with and who are known in the community for their particular role. There will also be improved information sharing across services as the locality teams share concerns in order to develop well informed plans to meet identified needs.

There will be benefits to creating those teams in terms of the enhanced partnership working around early intervention which will reduce unnecessary referrals and bottle necks in children and families accessing services.

3. **Early Years Leadership Team** - Locality based Early Years Leadership Teams are fundamentally planning forums, in all the North Ayrshire localities. These Teams are attended by Managers from across the Health and Social Care Partnership, Education and Partnership nurseries. They are focused on building professional networks and relationships as well as identifying local priorities that they can progress in their area.

4. **Care at Home -** Fundamental to achieving the National Outcomes of care delivered in a person's own home is the work of our Care at Home staff group. We have increasing demands commensurate with the rise in the older persons' population who are living longer, but also coping with chronic physical problems. Currently, we provide support to over 1,874 service users across North Ayrshire and/or provide a telecare solution to over 4,500.

The current priority for Care at Home is to keep people in their own homes and communities and also facilitate early discharge from hospital to home where appropriate. We have developed a single point of contact system for professionals where early assessment and decision taking as to the focus on the outcomes for the service user is paramount. Here an assessment is made by an Occupational Therapist as to the Reablement potential of anyone referred. Reablement is a service that focuses on helping a person maximise their independence by learning or re-learning the skills necessary for daily living and enhancing confidence to live at home. It is a person-centred, goals-based approach designed to reduce long term reliance on statutory services.

During the year 2016/17 there were 2067 referrals made to the Reablement Service of which 645 individuals (31.2%) were deemed suitable to be reabled. The remaining individuals were referred onto or were already in receipt of mainstream care at home services. Of those individuals, 386 (18.67%) were requiring permanent increases to their provision; 655 of those individuals (31.68%) had ongoing provision and did not

have potential to increase independence and the remaining 381 individuals (18.45%) required palliative and/or end of life care.

The Reablement Service achieved 47.5% successful outcomes in that service users were either fully reabled - requiring no further service or had a reduction in Care at Home services as a result of the intervention. However, we have also seen our waiting list for this service increase. Evaluating the reason for this, it was evident that, in part, this was due to the lack of capacity to complete social work assessments by community care teams in order to review the service user and avoid having packages continuing for longer than necessary.

To mitigate this we are reconfiguring our Hospital Social Work team and will from May 2017 have five Social Work Assistants joining the Reablement Team. Instead of assessing someone within a hospital setting they will carry out the assessment of the individual at home and, working alongside the OT's and OTA's in the person's home, it is envisaged that the reduction of care packages and the timeous cessation of care packages will increase.

From the Challenge Fund pot of money that the Council has made available to the Partnership there will be money allocated for three additional Occupational Therapists to sit within the care at home Reablement service. This will allow the mainstream care at home service to be involved in Reablement and will further prevent unnecessary admissions to other establishments.

5. **Community Alarm and Scottish Ambulance Service –** Following a successful pilot that ran from December 2015 to December 2016 in the Irvine area where 999 calls were responded to by social care workers from our Community Alarm service alongside the Scottish Ambulance service the service is being rolled out to other North Ayrshire localities. The pilot evidenced that 74.56% of people who called an ambulance via telecare remained in their own home with support of carers and recorded 7,670 hospital 'bed days' saved.

6. **Creating Multi- Disciplinary Teams around Primary Care -** It is well documented that GP's are under pressure. Over the past year we have had three GP practices resigning their contracts with NHS Ayrshire and Arran as of August 2017.

   Given the level of patient need in North Ayrshire and the known workforce and financial pressures being experienced locally, General Medical Services are becoming increasingly fragile and there is a need to act now to ensure high quality care is sustained into the future.

   We are intending to mitigate these circumstances by creating two types of Multi-Disciplinary Team working.

   - **Enhanced Practice Teams** comprising Advanced Nurse Practitioners, Mental Health Workers, Physiotherapists and Clinical Pharmacists.
   - **Complex Care teams** to support GPs by offering alternative supports which can divert patients from GP appointments. This core group may include an: AHP, Social Worker, Pharmacist, Care co-ordinator, Mental Health Worker and District Nurse.

7. **Addiction Services -** In 2016, across Ayrshire, there were 85 drug related deaths. This represents a 97.6% increase on the 2015 figure of 43 and accounts for 10% of all drug related deaths in Scotland. North Ayrshire accounted for 35 of those deaths, with this representing a 113% increase on 2015.

   North Ayrshire has a high incidence of drug and alcohol misuse. The increase across Scotland of drug related deaths was reflected in this area, where it doubled over the course of last year. The North Ayrshire Drugs and Alcohol Recovery Service (NADARS) was the first of the Partnership teams to provide an integrated Health and Social Care response in North Ayrshire and have developed a single point of contact system with multiple referral routes, including self-referral, with a daily response service offering joint assessments.

   However, the development of this service had to overcome many challenges, not least being one of information sharing and setting up joint recording systems.

   The forthcoming challenge will be in sustaining and building on success in the face of reduced Blood Borne Virus and Sexual Health related funding and pressures on the local Alcohol and Drug Partnership (ADP) funding, a portion of which part funds social work posts in North Ayrshire.

8. **Mental Health and Learning Disabilities -** Both teams have an integrated management structure, but face challenges in finding accommodation to enable them to be co-located with the NHS teams. The mental health team have seconded a team manager to the Change Programme to take forward the visioning, integration and development of the service for the future.

5.3 Early Intervention and Prevention

Early intervention and prevention is at the centre of shifting the balance of care. Social work is the lead agency in a range of intervention services that are designed to provide the right level of support to prevent an escalation of problems across all service areas. Without adopting the kind of approach, we will not be able to provide sustainable services. A few examples of our progress on this are detailed below:

1. **Pathways to a Positive Future** – One of our goals is to minimise the number of times a child has to move placement when they become accommodated. We know that multiple placement moves leads to attachment difficulties and social and emotional problems for children that can result in mental ill health, and behaviours that can place children or others at risk. This is most pronounced if occurring in infancy. To avert this, we established Pathways to a Positive Future, a dedicated resource based in Dreghorn that works with parents over a 12 week period, providing parenting capacity assessments which contribute to timeous decision making about a child's future. Early indications of success are in line with the project's intended purpose and a full evaluation has been carried out and the report will be produced in early 2017-18.

2. **Universal Early Years -** The Early Years Social Workers are part of the enhanced Universal Early Years Home Visiting Service team. This team is made up of Health Visitors, Assistant Nurse Practitioners, Health Care Support Workers, Employability Officers and Money Matters workers. We plan to recruit through the Challenge Fund, a Speech and Language Therapist, a peri-natal Mental Health Nurse and three Family Nurturers. The work of this team will be evaluated throughout next year.

   Steps have been taken to re- define our Early Years Social Workers' role which will enable the development of a quality assurance framework around tasks and outcomes. Initial discussions have taken place with Strathclyde University with a view to evaluating their impact of focusing on early intervention with individual children and their families.

3. **Youth Support Team** supports young people aged 8 to 16 who are experiencing difficulties with school behaviour and family relationships. The team delivers the CHARLIE programme over 30 weeks to young people aged 8 to 11 who are living with parents with substance use issues. The programme has evidenced positive outcomes for children and young people including a decrease in anxiety and increase in ability to control their emotional response to their situation. This enables them to talk more openly about their circumstances and set themselves positive goals for their future.

4. **Early and Effective Interventions** The delivery of a wide range of early and effective interventions to young people involved in offending continues to realise the aims of preventing these young people from an escalation of behaviours and thereby avoiding their involvement in the adult justice system and being placed in secure accommodation. The success of this is reflected in the fact that only one young person was placed in secure accommodation last year.

5. **Rosemount Project** successfully supported **91%** of the young people involved with the crisis intervention intensive support service to remain within their families on a long term basis.

   This was achieved via the delivery of creative intensive support packages tailored to meet individual need that include parenting programmes, individual counselling sessions and issue based group work. The approach of supporting the parents as well as the child has been successful with over 80% of parents leaving the programme with greater confidence in dealing with their children's behaviour, 90% feeling less stressed, and 100% reporting increased peer support from other parents.

6. **Throughcare** - 2016/17 has been a great year for the Throughcare service. For the second year running the team have received a grade 6 (Excellent) from the Care Inspectorate in their inspection of the Supported Carer Scheme. This has been in the area of care and support to young people and the Care Inspectorate acknowledged the "exceptional" outcomes achieved by the scheme. At the end of 2016, a CAMHS nurse was located within the Throughcare office. This is a joint venture between CAMHS and Throughcare in recognition of the barriers to good emotional well-being facing care leavers.

A joint event with the Ayrshire College in Kilwinning was held in 2016 to celebrate National Care Leavers Week. Over thirty young people attended the event to receive certificates from the NAHSCP Director and the Leader of the Council to recognise their efforts in education and training. The young people also brought their friends, partners and, in some cases, even their children.

7. **Community Connectors** - we have expanded our Community Connectors service and are linking in with the Scottish Government programme to develop and fund an expansion of Community Link Workers for areas of high deprivation. Currently ICF funding has enabled five HSCP workers and two Third Sector workers to operate in 17 out of the 20 general practices in North Ayrshire.

5.4 Improving Mental Health & Well-being

This priority was identified as the most important for the people of North Ayrshire and endorsed by the Locality Forums over the course of 2016/17. Examples of what we have done so far are as follows:

1. **Flexible Intervention Service** – This scheme commenced in 2015 for people experiencing mental ill-health or living with a learning disability, offering a responsive support service to avert problems escalating that would require greater resources and possibly, statutory interventions. The service is commissioned from an independent provider and its success has led to our being able to secure mainstream funding to allow it to continue.

2. **Palliative and End of Life Care** - We seek to improve mental health and well-being throughout the life course, recognising the importance of dignity and choice at all times. We have established a Palliative and End of Life Partnership Education Sub-Group with membership from Health, Social Work, Local Care Homes, the Ayrshire Hospice and Scottish Care. We plan to develop and deliver modular training across all sectors in North Ayrshire where people require Palliative and End of Life Care.

3. **Carers** - North Ayrshire's Carers' Strategy (2014-2018) aims to recognise and raise awareness of the commitment and valuable contribution our unpaid carers show every day to their families, friends and loved ones across North Ayrshire. The strategy underpins how the NAHSCP will continue to support local carers to continue in their caring role. It is recognised that a failure to fully support carers could result in even greater demands on services. Without appropriate support, carers could become overwhelmed by their caring responsibilities possibly leading to both poorer physical and mental health.

The North Ayrshire Carers Appreciation Card entitles carers to discounts, concessions and offers at a growing range of local shops and businesses. The card

can also be used to identify an individual as a carer to their doctor, when visiting their pharmacy or even in school or at university.

Currently we have 378 carers registered (29% of all those registered) and 39 local businesses supporting the card.

5.5 Engaging Communities

In line with the Christie Commission Report (2011) on the reform of public services, we know that effective services must be designed 'with and for people' and we recognise that meaningful engagement takes us nearer to this goal and will lead to the successful co-production of services.

Throughout our HSCP social work teams we can demonstrate the value of an inclusive and consultative approach with carers and service users involved in strategy and service redesign development, team development and, on an individual basis, in regard to their care plan. A few examples are given below of this:
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1. **Learning Disability** the newly launched Learning Disability Strategy was widely consulted about and the Head of Service for Mental Health signed the Charter of Involvement for Learning Disabilities confirming the centrality of the service user in taking forward the strategy.

2. **Mental Health** The mental health social work team facilitated the creation of the "Involved!" group with service users and carers demonstrating strengthened relationships and engagement of people who use the service. The team continue to deliver the 'Safe to be Involved' event in partnership with service users and carers that highlights activities that are undertaken throughout the year. In 2016/17 members of the Involved! Group joined the steering group for the community mental health service review and will be leading on the vision consultation work as the review progresses.

3. **Community Care** social work services have undertaken a substantial review. They asked for the views of carers and service users in formulating a new model. Community Care Services have historically been organised by age, with a Physical Disabilities team and an Older Peoples team. Both can suffer significant mobility and functional problems impacting on daily living. These age demarcations were not perceived as relevant anymore as we seek to place a greater emphasis on creating a range of relevant local services that are responsive to needs, regardless of age. Reflecting this, the service is re-organising to provide unified Locality Teams as of August 2017.

4. **Children and Families** teams regularly consult, and involve children and young people, with representatives from Who Cares? the national voluntary organisation working with care experienced children and care leavers across Scotland. Children and Families teams have helped give a voice to young people, for example, young people are involved in recruitment panels for residential care workers. In addition, support is provided for children and young people at 'Looked After and Accommodated

Reviews' and "Child Protection Meetings" to enable them to express their views, whether this be verbal, or written or via an Advocacy Worker.

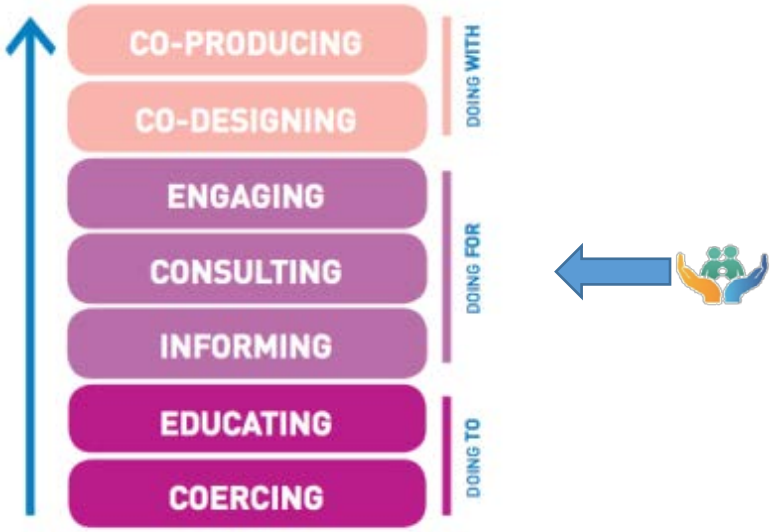
5. **Justice Services -** The Social Work team has been involved with Strathclyde University in setting up a User Engagement Council. Justice Services is a challenging area in which to build up effective partnerships with service users and engage them meaningfully in the design, review and shaping of Justice Services. The team have embraced this challenge enthusiastically and have set up a range of mechanisms and forums to engage service users meaningfully to ensure that their voices, views and opinions are heard and valued.

6. **Recovery at Work**, a constituted community group led by people in recovery from alcohol or drug problems has been fundamental to the delivery of family support (SMART programme). The group has a full health and well-being agenda, for example, forming walking groups, singing groups and organising film making courses. (Funky Films)

The Café Solace initiative demonstrates what we would all hope to achieve through engagement with service users and co-production. The first Café Solace was established in Ardrossan in 2015 and is now extended to a further two localities in North Ayrshire, providing nutritious meals for less than £3 to 4,745 people attending. I am also happy to report Café Solace are currently placed as COSLA 2017 silver award winners.

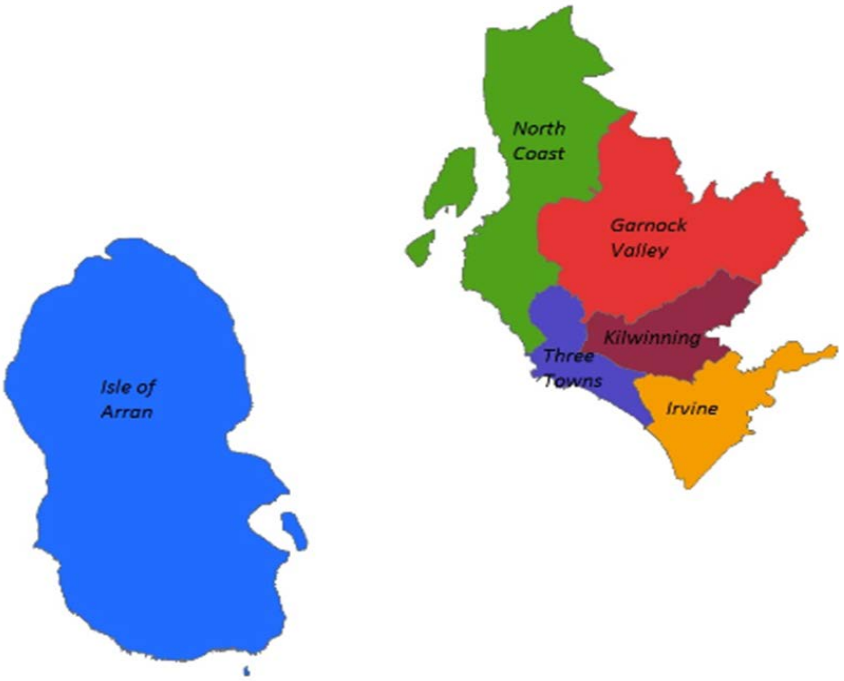
cafe solace

It is clear that we have the direction set, and indeed, have achieved notable success in establishing meaningful and productive partnerships with service users, carers and communities. However, on the whole, we have a lot of work still to do as we estimate our positon on the ladder of engagement below:



Source: new economics foundation

7. Locality Planning Forums - The development of Locality Planning Forums (LPF's) is integral to achieving true engagement.



Their purpose is to become a direct route for both the public and staff to inform about the provision, design and delivery of health and social care services. Core to the LPFs is local community representation, including Elected Members, people with lived experience, Carers, Third Sector representatives and Senior Managers from the partnership. Over 2016/ 17 the LPF's:

- Held "Local Connections Better Outcomes" events to enable community groups and local agencies find out what was happening in the community and develop conversations about what is good and what could be better.
- Identified local priorities for inclusion in the refreshed strategic plan.

All localities identified the need for services for low level mental health problems. In recognition of this, we match funded monies made available from Scottish Government and on "Decision Day" in February 2017 we held a vibrant conclusion to a Participatory Budgeting process where £50,000 was distributed among 42 projects whose mental health projects were voted as winners by over 250 local people.

For sustained benefits for communities, evidence highlights the effectiveness of co-production as a means of building capacity in communities, increasing self-management of long term conditions and reducing social isolation, whilst creating significant cost savings across the public sector system. In February 2017 a skilled Engagement Officer joined the HSCP and a strategy is being established that will take us further up the ladder towards co-production. The inter-relationship of the LPF's and the Community Planning Partnership's Locality Partnerships is evolving and provides further opportunities for partnership working with communities to achieve better outcomes.

6. Statutory Duties – Protection

We have a workforce that numbers 3, 252 split NAC (53%) and NHS (47%). Of these staff, just 5% are registered social workers (163). Only registered social workers can undertake certain statutory roles, often ones which require to balance competing needs, risks and rights. We have seen a large volume and pace of legislative change within our statutory framework. Many social workers specialise in particular areas of service and become experts in a particular sphere, but, as we have seen this resource is limited.

6.1 Child Protection

There has been significant activity around improving our approach to Child Protection within our area teams. This has resulted in work streams to embed improvement within the whole system. In particular we are currently establishing a dedicated Child Protection team which will be made up of existing social workers from area teams and managed by an existing team manager. This team will focus specifically on dealing with all new child protection concern referrals and carrying out all new child protection investigations. There is an emphasis on improving timescales, listening to the voice of the child and ensuring that families are very much part of the child protection process. We are also reviewing our administrative processes, and taking a fresh look at the way in which we organise Child Protection Conferences, to engage better with children and their families. (see Appendix 1 for statistical table)

6.2 Adult Support and Protection (ASP)

Whilst the legislation stipulates that actions in ASP require to be undertaken by a Council Officer, this role is delegated to social workers.

A stated aim of the North Ayrshire Adult Protection Committee has been to increase the number of ASP referrals which come from agencies other than Police Scotland or the Health and Social Care Partnership. The percentage of 'other' organisations who made ASP referrals during 2016 - 2017 continued its incremental increase from 49% to 62%. This increased awareness of the ASP Act and the need to refer has been supported by a programme of training and awareness raising events by ASP staff. In North Ayrshire, every ASP referral receives a formal ASP Inquiry and the increase in awareness and referral numbers does impact on the staff responsible for carrying out inquiries and investigations and providing support and protection under the Act. It has also been important during 2016 - 2017 to ensure that agencies make 'appropriate' referrals. The level of referrals from Care Homes, for example, has been very high and not all referrals have been legitimate ASP referrals.

Several events and meetings have taken place with Care Homes to address the issue of inappropriate ASP referrals, in addition to a change to the ASP referral paperwork and

process and this has resulted in the level of 'inappropriate' referrals from Care Homes decreasing. This work will be consolidated during 2017 - 2018.

Together with proposals to incorporate screening of ASP referrals into MAASH we intend to ensure that the limited social work expertise is properly and effectively aligned to enacting the legislation as it should be and to ensuring that resources and interventions are properly directed at adults at risk of harm who meet the three point test for ASP.

The work undertaken in relation to the ASP Stakeholder's Evaluation exercise, highlighted that referrers feel that the process and paperwork in relation to making ASP referrals in North Ayrshire is simple and concise and they would continue to make referrals and encourage their colleagues to do so. The same exercise also highlighted that service users and carers interviewed felt that their wishes had been central to the ASP process and that they (or their loved one) were safer as a result of the actions taken under ASP legislation.

A multi-agency Case File Audit will take place during 2017 - 2018. North Ayrshire are the only local authority to have put themselves forward to be considered for the pilot of a new Care Inspectorate model of inspection specifically designed for Adult Support and Protection.

6.3 Mental Health Officer (MHO) Service

The MHO service is co-ordinated and managed by our social work Mental Health Team. MHOs are experienced social workers who have completed further training at post-graduate level and have a particular role and responsibility in legislation relating to individuals with mental disorders. The MHO role is supplementary to their primary designation and currently the service has MHOs who also work as care managers in Mental Health, Learning Disability and Community care services. They practice across three pieces of legislation that significantly impact on individual liberty – their key role is to ensure that alternatives to the use of legislation are provided where possible, and to safeguard the person's legal rights through the process. (Activity on these legislations is available at Appendix 3)

In North Ayrshire, the need for the MHO service continues to grow (in line with trends across Scotland). Due to unpredictable 'peaks' in the use of mental health legislation which places a real pressure on MHO capacity, it is challenging to predict demand in relation to workforce planning. The increasing complexity of statutory work is also apparent in the range of individual situations which are presented to the service.

During 2016/17 the MHO service provided temporary backfill for MHO trainees, two trainees completed the qualification and three trainees commenced the course in 2016/17. The service also made a successful bid for pressure monies to develop an exclusive MHO post with a focus on the training of new MHOs in 2017/18. The quality of work done by the service is reflected in 81% completion rate for Social Circumstances Reports following Short Term Detention Certificates – the highest completion rate for local authorities in Scotland. Furthermore, there has been good feedback from the Mental Health Tribunal Service for the quality of information contained in North Ayrshire MHO reports.

However, since 2015, the service has been operating a waiting list for Private Guardianship applications with the service prioritising CSWO Welfare Guardianship applications and

renewals. To address this in 2016/17 the MHO service employed three recently retired MHOs one day per week to specifically concentrate on the Guardianship waiting list. This has made a real difference. However, as noted, the demands on the service still required the waiting list process to be in place. We have implemented a new administrative process for the management of the AWIA waiting list, including updating solicitors during the waiting period.

The Adults with Incapacity legislation does not allow the Local Authority to act as Financial Guardians and we are met with a reducing list of solicitors willing to take on Financial Guardianships on our behalf. This, in turn, has led to an increase of Financial Intervention Orders, which can be undertaken by the Local Authority, but places additional pressure on the capacity of the finance service in North Ayrshire to manage these.

6.4 Public Protection

On 15th December 2015 Ministers commenced section 10(1)(e) of the Management of Offenders etc. (Scotland) Act 2005 which took effect on 31st March 2016. This extended the scope of MAPPA to include other Risk of Serious Harm (ROSH) offenders managed in the community, where the responsible authorities assess that a risk of serious harm to the public exists and which requires an active multi-agency response. New paperwork was also produced which helped focus on the ROSH and the risk management plan required to manage the identified risks effectively. This closer adherence to ROSH has resulted in a clearer understanding and agreement of thresholds of risk, and has led to a reduction in MAPPA Level 2 cases and a corresponding increase in MAPPA Level 1's. (See Appendix)

There have been initial teething problems in regard to the responsibility for the completion of the ROSH and the new paperwork. The ROSH is part of the LS/CMI, which is the main Justice Social Work risk assessment and case/risk management tool. The responsibility for completing the ROSH and the new paperwork has now been clarified by the issuing of interim guidance by Social Work Scotland which has been approved by Chief Social Work Officers.

ViSOR - (Violent and Sex Offender Register) is a database of records of those required to register with the police under the Sexual Offences (Scotland) Act 2009. The vetting required by the UK National ViSOR Standards for access to this database has changed, and has resulted in a significant proportion of Justice Social Workers who are not vetted at the new required levels of NPPV2/3. (Non-Police Personnel Vetting). This creates a risk regarding Police Scotland's compliance with Home Office data protection requirements. A lack of vetting means Justice Social Workers are not permitted to access ViSOR training, contributing to poor levels of ViSOR use in social work offices across Scotland. Social Work Scotland are currently seeking legal advice on contractual obligations for employees in regard to being vetted for using ViSOR.

7. Workforce

The three Ayrshire Health and Social Care Partnerships were the first to employ dedicated workforce planning resources, with these new roles coming online between September and

November 2016. The main focus of the first few months for the NAHSCP postholder has been on establishing the workforce baseline for the H&SCP including, numbers, grade mix, profiling the full workforce etc. There has been engagement with key stakeholders, as well as the provision of workforce planning input to key projects and responding to the Scottish Government consultation on a national approach to workforce planning across health and social care.

The NAHSCP will produce a strategic workforce plan for 2018-2021 as part of wider strategic planning.

The main challenge moving forwards will be providing a comprehensive plan across the partnership that takes into account the needs of all the partners. Priorities for the year ahead will be further engagement with the Independent and Third Sectors (including the collation of detailed workforce information), implementing the Scottish Government's National Workforce Planning model, continued engagement with further and higher education establishments and developing workload planning and management approaches that support managers at an operational level.

A well- motivated and engaged staff group is key to delivering safe, effective and efficient services. This is clearly demonstrated by the Dirrans Centre, (focussing on rehabilitation from head injury, neurological long term conditions) operated with a core staff of social care support workers and occupational therapists. They achieved Platinum Employer of the Year Award from Investors in People for the work done in 2016/17 in maintaining a motivated, skilled team.

7.1 Professional Development

Continuous Professional Development increases skills and confidence in delivering quality services. We have 65 different course titles that are available to staff through the Health and Social Care Partnership Learning and Development calendar. Based on demand and identified learning needs**,** 54 of these titles were delivered between April 2016 and March 2017 to 1872 staff.

Staff continue to access other social services' training such as Moving and Handling, CALM, Adult Support and Protection and the North Ayrshire Council corporate calendar for Policies and Procedures, Management and Leadership training, the Child Protection Committee Training, GIRFEC, Women's Aid and NHS training for other specialist learning and development input.

Twenty staff have undertaken post graduate courses that provide an integrated academic and professional approach which develops the intellectual and practice skills necessary for practice in areas such as child protection, mental health, and permanency planning for children, social policy and the psychology of dementia care.

In addition, many staff have attended short-term courses, seminars and conferences including; the neuroscience of adoption and fostering, supporting teens who internalise distress, working with young parents, mental health first aid and life-story work with troubled children and teenagers. Staff have also received training to maintain their general first aid licence.

From consultation with managers, the Learning and Development section has been able to source and contribute to the development of specific training including; Working with Adults with Autism within Justice Services, Child Protection within the Family and an Introduction to working with Refugees and Asylum seekers.

7.2 Qualifying the Workforce

The North Ayrshire Social Services Scottish Vocational Qualifications Assessment Centre (NASSAC) delivers awards ranging from six months to three years duration. One hundred and twenty two staff and seven Modern Apprentices completed their award this year and a further fifty one candidates are currently working towards completion. Future candidates will be prioritised to meet the Scottish Social Services Council (SSSC) registration requirements.

Good progress is continuing in relation to qualifying the residential and Care at Home workforce in line with the SSSC registration requirements. Targets set for both adults and children and young people care groups have been reached during 2016/2017.

At April 2016, 79.6% of staff in residential care homes for adults had achieved the qualifications required for registration. At 31 March 2017 this figure had decreased to 75.6%. A number of factors such as staff redeployment, promotion to new roles requiring additional or different qualifications and staff turnover have been key influences.

At April 2016, 89% of staff in residential care homes for children and young people achieved the qualifications required in order to register with the Scottish Social Services Council. At 31 March 2017 this figure had decreased slightly to 88.3%. The same factors influencing figures for care homes for adults are also evident within residential child care.

We have worked with our in-house Care at Home service to map out the route and timescales for staff groups to attain their qualifications in line with the SSSC regulatory requirements. During 2016/2017 two Team Managers and one hundred and two Care at Home Assistants commenced their awards.

From March 2016 until April 2017 the NASSAC has delivered one workshop for the Professional Development Award in Supervision.

The Scottish Qualifications Authority (SQA) carried out an annual inspection within the NASSAC as part of their inspection process. Each inspection pertained to a different award delivered within the centre including Adult Care Awards, Childcare Awards and the Professional Development Award in Supervision. NASSAC received a glowing report and scored “significant strengths in all categories” of the process with particular reference made to the high standard of assessment and the quality of evidence provided by candidates.

7.3 Practice Teaching

Practice Learning is an essential component of social work training and the HSCP is committed to providing Practice Learning Opportunities (PLO) for social work students via the Learning Network West (LNW). North Ayrshire Health and Social Care Partnership is well regarded as a source of good quality learning opportunities and we value the partnership working and knowledge exchange activities with our colleagues from the

relevant universities, the LNW, Institute for Research and Innovation in Social Services (IRISS), the Social Work Scotland Learning and Development subgroup and the SSSC.

We have increased link worker training to twice per year prior to students coming out on placement and at the most recent event, we recruited 11 new link workers from a broad variety of settings which will provide a host of different learning opportunities for students. During the academic year 2016/2017 we provided 15 Practice Learning Opportunities for student social workers with another 10 students, at different stages of learning and from various universities, coming out on placement from August 2016. The Practice Development Award in Practice Learning (PDAPL) has recently been revised and will come into effect from the autumn cohort 2016. We also offer ongoing support to the standardisation and internal verification of this Award.

We have continued to promote and facilitate the Practitioners Forums for Practice Teachers and Link Workers to encourage a learning exchange culture across North, South and East Ayrshire. We have also facilitated monthly student groups on a Pan-Ayrshire basis during the peak placement period of September to May where a variety of speakers give input.

7.4 Post Qualifying Support

The forum for Newly Qualified Social Workers was relaunched on 22nd August 2016 in order to develop and promote good practice and to meet their SSSC Post Registration Training and Development requirements and this is currently being revised in order to support NQSW with a robust mandatory programme.

We have made considerable efforts over the past year to work on team development and in improving team work and staff morale. Sessions have been held with staff and managers and they have been productive in building a strong and motivated team

7.5 Recruitment and Retention

We continue to experience difficulties in recruiting care at home workers and are working with local colleges and schools to promote a career pathway in social care. Despite there being high levels of unemployment in North Ayrshire, care work is not an option suitable to everyone as it requires skills, resilience and dedication to complete what can be very demanding work both physically and emotionally.

Appendix

Adults with Incapacity Act (Scotland) 2000

Mental Health (Care and Treatments) 2003	*2013/14*	*2014/15*	*2015/16*	*2016/17*
Emergency Detentions	30	29	24	44
Short Term Detentions	71	72	75*	87
Compulsory Treatment	48	40	54	25
Warrants undertaken	2	1	3	1

Criminal Justice Act Scotland 1995	*2013/14*	*2014/15*	*2015/16*	*2016/17*
Compulsion Order and a Restriction Order (CORO)	4	4	4	4
Compulsion orders	4	4	6	5
Hospital Directions	1	1	1	1
Assessment Orders	4	1	2	2
Treatment Orders	2	1	1	2
Transfer for Treatment	1	0	3	3

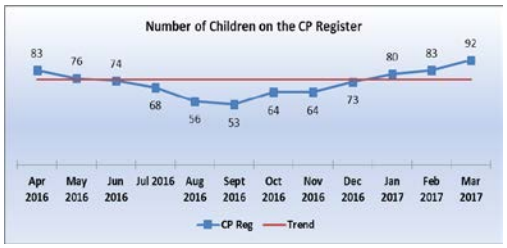
Adults with Incapacity Act (Scotland) 2000	*2013/14*	*2014/15*	*2015/16*	*2016/17*
Private Welfare Guardianships *	204	291	255 (60)	287 (67)
CSWO Guardianships **	44	47	59 (19)	52 (21)
Financial Intervention Order (LA) ***	42	58	53	41 & 21 in process
MHO report: PWG application	79	86	68	96

Adult Protection

	2013/14	*2014/15*	*2015/16*	*2016/17*
ASP Referrals	631	812	697	654
ASP Case Conferences	24	44	73	48
Protection Orders	9	7	6	1*
Adult Concern Reports	0	1039	1349	1446

Child Protection

	2013/14	*2014/15*	*2015/16*	*2016/17*
Child Protection Concerns	885	858	901	835
Child Protection Investigations (CP1s)	578	526	430	469

Child Protection Initial Conferences	81	176	162	133
Pre Birth Conferences	26	32	31	16
Trend in Number of Children on CP Reg (Graph)				

Looked After Children

	2013/14	*2014/15*	*2015/16*	*2016/17*
Children Newly Accommodated in North Ayrshire	100	91	81	64

	2013/14	*2014/15*	*2015/16*	*2016/17*
Foster Carers		85	97	100

Permanency Planning	*2013/14*	*2014/15*	*2015/16*	*2016/17*
Number of Permanency Plans Approved	25	38	22	37
Adoption - Approved and Placed	3	15	13	10
Adoptions Granted	9	3	15	13*
Permanence Orders Approved	27	7	11	16
Permanence Ordered Granted	12	14	6	9

Emergency Placements

	2015/16	*2016/17*
Child Protection Orders	13	12
S143 of the Children's Hearing (Scotland) Act 2011	21	24

Secure Placements

	2015/16	*2016/17*
Number of Secure Placements	3	1

Criminal Justice

	2016/17
Reports Submitted to the courts	**844** (CJSW Reports – 768, Section 203 – 22, Short Notice CJSW – 27, Supplementary CJSW – 27)
Reports Submitted	**118** (Leave Reports - 64 Background Reports – 54)

Multi-Agency Public Protection Arrangements (MAPPA)

	2014/15	*2015/16*	*2016/17*
Level 1 Mappa	130	142	155
Level 2 Mappa	10	14	4
Level 3 Mappa	1	1	1

NORTH AYRSHIRE
Health and Social Care Partnership

Name of Committee/Board
16th November 2017
Agenda Item 9

Subject:	**Findings & Recommendations from Service Review of Pan Ayrshire Psychological Services**
Purpose:	To provide an update on progress of the Service Review of Pan Ayrshire Psychological Services
Recommendation:	IJB approval of review recommendations

Glossary of Terms	
NHS AA	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
CAMHS	Child & Adolescent Mental Health Services

1. EXECUTIVE SUMMARY

1.1 The review of Psychological Services was commissioned on 16 July 2015 and commenced with an appreciative enquiry staff event in December 2015. Psychological Services in Ayrshire and Arran provide a vast range of services to improve the quality of life for many people with mental health problems across the region. However, like many aspects of health and social care, increasing demand, demographic changes, workforce profile and funding challenges are placing a strain on the service.

The bringing together of the Health and Social Care Partnership created the opportunity to review how Psychological Services are delivered and to consider the future Pan Ayrshire service model. Without significant changes to the way some services are provided, the ongoing ability to deliver outcomes including the waiting times standard will continue to be compromised.

1.2 The aims of the North Ayrshire Health and Social Care Partnership (NAHSCP) Psychological Services review were to:

- Ensure we continue to place service users at the heart of everything the service does;
- Address waiting time performance in some parts of the service;
- Improve efficiency and value for money across the service, including the ability to deliver savings and re-invest in low intensity mental health support;
- Maximise the impact that the service has;
- Improve equity and flexibility of service provision in line with a pan-Ayrshire specialist service.

1.3 The review involved the following activities:

- Examined current models of care and service specialty strengths and weaknesses.
- Benchmarking and review of models of provision – international and UK wide
- Stakeholder analysis - focus groups in some specialties (AMH & CAMHS).
- Appreciative Inquiry and Listening Event for Psychological Services staff.
- Design of a workforce database – Benson Wintere.
- Data analysis and projection of demand
- Engagement of an independent external "critical friend".

1.4 The review report includes an analysis of the following:

- National and local strategic context
- Project methodology
- Description of current service noting that to preserve equity of access this is an area-wide service with multiple specialties within both physical and mental health, some of which may be just one person. Each specialty is described as are the associated strengths and challenges within it.
- Service Specialities are:
  Child – Community Paediatrics, Medical Paediatrics & CAMHS.
  Adult Mental Health: Forensic Service, Community Mental Health Teams, Primary Care Mental Health Teams, Addictions, Adult In-patients.
  Older Adults, Physical Health & Neuropsychology: Older Adults In patients//Out patients; Stroke, Pain, Cardiac Care, General Medicine, Bariatric, MS, Oncology, Neuropsychology.
  Learning Disability – Adult in & Outpatient.
- Summary of recommendations.
- Workforce analysis and implications for future.

1.5 The review identified areas where things are working very well, with good examples of waiting time standards being met, training and supervision of the wider workforce, clarity of role, working flexibly and in collaboration with other services and teams. However, in certain parts of the service, the review highlighted waiting times are high and there is a need for shared agreement on role clarity and collaborative team working.

2. BACKGROUND

2.1 Psychological Services is an Ayrshire-wide specialist service covering all age ranges from birth (neo-natal unit) to death (palliative care psychology). Services are provided in both physical and mental health specialties. The service is centralised because:

- Small specialist resources e.g. 0.5 wte in stroke, cannot be replicated three times over to reflect local authority boundaries;
- Physical health psychology services and indeed specialist diagnostic services in mental health operate from inside other area-wide health services that transcend local authority boundaries.
- Centralised services facilitates expertise and preserves equality of access regardless of post code.

2.2 The service has been reviewed three times since 2010. The first review was to reflect changes in the then Mental health Services in 2010. The second in 2014 was in the context of integration. Both reviews concluded that a centralised, area-wide structure with professional management and governance was the best model to structure and organise what is a relatively expensive, specialist service. The results of the option appraisal carried out in 2014 are contained within appendix 12 of the review report.

3. PROPOSALS

3.1 Benchmarking exercises, both internal and external to the service, have demonstrated that there are some extremely successful examples of effective service delivery involving flexible, collaborative working across psychological specialties and within multi professional teams. These services are also associated with lower waiting times. This is especially the case in Older Adults, Physical Health, Neuropsychology, Learning Disabilities, Medical Paediatrics, Forensic and parts of Adult Community. Please see Appendix 7 (10.2 Paper for Benchmarking and Service Models for Psychological Services).

3.2 The following list of strengths and positive attributes of the service, as identified through staff engagement and consultation, also apply to the above services:

- Psychology staff are based together in some parts of the service.
- Named person links with service specialties and teams but is not managed within them (hub and spoke model).
- Pooling occurs to manage cover for maternity and sick leave and to facilitate rapid assessment of urgent cases.
- Referral system are appropriate to the professional group: (e.g.) Gatekeeping is managed by Psychologists, not by other staff or as part of a multidisciplinary team approach
- Admin systems e.g. systems of recording specific to the needs of the staff and patient group.
- Role clarity is good and the unique contribution of the profession is respected.

3.3 Interventions and activities are consistently at the expert, specialist level. Staff are not expected to perform “generic” service functions (such as screening referrals for a whole service) or engage in low level prevention work. The main findings provide evidence that change is required within certain parts of the service and across the wider health and social care system to ensure they are as efficient and effective as possible.

3.4 Analysis of the findings shows also show that in certain parts of the service:

- Waiting times are high
- Client-facing time needs to be reviewed
- Planning is not as evident as it should be
- Joint-working within some teams needs improvement, with a perceived lack of integration into multidisciplinary teams
- The referral criteria are not fully understood by those that refer to PS
- In some areas, capacity for supervision of others is limited. There is also a lack of resource freed up in those other professions to deliver after they have been trained and supervised
- Management information and investment in appropriate systems is lacking

3.5 Using this evidence, the output of previous functional reviews (see Appendix 12), detailed engagement and consultation with staff, and through leadership and management discussions, options have been identified as suitable for the future of the service.

3.6 These include the following:

- Professionally managed centralised area-wide Psychological Services hosted within Mental Health Services within North Health and Social Care Partnership.
- Decentralised Psychological Services split four ways, i.e., staff and budget split between three Health and Social Care Partnerships but managed by their Professional Specialty Leads
- De-centralised Psychological Services with budget/staff/part of budget/staff time managed within individual service specialties and localities,
- Operational Integration with Professional Leadership Support - Creation of one professional lead across Ayrshire, integrate staff and activities

3.7 The review identified areas where things are working very well, with good examples of waiting time standards being met, training and supervision of the wider workforce, clarity of role, working flexibly and in collaboration with other services and teams. However, in certain parts of the service, the review highlighted waiting times are high and there is a need for shared agreement on role clarity and collaborative team working.

3.8 Psychological Services across Ayrshire and Arran are clearly valued, and staff and stakeholders have given their time and expertise to help provide constructive insight and input into what is working well and areas to be considered for development. Alongside benchmarking (internally and externally), utilising external expertise and analysing management information, this review concludes that:

- In the case of some services it would be beneficial to further develop joint accountability for the functionality of the service alongside clinical accountability and governance through a professional leadership model. This practice is already in place in many parts of the service and is associated with high levels of collaboration and good working relationships.
- A pan-Ayrshire and Arran professional lead role be developed further, to provide strategic leadership for Psychological Services across the region and at senior Partnership level. Lead roles for each broad specialty area are also developed that have co-management responsibilities and accountability with the appropriate service managers.
- Psychological Services staff would be embedded in operational teams where appropriate. In addition, the joint accountability should result in more collaborative decisions on the balance of work of staff. The Meridian analysis highlighted a lack of management control, not just for Psychological staff, but within all the Mental Health teams. This has to be smarter if the service is to fully utilise staff time.
- In the case of Community Paediatrics, a more detailed analysis of patient pathways and processes is required to fully understand the extent of the situation. Learning Disability Nurses have been added to the skill mix to take the pressure from Psychological Services and further facilitate the development of a joint pathway for diagnosis of Neurodevelopmental conditions across CAMHS and Community Paediatrics.

3.9 Early recommendations from the above reports would indicate that a whole system approach is required for transformational change to occur and develop a service fit for the future.

3.10 An implementation plan will be developed to ensure the delivery of all recommendations within the review. This will be developed by the Pan Ayrshire Psychological lead following establishment of the revised integrated operational management arrangements. A Communications Plan for moving forward will also be developed.

3.11 **Anticipated Outcomes**

- Accurate information flows and reporting Pan Ayrshire
- Measurement of demand against the current standards and project future demand ensuring capacity for clinical and care developments in 2020 and beyond
- Improved access to services and compliance with national targets
- Improved Clinical Outcomes, based on the most effective clinical evidence improving personal outcomes for patients and their carers

3.12 **Measuring Impact**

Impact will measured against achievement of HEAT targets and patient satisfaction

4. IMPLICATIONS

Workforce planning implications. Service re-design in alignment with integration of Community Mental Health Services

Financial :	Changes will be implemented within current financial resources with a projected potential saving of up to £389,000 and potential to re-invest in low intensity and early intervention services which are negligibly absent within existing provision - a significant contributory factor in the high level demand for mental health services in primary care.
Human Resources :	Human resource implications and organisational change for very senior Psychology leadership level (8D and above) – reduction of 2 8D posts and change in roles for new leadership structure.
Legal :	None
Equality :	Equality impact assessment completed
Environmental & Sustainability :	None
Key Priorities :	In alignment with Partnership strategy and integration of services
Risk Implications :	Loss of clinical capacity from the service if some re-investment in low level interventions is not made in alignment with original purpose of the review.
Community Benefits :	N/A

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

5. CONSULTATION

5.1

Meeting	Date	Purpose
Mental Health Senior Management Team	9th August 2017	Discussion, review
Partnership Senior Management Team	5th October 2017	Approval for onward submissions
SPOG	6th October 2017	Approval
East and South Partnership Management Teams	3rd October 2017 (S) 5th October 2017 (E)	Approval
IJB (North, East and South)	16th November 2017	Approval
Area Professional Committee	TBC	

6. CONCLUSION

6.1 It is recommended that IJB approve the establishment of a pan-Ayrshire and Arran professional lead role to be developed further, to provide strategic leadership for Psychological Services across the region and at senior Partnership level. Psychological Services staff to be integrated and embedded in operational teams where appropriate. In addition, the joint accountability will result in more collaborative decisions on the balance of work of staff.

For more information please contact: Thelma Bowers on 01294 317803 or Thelmabowers@north-ayrshire.gcsx.gov.uk

Review of Pan Ayrshire Psychological Services

July 2017

Executive Summary

The review of Psychological Services was commissioned on 16 July 2015. Psychological Services in Ayrshire and Arran provide a vast range of services to improve the quality of life for many people with mental health problems across the region. However, like many aspects of health and social care, increasing demand, demographic changes, workforce profile and funding challenges are placing a strain on the service.

The bringing together of the Health and Social Care Partnership created the opportunity to review how Psychological Services are delivered and to consider the future Pan Ayrshire service model. Without significant changes to the way some services are provided, the ongoing ability to deliver outcomes including the waiting times standard will continue to be compromised.

The aims of the North Ayrshire Health and Social Care Partnership (NAHSCP) Psychological Services review were to:

- Ensure we continue to place service users at the heart of everything the service does;
- Address waiting time performance in some parts of the service;
- Improve efficiency and value for money across the service, including the ability to deliver savings;
- Maximise the impact that the service has;
- Improve equity and flexibility of service provision in line with a pan-Ayrshire specialist service.

The review identified areas where things are working very well, with good examples of waiting time standards being met, training and supervision of the wider workforce, clarity of role, working flexibly and in collaboration with other services and teams. However, in certain parts of the service, the review highlighted waiting times are high and there is a need for shared agreement on role clarity and collaborative team working.

It is clear, from the analysis of Psychological Service staff and stakeholder input, the output from external expertise and from the analysis of management information, that change is required in some areas of service.

Psychological Services across Ayrshire and Arran are clearly valued and staff and stakeholders have given their time and expertise to help provide constructive insight and input into what is working well and areas to be considered for development. Alongside benchmarking (internally and externally), utilising external expertise and analysing management information, this review recommends that:

- In the case of some services it would be beneficial to further develop joint accountability for the functionality of the service alongside clinical accountability and governance through a professional leadership model. This practice is already in place in many parts of the service and is associated with high levels of collaboration and good working relationships.
- A pan-Ayrshire and Arran professional lead role should be developed further, to provide strategic leadership for Psychological Services across the region and at senior Partnership level. Lead roles for each broad specialty area are also developed that have co-management responsibilities and accountability with the appropriate service managers.
- Psychological Services staff would be embedded in operational teams where appropriate. In addition, the joint accountability should result in more collaborative decisions on the balance of work of staff. The Meridian analysis highlighted a lack of management control, not just for Psychological staff, but within all the Mental Health teams. This has to be smarter if the service is to fully utilise staff time.
- In the case of Community Paediatrics, a more detailed analysis of patient pathways and processes is required to fully understand the extent of the situation. Discussions are underway to add Learning Disability Nurses to the skill mix to take the pressure from Psychological Services and further facilitate the development of a joint pathway for diagnosis of Neurodevelopmental conditions across CAMHS and Community Paediatrics.

Early recommendations from the above reports would indicate that a whole system approach is required for transformational change to occur and develop a service fit for the future.

Contents

Glossary of Terms

NHS	NHS Ayrshire and Arran
HSCP	Health and Social Care Partnership
NAHSCP	North Ayrshire Health and Social Care Partnership
PS	Psychological Services
RTT	Referral to Treatment
MH	Mental Health
DNA	Did Not Attend
WTE	Working Time Equivalent
CAMHS	Child and Adolescent Mental Health Services

1.0 Introduction / Purpose of Review

The review of Psychological Services was commissioned on 16 July 2015. Psychological Services in Ayrshire and Arran provide a vast range of services to improve the quality of life for many people with mental health problems across the region. However, like many aspects of health and social care, increasing demand, demographic changes, workforce profile and funding challenges are placing a strain on the service. Efficiencies are required across the entire health and social care system.

Psychological Services have been reviewed on a number of occasions in recent years, for example the NHS Ayrshire and Arran Service Futures Team reviewed the service during 2012-2014 This review aims to draw a line under previous work, and provide a single approach to moving forwards.

Within NHS Ayrshire and Arran, Psychological Services are delivered across physical and mental health services, the whole age-span and within community and in-patient settings. The service is managed on a pan-Ayrshire basis through a professional structure. Resource and skill-mix for service provision is varied and has depended on funding allocation and historical investment, particularly in the Physical Health setting. There is a current need to deliver financial efficiencies as part of a wider Partnership savings programme.

Many services are operating with minimal resource, as little as two sessions per week (e.g. Adult In-patient, Bariatrics). In addition, the already stretched Psychological Service has been required to take on additional work such as specialist assessment provision (Neuropsychological and Developmental diagnostic assessment).

Access to Psychological Therapies is measured by an 18 week referral to treatment standard (previously a HEAT target) set by the Scottish government. This target was not originally accompanied by any additional resource. At the time of writing the majority of waiting times fall within the waiting times standard. However, in some services, waiting times remain a challenge or appear compliant but mask unmet need. Waiting times do fluctuate related to the limited resource which is vulnerable to vacancies, maternity leave and sickness. Maternity leave is the highest in the organisation due to the demographics of staff.

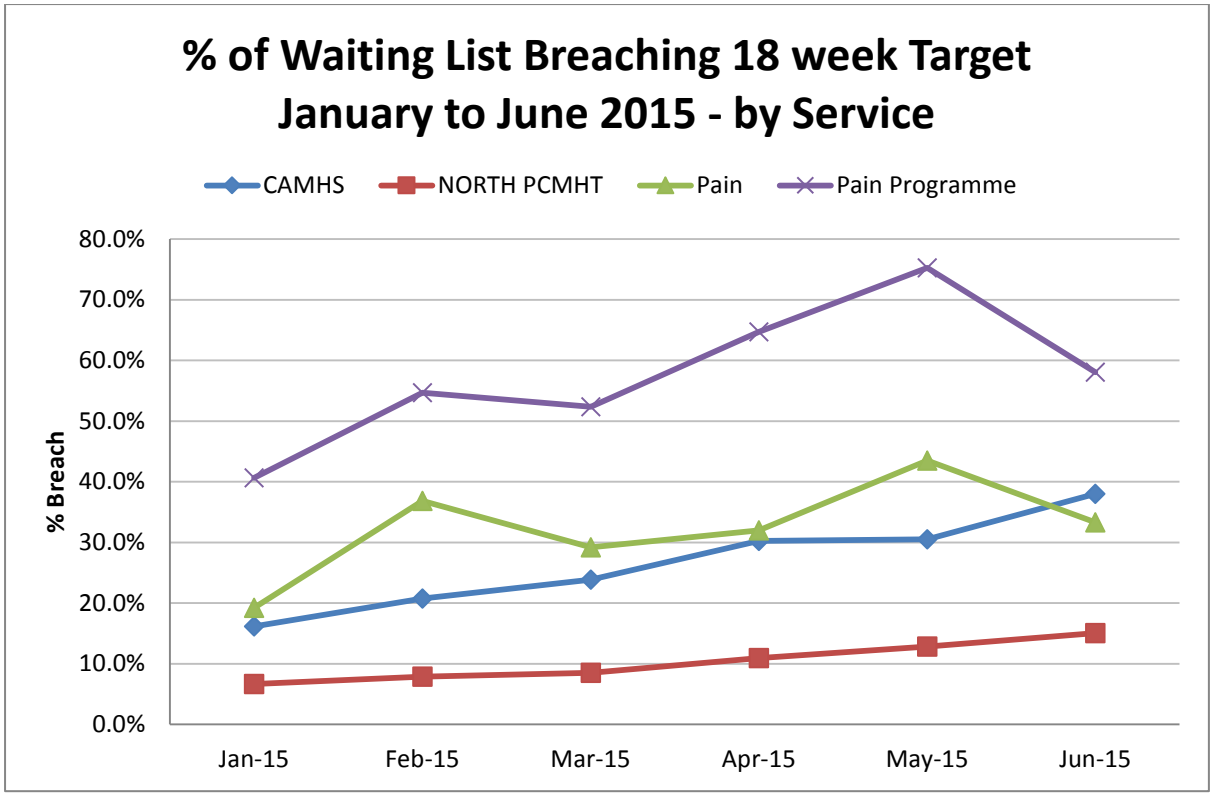


Figure 1 – % Waiting List Breaching 18 Week Target when review was commissioned– Jan to June 2015

Note. Pain provision was 0.4 wte at this time

The integration of services within the Ayrshire Health and Social Care Partnerships has created the opportunity to review how Pan Ayrshire Psychological Services are delivered and to consider the future service model. Without significant changes to the way services are provided, the ability to meet demand for psychological assessment and treatment will continue to be compromised.

The aims of the review, when it was commissioned were:

Aims	
Brief:	'To provide expert and objective advice to inform the identification of potential future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes'
The Service Wants:	➢ Articulate the journey to date: clearly set out the current situation in context ➢ To set out the challenges in the short to medium term ➢ To determine and evaluate options which will deliver future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes ➢ Ensure that the solutions are demonstrably driven by patients and carers ➢ To outline a road map ahead for the medium to long- term
The New Service should facilitate:	➢ Accurate information flows and reporting Pan Ayrshire ➢ Measurement of demand against the current standards and project future demand ensuring capacity for clinical and care developments in 2020 ➢ Redesign work to improve access targets ➢ Service redesign within existing resources and identify future service options which allow the service to be delivered within reducing financial resources to 2020 ➢ Improving Clinical Outcomes, based on the most effective clinical evidence ➢ Improving personal outcomes for patients and their carers
Our Approach:	✓ Stakeholder one to ones, including patient & Carers ✓ Appreciative Inquiry Approach with Mental Health Service Teams and key partnership stakeholders ✓ Data Analysis ✓ Service Improvement Facilitation ✓ Waiting Times analysis ✓ Performance Management ✓ Evaluation ✓ Development of Peer Research to sustain capture of patient and service user views in the future ✓ Programme and Project Management

The Project Initiation Document can be found in Appendix 1.

2.0 Context

This section summarises the context in which this review was conducted, outlines how psychology services are structured and delivered across Ayrshire and Arran, and provides information on the current workforce.

2.1 Strategic

In 2011, the Scottish Government set outs its vision for achieving sustainable quality in the delivery of healthcare services across Scotland, in the face of the significant challenges in public health, changing demographics and the economic environment. The vision for future health and care provision emphasises well-being and recovery, social inclusion, independence, equality and diversity, choice and working in partnership (between services and service users).

The 2020 Vision provides the strategic narrative and context for taking forward the implementation of the strategy and the required actions to improve efficiency and financial sustainability. The Scottish Government's 2020 Vision is that by 2020 everyone is able to live longer, healthier lives at home, or in a homely setting and, that we will have a healthcare system where, amongst other things, we have integrated health and social care services, there's a focus on supporting self-management, and that care is provided to the highest standards of quality and safety with the person at the centre of all decisions.

In 2013, the Public Bodies (Joint Working) (Scotland) Bill was introduced in the Scottish Parliament, setting out the legislative framework for integrating health and social care.

2.2 National

There has been a transformation in mental health services nationally over the last 50 years with advances in care, the development of community based mental health services and a greater emphasis on prevention and early intervention, promoting mental health issues and developing services for children and adults.

In 2012, the Scottish Government published a 3 year mental health strategy, with a revised strategy published in May 2017. This sits alongside the National Clinical Strategy for Scotland, and whilst this was welcomed, challenges remain around increasing demand for services resulting in long waiting times and difficulties in accessing the right service at the right time.

Poor mental health is not distributed evenly across the population and there is evidence of mental health inequalities in Scotland. Health inequalities are unfair differences in the health of the population that occur across social classes or between population groups. They are largely determined by social and economic factors and the way that resources of income and wealth are distributed. In areas of socio-economic deprivation, GP consultations involving mental health problems are twice as prevalent as in affluent areas.

The new mental health strategy recognises that in the last decade mental health services have changed dramatically, articulating however that there is still much to do with an ambitious plan to deliver better joined up services, to refocus these and to deliver them when they are needed.

2.3 Local

Since 2010, when the Mental Health Directorate was created, the service has maintained its area-wide management structure which sits separate to the management of the teams within which they operate. This includes both line management and professional supervision (see Appendix 2).

North Ayrshire HSCP is the lead partnership for Mental Health Services as well as some Early Years services for North, South and East Ayrshire. This means North Ayrshire HSCP is responsible for the strategic planning and operational budget of all Mental Health in-patient services, Learning Disability Assessment and Treatment Service, Child and Adolescent Mental Health Services, Psychology Services, Child Health Service, Children's Immunisation Team, Infant Feeding Service and Family Nurse Partnership.

North Ayrshire Health and Social Care Partnership have lead responsibility for Mental Health Services across Ayrshire, with '*improving mental health and wellbeing'* as a key strategic priority, with the following key objectives:

- Reviewing and Improving the services available to support mental health and wellbeing, including the integration or joining together of health and social care services to improve the quality and seamless access to provision at the earliest and most timely point of need.
- Implementing the mental health strategy for Scotland
- Increasing the capability of existing services and developing new models of service delivery to meet local needs

As a lead partnership we manage and provide professional leadership to staff across an all-Ayrshire service, such as Woodland View. We work together with East and South Ayrshire Health and Social Care Partnership to make sure that lead partnership work is complementary to Partnership's needs.

We also work together with East and South Ayrshire Health and Social Care Partnerships along with colleagues from NHS Ayrshire & Arran acute hospitals. This includes tackling a range of health and social care issues across all of Ayrshire. We develop frameworks and shared solutions that recognise our distinct environments and individual structures, such as reducing inequalities.

2.4 Psychological Services in Ayrshire and Arran

Psychological services in Ayrshire & Arran provide a vast range of services that improve the quality of life for many people with mental health problems within Ayrshire and Arran. However, these services are under considerable strain as demand grows and demographic changes impact on Psychology services.

Current arrangements are going to be difficult to sustain and a different whole system change is potentially required to meet the on-going mental health needs of the people of Ayrshire and Arran. The establishment of Health & Social Care Partnerships focused on locality needs means that services have to deliver for the locality rather than a pan-Ayrshire basis. There needs to be increased knowledge, availability and confidence in community-based resources/supports around mental health and the work of the Community Connectors could enhance this resilience approach.

There are also other services that provide low intensity interventions and therapies out-with health that could potentially lead to collaborative work or sign–posting people to in future.

The Psychological service is currently organised into a Pan Ayrshire centralised, area-wide structure. (See Appendix 2), a structure which is based on a previous service review undertaken in 2014. Information that benchmarks NHSAA against other Health Board areas is contained in Appendix 7.

- 30.3% of PS staff are non-Psychologist (Band 7 and below)
- 69.7% of PS staff are Psychologists (Band 8a and above)
- 86% of staff are aged between 21 and 50 (very different to the wider H&SCP age profiles where the majority of staff are older)
- 84% of PS staff are female

- Current ISD data places A&A's resource sixth out of the eleven terrestrial Health Boards

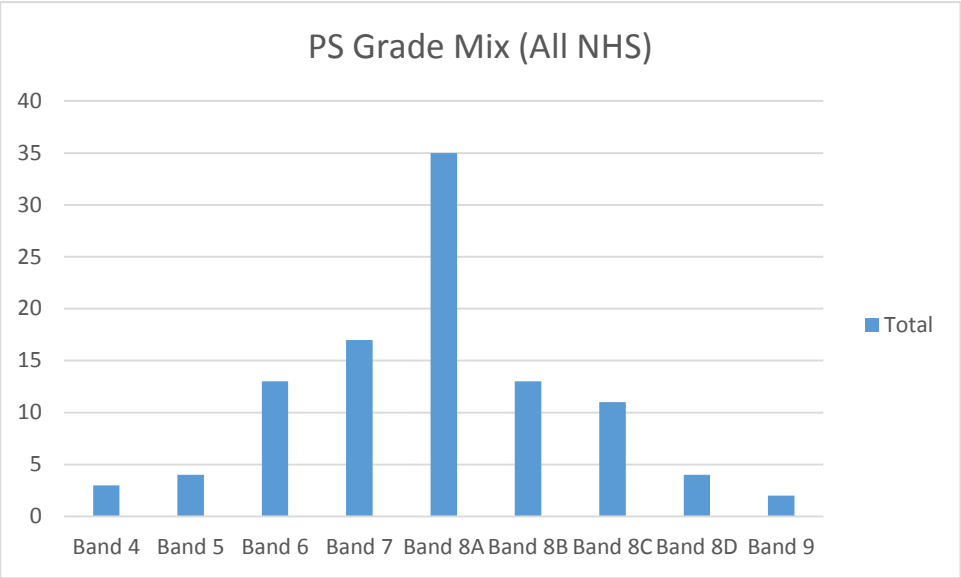


Figure 2 – Psychological Services Workforce Grade Mix

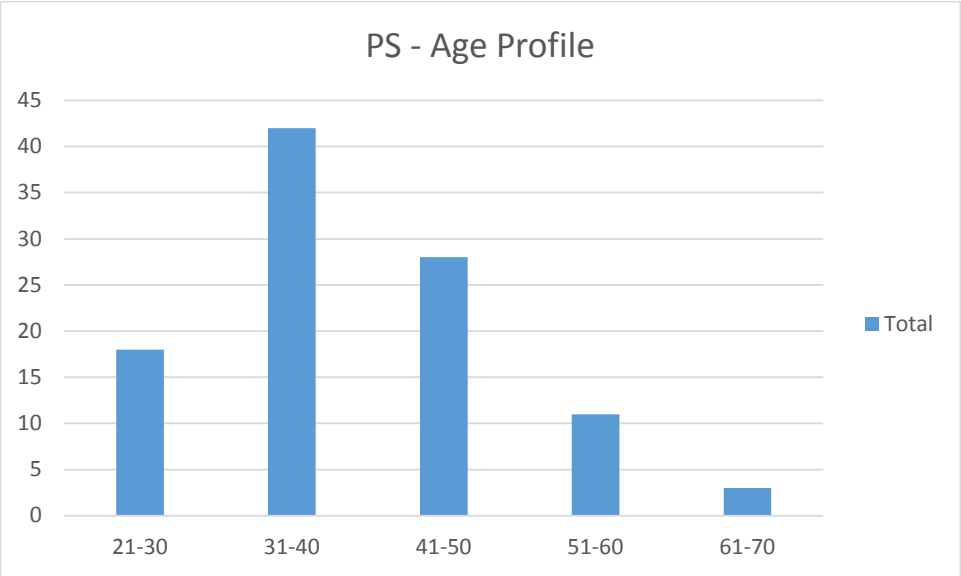


Figure 3 – Psychological Services Workforce Age Profile

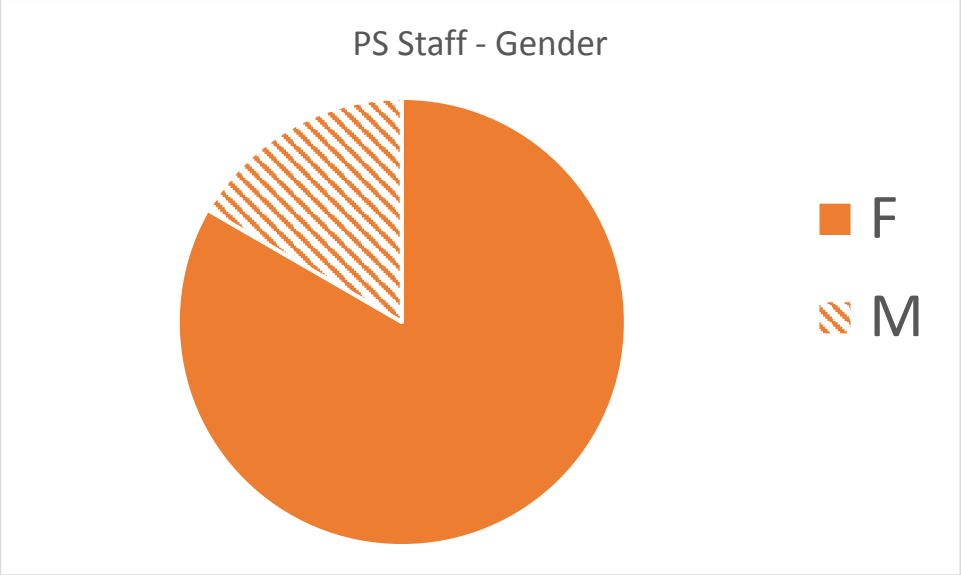


Figure 4 – Psychological Services Workforce Gender Split

Benchmarking exercises, both internal and external to the service, have demonstrated that there are some extremely successful examples of effective service delivery involving flexible, collaborative working across psychological specialties and within multi professional teams. These services are also associated with lower waiting times. This is especially the case in Older Adults, Physical Health, Neuropsychology, Learning Disabilities, Medical Paediatrics, Forensic and parts of Adult Community. Please see Appendix 7 (10.2 Paper for Benchmarking and Service Models for Psychological Services).

The following list of strengths and positive attributes of the service, as identified through staff engagement and consultation, also apply to the above services:

- Psychology staff are based together in some parts of the service.
- Named person links with service specialties and teams but is not managed within them (hub and spoke model).
- Pooling occurs to manage cover for maternity and sick leave and to facilitate rapid assessment of urgent cases.
- Referral system are appropriate to the professional group: (e.g.) Gatekeeping is managed by Psychologists, not by other staff or as part of a multidisciplinary team approach
- Admin systems e.g. systems of recording specific to the needs of the staff and patient group.
- Role clarity is good and the unique contribution of the profession is respected.
- Interventions and activities are consistently at the expert, specialist level. Staff are not expected to perform “generic” service functions (such as screening referrals for a whole service) or engage in low level prevention work.

3.0 Methodology

The review was conducted using a tried and tested HSCP methodology which allowed for a comprehensive process to be undertaken, involving staff, key stakeholders, reviews of management information and literature, and the utilisation of external expertise where appropriate. Project management was put in place for the review.

Staff Input Appreciate Inquiry Event (November 2015) Staff listening event (February 2017) 8C Staff workshop (May 2017) Summaries are included in Appendix 3.	Stakeholder Engagement Online questionnaire (July 2016) Follow up focus groups completed by February 2017 Summaries included in Appendix 4.
Management information Target performance Workforce data Waiting time information Financial information Structure charts Literature review Summaries included in Appendix 5	External expertise Use of critical friend Employment of external consultants – Benson Wintere and Meridian PI. Benchmarking exercises. Summaries included in Appendix 6.

A steering group was assembled for the project and two initial streams of work were identified. Those were workforce and models and data and demand. This would inform a further development of workforce at the end of the project to enable new ways of working to be developed.

The steering group membership was as follows:

- Cathy Kyle (Director) and Thelma Bowers (Head of Mental Health) - Joint Chair
- Lead Psychologists:
    - Alan James (Children)
    - Pamela McColm (Older Adults/Physical Health/Neuropsychology)
    - Helen Lynn (Learning Disabilities)
    - Janet Davies (Adult Community/In-patient, Forensic and Addictions)
    - Morgan MacPhail (CAMHS Psychology)
- Graham Sloan (Nurse Consultant)
- Jessie Mitchell (Business Support)
- Ruth Davie (QI Lead)
- Dale Meller (Senior Manager, Community Mental Health)

- Nicola Fraser (Project Manager)
- Michelle Sutherland (Change Programme)
- Andy Swanson then Calum Webster (OD lead)
- Craig Lean then Neil Archibald (Workforce Planning)
- Carol Fisher (South Ayrshire Health and Social Care Partnership Mental Health)
- Laura James (Community Mental Health Teams North)
- Debbie Bibby (Senior Data Analyst)

The steering group met monthly for around 18 months. This ensured that key staff had the chance to engage, input and influence the direction of the review at regular intervals, however attendance from non-PS staff was varied and often steering group meetings were only attended by PS staff (and staff from the NAHSCP Change Team). In addition, there was no representation on the group from East Ayrshire Health and Social Care Partnership despite formal invitation. It was agreed that clinical leads would take responsibility for engagement and communication with respective staff groups through existing channels. The HSCP Change Team facilitated some direct engagement (appreciative inquiry) sessions with PS staff in addition to this, but these were diarised events, not routine information giving sessions.

There was a significant challenge for the review team to extract reliable data from the service as mental health services do not have access to a standardised information and performance system to enable routine recording and collation of data or data analysts to systematically enable this. This systems issue contributed to significant delays in analysis and formulation of review findings to enable recommendations to be set. However considerable amounts of data and information (qualitative and quantitative) were gathered throughout the review and several additional reports produced for management to consider. These are summarised in Appendix 5

4.0 Outputs / Findings

4.1 Headlines:

Strengths / Positives	Areas for Improvement / Challenges
• High volumes of staff and stakeholder engagement • Good examples of successful services, working flexibly and collaboratively with other teams • Some services have very low waiting times • Considerable experience across the service, with a drive to deliver service improvements • Some significant progress in recent years on integration with other teams and services • Impending retirements within the service create the opportunity to make changes for little or no financial cost • Clinical expertise is valued • Younger age profile than the wider Partnership • Low sickness levels • Low levels of complaints • High patient satisfaction (please see Appendix X – patient satisfaction report and patient comments)	• Some services have very long waiting times • Current waiting times within service remain challenging in some areas. See appendix 5.1 for information. • Only 26% of clinicians' time is spent on direct client facing contact • Tests of change have been introduced, but impact limited due to capacity issues of the wider workforce to deliver psychological work following training and supervision • Some of the stakeholder perceptions of the service are that it is expensive and difficult to access some staff • Real lack of helpful and accurate data on workload – consultant commissioned but progress very slow • Lack of system investment to assist in case and workload management as well as the sharing of data across services • External consultants found that services are not running optimally • Some significant barriers to change within the service • Loss of senior level knowledge and experience over the next 12 to 24 months

In November 2015, a review of services started with an Appreciative Inquiry Event for all members of Psychology staff (approx. 90) with the objective of identifying the components of a thriving Psychological Service. In one specific area of the service, despite some ideas being generated and fed back to the service, little progress was

initially made. This was acknowledged by the Psychological Services Executive Team and is being remediated through a re-assignment of specialty responsibilities. In addition, closer working with the Senior Manager has resulted in removal of Psychologists from generic work which has had a positive impact on Psychology waiting times.

A literature review was carried out in order to explore other models in other countries to consider aspects to be incorporated into Ayrshire and Arran's model. The completed document was circulated to the steering group but never explored further in the steering group meetings or actions developed as the findings were felt not to be reflective of the current context e.g. use of private or insurance-based healthcare systems in Europe, Australasia and America.

Early on it was agreed that benchmarking should be carried out in order to compare the service with other similar health boards. This was completed in December 2016 and showed differences in models and structures (see Appendix 7). For example, the Adult Mental Health Psychological Services from around the country carried out a benchmarking exercise which highlighted that there was no single model of service delivery associated with waiting times standard compliance. Generally and not surprisingly, compliance with waiting times standard reflected available resource.

As part of an exploration of the current models of Psychological Services locally (see Appendix 8), a template was agreed to capture this information from all specialties. This detailed elements of service provision such as staffing complement, access criteria, interventions offered. Open space events were then carried out to explore each specialty with the aim of identifying challenges and successes and to aid engagement and communication. The main recommendations from the open space events (see Appendix 4) were:

- Leadership and visibility – to retain and develop a pan-Ayrshire Psychological Service Professional lead and to ensure links at Partnership level. Overall lead and budget for area-wide services to remain within NAHSCP to facilitate equity, flexible deployment if necessary, rational distribution of resources and advice on strategic direction;
- Role clarity and support – transparent agreement with service/speciality managers regarding balance of and type of work, ensuring that staff operate at specialist/expert levels only (supported by a dedicated workforce at lower intensity levels;
- Performance management – tighter performance management of activity types and levels, based on agreed job plans. Data systems developed to support this. Administrative support/systems and referral processes adapted to make them appropriate for PS staff and their work in some specialties so as to optimise clinical time;
- Structure – to reflect the above;

- Finance – any further savings from the above to be re-invested in service gaps/making temporary posts permanent;
- Retain what is working well.

Stakeholder engagement was also a priority for the service in order to better understand the views of referrers and colleagues. Initially this took the form of a survey monkey questionnaire that went out to all the stakeholders identified by the various Psychology specialties in July 2016. In order to improve feedback, it was agreed that focus groups would be carried out and this was limited to CAMHS, the Community Eating Disorder Eating Team, and the Adult Mental Health Community Teams (see Appendix 4).

Lack of helpful and accurate data was identified as a barrier to progressing with any workforce analysis and impacted on the ability to fully develop the Benson Wintere model. The Benson model is an ongoing project being implemented in Ayrshire & Arran psychological care services. The model is based on pre-existing modules of the Benson methodology. The primary purpose of this work was to encourage greater objectivity and transparency to encourage better interaction and discussion about the future of the service. An activity tracker was agreed as a mechanism to gain further information however this was not progressed. The process for gathering demand data was not robust and subsequently there were perceived errors in the outputs. The outputs were also perceived to be overly complex. As such a decision was made to focus on other areas that would also benefit from this sort of detailed productivity analysis, a spec was developed to procure the services of an outside consultant. The aim of the Consultancy project was to conduct a study which would incorporate an in-depth analysis of Demand, Capacity, Activity and Queue (DCAQ) within Mental Health and Learning Disability Services to identify and quantify operating deficiencies and estimate the improvement potential thereby contributing to budget savings and potential re-investment whilst meeting capacity to handle patient numbers, reducing waiting times, and providing a quality service which is also value for money. This also included reviewing processes in Woodland View Mental Health impatient facility (see Appendix 6).

As part of a whole Mental Health Service review, some Psychological Services staff were shadowed by Meridian PL and profiles called DILOs (day in the life of) were pulled together. Overall the results showed that across the 11 DILOs completed in Psychology Services, 26% of clinicians time was spent on direct client facing contact compared to the 31% perceived and 39% that they defined as the ideal level of contact. The clinicians had an observed average of 2.2 contacts per WTE day including DNAs, excluding DNAs the HCPs had an observed average of 1.9 contacts per WTE day.

A critical friend was also utilised during the review to give an external perspective of how the service could function differently and recommendations have been made in relation to structure, management arrangements and service model (see Appendix 9).

4.2 Resulting Themes for Improvement / Action

The main findings provide evidence that change is required within certain parts of the service and across the wider health and social care system to ensure they are as efficient and effective as possible.

Analysis of the findings shows that in certain parts of the service:

- Waiting times are high
- Client-facing time needs reviewed
- Planning is not as evident as it should be
- Joint-working within some teams needs improvement, with a perceived lack of integration into multidisciplinary teams
- The referral criteria are not fully understood by those that refer to PS
- In some areas, capacity for supervision of others is limited. There is also a lack of resource freed up in those other professions to deliver after they have been trained and supervised
- Management information and investment in appropriate systems is lacking

Using this evidence, the output of previous functional reviews (see Appendix 12), detailed engagement and consultation with staff, and through leadership and management discussions, options have been identified as suitable for the future of the service.

Options have been developed to allow consideration of the best service structure to deliver the key recommendations.

The options are as follows:

	Option
1	Centralised Service: Professionally managed centralised area-wide Psychological Services hosted within Mental Health Services within North Health and Social Care Partnership. Reports through Director of Mental Health Services North Health and Social Care Partnership. Clinical Director has formal links with South and East Partnerships and with Health Care Managers within Physical Health Services and Health Board. Functional Integration into specialty teams and area-wide working as appropriate. This can be status quo to a more radical version of a centralised service.
2	Partnership: Decentralised Psychological Services split four ways, i.e., staff and budget split between three Health and Social Care Partnerships but managed by their Professional Specialty Leads (for Adult MH; Child Services and Learning Disability) who report to the Director of each Partnership. Budget and staff within Physical Health, Medical and Community Paediatrics and NES-funded posts managed by Clinical Director of Psychological Services. Professional Lead roles and overall Professional Lead pertains in a matrix structure. Each Partnership and Acute will have a Professional Lead who provides professional leadership and governance to all Psychological Services staff within Partnership and Acute Service. The Professional Lead will have an identified specialist area and ensure leadership and governance within specialty area within Partnership, e.g., Child, Older Adult, Learning Disability and Adult Mental Health.
3	Totally Dispersed De-centralised Psychological Services with budget/staff/part of budget/staff time managed within individual service specialties and localities, i.e., split 34 ways with NES posts randomly allocated to one or more Health and Social Care Partnerships (e.g., 0.5wte managed within Stroke; 1.0wte within Oncology; 0.5wte to Cardiac Rehabilitation; 3/4wte within AMH Community Teams South, East and North; 0.43wte Older Adults MH; 0.43wte Older Adults Physical Health, etc. Professional leadership and governance dispersed within each area.
4	Operational Integration with Professional Leadership Support (See appendix options appraisal 4) Creation of one professional lead across Ayrshire, integrate staff and activities into children, adult and older people (with a lead for each service area). Co-management role with existing service managers to ensure joint accountability and responsibility for performance and create the ability to pool resources. Pan Ayrshire budget remains under the management of the North Partnership. Integrated arrangement means financial sign-offs must be agreed between Professional Lead, Operational Manager and Clinical Lead.

Options 1 – 3 were appraised as part of a half-day option appraisal event with senior Psychologists. Option 1 was the preferred option of the staff present at that event. A fourth option had been formulated as part of the critical friend challenge process but was not explored as part of this session.

5.0 Conclusions and Recommendations

The review identified areas where things are working very well, with good examples of waiting time standards being met, training and supervision of the wider workforce, clarity of role, working flexibly and in collaboration with other services and teams. However, in certain parts of the service, the review highlighted waiting times are high and there is a need for shared agreement on role clarity and collaborative team working.

Psychological Services across Ayrshire and Arran are clearly valued, and staff and stakeholders have given their time and expertise to help provide constructive insight and input into what is working well and areas to be considered for development. Alongside benchmarking (internally and externally), utilising external expertise and analysing management information, this review concludes that:

- In the case of some services it would be beneficial to further develop joint accountability for the functionality of the service alongside clinical accountability and governance through a professional leadership model. This practice is already in place in many parts of the service and is associated with high levels of collaboration and good working relationships.
- A pan-Ayrshire and Arran professional lead role be developed further, to provide strategic leadership for Psychological Services across the region and at senior Partnership level. Lead roles for each broad specialty area are also developed that have co-management responsibilities and accountability with the appropriate service managers.
- Psychological Services staff would be embedded in operational teams where appropriate. In addition, the joint accountability should result in more collaborative decisions on the balance of work of staff. The Meridian analysis highlighted a lack of management control, not just for Psychological staff, but within all the Mental Health teams. This has to be smarter if the service is to fully utilise staff time.
- In the case of Community Paediatrics, a more detailed analysis of patient pathways and processes is required to fully understand the extent of the situation. Discussions are underway to add Learning Disability Nurses to the skill mix to take the pressure from Psychological Services and further facilitate the development of a joint pathway for diagnosis of Neurodevelopmental conditions across CAMHS and Community Paediatrics.

Early recommendations from the above reports would indicate that a whole system approach is required for transformational change to occur and develop a service fit for the future. It is also recommended that option 4 be considered alongside the other options as a possible preferred option for Psychological Services across Ayrshire and Arran. The details in terms of joint accountability are to be determined.

The following table outlines the risks, challenges, dependencies, impacts and barriers to implementation for the recommended option:

Risks & Challenges	Dependencies
In the short-term, likely to be resistance amongst some staff to this approach. Service is already behind in communications, perceptions of the review are negative amongst some staff as a result. There has been limited sharing of information to date, including stakeholder, staff and external consultants work. A lot of time has moved on, opportunities missed to communicate and engage with wider PS staff group. Ensuring appropriate communication across all service specialities and localities.	Requires strong leadership and management. Requires solid communications, open and transparent, on a regular basis. Requires engagement with Business Support around provision of service to PS as a whole. Management engagement from other parts of Mental Health. Buy-in and support from East and South HSCPs. Restructuring and subsequent deletion of posts. Requires solid business and workforce planning, with the need to also workload plan where appropriate.
Impacts	**Barriers to Implementation**
2017-18: Organisational change begins 2018-19: New structure in place 2019-2020- whole system Service focussed on early intervention and prevention approaches which meets waiting times using MDT approaches	Current Admin support is not adequate to deliver the changes required. Some of the other teams will need to make changes to working practices to allow for integration. Staff engagement and buy-in – a lot of work to be done by MH leadership and management to bring wider workforce staff along with this change. Service will need to ensure posts are deleted to deliver efficiencies proposed.

6.0 Next Steps

Governance Timeline:

Meeting	Date	Purpose
Mental Health Senior Management Team	9th August 2017	Discussion, review
Partnership Senior Management Team	5th October 2017	Approval for onward submissions
SPOG	6th October 2017	Approval

East and South Partnership Management Teams	3rd October 2017 (S) 5th October 2017 (E)€	Approval
IJB (North, East and South)	16th November 2017	Approval
Area Professional Committee	TBC	

Action Plan / Implementation Plan / Communications Plan:

Action and implementation planning is vital and needs to put in place once an option is agreed. A Communications Plan for moving forward will need to be developed. Opportunities for communications with PS staff, wider Partnership (North, East, South) and Acute Service staff will need to be actively pursued.

Appendix Information:

No.	Title	Link
1	Psychological Services Review – Project Initiation Document	1.1 - Project Initiation Document
2	Psychological Services Structure	2.1 - Psychological Services Structure
3	Staff Engagement Summary	3.1 - Appreciative Inquiry 3.2 - Notes related to Appreciative Enquiry Day 3.3 - Appreciative Inquiry Outcomes 3.4 - Psychological Services Open Space 3.5 - Psychological Services Open Space
4	Stakeholder Engagement Summary	4.1 - Stakeholder Review for Psychological Services 4.2 - Focus Group Report 4.3 - Patient Satisfaction Report
5	Management Information	5.1 - Psychological Therapies Waiting Times 5.2 - Access to Psychology September 2017
6	External Expertise – Output	6.1 - The Benson Model 6.2 - Meridian Timetable
7	Benchmarking Report	7.1 - Child Phycology Benchmarking 7.2 - Learning Disability Phycology Benchmarking 7.3 - Benchmarking Service Models 7.4 - Psychology Benchmarking
8	Psychological Services Models	8.1 - Potential New Model of Psychology in Ayrshire
9	Report from Critical Friend – Mark Feinman	9.1 - Maximising the impact of the Psychological Therapies Agenda
10	Options Appraisal	10.1 - Options Appraisal

Health and Social Care Partnership

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

Project Initiation Document

NHS Ayrshire & Arran

Programme Initiation Document	Psychological Service Review
Project Title	Psychological Service Review
Distribution Date/Version Number	Version 0.1
Project Reference (From Work Package Log)	
Programme Sponsor	Iona Colvin
Partnership SMT Management Lead	Jo Gibson
Programme Manager	Michelle Sutherland
Executive Sponsor	Thelma Bowers
Senior Responsible Officer	Dr Catherine Kyle
Project Manager	TBC
Author	Dr Catherine Kyle/Michelle Sutherland
Start Date	9 October 2015
Completion date	31 March 2016

1. Background

Historically Psychological services and CAMHs have received improvement monies to manage the following areas:

Information Systems: Devising an Information System which is able to record and monitor demand, capacity, access and queue. The internal IT system was unable to record this information and therefore limited ability to use this information to inform change or improvements within the services. The development and introduction of a bespoke database not only provides activity monitoring but also evidence of improvements made by service changes.

Patient Focused Booking: To improve the patients experience at being able to book an appointment at a convenient day and time for them and having a text reminder system in place to remind people that their appointment is due. This will include the use of SMS messaging, telephone booking, the introduction of a reminder service, looking at DNA's and booking practices

Communication with Referrers and Patients: The following are actions and outcomes of the CAMHS workstream:

- Review of existing CAMHS feedback from patients, parents and referrers.
- Reflective letters.
- A public facing web site developed or CAMHS.
- Potential Educational DVD for schools done by CAMHS.
- Real time patient experience for those using CAMHS services sought.
- Evaluation of the way CAMHS communicate with their patients will be done.

Patient Pathways (ICP's): To ensure that agreed referral criteria and Integrated Care Pathways are in place for Psychological Therapies and CAMHS to improve the whole experience for the patient making it more person-centred. Expected outcomes are:

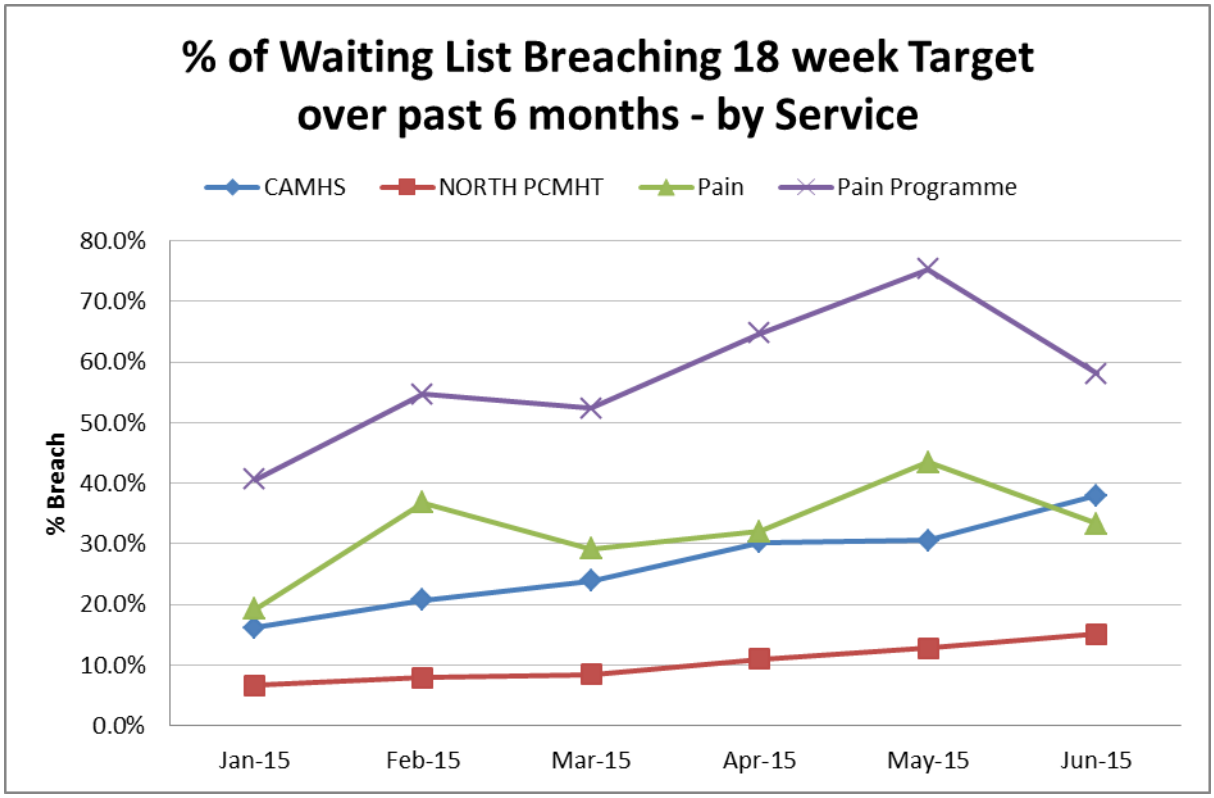
- Exploration of advantages of consultations being co-ordinated by other partner agencies
- Introduction of Integrated Care Pathways within Psychological Therapies and CAMHS

Workforce Planning: To review and consider the workforce delivering the services which support the access targets. The skill mix of teams, including roles and ways in which work is allocated, depending on experience, grade, level of training and supervision. Job planning and capacity building and consideration of filling vacancies with other grades/roles and professions.

However challenges around waiting times for some areas of psychology, the continued growth in demand and current skill mix remain**.**

2. Problem Statement and current impact on H&SCP

The work also highlighted the negative impact of pathway blocks, across the life course linked to Psychological Services waiting times.



3. Project Description

The Partnership will commission an external critical friend, to undertake a review of Psychological Services across the whole life course and clinical pathway to assess areas of action and improvement.

This work will include projections of demand to ensure changes recommended are future proofed and sustainable.

4. Service Objectives

Areas of Planned work

Aims	
Brief:	'To provide expert and objective advice to inform the identification of potential future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes'
The Service Wants:	➢ Articulate the journey to date: clearly set out the current situation in context ➢ To set out the challenges in the short to medium term ➢ To determine and evaluate options which will deliver future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes ➢ Ensure that the solutions are demonstrably driven by patients and carers

	➢ To outline a road map ahead for the medium to long- term
The New Service should facilitate:	➢ Accurate information flows and reporting Pan Ayrshire ➢ Measurement of demand against the current standards and project future demand ensuring capacity for clinical and care developments in 2020 ➢ Redesign work to improve access targets ➢ Service redesign within existing resources and identify future service options which allow the service to be delivered within reducing financial resources to 2020 ➢ Improving Clinical Outcomes, based on the most effective clinical evidence ➢ Improving personal outcomes for patients and their carers
Our Approach:	✓ Stakeholder one to ones, including patient & Carers ✓ Appreciative Inquiry Approach with Mental Health Service Teams and key partnership stakeholders ✓ Data Analysis ✓ Service Improvement Facilitation ✓ Waiting Times analysis ✓ Performance Management ✓ Evaluation ✓ Development of Peer Research to sustain capture of patient and service user views in the future ✓ Programme and Project Management

5. Outcomes

Service will meet current HEAT targets and be future proofed against growing demand.

6. Evaluation

The primary driver will be HEAT waiting times; however both the consultant led work and the change team will collate other data, including patient views using the Partnership Evaluation Handbook.

7. In Scope:

As described in section 4

8. Out of Scope

None - as a system wide service embedded in many specialties

9. Dependencies

Review of both the models of care at the new Woodland view and each H&SCP re-design of Community Mental Health Teams.

10. Approach/Key Activities

Programme Management approach with a steering group and workstreams.

11. Risks

The review does not meet the objectives set as a new style if workforce is not available or demand continues to grow. A risk register for the project will be developed.

12. Costs

A £71,000 QUEST application was submitted to fund a consultant. The remainder of the review costs will be met in-house.

13. Cost Benefit Analysis

The project and review will require to generate resource efficiencies through the future effective deployment of staff to best meet need.

14. Milestones:

Milestone Dates	Description	Responsibility
	Commission external consultant for report in January 2016 *Lead steering group and associated workstreams to deliver change via an implementation plan.*	Thelma Bowers Dr Catherine Kyle

Reporting:

Roles and Responsibilities

Executive Sponsor
Each project will require an executive sponsor, likely to be a member of the Partnership Senior Manager Team. The executive sponsor will direct, lead and champion the change agenda. The executive sponsor can direct the project team to ensure the project work meets the Programme outcomes agreed.

Senior Responsible Officer
Each project will require a Senior Responsible Officer, likely to be a senior manager level reporting to the Executive Sponsor as part of their management team. A SRO may have responsibility for several projects and will co-ordinate and champion the work with the project manager.

Project Manager
The project manager will be accountable to the Senior Responsible Officer and Programme Manager. They will be required to work collaboratively with the Change Team, PSMT, project teams and the partnership system.

The project manager and they will have access to specialist support from the change team. The Project Manager will ensure changes are clearly identified, measureable and meet Programme Board timescales. The Project Manager will drive the change agenda working effectively with the Senior Responsible Officer & Executive Sponsor to ensure success.

Escalation:

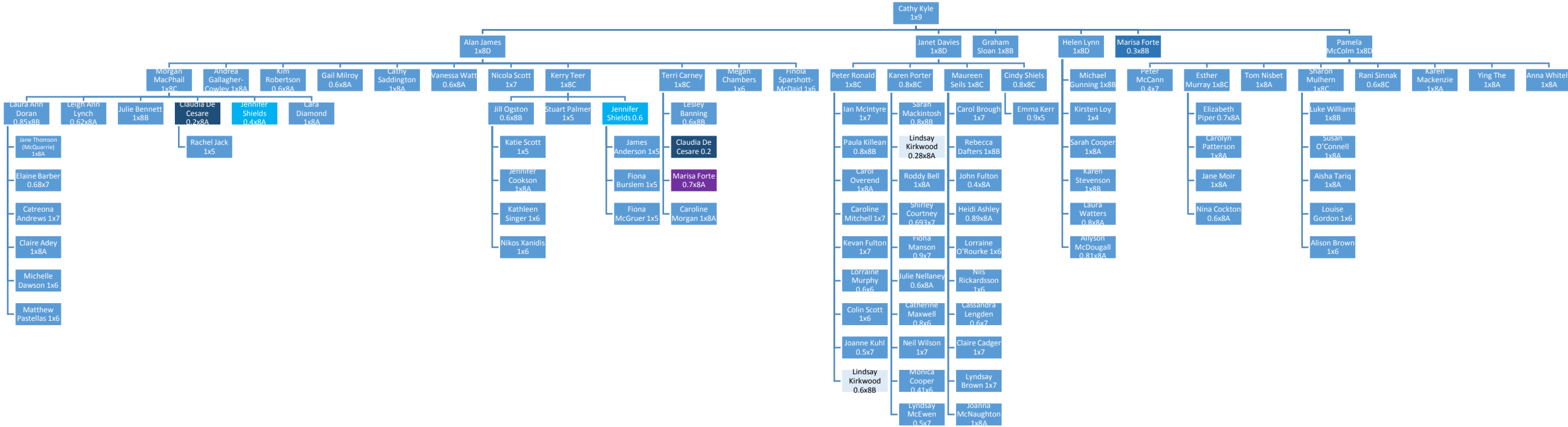
1. Senior Responsible Officer
2. Executive Sponsor
3. Programme Manager
4. Programme Board

Project Team & Contact Details

Support	Estimated time per month
Executive Sponsor	Thelma Bowers
Senior Responsible Manager	Dr Catherine Kyle
Programme Manager	Michelle Sutherland
Project Manager	TBC
Performance/Planning Support	Debbi Bibby
Service/ Process Improvement	Ruth Davie
Data Analyst	Debbi Bibby
Human Resources	NHS
Finance	Partnership
IT support	NHS

	Impact on H&SCP Business Support Functions **(Complete Appendix 1)**  Appendix 1 NA H&SCP Change Progr

Project Plan Agreement:-	Approved By:	Signature	Date
Programme Sponsor	Iona Colvin		
Partnership SMT Management Lead	Jo Gibson		
Executive Sponsor			
Senior Responsible Officer			


Cathy Kyle 1x9
Alan James 1x8D
Janet Davies 1x8D
Graham Sloan 1x8B
Helen Lynn 1x8D
Marisa Forte 0.3x8B
Pamela McColm 1x8D
Morgan MacPhail 1x8C
Andrea Gallagher-Cowley 1x8A
Kim Robertson 0.6x8A
Gail Milroy 0.6x8A
Cathy Saddington 1x8A
Vanessa Watt 0.6x8A
Nicola Scott 1x7
Kerry Teer 1x8C
Terri Carney 1x8C
Megan Chambers 1x6
Finola Sparshott-McDaid 1x6
Peter Ronald 1x8C
Karen Porter 0.8x8C
Maureen Seils 1x8C
Cindy Shiels 0.8x8C
Michael Gunning 1x8B
Peter McCann 0.4x7
Esther Murray 1x8C
Tom Nisbet 1x8A
Sharon Mulhern 1x8C
Rani Sinnak 0.6x8C
Karen Mackenzie 1x8A
Ying The 1x8A
Anna Whitel 1x8A
Laura Ann Doran 0.85x8B
Leigh Ann Lynch 0.62x8A
Julie Bennett 1x8B
Claudia De Cesare 0.2x8A
Jennifer Shields 0.4x8A
Cara Diamond 1x8A
Jill Ogston 0.6x8B
Stuart Palmer 1x5
Jennifer Shields 0.6
Lesley Banning 0.6x8B
Claudia De Cesare 0.2
Marisa Forte 0.7x8A
Caroline Morgan 1x8A
Ian McIntyre 1x7
Paula Killean 0.8x8B
Carol Overend 1x8A
Caroline Mitchell 1x7
Kevan Fulton 1x7
Lorraine Murphy 0.6x6
Colin Scott 1x6
Joanne Kuhl 0.5x7
Lindsay Kirkwood 0.6x8B
Sarah Mackintosh 0.8x8B
Lindsay Kirkwood 0.28x8A
Roddy Bell 1x8A
Shirley Courtney 0.693x7
Fiona Manson 0.9x7
Julie Nellaney 0.6x8A
Catherine Maxwell 0.8x6
Neil Wilson 1x7
Monica Cooper 0.41x6
Lyndsay McEwen 0.5x7
Carol Brough 1x7
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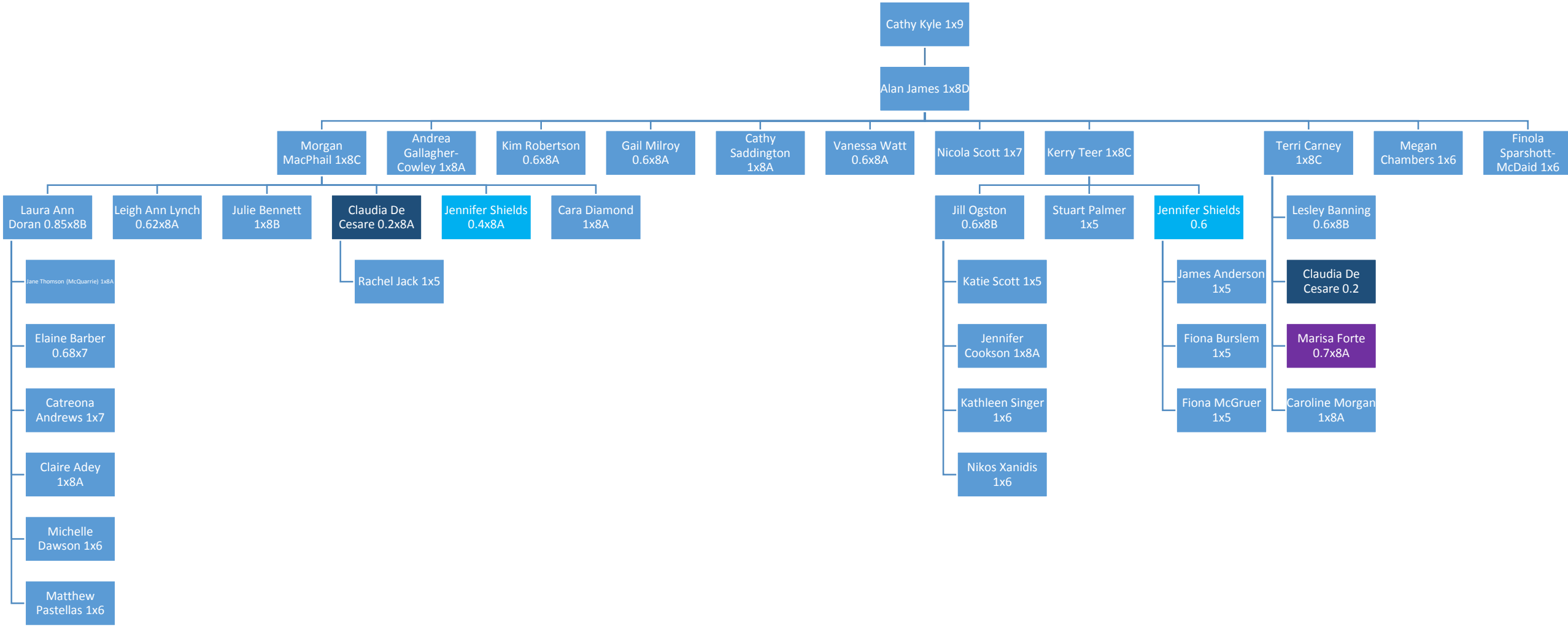
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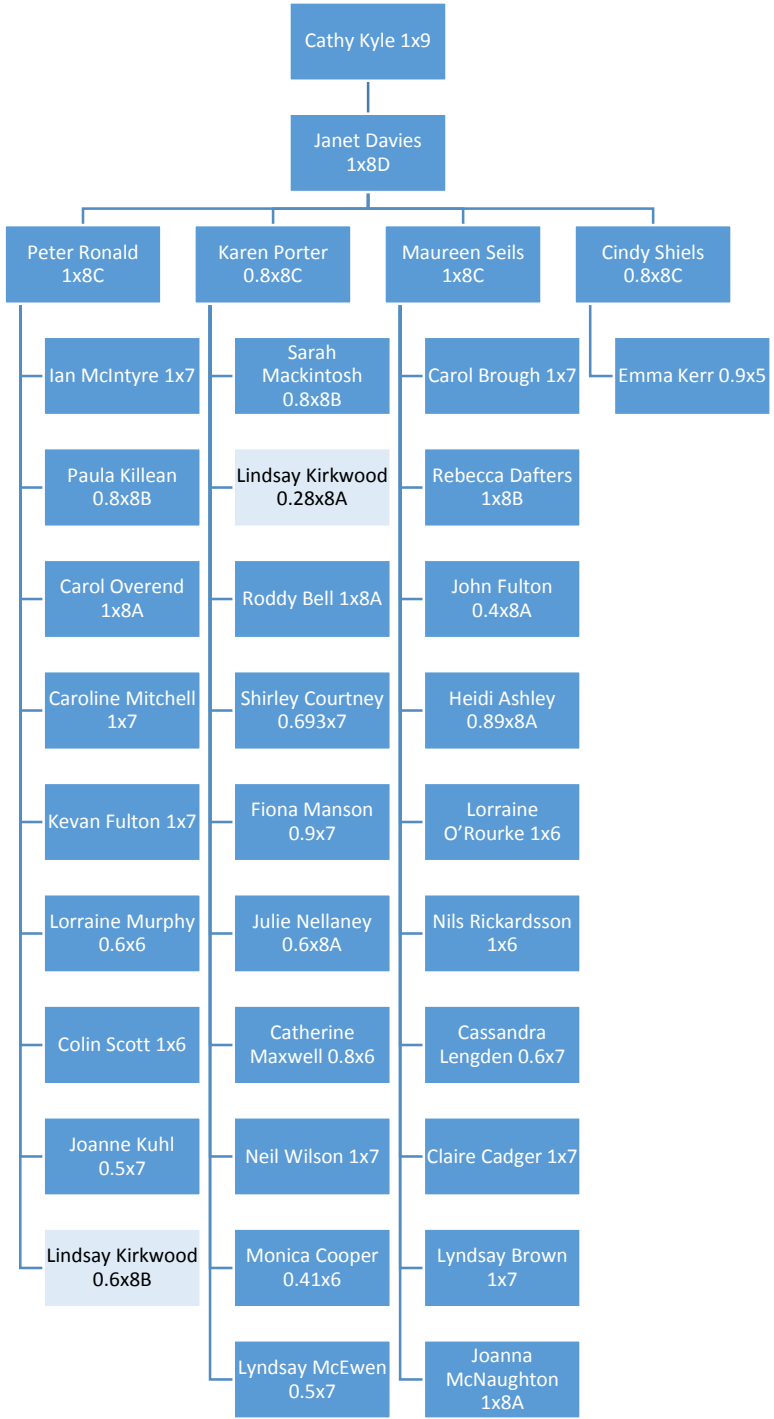
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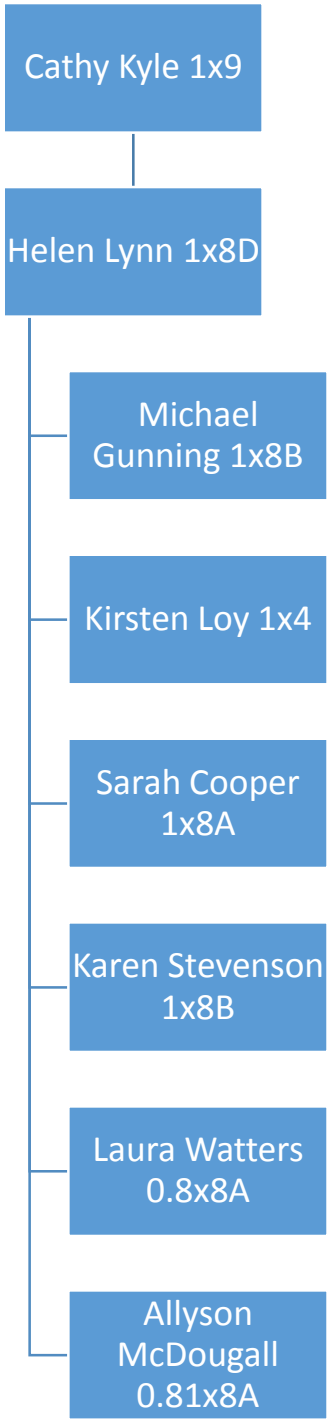
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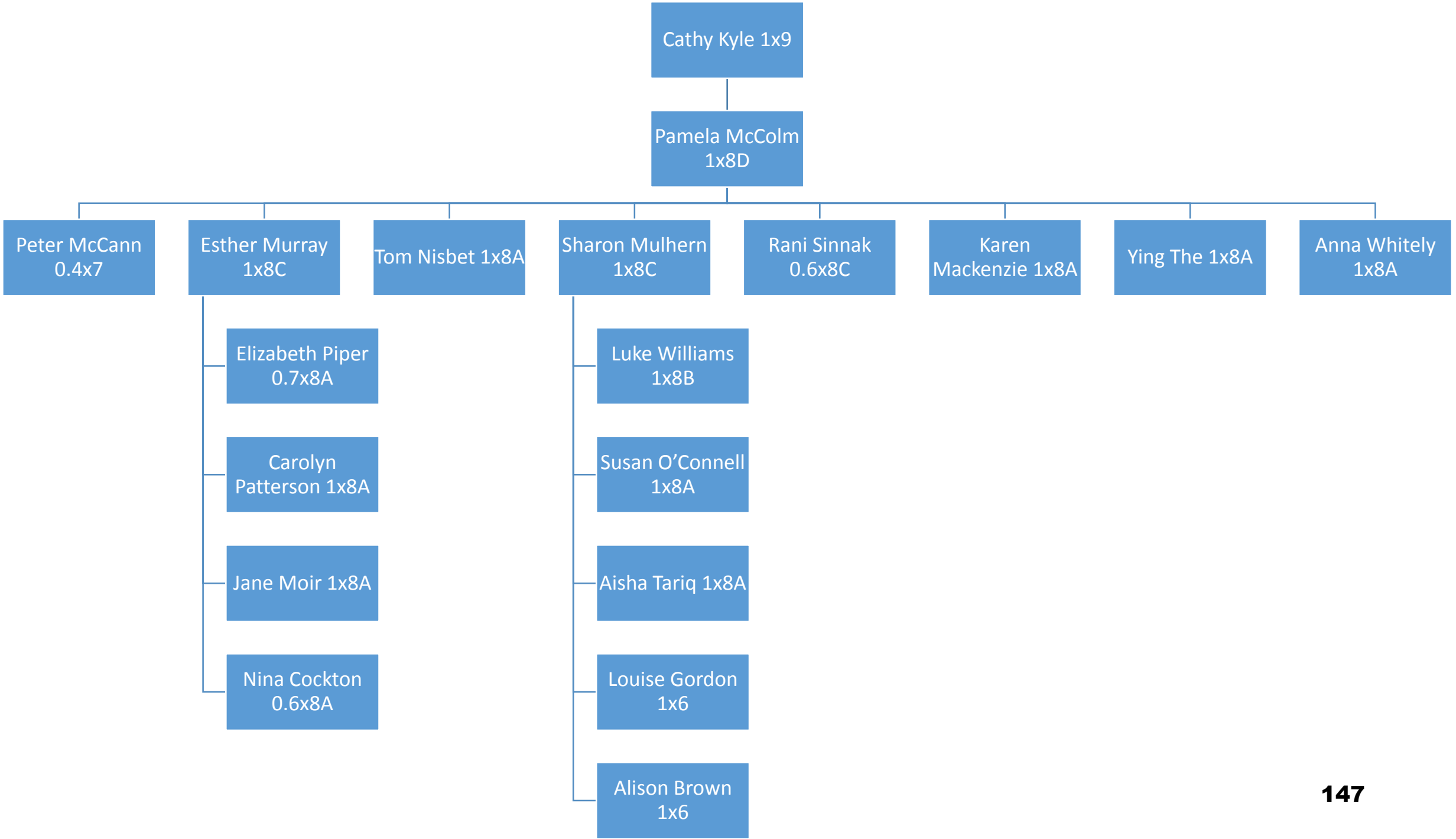
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North Ayrshire
Health and Social Care Partnership
Psychological Services

"A Thriving Psychological Service"

Appreciative Inquiry

Friday 27th November 2015

This Appreciative Inquiry was designed, planned and delivered to enable those working in psychological services the opportunity to think about and have meaningful conversations about new ways of working in an ever increasing demanding environment.

The theme for the day was entitled 'A thriving Psychological Service'. In preparation for the event a problem statement highlighting the challenges faced by the service was re-framed into an affirmative topic statement, reflecting three work-streams; Service Modelling & Mapping (Person Centred); Service Demand, Capacity & Activity (Waiting Times) and; Workforce.

'Sustainable, thriving Psychological Services are marked by exceptional quality service and patient satisfaction. Each person in the service is aligned with the values, working in an exemplary way that recognises, appreciates and enhances the professional skills and expertise of all. Everyone is proud of being part of this service and is committed to making a difference.'

There were 86 delegates in attendance who were guided in their conversations by eight appreciative inquiry hosts. The approach enabled delegates the opportunity to share experiences and think about the future of psychological services from a positive, future orientated position based on specific questions in response to the overarching affirmative topic choice.

The following is a collective summary of all of the conversations. The design and destiny output has been colour coded for ease of reference and are clustered in work-stream topics.

The output is the start of doing something different tomorrow than what is done today

Andrew N. Swanson
Organisational Development Lead
Change Team
10th December 2015

Service Modelling & mapping (Person Centred)

Discovery – 'the best of...' When excellence is at the heart;	**Dream – 'what might be...'** Provocative Proposition	**Design – 'what should be...'** The steps we are taking to plant the seeds for change to ensure things happen are;	**Destiny – 'what will be...'** We will ensure the dreams are carried forward by;
We are building relationships and bringing ourselves into each interaction. We are creative, flexible and open minded and use an evidence base approach in our interventions. We work in partnership. We innovate, develop and adapt in collaboration with our service users and colleagues from other services. We reflect and evaluate to drive continuous improvement. We are working autonomously, as we innovate and use our psychological knowledge to	Community Resilience and supporting the population psychologically Everyone recognising the psychological dimension of health. We protect and nurture what is great in our service; The access to services is at centre of seamless care. Resilience Building and empowering choice	Forming productive working relationships with our colleagues working in Mental Health and Social Care. Developing specialist services in order to reduce relapse rates and improve cost efficiency. Appreciating and respecting the working practices between teams. Maintaining and sharing best practice. Training and coaching referrers and other groups in understanding psychological knowledge and interventions. Influencing stakeholders in education (under graduate, school's curriculum), other professions and wider community, to reach younger people on psychological matters. Developing resilience training for mental health issues in schools and colleges; targeting 16-24 year olds and; influencing local media. Making best use of resources – Sharing work by involving others to different levels of training to develop skill mix.	Talking with our teams about developing stronger links with other services. Maintaining a strong professional identity that demonstrates value, develops relationship with wider teams and colleagues and enhances the work of integration Starting a paediatric parents group. Starting early intervention work with schools. The Learning Disabilities Service developing a resilience programme. Learning from other services and sharing findings with colleagues. Involving staff care colleagues in promoting compassionate focus.

develop services. We manage chaos effectively, drawing on our compassion for others. We influence teams by sharing our knowledge and putting this into developing practice.		Seeing people quickly by managing referrals and providing drop in clinics. Managing service user expectations and planning discharge where people are not reliant on services.	
		Researching the health economy evidence base for psychological interventions in different age groups.	Influencing the Psychology professional committee to have a whole population approach to resilience in 2016. Influencing decisions at the Medical subcommittee, Integrated Joint Board and Clinical Governance meetings. Using the Area psychology committee as a vehicle for taking forward strategic intent.
		Identifying illnesses and increasing capacity in other services to provide low intensity interventions. Using triage staff working in schools. Using social media to promote positive wellbeing. Including preventative work as part of job plans. Engaging meaningfully with the Third Sector.	Promoting psychological health in existing networks and MDT's and third sector organisations. A Commitment to be involved in future developments within the team. Regular communication between the Heads of speciality and their sub specialities. Approaching NES to develop more e-learning opportunities for training.

Service Demand, Capacity & Activity (Waiting Times)

Discovery – 'the best of...' When our contribution is celebrated;	**Dream – 'what might be...'** Provocative Proposition	**Design – 'what should be...'** The steps we are taking to plant the seeds for change to ensure things happen are;	**Destiny – 'what will be...'** We will ensure the dreams are carried forward by;
We engage, adapt, and innovate with our patients. We see quality care at the heart of all patient care across life spans. We thrive on creativity, feeling motivated and valued We appreciate that clinical governance is at the heart of the organisation We have a shared belief that good outcomes are associated with investment in training and good supervision We strive for patient centred care	Ethical and efficient access to services – Respectful collaborative professional relationships Psychological wellbeing is valued as much as physical wellbeing No not for us mentality – clear signposting. The right care at the right time Skilled Early assessment is a sound investment	Ensuring Health promotion material and information about our services are available in all waiting areas. Enhance and increase communication with referrers. Sharing our vision with colleagues. Encouraging more collaborative and respectful working with confident staff being clear about expectations. Making Small changes. Triage, assess, signpost and feedback – assessment on referral and feedback to referrer providing the right information to inform decisions. Being innovative in the way that we measure outcomes, including patient satisfaction - and acting upon measurements/feedback. Identifying a named administration colleague within the team. Improving the physical working environment enabling greater staff interaction.	Starting to do some of the suggested things at local level. Maximising our contribution to patient care. Being realistic by starting small and sharing with colleagues regularly. Establishing a forum to share best practice and ideas. Using Governance and professional committees to share ideas. Receiving feedback from today. Reviewing and analysing Information – outcome measures; DCQA. Increasing clinical capacity and reducing administration tasks.

Workforce

Discovery – 'the best of...' When we feel alive, engaged and proud our impact is...	**Dream – 'what might be...'** Provocative Proposition	**Design – 'what should be...'** The steps we are taking to plant the seeds for change to ensure things happen are;	**Destiny – 'what will be...'** We will ensure the dreams are carried forward by;
Seen wider than our immediate team. Inspiring us to take on new challenges. Enabling us to grow, develop and expand in a supportive manner. Acknowledged in that we are changing lives. Enabling us the freedom to work autonomously and are developing both personally and professionally. Valued and appreciated. That we don't need to fix what isn't broken. Driving others to enjoy success. Creating openness and	No health without mental health – In every practice When our lives are changed, lives are changed A THRIVING Psychological Service – sails forward, empowers, nurtures and delivers – and is valued	Working closely and getting to know primary care colleagues and GP's. Promoting the value of our specialism. Sharing what we offer that improves the lives of people and provides good value for money. Publishing a newsletter to raise our profile. Attending specialist interest groups. Using the Psychological page on Athena to share information. Bringing to life our workforce plan and taking into consideration career progression. Establishing a group that is responsible and accountable for progressing ideas and innovations. Introducing protected time for; Study/peer groups; Team planning; Twice a year workshops;	Starting a conversation with GP's on a personal and service level. Attending the Psychiatric team meetings. Prioritising what we do. Refreshing the Athena page and producing a monthly newsletter. Staff sending updates every month for inclusion in the newsletter. Taking every opportunity to support encourage, participate and influence. Expanding our lead specialists from within our existing budgets and influencing the distribution of funding within professional groups. Being actively involved in decisions that affect the service. Further exploration of other psychological interventions. Conducting a clinical and administration time and capacity review. Adopting regular protected time for wellbeing enhancement and service

freedom that encourages people.		Research; Celebrating success. Having more time to talk and looking after one another. Refocusing business meetings, making them more meaningful and relevant. Reviewing our clinical and administration time, to release more time to deliver. Creating a wellbeing measure	improvement. Attending and participating in business meetings. Someone in the team being responsible for environmental factors impacting on wellbeing Conducting an anonymous staff wellbeing measure in January 2016 and thereafter implementing a monitoring system.

30th November 2015 – Departmental Meeting Medical Paediatric Psychology
(notes related to Appreciative Enquiry Day)

Discussion was held on the Psychological Services Workshop held on Friday 27th November. On feedback it was agreed that it had been an interesting day and that the appreciative enquiry process achieved what it set out to do. That a hypothetical vision of a dream psychological service was framed, that staff had remained very engaged and positive and that reality for a day was suspended.

However, there was an agreed lack of clarity about:

- How this vision linked in with the current change process?
- What the aim of the current change process is and what the impact will be on current services?
- What role specialties (e.g.MPP) can contribute to the change process?
- How current areas of excellence within psychological services are protected?
- How leaders/change facilitators with little knowledge of psychological services can make informed choices?
- How the strong evidence base for psychological therapies and ways of working can challenge misleading assumptions and competing motives for change?

Appreciative Inquiry Outcomes

Practical Suggestions

1. Drop in clinics.
2. Plan discharge at the beginning
3. Discharge everyone on caseload longer than x months
4. Research and report false health economic data for different psychological interventions
5. Research and report false practice-based evidence i.e. what works in practice (including relapse rates)
6. Receive feedback from the Appreciative Inquiry
7. Have forum to share best practice
8. Feedback on assessment to referrers
9. Measure and report outcomes
10. Ensure work environment increases staff interaction
11. Give us named admin support
12. Reduce admin tasks for clinicians – conduct a clinical and admin time capacity review
13. Update Athena page
14. 2 workshops a year
15. Allow for time out for team and service improvement planning
16. Measure staff well being and monitor annually
17. Develop a strategy a) for the service
    b) for the Health Board/Partnership
18. Prioritise and have no waits for what is 'time-sensitive' e.g. early diagnosis in child and adult neuropsychological disorder
19. Ensure health promotional material available in all waiting areas
20. Review and analyse service performance, DCAQ
21. Don't fix what is not broken
22. Attend Psychiatric team meetings

Dreams/Steps/Destinies which need expansion

1. Improve working relationships with 3rd sector
2. Foster strong professional identity
3. Ensure best practice
4. Train others to develop skill mix
5. Develop resilience on communities and schools
6. Dedicate time to prevention and early intervention
7. Use Area Psychology Professional Committee to influence re psychological care and awareness across all services and in the public
8. Work closer with GP's

9. Access is central to seamless care
10. Develop specialist services
11. Develop resilience training in schools and colleges
12. Influence local media and social media
13. Manage service user expectations
14. Increase capacity in other services to provide low intensity interventions
15. Commitment to be involved in future developments within the team
16. Provide skilled early assessment
17. Enhance communication with referrers
18. More respectful/collaborative working with colleagues
19. Get to know primary care colleagues/GP's
20. Promote value of our supervision
21. Further explore other psychological interventions
22. Celebrate success
23. More time to talk and look after each other
24. Expand lead specialist from existing budgets
25. Influence distribution of funding within professional groups
26. Be actively involved in decisions which affect service

Psychological Services – Mapping & Modelling Work-stream
Open Space

There have been three open space events for Psychological Services to help the Mapping and Modelling work stream members to have a clear understanding of the services and consider areas for change. At each of the events the Head of Service presented an overview of their service and thereafter, the floor was open for participants to pose a question, make a comment and or an observation. These questions and comments enabled participants to engage in a group conversation around a topic of interest. The following is a summary of the output from these sessions.

Session Title: Clarity of Role

Convener(s): Janet & Michelle

Participants: Alan, Pamela, Craig, Michelle & Janet

Summary of Discussion:

- Utilising expertise appropriately especially at the stage of assessment
- Building a workforce model
- Interface between Mental Health, education and wider community
- Issue of role clarity, value and utilisation of different professional groups. E.g. CAAPS as experts
- Creation of child service, rather than distinct elements – effort to stop this viz Neurodevelopment pathway; positive, but not all parties involved

What will we do now? What needs to happen next?

- CAMHS and Community Paediatric, with Social Worker's, Educational psychologist co-located in one base
- An articulation of roles and expertise throughout teams
- Review CAMHS assessment stage and identify who contributes (role of CAAP's) and identify the level of expertise and further develop

Session Title: Quality Interventions and Quantity Interventions

Convener(s): Dale & Ruth

Participants: Morgan, Graham, Cathy, Laura, Thelma, John, Joan, Dale & Ruth

Summary of Discussion:

- Early interventions and prevention work - consideration of the development of a specified team
- Prioritising high clinical risks
- Assessment & treatment within a multi disciplinary team. More of a consulting role.
- A decision needs to be taken about where and how to record diagnosis, to ensure consistency across all teams

- Pressure to reduce time to diagnose (Neurodevelomental) – who can do what and who else might be involved?
- An analysis of exactly how much time is spent with people versus clinical personal and peer supervision - Time in motion study
- One stop clinics
- What do we stop doing?
- Managing & supporting people whilst on waiting lists

What will we do now? What needs to happen next?

- Consider self help information, with an electronic access to information
- Investment in supported self help – Includes peer led recovery; guided self help; self help workers similar to the PCMHT model
- Look at the oncology psychology service model to identify any learning
- Dedicated early intervention team
- Explore the feasibility of a time in motion study to ensue openness and transparency about activity levels in psychology and other services
- Drop in clinics – one stop shops
- Stop generic assessments
- Explore the feasibility of AHP support in teams
- Engage with other people around early intervention – Educational psychologists; HV's' AHP'S; Support Workers; Social Workers; Mental Health Workers
- Broaden supervision and support outwith NHS

Small test of change Proposals

Describe the What	How will this be achieved?	When?	Who?
• Articulation of roles and expertise throughout teams • Review CAMHS assessment stage and identify who contributes (role of CAP's) and identify the level of expertise and further develop	Workforce mapping – analysis of establishments, skill mix, Job roles & competencies	Within 2 weeks	Nicola Fraser, Carol Craig & Team Leaders
• Time in motion study to ensue openness and transparency about activity levels & demand & capacity in psychology and other services	Invite clinicians to complete an activity tracker over a 4 week period	1st – 30th June 2016	Alan James, Morgan MacPhail & Tommy Stevenson (Janet can provide a template used in Adult services)

Contributed to group: William Lauder; Thelma Bowers; Janet Davies; Karen Porter What is the name of this positive change?	That at all stages in the patient's journey through AMH that allocation to treatment waiting lists is based on (1) good quality information (2) consideration of psychological interventions as defined by the MATRIX (i.e. high volume interventions, low intensity interventions, high intensity interventions, highly specialist interventions)
What is the intended benefit?	Patients are matched to the appropriate psychological intervention to meet the difficulties that they are presenting with. Minimising patients experiencing poor journeys. Such as waiting for lengthy periods on a waiting list to receive a first appointment and then identified that transfer to a clinician providing a different psychological intervention is required. Or to be provided with a psychological intervention that is not matched to their presentation or is not of a sufficient therapeutic dose (e.g. complex trauma - anxiety management delivered in 8 session model when longer term engagement for this intervention would be required fit more CMHT nursing role).
Who is leading it?	When considering appropriate psychologically informed care for a patient psychology would have a key role (on occasion directly providing assessment but also within a consultancy role)
Who else is involved in making it happen?	MDT in AMH (PCMHT , CMHT, inpatient) – including Social work. Stakeholders beyond AMH e.g. Clinical Health, additions etc Health Improvement Scotland; Change Project
What are the key specific actions to take the positive change forward?	Critical to achieving this is: (1) Improving availability of Good Quality Information - suggestions for addressing limited referral information – triaging in GP practices; ICP completed by CMHT colleagues before consideration by psychology; more narrative assessments (completion of standardised ICP) (2) Improving Processes for Decision Making – suggestion assessments allocated via paper vetting to most appropriate team members (OT, nursing, psychology, psychiatry, social work). Standardised assessment carried out (ICP incorporate all areas of risk including if main carer child well-being) to ensure good quality information then assessor attend weekly MDT meeting to discuss evidence of suitability for what type of psychological intervention. Need for improved liaison between CMHT & PCMHT – particularly regarding who best placed to deliver high volume and low intensity interventions. (3) Availability of Psychological Interventions • that there is availability of all psychological interventions to allow Services to match patients to interventions (high volume to highly specialist) rather than to professional group. This would spotlight the limited provision of low intensity interventions in AMH and provide impetus to seeking solutions to considering the clinician's best placed to deliver low intensity psychological interventions.

	• sufficient availability of high intensity interventions so that patient can be stepped up if this is required and appropriate . • Recording of Delivery of Interventions- suggestion when appropriate training, supervision and protected time for delivery of LI interventions are in place (currently PCMHTs) then improve rate of recording when a low intensity intervention has been delivered. • Improve availability of supervision – when appropriate training has taken place and management agreement to substantive protected time to deliver psychological interventions consideration should be given to who best able to provide supervision. Role of NHS Ayrshire & Arran Psychological Therapies Training and Supervision Group as a central point for requests to be considered.
What are the timescales?	

What is the name of this positive change?	Psychology – data
What is the intended benefit?	1 – Service activity/management activity 2 – Annual activity meeting outcomes 3 – no outcome measures on system 4 – No agreed apps/web site resource for patients 5 – Poor feedback to GP/referrers/clients as not automatic
Who is leading it?	National MH KPI? Later IAP -> gap from where we are re audit and then benchmark via IAPs
Who else is involved in making it happen?	Clinical leads for each areas Morgan and Allan ?Gareth ISD data analyst, Amin, CAMHS, IT literacy
What are the key specific actions to take the positive change forward?	1 Psychology services need robust data – view current recording systems and where data comes from? Writing notes into Face from diaries is risky. 2 Review of paper to HSCP re data development system 3 ISD solutions in future re data analysts 4 Agree set up of apps/web resources 5 Review job plans so review of data/clinical needs are matched in new system
What are the timescales?	

What is the name of this positive change?	Clinical Health Early intervention/Assessment (within 3 weeks)
What is the intended benefit?	• Not sitting on waiting list inappropriately – redirect quickly. • Reduce stress on patients. • Generalise the learning for other Services.

Who is leading it?	All lead potential further change to generalise and implement the learning.
Who else is involved in making it happen?	• Liaison with referrers and onward connections. • Critical role of Administrative staff (who are not typists albeit they do type but this in many ways the least important aspect of their jobs).
What are the key specific actions to take the positive change forward?	• Plan time for change. • Set aside sufficient time for assessments. • Respect the specific skills and competencies of all Clinicians and understand the Third Sector. • Data. • Pathways.
What are the timescales?	2 years to establish change

Delivering care together

Psychological Services – Mapping & Modelling Work-stream
Open Space

There have been three open space events for Psychological Services to help the Mapping and Modelling work stream members to have a clear understanding of the services and consider areas for change. At each of the events the Head of Service presented an overview of their service and thereafter, the floor was open for participants to pose a question, make a comment and or an observation. These questions and comments enabled participants to engage in a group conversation around a topic of interest.
The following is a summary of the output from these sessions.
No tests of change were identified for Learning Disabilities Service

Test of change Proposals: CAMHs and Community Paediatrics

What is the name of this positive change?	**Articulation of roles and expertise throughout teams**
What is the intended benefit?	Workforce mapping – analysis of establishments, skill mix, Job roles & competencies
Who is leading it?	Carol Craig & Team Leaders (Group Participants: Alan, Pamela, Craig, Michelle & Janet)
Who else is involved in making it happen?	• Building a workforce model which meets patient needs and manages demand • Utilising expertise appropriately especially at the stage of assessment • Interface between Mental Health, education and wider community • Issue of role clarity, value and utilisation of different professional groups. E.g. CAAPS as experts • Creation of child service, rather than distinct elements – effort to stop this viz Neurodevelopment pathway; positive, but not all parties involved
What are the key specific actions to take the positive change forward?	• CAMHS and Community Paediatric, with Social Worker's, Educational psychologist co-located in one base • An articulation of roles and expertise throughout teams
What are the timescales?	October 2016

What is the name of this positive change?	**Review CAMHS assessment stage and identify who contributes (role of CAP's) and identify the level of expertise and further develop**
What is the intended benefit?	Assessment Process Mapping – analysis of process, times staff establishments, skill mix, Job roles & competencies
Who is leading it?	Alan James, Morgan MacPhail & Tommy Stevenson

	(Janet can provide a template used in Adult services)
Who else is involved in making it happen?	• Service Improvement • Building a workforce model • Utilising expertise appropriately especially at the stage of assessment • Interface between Mental Health, education and wider community • Issue of role clarity, value and utilisation of different professional groups. E.g. CAAPS as experts • Creation of child service, rather than distinct elements – effort to stop this viz Neurodevelopment pathway; positive, but not all parties involved
What are the key specific actions to take the positive change forward?	• Review CAMHS assessment stage and identify who contributes (role of CAAP's) and identify the level of expertise and further develop • Findings influence the workforce modelling work
What are the timescales?	October 2016

What is the name of this positive change?	**Quality Interventions and Quantity Interventions**
What is the intended benefit?	Time in motion study to ensue openness and transparency about activity levels & demand & capacity in psychology and other services
Who is leading it?	Dale & Ruth (Group Participants Morgan, Graham, Cathy, Laura, Thelma, John, Joan, Dale & Ruth)
Who else is involved in making it happen?	• Service Improvement • Building a workforce model • Interface between Mental Health, education and wider community • Issue of role clarity, value and utilisation of different professional groups. E.g. CAAPS as experts • Creation of child service, rather than distinct elements – effort to stop this viz Neurodevelopment pathway; positive, but not all parties involved
What are the key specific actions to take the positive change forward?	• Invite clinicians to complete an activity tracker over a 4 week period • Consider self-help information, with an electronic access to information • Investment in supported self-help – Includes peer led recovery; guided self-help; self-help workers similar to the PCMHT model • Look at the oncology psychology service model to identify any learning • Dedicated early intervention team

	• Explore the feasibility of a time in motion study to ensue openness and transparency about activity levels in psychology and other services • Drop in clinics – one stop shops • Stop generic assessments • Explore the feasibility of AHP support in teams • Engage with other people around early intervention – Educational psychologists; HV's' AHP'S; Support Workers; Social Workers; Mental Health Workers • Broaden supervision and support outwith NHS
What are the timescales?	1st August -31st August

Test of change Proposals: Primary Care

What is the name of this positive change?	Early intervention/Assessment process review (within 3 weeks) to reduce resource pressures and long waits
What is the intended benefit?	• Clarify role of PCMH • Clarify referral criteria • Clarify assessment process • Not sitting on waiting list inappropriately – redirect quickly. • Reduce stress on patients. • Generalise the learning for other Services.
Who is leading it?	Janet - All lead potential further change to generalise and implement the learning.
Who else is involved in making it happen?	• Liaison with referrers and onward connections. • Test opt-in model • Tests specialist input at assessment phase and assess impact on treatment phase • Test Triage model • Critical role of Administrative staff (who are not typists albeit they do type but this in many ways the least important aspect of their jobs).
What are the key specific actions to take the positive change forward?	• Plan time for change. • Set aside sufficient time for assessments. • Respect the specific skills and competencies of all Clinicians and understand the Third Sector. • Data. • Pathways. • Build resilience, engagement and recovery models
What are the timescales?	3 week test and approx. 2 years to establish change

What is the name of this positive change? Contributed to group: William Lauder; Thelma Bowers; Janet Davies; Karen Porter	That at all stages in the patient's journey through AMH that allocation to treatment waiting lists is based on (1) good quality information (2) consideration of psychological interventions as defined by the MATRIX (i.e. high volume interventions, low intensity interventions, high intensity interventions, highly specialist interventions)
What is the intended benefit?	Patients are matched to the appropriate psychological intervention to meet the difficulties that they are presenting with. Minimising patients experiencing poor journeys. Such as waiting for lengthy periods on a waiting list to receive a first appointment and then identified that transfer to a clinician providing a different psychological intervention is required. Or to be provided with a psychological intervention that is not matched to their presentation or is not of a sufficient therapeutic dose (e.g. complex trauma - anxiety management delivered in 8 session model when longer term engagement for this intervention would be required fit more CMHT nursing role).
Who is leading it?	When considering appropriate psychologically informed care for a patient psychology would have a key role (on occasion directly providing assessment but also within a consultancy role)
Who else is involved in making it happen?	MDT in AMH (PCMHT , CMHT, inpatient) – including Social work. Stakeholders beyond AMH e.g. Clinical Health, additions etc Health Improvement Scotland; Change Project
What are the key specific actions to take the positive change forward?	Critical to achieving this is: (1) Improving availability of Good Quality Information - suggestions for addressing limited referral information – triaging in GP practices; ICP completed by CMHT colleagues before consideration by psychology; more narrative assessments (completion of standardised ICP) (2) Improving Processes for Decision Making – suggestion assessments allocated via paper vetting to most appropriate team members (OT, nursing, psychology, psychiatry, social work). Standardised assessment carried out (ICP incorporate all areas of risk including if main carer child well-being) to ensure good quality information then assessor attend weekly MDT meeting to discuss evidence of suitability for what type of psychological intervention. Need for improved liaison between CMHT & PCMHT – particularly regarding who best placed to deliver high volume and low intensity interventions. (3) Availability of Psychological Interventions • that there is availability of all psychological interventions to allow Services to match patients to interventions (high volume to highly specialist) rather than to professional group. This would spotlight the limited provision of low intensity interventions in AMH and provide impetus to seeking

	solutions to considering the clinician's best placed to deliver low intensity psychological interventions. • Sufficient availability of high intensity interventions so that patient can be stepped up if this is required and appropriate. • Recording of Delivery of Interventions- suggestion when appropriate training, supervision and protected time for delivery of LI interventions are in place (currently PCMHTs) then improve rate of recording when a low intensity intervention has been delivered. • Improve availability of supervision – when appropriate training has taken place and management agreement to substantive protected time to deliver psychological interventions consideration should be given to who best able to provide supervision. Role of NHS Ayrshire & Arran Psychological Therapies Training and Supervision Group as a central point for requests to be considered.
What are the timescales?	August 2016

What is the name of this positive change?	Psychology data system development
What is the intended benefit?	1 – Service activity/management activity known 2 – Annual activity meeting outcomes known 3 – no outcome measures on system known 4 – No agreed apps/web site resource for patients known 5 – Poor feedback to GP/referrers/clients as not automatic known
Who is leading it?	Mark Fleming (National MH KPI support at a later stage to be confirmed)
Who else is involved in making it happen?	Clinical leads for each areas Morgan and Allan Possibly Gareth ISD data analyst, Amin, CAMHS, IT literacy
What are the key specific actions to take the positive change forward?	1 Psychology services need robust data – view current recording systems and where data comes from? Writing notes into Face from diaries is risky. 2 Review of paper to HSCP re data development system 3 ISD solutions in future re data analysts 4 Agree set up of apps/web resources 5 Review job plans so review of data/clinical needs are matched in new system
What are the timescales?	Review commence November 2016

Test of change – Specialist services

What is the name of this positive change?	Clinical Health Early intervention/Assessment (within 3 weeks)
What is the intended benefit?	• Not sitting on waiting list inappropriately – redirect quickly. • Reduce stress on patients. • Generalise the learning for other Services.
Who is leading it?	All leads- potential further change to generalise and implement the learning.
Who else is involved in making it happen?	• Liaison with referrers and onward connections. • Critical role of Administrative staff (who are not typists albeit they do type but this in many ways the least important aspect of their jobs).
What are the key specific actions to take the positive change forward?	• Plan time for change. • Set aside sufficient time for assessments. • Respect the specific skills and competencies of all Clinicians and understand the Third Sector. • Data. • Pathways.
What are the timescales?	2 years to establish change

North Ayrshire Health and Social Care Partnership Change Team

Stakeholder Review for Psychological Services

Report Author: John Burns, Evaluation Officer, Change and Improvement Team, North Ayrshire Health and Social Care Partnership

Date: August 2016

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Acknowledgements

This report has only been possible due to the participation of Psychological Services and their willingness to undertake such a stakeholder review, and the many stakeholders willing to take the time to participate.

The North Ayrshire Health and Social Care Partnership Change and Improvement Team would like to extend its thanks to Cathy Kyle, Clinical Director of Psychological Services, and her Executive Management Team for their support in identification of and communication to stakeholders about this exercise, and to all of the stakeholder groups for taking the time to share their expertise and experience.

As is often the case with these reports, it is intended to inform change. We hope the information herein reflects the views expressed by the many stakeholders and goes on to provide evidence to facilitate the ongoing delivery of quality services where this is indeed working well, and to identify and inform areas for development with the findings suggesting many of which can and should be done in collaboration between Psychological Services and their stakeholders.

John Burns, Evaluation Officer, HSCP Change and Improvement Team

Executive Summary

Background

Psychological Services in Ayrshire and Arran are currently managed and delivered on a pan Ayrshire basis. They provide specialist psychological services to the population of Ayrshire and Arran across the whole age-range and within both mental health and physical health services. All activities are performed in accordance with the prevailing evidence base and aim to reduce distress/disorder and to enhance the psychological and physical wellbeing of patients, families, carers and staff.

Psychological Services currently report against a HEAT standard of 18 weeks from referral to treatment. As with many services demand has gone up with now subsequent increase in staffing, leading to a need to review the way in which the services are delivered.

As part of a review of Psychological Services, it was agreed that stakeholders' views on how they currently experience the service would be essential in considering how the service might be improved. This report details the findings of a stakeholder review undertaken by the North Ayrshire Health and Social Care Partnership Change and Improvement Team on behalf of Psychological Services.

The NA Change and Improvement Team would like to thank Psychological Services for their support throughout and to the stakeholders who took the time to provide their views.

Approach

The Change and Improvement Team consulted with the Clinical Director, Psychological Services, to consider the approaches available to them to consult with their stakeholders. A survey methodology was chosen to provide qualitative and quantitative data to be collected; this provides measurements to be taken and baselines to be set as well as providing narrative and richer information to explain why respondents may have answered in a particular way.

Targeted and snowball sampling strategies were employed whereby an initial list of 164 stakeholders were identified by Psychological Services and were sent the link to the online survey. Each stakeholder was asked if they could cascade the link to any other relevant stakeholders. Whilst this approach sacrifices the ability to provide a response rate, with the eventual sample size remaining unknown, this was felt to be worthwhile in order to invite as many stakeholders as possible to participate. The survey received 83 responses.

Analysis of the findings was undertaken by the Change and Improvement Team and highlighted a number of themes and perspectives. With Psychological Services being a disparate service, it is was not unexpected to find contradictory views, for example, where

something is going well in one part of the service delivery, the same thing might not be working well, or even occurring, in another part of the service. Despite this, some key themes emerged in relation to:

1) How contact with the service is organised

2) Joint working

3) Knowledge of Psychological Services

4) Experiences of staff and the delivery/receipt of services

Stakeholders were asked where they think Psychological Services work well and where there may be areas for improvement. Direct statements are used to corroborate points made throughout the report.

Findings

What is working well:

Psychological Services appear to have a strong foundation to build upon with a number of areas highlighted as strengths and working well either for stakeholders or for patients, and include:

- Almost all participants, where apt, reportedly knew how to make a referral (92.77%).
- Almost 41% of respondents noted that they were either satisfied or very satisfied with the levels of joint working between their service and PS.
- Appetite for change and opportunities to improve services exist based on respondents' feedback and hope for change.
- The majority of respondents reported their knowledge of PS services available to patients as good or excellent with another 35% describing it as average.
- Staff have been reported as being open and honest, treating patients with dignity and respect, are skilled and competent and deliver a service valued by service users.

Areas for development:

The following areas are more important/emphasised by stakeholder with experience of certain parts of Psychological Services and the report includes detail on this. Nevertheless, most of these points were raised by most of the stakeholders thus warranting their inclusion.

- Feedback on referrals could be improved. If the aspiration is to provide feedback to referrers on all referrals received (and this could vary from confirming referral has been received through to how the referral has progressed, and would depend heavily on the case and referrer) then there is some way to go. Less than half (42.17%) of referrers reported that they always received feedback.

- Despite knowing how to make a referral, referral guidelines were noted as requiring improvement. Some stakeholders reported being unclear about when a patient is deemed 'appropriate'. Clarity around this would perhaps increase appropriate referrals and thus reduce the time and resource implications of inappropriate referrals.
- Joint working is an area identified by stakeholders as an area requiring improvement. Those identifying as neither satisfied nor dissatisfied, dissatisfied or very dissatisfied were spread across Psychological Services and across localities.
- Stakeholders are unaware of the outcomes Psychological Services work towards and deliver for patients.
- Respondents infer that Psychological Services, in some instances, have become insular and distant, that it is often too complicated to make a referral, where the criteria is inconsistent, decision making is hidden and inconsistent, and outcomes too rarely communicated clearly to patients and referrers.

Conclusion

Psychological Services in Ayrshire and Arran are clearly valued; stakeholders have given their time and expertise to help provide insight into what is working well and areas to be considered for development.

This report provides a time-limited perspective, a snap-shot of stakeholder views and suggestions. It would be prudent for Psychological Services to take cognisance of stakeholder views, particularly in any review of how services are to be configured and delivered, and with increasing emphasis on partnership working.

A comparative analysis is proposed whereby stakeholder views will be collated and assessed in due course to allow Psychological Services to undertake a review and implement any changes before revisiting stakeholder views.

1. Introduction

1.1 The North Ayrshire Health and Social Care Partnership (NAHSCP) is undertaking an ambitious programme of change in line with the introduction of The Public Bodies (Joint Working) (Scotland) Act which came in to effect on 2nd April 2014 and sets the legislative context for the integration of NHS and Local Authority community based services in Scotland.

1.2 Psychological Services (PS) are provided across Ayrshire and Arran and are embedded within various specialist teams. PS deploy a range of staff within these specialist roles to undertake focused work.

1.3 The NAHSCP has created a Change and Improvement Team designed to support services undertake work in relation to integration and service redesign. This team was asked to facilitate the stakeholder review on behalf of PS. Working in collaboration with the Clinical Director and their Executive Team, a stakeholder list was created to encompass as many PS stakeholders as possible. The most basic definition of a 'stakeholder' was those who refer in and work jointly with PS.

1.4 A combined sampling strategy of targeted and snowballing was used which involved creating an initial stakeholder list of 164 participants with these individuals asked to cascade to other stakeholders they thought appropriate. An online survey methodology was adopted to collate qualitative and quantitative data on their views and experiences of PS in Ayrshire. A copy of the survey is attached as Appendix 2.

1.5 83 responses were received with the survey open for 3 weeks between July 11th and August 1st 2016. Although initially intended to be available for 2 weeks, 3 weeks was felt to be more appropriate due to the expectation that people may be on summer leave.

1.6 The following report provides analysis of the responses from stakeholders; scaled responses are reported in absolutes and percentages. Narrative responses were analysed to highlight any recurring themes. The service being commented upon and the locality from which the respondent worked is noted in parenthesis next to their comment.

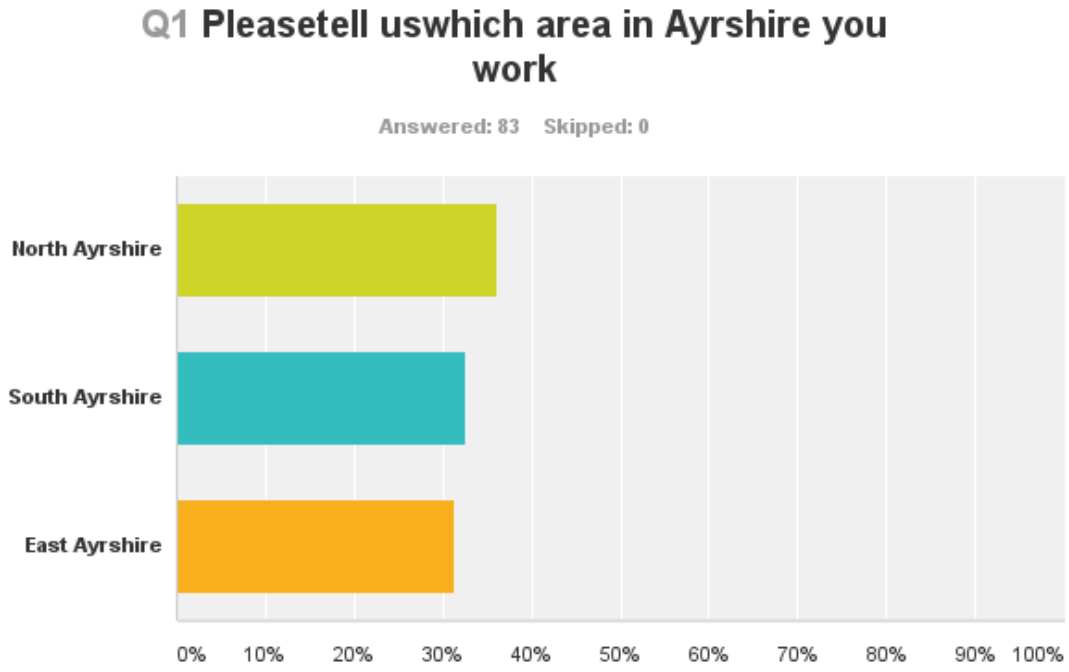
1.7 Whilst such analysis can never capture all the comments made from such a broad spectrum of stakeholders, there were a number of themes which emerged consistently across the stakeholder groups. Direct quotations are provided as corroboration and evidence for points made throughout this report.

2. Stakeholder Roles and Frequency of Contact

2.1 Initial questions sought to establish which locality participants worked in Ayrshire, which organisation and department they worked within and their designation. Almost all participants provided this information with one participant omitting their job role.

2.2 An almost equal spread of participants reported that they worked within each locality with 30 (36.14%) from North, 27 (32.53%) from South and 26 (31.33%) from East. It should be noted that a flaw in the survey design was that some respondents work across Ayrshire and, as this was not an option, would have had to choose one of the three. It is a relatively safe assumption that they would have however opted for the one with which they have most contact/deliver most frequently.

Graph 1. Locality of participants.



2.3 The 83 respondents worked across a variety of services including:

- General Practice (16)
- Children and Adolescent Mental Health (CAMHS: 8)
- Primary Community Mental Health (7)
- Paediatrics (6)
- Educational Psychology (6)
- Community Mental Health (5)
- Learning Disability (5)
- Various others including Education and Youth Employment, Cardiology and 'NHS'.

2.4 The job roles reported included: Charge Nurse, Community Psychiatric Nurse, GP, Social Worker, Consultant Psychiatrist, Occupational Therapist, Acting Head Teacher, Educational Psychologist, Advocacy Worker, Team Leader, Team Manager, Service Manager and Senior Manager amongst others.

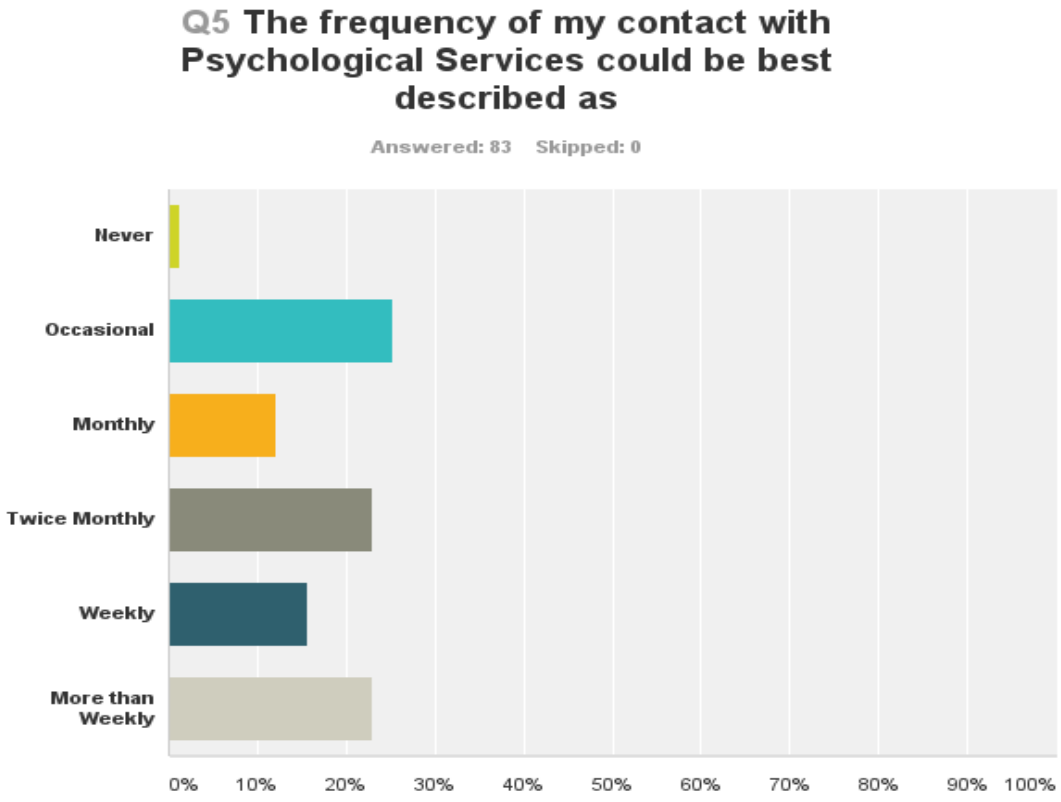
2.5 The areas of Psychological Services with which the participants come into contact include:

- CAMHS
- CMHT
- PCMHT
- Learning Disability (community)
- Children Services Community Paediatrics
- Children Services Medical Paediatrics
- Learning Disabilities (other)
- Older Adult MHS (community)
- Adult MHS Inpatient Non Acute
- Learning Disabilities Inpatient
- Adult MH Inpatient Acute
- Older Adult Services (other)
- Coronary Heart Disease
- Others reporting 'multiple contacts' or 'contact across Psychological Services'

2.6 It should be noted that a) respondents only commented on the aforementioned and therefore this report only has bearing on these services and b) CAMHS staff who responded to the survey include staff (with roles such as Charge Nurse, OT and Psychiatrist) who, although based within CAMHS, are required to make referrals to CAMHS akin to external agencies and so are included within the definition of 'stakeholder' for the purposes of this report.

2.7 The 83 respondents noted their contact with PS to vary from never (1/1.20%) through to more than weekly (19/22.89%). Graph 2 shows the range of contact frequency.

Graph 2. Contact Frequency.



3. Referrals and Joint Working

3.1 A strong majority of participants reported that they know how to make a referral to PS with 77 (92.77%) answering in the affirmative whilst 5 (6.02%) respondents answered that they didn't and 1 said this was not applicable.

3.2 Feedback in relation to referrals made to PS was variable with 35 (42.17%) participants saying the always received feedback, 23 (27.71%) said frequently, 12 (14.46%) infrequently and 3 (3.61%) never. 10 (12.05%) participants believed this was not applicable; somewhat of an anomaly given only 1 participant previously said making a referral was not applicable, inferring 9 don't believe feedback on referrals is applicable to them.

3.3 Twenty comments were made in this area. A simplistic four tier analysis allows each comment to be categorised as positive, ambivalent/mixed e.g. 'feedback is good but takes a long time', negative and not applicable. The analysis of the 20 comments for the feedback

on referrals showed 4 positive, 6 ambivalent, 7 negative and 3 not applicable. A positive comment includes,

"Excellent communication with the team at the North west centre" (CAMHS, East Ayrshire)

Whilst others highlighted difficulties,

"This (feedback) would be helpful but is never delivered" (PCMHT, North Ayrshire)

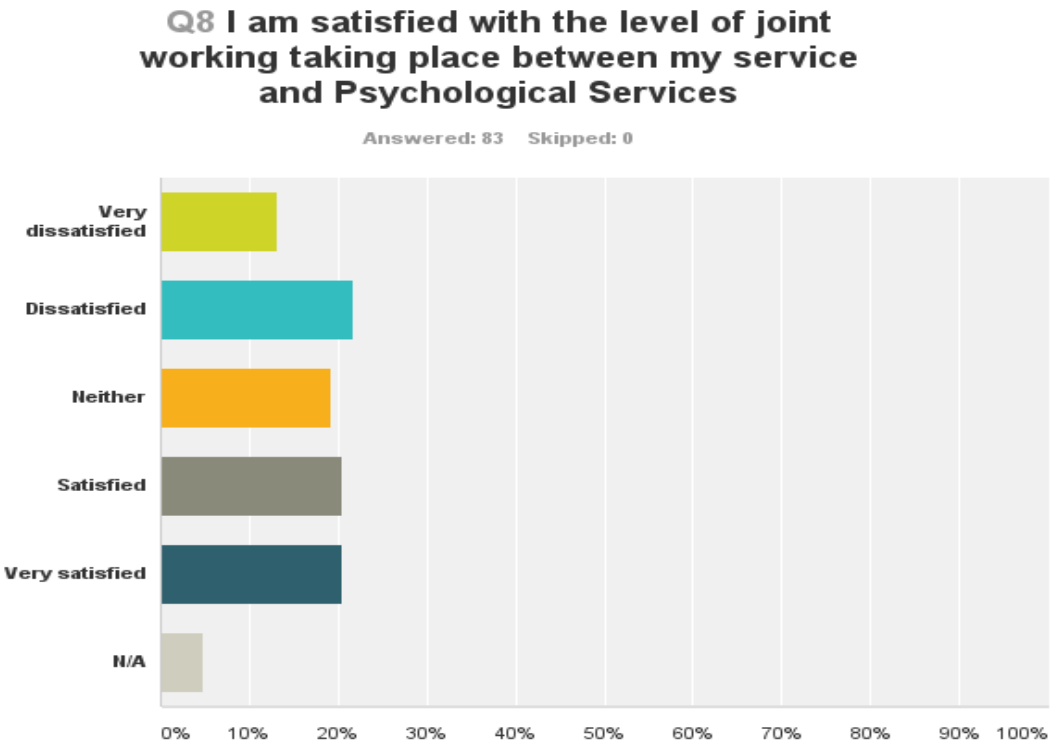
"We receive the usual letters that patient did not contact in e.g. 14 days which in a vast variety of cases is a symptom of their problems in general…I received the guidelines as to which areas they (CAMHS) cover…and…just looking at the guidelines highlighted to me that CAMHS are not playing by their own rules!!" (Across PS, East Ayrshire)

"(I) Get feedback on referrals not accepted. Have given feedback that I do not agree, that reason for not taking are inconsistent and appear to be waiting times related at times. Do not agree with stepping down to PCMHT complex referrals because the patients' suitability needs to be tested out at low intensity level." (CMHT, North Ayrshire).

"Time between referral and feedback is very lengthy" (Older Adults MHS Community, South Ayrshire).

3.4 The next question focused on joint working with graph 3 depicting the results.

Graph 3 – Levels of satisfaction with joint working.



3.5 Graph 3 shows 17 (20.48%) were very satisfied with another 17% reporting satisfied. This leaves a majority reporting they were neither satisfied nor dissatisfied (16/19.28%), dissatisfied (18/21.69%) or very dissatisfied (11/13.25%). Four respondents answered 'not applicable'.

3.6 Closer analysis shows those who were either dissatisfied or very dissatisfied (29 respondents) work in North (12 respondents), East (9) and South (8) and have contact with the following services: CAMHS (10), PCMHT (5), CMHT (4), Children's Services Community Paeds (3), Other (3 – who reported contact across PS), Learning Disability Community (2), Adult Mental Health Inpatients Non Acute (1) and Older Adult Mental Health Services Community (1). An additional observation is that 46% of those dissatisfied or very dissatisfied had weekly or more than weekly contact with PS.

3.7 Analysis of the 25 comments in this section showed a more complex picture than Graph 3 suggests. There were no positive comments regarding joint working; any positive comments were tapered by a 'but' or 'needs to improve' and so can be considered ambivalent/mixed with 9 such comments whilst 16 can be categorised as negative/critical. It should be noted that within the comments there was a suggestion that better resourcing/deployment of PS could improve joint working. Comments from this section include:

"Little joint working in marked contrast to my experiences elsewhere. Never see a psychologist and communication is by letter" (CMHT, East Ayrshire)

"Some individual clinicians work very well in a joint way, others do not, giving an overall sense of dissatisfaction" (CAMHS, South Ayrshire)

"Lack of capacity within Psychology Services adversely affects service and leads to lower referral rates and joint working, supervision of staff undertaking formal interventions" (Across PS, North Ayrshire)

"I feel this is not any particular service's fault, but perhaps a lack of good 'joint working' on the fault of both parties. More understanding of each other's roles is required for better services for children and families" (Children's Community Services, Paeds, North Ayrshire)

"'Wash my hands of it' approach rather than proper liaison with other services is scandalous: it is their duty to make sure that alternative available rather than their usual, education/ SW problem: most have been there and done that!" (Across PS, East Ayrshire)

3.8 Whilst the comments above suggest experience of contact with PS could be improved, when participants were asked whether they thought their contact with PS worked well, the majority (61/73.49%) reported 'yes' and 22 (26.51%) said 'no'. Despite this, when asked 'If applicable, do you have any suggestions as to how to improve your contact with Psychological Services?' 49 respondents left comments.

3.9 The comments of the 49 respondents can be categorised into 4 themes (where 2 or more respondents highlighted the same area) including service/staff configuration and deployment (20), reducing waiting times (11), increasing staff numbers (6), and information sharing (2).

3.9.1 'Configuration and deployment' involves the opportunities for development of the role PS staff play within teams; their accessibility, participation within multidisciplinary teams and assessments and general integration within teams, role clarity and consistency were reported by respondents as areas which would improve their contact with PS. Comments included:

"There is a distance between psychology and all other disciplines. Some clinicians are hard to approach. To discuss cases (not specifically for referral) you have to book a slot that may be weeks in advance which can feel very formal. Closer joint working would encourage better relationships" (CAMHS, South Ayrshire)

"Broadly it is okay but would say Psychology is now a team within a team…and is gradually creating more barriers to referral…working as a team has always been a challenge but staff are increasingly moving away from being active team members…" (CMHT, North Ayrshire)

"It would be helpful to have more input at MDT meetings" (Older Adults MHS Community, South Ayrshire)

"Operational management should sit within the relevant specialties and services. In no way should this compromise professional identity, but professional needs should be balanced against service strategy" (CAMHS, North Ayrshire)

"Making themselves more team focused and less defensive" (CAMHS, North Ayrshire)

"Joint screening of referrals" (PCMHT, East Ayrshire).

3.9.2 These suggestions for improvement, particularly around closer integration and joint working demonstrates an appetite in partners for closer collaboration. This report recommends such opportunities be thoroughly examined during the consideration and implementation of any new models of PS delivery. Governance and line management undoubtedly requires to be considered and there should be no 'trade-off' between maintaining professional integrity and standards (e.g. supervision) and becoming more integrated within teams, participating in multidisciplinary screening and assessment/closer joint working, as these are not mutually exclusive concepts.

4. Stakeholder Knowledge of Psychological Services

4.1 This part of the survey queried participants knowledge of PS by asking how they would rate their knowledge, whether they were confident in their ability to explain services

offered by PS to patients prior to referring, whether they were aware of the outcomes PS works to deliver and, if applicable, what would help to improve and/or sustain their knowledge of PS.

4.2 The majority of participants (50/60.24%) ranked their knowledge of PS as good or excellent with 29 (34.94%) describing it as average and 4 (4.82%) reporting as poor. Whilst 9 respondents said it was 'N/A' whether they were confident in explaining the services offered by PS to patients prior to referring, 78.74% (54) of the remaining number (74) said they were confident and more than a fifth (21.62%) said they were not confident.

4.3 Despite almost 80% of respondents reporting that they were confident to describe the services available to patients via PS, the intended outcome of interventions were not reported to be as clear to as many; 33 (39.76%) of respondents said that they did not know what outcomes PS work towards delivering whilst 50 (60.24%) said that they do.

4.4 In terms of how knowledge could be sustained and/or improved, participants were asked to consider options (and were able to select more than one) including a leaflet (48/57.83%), annual report (24/28.92%), shadowing opportunities (32/38.55%) and/or annual presentation (35/42.17%).

4.5 24 comments were provided by respondents for this section. With clear overlap between knowledge of the service and 'what would improve contact' question above, the majority of comments revolved around transparency and joint working with a small hand-full highlighting a perceived lack of patient information leaflets/sheets/literature explaining the services available. Respondents infer that PS in some instances have become insular and distant, that it is often too complicated to make a referral, where the criteria is inconsistent, decision making is hidden and outcomes too rarely communicated clearly to patients and referrers. Comments from this section include,

"A consistent approach and response to questions previously made about specific areas of each department. Boundaries become blurred, which appears to us an attempt to avoid seeing referrals." (Across PS, South Ayrshire)

"Agreed criteria for assessment and treatment that are not interpreted differently. It is the shifting of opinions and referrals being treated differently that make me less confident about referring" (PCMHT, North Ayrshire)

"Transparency during daily working" (CAMHS, North Ayrshire)

"In service training for staff on eligibility criteria for psychology to increase access for our patients" (PCMHT, East Ayrshire)

"An information sheet about what interventions are offered and at what level would be really helpful to know when it is appropriate to refer" (CAMHS, South Ayrshire)

4.6 Despite this, or perhaps because of this, time and again, respondents are petitioning for opportunities to close gaps and reduce barriers, to disambiguate a situation that appears to have created both confused and confusing service delivery, for example,

“More joined up continuous working to discuss the needs of children and families and how we can effectively meet those together - sharing evaluations with one another and making changes effectively” (Children’s Services Community Paeds, North Ayrshire)

“Joint meetings to improve understanding of each other's models of work” (CAMHS, North Ayrshire)

5. Perceptions and Experience of Psychological Services Staff

5.1 Table 1 provides an indication of respondents’ views on their perceptions and experience of PS staff across a number of measures. Some key points are noted below.

Table 1 – Perceptions and Experience of PS Staff

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree	Total
1. The aims and objectives of psychological services are clear	4.88% 4	15.85% 13	31.71% 26	**39.02%** **32**	8.54% 7	82
2. Arrangements for information sharing are effective	7.23% 6	19.28% 16	22.89% 19	**38.55%** **32**	12.05% 10	83
3. Communication between my service and psychological services is effective	7.23% 6	9.64% 8	22.89% 19	**43.37%** **36**	16.87% 14	83
4. Decisions about treatment appear consistent within the service	6.17% 5	13.58% 11	**35.80%** **29**	32.10% 26	12.35% 10	81
5. Staff are caring and compassionate	1.25% 1	1.25% 1	13.75% 11	**58.75%** **47**	25.00% 20	80
6. Staff treat service users with dignity and respect	0.00% 0	0.00% 0	16.88% 13	**53.25%** **41**	29.87% 23	77
7. Staff are open and honest	0.00% 0	3.80% 3	13.92% 11	**58.23%** **46**	24.05% 19	79
8. The services delivers positive outcomes	1.27% 1	11.39% 9	30.38% 24	**35.44%** **28**	21.52% 17	79
9. Staff are skilled and competent	0.00% 0	0.00% 0	18.42% 14	**55.26%** **42**	26.32% 20	76
10. Staff offer my service adequate training, supervision and consultancy in psychological matters	3.70% 3	23.46% 19	28.40% 23	**34.57%** **28**	9.88% 8	81
11. There are sufficient staff to meet my referral needs	17.28% 14	**33.33%** **27**	30.86% 25	13.58% 11	4.94% 4	81
12. Psychological services understand my primary service user groups' needs	6.33% 5	21.52% 17	24.05% 19	**34.18%** **27**	13.92% 11	79
13. Psychological services responds well to crisis situations	17.50% 14	22.50% 18	**23.75%** **19**	**23.75%** **19**	12.50% 10	80
14. I think service users value the service	1.27% 1	5.06% 4	27.85% 22	**46.84%** **37**	18.99% 15	79
15. I think colleagues value the service	3.75% 3	7.50% 6	18.75% 15	**50.00%** **40**	20.00% 16	80
16. If I experienced a related problem I would be confident in the support I would receive if I attended the service	3.80% 3	15.19% 12	27.85% 22	**37.97%** **30**	15.19% 12	79

5.2 On the whole, respondents appear to have positive perceptions and experiences of PS staff with the emboldened figures (showing the highest number – but not the majority) almost always falling on the affirmative side. The exceptions to this are questions 4, 11 and 13 which pertain to consistent decision making (Q4.), staffing levels/deployment (Q11) and responding to crises (Q13).

5.3 Question 11 is the only question where the highest number of respondents disagreed with the statement that there were sufficient staff to meet their referral needs. Questions 4 and 11 were where the highest number of respondents opted for the neither agree nor disagree option (and where it was joint first with 'agree' in question 13).

6. Final Comments

6.1 Respondents were asked in the final section if they thought anything was working particularly well and if they felt there were any specific areas for improvement. 56 respondents identified things which worked well whilst 61 reported areas they felt required development. The following section considers these statements.

Areas working well

6.2 Although 56 respondents made comment, some were inappropriate for this section e.g. they spoke only about areas for improvement or they said 'not applicable'. Of the remainder there were some comments which appeared only once, for example one respondent noted a quick turnaround from referral to treatment whilst another commented that a consistent approach tends to be applied.

6.3 These outliers were not able to be themed; the analysis sought examples of where the same or similar area was repeatedly identified. This led to the identification of 'joint/integrated working' (14 comments), 'feedback/communication' (11), 'quality of service' (8), 'assessments' (6), 'competency' (5) and 'supervision' (3).

6.4 **Joint** or **integrated working** was the most frequently identified theme, identified by 14 respondents as something which works well. Respondents identified integrated working as something that works well through comments such as

"Being part of the team makes the process slicker" (Coronary Heart Disease, North Ayrshire)

"Co-location and ability to discuss cases informally when required. Opportunities for psychologists to guide support staff in providing an appropriate support plan" (Learning Disabilities Community, East Ayrshire)

"Integration with community teams" (Older Adult MHS Community, South Ayrshire)

"When we had a psychologist working within the diabetes service, they were very much part of the 'Diabetes team' helping to support and shape the service we had" (Children's Services Com Paeds, Pan Ayrshire).

6.5 These comments regarding integrated and joint working provide a sharp contrast to earlier comments from different stakeholders experiencing PS as insular and separate entities with both perspectives emphasising the importance of collaboration. This is highlighted further below.

6.6 **Feedback/communication** was identified as something that is working well be 11 respondents, and comments included,

"Communication is good, plans are clear" (Learning Disability Community, South Ayrshire)

"Communication and sharing information" (Learning Disability Community, East Ayrshire)

"Communication and number of patients being assessed has increased" (CMHT, North Ayrshire)

"Face to face interaction in clinical areas" (Children's Services Medical Paeds, Pan Ayrshire)

6.7 The **quality of service** was identified as something working well by 8 respondents, and comments included,

"When patients are seen they get a good service" (Children's Services Com Paeds, Pan Ayrshire)

"They work well with the patient that they see and feedback is usually positive" (CMHT, East Ayrshire)

"When they get to be seen patients are usually satisfied and help by service" (CMHT, North Ayrshire)

"When links are well established to families" (CAMHS, North Ayrshire)

6.8 Six respondents highlighted **assessment** as being something they thought worked well. For example,

"Work well in relation to ASP and assessment of IQ and ability" (Learning Disability Communities, South Ayrshire),

"Neuro-psychological assessments within the community" (Older Adult Services Other, North Ayrshire)

While one respondent noted the assessment component worked well but how assessment outcomes are used requires improvement,

"The service has very good and varied Psychological assessment tests. But the feedback and the use of the test results in care planning needs work" (CAMHS, East Ayrshire)

6.9 Staff **competency** was identified by 5 respondents and, corroborating the feedback from the matrix above, comments included

"Staff have the skills and knowledge required" (CAMHS, North Ayrshire)

"As a professional group there are excellent and skilled individuals who work with complex groups and individuals" (CAMHS, North Ayrshire)

6.10 **Supervision** was the least frequently identified theme as something working well with 3 respondents making the following comments,

"Supervision / reflective practice sessions" (PCMHT, East Ayrshire)

"Clinical supervision and consultation" (CMHT, South Ayrshire)

Areas for development

6.11 The final question respondents were asked, 'In your opinion are there any areas requiring development?' was answered by 61 participants. Similarly to the approach taken in analysing the above, comments were analysed and themed. A number of comments appeared only once or were not specific and so cannot be considered 'themes' and include,

"Many areas require development" (Across PS, South Ayrshire)

"Easy read literature" ([unclear if this is for staff, patients or both] Learning Disability Community, South Ayrshire)

"I feel I often work with pt's I do not have the skills to deal with Psychologically as I have no specific certified CBT training despite asking for this repeatedly" (CMHT, North Ayrshire)

6.12 Other responses which could not be themed include two which noted 'none'/'none that I know of'.

6.13 Of the remaining 51 responses, 6 themes could be identified with a number of responses fitting more than one theme. The themes include: 'joint working' (22), 'increased availability' (16 comments), 'additional staff' (10), 'waiting times' (10), 'referral guidelines' (7), and 'patient pathways' (6). Although some of these overlap, they were expressed in different ways and are explored in more detail below.

6.14 **Joint working**, although highlighted by 14 respondents as working well, it was the most frequently reported area for improvement, cited by 22 respondents. 'Joint working' encapsulates areas such as role clarity; professional respect, courtesy and trust; collaborative/MDT approaches to screening and assessment and general integration (or lack thereof), and openness to change. Some of these barriers have been identified above when respondents described their contact with PS. It should be borne in mind is that stakeholders have demonstrated a willingness to engage with PS to improve and develop the areas identified. Comments in relation to joint working as an area requiring development include,

"Better understanding from both psychology and our service on roles and responsibilities to ensure improved MDT working" (CAMHS, South Ayrshire)

"Screening of referrals; psychology departments understanding of what Nursing staff do (and) nursing documentation and how this differs from psychology requirement. Discussion between psychology screening staff and nursing/consultants making referrals (and) joint decision making. Not judging from notes (and forming) an opinion on readiness to engage when a highly skilled clinician has already judged same in making a referral, and then not discussing subsequent decision to accept (or not) the referral with that clinician/patient" (CMHT, East Ayrshire)

"There are occasions patients need to be seen before decisions are made with regard to treatment. There is a widespread perception that more difficult patients are not seen by Psychological Services or they do not wish to help us with them. Often they will not be able to be taken on but a psychological formulation could be very helpful. This could assist clinicians greatly and lead to a better sense of sharing the clinical load" (CMHT, South Ayrshire)

"Joint screening of referrals may result in better outcome for patients and more balanced waiting lists" (PCMHT, South Ayrshire)

"CAMHS is in the process of significant transformation; some individual clinicians have demonstrated a real willingness to be part of team activity and also in innovative thinking however there is a sense that they are blocked by senior line management who focus on maintaining the status quo" (CAMHS, South Ayrshire)

"The division of psychology between CMHT/PCMHT. They should be the same service and the CBT waiting list should be a joint waiting list. The Psychology service continues to appear a separate and distant service from CMHT/ PCMHT" (PCMHT, North Ayrshire)

6.15 **Increased availability** discounted waiting times and staff numbers/configuration. Whilst linked in some ways, and also to the referral guidelines theme, the increased availability theme pertained to better use of the existing resources; strengthening where practice(s) are weak (e.g. GP referrals/opt in approaches/correspondence), reflecting on whether the service(s) is available when patients need it most (e.g. out of hours), and which

patient groups might need a service where there is none (e.g. addictions). The following comments from respondents were categorised within this theme:

“Increasing access-psychology staff being more willing to work with clients who are not totally stable and perhaps offer the safety/stabilisation work themselves” (PCMHT, East Ayrshire)

“There should be psychologists working in Addictions. There is also a lack of Psychology input in eating disorders - 2 sessions does not allow the Psychologist to operate as part of the CED team” (CMHT, East Ayrshire)

“Easier access to services, more advice on services available” (CAMHS, North Ayrshire)

“Emergency out of hours service there is none after 5pm I have had to attend A & E with a child as there is no outreach / emergency service for children. A 5 hr wait at A & E for an adult services to respond form North Ayrshire ... not adequate service” (CAMHS, East Ayrshire)

6.16 **Additional staff**, identified by 10 respondents, has been themed separately from waiting times and availability because, although inextricably linked, there are two important points to be made here. The first is around retention and recruitment which comments below highlight. The second point is that for external agencies referring into PS, it may appear that there is not enough staff to resource the demand. However, consideration must be given to how staff are configured and deployed. Previous comments about opportunities for joint working and making PS delivery more efficient may mitigate for what respondents think is a staff numbers issue. In all likelihood, an approach that takes cognisance of both perspectives may be required. This is discussed below. Comments regarding additional staff include,

“Staff retention- patients often frustrated that same clinician not available to complete their treatment” (PCMHT, South Ayrshire)

“I do not think at present the service delivers positive outcomes in enough cases due to lack of available appointments and ever changing staff. We have had families see 3 different psychologists over 3 appointments” (Children’s Services, Community Paeds, Pan Ayrshire)

“Making sure that vacancies are filled in a timely manner, and appreciating that continuity is important especially for children who have chronic health conditions” (Children’s Services, Medical Paeds, Pan Ayrshire)

6.17 **Waiting times** was identified by 10 respondents as an area requiring development. These comments were very similar and listing “Waiting times are too long” or paraphrases

thereof was not thought to be helpful. Instead, we have noted which parts of PS the respondents noted as the area they came into contact with most and their locality:

Children's Services, Com Paeds (Pan Ayrshire) x 3
PCMHT (North Ayrshire) x 2
CMHT (North Ayrshire)
Learning Disability Community (East Ayrshire)
Adult Mental Health Inpatient Acute (East Ayrshire)
Older Adults MHS, Community (South Ayrshire)
PCMHT (East Ayrshire)

These responses, kept in context of their number, illustrate waiting times appears to be an issue for a spread of PS across Ayrshire.

6.18 Whilst 6 respondents made explicit reference to pathways, there is a clear overlap with the final theme, **referral guidelines**. This theme was identified by 7 respondents and, if improved, would arguably lead to clearer pathways into, through and out of PS. Comments made in relation to referral guidelines were from respondents who had contact with CAMHS (North Ayrshire) x 2; Across PS (Pan Ayrshire); CMHT (North Ayrshire); Children's Services, Community Paeds (Pan Ayrshire); and CAMHS (South Ayrshire) x 2. Comments regarding referral guidelines include,

"There still seems to be disagreements internally regarding referrals and who is responsible. This continues to cause difficulties for those services who are referring and also for children and families" (CAMHS, South Ayrshire)

"Clear and consistent assessment and suitability for treatment criteria" (CMHT, North Ayrshire)

6.19 **Patient Pathways** was identified as an area for development by 6 respondents. This theme emerged from the following statements,

"Clearer pathways and joined up working are needed" (CAMHS, South Ayrshire)

"Transition work with young adults. Many leave school with significant emotional and behavioural issues that are hard to support within adult services" (Learning Disability, Community, East Ayrshire)

"Streamlining patient care pathway may need some attention to ensure throughput" (CAMHS, East Ayrshire).

6.20 From these comments it would appear that suitability criteria – which patients should be referred where and when – continues to be an issue for some services. It goes

without saying that this is one of the most basic requirements of a service in order for it to work well and subsequently requires resolution.

6.21 These areas have been identified by respondents as areas for development; they should not be considered as 'weaknesses' and not to be considered as challenges which PS alone face nor face alone. PS were commended by stakeholders for taking the opportunity to invite the views of stakeholders. As has been seen from many of the comments, stakeholders would in turn like to take the opportunity to work with PS to build and strengthen PS across Ayrshire.

7. Conclusion

7.1 Psychological Services in Ayrshire and Arran are clearly valued; stakeholders have given their time and expertise to help provide insight into what is working well and areas to be considered for development.

7.2 This report provides a time-limited perspective, a snap-shot of stakeholder views and suggestions. It would be prudent for Psychological Services to take cognisance of stakeholder views, particularly in any review of how services are to be configured and delivered, and with increasing emphasis on partnership working.

7.3 This report recommends the areas of strength are bolstered and built upon and the areas for development are considered as catalysts, where appropriate, for small tests of change before considering their wider application or in other specialties.

7.4 As noted, a 'one-size-fits-all' approach will not be helpful given the diverse and disparate nature of Psychological Services delivery however a strategically co-ordinated approach to service development could see a pooling of resources and sharing of learning.

North Ayrshire Council
Comhairle Siorrachd Àir a Tuath

NHS Ayrshire & Arran

North Ayrshire Health and Social Care Partnership Change and Improvement Team

Stakeholder Review for Psychological Services (Child, Adult and Community Eating Disorder Services): Focus Groups Report

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Date: March 2017

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Acknowledgements

This report has only been possible due to the participation of Psychological Services and their willingness to undertake such a stakeholder review, and the many stakeholders willing to take the time to participate.

The North Ayrshire Health and Social Care Partnership Change and Improvement Team would like to extend its thanks to Psychological Services and their Executive Management Team for their support in identification of and communication to stakeholders about this exercise. We would like to thank the focus group participants for taking the time to share their expertise and experience, and take cognisance of the challenges which arise when a service review involves a co-located service and their colleagues.

We hope the information herein reflects the views expressed by the many stakeholders and goes on to provide evidence to facilitate the ongoing delivery of quality services where this is indeed working well, and to identify and inform areas for development with the findings suggesting many of which can and should be done in collaboration between Psychological Services and their stakeholders.

John Burns, Evaluation Officer, HSCP Change and Improvement Team

1. Introduction

1.1.1 The North Ayrshire Health and Social Care Partnership (NAHSCP) is undertaking an ambitious programme of change in line with the introduction of The Public Bodies (Joint Working) (Scotland) Act which came in to effect on 2nd April 2014 and sets the legislative context for the integration of NHS and Local Authority community based services in Scotland.

1.1.2 Psychological Services (PS) are provided across Ayrshire and Arran and are embedded within various specialist teams. PS deploy a range of staff within these specialist roles to undertake focused work.

1.1.3 The NAHSCP has created a Change and Improvement Team designed to support services to undertake work in relation to integration and service redesign. This team was asked to facilitate a stakeholder review on behalf of PS building on a review process undertaken by NHSAA Service Improvement Team which commenced in 2013.

1.1.4 The first stage of this work involved working in collaboration with the Clinical Director and their Senior Management Team to create a stakeholder list which encompassed as many PS stakeholders as possible. The most basic definition of a 'stakeholder' was those who refer in and work jointly with PS.

1.1.5 A combined sampling strategy of targeted and snowballing was used which involved an initial stakeholder list of 164 participants, and these individuals were asked to cascade to other stakeholders they thought appropriate. An online survey methodology was adopted to collate qualitative and quantitative data on their views and experiences of PS in Ayrshire. A copy of the survey is available upon request.

1.1.6 83 responses were received with the survey open for 3 weeks between July 11th and August 1st 2016.

1.1.7 As a follow-up to this, the PS Steering Group requested the HSCP Change and Improvement Team facilitate a series of focus groups to help corroborate, fact-check and unpick some of the findings from the online survey, as well as provide more in-depth, richer data; focus group methodology facilitates a greater depth of response than an online survey.

Methods

1.1.8 A focus group design was agreed to be appropriate due to the number of stakeholders involved i.e. individual interviews would be unmanageable and, as this piece of work hoped to gather richer data than that which was received via initial survey, focus groups were agreed to be the preferred method.

1.1.8 In collaboration with the PS Senior Management Team, the original survey findings were used to inform a focus group topic guide.

1.1.9 Services which have the most frequent contact with PS across Ayrshire were identified as appropriate for inclusion and included: Child and Adolescent Mental Health Services (CAMHS), Primary Care Mental Health Team (PCMHT), Community Mental Health Team (CMHT) and Community Eating Disorders Service (CEDS), and PS Senior Management finalised the questions in the topic guide.

1.2.1 With the exception of the CEDS which is a pan Ayrshire service, the other services, although provided across Ayrshire, are located within each of the three Ayrshires and PS are fully embedded in these teams. The reason for inclusion of the CEDS team was in part to inform the discussion around whether Psychology input to the team should be increased. Depending on the stage patients are at in their journey most referrals for access to Psychology by CEDS are made to either the CAMHS or Adult mental health teams. Therefore there are 3 CAMHS, PCMHT and CMHT teams, each with similar but different experiences of PS. It was agreed that each would be invited to participate in a focus group whereby team managers were asked to invite a sample with different job roles to join a focus group. There were 10 focus groups undertaken between September and Nov 2016. These focus groups were recorded, transcribed and analysed to inform the findings below.

1.2.2 The Change and Service Improvement Programme Manager and the Head of Services for Mental Health Services undertook a cross referencing of each transcript and the final report to ensure the final report was a true reflection of the focus group discussion. This was agreed

1.2.3 Where possible, the anonymity of participants has been maintained. Given many of the participants work in small teams with a small number of professional roles therein, the report has referred to teams rather than individuals/roles where appropriate; quotations are provided and alongside this is the name of the team from which that participant works. The report is written in a structure that reflects the topic guide used to facilitate the focus groups. This is included as Appendix 1.

2. Contact and roles

2.1.1 The initial questions for the focus groups asked staff to confirm their roles, and how these brought the participants into contact with PS. Participants were then asked to describe what works well with their contact with PS and what could be improved.

2.1.2 As would be expected with such a broad range of professionals, roles were varied and included: Consultant Psychiatrists, Occupation Therapists, Charge Nurses, Self-Help Workers, Team Managers, Team Secretaries, Community Psychiatric Nurses, Psychotherapists, and a Speech and Language Worker.

2.1.3 Contact frequency was in most instances daily or every other day. Reasons for contact varied from joint working, supervision, informal discussion, referral, and in a number of cases contact was due to co-location/integration: some staff in the focus groups shared office space or were in the same building as PS staff.

Contact with PS

What works well?

2.1.4 In relation to what works well regarding their contact with PS staff, a number of stakeholders noted co-location and collegial relationships. These were said to help facilitate informal discussions,

“The move to co-location was a big step in right direction but need to see it more integrated.” – South CMHT

“The informal enquiries are good and they can be supportive to help you formulate what you might be doing. Handy having them within the base as we do lot of informal catching up with them just because they are within the building.” - East PCMHT

2.1.5 Indeed, informal discussions were identified by more than half of the focus groups as how contact works well, however one clear exception was found,

“It is difficult to access Psychology for an informal discussion. If you call you are told just to put the referral in. We have the same allocation of time for Psychiatry but they are available for informal chats and are much more visible. They (PS) have become much more remote and we don’t know how or who to contact.” - CEDS

2.1.6 Although noted later in this report, supervision and feedback was also identified as an area where contact was said to work well for many of the teams and their interface with PS; the interpersonal skills and collegial relationships built up between PS staff and the teams with which they work were identified as being strengths,

“They (PS staff) are very approachable when you approach them, and they will give you guidance” – North CMHT

“Everyone is very approachable, a lot of discussions can be informal and advice can be given about how to progress.” – North CAMHS

“It’s good within the clinical supervision to get direction on the psychological interventions you’re doing with people.” - East CMHT

2.1.7 Another team (North CAMHS) noted joint team meetings as being an asset. Others identified attendance at meetings as an opportunity for development (noted below).

Areas for Development

2.1.8 In terms of how contact could be improved, a number of areas were identified, including supervision. It appears that supervision and support available to staff from PS is variable between the teams and within the teams.

2.1.9 For example, one self-help worker within a team received supervision from PS whilst another did not. This may be due to particular training or interventions delivered. One team noted supervision could be sacrificed due to other demands,

"We did have supervision for a bit but that person is so thin on the ground, they're here, there and everywhere, and it would be something that would fall to way side." - CEDS

2.2.1 A different focus group felt they were unsure as to why their contact with PS had changed,

"It seems to have changed a bit because we used to have more contact when the clinical lead was able to be at more business meetings but that is not the same now and we don't know the reason" – South PCMHT

2.2.2 Meeting attendance was highlighted by a number of focus groups as an area where opportunity for improvement exists. Participation in team meetings could help with issues of integration and transparency. A number of focus groups commented on the lack of presence at 'team' meetings, despite PS being part of the team,

"Would be good to start building on relationships with the Psychology staff, having them attend our meetings more" – North CMHT

"…they very often lack when you're asking them to attend meetings…" – North PCMHT

"Attendance at meetings could be better distributed among psych staff to ensure better attendance." – South PCMHT

"It might be a resource issue that the team meeting is luxury…" – South CAMHS

2.2.3 One participant suggested the following would be useful in terms of meeting attendance (however it should be noted that some teams decide allocations differently),

"That Psychology would come to allocation meetings with a fairly open diary, for example, 'I have 3 or 4 slots to see the patients that the team are struggling with, how can I best use this time?'. And to be transparent about that." – South CMHT

2.2.4 In terms of a key area for improvement in relation to contact generally is in the area of integration and co-location. This is revisited within the report though at this stage, and in response to the question of how contact works, three different teams commented,

“Psychology Services have gone from a stand-alone team in a different building to more-or-less a stand-alone team that share our building, and I think that’s an area for development.” – South CMHT

“It feels like they are very much a separate team.” – North CMHT

“I think that having a psychologist within the team somebody being there not somebody sitting under the umbrella of specialist of eating disorders but someone that is sitting in an office. If someone was here they could be the link into psychology and that would make it so much easier” - CEDS

2.2.5 Another participant commented that contact has become ‘quite fragmented.’ A review of the evidence from the 10 focus groups would concur with this description for the majority of the teams though, as noted, there were examples where, even though fragmented, contact was positive.

Service Awareness

2.2.6 The next section of the topic guide for the focus groups explored ‘service awareness’ and asked if participants were aware of the services available from PS, were aware of the criteria for accessing them and knew how to make a referral. Participants were asked what worked well and what could be improved.

<u>What works well?</u>

2.2.7 Almost all focus groups said that they were aware of the services available from PS, and could recite different treatment techniques and methodologies. There were some caveats with participants suggesting some PS staff can undertake different pieces of specialist work from each other and have different specialisms but that generic skills were similar across PS.

2.2.8 Teams had different mechanisms for making referrals and each appeared to understand their own. Some were through specific allocation meetings, others were at team meetings, elsewhere it was a team manager who appeared to facilitate.

2.2.9 This flexibility can be a strength as it has likely evolved in response to the needs of the service, however there were issues about accessibility and transparency noted below, and that the needs of the patients and not the service should be the driver for processes.

2.3.1 In terms of criteria for accessing/referring to PS, CAMHS teams reported clarity in this area. This is elaborated upon below.

Areas for Development

2.3.2 Criteria for accessing PS was reportedly confused and confusing for some teams. This had an impact on how to refer, when to refer, whom to refer, and ultimately whether to refer at all. This is a potentially high risk area whereby 'appropriate' patients are not referred because of the confusion around what is appropriate and what is not.

2.3.4 Others noted an inconsistency in the implementation of criteria whilst some participants felt the criteria has led, intentionally or otherwise, to PS selecting patients in a way that seemed incongruent and counterproductive.

"The referral criteria excluded the patient group we work with." – East CMHT

"Made countless referrals in the past, over last year, stopped referrals as knocked back for variety of reasons." – East CMHT

"I've never come across a criteria for psychology" – CEDS

"There is a criteria there but I don't think there is any consistency in how it's applied. I've sat in clinical meetings…one case is accepted…and the next week or even within that same clinical meeting, very similar cases are discussed and they are declined" – North PCMHT

"Our first thought when we see someone who we think might need psychology is 'How can I find a way not to make this referral?' because you know it's not going to be welcome and it's going to be a difficult conversation…" – South CMHT

"There's guidelines on who we shouldn't (refer) which almost, to be frank, sound like they (PS) are looking for people who are well…It is really frustrating when I've been in this team for many years and I do not know what a referral is that psychology would accept"" – North PCMHT

"The steps can be a quagmire for us and the client" – East PCMHT

2.3.5 The following exchange appeared to cause concern within one focus group. There is no evidence to suggest or dismiss the following example is widespread,

"As a team manager I know I am trying to balance waiting times all the time, and I'm aware that sometimes maybe my boundaries shift a little, because we don't want people to wait for ages, it's a terrible place to be in. So I think sometimes there is some waiting list management, kind of boundaries shift, you know where you think 'our waiting times are maybe getting a little too low and we don't want it to look like we don't have anything to do' so we'll be a bit more open about assessing people this week and then if their waiting lists are drifting up then they're going to be a bit more cautious" – Team Manager

"We all know that, that that's what's going on but that's the first time we've heard it said out-loud but that gap there that's created depending on how they're feeling, that falls to us because we won't walk away." – Charge Nurse

2.3.6 The above identifies a clear need for action in the area of service awareness – particularly around criteria for accessing PS. Perhaps learning could be taken from within mental health services; each CAMHS service reported to be clear on the criteria for accessing PS. Separate issues of waiting times arose and a specific issue in relation to the type of work undertaken by PS in CAMHS is noted below however, criteria was not a contested area.

2.3.7 The issue in relation to the type of work PS undertakes in CAMHS revolves around what was framed as "neuro vs mental health" work. This dichotomy was identified in two of the three CAMHS teams to a greater or lesser extent as per the following examples,

"I thought I was coming to a MH service and when I got my job I wasn't aware we were going to be doing anything neuro so that took time to adjust. I still feel there's a heavier focus on neuro but struggle with this as a mental health team, I think there needs to be a better balance. There's people with serious mental health issues not being seen." – North CAMHS

"I feel that (it) has moved toward more focus on the neuro stuff. It has been to the detriment of any other sort of intervention." – South CAMHS

2.3.8 As noted, this is an area unique to CAMHS and will require further investigation and collaboration to resolve.

3. Joint Working

3.1.1 The focus groups went on to explore joint working and were asked about examples of where this is effective and areas where it could improve. They were also asked about the different roles performed by PS which they may value with supervision, research, training, consultation and treatment provided as examples.

<u>What works well?</u>

3.1.2 As might be expected, where joint working was identified as having took place it tended to be spoken of positively; focus group participants reportedly enjoyed joint working and recognised the benefits this can bring for the professionals involved as well as patients.

3.1.3 Joint working was described to work on a spectrum. The examples below are where respondents provided some positive comments on their experience of joint working.

“I have done some co-facilitation of group work with psych and it worked really well. I hoped that it would be repeated but it hasn’t.” – South CMHT

“Communication is really good and the formulation and some joint working and they can guide you on what you can do next” – CEDS

“We do a lot of joint working around neuro development” – North CAMHS

“(There is) some joint working with psychology where they may have a patient they see every 4 weeks, with us seeing that person every 2 weeks, in some situations this has worked well” – North CMHT

“Our joint team meetings work well” – North CAMHS

“Joint work with CBT nurses from the team, the patient referred to us worked very well with lots of discussion.” - East CMHT

“I have had only one instance where I have done a joint meeting with a client involved in my care. It was a CBT client who was going to be transferred over to psychology and the psychologist and myself met with the patient and the patient’s mum, and that actually went really well. Very positive.” – North PCMHT

3.1.4 There were comments made about being able to access notes that historically have been inaccessible to staff. This was cited as an improvement which can facilitate joint working.

3.1.5 Examples of joint working, and what staff might consider to be joint working, can be seen to exist on a continuum where the above examples would be at the positive end. The next three examples see the concept somewhat stretched,

“I’ve had got one case where we were working, feeling like we were working really well and catching up so it feels really shared there are others where it doesn’t feel like that and you occasionally touch base but you may not necessarily know what is going on and you may get a referral and then it stops and you’re left with it and it just stops.” – South CAMHS

"We do our bit, and then it is passed onto psychology. Informal chat and supervision is the only type of joint working." – East PCMHT

Areas for development

3.1.6 At the other end of the continuum we see joint working as something that either doesn't take place or is mistaken as a patient being open to both parts of a service.

3.1.7 To be clear, and as most staff involved would likely agree, a patient allocated to a Mental Health Nurse or an OT *and* a member of PS does not in itself qualify as joint working if there is no deliberate and purposeful collaboration taking place between at least the two professionals, if not the two professionals with the patient.

3.1.8 For example, a situation was described in South Ayrshire CMHT whereby a member of staff identified a piece of 'joint working' and went on to describe how the patient was allocated to both PS staff and CMHT staff. When asked if this work is undertaken in any structured or co-ordinated way they responded,

"No, we have not done that… In the passing I will speak to the psychologist and she maybe gives me a bit of guidance…" – South CMHT

3.1.9 Other comments in relation to joint working which suggests it could be an area for improvement include,

"Don't tend to joint work." – East CAMHS

"…as soon as you hear word 'eating' in it they don't want to help… We are not a standalone service we deal with complex patients…. At the end of the day its behaviour so why should it be any different?" - CEDS

"A joint assessment was attempted but I think it was very difficult to arrange, it was very difficult to agree, it was extremely stressful for the clinician involved and it was just a whole to-do." – North PCMHT

"Informal chat and supervision is the only type of joint working." – East PCMHT

"My experience is that psychologists do not actually want to do a specific joint piece of work with us. What they will do is they will offer consultation ." – South CMHT

3.2.1 This final comment brings us to the different roles PS staff perform and the views of participants regarding these.

4. Perceptions

4.1.1 This section of the topic guide asked participants what they valued in relation to PS provision. This varied between disciplines and experience, for example, some staff received supervision due to the interventions they were trained to deliver, others' valued consultation and support around treatment formulation. Below are some examples of what participants reported in this part of the focus groups,

"Value being able to talk to psychology… a (PS) colleague has given their time to let the team off load about a case and give advice. This is on the off chance, very useful." – East CAMHS

"In the few occasions they do take the right people and it works." – East CMHT

"When we can get them involved…there are examples of them having made a meaningful impact…if only we could have their input more" – South CMHT

"Supervision from psychology staff is valuable and expertise within the team and services which they provide are very valued." – North CMHT

"Supervision that is one of the things I value, when I go to clinical supervision with (PS staff member) is that he will help me to form a case formulation for some of the people that I see." – South CMHT

"Their clinical expertise, I absolutely value that." – North PCMHT

"In CAMHS the clinicians have become good and being open and receptive with eating disorders and joint working with them." - CEDS

5. Priorities

5.1.1 The final section of the topic guide asked participants about what they thought the priorities should be for PS in the future. Below are some examples which were suggested.

"Clear about the referral pathways to psychology within our own team." – East CAMHS

"Respect the teams' judgements when referring a patient and at least see this person." – East CMHT

“More joint working and training” – East PCMHT

“I’m confident things will continue to move in a positive direction and perhaps this exercise can help focus that.” – South CMHT

“All referrals from a nursing point of view are urgent, meaning the patient should be seen within seven days, the team needs to be adaptive to what is required, therefore to carry out these psychological therapies a ring fenced time is necessary. We can’t ring fence time without the resources and the staff.” – North CMHT

6. Role clarity, management, integration and transparency

6.1.1 This section is not included in the topic guide however, following review and analysis of the transcripts, these areas can be considered important themes which to a greater or lesser extent emerged across the focus groups.

Role Clarity

6.1.2 Regarding role clarity, a devolving of responsibilities was described across the teams whereby a range of staff have become involved in the delivery of interventions which were traditionally the responsibility of PS staff.

6.1.3 This, combined with the training and qualifications involved in mental health nursing as a profession has led to greater confusion about why PS staff have been found to treat nursing staff assessments with lower credibility and what the ‘chain of command’ should be.

6.1.4 Situations where assessments themselves are assessed or worse, felt to be discarded or treated as irrelevant were described to result in a frustrating situation. Examples of this include,

“My experience is that psychologists don’t want to do a specific piece of joint work with us, what they will do is offer consultation (to staff)…and there’s difficulty with that because obviously I’m a nurse and have my own professional standards and skill set and there’s a real professional difficulty at times that PS want to tell me what to do or how to do something when in actual fact that that’s my skill set and I’ve already done that, and I’ve done it to the degree that it’s that psychological work that you (psychology) would do that’s important now, and they will disagree” – South CMHT

“When I go as a professional nurse and I have been with the health service for thirty-odd years, I know my stuff, if I have assessed somebody, I would be the first one to say ‘I am not sure, give me a bit of advice’ or whatever, but generally if I have assessed somebody, I don’t tend to miss something, so if I take it to psychology and

ask for …a..b..c.., I want this person to go to psychology because they have a really bad anxiety, and that is the crux of the problem, and they tell me something like 'give them a self-help workbook' that makes me feel like what value is the three hours that I have just spent with that person, turning over every stone, writing it all down." – North PCMHT

"It can be frustrating as clinicians when our clinical judgement is that yes CBT or counselling is the way to go, but we're told no they can't have that intervention. They (PS) might give us clear feedback on why, but it feels as though we constantly pick it up, they can offer more specialised input and sometimes we feel as though we've done as much work as we can." – East PCMHT

"It's not unknown for psychologists to refer to us as 'un-psychologically minded colleagues' although we are all doing psychological work of some description… I think there needs to be that clarity. It's almost you think of the triangular kind of thing. There are a lot of psychological interventions that can be done by nursing, OT staff….. but what is the top of the triangle that they do… there is not a clarity there." – South CMHT

6.1.5 From the above, and although it ties in with 'accessing' PS and 'joint working' it speaks to a wider issues of clarity around roles and responsibilities – who does what, when and why, so as to avoid duplication, reassessing patients and exacerbating waiting – it would appear that work is required around how the team(s) function as a unit or service. This ties in with the issues identified with how the teams are structured in terms of their management.

Management

6.2.1 The management of PS services has been portrayed as confused and confusing. The team responsible for carrying out the focus groups, without any expert knowledge or experience of the service(s), found it difficult to understand but this is perhaps unsurprising given the teams themselves reported difficulties in their understanding of the rationale for certain practices, and the problems the existing structures either cause or compound. The following example highlights some of the complications regarding the current situation,

"I think the structure is a barrier. For example, when a consultant wants to do something and they need to ask someone for permission when they're independence for action in terms of 'agenda for change' is a 5, and the team leader is a 4 but yet the consultant needs permission. How can that work? Well, it clearly doesn't… The structure doesn't and can't work for some professions…It's uncomfortable for the senior positioned staff member as well as the 'junior' providing the instruction." – North CAMHS

6.2.2 Another reflection of the ambiguity is seen in a team managers description of their management responsibilities for PS staff as the describe their role as,

“I day to day manage the psychology staff at some kind of level that are internal to this team.” – PCMHT Team Manager

6.2.3 If a position could be found that removes the barriers identified in the first quote above, perhaps Team Managers would be able to better describe their role in managing PS staff. The management structure and the associated challenges are arguably linked to issues regarding integration.

Integration

6.2.4 Although many participants felt the current situation to be an improvement on the past, however slight, it would appear unsustainable and, given the pressures staff are experiencing (PS and Mental Health Services), cannot be considered to be working at its most effective and delivering the best outcomes for patients.

6.2.5 ‘Integration’, according to North Ayrshire Health and Social Care Partnership’s Strategic Plan 2015-2018, involves providing services ‘seamless from the perspective of the service user.’

6.2.6 Whilst patient views have not been sought regarding the interface between Mental Health Services and PS, the following is evidence that there remains much to do in terms of service design and delivery if the services are to overcome the current difficulties and achieve the HSCP strategic priority of seamless service provision.

“For us doing an admin support to them, it is very much two teams” PCMHT

“…we feel they are not really investing or fully integrating with us.” – North PCMHT

“Psychology Services have gone from a stand-alone team in a different building to more-or-less a stand-alone team that share our building, and I think that’s an area for development.” – South CMHT

“It feels like they are very much a separate team… It feels like an elitist service.” – North CMHT

6.2.7 Overall, there seemed a sense of ‘them and us’ and so long as that continues it will undermine efforts to provide an integrated service for patients.

6.2.8 Despite such issues, it should be noted that there remains an appetite across the services to deliver more efficient, effective and joint up working with the following echoed across the teams,

“I would think that if psychologists were actually integrated in the team and picking up referrals at the point of screening and allocation and all the rest in the way that medics and nursing and OT staff do as a unit currently, then that would break down a big barrier and would be a good thing for patients.” – South PCMHT

Transparency

6.2.9 Transparency emerged as a theme through various participants reporting to be unsure of what PS staff actually do with their time, how much and what type of work they do.

6.3.1 The feedback from participants inferred issues of transparency exist around how PS staff manage their time, how their (PS) time seems to be more valuable and protected than that of Mental Health staff, and how much of PS staff time is spent with patients which, if left unchecked, is likely to fuel suspicion and division, further undermining any approaches to integration and joint working. The following comments provide examples of where action may be required,

“Having this feedback would inform us of the services they provide. Feels like there is some secrecy of what type of interventions they offer.” – East CMHT

“If we saw they had a large caseload we would be sympathetic towards their caseload if it is high. We are not informed of the work they are carrying out with our patients, if they are moving forward or are likely to be referred back to us.” – East CMHT

“Transparency, improved communication, improved understanding of our roles… Definitely equity. Equity of workload. Equity of respect. I have said that for years, that this is what is needed.” – North PCMHT

“Every week I sit with colleagues and we have our diaries open and we’ve got X number of new patient slots and we divvy them according to who we think is best suited to deal with whatever’s come our way. And if Psychology were sitting in a transparent open way like that, with an agreement about how much time should be allocated to new assessments, return appointments, supervising other people and running groups and that sort of thing, not to be overburdening people by any means, just so that it was transparent and clear that we were using them as best as we could, in the way that we do each other” - South CMHT

7. Limitations

7.1.1 There have been a number of limitations to this work which should be noted for as learning for any future work in this area and by the North Ayrshire Health and Social Care Partnership.

7.1.2 This piece of work has taken longer than may have been anticipated due to a number of factors which can partly be explained by the large number of people involved, reaching consensus and co-ordinating a large number of focus groups.

7.1.3 Whilst good practice would see a topic guide co-produced by the service being evaluated (PS in this case) and the service undertaking the evaluation work (the HSCP Change and Improvement Team), it is important to strike a balance and reach timeous consensus.

7.1.4 A significant limitation which resulted in further delay lay in engaging stakeholders to participate. Clear and consistent communication from the outset of any future engagement work might see such delay reduced.

7.1.5 A difficulty inherent in evaluating a service which is co-located with its stakeholder is the dynamic which exists between people. For example, if a member of staff from the service being evaluated communicates unfavourably or otherwise to those who will be participating in the review, it places undue pressure on participants.

7.1.6 A limitation in producing a final report lay in the transcribing of focus group recordings. This is something the HSCP recognises and is taking due consideration of for any future work where large quantities of qualitative data might be produced. In this case there were 10 focus groups requiring more than 35 hours to complete. Resource support and training in this area is being considered.

8. Conclusion and Recommendation

8.1.1 This evaluation work was undertaken as a follow-up to the online survey of PS stakeholders. The findings and recommendations from the survey identified areas which the PS Senior Management staff hoped to learn more about and the content should be read in this context.

8.1.2 Many of the findings from the survey have been corroborated by staff who participated in the focus groups. There has been extensive use of direct quotations to provide evidence of areas which may require development and to ensure inference and suggestions of selective data usage is kept to a minimum.

8.1.3 Each transcript and the final report was read by the Change and Improvement Team Programme Manager and the Head of Service for Mental Health to ensure the

validity and reliability of the findings and recommendations.

8.1.4 Each section within this report reflects the topic guide used for the focus groups. A number of strengths and areas which work well have been identified and these should built upon when considering how best to address the areas for development.

8.1.5 In terms of these areas, each section of the topic guide identified areas for development though if the themes identified latterly as role clarity, management, integration and transparency were to be addressed, it is likely that many of the other areas for development would be addressed directly and indirectly as a result.

8.1.6 The recommendation of this report is that the Psychology Steering group considers the areas for development and, if necessary, is supported by the Improvement Team to consider an action plan for prioritising and addressing these.

Appendix 1: Focus Group Topic Guide

CONTACT

1. What is your role and how does it bring you into contact with Psychology Staff.

2. Can you describe your contact with the Psychology provision in your area?
    a. What works well?
    b. What can be improved on?

SERVICE AWARENESS

3. Are you aware of the services Psychology provide?

4. Are you aware of the criteria for accessing them?

5. Are you aware of how to make a referral to Psychology?

    - What works well and what can be improved on?

JOINT WORKING

6. Describe any joint working you have done with Psychology.
7. What roles (supervision, training, consultation, assessment, research, treatment) do you value?

PERCEPTIONS

8. What do you value about psychology provision in your area?

CONCLUDING QUESTIONS

9. What do you think the priorities should be for Psychology provision?

10. Is there anything else you would like to add to the discussion that relates to the Psychology provision in your area?

NHS Ayrshire & Arran

Psychological Services

Patient Satisfaction Report

Catherine Kyle
Clinical Director: Psychological Services

July 2016

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Psychological Services

Patient Satisfaction Report August 2014 – 31 March 2016

Introduction

As part of routine practice within Psychological Services, we measure patient satisfaction levels and, where, we can, make improvements according to patient's views. We measure patient satisfaction levels within Older Adults, Eating Disorders, Physical Health and Neuropsychology Services. We discontinued this practice in Mental Health Psychological Specialties when Mental Health Services started to use a generic patient experience questionnaire. This report summarises this information for the past two years.

Method

All patients of Older Adults, Eating Disorders, Physical Health, Neuro-rehabilitation and Neuropsychology Services staff are routinely sent a simple satisfaction questionnaire after discharge appointments and invited to return it using a stamped addressed envelope. Questionnaires are anonymous and ask just four questions (i.e.) 1) What was most helpful, 2) What was least helpful, 3) Do you have any suggestions as to how we can improve the service and 4) Further comments. The questionnaire also asks respondents to say whether they are dissatisfied, slightly satisfied, mainly satisfied or very satisfied. The single sheet questionnaire is appended at Appendix 1, as are all actual responses to the questions by Service Specialty in Appendix 2 & 3. Heads of Specialty Services, their staff and the Director see all the responses and are asked to note suggestions and implement where possible. Collated results are also discussed annually at the Psychological Services Clinical Governance, Research and strategy Group. The exercise is highly valuable in giving staff personal feedback about what patients are saying about their care and in enabling the service to share good practice and implement improvements based on patients' suggestions.

Results

Eight specialty psychology services have returned responses. Total number of responses is 256.

Figure 1. shows the actual number of responses across satisfaction levels overall.

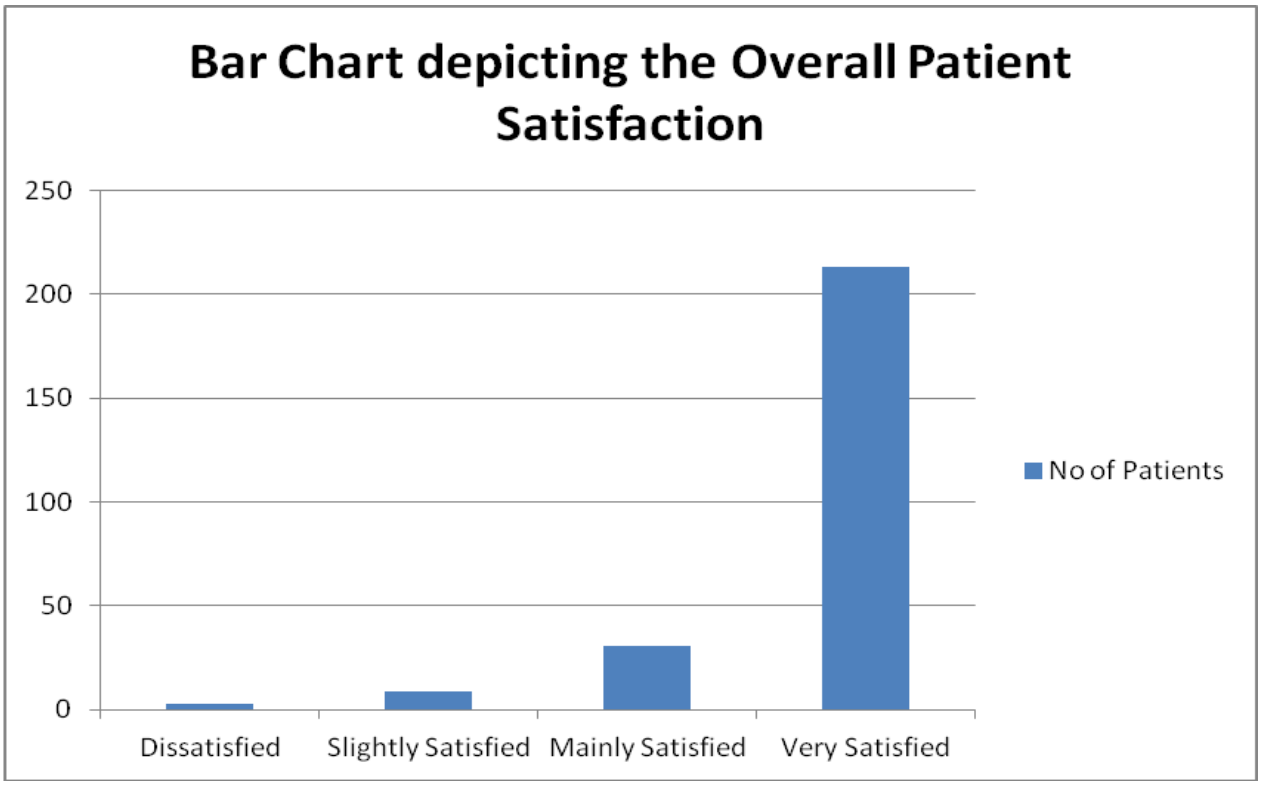


Figure 2. shows the % spread of responses across satisfaction levels overall.

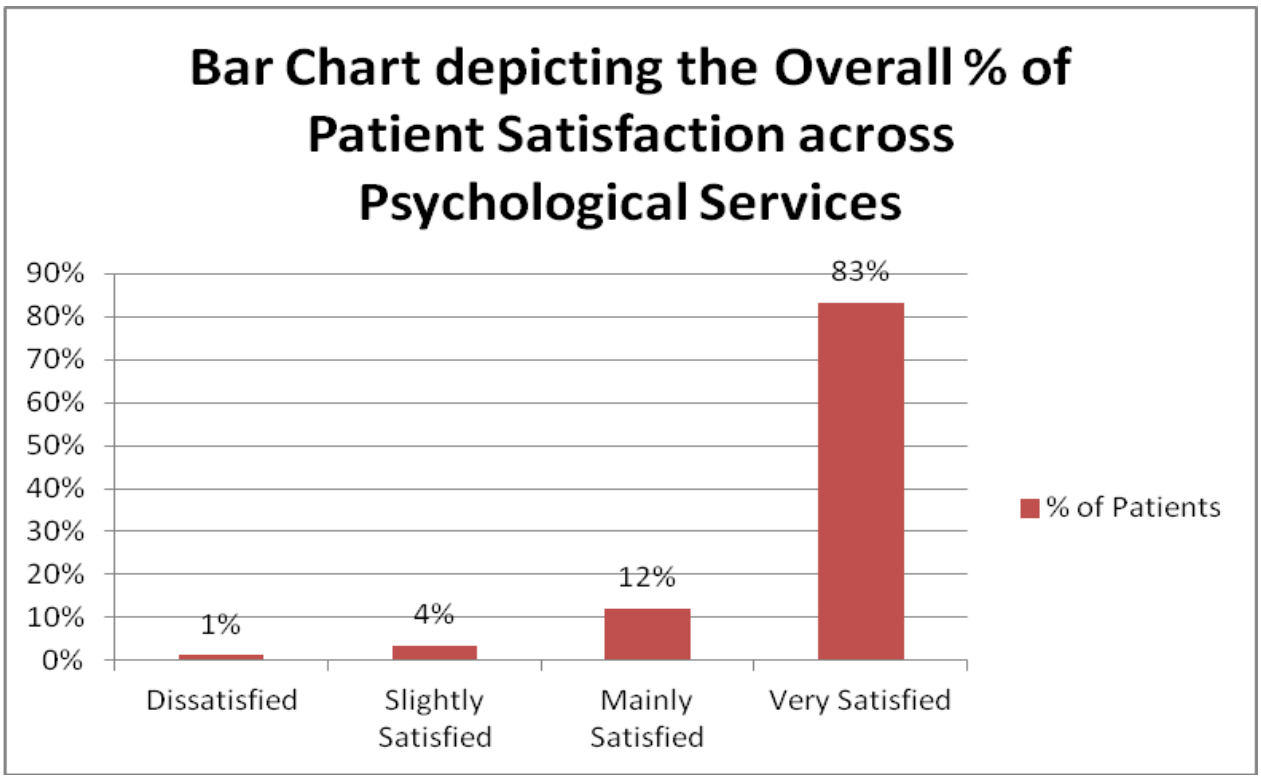


Figure 3. shows actual numbers of responses across satisfaction levels by service specialty.

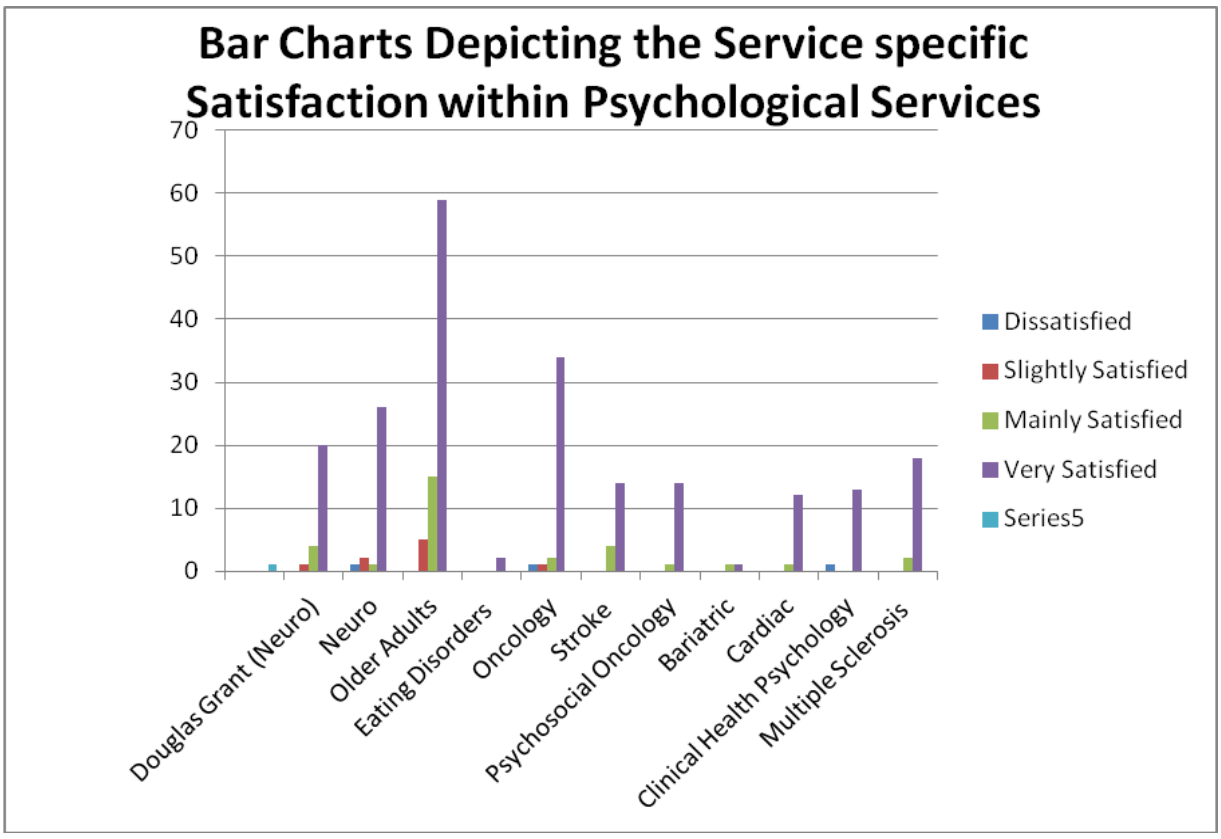
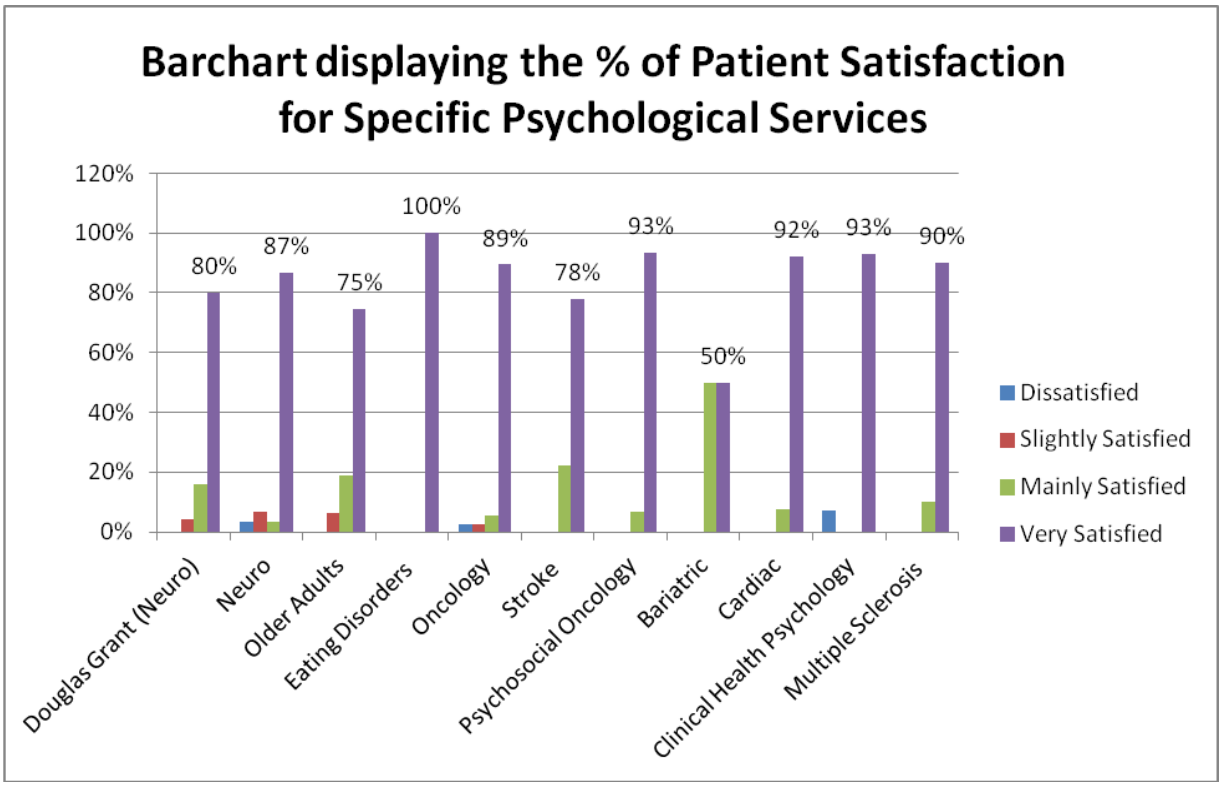


Figure 4. shows % of spread across satisfaction levels by service specialty.



It can be seen that, overall, the vast majority of patients are either very satisfied (83.20%) or mainly satisfied (12.11%).

Qualitative Responses

Actual responses are appended in Appendix 2 & 3.

To summarise, responses show that patients find the following most helpful about our services: professionalism, knowledge about their condition and technical expertise and empathy, compassion and rapport.

Least helpful aspects of the service and suggestions for improvement centre around a risk for a wider availability of appointment times/days and faster access (though all services are within 18 weeks), need for help with wider issues and problems, poor quality accommodation, lack of tea bar (ACH etc) and one patient expressed dissatisfaction with all of their care from wider MHS (disagreed with overall diagnosis). (ACH Outpatients Clinic). Only three patients of the 256 gave a rating of "dissatisfaction".

All Other comments are all extremely positive. It is extremely rewarding for staff to see such gratitude and praise from their patients.

Discussion

It is pleasing to note the very high satisfaction levels with the service. These, and the comments received, suggest the quality of the service and its clinical outcomes for patients is extremely good. It is noted that some patients comment negatively on its quantity (e.g. long wait times). However, there is a danger that if wait times are reduced, it could be at the cost of reducing quality. Short waits for "quick fixes" will not work for the most complex patients and shorter insufficient inputs can actually be detrimental. Thus, without increased resources, the service faces considerable challenges in meeting patients' suggestions for improvement and also in meeting Government targets for waiting times without simultaneously eliminating what patients value most about their care. Of note to the wider NHS is the problems patients face in accessing the service in the first place (transport). There are suggestions for providing more local clinics though this would not be practical in such small specialties where we only have one or less than one whole time equivalent staff member. In addition, sometimes what patients' value most (e.g. being able to access a number of disciplines at once at a hospital setting) runs counter to their suggestions for more local clinics.

Routine measurement of satisfaction is an important aspect of Psychological Services and we will continue using our own brief instrument, in those areas which are outside MH Services, and will explore the feasibility of re introducing it into Mental Health Psychological Specialities because of its usefulness in providing us with information specifically about our own staff and services.

The results in this report will now be discussed at our Clinical Governance, Research and Strategy Group and actions for improvement will be agreed and implemented where we have the ability to do so.

Catherine Kyle
Clinical Director: Psychological Services

Appendix 1

NHS AYRSHIRE & ARRAN PSYCHOLOGICAL SERVICE

In order to improve the service we offer to patients and their families we would be grateful for your opinion of the Psychology service you received from _____.

Please complete the anonymous questionnaire and place it in the suggestion box in the hallway.

	Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
How satisfied were you with the service you received?				
What was most helpful about the service?				
What was least helpful about the service?				

Do you have any suggestions as to how we can improve our service?:

Thank you for taking the time to complete this questionnaire.

Appendix 2

NHS AYRSHIRE & ARRAN PSYCHOLOGY SERVICE PATIENT SATISFACTION SUMMARY

From August 2014 – March 2015

1 Douglas Grant Neuro *Themed Responses from Questionnaires in Douglas Grant Rehabilitation Service (Neuro-Rehabilitation Psychology)*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
			3

What was most helpful about the service
The time that was taken to listen to my problems without interference.
Being able to be honest. Not having to put brave face on.
I received good advice re my anxiety problems.

What was least helpful about the service
Nothing. I can go back again if I feel the need.

Do you have any suggestions as to how we can improve our service?:
No, extremely appreciate all the help and advice I was given. Thank you.
Make service available to more people in family.

2 *Neuropsychology Service (Neuropsychological Assessment and Diagnostic Psychology)*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
1		***1***	***14***

What was most helpful about the service
Everything!
Being able to just sit and talk.
Talking about how I felt about my epilepsy and how I'm coping with it.

Helped me to understand my condition after stroke better, what I was feeling was normal.
Caring interested professional attitude.
A sense of hope derived from attendance.
I very much appreciated correspondence from Psychologist and her secretary and felt that the service provided was quick, accommodating and efficient.
Having someone who listened to me.
Being able to talk to someone who understood how your medication can affect your condition and moods was grateful for the advice and help.
The fact that Psychologist could speak to me on the phone.
They sat and listened to any problems you had.
Understanding and patient.
I didn't feel rushed. Very prepared to listen to my problems. I didn't have to wait too long in the waiting area. I was made aware of problems that I didn't know existed.
Psychologist made me feel comfortable and was genuinely interested in what I had to say and made it really easy to open up to her.
Opening up problems I have.
I was told by Dr that I would be receiving memory strategies and CBT but maybe I have been put on a waiting list. Still waiting?

What was least helpful about the service
I don't think there was one, perhaps just explain a little more what each test was.
Nothing was unhelpful about the service I received from Neuropsychology but the service from Neurology impacted on my treatment and left me a bit perplexed as I had conflicting information by Neuropsychologist was excellent and I very much appreciated her input and support.
The time spent on each session could have been longer.
None as Neuropsychologist was very good with the problems I had and was getting another Dr to help me with them.
There was nothing I felt was least helpful. I was grateful for the help provided.
The follow up appointments not being communicated or kept informed when they will be happening. Still waiting.

Do you have any suggestions as to how we can improve our service?:
No it was great.
I would have liked to have had been able to discuss my stroke shortly after having it to be able to understand my emotions, and other effects as I was struggling to understand them.
Don't really know enough to make a suggestion except perhaps more access/appointments.
The service provided is excellent and I have no suggestions to improve this.
I thought it was very good all round service and I felt a lot better for having it.
Home visits for housebound people or people with poor mobility.
Give your clients a better understanding when the follow up appointments will be happening. Understandably there is long waiting list, but even communicating to client where they are on waiting list would be helpful as they would not feel you have forgotten them. Still waiting.

3 *Older Adults Service (across Mental and Physical Health Psychology Services)*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
	3	***8***	***28***

What was most helpful about the service

The literature to organise my day.
She listens to what you are saying. She was very nice.
Reassured that there was no physical problems.
*No benefit gained as an individual.
The way the Dr asked question I felt very related when I had an appointment.
Quick referral and no time limit on appointments. I found both Dr and Assistant to be very good at giving me explanations I could understand.
Willing to work together, given time to share difficult issues, and encouraged to take one step at a time, both knowing when to finish it all, and prepared to work on all I had been taught overall extremely positive.
When I went to see Dr for the first time my head was all over the place. But one Dr started to help me I was beginning to see the list at the end of the tunnel.
Acknowledgment of my vulnerability.
Dr what a "Superstar" so professional, understanding and a real person.
It was all done with ease and the patient in mind.
Assistant gave me a lot of encouragement.
Helped to put my life back on track again.
The gentle approach seeing the same person each time and building trust. I am much happier and confident in myself.
Everything.
Having appointment at home.
I was able to talk to her openly.
While it may have been helpful for the psychologists to talk my back ground/life experiences. I did not feel it was particularly helpful to me in the sense that there was no advice offered.
The friendliness of all staff made it much easier to relax and get the most out of each session. Not having to travel great distances to attend sessions. Feeling able to cope now, put what I learned into practice, and still working on it!!
Her quiet manner in letting me speak at my own time. Got me to bring everything to the service. I am a different person now. Thanks to her.
The most helpful aspect of the service was having the opportunity to talk at length about my problems and know that I was being listened to and given support. I was treated with great respect at all times and was never made to feel that I was an "older adult".
It was reassuring.
Being listened to and able to talk.
That I was listened to and the end got a solution.
Her calm listening, discussing abilities.
The one to one in your own home.

To be able to speak and get things out that are in the past as the future.
Took time to listen to many issues I had suffered from over many years.
Gave me an understanding and revelation that I was not responsible for the hurts inflicted on me was not my fault and an understanding of why these happened.
Not far from home.
Trainee Psychologist was very helpful in the question and answer programme.
Being able to talk to Psychologist and she listened.
Explaining my illness
That it dealt with my Panic attacks.
Friendly and understanding.
I found Psychologist an easy person to open up to.
That is difficult to comment on as we are still awaiting an outcome, but Psychologist was very pleasant and listened to what we had to say.

What was least helpful about the service
Length of time it took to receive the literature. (Over two weeks?)
As she was a trainee, would have preferred someone older who knew about the era I grew up in 1943 – 1958 which was I left home at 15 ½. Years old.
I feel that I need medication also that was not available.
*If there is no benefit, there is no relevance! Helpfulness.
I did not find any aspect of the service unhelpful.
I cannot praise Dr enough for all the help she has haven me. I am still keeping well and if I do feel down I use my hearing to listen for sound and it distracts from my unwanted thoughts.
No negatives at all.
Timescale
The reception at the clinic in NWC Kilmarnock.
Did not know what to expect so an unsure about this.
The waiting time for the first appointment.
I felt a bit awkward at first about having my consultation recorded but felt more comfortable with this over time.
Personally have no complaints.
Felt that due to circumstances my consultation may have been cut short, however I did not want to start over again with someone else.
Just that I felt I could have continued a bit longer but did not want to start over with someone new after Psychologist was transferred but pleased for Psychologist.
There was no least helpful in any meeting I had with them. Both were very helpful.
Some of the appointment times, but realize you have to fit in other people.
The time taken for an outcome. Husband referred in October 14 and is not being seen until 17 March 2015.
Psychologist. No appointment made for bereavement counseling.

Do you have any suggestions as to how we can improve our service?:
Quick response to sending out information.
Therapy more frequently!
*please note – above response has no bearing on the competence of Psychologist.
This was the first time I used the service and found it to be very helpful in my opinion you cannot improve it.
For me personally a family member was invited to share separately and together with Dr

and myself of how things were for me, we found this very helpful, also when it came to the end I had a summary of my progress, and also in writing a reminder of the positive steps to deal with situations as they arise.
In the never ending drive towards continual improvement as demanded by today's targets and "in house" surveys all I can suggest is find another 1,000 Dr T's who by their very nature are so on top of the game that we through ever what circumstances we the patient find ourselves in.
I still feel that in my case where no disease has been found then hypnotherapy should be tried. It would help my sleep problem, my memory lapses and overall condition. Surely hypnotherapy should be available as it is elsewhere in the UK. Your comments would be appreciated.
Your service is great.
No I was given support and help I needed at the time I'd have no problem contacting the service if required in future. Grateful thanks to all.
My experience was very positive but Psychologists choice of shoes left a lot to be desired!☺
There is a much greater need for this service as mental health issues are becoming much more talked about and not being "swept under the carpet". More patients = more Psychologists = more money for the health board to spend on the service. But will they?
It's no different from a broken leg, though you can't see it, with the proper care and support, it will get better. Keep up the good work.
Nothing I could suggest, to improve your service. Psychologist in my opinion is first class, pass on my thanks to her.
No suggestions needed. I think you already offer a very helpful and valuable service.
No but keep up the good work.
Can't think of anything to improve it.
No, I think you give a great service, especially not having to go to the mainland when you live on an island.
This is a hard question for me to answer as a private person I would like to have some hypnoses to see if all my problems are due to myself.
No. I think it's great. You are providing support for older patients.
No as quite satisfied but just as stated above but am please I can reapply if necessary which gives me a sense of security and well being.
I would not like to change the system.
Don't have any suggestions as to how you could improve your service, but must I found it first class.
If the waiting time could be reduced between referral and receiving an outcome. I feel five months have passed and we are no further forward. We are in limbo.
In my opinion you are doing a wonderful job. Please keep up the good work.
Service excellent.

4 *Eating Disorders Service Provision*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***

			1

What was most helpful about the service Service helped me and I appreciated the time spent.

What was least helpful about the service

Do you have any suggestions as to how we can improve our service?:

5 *Psychosocial Oncology Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
		1	***14***

What was most helpful about the service The relaxed informal chats. Psychologist created a very relaxing atmosphere which put me at ease. There had been a suggestion by one of the GP's that I may be depressed which Psychologist was able to reassure me that I was anxious. Having a one to one session and being able to talk about my fears of my cancer diagnosis. The opportunity to talk to someone who wasn't family. Suggestions on how to think in a more positive way. Patience and taking time to listen to my concerns and help suggest positive steps towards my future which worked. Initial meeting was in same ward and time as chemo session so very helpful. I stopped going out – now I am not so worried about going out. Talking through worries with someone outwith the family. I was able to take my time to open up about various issues. Never felt rushed, or judged. The service I received was 1st class and has helped me very much. I could talk in confidence the Psychologist made me feel at ease and I felt comfortable talking to her. I don't talk to people I'm not sure about but Psychologist was lovely and I was ok. Ease of conversation. I wasn't looking forward to this service but was pleasantly relived at the friendly and patient attention I got as she listened to my multitude of problems which have mostly dissipated through talking. Speaking to someone who listened.

What was least helpful about the service
Mainland only consultations.
Found it all helpful.
Not enough meetings before being moved to someone else.

Do you have any suggestions as to how we can improve our service?:
Don't lose the Psychologists I saw.
Psychologist tome me that she was going to write to other parties involved in my treatment which I understand was done. I appreciated this to try to move things along (to get to the bottom of the pain I am still experiencing).it appears there is poor inter-departmental communication and follow up. I have now had to pursue a diagnosis privately and this is ongoing.
I only had 1 appointment which no follow-up which I found suited my needs perfectly.
I was completely satisfied, thank you.
Clinic sessions held on Isle of Arran.
I am so glad I went Psychologist made me feel ok about myself. So lovely t talk to – so happy I went – one in a million.
All going through Oncology Department could benefit from someone to talk to not just those that ask for help.

6 *Stroke Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
		2	***6***

What was most helpful about the service
Trying to understand what I was going through. Learning I wasn't alone but quite normal and confused using system to unblock the brain.
To not have far to travel, and someone explain just how diverse the symptoms of stroke are to the individual.
Psychologist was very attentive to my wife's needs and was also very informative about the best way forward to help her.
One to one contact. Allowed to express views. Receiving valuable information which I personally have put into practice.
I was very satisfied with the Psychologist. He was easy to talk with and very helpful to explain things when I asked questions.
Explaining to my wife, that I do listen to her, I just don't always remember what she says. Also that it's not just my age (not remembering).
Helped me to understand what's happened and express my feelings.
Listened to me and referred me on to mental health team at three towns.

What was least helpful about the service

The amount of time it took to get an appointment. This is not at Dr but the system.
*Overall it was fine. Occasionally the appointment time was cut short, due to overbooking appointments.
I do not think there is anything wrong with the Psychologist I saw.
Nothing. I found it completely helpful.

Do you have any suggestions as to how we can improve our service?:
Try to improve in the time it takes to get to see someone.
*As above. Not to feel you are on the clock and that someone is being kept waiting to see the Dr.
Nothing I could suggest would be any better than the excellent help given to us by Psychologist.
Very happy with service.
Maybe have a fixed office for Psychologist and more Doctors like him.
If you have kids that they are able to have someone to talk to and listen.

7a *Clinical Health Psychology (Bariatric) Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
			12

What was most helpful about the service
The advice about the medical procedure that might go ahead.
Took time to explain and go through things with you.
Yes very.
Couldn't do enough to help with any questions I had. Explanations were very easy to the understanding of any problems I had.
I know there are someone to talk to.
Psychologist was very patient and very good at explaining things when I needed to understand things. She did not rush me to answer, she let me take things at my pace.
Everything. Got great help and insight into my eating issues. Learned a lot about myself.
Regular appointments. Follow up appointment if required.
Getting the advice when I needed it.
Being able to talk to someone on a one to one basis.
Exploring options to achieve my goals. Expressing doubts and then a follow up to review my acceptance etc.
The chance to talk out your worried to someone to share your low points and celebrate your highs.

What was least helpful about the service
Time off work to attend.
The location of the clinic to where we live.
Being there to help if I needed to phone if I needed help.
The time lapse between appointments, although my Psychologist was always happy to

accommodate you.

Do you have any suggestions as to how we can improve our service?:
No advice. Satisfied.
Everything was fine.
In my opinion you can do more than you already do for patients.
If a late night or weekend appointment could be available.
Extending the consultation time as sometimes it took me a while to get across what I wanted to say.
Get more people in earlier. Would really help a lot of people. Psychologist was great☺ thanks.
I am quite happy with the service I received.
Excellent!
Employ more staff like this Psychologist. It almost became a pleasure to visit her. A very good Psychologist. Well done!

7b Clinical Health Psychology (Cardiac) Service

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
			6

What was most helpful about the service
The way the Psychologist made me feel relaxed although the appointment.
The quick time in getting an appointment with Psychologist being able to talk to me about what happen to me.
I thought Psychologist was very good and caring.
Talking to someone.
The advice and attention I received has helped me in my recovery.
Helped me to understand my condition and how to come to terms with it.

What was least helpful about the service
Disappointed that I had to go to the bottom of the waiting list again. I thought the Psychologist said if I had to see someone else that I would not wait as long.
Didn't find anything unhelpful.
Long time for appointment.
Was satisfied with all parts of service provided.

Do you have any suggestions as to how we can improve our service?:
Overall very happy with the service.
No. I found the service was good.
Please keep up the good work as the service and compassion shown was first class.

7c. Clinical Health Psychology (Oncology) Service

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
		1	***12***

What was most helpful about the service
Just good to have someone to listen to me.
Helping me to understand and get over the anxiety caused by the chemo.
Having the time to reflect and identify triggers/stressors that I was unable to see for myself.
Within a short time my anxieties of re-occurrence subsided.
Everything. Plenty information help and support given.
Patience to listen to what I had to say. Thank you for all your help. It made a difference.
Affirmation of mental health being ok.
The total understanding of my situation was very impressive.
Caring, knowledgeable and worthwhile (Professional).
Having the ability to talk to a professional, who can provide 'tactics' to move on and even just being able to talk without hurting anyone (family may find stressful).
I was connected with other heath professional which has turned my physical and mental health around. Thank you.
She listened to everything I was saying.
Just being able to talk to somebody who understands and not a family member.

What was least helpful about the service
That I was unable to take the Psychologist home in my pocket.
Just the fact that I had to travel to Irvine.

Do you have any suggestions as to how we can improve our service?:
I fell everyone who has to undergo chemo would benefit with psychological assistance.
Maybe not having clinics in the cancer ward area.
Carry on as you are.
No suggestions. Thank you for your help.
No. I was very satisfied with the service.

8 *Multiple Sclerosis Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
			14

Have the issues with which you were referred improved

No they are worse	***No they are the same***	***Yes, there is some improvement***	***Yes, there is a lot of improvement***

What was most helpful about the service

Very good listener.
The caring attitude and the positive advice offered and happily accepted.
The fact that she listened to what I had to say then acted on it.
Being able to talk freely.
Talking to an independent person.
Helped me sort out what I didn't want to that I had MS.
The opportunity to discuss my feelings and situation with no rush and with someone able to listen and give feedback.
Everything that was offered.
Everyone was most helpful.
The friendly manner that made you open up and talk about how you really feel and what difficulties you are facing.
Friendly, patient, confidential, ready to listen; not to judge and kind helpful advice. Trust and someone to tell, talk to.
Psychologist herself was the most helpful. She has an amazing ability to listen, interpret and validate my incoherent life.

What was least helpful about the service

I was very satisfied with everything.
I have no criticism of the service. I received the highest care possible and I am very grateful to the Psychologist.
All the advice I was given was very helpful and I found nothing about the service unhelpful at all.

Do you have any suggestions as to how we can improve our service?:

Most impressed with the co-ordination between professionals throughout various departments in DGRC. I think you would be hard pressed to improve the service provided, certainly in my case.
Excellent as is.
No. I have attended previous Psychologists and felt I had not really benefitted. However this Psychologist completely dispelled that. She is very approachable and shows great empathy towards my situation. I cannot praise and thank her enough.

Further Comments

Appendix 3

NHS AYRSHIRE & ARRAN PSYCHOLOGY SERVICE PATIENT SATISFACTION SUMMARY

From 1 March 2015 – 31 March 2016

1 Douglas Grant Neuro *Themed Responses from Questionnaires in Douglas Grant Rehabilitation Service (Neuro-Rehabilitation Psychology)*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
	1	***4***	***17***

What was most helpful about the service

Having someone to talk to who listened and acknowledged what I had been through and gave me practical ways to move forward.
Clever Questioning proved what I was thinking.
Everything.
Everyone is so helpful
Having my case being based around my condition. Being reassured that it's not psychological my fault.
Advice on looking after myself and extent of injury.
Having had surgery (bi frontal craniotomy) on 27 July it was important to me to undergo assessment to reassure me that I had no remaining issues.
Brining back my confidence and helping me with techniques to overcome my difficulties.
Understanding.
How the Doctor took time to both listen to my thoughts and symptoms and explain everything to me.
Learning how to let go or embrace certain patterns or feelings.
Explained it fully what concerned me.
Was allowed to take my own time between goals.
Testing to see how memory was affected.
The Whole course.
The ability to talk about my illness and how it affects me, and to find ways around this, also how to try and think differently to help myself and not to expect others to fix the unfixable. Being able to talk through feelings and thoughts without being judged was so helpful to me.
Psychologist came to my house to see me in my own environment which took away the anxiety, and gave better results on my tests.
Psychologist took time to read information from my relative's notes that we were unaware of – found out lots we didn't know from previous admissions.
Being able to talk and have someone to listen.
Proving to the relevant Consultant that on the whole the exercise was unnecessary.

Also providing the satisfaction that the problem is physical. Psychologist was, however, very understanding.

What was least helpful about the service No tea bar. Found the services very helpful, the only downfall was the lack of appointment times/days. Although helpful, info became repetitive over time. No help with anger management. Assumptions were made. Travelling to and from the service was very good.

Do you have any suggestions as to how we can improve our service?: Little Quicker. Couldn't get better. Keep doing what you're doing. Maybe more times and days available to patient other than that, a very good service. Psychologist is a wonderful lady and doctor. Give more praise for slightest of improvements. I would like help with all of the issues I was referred for. To see a signpost for the Douglas Grant building as you come through the main gate would be helpful. I think this is an invaluable service the Psychologist helped immensely and helped me change my whole thought and feeling pattern, who also guide you through the many ways of illness etc and thank you so very much.

2 *<u>Neuropsychology Service (Neuropsychological Assessment and Diagnostic Psychology)</u>*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
	2		***12***

What was most helpful about the service Nothing except being told I'm not a nutter! Trying to deal with stress and dealing with my fits. Great services. The fact that Psychologist could speak to me on the phone, Knowing about the diagnosis I have. Psychologist was very encouraging and reassuring. Recognising that my neurological condition would not result in me having to be in a wheelchair!! That was my greatest fear. Trying out ways to overcome my problem gait. Although only slightly improved (by taking smaller strides and stopping more frequently) I know I have given it my best effort and have come to terms with this. Explaining the condition in full. Someone to talk to and understand my problem after my illness. A great help to me.

Helped dealing with seizure.
Talking to a sympathetic qualified therapist that I hoped would get to the root of my stress problem.
The Psychologist was courteous, punctual and seemed decent.
What I found most helpful was the testing made me think and concentrate. The results made me aware of the difference in how my brain works now compared to when the tests were carried out before I had brain surgery. I was a little shocked.
Very Patient, able to discuss things with her and get a good understanding.

What was least helpful about the service
My 1st appointment as it was held at Arrol Park where my disabled brother died.
The time which was spent on each session could have been longer.
Being told about my condition.
I was made to feel that I had made up the pain in my head – like all my pain was mentally controlled. I had 2 serious surgical operations this pain was not made up.
I felt "guilty"/ A Failure that despite using the techniques suggested I did not have desired outcome as Neurologist had indicated the problem was psychological and "in my head". P.S. I found not focusing on walking by thinking other things or singing while walking did not really make any difference or by "Believing" I had no walking problem as "all in my head".
Having been told about my condition and now advanced it may become.
Disappointingly still no improvement. Depressing.
I remember === and Mother who's here saying they were a little disappointed when they said my answers came back as brain dead I didn't take Valium that day but did the other appointments I took them in front of they so I could relax and I'm still unsure of the results I couldn't take in what they were telling me. I need people for that.
I enjoyed the experience, Dr was very nice and helpful. It was good not to have to go all the way to Glasgow for the service.

Do you have any suggestions as to how we can improve our service?:
None service was great. Psychologist did their best to help me.
Home visits for housebound people or people with poor mobility.
Was totally satisfied with Psychologist services and all the information they provided to the family.
At the end of each session a plan was made for the next session. This never materialized. I felt positive in my approach to assistance from a psychologist and new I am completely negative due to my complete dissatisfied service.
Sorry I don't. I think it is a good service.
Sorry I wish I had!
Yes in the picture things all the tests I was unsure of he told me to guess I could have guessed them all correctly or incorrectly this made me very irritated and I expressed this I was getting agitated by this why I use valium to keep me calm and kinda settles I was surprised he let me take the valium as there unsubscribed and I need to buy them I think without these in me I'd have walked out I get agitated easy if you don't know certain answers guessing isn't the way.

3 *Older Adults Service (across Mental and Physical Health Psychology Services)*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
	2	***7***	***31***

What was most helpful about the service

Everybody was very helpful and patient.
Psychologist has a very professional yet friendly approach. I feel at east discussing problems with her and never feel a need to hold back.
Prompt attention to my anxiety about my concerns with regular appointments and assurance given by Dr.
Having the opportunity to talk and be listened too on a regular basis.
Dr was very patient and listened to what I had to say and felt after our loss.
Psychologist summed up my problems quickly and accurately and referred me to neurology who gave a diagnosis and treatment of a long term problem which was quite complex (Residual Guillian Barre and Parkinson).
The compassionate way mum was spoken to and the kindness shown throughout.
Took time to listen and care. A rate thing nowadays.
Treated courteously and not left waiting.
I must say that the informative way in which the meetings were conducted, encouraged me to discuss what I really felt. Also the fact that my wife could come along to some of the meetings was very helpful.
The confirmation that my mental health was satisfactory.
Just being able to talk and ask questions.
Being able to talk openly about personal problems.
Memory tips was pleased about questions.
For the first time someone (Psychologist) explained what I was suffering from, anxiety and not depression. Also a bit part of it was the home visits by the Psychology Assistant.
Surroundings was quiet and peaceful, well away from the main corridor and very private.
All staff were respectful and mannerly and very understanding.
Being able to speak freely.
Although I was very uptight about seeing the Psychologist, she completely pt me at east and I was able to answer her questions.
Being put at ease and being able to talk.
Psychologist manner, treatment was paced well, not rushed. Ideas and concepts were very clearly explained. Did not feel threatened or stressed.
For me knowing that I could bare my soul and not being judged.
Meeting a kind and friendly Doctor and being told straight to the point what is wrong with my wife.
It helped me learn how to cope in stressful situations and gave me confidence in myself, I also found I could talk to the Trainee Psychologist which really helped me.
The approachability and willingness to discuss the case was excellent. The understanding and insight provided by the Psychologist was invaluable.

Having someone to talk to who listened and discussed and being told that I could contact directly if I was in need of appointment.
Everything.
Dr showed much patience with me and was very helpful.
Dr was very helpful and easy to talk to.
It is good to talk to someone who is not directly involved with friends and family.
Very patient and understanding talking through my mini-breakdown and memory problem very helpful to me.
Being able to talk freely with someone independent of family and friends. Viewing your demons from a different angle.
How to self solve problems – discuss problems – from someone else's perspective.
Hopefully got the meds that will stop/slow down the deterioration in my cognitive state.
Dr's communication is good for both patient and carer.
Didn't get much from visits!
Everything to a high standard of care and understanding.

What was least helpful about the service
Cannot find fault in any of the NHS Services for the elderly.
Nothing was unhelpful.
Extremely helpful! Always felt a little better after appointments with the Psychologist.
I didn't think our last visit was necessary and mum gets worried about any kind of memory tests. Advice given was common sense.
Sending my mum back to the GP
I had no concerns.
Everything was helpful and very good.
Really I don't think that I experienced anything that wasn't helpful.
All good.
Have no complaint whatsoever.
I cannot think of any way to improve the service.
3 questions weren't answered. Found this annoying and worrisome. It may be that answering would have negative effect but not answering was just as negative.
The only think that is least helpful is Dr ? is leaving AYRSHIRE & Arran NHS.
Thant they were not involved from the beginning of the case. It felt like a battle to get the service involved – this was not their doing.
Trying to park the car!
Nothing.
I was very nervous at first.
Extremely Helpful.
Such a slow process.
Having one appointment postponed. Also mention of 'brain scan'* at 1st appointment with Dr G did not transpire.
Didn't get much from visits!
No complaints of anything.

Do you have any suggestions as to how we can improve our service?:
No. I am impressed by whole of East Ayrshire/AAHB services since moving here 5 years ago.
I cannot help on this service as the staff and Doctors give excellent service to the general health of the elderly in every clinic I have attended.
Find a cure for this horrible disease Dementia.

If more Dr's were like my Psychologist then the NHS would thrive.
Very Helpful, so no suggestions required.
Since I met Psychologist I've started watching Andre Rieu. His music is great and I watch it every day.
I hope very much this service will continue to help others in the future and it would be good to know that this service will be available if needed in the future for me if I need it. I would to thank Dr and Assistant for the way that I was treated. I can't thank them enough.
I had a sympathetic listener and advisor and cannot see what more I could expect.
At outset I would have liked a clear and detailed explanation about what was to be achieved and how it would be carried out. Because of the nature of the process maybe this isn't possible.
I have no suggestions other than keep Dr ? at Ayrshire & Arran. Good luck to you Dr ? in your new post.
NICE Guidelines must be followed. Psychology to Psychiatric treatment must be provided in tandem, for the proven best outcomes. The current approach of often only psychiatric treatment is totally misguided. Longer term support for families would be most welcomed.
Nothing I can think of.
A little soft music might help a nervous person.
My opinion is that the service is perfectly adequate as it is!
Perhaps deal in more depth on some issues.
Speed up the <u>whole</u> process.
Better not to mention possible referrals GL (in ans to our Q) said it will be 12 weeks but we aren't sure if we have been referred. Also over the months* the patient has deteriorated so much that she will in all eventually refuse brain scan. Dr G saw mum 3/10/14 (Mum ref to Dr G 27.05.14). Second opinions should be fast tracked though we appreciate it. Concerns first raised with us September 2013 due to behavior change.
More than just talking and doing written exercises.
Nothing more to add excellent care from start.

4 *<u>Eating Disorders Service Provision</u>*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
			1

What was most helpful about the service
Being able to talk about things that bother you with someone.

What was least helpful about the service

Do you have any suggestions as to how we can improve our service?:

Ensure contact is kept with patients who require assistant, i.e. if absent for a period of time, organize a replacement or inform the patient, mental health is a serious issue – losing support can have serious consequences.

5 *Psychosocial Oncology Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
1	***1***	***2***	***22***

What was most helpful about the service

The quality of the service.
Just talking to someone other than family.
Being able to discuss my circumstances.
Didn't feel it was of any use to me.
Everything about the service was great.
Opportunity to talk freely and reach my own solutions/connections.
Easy to talk to. All points covered. Understanding. Reasonably successful outcome.
She made what could have been a difficult talk very easy and comfortable.
Talking about my illness. Dr was very understanding and good to talk to.
Empathy and general support shown during sessions.
Home visit – less stressful to patient. Provided support and advice to both patient and carer.
It was most helpful in getting my head round my problems.
Dr was very good at getting to the bottom of the problem/s and very effective in her counselling me to look at my situation from a more positive perspective. She made me feel better about myself initially.
Speaking to someone who will listen not judge and give good advice. Knowing what is talked about is confidential.
Lovely to talk to Dr, very understanding.
Further ongoing help as to the continuing treatment and advice.
Helps to come to terms with yourself.
Talking to her. She was very nice.
Being able to talk things over and Dr understanding things.
The fact that it was one to one, as the support I had in the past was group therapy which I struggled with.
The ease and comfort to talk openly.
Very thorough review.
It helped me gain control of my life again. The kind, friendly and practical help was invaluable. I could not do it alone.
Feeling like someone might be able to provide practical strategies to recover from stress symptoms following 2nd cancer diagnosis.
Psychologist pulled me out of a black hole.

What was least helpful about the service

No minuses it was all good.
None it was just talking to each other and plus it was too far away to travel to as I was fed-up before reaching my appointment.
Number of cancellations – only available two days a week which did not really suit me.
I cannot think of anything.
In no way was it unhelpful.
Nothing. All was good.
There was no leased helpful advice.
Travelling.
Perhaps the venue.
Waiting for my 1st appointment. The room was awful.
Very limited availability made it difficult to get to appointments so had to postpone them.

Do you have any suggestions as to how we can improve our service?:
Happy with it all.
Have it closer to hand. Don't have so long waiting time. And if they were able to prescribe medication to help with the depression and other.
I cannot say how you can improve the service as I was delighted with everything.
Not really except perhaps a higher chair for someone who has difficulty getting up from low sofas or chairs.
Offer the service at an earlier stage.
I was very pleased with both my sessions with Dr.
AS far as my help I was most satisfied.
No. I think things very good as I could not have coped without the help, as sometimes I was so low and just to talk to someone outside my own friends and family is so good, I could open up to her.
No. Just keep up the level of support. A big thank you.
Have Dr come to my house and live ☺Pleassse … She was a ray of sunshine for me and so easy to talk to.
It would have been better, if you had a room suitable for this service. My first appointment was in little more than a cupboard. After that the room we were in was dull, the chairs were too low. I had trouble getting up. You need a Counseling room.
While I appreciate this may be difficult, more flexible availability to allow me to attend appointments yet to keep my job which I see as an important part of feeling "normal" and so helping also with my recovery. We have agreed that I will ask for a referral again later in the year in the hope that my working pattern may be more compatible with service availability but I am keep to get support asap. Please don't consider me dissatisfied – just an unfortunate clash!

6 *Stroke Service*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***

		2	***8***

What was most helpful about the service
Explanation in detail.
My last appointment with Dr was very positive thanks to his understanding and encouraging manner. I felt motivated too and empowered to go forward with my ongoing rehab. There is now a light at the end of this time.
Having a stranger to talk to (not a family member) and release inner feelings.
Reception staff unhelpful and misinformed.
Support and Reassurance
Time keeping. Very helpful. Always taking care to help.
Helped with advice on dealing with things after stroke.
The explanation of my stroke and the affects.
Helped when I was in really dark place.
I found my session with Dr invaluable. I have Aphasia following a stroke and Dr explained in simple terms the functions of the brain which had been affected. This gave me an insight and confidence and helped me understand better what has happened to me. Dr also met with my wife x 2 and has offered strategies to allow me to go forward with my rehabilitation. We cannot thank him enough.

What was least helpful about the service
Everything was very helpful – no negatives.

Do you have any suggestions as to how we can improve our service?:
More Dr like this one would be good.
Possibly include family more at sessions. Would be useful to have a contact for when you feel you need assistance outwith appointments.
Try make the appointment a bit quicker cuts down stroke victim anxiety.
No I do not, I found the service most helpful and comforting. I found a friend in Dr and he brought me from a very dark place and also helped with problems I was having with and regarding bowels.
In my experience I wish I had been able to meet with Dr right away following my stroke which might have stopped the difficult situation I found myself in.

7a *<u>Clinical Health Psychology (Bariatric) Service</u>*

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
		1	***1***

What was most helpful about the service
Knowing if things were getting tough that you can phone the service and arrange another appointment anytime.
Being able to talk to someone who listed and didn't judge.

What was least helpful about the service
I don't think there is anything not helpful about the service.

Do you have any suggestions as to how we can improve our service?:
I don't think there are any things I can think of to improve the service. I think it is very helpful as it is now.

7b Clinical Health Psychology (Cardiac) Service

How satisfied were you with the service you received			
Dissatisfied	***Slightly satisfied***	***Mainly satisfied***	***Very satisfied***
		1	***6***

What was most helpful about the service
Explaining various methods to reduce stress.
I only had 1 appointment.
Everything explained well and service I recieved was second to none. Also Dr assured me that she was there for me in the future if I need her help.
Apart from having 2 x procedures carried out I also lost my Brother and Sister to heart diseases and the break-up of my marriage all in the same year. Dr helped me come to terms with everything. A wonderful person and a credit to NHS.
Dr clearly knew her psychology but she was also grounded in the reality of life. She had a natural ability to communicate and show empathy. Traits that all medical staff should posses but, sadly, many don't.
The way she explained everything to me so as I understood.
Knowing I could talk to Dr about anything and that there was time set aside for me to do so.

What was least helpful about the service
No complaints.
The 1st meeting should be held in a location closest to a patient's home – not, as in my case, the one furthest away.
Getting parked at Crosshouse Hospital was very stressful and meant that I needed to arrive at the hospital at least half an hour before my appointment.

Do you have any suggestions as to how we can improve our service?:
No, very good in funny way. Keep up the good work.
Sorry I can't think of any maybe another Dr like the one I seen.

7c. Clinical Health Psychology Service

How satisfied were you with the service you received

Dissatisfied	*Slightly satisfied*	*Mainly satisfied*	*Very satisfied*
1			*1*

What was most helpful about the service
Having someone that I could speak to without being judged.
Due to my illness, the service that I received wasn't very helpful

What was least helpful about the service
Having to write things down every day.
No help given. Didn't listen. Silly tasks to be completed.

Do you have any suggestions as to how we can improve our service?:
Listen to what the patient is saying.

8 *Multiple Sclerosis Service*

How satisfied were you with the service you received

Dissatisfied	*Slightly satisfied*	*Mainly satisfied*	*Very satisfied*
		2	*4*

What was most helpful about the service
Helpful strategies to face my problems.
That my therapist knew about MS.
Allowed me to realise that my memory was affected by MS.
Being listened to and helped to sort out worries and problems.
Someone to share problems with as I take care of myself and I had been feeling like committing suicide.
General discussion with Psychologist regarding MS and her giving re-assurance to me.

What was least helpful about the service
I have nothing to criticise about the service.
Would have liked more discussion regarding my specific MS problems.

Do you have any suggestions as to how we can improve our service?:
Perhaps a follow up maybe helpful as when one goes home and tries to adjust to acceptance of what their MS problems are and how they are, in reality, coping with these problems, which can sometimes be difficult.

Appendix 5.1

Psychological Therapies Waiting Times In NHSScotland

Quarter ending 31 March 2017

Publication date – 6 June 2017

Contents

Introduction

This publication contains information about how long people waited to start treatment for Psychological Therapies provided by the NHS in Scotland. This information has been published quarterly since August 2013. The information in this publication covers the period January to March 2017, with figures from the last 4 quarters for reference.

Psychological Therapies refer to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The standard applies specifically to Psychological Therapies for treatment of a mental illness or disorder.

The Scottish Government requires the NHS in Scotland to measure the time people wait for treatment and this includes people waiting for Psychological Therapies. The Scottish Government has set a standard for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. Following the conclusion of previously planned work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies standard should be delivered for at least 90% of patients.

This standard includes Psychological Therapies as defined above. These include Psychological Therapies listed in 'The Matrix: A guide to delivering evidence based Psychological Therapies in Scotland' at www.nes.scot.nhs.uk and also those not listed but which clinicians decide are the most appropriate treatment to meet a patient's needs. The standard applies: where the therapy is delivered to individuals or groups on a face-to-face basis, by staff trained to recognised standards, operating under appropriate supervision, in dedicated/ focused sessions; where the therapy is delivered through family, health and/or care staff who are being trained or supported to deliver a particular intervention to a named patient/client; to all ages (including CAMH services); in inpatient as well as community settings; in physical health settings where there is associated mental illness such as depression or anxiety, for example chronic pain and cancer; for substance misuse where there is associated mental illness; and for learning disabilities where there is associated mental illness.

This publication also includes information on Psychological Therapy referrals and waiting times for people aged 65 and over.

For the first time NHS24 data from the Living Life Service is included in the publication from February 2017, more information on this service can be found here. This data is only available at NHSScotland level.

The systems for collecting data locally are still being developed, and as a result, some people who had treatment for Psychological Therapies are not included in this publication. However, the information in this publication does give a good indication of waiting times in most areas of Scotland. The volume of information we have been able to collect from NHS Boards has increased each quarter and we expect this to continue to increase in coming months. The Psychological Therapies HEAT Standard, Guidance and Scenarios document was updated in March 2014 to reinforce clarity for Boards on the scope of the standard and how to interpret a wide range of scenarios. The revised guidance was issued to Boards and made available on the ISD website at http://www.isdscotland.org/Health-Topics/Waiting-Times/Psychological-Therapies/

There will be differences in the measures used and collection methods of Psychological Therapies waiting times statistics, as well as differences in service structures between the administrations. The different datasets will not be strictly comparable.

Users need to carefully read the publications when making comparisons.

More information on the data quality can be found in A2-Data Quality, pages 26-39 of this publication.

Main points

- Waiting times information for Psychological Therapies are developmental. NHS Boards are working with ISD and the Scottish Government to improve the consistency and completeness of the information. The Scottish Government has set a standard for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. The standard should be delivered for at least 90% of patients.

For the quarter ending March 2017:

- 11,208 people started treatment for Psychological Therapies in Scotland which is a decrease from the previous quarter (11,393).
- Over seven out of ten (73.7%) patients were seen within 18 weeks which compares with 77.5% in the previous quarter.
- Three NHS Boards met the standard of treating 90% of patients referred within 18 weeks - these were NHS Highland, NHS Lanarkshire and NHS Western Isles. Please see notes for information relating to NHS Greater Glasgow & Clyde.
- 604 people aged 65 and over started treatment for Psychological Therapies in this quarter and 79.8% were seen within 18 weeks which is an increase from the previous quarter (593).

1. From September 2016 data completeness for NHS Greater Glasgow and Clyde is between 20-30% due to IT system changes; no conclusions can be drawn from their data. Revised figures will be published on completion of IT changes. Therefore, Scotland figures will change.
2. For the first time NHS 24 data from the Living Life Service is included in the publication from February 2017. This data is only available at NHSScotland level.

How long people waited to start their treatment

This section shows waiting times for patients who started their treatment during the period January to March 2017, with previous quarters data for reference. This information is still developmental. NHS Boards are working with ISD and the Scottish Government to improve the consistency and completeness of the information.

During the period January to March 2017 (see Table 1):

- 11,208 people started their treatment for Psychological Therapies in Scotland, in comparison to 11,393 for quarter ending December 2016.
- Using adjusted waits where available, 73.7% of people seen for Psychological Therapies started their treatment within 18 weeks of being referred, this is less than the previous quarter (October to December 2016) of 77.5%. For quarter ending March 2017 half of all people seen started their treatment within nine weeks which is an increase compared to the previous quarter.
- Using unadjusted waits, 70% of people seen for Psychological Therapies started their treatment within 18 weeks of being referred this is less than the previous quarter (October to December 2016) of 73.8%. For quarter ending March 2017 half of all people seen started their treatment within eleven weeks which is more than the October to December 2016 quarter (ten weeks).

Table 1. Waiting times for people who started their treatment in January 2016 – March 2017, NHS Scotland[1,2,3,4,5,6,7,8,9]

Quarter	People seen	With adjustments[1,2,3]			Unadjusted		
		Seen within 18 weeks (number)	Seen within 18 weeks (%)	Average (median) wait (weeks)	Seen within 18 weeks (number)	Seen within 18 weeks (%)	Average (median) wait (weeks)
Jan to Mar 2016[4,6,8]	13,556	11,226	82.8	7	10,745	79.3	9
Apr to Jun 2016[5,7,8]	12,984	10,505	80.9	8	10,033	77.3	10
Jul to Sep 2016[5,7,8]	11,360	8,966	78.9	8	8,519	75.0	10
Oct to Dec 2016[5,7]	11,393	8,825	77.5	8	8,410	73.8	10
Jan to Mar 2017[9]	11,208	8,255	73.7	9	7,842	70.0	11

Notes

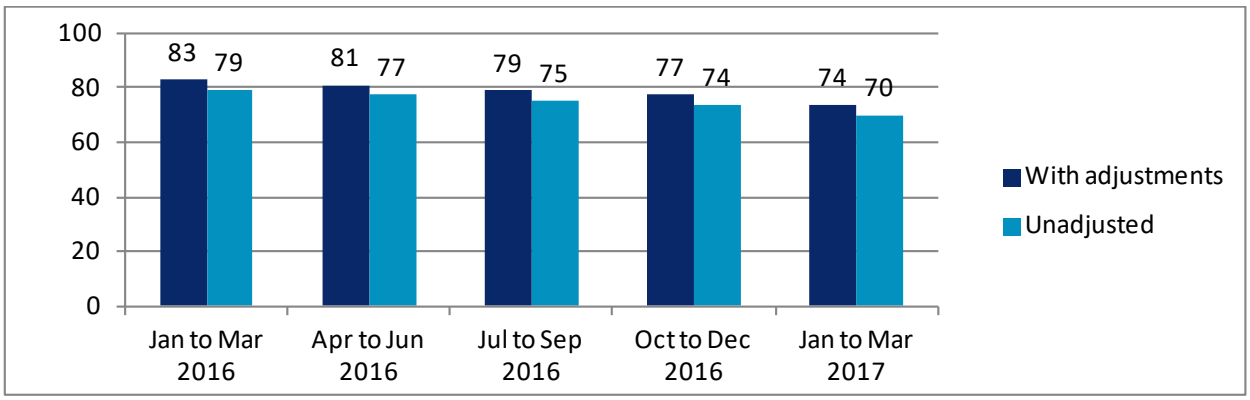
3. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available.
4. NHS Orkney data is not available.
5. For details of adjustments see Table 2.
6. Patients seen data for NHS Highland are estimated to be 30% complete up to April 2016 due to system issues.
7. NHS Highland has resubmitted data from April to December 2016.
8. NHS Greater Glasgow & Clyde are migrating to a new Patient Management System, this is having an impact on the completeness of the data submitted from September 2016. Caution should be taken when making comparisons between quarters.
9. NHS 24 Living Life Service is included from February 2017.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Chart 1 shows the percentage of people seen within 18 weeks split by quarter for the last five quarters. Information by NHS Board is shown in Tables 2 and 3 and Chart 2. While NHS Boards are developing their systems to improve the completeness and consistency of these

data, NHS Board figures may not be directly comparable. We expect to be able to make more accurate comparisons by NHS Boards in future publications.

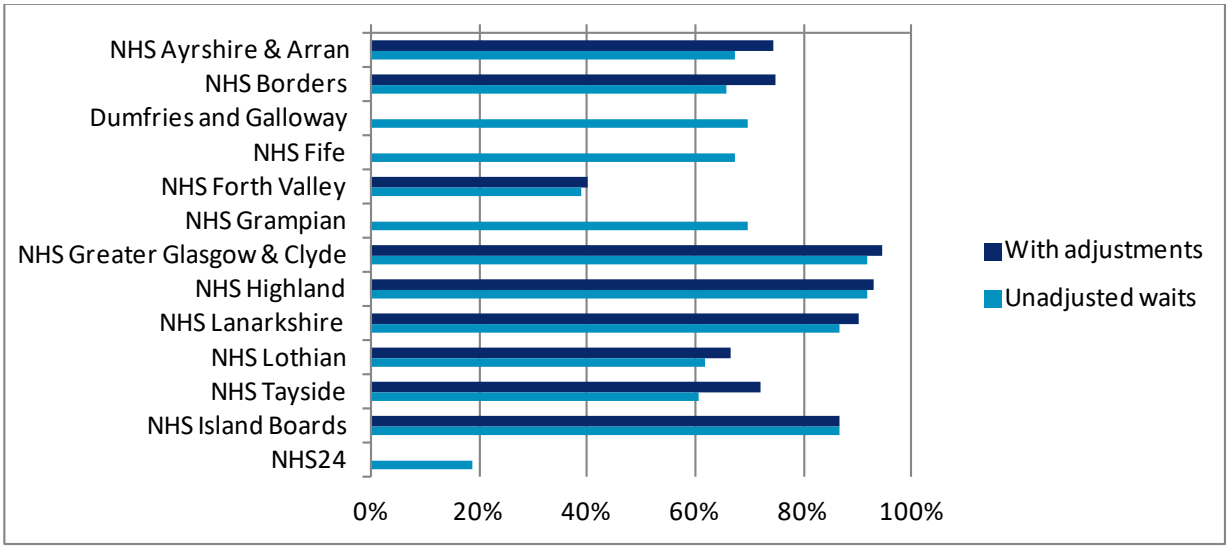
Chart 1. Percentage of people who started their treatment within 18 weeks, NHS Scotland[1,2,3,4,5,6,7] , quarters ending March 2016 to March 2017



Notes
1. Scotland level adjusted data include unadjusted waits for NHS Boards where adjusted waits are not available.
2. NHS Orkney data is not available.
3. For details of adjustments see Table 2.
4. NHS Greater Glasgow & Clyde are migrating to a new Patient Management System, this is having an impact on the completeness of the data submitted from September 2016. Caution should be taken when making comparisons between quarters.
5. Patients seen data for NHS Highland are estimated to be 30% complete up to April 2016 due to system issues.
6. NHS Highland has resubmitted April to December 2016 data.
7. NHS 24 Living Life Service is included from February 2017.

Chart 2. Percentage of people who started their treatment within 18 weeks by NHS Board, January to March 2017[1,2,3,4]

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.



Notes
1. For details of adjustments see Table 2.
2. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
3. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
4. NHS 24 Living Life Service is included from February 2017.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Table 2. Waiting times (with adjustments[1]) for people who started their treatment in January to March 2017 by NHS Board[2,3,4,5]

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of Treatment	People seen	People seen within 18 weeks (Number)	People seen within 18 weeks (%)	Average (median) wait (weeks)	Waiting time adjustments[1]
Scotland[2,3,4,5]	11,208	8,255	73.7	9	..
NHS Ayrshire & Arran	1,442	1,071	74.3	7	NA, U
NHS Borders	160	120	75.0	10	NA, U, RO
NHS Dumfries & Galloway	721	503	69.8	9	Unadjusted
NHS Fife	1,286	867	67.4	9	Unadjusted
NHS Forth Valley	788	315	40.0	25	NA, U
NHS Grampian	849	591	69.6	12	Unadjusted
NHS Greater Glasgow & Clyde[3]	894	847	94.7	6	NA
NHS Highland	556	516	92.8	6	NA,U, RO
NHS Lanarkshire	1,652	1,489	90.1	8	NA,U, RO
NHS Lothian	1,660	1,106	66.6	13	NA, U, RO
NHS Tayside	1,067	769	72.1	12	NA, U, RO
NHS Island Boards[4]	53	46	86.8	7	..
NHS24[5]	80	15	18.8	26	Unadjusted

Notes

.. Data not available

1. Waiting time adjustments:
   NA: Non Attendance. Waiting time may be reset if a person misses or rearranges an appointment.
   U: Unavailability. Time a person is unavailable may be subtracted from the waiting time.
   RO: Refuses Reasonable Offer. Waiting time may be reset if a person declines 2 or more dates.
   For further information see page 27.
2. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available.
3. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
4. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
5. NHS 24 Living Life Service is included from February 2017.

Further information by NHS Board can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Table 3. Unadjusted waiting times for people who started their treatment in January – March 2017 by NHS Board[1,2,3]

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of Treatment	People seen	People seen within 18 weeks (Number)	People seen within 18 weeks (%)	Average (median) wait (weeks)
Scotland[1,2,3,4]	11,208	7,842	70.0	11
NHS Ayrshire & Arran	1,442	973	67.5	10
NHS Borders	160	105	65.6	13
NHS Dumfries & Galloway	721	503	69.8	9
NHS Fife	1,286	867	67.4	9
NHS Forth Valley	788	308	39.1	25
NHS Grampian	849	591	69.6	12
NHS Greater Glasgow & Clyde[1]	894	822	91.9	6
NHS Highland[1]	556	510	91.7	6
NHS Lanarkshire	1,652	1,430	86.6	11
NHS Lothian	1,660	1,025	61.7	15
NHS Tayside	1,067	647	60.6	17
NHS Island Boards [2]	53	46	86.8	10
NHS24[3]	80	15	18.8	26

Notes

1. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
2. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
3. NHS 24 Living Life Service is included from February 2017.

Further information by NHS Board can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

People waiting at the end of the quarter

This section presents a summary of waiting times information for Psychological Therapies for people who are waiting at the end of quarter month.

This is a useful measure for managers of these services as it can help them take early action to ensure that patient waits do not exceed the standard. However this measure does not show how long people actually wait before they received care.

This information is still developmental. NHS Boards are working with ISD and the Scottish Government to improve the consistency and completeness of the information.

At the end of March 2017 (Table 4):

- 20,952 people were waiting to start treatment for Psychological Therapies in Scotland, this is an increase on quarter end December 2016 (20,195).
- Using adjusted waits where available, 15,328 (73.2%) people had been waiting less than 18 weeks, this is an increase on the quarter end December 2016 figure of 14,984 (74.2%).
- Using unadjusted waits 15,011 (71.6%) people had been waiting less than 18 weeks, this is an increase on the quarter end December 2016 figure of 14,592 (72.3%).

Table 4. Waiting times for people waiting at the end of the quarter in Scotland[1,2,3,4]

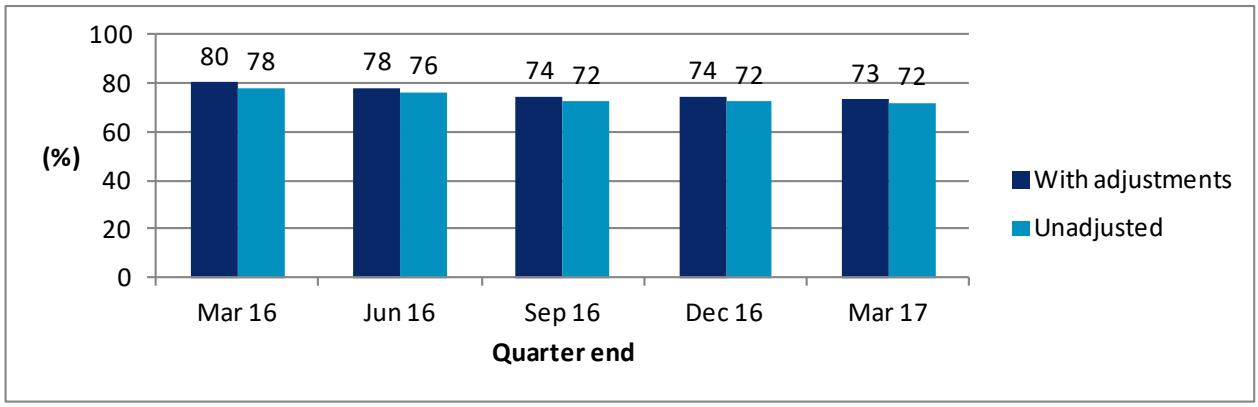
Quarter End	Total People Waiting	With adjustments[1,2,3,4]		Unadjusted[2,3,4]	
		Waiting less than 18 weeks (Number)	Waiting less than 18 weeks (%)	Waiting less than 18 weeks (Number)	Waiting less than 18 weeks (%)
Mar 16	18,331	14,689	80.1	14,288	77.9
Jun 16	18,048	14,073	78.0	13,775	76.3
Sep 16	18,225	13,549	74.3	13,178	72.3
Dec 16	20,195	14,984	74.2	14,592	72.3
Mar 17	20,952	15,328	73.2	15,011	71.6

Notes

1. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available.
2. NHS Greater Glasgow & Clyde are migrating to a new Patient Management System, this is having an impact on the completeness of the data submitted from September 2016. Caution should be taken when making comparisons between quarters.
3. NHS Orkney data is not available.
4. NHS24 Living Life Service is included from February 2017.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Chart 3. Percentage of people waiting less than 18 weeks, NHS Scotland[1,2,3,4,5], January 2016 - March 2017



Notes

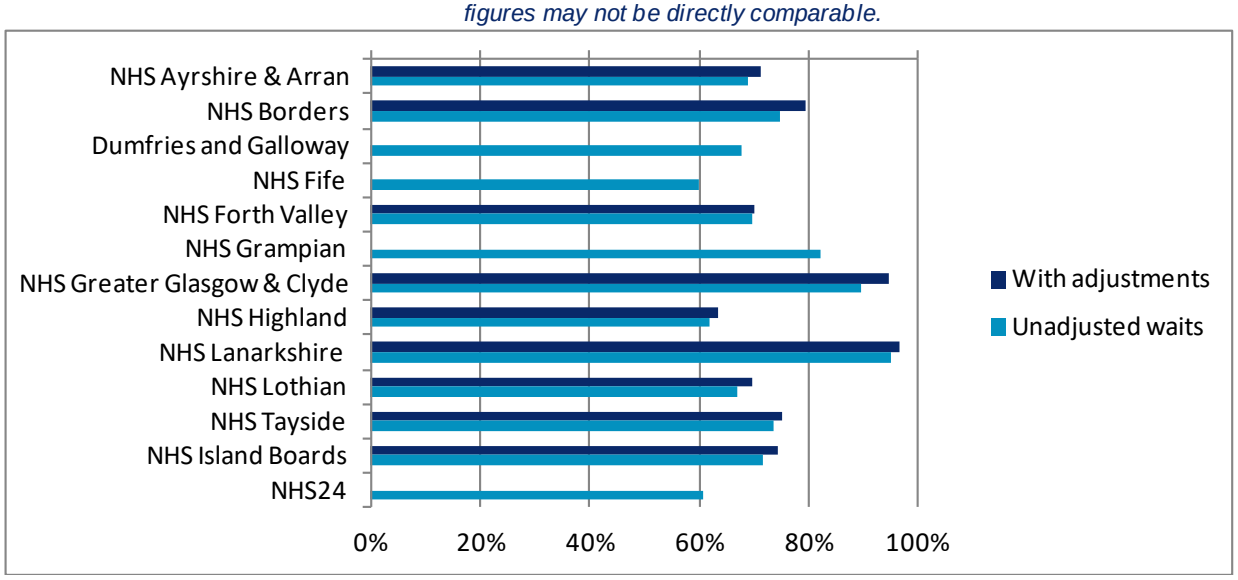
1. Scotland level adjusted information includes unadjusted waits for NHS Boards where adjusted waits are not available.
2. For details of adjustments see Table 5.
3. NHS Greater Glasgow & Clyde are migrating to a new Patient Management System, this is having an impact on the completeness of the data submitted from September 2016. Caution should be taken when making comparisons between quarters.
4. NHS Orkney data is not available.
5. NHS24 Living Life Service is included from February 2017.

Chart 3 shows the percentage of people waiting less than 18 weeks, split by quarter end, for the last five quarters.

Information by NHS Board is shown in Chart 4 and Tables 5 and 6.

Chart 4. Percentage of people waiting less than 18 weeks by NHS Board[1,2,3,4], 31 March 2017

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.



Notes

1. For details of adjustments see Table 5.
2. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
3. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
4. NHS24 Living Life Service is included from February 2017.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Table 5. Waiting times (with adjustments[1,2]) for people waiting at 31 March 2017[3,4,5] by NHS Board

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of treatment	Total People Waiting	Waiting less than 18 weeks (Number)	Waiting less than 18 weeks (%)	Waiting time adjustments[1]
NHS Scotland[2,3,4,5]	20,952	15,328	73.2%	..
NHS Ayrshire & Arran	2,730	1,945	71.2%	NA, U
NHS Borders	401	319	79.6%	NA, U, RO
NHS Dumfries & Galloway	1,122	761	67.8%	Unadjusted
NHS Fife	2,736	1,644	60.1%	Unadjusted
NHS Forth Valley	1,535	1,075	70.0%	NA, U
NHS Grampian	1,229	1,012	82.3%	Unadjusted
NHS Greater Glasgow & Clyde[3]	323	306	94.7%	NA
NHS Highland	1,519	962	63.3%	NA, U, RO
NHS Lanarkshire	2,512	2,425	96.5%	NA, U, RO
NHS Lothian	4,455	3,101	69.6%	NA
NHS Tayside	2,136	1,609	75.3%	NA, U, RO
NHS Island Boards[4]	109	81	74.3%	..
NHS24[5]	145	88	60.7%	Unadjusted

Notes

.. Data not available

1. Waiting time adjustments:
   NA: Non Attendance. Waiting time may be reset if a person misses or rearranges an appointment.
   U: Unavailability. Time a person is unavailable may be subtracted from the waiting time.
   RO: Refuses Reasonable Offer. Waiting time may be reset if a person declines 2 or more dates.
   For further information see page 27.
2. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available.
3. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
4. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
5. NHS24 Living Life Service is included from February 2017.

Further information by NHS Board can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Table 6. Unadjusted waiting times for people waiting at 31 March 2017 by NHS Board[1,2,3]

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of treatment	Total People Waiting	Waiting less than 18 weeks (Number)	Waiting less than 18 weeks (%)
NHS Scotland[1,2,3]	20,952	15,011	71.6%
NHS Ayrshire & Arran	2,730	1,882	68.9%
NHS Borders	401	300	74.8%
NHS Dumfries & Galloway	1,122	761	67.8%
NHS Fife	2,736	1,644	60.1%
NHS Forth Valley	1,535	1,073	69.9%
NHS Grampian	1,229	1,012	82.3%
NHS Greater Glasgow & Clyde[1]	323	290	89.8%
NHS Highland	1,519	941	61.9%
NHS Lanarkshire	2,512	2,384	94.9%
NHS Lothian	4,455	2,983	67.0%
NHS Tayside	2,136	1,575	73.7%
NHS Island Boards[2]	109	78	71.6%
NHS24[3]	145	88	60.7%

Notes

1. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
2. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
3. NHS24 Living Life Service is included from February 2017.

Further information by NHS Board can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Number of people referred for Psychological Therapies

This section has information on how many people are referred for Psychological Therapies. Waiting lists can build up where demand for services exceeds the capacity of that service, so the number of referrals is a key measure for managing waiting times. This information is still developmental.

There are considerable variations in service structures across NHS Boards, and therefore a number of different referral pathways for people seeking to access Psychological Therapies.

In some areas referrals are made directly into discrete Psychological Therapies services, and it is relatively straightforward for Boards to report the numbers of referrals for Psychological Therapies, the date of receipt of referral and the date of commencement of treatment.

In other areas, however, there are no discrete Psychological Therapies services and Psychological Therapy is delivered, by appropriately trained staff, from within more generic Mental Health teams. These teams generally have a single point for receipt of referrals, and a subsequent process for allocation to a psychological therapist. In this case the date of receipt of referral is the date the referral is received by the Mental Health Team. These teams will require a process by which to identify those patients referred on for a Psychological Therapy and to record the commencement of therapy.

While NHS Boards are developing their systems, Board figures may not be directly comparable. Information on what referrals have been reported for each Board is detailed in the data quality section on pages 26-38.

A rejected referral is where the request is deemed as not appropriate.

The numbers of referrals for the quarter January – March 2017 by NHS Board are shown in Table 7.

Table 7. Referrals for Psychological Therapies[1] by NHS Board, January to March 2017

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of Treatment	All referrals		Referrals excluding rejected referrals[3]	
	Number of referrals	Referrals per 1,000 people	Number of referrals	Referrals per 1,000 people
NHS Scotland[1,2,3,4,5,6]	24,601	4.6	22,437	4.2
NHS Ayrshire & Arran[2]	3,632	9.8	2,507	6.8
NHS Borders	293	2.6	290	2.5
NHS Dumfries & Galloway	1,005	6.7	966	6.4
NHS Fife	2,207	6.0	2,085	5.7
NHS Forth Valley	1,060	3.5	984	3.3
NHS Grampian[3]	1,354	2.3	1,354	2.3
NHS Greater Glasgow & Clyde[3,4]	4,709	4.1	4,709	4.1
NHS Highland	1,417	4.4	1,415	4.4
NHS Lanarkshire	3,685	5.6	3,211	4.9
NHS Lothian	3,268	3.8	3,219	3.8
NHS Shetland	80	3.4	79	3.4
NHS Tayside	1,759	4.3	1,521	3.7
NHS Western Isles	11	0.4	11	0.4
NHS24[6]	121	..	86	..

Notes

.. Data not available

1. As explained on page 13 some Boards are unable to separate out referrals to Psychological Therapies from all mental heath referrals.
2. NHS Ayrshire & Arran currently provide all referrals to MH but are working on separating out referrals to Psychological Therapies.
3. NHS Grampian and NHS Greater Glasgow & Clyde are currently unable to provide the number of referrals rejected. Therefore these data will be over estimated.
4. NHS Greater Glasgow & Clyde are unable to separate out referrals to Psychological Therapies only due to the structure of their MH departments. This is explained further in the data quality section, pages 26-39.
5. NHS Orkney data is not available.
6. NHS 24 Living Life Service is included from February 2017.

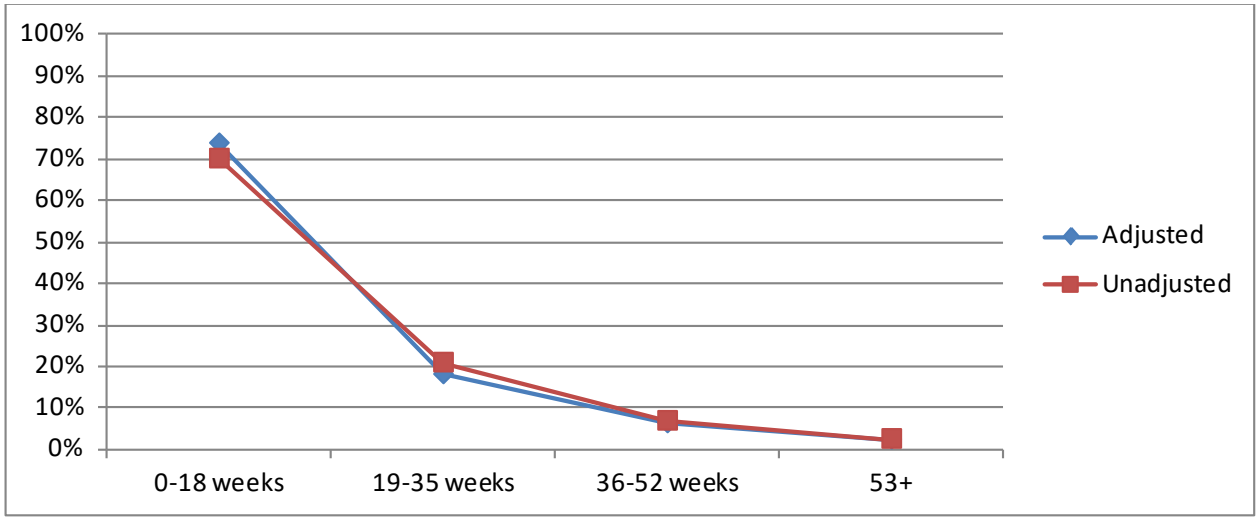
Further information on referrals for the current and last four quarters can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Distribution of wait

Chart 5 and Table 8 presents distribution information for patients who started their treatment during the quarter January to March 2017. Chart 5 incorporates both adjusted and unadjusted data and shows the percentage of patients in relation to the number of weeks waited for treatment. Table 8 is adjusted data and shows the percentage of patients in wait time band by NHS Board.

Chart 5. NHS Scotland [1,2,3,4]: Distribution of completed waits (adjusted[1] and unadjusted) during the quarter January to March 2017.



Notes

1. Scotland level adjusted information includes unadjusted waits for NHS Boards where adjusted waits are not available, for details of adjustments see Table 5.
2. NHS Orkney data is not available.
3. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
4. NHS24 Living Life Service is included from February 2017.

The table on the following page details the patients who started their treatment by Board.

Table 8. Distribution of wait (adjusted[1]) for people who started their treatment in January to March 2017, by NHS Board[2,3,4]

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of Treatment	Wait time band (adjusted wait)			
	0-18 weeks (%)	19-35 weeks (%)	36-52 weeks (%)	53+ weeks (%)
NHS Scotland[1,2,3,4]	73.7	18.0	6.1	2.2
NHS Ayrshire & Arran	74.3	15.2	8.5	2.1
NHS Borders	75.0	18.8	5.0	1.3
NHS Dumfries & Galloway	69.8	19.7	9.4	1.1
NHS Fife	67.4	14.2	8.9	9.5
NHS Forth Valley	40.0	47.7	12.3	-
NHS Grampian	69.6	25.8	4.2	0.4
NHS Greater Glasgow & Clyde[2]	94.7	4.9	0.2	0.1
NHS Highland	92.8	4.7	1.3	1.3
NHS Lanarkshire	90.1	9.7	0.1	-
NHS Lothian	66.6	18.6	10.2	4.6
NHS Tayside	72.1	22.1	5.7	0.1
NHS Island Boards[3]	86.8	13.2	-	-
NHS24[4]	18.8	78.8	2.5	-

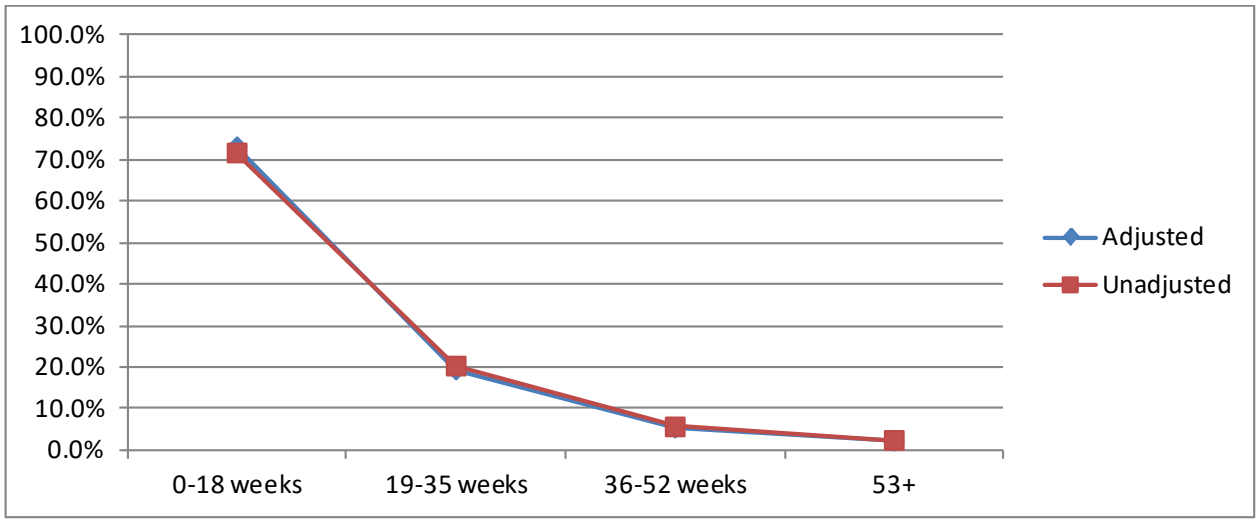
Notes
'-'denotes zero

1. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available, for details of adjustments see Table 5.
2. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
3. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
4. NHS24 Living Life Service is included from February 2017.

Further information on the distribution of wait can be found here.

Chart 6 and Table 9 presents distribution information for patients who are waiting to start their treatment as at the end of December 2016. Chart 6 incorporates both adjusted and unadjusted data and shows the percentage of patients in relation to the number of weeks they have been waiting for treatment. Table 9 is adjusted data and shows the percentage of patients in wait time bands by NHS Board.

Chart 6. NHS Scotland[1,2,3] : Distribution of patients waiting for treatment (adjusted[4] and unadjusted) as at 31 March 2017.



Notes

1. Scotland level adjusted information includes unadjusted waits for NHS Boards where adjusted waits are not available, for details of adjustments see Table 5.
2. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete
3. NHS Orkney data is not available.
4. NHS24 Living Life Service is included from February 2017.

Table 9. Distribution of wait (adjusted[1]) for people waiting at 31 March 2017, by NHS Board

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

NHS Board of Treatment	Wait time band (adjusted wait)			
	0-18 weeks (%)	19-35 weeks (%)	36-52 weeks (%)	53+ weeks (%)
NHS Scotland[1,2,3,4]	73.2	19.3	5.3	2.2
NHS Ayrshire & Arran	71.2	20.4	6.6	1.8
NHS Borders	79.6	17.7	2.5	0.2
NHS Dumfries & Galloway	67.8	23.2	8.0	1.0
NHS Fife	60.1	26.4	9.3	4.2
NHS Forth Valley	70.0	29.1	0.8	-
NHS Grampian	82.3	15.3	2.2	0.2
NHS Greater Glasgow & Clyde[2]	94.7	4.6	0.3	0.3
NHS Highland	63.3	19.2	8.5	9.0
NHS Lanarkshire	96.5	3.5	-	-
NHS Lothian	69.6	20.3	7.5	2.6
NHS Tayside	75.3	20.9	3.7	-
NHS Island Boards[3]	74.3	3.7	1.8	20.2
NHS24[4]	60.7	39.3	-	-

Notes
'-'denotes zero

1. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available, for details of adjustments see Table 5.
2. NHS Greater Glasgow & Clyde January to March 2017 is estimated to be 20-30% complete.
3. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
4. NHS24 Living Life Service is included from February 2017.

Further information on the distribution of wait can be found here.

People aged 65 and over

This publication includes information on referrals and waiting times for Psychological Therapies treatment for people aged 65 and over. This information has only been shown at quarter level due to small numbers and the potential for disclosure.

The numbers of referrals for people aged 65 and over for the quarter January to March 2017 by NHS Board are shown in Table 10.

Table 10. Referrals for Psychological Therapies[1,2,4] for people aged 65 and over by NHS Board, January to March 2017

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

	All referrals[2,4]		Referrals excluding rejected referrals[5]	
NHS Board of Treatment	Number of referrals	Referrals per 1,000 people	Number of referrals	Referrals per 1,000 people
NHS Scotland[1,7]	1,016	1.1	968	1.0
NHS Ayrshire & Arran[2]	71	0.9	62	0.8
NHS Borders[3]	10	0.4	10	0.4
NHS Dumfries & Galloway	63	1.8	61	1.7
NHS Fife	79	1.1	78	1.1
NHS Forth Valley	61	1.1	54	1.0
NHS Grampian[4]	20	0.2	20	0.2
NHS Greater Glasgow & Clyde[4,5]	82	0.4	82	0.4
NHS Highland	47	0.7	46	0.7
NHS Lanarkshire	150	1.3	149	1.3
NHS Lothian	233	1.7	227	1.7
NHS Tayside	191	2.3	172	2.0
NHS Island Boards[6]	*	0.5	*	0.5
NHS24[7]	*	..	*	..

Notes

.. Data not available
* Data has had disclosure control applied to protect patient confidentiality.

1. As explained on page 14 some Boards are unable to separate out referrals to Psychological Therapies from all mental heath referrals.
2. NHS Ayrshire & Arran currently provide all referrals to MH but are working on separating out referrals to Psychological Therapies.
3. NHS Borders data is based on people aged 70 and over.
4. NHS Greater Glasgow & Clyde are unable to separate out referrals to Psychological Therapies only due to the structure of their MH departments. This is explained further in the data quality section on page 30.
5. NHS Grampian and NHS Greater Glasgow & Clyde are currently unable to provide the number of referrals rejected. Therefore these data will be over estimated.
6. NHS Orkney data is not available. NHS Shetland and NHS Western Isles are combined to prevent disclosive numbers.
7. NHS24 Living Life Service is included from February 2017.

Table 11 shows quarterly waiting times for patients aged 65 and over that started their treatment from January 2016 to March 2017.

Table 11. Waiting times (with adjustments[1,4]) for people aged 65 and over that started their treatment during the last five quarters, NHS Scotland[2,3,5,6].

While NHS Boards are developing their systems to improve the completeness and consistency of these data, NHS Board figures may not be directly comparable.

Quarter	People seen	Seen within 18 weeks (number)	Seen within 18 weeks (%)	Average (median) wait (weeks)
Jan to Mar 2016[2,3,5]	762	670	87.9	5
Apr to Jun 2016[2,3,4,5]	714	623	87.3	6
Jul to Sep 2016[2,3,4,5]	625	559	89.4	5
Oct to Dec 2016[2,3,4,5]	593	518	87.4	6
Jan to Mar 2017[2,3,5,6]	604	482	79.8	7

Notes

1. Scotland level data include unadjusted waits for NHS Boards where adjusted waits are not available, for details of adjustments see Table 2
2. NHS Borders data is based on people aged 70 and over.
3. NHS Orkney data is not available.
4. NHS Highland has resubmitted data from April to December 2016.
5. NHS Greater Glasgow & Clyde are migrating to a new Patient Management System, this is having an impact on the completeness of the data submitted from September 2016.. Caution should be taken when making comparisons between quarters.
6. NHS 24 Living Life Service is included from February 2017.

When comparing the current quarter to the previous quarter there has been an increase in the number of people seen (aged 65 and over) from 593 to 604 and a decrease in the percentage of patients seen within 18 weeks, from 87.4% to 79.8%. The median wait has increased from 6 to 7 weeks.

Further information on referrals for the last five quarters can be found here.

Information on data quality and data completeness at NHS Board level is available on pages 26-39.

Glossary

Psychological Therapies	Psychological Therapies refer to a range of interventions, based on psychological concepts and theory, which are designed to help people understand and make changes to their thinking, behaviour and relationships in order to relieve distress and to improve functioning. The standard applies specifically to Psychological Therapies for treatment of a mental illness or disorder.
Rejected Referrals	Where the request to a healthcare professional or to an organisation to provide appropriate healthcare to a patient is deemed as not appropriate.
Start of treatment	This is when treatment starts or the person is removed from the waiting list. Not all people who are referred for Psychological Therapies go on to have treatment. Some people attend an assessment appointment, need no further treatment, and so are removed from the waiting list. Some people are offered treatment, but decide not to go ahead.
Adjusted waiting time	This is how long a person waited after taking into account any periods they were unavailable and any appointments that they missed or rearranged. The adjustments are described on Page 27. If a person has no periods of unavailability and attends on the first date that they accept, then no adjustments are made and their adjusted waiting time is the same as their unadjusted waiting time.
Unadjusted waiting time	The total time from the date the referral was received by the service to the date treatment commenced.
Median	This is the time period (number of weeks) that half of the patients seen started treatment within.
90th Percentile	This is the time period (number of weeks) that 90% of the patients seen started treatment within.
HEAT standards	A set of standards agreed between the Scottish Government and NHS Scotland relating to Health Improvement, Efficiency, Access or Treatment (HEAT).

List of Tables

Table No.	Name	Time period	File & size
1	Adjusted Completed waits for people seen	January 2016 to March 2017	Excel [739kb]
2	Unadjusted Completed waits for people seen	January 2016 to March 2017	Excel [815kb]
3	Adjusted Waiting times for people waiting	January 2016 to March 2017	Excel [351kb]
4	Unadjusted waiting times for people waiting	January 2016 to March 2017	Excel [808kb]
5	Adjusted Completed waits patient distribution	January 2016 to March 2017	Excel [364kb]
6	Unadjusted waiting times patient distribution	January 2016 to March 2017	Excel [852kb]
7	Referrals	January 2016 to March 2017	Excel [341kb]
8	Patients aged 65 and over	January 2016 to March 2017	Excel [1,261kb]

Note: in order to view the tables to full effect, your macro security settings will need to be set to medium. To change macro security settings use Tools, Macro, Security - set security level to Medium and re-open the report.

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Further Information

Further information can be found on the ISD website

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Appendix

A1 – Background Information

Data collection

When the Psychological Therapies data collection was first set up, the IT systems across NHS Boards were not set up to collect the data at patient level. Therefore, it was agreed to collect aggregate level data. NHS Boards submit aggregate level data to ISD in an Excel template. The template has evolved over time. The current template is set up to collect information on patients who waited during the month and information on patients waiting at the end of each month. This information (number of people) is collected in weekly time bands to allow calculation of the median and 90th percentile. A separate Excel sheet is set up for adjusted and unadjusted waits.

Why are waiting times important?

The Scottish Government is committed to delivering faster access to Psychological Therapies for those with mental illness or disorder. Patients and clinicians have identified access to therapies as a key service improvement to better meet their needs and expectations. Psychological Therapies have an important role in helping people with mental health problems, who should have access to effective treatment, both physical and psychological. It is generally accepted that these therapies can have demonstrable benefit in reducing distress, symptoms, risk of harm to self or others, health related quality of life and return to work. The Scottish Government recognises that delivering faster access is a significant and complex challenge, and sees the standard as an opportunity to drive local service redesign informed by evidence.

Mental Health Policy and Standards

The Mental Health Strategy is set within the context of the NHS Scotland Quality Strategy http://www.scotland.gov.uk/Publications/2010/05/10102307/0 which sets out three quality ambitions that care must be person-centred, safe and effective.

Developments in mental health care have been driven by a series of reports and policy recommendations:

In April 2011, a HEAT Target for Psychological Therapies was introduced. This target (now a standard) is that no person will wait longer than 18 weeks from referral to treatment for Psychological Therapies from December 2014. Following the conclusion of previously planned work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies standard should be delivered for at least 90% of patients.

In August 2012, the Mental Health Strategy for Scotland: 2012-2015 was produced which set the policy direction for the next four years and included a commitment to achieving and maintaining waiting times standards. In March 2017, this was updated and reissued as the Mental Health Strategy 2017-2027.

In November 2012, the Scottish Government issued the Summary Report on the Application of NHSScotland Waiting Times Guidance.

Child & Adolescent Mental Health (CAMH) Services Waiting Times

Waiting times for CAMH Services are also published this quarter.

Workforce Information

The Psychology Workforce Planning Project was initiated in 2001 and is a collaboration between NHS Education for Scotland (NES) and ISD.

Scottish Government asked Healthcare Improvement Scotland to lead a programme of work to improve access to Psychological Therapies. ISD are a partner in this programme of work providing data, analytical and intelligence support working closely with NHS Boards.

http://www.isdscotland.org/Health-Topics/Mental-Health/MHAIST/

A2 – Data Quality

Psychological Therapies waiting times data have been collected nationally since April 2011, although initially data were very incomplete and of poor quality. There have been significant improvements in data quality and completeness over time, but some systems for collecting data locally are still at an early stage of development, and as a result, the data are not yet complete. Over the coming months, we expect the quality and completeness of data to continue to improve.

This section provides information on the quality and completeness of data supplied by NHS Boards to ISD. As part of the quality assurance process for this publication ISD has asked Boards to provide information on any data quality and completeness issues that may affect interpretation of the statistics. ISD will routinely ask NHS Boards for updates on these issues and this information will be used to determine if the data remain as developmental.

ISD also routinely seeks clarification from NHS Boards amongst other things where there may be large changes in numbers, unusual patterns in the data or changes in trends. These changes may be influenced by a variety of factors including service changes/reconfiguration or data recording changes.

Health Board Accuracy

ISD only receive aggregated data from each Health Board, this can not be thoroughly validated by ISD. Derivations of the figures and data accuracy are matters for the individual Health Boards. There is a great variation in who compiles the data in Health Boards from administrative staff and information analysts to service managers. The Health Boards do check the data to be submitted but again this varies from daily checks of the Waiting Times data to weekly or monthly checks. Checks prior to submission are carried out by a range of people; Managers, Clinical Directors and Heads of Service. Some of the submitting Health Boards have a Standard Operating Procedure (SOP) to assist them in the compilation of the data, others are compiling theses. The Health Boards discuss the data at team, management and performance meetings.

Adjustment of waiting times

Waiting times for most NHS services are worked out using a calculation that takes into account any periods a person is unavailable and missed or cancelled appointments. These are referred to as adjustments. Some NHS Boards are not able to make all the appropriate adjustments to waiting times for Psychological Therapies so we have included information on what adjustments each NHS Board has made.

Waiting time adjustments allow fair reporting of waiting times which have been affected by factors outside the NHS Board's control. However, the timing of appointments is always based on clinical need. For Psychological Therapies services, resetting the waiting time to zero is done for reporting purposes only and does not impact on the timing of any further appointments.

The main adjustments that are made to Psychological Therapies waiting times are:

- If a person is unavailable (for example on holiday), the period for which they are unavailable is subtracted from their total waiting time.
- If a person does not attend an appointment and has to be given another, their waiting time is reset to zero.
- If a person rearranges an appointment, their waiting time is reset to zero on the day they contact the service to rearrange their appointment.
- If a person is offered several appointments and declines them all, their waiting time is reset to zero. NHS Boards report that this happens very rarely as most appointments are agreed by telephone.

This report also shows unadjusted waiting times. These are the actual times people have waited. The Scottish Government have agreed that the HEAT standard will be measured using adjusted waiting times. Where NHS Boards are still developing systems to adjust waiting times for Psychological Therapies, their unadjusted waits have been used to estimate the Scotland figure. The Summary Report on the Application of NHS Scotland Waiting Times Guidance provides more explanation on the main adjustments that are made to Psychological Therapies waiting times.

Adjusted and unadjusted waiting times

It is not possible to report nationally consistent data at Scotland level due to the differences in adjustments made to waiting times across the NHS Boards.

When the HEAT standard was announced, NHS Boards were asked to adjust waiting times where patients were unavailable or did not attend an appointment and had to be given another. This calculation of wait is used in other NHS services such as inpatients, outpatients and audiology.

Some NHS Boards developed systems to enable this calculation for Psychological Therapies. However, not all systems are able to make all the appropriate adjustments, so all data which includes adjusted figures also includes information about what adjustments have been applied.

NHS Boards are also asked to provide unadjusted waiting times. These are the actual times people have waited. All NHS Boards providing data are able to provide unadjusted waiting times.

Psychological Therapies at a glance - Adjustments

Health Board	Adjustments
Ayrshire & Arran	Up to date of treatment
Borders	Up to date of treatment
Dumfries & Galloway	No adjusted data submitted
Fife	No adjusted data submitted
Forth Valley	Up to date of breach (18 weeks)
Grampian	No adjusted data submitted
Greater Glasgow & Clyde	Up to date of treatment
Highland	Up to date of breach (18 weeks)
Lanarkshire	Up to date of breach (18 weeks)
Lothian	Up to 12 weeks for each stage of the pathway (assessment/treatment)
Orkney	No data submitted for this reporting period
Shetland	Up to date of treatment
Tayside	Up to date of treatment
Western Isles	Up to date of breach (18 weeks)
NHS24 Living Life	No adjusted data submitted

Number of People Referred for Psychological Therapies

Waiting lists can build up where demand for services exceeds the capacity of that service, so the number of referrals is a key measure for managing waiting times. There are considerable variations in service structures across NHS Boards, and therefore a number of different referral pathways for people seeking to access Psychological Therapies.

In some areas referrals are made directly into discrete Psychological Therapies services, and it is relatively straightforward for Boards to report the numbers of referrals for Psychological Therapies, the date of receipt of referral and the date of commencement of treatment. In other areas, however, there are no discrete Psychological Therapies services and Psychological Therapy is delivered, by appropriately trained staff, from within more generic Mental Health teams. These teams generally have a single point for receipt of referrals, and a subsequent process for allocation to a psychological therapist. In this case the date of receipt of referral is the date the referral is received by the Mental Health Team. These teams will require a process by which to identify those patients referred on for a Psychological Therapy and to record the commencement of therapy.

While NHS Boards are developing their systems, Board figures may not be directly comparable. Information on this by Board is included in the NHS Board level data quality issues section.

Psychological Therapies at a glance – Referrals to Psychological Therapies

Health Board	Referrals to Psychological Services
Ayrshire & Arran	All referrals to Mental Health Service
Borders	Yes
Dumfries & Galloway	Yes
Fife	Yes
Forth Valley	Yes
Grampian	Yes but are unable to record rejected referrals
Greater Glasgow & Clyde	Combination of referrals for Psychological Therapies alone and all referrals to the Mental Health Service depending on the reporting service. They are unable to submit the number of rejected referrals.
Highland	Yes
Lanarkshire	Yes
Lothian	All referrals triaged from a mental health locality single referral point to services that deliver Psychological Therapies and referrals to services that deliver Psychological Therapies which accept direct referrals.
Orkney	No data submitted for this reporting period
Shetland	Yes
Tayside	Yes
Western Isles	Yes
NHS24 Living Life	Yes

Referral to treatment calculation

Some NHS Boards are not able to calculate the waiting times from referral to treatment yet. While systems are being developed to do this, they are using a proxy for treatment. The Guidance and Scenarios HEAT standard document advises Boards should use the second appointment as a proxy for treatment. Where Boards are still using assessment / first appointment as proxy for treatment their waiting times could increase once they are able to calculate referral to treatment. Information on which NHS Boards are still developing their systems for this is detailed in the NHS Board level data quality issues section.

Psychological Therapies at a glance - Referral to Treatment measure

Health Board	Referral to Treatment measure
Ayrshire & Arran	No proxy used
Borders	No proxy used
Dumfries & Galloway	2 weeks after the1st appointment (this is 2nd appointment) 1st appointment proxy used for Self Help Service
Fife	No proxy used
Forth Valley	No proxy used
Grampian	Adult Services - assessment and treatment starts at the first appointment CAMHS - CAPA model - 2nd appointment (almost all cases have started treatment at this point a very small number may be undergoing specialist/more intensive assessment at this appointment)
Greater Glasgow & Clyde	2nd appointment for CAMHS activity
Highland	No proxy used for some services 1st appointment proxy used for others
Lanarkshire	No proxy used
Lothian	No proxy used
Orkney	No data submitted for this reporting period
Shetland	No proxy used
Tayside	No proxy used
Western Isles	No proxy used
NHS24 Living Life	1st appointment is initial assessment and 2nd appointment is treatment

CAMH Services for Psychological Therapies

Referrals for Psychological Therapies from CAMHS services are included as part of this standard as well as being included with the CAMHS standard. Not all Boards are including this information in their Psychological Therapies data yet. Information on this by Board is included in the NHS Board level data quality issues section.

Psychological Therapies at a glance – Inclusion of CAMH PT Activity

Health Board	Inclusion of CAMH PT Activity
Ayrshire & Arran	Yes
Borders	Yes
Dumfries & Galloway	Child Psychology is included, CAMH Services are not
Fife	Yes
Forth Valley	No
Grampian	All CAMHS activity
Greater Glasgow & Clyde	Yes
Highland	No
Lanarkshire	Yes for patients seen All CAMHS activity for patients waiting
Lothian	Yes
Orkney	No data submitted for this reporting period
Shetland	No CAMHS PT activity to record
Tayside	Yes
Western Isles	Yes
NHS24 Living Life	Includes patients from the age of 16

Data completeness: common issues

Waiting times data are extracted from local administration systems which are updated frequently with information about appointments, attendances, etc. This may lead to different reported numbers of patients seen or waiting depending on the date the data were extracted. However, any differences equate to a relatively small proportion of total numbers of patients seen or waiting.

Data completeness

While NHS Boards are developing their systems to report information on Psychological Therapies, some NHS Boards are not able to provide information for all services. Information on which services NHS Boards are not able to report on and an estimate of the percentage completeness is detailed in the NHS Board level data quality issues below if NHS Boards have provided ISD with this information during the quality assurance stage.

Data quality issues by NHS Board

This section details specific data quality issues for each NHS Board and provides completeness estimates where there is data missing due to systems still being developed.

NHS Ayrshire & Arran

Data remains at an estimated 99% completion. Work continues to incorporate the missing services; addictions, inpatients and forensics into the return. The Board maintains the expectation that the level of Psychological activity within these services is minimal, and understands that patients are being treated within 18 weeks, and so their eventual inclusion is expected to have a negligible effect on the wider waiting times compliance.

NHS Ayrshire & Arran have developed a purpose built database to capture and record all RTT patient contact within Adult Mental Health Services. Data reported incorporates matrix-defined and non-matrix treatment for PCMHTs multidisciplinary staff, Psychological Services staff and OT's working within Adult Mental Health.

The database clearly identifies assessment and first treatment dates. If treatment commenced at assessment then this is a clinical decision and is recorded as such on the database upon the clinician's instruction.

Data is provided for children receiving or waiting to commence a Psychological Therapy within CAMHS, Community and Medical Paediatrics.

The Board are currently reporting all referrals to the Mental Health Service. Work is ongoing to ensure that the Board will be able to extract identified Psychological Therapy activity. Recent capacity constraints due to loss of dedicated analysts have resulted in a delay to this work.

Adjustments are made up to the first treatment appointment for non-attendance and periods of unavailability (infrequently) but the databases do not record reasonable offers so no adjustments are made if a patient declines 2 or more appointment dates.

The Board have advised us that they are able to report on rejected referrals where vetted as inappropriate for a specific mental health team, however inappropriate referrals to Mental Health Services are referred back to the referrer with sign-posting to appropriate services.

NHS Borders

The Board estimate the data to be 100% complete.

The Board have to rely on manual inputting to excel sheets as their IT system is not fit for purpose. With a standalone spreadsheet system for reporting there is increased potential for error, but they now have systems in place to check the quality of data and are confident they are now reporting accurately.

CAMHS data is included for referrals for a Psychological Therapy. They have advised us that inappropriate referrals are referred back to the referrer with sign-posting to appropriate services.

The Board reports figures for referrals to Psychological Therapies only.

The Board records referral to treatment.

Adjustments are made up to date of treatment.

NHS Dumfries & Galloway

The Board estimate the data to be approximately 97% complete.

From April 2014, the Board are using a proxy which will be 2 weeks after the 1st appointment (which is the normal for 2nd appointments for this Board) for all services except the self help team which will remain at 1st appointment being the start of treatment which is the norm for that service in NHS Dumfries & Galloway.

Currently data for CAMH services and Child Psychology are recorded on different systems; CAMH services is in Topas and Child Psychology in an Access-based patient management system. The CAMH services data are adjusted and the Child Psychology are unadjusted. The two sets of data are also measured differently, for Child Psychology a proxy of first appointment plus 2 weeks is used to measure treatment. Therefore, at present only information for Child Psychology is included in this publication, CAMH service activity is not included

The Board report on referrals to Psychology Services only. They have advised us that inappropriate referrals are referred back to the referrer with sign-posting to appropriate services.

The Board have had a few issues with IT systems communicating with each other. While monthly data reported is reasonably accurate this can threaten the integrity of the data e.g. discharges logged on Mandatory Data Set system were not communicating across to the Patient Management System from which they draw monthly data. When integrity threats are detected they put monitoring systems in place for the future.

The Board supply unadjusted data only. There is no current timescale for the submission of adjusted data due to development/decision of new IT system.

The Board is undergoing an overdue data-cleansing exercise due to loss of admin capacity earlier this year and compounded by a gap between an outgoing QuEST Assistant and the arrival of the new Assistant. An internal audit indicated that the number of waits are higher than they should be, resulting in inflated waiting time figures. The results of the audit are being fedback into the service to improve the data quality going forward. The speed of rectification of errors which are down to the IT system will depend upon availability of IT resource to inform the exercise.

NHS Fife

The Board estimate the data to be approximately 90% complete.

From the August 2014 data the Board are measuring referral to treatment, prior to this they reported to 1st appointment as a proxy for treatment.

The reported data includes Psychology and CAMH Services. A further service was included from March 2017.

The Occupational Therapy Service had been trialling an electronic record system, this has led to missing data in referrals, people waiting and people seen over the past few months. The Board have advised us that this involves small numbers.

From October 2014 CAMHS Psychological Therapy activity is included.

The Board report on referrals for Psychological Therapies only. They have advised us that inappropriate referrals are referred back to the referrer with sign-posting to appropriate services.

The Board are unable to provide adjusted waits at present, as this relies on an improved IT system. Testing commenced within the psychology service but not yet validated. Other services are still unable to adjust waits.

NHS Forth Valley

The Board currently report on the three main psychological therapy specialist services – Adult Psychology, Dynamic Psychotherapy and Behavioural Psychotherapy. Changes have now been made to the Board data collection systems to allow the separation of CAMHS PTs activity from other CAMHS activity, and this is being trialled within the service as of 13 February. This will allow the inclusion of CAMHS PTs activity within the PTs submission from 1 April 2017.

All 3 specialties reported on measure referral to treatment.

The Board reports figures for referrals to Psychological Therapies only.

Adjustments are made up to date of breach (18 weeks).

The Board have advised us that rejected referrals are coded on TOPAS, the would be rejected because they were either considered more appropriate for another service within the NHS, a third sector partner or not appropriate for referral.

NHS Grampian

The Board supply unadjusted data only. Their current standalone system cannot record adjusted figures. They hope to migrate to TRAK in 2017. The Board are currently planning to pilot the new TRAKCARE Mental Health Community Module with one of their smaller team's May/June 2017 before rolling out across MHLDS NHS Grampian.

The Board have also stated for Adult Mental Health psychology – if they were reporting adjusted waits "we would meet the 18 week target for Aberdeen City and would be much closer to the target for Aberdeenshire".

All services are included so they have 100% of areas reporting, whilst there are known data quality issues that they are actively working to resolve these should not affect the submitted data. **T**he Primary Care Psychological Therapists are based in GP Surgeries who do not have access to NHS Grampian Mental Health & Learning Disability Services Standalone System. System Analysts, Project Manager and Senior Clinicians are actively trying to clarify how to capture this data. They have developed a local system of capturing Primary Care Psychological Therapist activity to include in their monthly reports and this should be reflected in the next one-two months of reporting.

The Board include all CAMHS activity as all bar a very small number of detailed cases result in a Psychological Therapy.

For Adult Services the first appointment includes both assessment and treatment The Board identify the second appointment or partnership appointment for all CAMHS cases as the start of treatment as defined through the CAPA model.

The Board reports figures for referrals to Psychological Therapies however are unable to submit the number of rejected referrals. They hope to begin to report this if the pilot proves successful and TRAKCARE gets rolled out across MHLDS.

The Board have advised us that referrals are received by each Community Mental Health Team. If at the CMHT meeting a referral is not deemed appropriate and thus rejected, the CMHT will appoint the most appropriate clinician to feedback and advise the referrer of the outcome and when appropriate suggest appropriate onward referral to other services.

NHS Greater Glasgow & Clyde

Due to the implementation of a new system the Board have advised that their data is not 100% complete The Board estimate the data to be 20-30% complete for mental health for this quarter. Their current patient information (PiMS) is being replaced by a new system (EMIS) in a phased rollout. Phase one of the rollout was due for completion by the end of 2016, with phase two starting in 2017. Prior to reporting on psychological therapies data from EMIS, they are trying to ensure the accuracy and completeness of the data being recorded, and its consistency with data recorded on PiMS. With this objective in mind, data quality checks are being developed to identify inconsistencies and anomalies in recording. During the phased rollout they will be looking to extract the PT data from EMIS with a view to report on the monthly ISD submission. They envisage having a first draft within the first 6 months of the implementation.
From November 2014 CAMHS Psychological Therapy activity is included.

The Board report a combination of 1) referrals for Psychological Therapies alone and 2) all referrals to the mental health service depending on the reporting service. They are unable to submit the number of rejected referrals.

NHS Greater Glasgow & Clyde (NHS GG&C) does not have discrete Psychological Therapy departments, but provides Psychological Therapies for the treatment of a mental illness or disorder as part of locality based Primary Care Mental Health teams, Community Mental Health teams and Specialist Mental Health teams. Therapies are delivered by Clinical Psychologists, Nurses, CBT Therapists and Occupational Therapists and Psychotherapists, working within those teams, who are trained and supervised to deliver a range of Psychological Therapies listed in the Matrix.

In NHS GG&C, the waiting time for access to Psychological Therapies, for newly referred patients, is counted from the date that the referral is received by the team (including self referrals to Primary Care Mental Health teams).

The waiting time for clients of non mental health services who have a need for a Psychological Therapy for treatment of a mental disorder identified, begins once the client is referred for therapy to the appropriate clinician within that team or to another team with a Psychological Therapy resource.

The Board have stated that the data is provided with a breakdown of age (65+) for all services except acute.

Adjustments are made up to date of treatment.

The Board have advised us that they are unable to report on inappropriate referrals (those that have been rejected as not suitable for a Psychological Therapy).

NHS Highland

The Board estimate the data to be nearly 100% complete.

Data are not available until October 2014 due to the Board migrating to a new patient management system (from iSoft (PAS) to Trakcare (PMS)).

Adjustments and clock resets for the patient being unavailable/not attending are made up to 18 weeks (date of breach). As at 31st March 2017, 80% of patients waiting times are adjusted in this way. The remaining 20% have had no adjustments made to their waiting time.

The following services report first appointment proxy for treatment start: CBT Northwest and Lochaber, Guided Self Help, and Occupational Health. All other Psychological services in NHS Highland report referral to treatment.

CAMHS Psychological Therapies are not included in the return.

The Board submit figures for referrals to Psychological Therapies.

The Board have advised us that they would be able to use the National Code for the Removal Reason to indicate what happened after a referral was rejected.

NHS Lanarkshire

The Board estimate the data to be approximately 97% complete. They now include the Pain Management Service, TBI, and Stroke MCN service in their reporting. Work to include EVA services is ongoing. Their Rutherglen/Cambusland team is part of GG&C IT systems, and is transitioning to the EMIS system. This has caused some local delays in obtaining data – expected to be resolved over the next few months.

From January 2015 the submission is based on data extracted from Trakcare. The Board are reassured that the data reported is accurate.

The Board include only referrals that are waiting for a Psychological Therapy.

Adjustments, up to 18 weeks, have been in place for Psychological Therapies on TrakCare since May 2014.

From January 2015 all CAMHS activity is included for patients waiting as it is not possible to extract only those referrals for psychological therapy. This is being reviewed, towards being able to provide only CAMHS PT waits. Only CAMHS PT activity is submitted for patients seen.

The Board records referral to treatment.

The Board have advised us that rejected referrals are those which are deemed unsuitable for psychological therapy, and these are returned to the referrer with an explanation. In addition to the “rejected referral” category, they also have a clear process for signposting referrals to more suitable services without requiring that the patient return to the referrer for this.

NHS Lothian

Further services are still to be included in the submission (Inpatient Psychological Therapies Services, Forensic Services and Rehabilitation Services) the Board are awaiting the relevant changes in TRAK to allow reporting of psychological therapies activity from all relevant services. Data for Clinical Health Psychology, Neuropsychology and Guided Self Help services delivered by a 3rd sector organisation via an SLA are included from October 2015.

The Board apply adjustments for up to 12 weeks against each stage of the pathway. So, for those awaiting assessment and for those on the treatment stage adjustments are not applied after a 12 weeks wait. This is an interim arrangement and is liable to change.

NHS Lothian referral data for Psychological Therapies includes all referrals triaged from a mental health locality single referral point to services that deliver Psychological Therapies and referrals to services that deliver Psychological Therapies which accept direct referrals. The numbers of rejected referrals reported are from all these services which deliver Psychological Therapies.

The Board has included CAMHS Psychological Therapies in the return from July 2016.

The Board records referral to treatment.

The Board have advised us that capacity issues and data errors may have a slight impact on their data; however they are working to improve the detection and correction of such errors and overall data quality.

The Board have advised us that there are a number of Triage outcomes that services use which would indicate an alternative that was recommended where a referral was rejected (e.g. “Re-directed to other NHS Service”, “Recommended alcohol / SMD service”, “Recommended counselling / 3rd sector” etc). They do not have information on eventual outcomes where a referral was rejected.

NHS Orkney

The Board have advised us that, due to a new system implementation and staff shortages they have been unable to submit data from June 2015, prior to this they estimate the data is 100% complete.

The Board anticipates they will be in a position to submit PT data for March 2017 within the next month; however this will depend upon the return of staff notes from an external scanning company to enable commencement of the electronic note system cCube, to facilitate Trak amendments. If this takes longer than anticipated then manual manipulation of the data may be required but this would mean that future audits of Trak would differ from the submissions.

The Board have created a suite of basic audit reports however, due to CMHT staff shortages the processing and fixing of these within Trak has been suspended at present. A short term solution for this is for the HI team to cover this work, but this will be done around their current workload and as and when they can meet with the clinicians around their clinics.

Previous months submissions will be submitted over time, as and when time permits.

Scripts for assessment dates have been created, but the main problem now is the UCPN in Trak being broken, which means the scripts cannot look back at a single patient pathway, leading to various data issues.

We are trying our best to work around this for now, as we have no other option because we want to get reporting on PT asap, but as you can imagine this has been very problematic. Add to this data entry errors and also a larger set of data than CAMHS, this is has leading to a lot of extra work for us.

Further investigations are ongoing to solve this issue at present, and we believe once we can show what keeps the UCPN in Trak, and then what breaks the UCPN, training and audits will be set up keep the patient UCPN, which is vital for our scripts. This is a hospital wide issue regarding the UCPN.

The scripts will need to then be rewritten using the UCPN as the core component, this will not take as much time as the various work a rounds we currently have to script for.

Once this is done, reporting will become much easier and we should be able to include patient pathway adjustments for UNA, DNA etc.

We have spoken to other boards about using the UCPN in Trak, and the people we have spoken to use other systems for this whereas we have to try and make Trak work for us.

The Board have advised us that inappropriate referrals are referred back to the referrer with sign-posting to appropriate services.

For data reported prior to June 2015 (from TOPAS PMS):

From January 2015 the Board had submitted both adjusted and unadjusted data.

The Board does not include CAMHS Psychological Therapies in the return.

The Board records referral to treatment.

The Board includes all referrals waiting for a Psychological Therapy.

NHS Shetland

The Board estimate the data to be nearly 100% complete.

The Board do not have any CAMHS Psychological Therapies activity. Activity will be recorded when clinicians are trained to deliver CAMHS PT's.

Data from March to May 2015 are unavailable due to moving to a new patient management system, the Board do not believe they will be able to submit this data in the future.

The Board records referral to treatment.

The Board includes all referrals waiting for a Psychological Therapy.

The Board have advised us that the restructuring of the service for provision of psychological therapies is complete. The consultant Clinical Psychologist is working on those cases with the longest waits to match resource to need. A variety of methods are being used by the Consultant Clinical Psychologist to manage the waiting list.

Adjustments are made up to date of treatment.

The Board have advised us that inappropriate referrals are referred back to the referrer with sign-posting to appropriate services.

NHS Tayside

The Board estimate the data to be approximately 100% complete; however due to issues with admin support the submissions for Perth adult psychological therapies service has not been checked and verified.

The Board use the first appointment to measure start of treatment. The Board have advised that, for the majority of patients, treatment will commence at the first appointment, therefore this is not being used as a proxy. The instances where only an assessment may have occurred at first appointment would account for approximately 10% of recent activity, for these cases first appointment is used as a proxy for first treatment.

The Board have stated that the data includes referrals to the Multi-disciplinary Adult Psychotherapy Service which is separate and distinct from the Psychological Therapies Service.

CAMHS Psychological Therapy activity is included.

The Board include all referrals to Psychological Therapies from the Psychological Therapies Services and the Multi-disciplinary Adult Psychotherapy Service which is a separate and distinct service.

Adjustments are made up to date of treatment - After a breach had occurred any unavailability would still be added to their PAS but it would not change the clock start date or breach date.

The Board have advised us that reason coding for rejected referrals is available within TOPAS, and will also be available when they move to TRAK (end of June 2017).

NHS Western Isles

The Board estimate the data to be approximately 100% complete.

CAMHS Psychological Therapy activity is included.

The Board include only referrals to Psychological Therapies.

For most services provided by NHS Western Isles, referrals are electronic through their Referral Management System and are allocated directly to a clinician. The first appointment

from this is classed as first treatment, there is no assessment stage, treatment will always start at the first appointment, and this is not being used as a proxy. In relation to CAMHS psychological therapy a patient may have a number of appointments with a clinician who then may decide psychological therapy is appropriate. If this is the case then the previous appointment is used as the base for the referral start. Within the CAMHS team there is no separate Psychological Therapy team so a clinician may decide PT and then refer to themselves or another clinician depending on the type of therapy. This tends to be recorded within the same pathway by bypassing the RMS and therefore the previous appointment is the only point that can be used as a measure.

This has implications for measuring referrals as it makes it difficult to gauge whether someone is a new or return patient. This involves manual work.

Adjustments are made up to date of breach (18 weeks).

The Board have advised us that they can report on inappropriate referrals but only those referrals that come through the RMS specifically for psychological therapy. For CAMHS the referral is not really treated as a referral due to clinicians working with patients over a number of appointments. Psychological Therapy in this case is not rejected as the clinician has decided over a course of appointments it is appropriate.

NHS 24 Living Life

NHS 24 estimate the data to be approximately 100% complete.

The data include only referrals to Psychological Therapies.

NHS 24 are unable to provide adjusted waits.

The referral process for NHS 24 is that all enquiries to the service are offered an initial assessment which results in either moving to therapy or GSH waiting list or rejection.

They have advised us that inappropriate/rejected referrals are encouraged to attend their GP.

NHS 24 does provide CBT to patients from the age of 16 but are not a CAMH Service.

The first contact is identified as an initial assessment, therefore start of treatment is 2nd contact.

A3 – Publication Metadata (including revisions details)

Metadata Indicator	Description
Publication title	Psychological Therapies Waiting Times in Scotland http://www.isdscotland.org/Health-Topics/Waiting-Times/Psychological-Therapies/
Description	Monthly and quarterly summary of waiting times and waiting lists for Psychological Therapies
Theme	Health and Social Care
Topic	Access and Waiting Times
Format	Excel workbooks
Data source(s)	Aggregate counts accredited and derived from individual NHS Scotland Boards are submitted monthly to ISD using a defined Excel template.
Date that data are acquired	Deadline for data submission is the 24th of each month, though files can be resubmitted up to 3 weeks before publication where the quality assurance process identifies differences with local figures.
Release date	The first Tuesday of the month for each publication
Frequency	Quarterly
Timeframe of data and timeliness	Data from October to December 2016, with figures from the previous 4 quarters for reference.
Continuity of data	Information has been collected nationally since April 2011 with a revised dataset introduced in April 2013. Includes monthly information is included in the report for the last fifteen months. From February 2017, NHS 24 Living Life data included.
Revisions statement	Previously published waiting times are revised at each publication to reflect the latest available data submitted to ISD by the NHS Boards.
Revisions relevant to this publication	NHS Highland resubmitted data from April to December 2016; this affects only patients seen, the amendments below are based on the adjusted data. **Patients seen** Quarter ending June 2016 NHS Highland (+164) This has decreased the NHS Highland percentage of patients seen within 18 weeks by 12.0%. The NHSScotland percentage of patients seen within 18 weeks has decreased by 0.4% The median for NHS Highland has increased by 2 weeks

	but has remained the same for NHS Scotland. The 90th percentile has increase by 17 weeks for NHS Highland but has remained the same for NHS Scotland. Quarter ending September 2016 NHS Highland (+196) This has decreased the NHS Highland percentage of patients seen within 18 weeks by 15.6%. The NHSScotland percentage of patients seen within 18 weeks has decreased by 0.7% The median for NHS Highland has increased by 2 weeks but has remained the same for NHS Scotland. The 90th percentile has increase by 18 weeks for NHS Highland and has increased by one week for NHS Scotland. Quarter ending December 2016 NHS Highland (+159) This has decreased the NHS Highland percentage of patients seen within 18 weeks by 6.3%. The NHSScotland percentage of patients seen within 18 weeks has remained the same. The median for NHS Highland has increased by one week but has remained the same for NHS Scotland. The 90th percentile has increase by 4 weeks for NHS Highland but has remained the same for NHS Scotland. **Patients seen aged 65 and over** Quarter ending June 2016 NHS Highland (+5) The percentage of patients seen within 18 weeks aged 65 and for NHS Highland has remained the same. The median has remained the same and the 90th percentile has increased by 2 weeks. The NHS Scotland percentage of patients seen within 18 weeks aged 65 and over has increased by (0.1%). The median has reduced by one week and 90th percentile has remained the same. Quarter ending September 2016 NHS Highland (+8) The percentage of patients seen within 18 weeks aged 65 and for NHS Highland has decreased by 17.2%. The median has increased by one week and the 90th percentile has increased by 16 weeks. The NHS Scotland percentage of patients seen within 18 weeks aged 65 and over has decreased by (0.7%). The median has remained the same and 90th percentile has increased by 3 weeks. Quarter ending December 2016 NHS Highland (+13)

	The percentage of patients seen within 18 weeks aged 65 and for NHS Highland has decreased by 15.2%. The median has increased by 2 weeks and the 90th percentile has increased by 13 weeks. The NHS Scotland percentage of patients seen within 18 weeks aged 65 and over has decreased by (0.5%). The median has decreased by one week and the 90th percentile has increased by 2 weeks..
Concepts and definitions	Definitions not contained in this report are available here.
Relevance and key uses of the statistics	Waiting times are important to patients and are a measure of how the NHS is responding to demands for services. Measuring and regular reporting of waiting times highlights where there are delays in the system and enables monitoring of the effectiveness of NHS performance throughout the country. The NHS in Scotland has been set a number of standards for maximum waiting times. Other uses of the data include information requests for a variety of customers, e.g. research charities; public companies; Freedom of Information requests; information support to Boards; health intelligence work; parliamentary questions and HEAT standards.
Accuracy	These data are classified as developmental. ISD only receives aggregate data from each NHS Board. Although aggregated data cannot be systematically validated by ISD, reported data are compared to previous figures and to expected trends. Derivation of the figures and data accuracy are matters for individual NHS Boards.
Completeness	100% of submitted data are used for analysis and publication.
Comparability	There will be differences in the measures used and collection methods of Psychological Therapies waiting times statistics, as well as differences in service structures between the administrations. Users need to carefully read the publications when making comparisons. Links to Psychological Therapies waiting time information can be found below: England: http://www.hscic.gov.uk/mentalhealth Northern Ireland: They do have a Ministerial Target of 13 weeks for patients waiting. This information is not published and they do not have any referral to treatment data for Psychological Therapies. Wales They do not have a waiting times target for Psychological Therapies currently.

Accessibility	It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines.
Coherence and clarity	Key statistics for the latest quarter are linked to on the main Waiting Times page www.isdscotland.org/Health-Topics/Waiting-Times/. Statistics are presented within Excel spreadsheets. NHS Board and national figures are presented. Further features to aid clarity: 1. Tables are printer friendly. 2. Key data presented graphically.
Value type and unit of measurement	Number and percentage of patients seen, number and percentage of patients waiting, median and 90th percentile waits, number of patients referred, number of patients accepted (number referred minus number rejected) and referral rate per 1,000 population; by NHS Board.
Disclosure	The ISD protocol on Statistical Disclosure Protocol is followed.
Official Statistics designation	Official Statistics
UK Statistics Authority Assessment	
Last published	7 March 2017
Next published	5 September 2017
Date of first publication	27 August 2013
Help email	NSS.isdPsychtherapies@nhs.net
Date form completed	

A4 – Early Access details (including Pre-Release Access)

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department

NHS Board Chief Executives

NHS Board Communication leads

A5 – ISD and Official Statistics

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

Purpose: To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

Mission: Better Information, Better Decisions, Better Health

Vision: To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of 'Official Statistics'. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD's statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD's statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the ISD website.

The United Kingdom Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007 and signifying compliance with the Code of Practice for Official Statistics. Designation can be broadly interpreted to mean that the statistics:

- meet identified user needs;
- are well explained and readily accessible;
- are produced according to sound methods, and
- are managed impartially and objectively in the public interest.

Once statistics have been designated as National Statistics it is a statutory requirement that the Code of Practice shall continue to be observed.

Access to Psychology September 2017

	Key
Decrease	↓
No significant change	↔
Increase	↑

Child Psychology	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CAMHS Psychology		**51**	**19**	**1**	**0**	**71**
East Team	*28*	*16*	*12*			***28***
North Team	*39*	*21*	*3*	*1*		***25***
South Team	*31*	*14*	*4*			***18***
Community Paediatrics		**74**	**3**	**0**	**0**	**77**
Neuro Clinic	*13*	*23*				***23***
RH	*30*	*51*	*3*			***54***
Medical Paediatrics	**7**	**20**				**20**

Child Psychology	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CAMHS Psychology		**42**	**50**	**27**	**15**	**134**
East Team	*81*	*7*	*12*	*11*	*3*	***33***
North Team	*72*	*10*	*31*	*14*	*12*	***67***
South Team	*51*	*25*	*7*	*2*		***34***
Community Paediatrics		**72**	**45**	**28**	**31**	**176**
ASD	*116*		*1*		*11*	***12***
ASD 2nd Opinion	*82*				*2*	***2***
DMD	*33*	*2*	*1*			***3***
Neuro Clinic	*59*	*18*	*17*	*12*	*5*	***52***
Neuropsychology	*31*	*1*	*1*			***2***
RH	*84*	*50*	*25*	*15*	*11*	***101***
RH FASD	*71*	*1*		*1*	*2*	***4***
Medical Paediatrics	**14**	**25**				**25**

Performance on Total Waiting	Performance on Maximum Wait
↓	↓
↓	↓
↓	↓
↓	↓
↓	
↓	↓
↓	↓
↓	↓

Investment in Child Psychology Capacity to provide weekend clinic slots.

Investment and Service Redesign in Community Paediatrics introducing Assessment Appointment

Community Eating Disorder	5	5				**5**

Community Eating Disorder	23	8	1			**9**

↓	↓

Learning Disability Service (Psychology Service)	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
East	14	13				**13**
North	17	7				**7**
South	12	18				**18**
Total		**38**				**38**

Learning Disability Service (Psychology Service)	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
East	15	12				**12**
North	12	8				**8**
South	13	11				**11**
Total		**31**				**31**

Waiting List	Max Wait
↔	↔
↔	↑
↑	↔

Clinical Health Psychological Services	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
Bariatrics	3	14				**14**
Cardiac	20	18	4			**22**
Eating Disorder	22	1	1			**2**
General Medicine	30	34	23			**57**
MS	5	7				**7**
Neuro Rehab	14	4				**4**
Neuropsychology	46	18	1	1		**20**
Older Adults	6	20				**20**
Oncology	3	3				**3**
Pain	27	33	27			**60**
Stroke	7	6				**6**
		158	**56**	**1**	**0**	**215**

Physical Health Psychological Services	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
Bariatrics	1	7				**7**
Cardiac	29	27	5			**32**
Eating Disorder	1	1				**1**
General Medicine	21	19	2			**21**
MS	5	10				**10**
Neuro Rehab	2	3				**3**
Neuropsychology	14	17				**17**
Older Adults	16	27				**27**
Oncology	4	3				**3**
Pain	16	19				**19**
Stroke	19	10	2			**12**
		143	**9**	**0**	**0**	**152**

Waiting List	Max Wait
↑	↑
↓	↓
↔	↑
↑	↑
↓	↔
↔	↑
↑	↑
↓	↓
↔	↔
↑	↑
↑	↓

Patients Waiting as at 30th September 2017

Primary Care Mental Health	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT - Total	34	14	13			**27**
Counselling	14	10				**10**

NORTH PCMHT	Max Wait (Weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT	34	27	2			**29**
Counselling	60	27	16	5	2	**50**

SOUTH PCMHT	Max Wait (Weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT	22	27	1			**28**
Counselling	17	20				**20**

Introduction of cCBT 2017 and Telephone Triage

Patients Waiting as at 30th September 2016

Primary Care Mental Health	Max Wait (weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT	*25*	*17*	*7*			**24**
Counselling	38	16	57	7		**80**

NORTH PCMHT	Max Wait (Weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT	53	69	40	4	1	**114**
Counselling inc Telelink	30	40	22			**62**

SOUTH PCMHT	Max Wait (Weeks)	0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
CBT	25	33	5			**38**
Counselling	23	20	3			**23**

Waiting List	Max Wait
↑	↑
↓	↓
↓	↓
↓	↑
↓	↓
↓	↓

Community Mental Health		0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
East CMHT	**Max Wait (weeks)**					
CBT Treatment	46	6	9	8		**23**
Psychology - Assessment	73	23	1		1	**25**
Psychology - Treatment	88	12	10	11	19	**52**
Recovery & Wellbeing Group	58	7	21	2	1	**31**

Community Mental Health		0-18 weeks	19-35 weeks	36-52 weeks	1 year plus	Total
East CMHT	**Max Wait (weeks)**					
CBT Treatment	28	8	5			**13**
Psychology - Assessment	22	22	2			**24**
Psychology - Treatment	54	12	8	6	1	**27**
Recovery & Wellbeing Group	30	2	2			**4**

Waiting List	Max Wait
↑	↑
↔	↑
↑	↑
↑	↑

North CMHT	**Max Wait (weeks)**	**54**	**7**	**1**	**0**	**62**
CBT Treatment	15	16				**16**
Psychology - Inpatient Services	2	1				**1**
Psychology - Assessment	38	21	5	1		**27**
Psychology - Treatment	21	16	2			**18**

North CMHT	**Max Wait (weeks)**	**35**	**2**	**0**	**0**	**37**
CBT Treatment	13	12				**12**
Psychology - Inpatient Services						
Psychology - Assessment	26	7	1			**8**
Psychology - Treatment	22	16	1			**17**

Waiting List	Max Wait
↑	↔
↑	↑
↔	↔

SOUTH CMHT	**Max Wait (weeks)**	**17**	**1**	**0**	**0**	**18**
CBT Treatment	15	6				**6**
Compassion Focused Therapy	15	2				**2**
Psychology - Treatment	21	9	1			**10**

SOUTH CMHT	**Max Wait (weeks)**	**12**	**4**	**0**	**0**	**16**
CBT Treatment	28	5	2			**7**
Psychology - Treatment	21	7	2			**9**

Waiting List	Max Wait
↔	↓
↔	↔

1. BACKGROUND / INTRODUCTION

Overview

The Benson model in an ongoing project being implemented in Ayrshire & Arran psychological care services. The model is based on pre-existing modules of the Benson methodology. The primary purpose this work was to encourage greater objectivity and transparency to encourage better interaction and discussion about the future of the service. We are also looking to improve the core data and develop a more evidence based approach, and ensure collaboration between provider and commissioner. This will facilitate more focused discussion, and allow us to focus on the role of the workforce, and areas of prioritisation in the future.

As the model is focused on demand, we can also look at how best to meet future patient needs and impact on future budgets. The model will support development of various scenarios to help explore alternative approaches.

Approach

- This project involved the development of an integrated demand forecast model to allow service forecasting and assessment of alternative approaches to Psychological care services in Ayrshire & Arran
- The model has initially been piloted in CAMHS and will later roll out to other pathways / departments; the order of this will depend on the existing level of completeness / robustness of the respective historical service datasets.
- The model is calibrated to historic activity to ensure establishment of a realistic, evidenced baseline.
- The Benson approach provides a live, updatable, transparent basis, capturing direct and indirect costs associated with providing services to the eligible child population.
- The model has been applied across several health and care environments in the UK – there are around 45 sites in England. This provides an advantage in leveraging off existing components and modules already developed, reducing build time and providing functionality that has been successfully applied elsewhere. This has now been adapted to mental health and psychological care services both here and with English providers.
- The model is developed in Excel using Visual Basic (VBA). Following the development and support referred to below, and delivery of a fully functional model, the model will be owned by A&A with remote support from Benson Wintere as required.

Scope

The model covers all Psychological services delivered in Ayrshire & Arran. This will include profiling activity underlying the following key workstreams:

Pilot area

- Children's mental health (CAMHS) – this is the area we have piloted using the North, East and South teams

Subsequent areas of rollout:

- Learning Disability Services
- Physical health
- Medical paediatrics
- Community paediatrics
- PCMHT / CMHT

We have selected the CAMHS workstream as an initial area of focus to allow quicker development and testing of the initial model. Once the functionality has been completed the model will then be rolled out to the other workstreams, provided the data quality is sufficient.

The model focuses on the following key components to help determine staffing requirements:

- Patients caseloads
- Referrals
- Services
- Clinical demand

This would use appropriate drivers to model the following types of costs:

- Staffing
- Indirect Overheads

Objectives
We have built the model to help address the following requirements:

- Planning for future capacity and new ways of working, cost savings
- An objective basis to allocate staff, and express / develop safe staffing strategies
- Formalisation of roles and responsibilities
- Service redesign
- Review commissioning and funding arrangements
- More transparent and constructive commissioning

More broadly we believe it supports the following local initiatives as expressed in the A&A strategic plan:

- undertake a review of Psychological Services across the whole life course and clinical pathway to assess areas of action and improvement
- This work will include **projections of demand** to ensure changes recommended are future proofed and sustainable.
- This will inform the identification of potential future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes.
- To determine and evaluate options which will deliver future models for Psychological Services to ensure sustainable delivery of Mental Health access targets and patient outcomes
- Measurement of demand against the current standards and project future demand ensuring capacity for clinical and care developments in 2020
- Redesign work to improve access targets
- Service redesign within existing resources and identify future service options which allow the service to be delivered within reducing financial resources to 2020
- Improving Clinical Outcomes, based on the most effective clinical evidence
- Improving personal outcomes for patients and their carers

Project structure
The model involved the following key phases:

- Formation and ongoing correspondence and consultation with steering group (see section below).
- Running an introductory session and four on-site workshops to discuss future strategies to reflect in the model, develop care pathway profiles, discuss data requirements, review and sensor check model assumptions / outputs, and review working versions of the model
- Data collection, validation, triangulation and calibration – see data section
- Model development, adaptation and testing
- Deliver reports in a suitable format to the steering group to summarise work performed, findings, and recommendations
- Remote rollout of working version and collection of feedback
- Set up live project workspace for access, rollout, and to facilitate secure sharing of data / documents
- Costing of model and various scenarios; comparison to available funding; identify potential cost savings of specific changes

Steering group
This comprise representation from the provider (Heads of Service, Data and other key management) and Commissioner (NA council). The steering group met at inception and regularly during the course of the project to review progress, outputs and agree new changes in approach. The steering group has overseen the development of the model and facilitated provision of necessary resources, data and intelligence to populate the model. This group will continue to meet as the model is updated and new areas added.

Model requirements

- The model reflects multiple care pathways referred to above with CAMHS used as the initial pilot area (or pathway)
- We apply a demand led approach necessitating profiling of historic service data and applying assumptions about estimated future service user population and estimate clinical demands in line with defined service pathways and activities
- This informs predicted staffing requirements based on assumptions about clinical responsibilities and clinical capacity
- A base year is used representing recent 12 month period; this is used to reflect and calibrate visiting and costs to historic data
- The model will forecast 3 further years to show future changes / initiatives in the service
- A baseline scenario may be compared with one or several scenarios to identify implications of making changes or adopting alternative strategies in specific areas, for example adding or reducing service offer
- Financial inputs required include funding, direct costs (staffing) and indirect costs. An inflation factor is applied to reflect known or anticipated future cost growth.

Outputs

Reporting will be provided at the department level, on an annual basis and include:

- Staffing requirements
- Direct and indirect service costs
- Predicted impact on waiting times / list size

Calculating clinical workload

Activities relating to the following key phases are included in the model:

- Referral
- Assessment
- Planned care
- Unplanned care
- Review
- Discharge

Travel time has also been estimated for activities where travel is required.

Expressing demand: Care matrix approach

A "care matrix" is applied to reflect and help calculate the range of services delivered and acuity/risk levels of the patients. This ensures we can profile patients with greater granularity and accuracy taking into account the different needs and patient characteristics across different pathways and levels of acuity. This will assist in providing a logical input into the model, and align with an aggregated quantitative approach.

The care matrix captures intensity of patient contact across 3 different levels of acuity from level 1 (low) to level 3 (high). Patients have initially been assigned to these 3 levels by observation of intensity of care. The inputs in the care matrix have been initially baselined by calibrating to historic activity.

The care matrix will be adjustable in line with future development and new intelligence / feedback.

Calculating staff clinical capacity

Workload will reflect the estimated patients, care pathways and activities and be estimated for future periods. Staffing will be determined in line with the following considerations:

- Management and administrative roles / clinical responsibilities
- Assignment of minimum responsibilities or specialist roles to particular activities or patient groups
- Clinical capacity of staff reflecting level of non-clinical responsibilities, absence and leave
- The activities will be assigned to staff reflecting requisite levels of experience / staff level
- Supplemented by assumptions around management / support staff
- This will help the model to identify future staffing requirements

Scenario development
In future the model can facilitate development of scenarios reflecting new ways of working e.g:

- Formal service offer and future change in offer / commissioning
- Role profiles for future delivery model
- Increased levels of integration across the services to reflect single point of contact approach, reduce duplication, and provide support and management in a more joined up way

Data

To ensure an evidence based approach, the model must be baselined to historic activity. The model will leverage off existing data and analysis completed by North Ayrshire. This will ensure alignment with existing work and reduce further requirements.

In line with requests and modifications made to the data specification, the existing model is based on CAMHS data provided for 3 teams – North, South and East. The data provided included all clinical activity over a 12 month period from 1 December 2015 to 30 November 2016. It also included all referrals for that period including (non-identifiable) information on the patients.

The data and previous submissions have been reviewed and tested for reasonableness and triangulated with other data sources. This has allowed us to develop and improve the data quality / scope across the project.

This data has allowed us to build patient profiles to reflect patient longevity (active period), intensity (number of care interventions per month) and mix of services used (services are mapped into a standard Benson classification). This then facilitates calculation of clinical time using time units for each service, and allocation of clinical responsibilities in line with patient acuity/ service as per the matrix approach applied described above.

Data development has represented a significant part of the project. Following a significant amount of review activity at inception we concluded there was a lack of completeness, consistency, timeliness and standardisation in the core datasets across the organisation.

This has been an evolving piece of work and continues to be a challenge which has caused some delay to the project / rollout across the different pathways within A&A.

This has been a key driver i.e. to ensure we can establish a standardised structure across each pathway and place greater emphasis and established controls to ensure we have more reliable data to feed the models and ensure better analysis.

Patient information is required on an aggregated basis. This means no individual or identifiable patient information are requested or required. This approach requires aggregation of total patients and identification of patterns or rates of conditions and acuities within that population.

Benchmarking

Where possible Benson Wintere as model administrators use indicators and metrics available from other Benson models/modules, plus available research to externally validate our models. This could apply for instance to help develop the following areas:

- Staff capacity
- Travel time
- Clinical admin time

This will be an ongoing area of development and may be enhanced and improved over time.

2. SCREENSHOTS

The following screenshots are taken from the working version of the CAMHS model. We have selected specific screenshots an provided some additional comments to give further insight. The actual model is navigated using the buttons at the top of the screen.

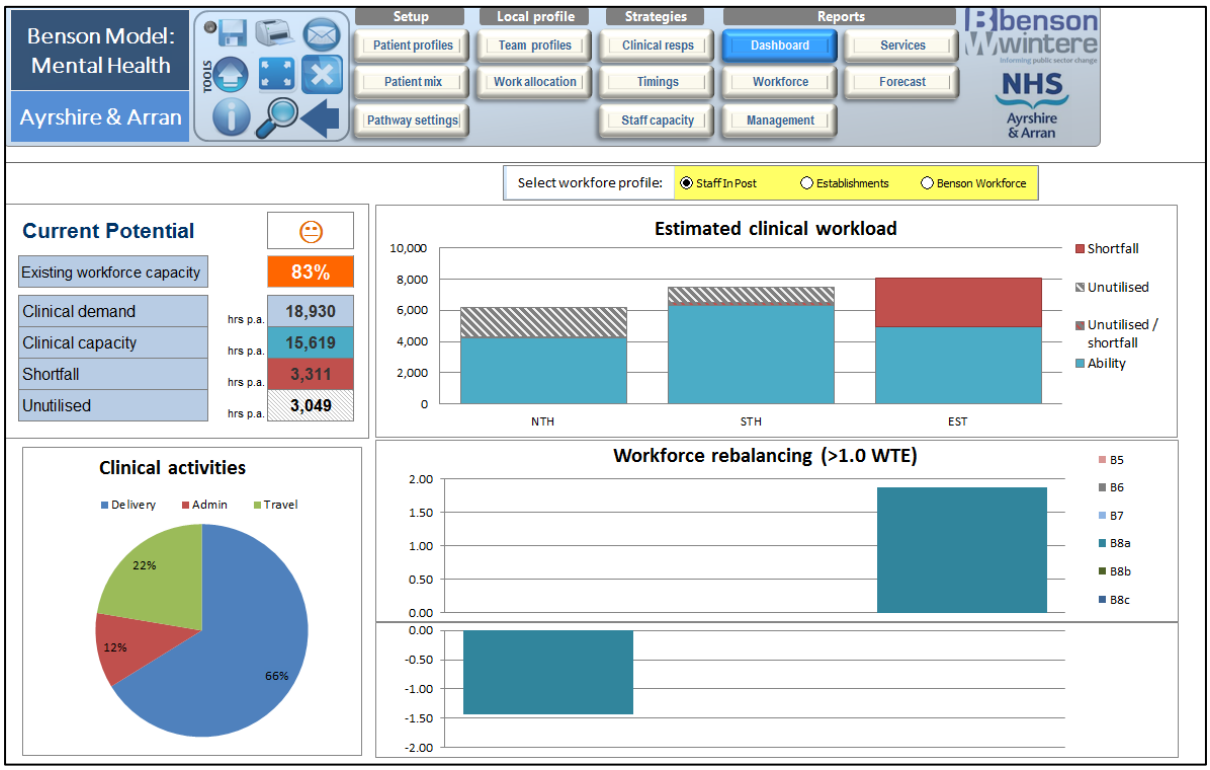
The model is based on a one year period – it estimates the clinical workload for each team and for each type of practitioner based on the assumption in the model (rate of referral, patient profiles, service timings and clinical / non-clinical staff responsibilities).

The current model is subject to several caveats due to ongoing work being performed on the data and assumptions. However the functionality and look of the model will not change fundamentally.

Screenshot 1 – Dashboard Report

The dashboard shows the projected capacity of each team against projected demand, based on existing staffing. See below there are 3 teams (N, S, E) for CAMHS. The red in east indicates the workforce is insufficient – there is a shortfall. The other 2 teams have unused capacity. This may be due to the way we have attributed existing staff to teams which is subject to further development.

The current potential (top left) shows the existing staff can deliver 83% of the clinical workload. However this could be improved if we reallocated staff from North & South to East.



Screenshot 2 – Workforce Report

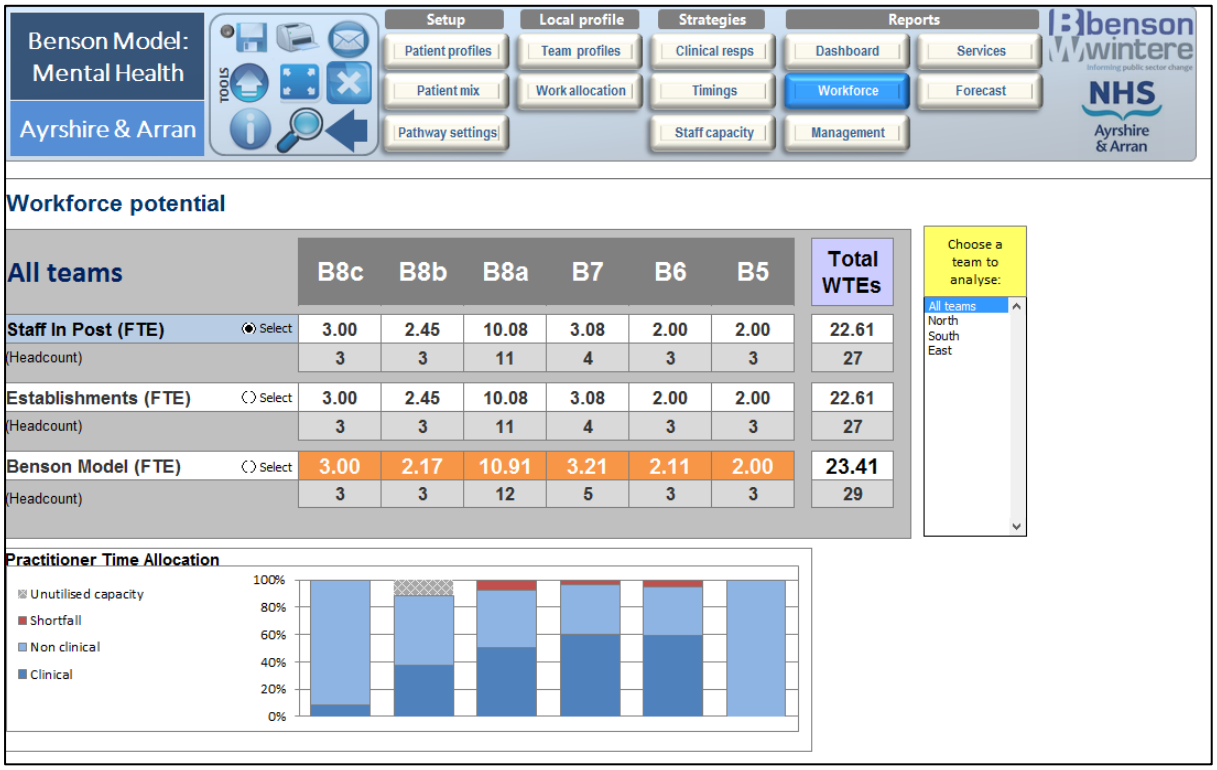
The workforce report compares current staffing with funded (establishments) and the optimum staffing levels calculated by the Benson model.

There are 3 staffing profiles displayed:

1. **Staff in Post** - current staff on the ground. This allows the model to determine the capacity of the existing workforce.

2. **Establishments** – funded positions based on existing commissioning levels. This allows the model to determine the sufficiency of current funded workforce.

3. **Benson model** – the optimum future workforce calculated by the Benson model. This is the theoretical best fit and is calculated both overall and for each team (N, S, E). The Benson model workforce is attributable to the assumptions in the model around the way work is allocated and the size of the clinical workload. For instance if we are moving more work to Band 7 staff the Benson will show that we required more Band 7s and less of the staff who have traditionally performed this work.



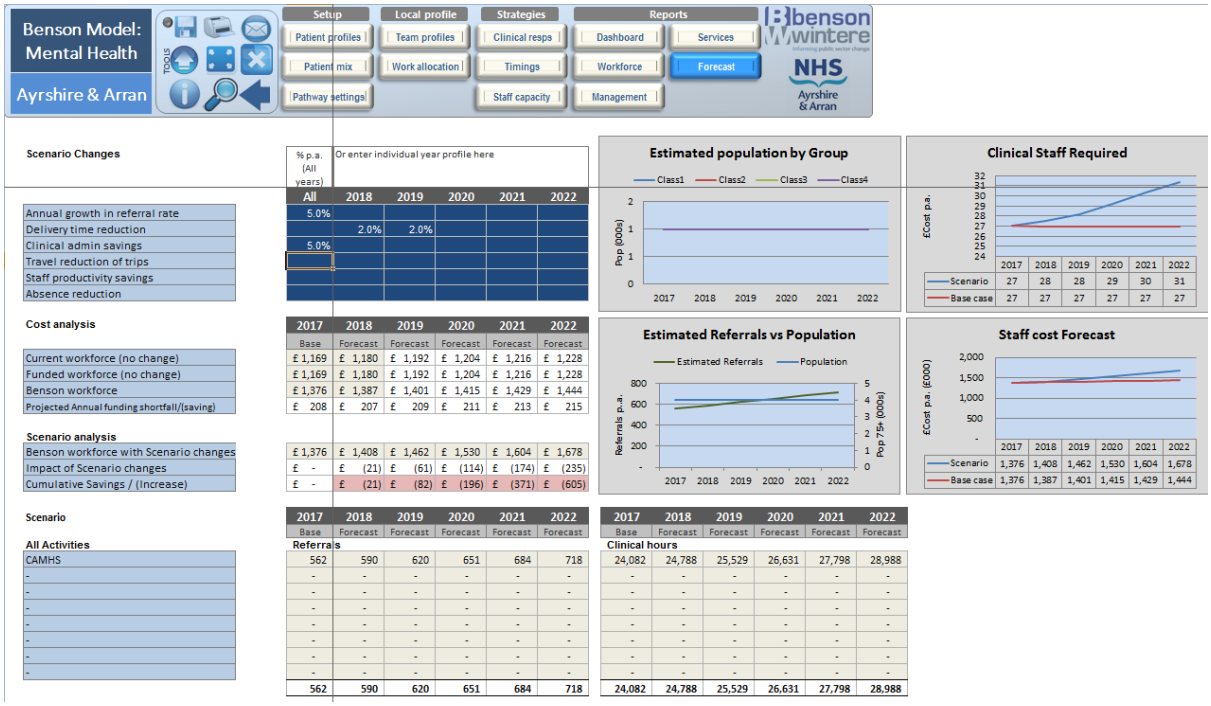
The graphs at the bottom indicated the capacity of the adjacent staff type based on the selected profile. In this example we have selected the "Staff in Post" profile. The red area for B8a, B7 and B6 indicates there is a shortfall of these staff. The grey patterned area under B8b indicates there is a shortfall of clinical work forecast for this type of staff given the clinical capacity at our disposal.

The dark blue area indicates non-clinical work (as input in the workforce profiles, see below); the light blue is clinical. Therefore we can see we have profiled the B8c's and B8b's with much more non clinical/managerial work than other practitioners.

Screenshot 3 – Forecast Report

This report takes the Benson workforce and estimates change over the next 5 years. We can also use this to cost the services (direct and indirect costs). This is based on expected change in certain variables, for instance:

- Rate of referral
- Delivery time changes
- Increase in clinical capacity
- Reduction of absence levels
- Reduction of administration time

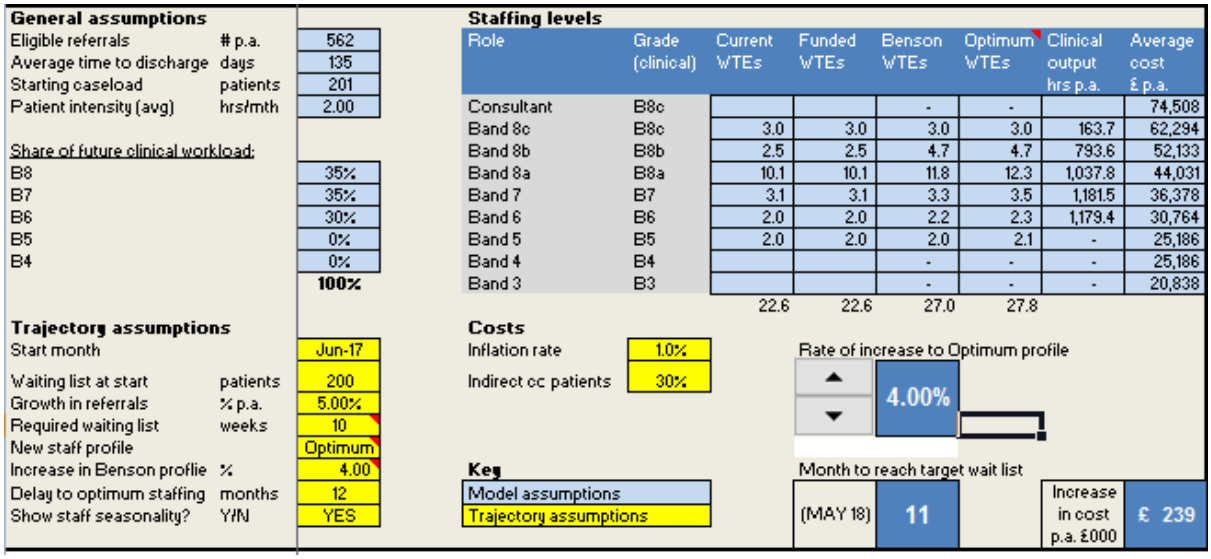


Screenshot 4 – Waiting List Analysis

Note these are not taken from the Benson model – this is a separate piece of analysis informed by the Outputs taken from the current Benson model.

The waiting list analysis also looks at other factors including seasonality of referrals. It uses this information to predict impact on both waiting time and waiting list.

The screenshots below are for illustration only. This is an ongoing piece of work and is subject to change in the underlying assumptions. We can also develop and bespoke this work more to ensure it reflects the factor driving waiting time.



General assumptions

Eligible referrals	# p.a.	562
Average time to discharge	days	135
Starting caseload	patients	201
Patient intensity (avg)	hrs/mth	2.00
Share of future clinical workload:		
B8		35%
B7		35%
B6		30%
B5		0%
B4		0%
		100%

Trajectory assumptions

Start month		Jun-17
Waiting list at start	patients	200
Growth in referrals	% p.a.	5.00%
Required waiting list	weeks	10
New staff profile		Optimum
Increase in Benson proflie	%	4.00
Delay to optimum staffing	months	12
Show staff seasonality?	Y/N	YES

Staffing levels

Role	Grade (clinical)	Current WTEs	Funded WTEs	Benson WTEs	Optimum WTEs	Clinical output hrs p.a.	Average cost £ p.a.
Consultant	B8c			-	-		74,508
Band 8c	B8c	3.0	3.0	3.0	3.0	163.7	62,294
Band 8b	B8b	2.5	2.5	4.7	4.7	793.6	52,133
Band 8a	B8a	10.1	10.1	11.8	12.3	1,037.8	44,031
Band 7	B7	3.1	3.1	3.3	3.5	1,181.5	36,378
Band 6	B6	2.0	2.0	2.2	2.3	1,179.4	30,764
Band 5	B5	2.0	2.0	2.0	2.1	-	25,186
Band 4	B4			-	-	-	25,186
Band 3	B3			-	-	-	20,838
		22.6	22.6	27.0	27.8		

Costs

Inflation rate	1.0%
Indirect cc patients	30%

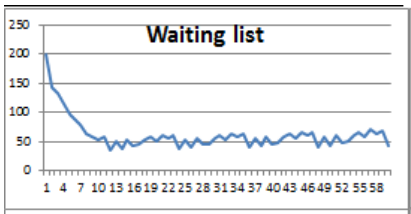
Rate of increase to Optimum profile: 4.00%

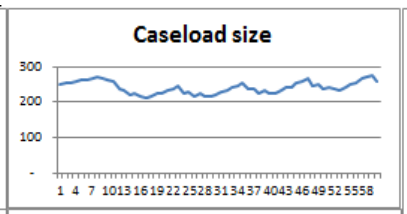
Key

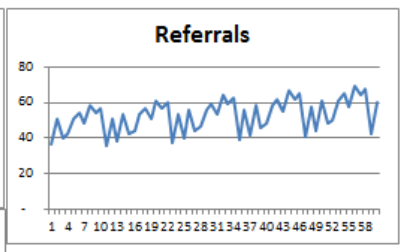
Model assumptions
Trajectory assumptions

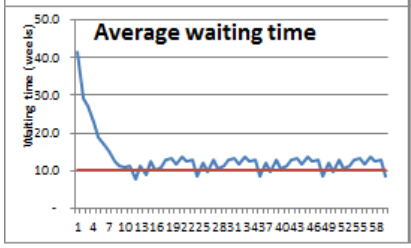
Month to reach target wait list: (MAY 18) 11

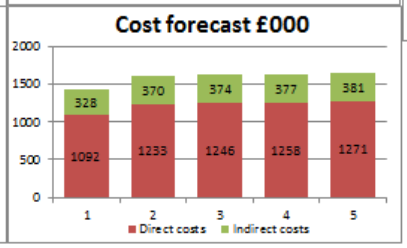
Increase in cost p.a. £000: £ 239









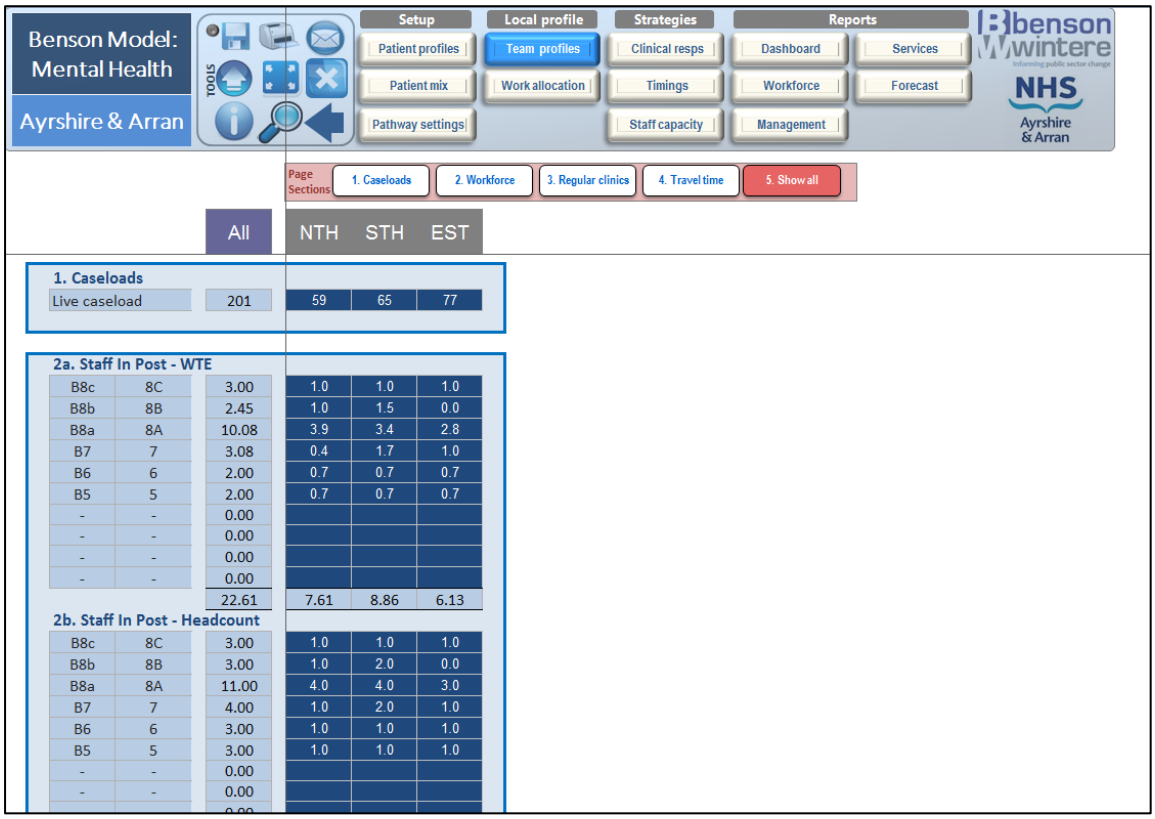


Screenshot 5 – Team Profiles

Team profiles are updated regularly. An excerpt of this is shown below – some areas are not visible. This allows the steering group to capture the following:

- Staffing levels
- Caseloads
- Travel time
- Other information specific to the team / local area, for instance care facilities or clinics.

As with other settings sheets, the dark blue cells indicate input cells and may be changed either by Benson Wintere as administrators, or by anyone with permissions on the steering group.

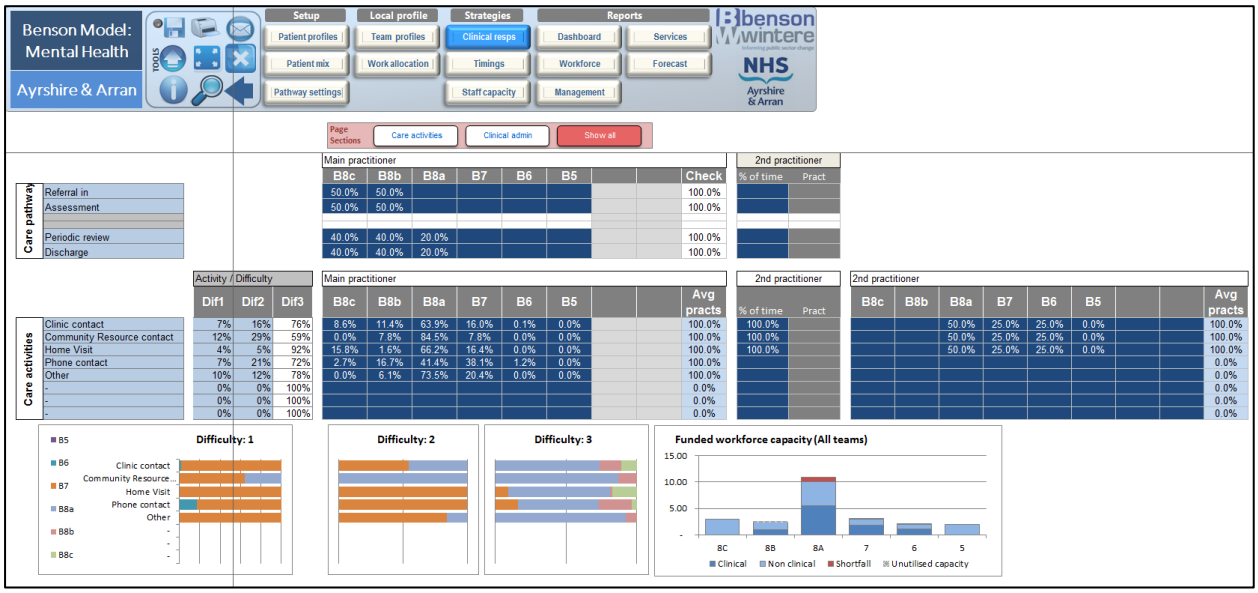


Screenshot 6 – Clinical Responsibilities

The table below allows us to express all clinical responsibilities for each type of staff aligned to the activity/service classifications used in the Benson model.

These have initially been baselined to the activity data, i.e. showing staff currently executing this work. This may change as we may want to use the model to develop scenarios where we re-designate some of this work to other staff types.

There is also a role for a support practitioner (the table on the right) reflecting where we may choose to use a 2nd member of staff.



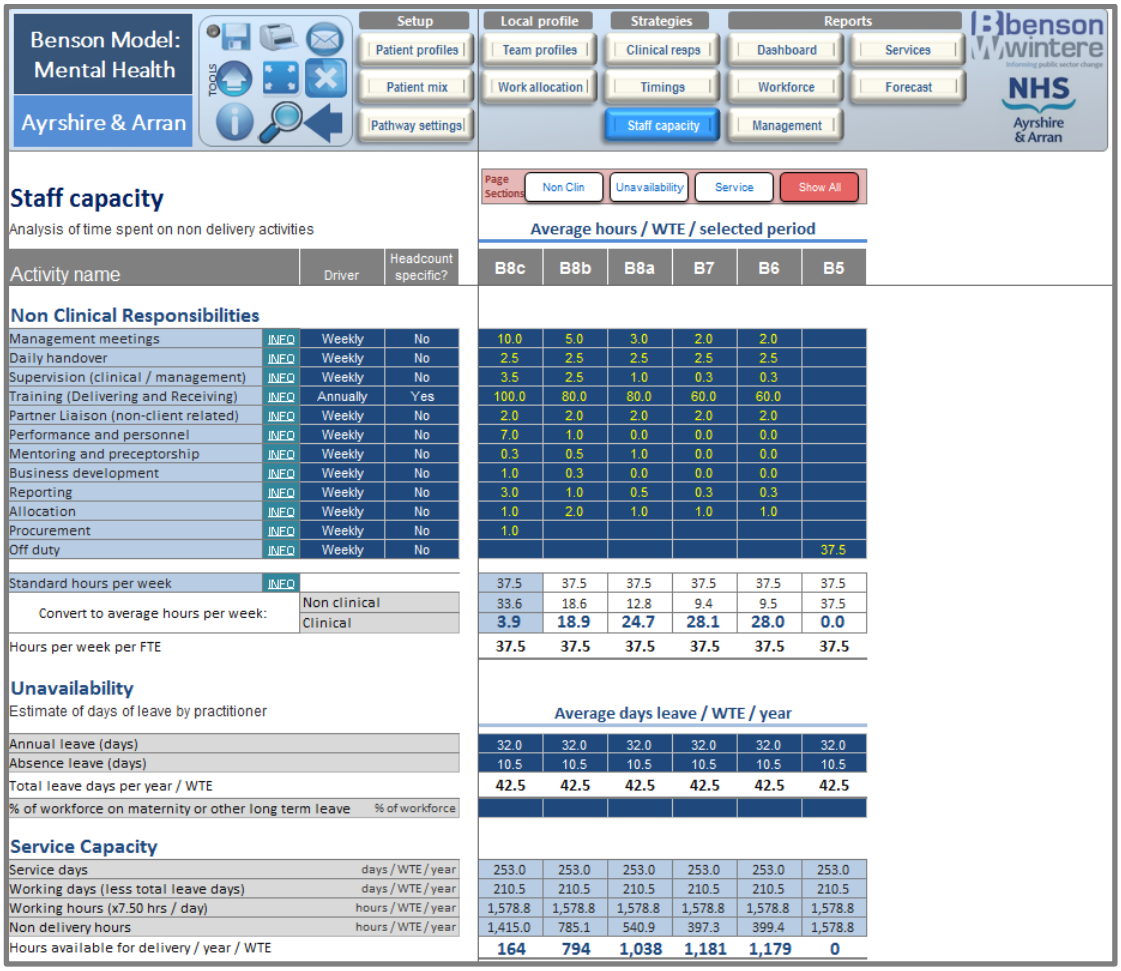
Screenshot 7 – Clinical Time Allocation

Here we set times (in minutes) to each visit type. Note we have been unable to use the consultant intervention classifications as c50% not classified; instead using the model of intervention i.e. phone/clinic/home contact.

Once again we have initially baselined this to activity data.

Screenshot 7 – Staff Capacity / Clinical Productivity

This shows non-clinical staff roles to facilitate calculation of clinical hours available per week / year. This helps the model to determine how many staff are required to satisfy clinical demand levels.



3. INTRALINKS

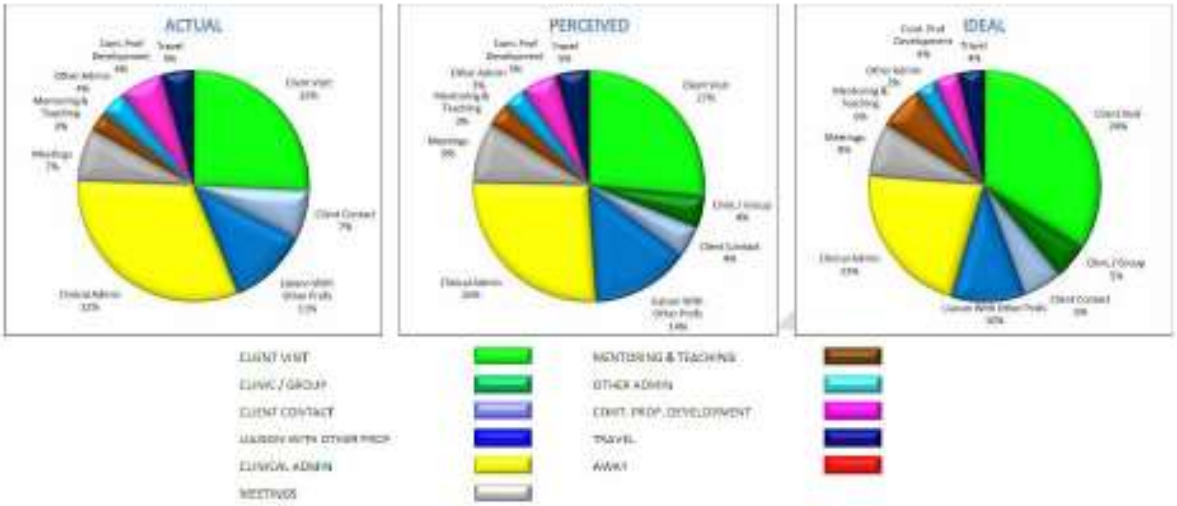
- Intralinks is Benson Wintere's online file sharing provider
- Each provider has their own secure folder
- Allows users to upload and download the model, reports & related documents
- Each user access by login/password
- Enables remote support, changes and updates to be made by Benson Wintere

4. PROJECT DEVELOPMENT

We will be focusing on:

- Developing the forecasting and costing to complete the pilot
- Extending the approach to other care pathways as mentioned above
- Further assistance to improve the datasets across all pathways to support extension of the Benson model in these areas
- Support to enable updates, refinement and collaboration
- Help development of strategies / changes / reporting from the model
- Further extensions to the core project may include looking at workforce scheduling and more detailed forecasting / costing

Figure 8: Time Utilisation – Psychology



Overall across the 11 DILOs completed in Psychology Services, 26% of HCPs' time was spent on direct client facing contact compared to the 31% perceived and 39% that they defined as the ideal level of contact.

Figure 9: Contacts per WTE day – Psychology

Patient Facing Contact Summary

Band	DILO F2F Activity inc.DNAs	DILO DNAs	DILO F2F Activity exc.DNA	DIARY F2F Activity (Per Day)	CASELOAD F2F Activity	DATA F2F Activity	DILO Contact Duration	DILO Ave. F2F Duration	DATA Ave F2F Duration	F2F %	Admin %	Travel %	DILO Ave. Travel
Band 8c	3.0	0.0	3.0	1.5	1.5	2.2	176	58.7	63.5	35%	7%	11%	18.7
Band 8b	3.0	1.0	2.0	2.7	2.3	2.0	140	46.7	-	32%	25%	11%	16.0
Band 8a	1.0	0.0	1.0	1.9	2.6	1.8	76	76.0	78.9	13%	32%	1%	4.0
Band 8a	2.0	0.0	2.0	1.9	2.7	1.9	112	56.0	45.0	22%	50%	15%	38.0
Band 8a	1.0	0.0	1.0	3.2	1.8	-	72	72.0	-	15%	44%	0%	0.0
Band 8a	2.0	0.0	2.0	2.2	2.5	2.9	118	59.0	45.1	27%	17%	0%	0.0
Band 8b	3.0	0.0	3.0	1.9	1.8	-	182	60.7	-	38%	29%	2%	4.0
Band 8b	2.0	0.0	2.0	2.4	3.2	2.9	188	94.0	64.1	42%	29%	4%	9.0
Band 8a	1.0	0.0	1.0	1.0	1.3	-	66	66.0	-	14%	36%	1%	4.0
Band 8b	3.0	2.0	1.0	4.3	4.2	2.7	68	22.7	90.0	15%	35%	3%	4.0
Band 8b	3.0	0.0	3.0	1.9	1.7	3.9	140	46.7	49.6	35%	49%	0%	0.0
Average	2.2	0.3	1.9	2.3	2.3	2.5	122	55.8	62.3	26%	32%	4%	8.9

The HCPs had an observed average of 2.2 contacts per WTE day including DNAs, excluding DNAs the HCPs had an observed average of 1.9 contacts per WTE day.

Benchmarking
December 2016

Child Psychology input within Health and Social Care Partnerships across Scotland

Greater Glasgow & Clyde

0-18 population 250,000

Specialisms- 8 Locality CAMHS Teams

Tier 4 LAAC Team, Inpatient (child) and Inpatient(Adolescent)

Acute Paediatric Neuropsychology, Paediatric Clinical Psychology, Liaison Psychology and Maternity and Neonatal Psychology

8d - 0.9 wte

8c – 15.62 wte

8b – 1.7 wte

8a – 24.6 wte

7 – 13.8 wte

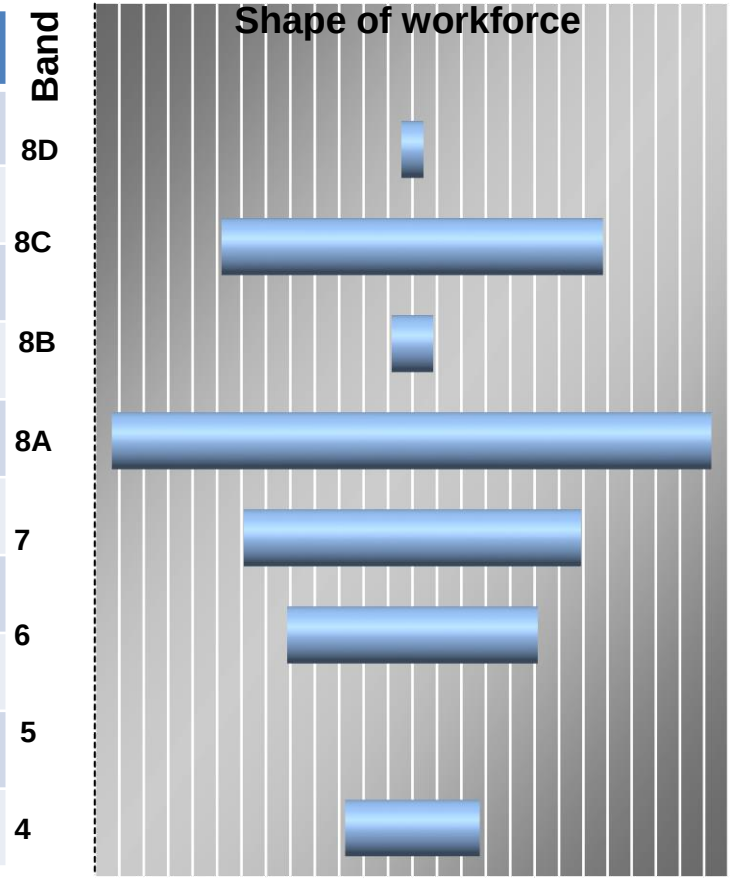
6 – 10.25 wte Psychological Therapists

4 – 5.5 wte Assistants

Total - 72.37 wte

Greater Glasgow and Clyde

Band	Current WTE	% Workforce
9		0.0%
8D	0.90	1.2%
8C	15.62	21.6%
8B	1.70	2.3%
8A	24.60	34.0%
7	13.80	19.1%
6	10.25	14.2%
5	0.00	0.0%
4	5.50	7.6%
Total	72.37	



Lanarkshire

0-18 population estimate 124,000(15-16 live births 6,900) (no data therefore calculation is live births times 18) - under 15 population dropping by about 5% over 10 years. So actual number maybe slightly more.

Specialisms - Primary Mental Health Team, CAMHS, LAAC, Paediatrics, Reach Out, (LD CAMHS) just transferred to Adult supervised by Lead Psychologist

8d – 1.0 wte ,Current Lead is 8c post in process of being rebanded.

8c – 2.5 wte

8b – 6.4 wte

8a – 11.55 wte

7 – 6.0 wte

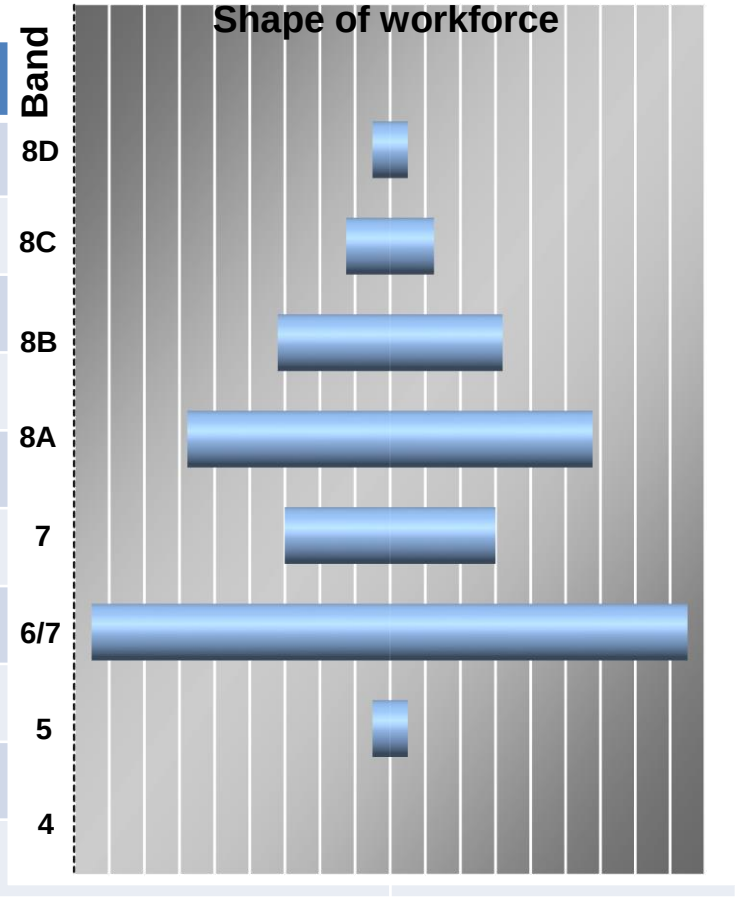
6/7 – 17 wte Advanced and Practitioner Psychologists (These are CAAPs as the main recruiting source)

5 – 1.0 wte Assistant

Total – 45.45 wte

Lanarkshire

Band	Current WTE	% Workforce	
9		0.0%	
8D	1.00	2.2%	
8C	2.50	5.5%	
8B	6.40	14.1%	
8A	11.55	25.4%	
7	6.00	13.2%	
6/7	17.00	37.4%	
5	1.00	2.2%	
4	0.00	0.0%	
Total	45.45		



Grampian

0-18 population – 105,000

Specialisms – Locality services headed as The Hub, Aberdeen City, Aberdeenshire, Morayshire, Learning Disability. Urgent cover dealt with by all Psychologists.

8d – 0.8 wte

8c – 3.0 wte

8b – 6.1 wte

8a – 11.6 wte

7 – 1.8 wte Advanced Psychology Practitioner

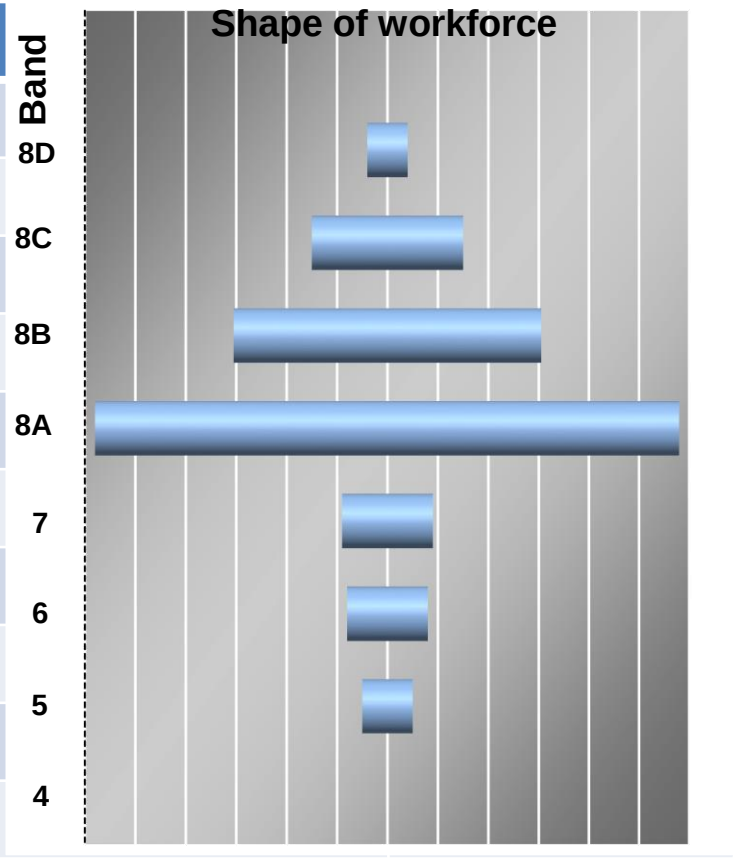
6 – 1.6 wte Psychology Practitioner

5 – 1.0 wte Assistant

Total – 25.9 wte

Grampian

Band	Current WTE	% Workforce	
9		0.0%	
8D	0.80	3.1%	
8C	3.00	11.6%	
8B	6.10	23.6%	
8A	11.60	44.8%	
7	1.80	6.9%	
6	1.60	6.2%	
5	1.00	3.9%	
4	0.00	0.0%	
Total	25.90		



Dumfries and Galloway

0 -18 years population – 30,000 .

Speciality Areas – Medical Paediatrics ,Neurodevelopment and Looked After and Accommodated (LAAC)

Band 9 – 1.0 wte Clinical Psychologist (previously 8d in Child now 9 including Director of overall Psychology Service)

8c – 1.6 wte

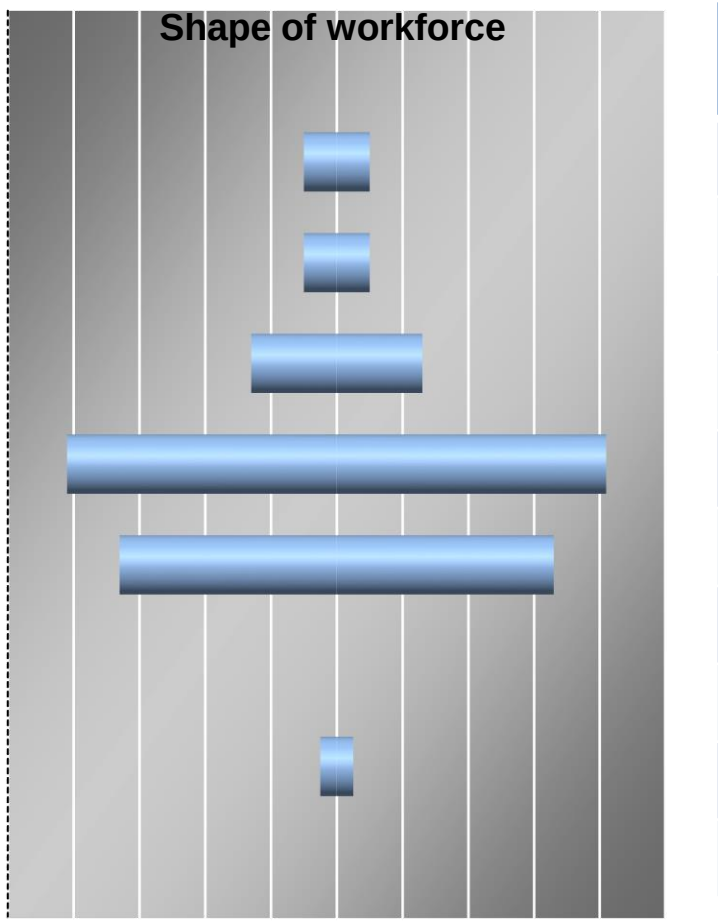
8a – 0.4 wte

6 – 1.8 wte Psychological Therapists

Total – 8.4 wte

Dumfries and Galloway

Band	Current WTE	% Workforce
9		0.0%
8D	1.00	11.9%
8C	1.60	19.0%
8B	0.00	0.0%
8A	4.00	47.6%
7		0.0%
6	1.80	21.4%
5		0.0%
4	0.00	0.0%
Total	8.40	



Fife

0 – 18 years population 70,000

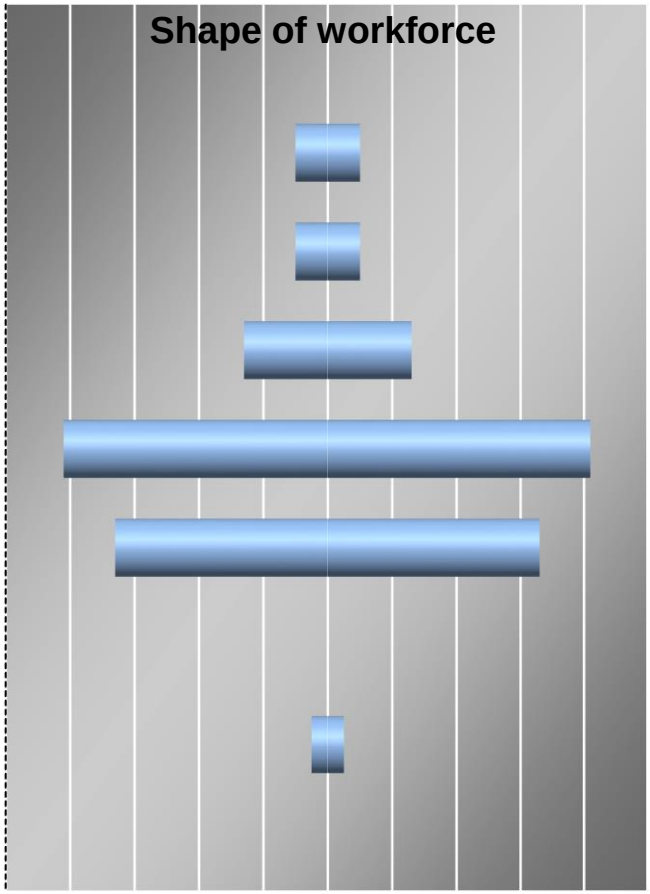
Speciality areas – Primary Care, CAMHS(3 teams),LAAC, Medici Paediatrics, ADHD, Child Learning Disability & Autism.

Band 8d – 1 wte
8c – 1 wte
8b – 2.6 wte
8a – 8.2 wte
7 - 5.6 Associated Psychologists(CAAP)
1.0 wte LD Nurse
5 – 0.5 wte Psychology Assistant

Total **19.90 WTE**

Fife

Band	Current WTE	% Workforce
9		0.0%
8D	1.00	5.0%
8C	1.00	5.0%
8B	2.60	13.1%
8A	8.20	41.2%
7	6.60	33.2%
6	0.00	0.0%
5	0.50	2.5%
4	0.00	0.0%
Total	19.90	



Ayrshire & Arran		
Band	Current WTE	% Workforce
9		0.0%
8D	1.00	4.2%
8C	3.00	12.5%
8B	1.91	8.0%
8A	10.40	43.4%
7	3.88	16.2%
6	0.00	0.0%
5	3.80	15.8%
4		0.0%
Total	23.99	

Greater Glasgow & Clyde		
Band	Current WTE	% Workforce
9		0.0%
8D	0.90	1.2%
8C	15.62	21.6%
8B	1.70	2.3%
8A	24.60	34.0%
7	13.80	19.1%
6	10.25	14.2%
5	0.00	0.0%
4	5.50	7.6%
Total	72.37	

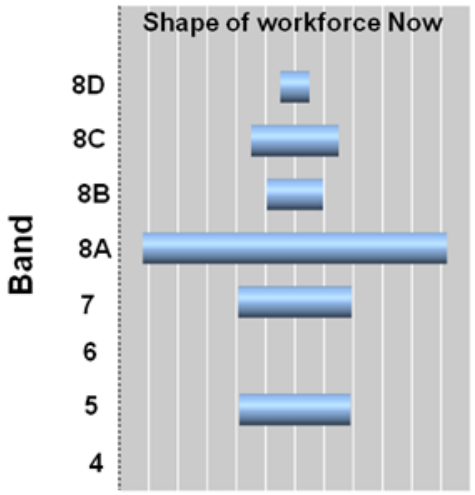
Lanarkshire		
Band	Current WTE	% Workforce
9		0.0%
8D	1.00	2.2%
8C	2.50	5.5%
8B	6.40	14.1%
8A	11.55	25.4%
7	6.00	13.2%
6/7	17.00	37.4%
5	1.00	2.2%
4	0.00	0.0%
Total	45.45	

Grampian		
Band	Current WTE	% Workforce
9		0.0%
8D	0.80	3.1%
8C	3.00	11.6%
8B	6.10	23.6%
8A	11.60	44.8%
7	1.80	6.9%
6	1.60	6.2%
5	1.00	3.9%
4	0.00	0.0%
Total	25.90	

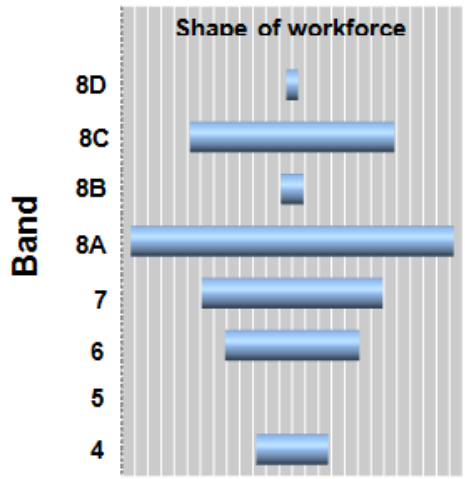
Dumfries & Galloway		
Band	Current WTE	% Workforce
9		0.0%
8D	1.00	11.9%
8C	1.60	19.0%
8B	0.00	0.0%
8A	4.00	47.6%
7		0.0%
6	1.80	21.4%
5		0.0%
4	0.00	0.0%
Total	8.40	

Fife		
Band	Current WTE	% Workforce
9		0.0%
8D	1.00	5.0%
8C	1.00	5.0%
8B	2.60	13.1%
8A	8.20	41.2%
7	6.60	33.2%
6	0.00	0.0%
5	0.50	2.5%
4	0.00	0.0%
Total	19.90	

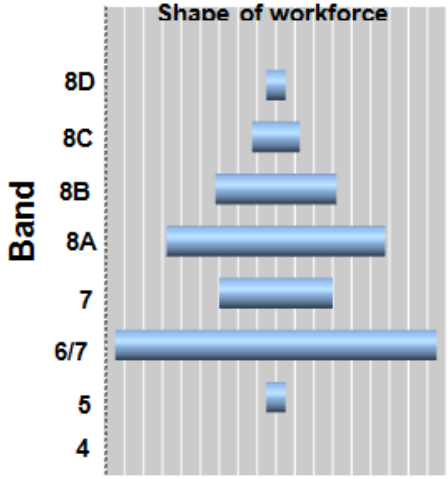
Ayrshire & Arran



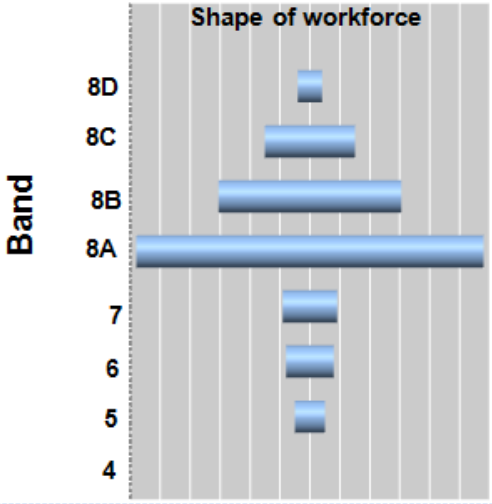
Greater Glasgow & Clyde



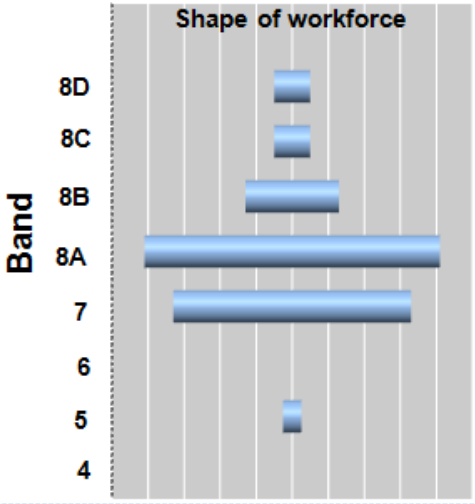
Lanarkshire



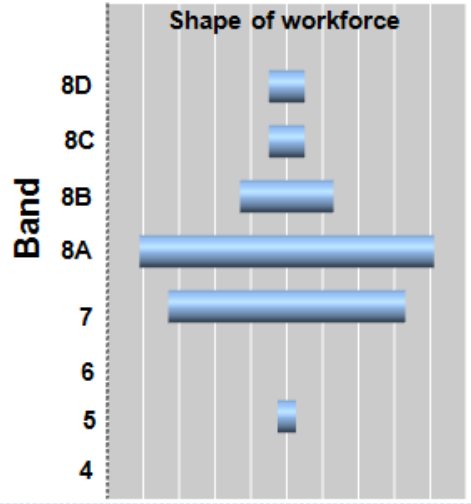
Grampian



Dumfries & Galloway



Fife



Benchmarking
November 2016

Learning Disability Psychology input within Health and Social Care Partnerships across Scotland

Who A&A benchmarked with

1. Lanarkshire
2. Fife
3. Grampian
4. Tayside
5. Glasgow
6. Borders
7. Forth Valley
8. Highland
9. D&G
10. Lothian

Benchmarking questions asked

1. Are the LD clinical psychologist's integrated members of the locality CLDT's
2. Who manages LD Clinical Psychology?
3. How do people with LD access a clinical psychologist?
4. What is the maximum wait to be seen?
5. Do you have any exclusion criteria (ASD, severe challenging behaviour, PD, addictions, in prison, over 65's, under 16's etc)?
6. Do you see people with borderline intelligence?
7. What are the main reasons for referral?
8. Ave length of time on caseload?
9. What's the skill mix in the department?

Q1 Are the LD clinical psychologist's integrated members of the locality CLDT

- Ayrshire and Arran
- Lanarkshire
- Grampian
- Glasgow
- Borders (AHP's dont)
- Lothian

- Yes
- Yes
- Yes
- Yes
- Yes
- Yes

Described self as integrated with a retained LD Psychology department where psychologists were assigned to specific CLDT's where they were based (other than Glasgow).

- Fife
- Tayside
- Forth Valley
- Highland
- D&G.. Interfacing. CLDT nurses only

- No
- No
- No
- No
- No

Described self as not integrated with a retained psychology department but referrals generally came into the department from the CLDT's and staff would at times move between teams where need was greatest.

- The reality is that each service was on a continuum of integratedness

Definition of integrated

A definition of integration was not provided in this exercise as I wanted to establish how services perceived themselves. Below are some dictionary definitions of what the word integrate/integrated means.

- bring (people or groups with particular characteristics or needs) into equal participation in or membership of a social group or institution.
- to combine two or more things in order to become more effective:
- organized or structured so that constituent units function cooperatively:

The more interesting question is whether the psychology department was part of an effective multidisciplinary system.

- MDT connectedness/human relationships
- Effective leadership
- Role clarity
- Values driven with clear direction of travel
- Effective and efficient processes in place
- Close proximity with regular contact

When these factors were in evidence the system functioned well.

Q2 Who line manages

- Ayrshire and Arran
- Lanarkshire
- Fife
- Tayside
- Forth Valley
- Highland
- D&G
- Lothian

- Head of LD Psychology..HOP

- Borders
- Grampian

- Head of LD Psychology.. Head of LD Prof Head

- Glasgow

- Team Leaders...Prof Head's of specialty... LD General Manager

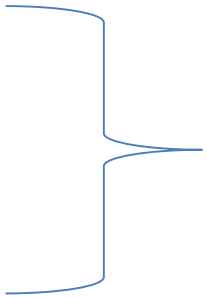
Q3How do people with LD access a clinical psychologist?

- Ayrshire and Arran
- Lanarkshire (access only via other team members. New screened by nurses.
- Fife
- Grampian
- Tayside
- Glasgow
- Borders
- Forth Valley
- Highland
- D&G(most discussed at CLDT but free to manage own direct referrals

Generally new referrals Via CLDT;
one point access.
Interdisciplinary cross referrals.

Q4 What is the **longest** wait to be seen

- Ayrshire and Arran
- Lanarkshire
- Tayside
- Borders
- Forth Valley
- D&G



- All meeting HEAT standard and local 18 week RTT standard for all cases. Breaches are rare.

- Fife

- Longest wait approx 20 weeks

- Highland

- 90% seen within 18weeks (reason not 100% is geographical area without cover last year due to vacancy plus have had no admin support for last 6 months)

- Glasgow

- Many seen within 18 weeks but a few waiting 20-30 weeks (had been running with 3 staff vacancies until recently)

- Grampian

- Longest wait approx 33 weeks

Q5 Do you have any exclusion criteria

- Ayrshire and Arran
- Lanarkshire
- Fife
- Grampian
- Tayside
- Glasgow
- Borders
- Forth Valley
- Highland

- similar access criteria; an adult service, referrals from the age of 16 or 18 upwards, do not generally see children or people who don't require specialist clinical psychology input.

- D&G

- D&G provided a tertiary lifespan intellectual disability and forensic service. Work through others via consultancy model only.

Q6 Do you see people with borderline intelligence

- Ayrshire and Arran
- Lanarkshire
- Fife
- Grampian
- Tayside
- Glasgow
- Borders
- Forth Valley
- Highland
- D&G

- Similar feedback. Most services will see complex individuals with unusual discrepant cognitive profiles that span LD/borderline where LD most appropriate service. Some will also see if historically been seen in service and significant involvement. Some also see if ASD presentation at borderline intelligence where reason for referral is complex requiring specialist LD psychology input.

What are the main reasons for referral?

- Across Scotland the main reasons for referral to LD Psychology were broadly similar

- Some services had dedicated forensic services others had them embedded within LD Psychology

- Challenging behaviour
- Mental Health issues
- Neuro assessment (memory, ASD, Query LD etc)

- Capacity/ASP issues
- Personality disorder/self harm/drug and alcohol issues (NB.D&G don't recognise PD or psychopathology in LD due to poor evidence base)
- Forensic issues
- Sexual issues

Q8 Ave length of time on caseload?

- Across Scotland the length of time on caseload was broadly similar and depended on reason for referral. Ranged from a few weeks for assessment only, 6-18 weeks for psychological therapy, to a number of years for a small number of the most complex individuals with severe challenging behaviour and those with PD/self harm
- In A&A the new to return ratio is 1:8 for LD Psychology which is the same as community paeds and the elderly. CMHT is 1:6 as a comparison. This information was not requested during benchmarking around Scotland.

What's the skill mix in the department?

- Wte's vary with population size with
- Borders the smallest population at 114,165 and 2.5wte's
- Glasgow and Clyde with over a million and 9.38wte's

- Skill mix mainly Clinical psychologists and assistant psychologists. D&G have input from counselling/forensic psychologist, Lanarkshire employ CBT Nurse Therapist at band7
- CP's range from 8a-8D with the exception of Glasgow range from 7-9 (Glasgow reporting difficult to keep 7's in post as staff quickly move to 8a vacancies elsewhere)

Closest in size is Fife

A&A

- 1x 8D
- 2x8B
- 2.18A
- 1x band 4 assistant

Fife

0.8 x8D

1x8C

2.8x 8B

0.7 x 8A

3 x band 4 assistants

NB. Fife has an inpatient LD forensic Unit on site which takes up 0.2wte of Head of LD Psychology service time.

In addition

- A&A is only area with a Clinical Psychologist who also functions as LDS Clinical Director
- LD Psychology influence in Ayrshire has been pivotal in innovative projects developing in Ayrshire such as Bridge to Vision, TRI Rugby, Health Improvement Strategy “We Want Good Health...the Same as You” etc

Conclusions

- HOLDS exists and Heads share ideas and good practice. Meet 4 times a year. A&A current Chair. Might help explain why services function in similar ways.
- A&A compares favourably with other LD psychology departments especially in terms of meeting HEAT standards, team integration, leadership influence.

10.2 **BENCHMARKING SERVICE MODELS**

1. Current Structure

In brief

The overall staff group is 109 staff (91.83 WTE) Our aims are to:

- Provide the highest quality of specialist psychological care.
- Meet the needs of patients wherever they live and whatever service they arise in and minimise gaps through rapid, flexible deployment of staff across partnership areas and specialties to cover provision of specialist assessment and therapies during sickness and maternity leave.
- Enable patients to benefit from an equitable and rational distribution of resource across partnership areas and specialty groups. To achieve the above there is a single point of contact for MH Services, Physical Health Services, Health Board and HSCPs which provides a strategic and operational overview of all Psychological Service.
- Provide clear accountability for provision of specialist Psychological Service across the whole system including accountability for accreditation and training, Psychological Service quality and the delivery of the performance targets across all specialties.
- Enable patients to benefit from psychological expertise in all its applications to health care.
- Provide high level psychological leadership for the benefit of patients and organisation.

1. OTHER SERVICE MODELS

Although most Psychological Services in Scotland are organised on an area-wide, professionally led and managed basis, they vary somewhat in their provision. All, unless extremely small e.g. Western Isles have broad specialty areas covering adult and child mental health, physical health and learning disabilities. But within these specialties, there are difficulties (e.g.) some have no specialist service to children with physical health problems or learning disabilities. Some have no Psychologists within adult mental health multidisciplinary teams, but rather operate a separate, centralised specialist service into which both primary care and community mental health teams can refer. None have the range of skill mix that exists in Ayrshire and so in that sense are less integrated, and less able to deliver stepped care than us. This is also the situation in Adult Mental Health in Northern Ireland where Psychological Services are linked but not integrated into other Mental Health Services.

- In England and Wales there has been a huge investment (actually 1.2 billion, with the aim of training 9,000 new therapists and with continuing investment to date) into establishing the Increasing Access to Psychological Therapies (IAPT) Programme. When the HEAT target was set in Scotland there was no such investment. Nonetheless SG has articulated its continuing aim to increase access and, more recently, has provided funding to Health Boards (with additional funding for posts from NES). The funding has been focused on developing posts in the Older Adult/Physical Health, Children and Primary Care Mental Health Services. However, the funding is fixed term four years only.

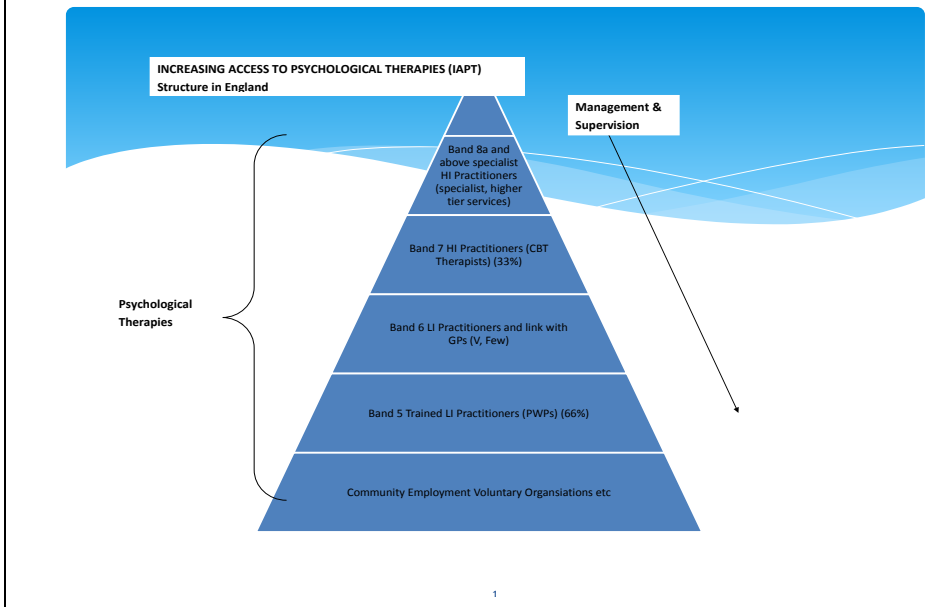
- The IAPT programme for Adult Mental Health in England and Wales employs only staff trained in evidence based PT's. It currently "treats" 16% of prevalence of mild-moderate mental health problems. In Ayrshire some psychology staff (Clinical Associates (CAAPS) and Counsellors are deployed into Primary Care Mental Health Teams (PCMHT), and along

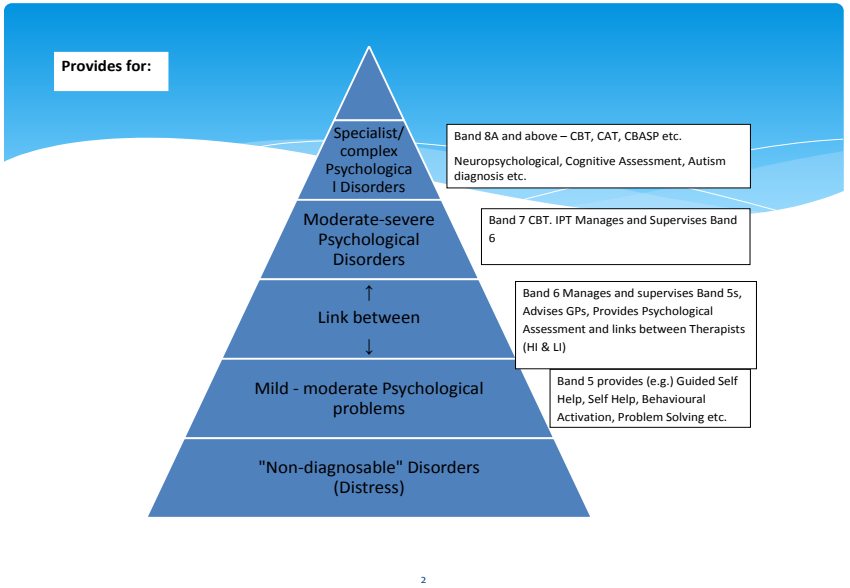
with largely untrained staff (in Psychological Therapies) to deal with this patient group. However, the resource overall is insufficient and inadequately trained.

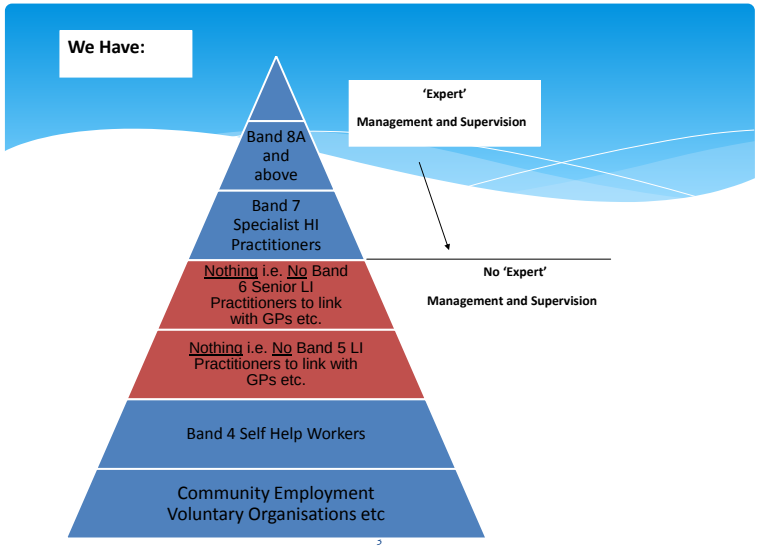
- The IAPT programme report notes that to achieve good outcome expert therapists should be 30% of overall resource i.e. equivalent to our CAAPS. We are low on this resource and indeed the biggest staff group in PCMHTs is not trained in evidence based Psychological Therapies at all.

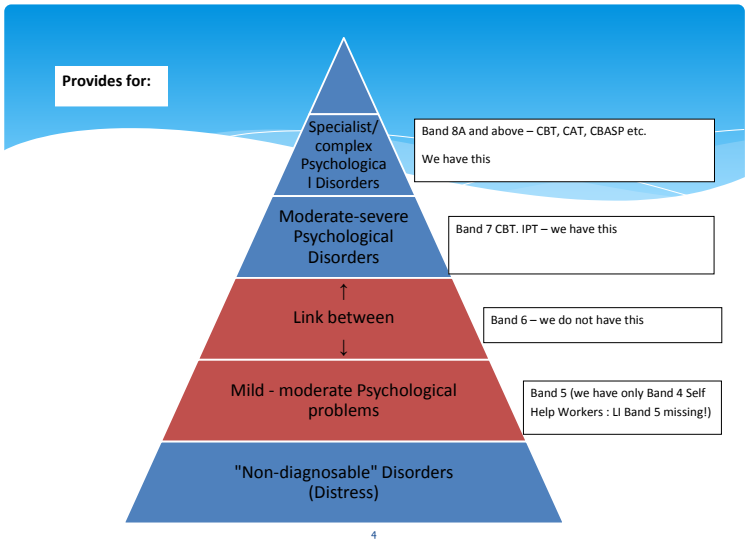
- In relation to above, better recovery rates within IAPT are achieved by:
  NICE compliant treatment.
  "Stepping Up" treatment to High Intensity (e.g. CBT) quickly when needed.
  Having expert clinical leadership, personalised CPD and supervision.
  Having proper assessment and diagnosis in the first instance.
  Ensuring certain diagnoses e.g. PTSD, Social Phobia go immediately to High Intensity practitioners i.e. are not "generically" assessed and treated.

The diagrams below compare what the IAPT programme provides with Ayrshire's provision and demonstrates the gap in terms of provision of low intensity interventions (which should not be provided by expert psychological therapists/Psychologists but should be supervised by such staff.


INCREASING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT)
Structure in England
Management & Supervision
Band 8a and above specialist HI Practitioners (specialist, higher tier services)
Band 7 HI Practitioners (CBT Therapists) (33%)
Band 6 LI Practitioners and link with GPs (V, Few)
Band 5 Trained LI Practitioners (PWPs) (66%)
Community Employment Voluntary Organsiations etc
Psychological Therapies
1


Provides for:
Specialist/ complex Psychological Disorders
Band 8A and above – CBT, CAT, CBASP etc.
Neuropsychological, Cognitive Assessment, Autism diagnosis etc.
Moderate-severe Psychological Disorders
Band 7 CBT. IPT Manages and Supervises Band 6
Link between
Band 6 Manages and supervises Band 5s, Advises GPs, Provides Psychological Assessment and links between Therapists (HI & LI)
Mild - moderate Psychological problems
Band 5 provides (e.g.) Guided Self Help, Self Help, Behavioural Activation, Problem Solving etc.
"Non-diagnosable" Disorders (Distress)
2


We Have:
'Expert'
Management and Supervision
Band 8A and above
Band 7 Specialist HI Practitioners
Nothing i.e. No Band 6 Senior LI Practitioners to link with GPs etc.
No 'Expert'
Management and Supervision
Nothing i.e. No Band 5 LI Practitioners to link with GPs etc.
Band 4 Self Help Workers
Community Employment Voluntary Organisations etc
3


Provides for:
Specialist/ complex Psychological Disorders
Band 8A and above – CBT, CAT, CBASP etc.
We have this
Moderate-severe Psychological Disorders
Band 7 CBT. IPT – we have this
Link between
Band 6 – we do not have this
Mild - moderate Psychological problems
Band 5 (we have only Band 4 Self Help Workers : LI Band 5 missing!)
"Non-diagnosable" Disorders (Distress)
4

- Service models in other countries vary widely in line with their healthcare systems and geography. Examples include those related to IT, (tele-therapy, App-based adjuncts to therapy and computer-delivered CBT) and also different models of deployment of Psychologists such as within GP practices and behavioural medicine hubs.

2. SERVICE STRENGHTS CHALLENGES

SERVICE STRENGTHS AND WEAKNESSES

- High levels of routinely measured patient satisfaction and low level of complaints (approx 1 per year).
- The area-wide, professionally managed and governed model is attractive to staff and beneficial for patients. It has contributed to improved recruitment and retention. It is the preferred model for PSs around the country.
- A single clinical lead enables a strategic overview, planning and rational prioritisation across all Specialties and a single point of contact for all stakeholders.
- Professional, expert overview ensures application of evidence base, appropriate implementation of continuing professional development and clinical supervision systems, and maintenance and monitoring of accreditation across the Specialties.
- The area-wide PS enables greater flexibility in terms of deployment of resource to ensure equity and availability of expertise wherever need arises.
- The local PS has a good national reputation which assists with recruitment. This is linked to strong connections with NES, the Master and Doctorate training courses and other national specialty-specific groups. Excellent CPD supported by income generation, and area-wide management and governance provides a culture which matches the expectations of the workforce.
- We have good recruitment and retention, low sickness levels, high staff satisfaction and motivation, a broad professional skill mix and are integrated with the Multi Disciplinary Teams of the Specialties in which we work.
- All Specialties measure clinical outcomes but there is no PS wide system available as yet to enable electronic collation of aggregated data for reporting on effectiveness.
- Multidisciplinary team working and tiered systems. These are best where teams are small and role clarity is good e.g. in LD Services, Older Adults, Physical Health.
- The PS systems enable smooth and flexible communication between the Specialties.
- Significant level of activity evident in skilling up the wider workforce.
- Staff contribution at organisational, national and international levels regarding psychological factors within the Specialist areas.

Service Challenges

- CLINICAL RESOURCE & DATA: The greatest challenge across the whole PS is the lack of sufficient expert resource and insufficient data to evaluate service provision.
- RESOURCE: In relation to other staff groups, we have small resources in all Specialties, inadequate resources in some (e.g. 3.3 wte for six Older Adult Community Teams, MH and Physical Health In-Patients, 0.2 wte for Eating Disorders), and no specialist resource in others (e.g. Addictions).
- ROLE CLARITY: Some systems within the multi-disciplinary teams are inappropriate in terms of utilising specialist but limited psychological capacity to undertake generic work (see

CAMHS) and in non-psychological experts gate-keeping for specialist psychological interventions. Lack of role-clarity fosters this.

- EXPECTATION OF COLLEAGUES: The specialist resource is inadequately supported by a complimentary "less expert" one that can manage the less complex psychological presentations. Attempts to train up the wider workforce have failed due to lack of capacity to release these staff for training or post-training dedicated psychological work. There is no facility for the PS to gate-keep and deploy these staff appropriate to the training received. This is especially so in AMH.
- INADEQATE SYSTESM: Our data systems are able to report on numbers waiting and longest waits for first assessment and treatment appointment but are not yet able to record and report on review appointments (total time of patient contact) and problem/diagnosis type. Currently, we are unable to provide data on demand in relation to capacity. As yet clinical outcomes are not systematically recorded or reported.
- RESOURCE: The PS has the highest maternity leave for any service within Ayrshire & Arran. It is difficult to backfill posts on a temporary basis. The implementation of Family Friendly policies is associated with staff returning from maternity leave to reduced hours resulting in split and part-time posts, increased supervision and management demands and increased need for accommodation.
- SUCCESSION PLANNING: Retirements of many senior PS clinicians will take place within the next few years so smooth succession planning is a priority.
- PUBLIC EXPECTATION: Whilst resource is small, PS aspirations and patient expectations and demands are high. A diversity of evidence based psychological approaches are now available for a wide variety of presentations and staff are required to train and become specialists in multiple areas. This is beneficial for patients and the PS as it meets local need and avoids out of area treatments bit it also increases the pool of patients making legitimate demands of an already stretched PS.
- ADMIN SUPPORT: Lack of sufficient administrative support. Two specialities noted that their staff were losing clinical time to administration tasks that an Administrative assistant would perform equally well and indeed better than them. Each Psychological Specialty should also review their administration needs (e.g. lack of support for scheduling fast response clinics and setting up patient bookings).
- WAITING TIMES/UNMET NEED: Waiting times, due to all of above, are high in some Specialties and even where they are not, this is sometimes at the expense of unmet and hidden need.

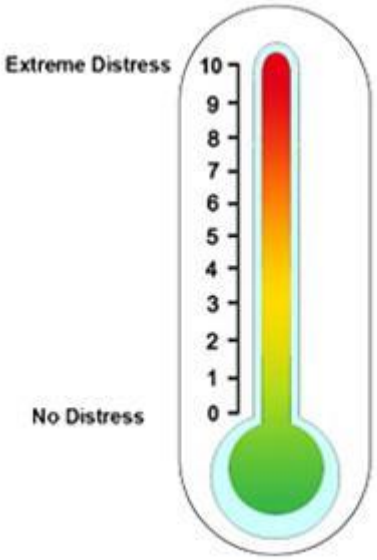
3. STEPPED CARE MODELS

The IAPT model is the most obvious UK example of stepped care, in this case in Adult Mental Health, though it is now expanding into Children's and Older Adults Mental Health provision.

In Ayrshire, Psychological Services has attempted to create a similar model in Adult Mental Health and CAMHS, and has trained and supervised (mainly nursing) staff from outside of Psychological Services at a cost to its own provision of direct patient care. There has been little return from this. Other than some Occupational Therapy staff, who have been dedicated time to practice, the rest simply do not have the capacity to be released from their other duties to practice low intensity interventions. It is clear that this is a flawed strategy and that in future a dedicated and trained workforce must be created.

Within Psychological Services itself and in other specialties, there has been more success in establishing stepped care models. Our skill mix of Assistant Psychologists, Counsellors, Clinical Associates and Clinical Nurse Specialists in CBT enables us to provide a steeped approach to patients within Psychological Services. For example, in CAMHS, and early

presentation of a potentially serious disorder may be seen by a Clinical Associate whilst more complex, severe difficulties would be seen by the Psychologist. Additionally, in some specialties, most notably Physical Health we have some very successful models of stepped care involving on-Psychology staff. Examples include skilling up and supervising ward staff in positive behavioural approaches in Older Adults in patients and Learning Disabilities. More formal systems exist in Oncology, Stroke and Coronary Heart Disease involving the “Distress Thermometer” assessment instrument administered by non-Psychology staff alone with interventions supervised by the Psychologist for less complex presentations and referral on as appropriate.



NHS Ayrshire & Arran

Psychology Benchmarking

The Older Adult, Neuropsychology and Clinical Health Psychology Service is made up of three unique and distinct services. The integration agenda is ongoing in each Health Board area. Lothian has a similar service structure to Ayrshire but population is very different. The tables are not complete but reflect the variability in service provision

The Older Adult Services (Table 1) are bespoke in each Health Board area with some having specific services for young onset dementia and some having specific roles with General Hospitals. The demands from NES training on supervision and support has been developed to meet local needs. A comparison of a Health Board of similar size (Fife) reflects Ayrshire slightly lower substantive number but this is balanced out by temporary posts.

Neuropsychology Services (Table 2) are not uniform throughout Health Board areas. However, this does not mean Neuropsychology is not provided but often may be part of the Older Adult or Clinical Health Service. There are small numbers operating with Neuropsychology Service. Glasgow although not reflected in numbers is hosted with the national facility at the Queen Elizabeth University Hospital.

Clinical Health (Table 3) while represented in most areas again has been very dependent on funding available. Glasgow is unique in its developments and would not be representative.

Older Adults

	Ayrshire and Arran	Fife	Forth Valley	Tayside	Lothian	GG&C	Dumfries & Galloway	Highlands	Borders	Lanarkshire
Estimated population	367,000	366,000	300,000	400,000	800,000	1,200,000	148,000	310,000	113,000	563,000
Staffing	8c 1.5 8b 1.2 8a 1.6(0.6 vacant) *0.8wte 8a from NES funding which I anticipate allocating to the city and shire.*	4.0 *Additional 1.4 coming from the NES monies.*	8c 0.5 8b 0.5 8a 1.0 7 0.5 CAAP *New NES money, made permanent by the Board - currently out to advert.*	8c 1.0 8a 4.2 *With the recent investment we are getting some of the direct allocation money to Tayside and the NES money - so combined we are getting 1.0 wte 8b and 2 8a and 1.0 band 4a and c post.*	8c 1.0 8a 4.7 Perm 8a 1.0 FT CBT 0.4 (notional nurse) *For 2nd round NES money - 0.6wte 8b, 1.5wte 8a and all (2.6wte 7/equiv) CAAP money.*	11.5	8c 1.0 8b 1.0 8a 1.0 *Hopefully the NES money will bring 0.8 of an 8a next year as using first years monies to fund CBT post.*	8c 1.6 8a 1.0 *Recruiting 8b through NES resource. Band 9 lost through restructure, now 8d (4 days p/week) professional lead. Heads of service (8c's) also lost managerial responsibility for their services and we have all to be managed under community teams.*	8c 1.0 *0.5 8a - NES monies in recruitment.*	8c 1.0 8b 1.0 8a 4.0 7 1.0 CAAP 7 1.0 SCN Therapist *From SG money 2.0 8a. From NES 1.0 8b and 1.0 band 7. 8d posts down banded to 8c when staff left posts.*
Is there a skill mix? If so what?					CBT 0.4 (notional nurse)					

Table 1

Neuropsychology

Question	***Board***					
Name of your board?	Ayrshire	NHS Tayside	Dumfries & Galloway	***Fife***	Highlands	Grampian (Inc Orkney & Shetland)
Do you have a general neuropsychology service	Yes	Yes	Yes	***No***	Yes	Yes
Estimate of population?		500,000	146,000		250K (excluding Argyll & Bute)	500,000 (then add 20,000 each for Orkney and Shetland)
Number of staff within your service (banding and weightings if possible)	1 wte 8c 0.5 8B 1.5 8A	1wte8C 5wte 8A	1 wte 8D		0.15 wte 8c 0.4 wte 8a	1.6 wte 8C 2.1 wte 8B 0.7 wte 8A 2 wte Assistant
Is there a skill mix of staff in your service if so what is this?	All Clinical Psychologists	All Clinical Psychologists	All Clinical Psychologist		All Clinical Psychologist	All Clinical Psychologist

Table 2

Clinical Health Psychology

	Ayrshire and Arran	Fife	Forth Valley	Tayside	Lothian	GG&C	Dumfries and Galloway
Estimated population	373,000	366,000	299,000	412,000	844,000	1,217,000	151,000
Staffing	4.2wte (services delivered to specialities: pain, bariatrics, cardiac, Oncology and palliative care, stroke, MS, general medicine)	7.5wte (services delivered to specialities: pain, weight management and bariatrics, BBV, Oncology and palliative care, rheumatology, general medicine, Intensive care INSPIRE project)	3.16wte (services delivered to specialities: pain, Oncology, general medicine, diabetes)	7.3 wte (services delivered to specialities: general medicine, Bariatric, HIV, Dental, Aesthetic assessment service)	14.2 wte (services delivered to specialities: pain, amputee, bariatrics, BBV, cardiac, clinical genetics, cystic fibrosis, COPD, Oncology, palliative care, plastics weight management ME/CFS, haemophilia)	40.2 wte clinical psychologists (services delivered to specialities: stroke, cardiac, COPD, oncology, plastics, cystic fibrosis, liaison psychiatry, CTCBI, spinal injuries, Institute of Neurological Sciences, pain and PMP, weight management, westMARC)	4 wte (Specialities inc.: oncology, A&E, stroke, diabetes, renal, cardiac, obstetrics.)
Is there a skill mix? If so what?	Clinical psychology and currently a temporary CBT therapist	Yes. Clinical Psychologist and health psychologists	All clinical psychologists except 0.5wte counselling psychologist.	Yes. Clinical Psychologists and CAAPS	Clinical psychologists and 1 wte assistant psychologist.	Clinical psychologist and assistant psychologists.	Yes. Clinical psychology and psychological therapists.

Table 3

Discussion Paper - Potential New Model of Psychology in Ayrshire

North Ayrshire
Health and Social Care Partnership
Psychological Services

Contents

Discussion Paper - Potential New Model of Psychology in Ayrshire

Introduction

Psychology services in Ayrshire & Arran provide a vast range of services that improve the quality of life for many people with mental health problems within Ayrshire and Arran. However, these services are under considerable strain as demand grows and demographic changes impact on Psychology services.

Current arrangements are going to be difficult to sustain and a different whole system change is potentially required to meet the on-going mental health needs of the people of Ayrshire and Arran. With the establishment of Health & Social Care Partnerships and focused locality working services have to look at the needs of a locality rather than a pan-Ayrshire basis. There needs to be increased knowledge, availability and confidence in community-based resources/supports around mental health and the work of the Community Connectors could enhance this resilience approach.

There are also other services that provide low intensity interventions and therapies out-with health that could potentially lead to collaborative work or sign–posting people to in future.

This report hopes to outline the potential next steps required to improve this service by looking at; demand management and changes to the current models of; location, skill-mix and lines of managerial and clinical supervision.

Background

2013-2015

During the CAMHS & Psychological Therapies Referral to Treatment Programme (2013-2015) a workforce work stream was developed and the scope was to concentrate on:-

- Review current skill and staff mix
- Skills and capacity in tier 2 services
- DCAQ

The focus was mainly on indentifying the level of intensity of Psychology Therapy work carried out in Ayrshire & Arran and very little DCAQ work was completed in relation to actual tracking information, as the type of tracker and agreement to use it was not agreed. The project desirables and outcomes were:-

- Identifying who was delivering Psychological therapies and assess capacity
- Identifying any skills gaps that would prevent NHS A&A from delivering the HEAT targets.
- Ensuring supervision arrangements are in place and procedures are standardised with regard to supervision.

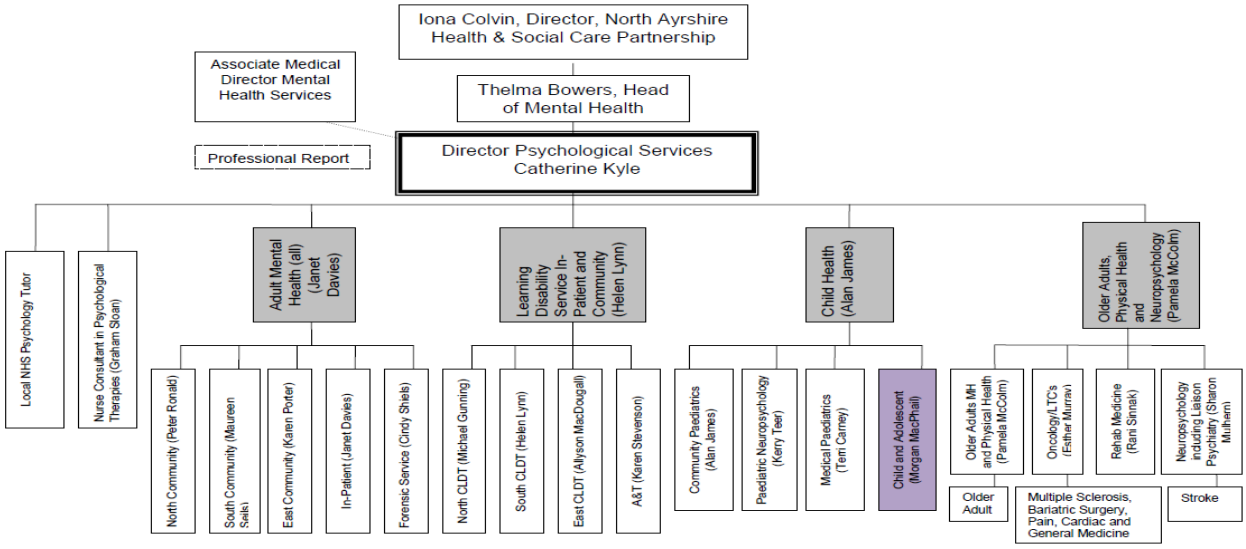
2015-2016

From 2015 the Change Team has been co-ordinating a new Psychological Therapies work stream with the main focus being:-

- The current service provision (current caseload unable to be pulled directly from FACE)
- Referral criteria

- Considering whether any aspect of current services could be provided by others
- Discharge and transfer process
- Managing waiting lists
- Seeking ideas or innovations for a new model of service for Psychological Therapies and how this would look for the service, team and individuals.
- Demand and Capacity of current caseload work streams
- Open Space Events
- Appreciative Inquiry Events for Psychological Therapies and CAMHS Neuro-developmental.
- Neuro-developmental Pathway (ASD and ADHD) which is being led by CAMHS working in collaboration with; Educational Psychology, Education, Social Work, School Nursing & Community Paediatrics.

Current Psychology Structure



Current waiting times as at June 2016

The longest waits sit within CAMHS and Community Paediatrics

- CAMHS waiting list had a maximum wait of 42 weeks in the East Team. There were 385 patients sitting on the waiting list as this time across the 3 localities.
- CAMHS Psychology had a maximum wait of 70 weeks with 164 patients on the waiting list.
- Community Paediatrics had a maximum wait of 110 weeks with 175 patients on the waiting list.
- Medical Paediatrics had a maximum wait of 17 weeks with only 23 on the waiting list
- Community Eating Disorders had a maximum wait of 13 weeks and 10 on the waiting list.
- Learning Disability Service had a maximum wait of 12 weeks across the 3 areas with the waiting list varying form 7-21 patients.

- Within Physical Health the longest waits were in the Pain Programme of 57 weeks.
- East PCMHT's longest waits were in PCP (Nursing) of 34 weeks and Counselling 28 weeks with a total of 508 on the waiting list.
- North PCMHT's longest waits were for CBT of 46 weeks and IPT of 32 weeks. There were 468 on the total waiting list.
- South PCMHT's longest waits were for Class Health awareness of 44 weeks and CBT of 40 weeks. There were 384 of the waiting list.
- East CMHT had a wait of 47 weeks for Nursing and 43 weeks for Psychology as the longest waits with 326 on the waiting list.
- North CMHT had Psychology as the longest wait at 18 weeks and Nursing of 17 weeks and 92 on the waiting list.
- South CMHT had a maximum wait of 61 weeks for IPS with 25 weeks for OT and 167 on the waiting list.

Current Findings

Some great work has been done around trying to improve the service in its current form with limited resources particularly in Older Adults Physical Health and referral criteria in Adult Mental Health. However, in today's financial climate there needs to be increased clarity on a local level about caseloads held by clinical staff and the factors (e.g. professional working practices, geographical areas covered, seniority and involvement in other work related activities) that may influence this capacity. The overall structure appears to be very top heavy and waiting lists continue to be too long. This report considers the possibility at looking more in depth at job planning, capacity building, skill mix and consideration of filling vacancies from other grades, roles and/or professions.

Gaps, Issues and Challenges

Overall Challenges for Psychological Therapies

- 30+ specialities and there is no historical date and no agreed classification for problem/diagnosis type, or agreed time to see patients in hours.
- No information on travel, admin and meetings by diagnosis
- FACE could be used as an intermediate step, but there are many gaps as it relies on the information being inputted.
- There is unmet need across psychological therapies.
- Poor clarity over roles
- Maternity leave and recruitment
- Taking cognisance of the stakeholder views from the Psychology Services Stakeholder Review August 2016.

Adult Services

- Clarity over roles and level of psychological intervention work that is expected as part of the wider team.
- Increased knowledge, availability and confidence in community based recourse and supports e.g. through Community Connectors.
- Clarity over role of Primary Care Mental Health teams.
- The PCMHT's main focus is around brief high intensity psychological therapy with psychology staff consisting of counsellors, CBT/CAAP's, but there is a different vetting and assessment process in the 3 PCMHT's and an initial screening and triage assessment stage may need to be considered due to the long waits.
- Screening tools at assessment.
- Limited number of waiting lists which are transparent and reflect unmet need.

- More skill mix within teams.
- Some low intensity work could be carried out by other members of the team with the appropriate training and supervision. Dedicated staff for lower intensity work this would provide confidence and capacity within the team to provide a more tiered model of psychological interventions. This may even reduce the number of specialist psychological therapy sessions required.

Older Acute/ Physical Health

- Stroke population – based on population and prevalence rates there will be an increasing number of people requiring specialist intervention year on year.
- Currently there is no regular therapeutic work being done within acute or rehabilitation wards, only assessment and advice and there is a clear requirement for this.
- There are no systems in place at present for screening all stroke patients for emotional disturbance and cognitive impairment as set out in the SIGN guidelines.
- There are currently no Tier 3 staff within the stroke service.
- Current resources within neuropsychology services will struggle to support the programme of teaching, training and implementation required to target the unmet need with our primary, secondary and integrated care settings.
- Due to the lack of a tier 2 service this is the only way for bariatric patients to access psychology if they do not meet surgical criteria.

Child

- There are challenges with CAMHS and the adult teams where psychology sits within the team, but is managed out with the teams. This has hindered the cohesiveness of the teams and multi-disciplinary decision-making. Ideally it would be useful for psychology to be embedded and managed with the teams they are working with professional and clinical accountability through their profession.
- Waiting list initiatives in CAMHS and Community Paediatrics
- Screening tools at assessment.
- Limited number of waiting lists which are transparent and reflect unmet need.
- More skill mix within teams.
- Some low intensity work could be carried out by other members of the team with the appropriate training and supervision. Dedicated staff for lower intensity work this would provide confidence and capacity within the team to provide a more tiered model of psychological interventions. This may even reduce the number of specialist psychological therapy sessions required.

Clinical Supervision – differences for each Grade

Across psychological therapies there are varying levels of clinical supervision being carried out. This varies greatly with some qualified psychologists much more than the British Psychological Society's 1.5 hours considered appropriate per month and 1 hours formal scheduled supervision for trainees. ***Cambridgeshire and Peterborough NHS Trust*** have drawn on the professional documents available from the British Psychological Society and the Health Care Professions Council and have recommended minimum levels of clinical supervision for full-time psychologists;

- Band 7 – weekly (1 hour) clinical supervision for the first 2 years since qualification, then fortnightly (40 hours minimum per year)

- Band 8a – Fortnightly (1 hour) clinical supervision (20 hours minimum per year)
- Ban 8b and above – minimum of 11 supervisions per year, ideally 1.5 hours in length.

The minimum number of supervisions per year regardless of full or part time working is 11 supervisions per year.

Activity Tracker

Psychological Therapies in Ayrshire and Arran will have to undertake an activity tracker exercise in order to look at the caseloads held by clinical staff and the factors (e.g. professional working practices, geographical areas covered, seniority and involvement in other work related activities) that may influence this capacity. Other areas have done similar exercises including ***Cambridgeshire and Peterborough NHS Trust.*** They have developed a spreadsheet to support managers and psychologists in developing locally agreed job plans.

Band	Direct Clinical Care			Supporting Professional Activities	Additional Responsibilities	Total for WTE
	DCC1	DCC2	DCC3			
7	19	9.5	1.5	7.5	0	37.5
8a	18	8.5	2.5	7.5	1	37.5
8b	14	8	2.5	5.5	7.5	37.5
8c						0
8d	9	4.5	4.5	4.5	15	37.5

(OP Psychology Job Planning & Service Planning Guide, Cambridgeshire & Peterborough NHS Foundation Trust)

Stakeholder Review Psychological Therapies

The stakeholder review in August 2016 highlighted that Psychological Therapies are very much valued within Ayrshire and Arran, but it also provided some insight into areas which could be improved. These areas have also been themes identified in this paper; clearer referral criteria, more joint and partnership working, clearer outcomes and team working.

Focusing on the service requirements

- A profile of the current waiting list and case-loads would be useful to ascertain what the psychological therapy requirements are for Ayrshire & Arran and this could be more useful if it was done down to individual locality need e.g. some areas may need more low intensity clinicians and others may need more specialists. There is also unmet need in terms of population and prevalence rates for psychological assessment and intervention within the stroke population, addictions services, inpatient and older people's services.
- Psychological Therapies are no different to other areas of the NHS and the needs of the service have to fully consider before granting different working hours. "The NHS employer has a duty to consider this and will seek to facilitate this, wherever possible bearing in mind the needs of the service." (*Supporting a Work Life Balance Maternity Leave Policy, NHS Ayrshire & Arran Organisation & Human Resource Development Policy, 23rd Nov 2015.*

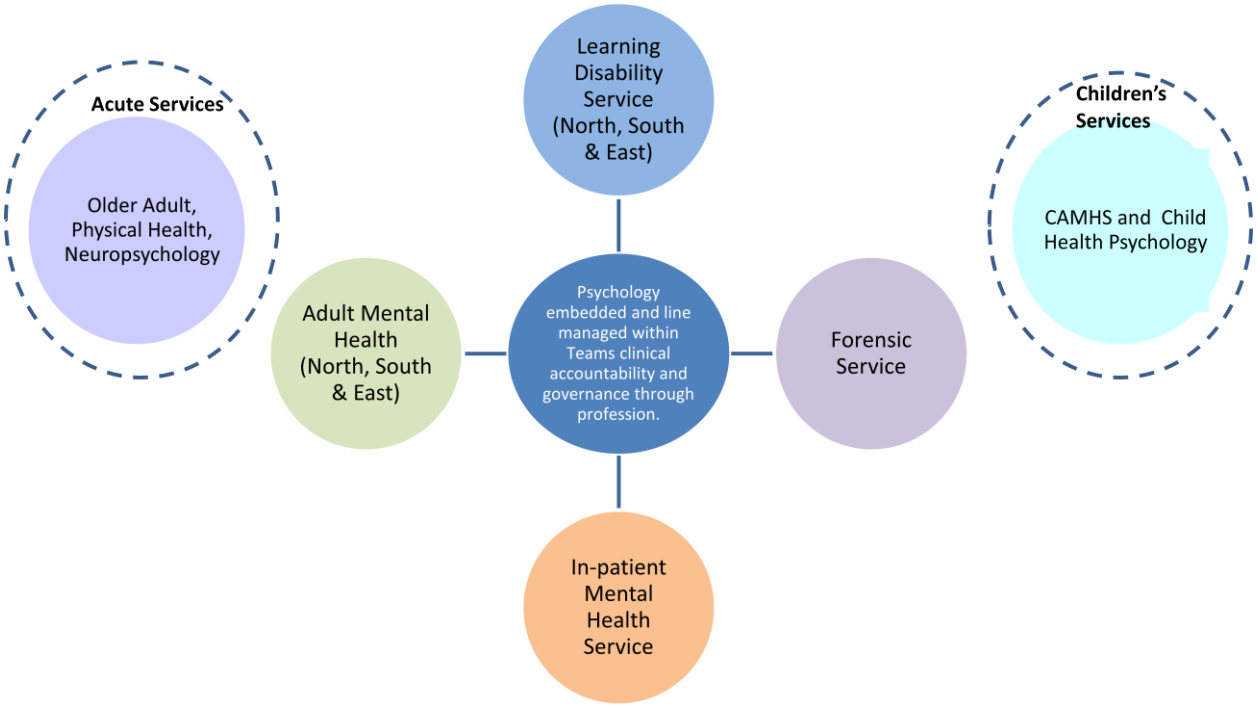
Community Resilience

There are many ways that Community Resilience could be built like working with; SAMH, KA Leisure, schools and Community Connectors.

Future Model

It is recommended that the following structure is put in place which focuses on the needs of the people of Ayrshire and Arran.

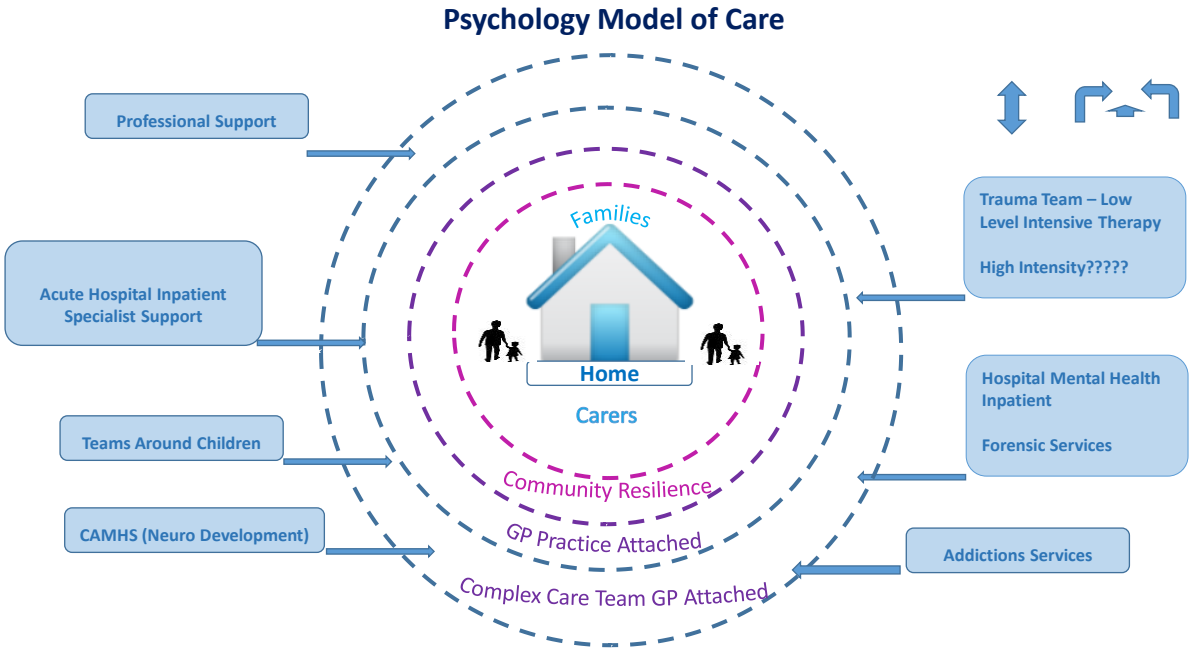
Future Models of Psychology in terms of Structure – Figure 1



The model above in **Figure 1** suggests a potential shift of resources to Acute Services and Children's Services of some areas currently under the current Mental Health structure. It also focuses more on embedding and line management of psychology within Teams out in localities with clinical and accountability and governance through profession. This suggestion is quite a shift away from what currently happens in Ayrshire, but in order to fully embed teams within a locality area maybe required. This would allow better job planning, capacity building and cohesion within a geographical area. There are too many waiting lists for psychological therapies which have special criteria and gate-keeping that the actual demand may not be truly known for many of the services.

Figure 2 explores the possibility of putting families and carers at the centre of everything Psychology does with Community resilience and other services including GP practices supporting the population of Ayrshire and Arran's mental health and wellbeing.

Figure 2 – Potential Future Psychology Model of Care



Recommendations

- An activity tracker to facilitate some DCAQ work is absolutely essential and could either be done in-house using the ISD tool or by an external company.

Next Steps

Psychological Therapies to undertake some DCAQ/activity tracking exercise in September 2016 in order to get some baseline information. This will create clarity regarding service capacity which in turn will help with service planning and development and reduce the psychological therapy waiting lists.

References

British Psychological Society (2009). Code of ethics and conduct: guidance published by the Ethics Committee of the British Psychological Society. Leicester: British Psychological Society.

Cambridgeshire & Peterborough NHS Foundation Trust, OP Psychology Job Planning & Service Planning Guide,

Health & Care Professions Council (2006). Information for registrants: Continuing professional development and your registration. London: HCPC

NHS Ayrshire & Arran Organisation & Human Resource Development Policy, 23rd Nov 2015. Supporting a Work Life Balance Maternity Leave Policy.

North Ayrshire Health & Social Care Change Team, Aug 2016, Stakeholder Review for Psychological Services.

Briefing Note: Psychology Services in Ayrshire Health and Community Partnerships: Maximising the impact of the Psychological Therapies Agenda.

Purpose

Mark Feinmann, following a request by Iona Colvin, Corporate Director for the North Ayrshire Health and Social Care Partnership, undertook a review of Clinical Psychology Services. This document provides a brief summary of the findings of the review and details a set of actions to be undertaken to implement the findings of the review.

The review considered Clinical Psychology Services in light of its fitness for purpose to directly provide, supervise and support the delivery of Psychological Therapies within Mental Health and Children's Services. These two domains were chosen because of the significant challenges that are being experienced by both services in achieving the standards set by the Scottish Government.

The method adopted for the review involved determining the overall shape of Mental Health and Children's Services and whether Clinical Psychology services were optimally contributing to the development and the delivery of Psychological Therapies within those Services. In particular, the reviewer focused on the network of services in place, the multi disciplinary teams that deliver the key components of the network, the adequacy of the available IM&T and the robustness of the management arrangements.

The reviewer met with Key Managers, IM&T staff and Clinical Psychology leads. The review forms part of the whole systems review of Mental Health unit being led by Thelma Bowers.

Psychological Therapies

The Scottish Government indicates that "Psychological therapies can have demonstrable benefit in reducing distress, symptoms, risk of harm to self or others, health related quality of life and return to work." The Government set an 18-week standard for improving access to and waiting times for psychological therapies that were to be implemented by December 2014. To help achieve the standard, the Scottish Government highlighted the importance of the following service components:

- A comprehensive network of multi disciplinary teams that connect well to meet the full range of people's needs. These include lower-intensity interventions that can prevent people needing to access higher intensity treatments.
- A prescribed evidence-base for those Psychological Therapies for each element of the network. Guidance, in the form of the PT Matrix, describes the robustness of the evidence base for treatments for adults, children, young people and families and some aspects of long-term conditions management and physical health care. It is recommended that treatments without an evidence base should not be utilised.
- In addition to reporting on Waiting Times, the routine Collection and Recording of Clinical Outcome data on a session-by-session basis should be established. The data being used at a patient, practitioner and service level should measure the quality and effectiveness of the interventions being delivered.
- To deliver the range of therapy skills detailed in the Matrix, a skill mix from across professional groups should be established to deliver the low and high intensity and specialist therapies. The skill mix should reflect the benchmarking of services to meet

current and projected demand. It is a priority to ensure that all staff within the teams have the competencies to provide evidence based psychological therapies.

- A training and supervision framework should be established to ensure effective governance of the delivery of Psychological Therapy framework.
- A clear pathway for patients to access the service and receive timeous support appropriate to their needs should be established. Self-referral to services should be prioritsed. Establishing an effective team allocation process that utilises lean methodology (e.g. CAPPA) to manage throughput within the team, can ensure that pinch points are reduced. Attention to effective discharge mechanisms along with appropriate re-entry also needs to be reviewed.

Responsibilities of Clinical Psychologists

Clinical Psychology should function within a network of teams that deliver a whole system response to demand. A clear description of the network is an essential precursor to any change in the role and responsibilities of Clinical Psychology:

- Mental Health Services: the relationship between non statutory services that provide social and care support, the PCMHT that provides low and high intensity PT, the CMHT that supports people with severe and enduring mental health needs and the Crisis Team and In-patient beds need to be woven together, with access through Self Referral or GP referral and clear step-ups from one service level to the next. Psychological Services should be present at all levels and be an active and strong member of the teams that delivers these services.
- Children's Services: CAMHs and Children's Pediatric services should form part of the whole system of Children's Services that are provided by the Health and Social care Partnership. The early intervention programmes delivered by Health Visitors, Education services and the Non Statutory sector should dovetail with those clinical services providing low and high intensity Psychological Therapies (e.g. parenting programmes) As with Mental health the interface of these services with CAMHs and the Pediatric Teams that provide the more detailed assessment and treatment services, should be explicit.

Team Flow – or ensuring that services are provided timeously, reflect assessed need and allow for step up to more intensive interventions is a service development priority. Systems such as CAPPA ensure that the team manages the flow rather than an individual profession. Such a culture of team working should be established across services.

Clinical Psychology should be <u>of</u> the team, <u>for</u> the team and <u>in</u> the team. A culture of team identity and membership should be established throughout Clinical Psychology services.

Clinical Psychology has a central role to play in providing high intensity and highly Specialist evidence based therapies on either a 1:1 or group basis. They should deliver these services as core members of Primary Care MH teams, Community Mental Health teams, CAMHs teams and Pediatric teams.

Clinical Psychologist should also provide supervision to those staff that provide the lower intensity therapies and ensure that the training programs are in place for all staff. Psychologists should use their skills in research and evaluation to support an ongoing programme of training and monitoring of the utilisation of psychological therapies .

The results of the Meridian benchmarking exercise should be utilised to determine the balance of clinical, supervision/support and non-clinical activity undertaken by different grades of Psychologist and others delivering Psychological Therapies.

Psychologists in the team should concentrate on the effective delivery of Psychological Therapies and be responsible within the team for the governance of these therapies - Clinical Psychology providing or assuring the delivery of Psychological Therapies. Each team, or network of teams should have a named Consultant Psychologist (Grade 8c) who is responsible not only for the practice of psychologists in the team but also for the delivery of Psychological Therapies by other members of the team. All registered professional will also have their own governance arrangements which must be respected.

The Consultant Psychologist is not responsible for the day-to-day management of the team. Team leaders and their respective managers are there to ensure that lean systems are in place to ensure the effective flow of patients through the service. The deployment of a team member should be determined by the need to effectively manage patient flow through a team and is the responsibility of the team leader.

Consultant Clinical psychologists should have a dual accountability to a Lead Care group Clinical Psychologist for governance and to a Service Manager for team systems and processes. The Budget for Clinical Psychology should remain with the lead Clinical psychologist until the new arrangements have been established

Clinical psychologists should have a key role in ensuring that Outcome data and the means to capture it and analyse it, is established so as to ensure the effective governance of the service.
Prioritising the appointment of data analysers is essential.

The complexity of Service delivery in Health and Social care requires those in leadership positions to have more than one role and to be accountable to more than one person. The four 8D Clinical Psychology posts in Ayrshire should have both a service responsibility - Children, Mental Health, Disability and Acute along with a general management responsibility. These general management responsibilities require further elaboration.

Work-plan

Outcome	**Action**
Agree Network of Services framework in Mental health and Children	
Agree range of PT to be delivered by teams within network	Review of Matrix and comparison with therapies currently being provided.
Determine which staff will deliver PTs (low & high intensity and specialist therapies	Determine the interventions to be undertaken by Clinical Psychology and those undertaken by other members of the team. Utilize the Meridian benchmarking data to inform resource deployment within the teams
Agree size, scope and shape of network of teams	Determine which therapies to stop ****and develop HR plan to reshape team to reflect demand
Agree framework for supervision and support and ensure process	

fit within HSCP Governance frameworks. Roll out of system across Partnerships	
Introducing CORENET for all activity undertaken by teams	
Introduce CAPPA model to make sure that patient flow is built round a team construct	

Option	Pros	Cons	Dependencies	Challenges to Implementation
Centralised: Professionally and operationally managed centralised area-wide Psychological Services hosted within NAHSCP. Functional integration into specialty teams and area-wide working as appropriate.	Scalable option allowing for a more reactive, flexible service to meet local and national agendas whilst ensuring patient need is central to its operational and strategic direction. Allows flexibility in the deployment and monitoring of resources. Flexibility to utilise staff to meet demand. Improved supervision of quality of work. Promotes recruitment and retention of staff. Improved patient care. Continuity and equity of service across Ayrshire. Improved management with better oversight of operational and professional management. More effective management and accountability. Respond more effectively to current challenges to service delivery. Takes on board current concerns from Psychology staff that the service will not be strategically, and operationally managed by Psychology staff. Helps improve targeted training and development. May address concerns identified in stakeholder reports. Allows for the recognition of areas within the service where there are existing examples of well-established good team working/functional integration. Promotes role clarity, strengthens pathways of care and collaboration across services.	Likely to generate the perception that the service is not promoting integration in like with wider partnership approach if the service is centralised and not fully integrated? Might send a negative message to others and promote an image of exclusion from wider MH services. Functional integration might be challenging without resource ownership. Could lead to a negative demand impact in some teams.	Requires other parts of the system to change as well. Needs strong leadership and management who are able to promote the advantages of a centralised, scalable model. Will require a programme of service engagement and PR to ensure that rationale is understood and well communicated. Try to address perception that the service isn't changing, and isn't integrating like rest of the H&SCP. Needs investment in databases and reporting mechanisms. Will require a review of the infrastructure of admin support which could promote restructuring of existing provision or highlight need for additional support.	Communicating the rationale. Engagement with stakeholders. Selling the overall vision to those out with the service. Investing resource in engagement with other teams, providing more information on what PS is there to do, why centralising is the chosen approach and developing people's understanding of role.

Option	Pros	Cons	Dependencies	Challenges to Implementation
Partnership: Decentralised services split 4 ways – North, East, South and Acute. Each Partnership and Acute will have a Professional Lead.	Responsive to localities. Potential to help focus on areas with more deprivation. Fits more with who refers to the service. Strengthen links with Physical Health. Potential access more funding through Acute. SG guidance on Acute paying for these services. Acute taking more ownership. Access to more opportunities. Develop more effective working relationships.	Existing resources spread too thinly. Potential problems in recruitment and retention. Potential to lose resource if vacancies arise and H&SCP / Acute decide to spend money in other ways. Loss of specialist skills. No flexibility or resilience. Potential to see a drop in service levels, inequity across Ayrshire in service delivery and service/professional identity. Can't ensure patients will be in the right part of the service. Some managers may not be able/keen to take on additional staff. Potential for specialisms to be managed by someone outwith their specialist service. Potential for huge negative impact on smaller specialisms. Fragmentation of a large service will increase vulnerabilities and risk to quality of care, service delivery etc. Disparate operational and professional practices will pop-up in the different partnerships.	Appropriate management arrangements. Ring fenced funding to secure current set up and to future proof service resource levels. Some roles span inpatient and community and also work pan-Ayrshire (eating disorders, forensic) – decision would need to be made on where these posts sit. Rests on the assumption that the current partnership model works for NHSAA.	Longer term planning for PS, when potentially losing service/professional identity. Staff morale – will feel under-valued. Pits the provision of psychological services against wider competing demands/priorities which may result in inequity. Rests on wider buy-in to psychological therapies.

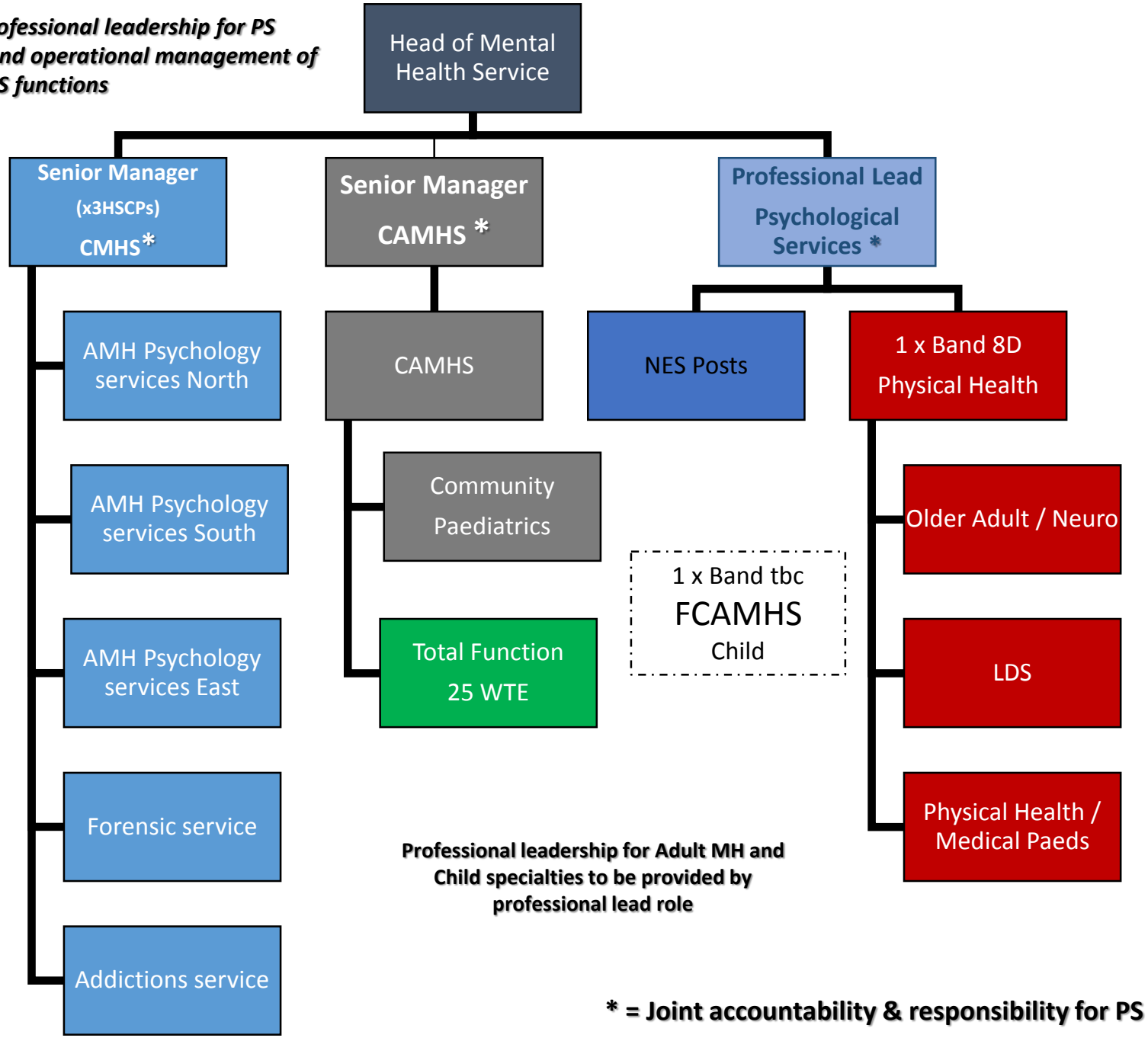
Option	Pros	Cons	Dependencies	Challenges to Implementation
Totally Dispersed: Budget, staff, all resources managed within individual services specialties and localities. Split 34 ways with NES posts randomly allocated to one or more H&SCPs. Professional Leadership and governance dispersed within each area.	Teams take more direct ownership of service. Develop focus on particular specialisms in more depth. Potential for savings in management structure.	Existing resources will be spread too thinly. Challenging to manage workload. No flexibility or resilience. Impact on service quality and ability to see patients quickly. Impact on recruitment and retention. Trainees won't experience all necessary competencies. Training and development opportunities limited. Potential for negative impact on smaller specialisms, and therefore clients seen by those services, is resources viewed as being needed elsewhere.	Staff and team management willing to move, other managers able/keen to take on additional management responsibilities.	The existing structure won't be suitable for a number of staff to be effectively managed. Requires other teams to change ways of working and management arrangements.

Option	Pros	Cons	Dependencies	Challenges to Implementation
Operational Integration with Professional Leadership Support Creation of one professional lead across Ayrshire, integrate staff and activities into children, adult and older people (with a lead for each service area). Co-management role with existing service managers to ensure joint accountability and responsibility for performance.	Greatest potential to deliver against the review's overall aims and objectives. Delivers against the integration agenda Provides financial efficiency through the deletion and removal of posts from the current structure (ensuring necessary savings are realised) Ensures the service user is more at the centre of service design and delivery Provides responsibility and accountability at the most appropriate level Builds on some of the strengths of the other options, embedding professional leadership across the entire service along with enhanced operational management capacity. High profile professional leadership for the service	Unpopular with operational staff. Increases management scope for some managers. Existing Business Support arrangements not suitable.	Requires strong leadership and management. Requires solid communications, open and transparent, on a regular basis. Requires engagement with Business Support around provision of service to PS as a whole. Management engagement from other parts of Mental Health. Buy-in and support from East and South HSCPs. Restructuring and subsequent deletion of posts. Requires solid business and workforce planning, with the need to also workload plan where appropriate.	Current Admin support is not adequate to deliver the changes required. Some of the other teams will need to make changes to working practices to allow for integration. Staff engagement and buy-in – a lot of work to be done by MH leadership and management to bring staff along with this change. Service will need to ensure posts are deleted to deliver efficiencies proposed

Removal of Grade 9 Clinical Director post, replace with 8D professional lead.				

Option 4

Mix of professional leadership for PS service, and operational management of smaller PS functions



Professional leadership for Adult MH and Child specialties to be provided by professional lead role

*** = Joint accountability & responsibility for PS service**

NORTH AYRSHIRE
Health and Social Care Partnership

Integration Joint Board
16th November 2017
Agenda Item No. 10

Subject:	**HSCP Strategic Plan 2018-21 (1st Draft)**
Purpose:	To inform IJB of the current status of the development of the partnership's new three year strategic plan for the period April 2018 – March 2021
Recommendation:	The IJB are asked to consider the current content and layout of the 1st draft of Strategic Plan The IJB supports the continued development of the new Strategic Plan.

Glossary of Terms	
ASPIRE	All Service Performance Information, Review and Evaluation
CPP	Community Planning Partnership
HSCP	Health and Social Care Partnership
IJB	Integration Joint Board
PAC	Performance and Audit Committee
SPG	Strategic Planning Group
WMTY	What Matters to You

1. EXECUTIVE SUMMARY

1.1 A writing group has been working for some months to develop the new Strategic Plan for the period 2018 to 2021. The first draft has now been complete.

1.2 The writing group is now actively engaging with key stakeholders to gather feedback on the current draft, ahead of public consultation.

1.3 The new three year strategic plan will be published in April 2017.

2. BACKGROUND

2.1 North Ayrshire HSCP launched its original three year plan in April 2015. This plan underlined the vision and strategic direction of what the partnership aimed to achieve in its first three years and beyond

2.2 This plan will expire at the end of March 2018 and as such, we are now required to develop its successor which shall be in place from April 2018.

3. PROPOSALS

3.1 The current version of the strategic plan is structured as follows:

3.1.1 **Directors Statement**
To be completed

3.1.2 **Reflections on the 2015-2018 plan**
Providing an overview of our key performance and achievements of the Partnerships

3.1.3 **Profile of North Ayrshire with main challenges**
Providing an overview of the area's characteristics, population, key strengths and challenges.

3.1.4 **Stepping Stones to Change**
Employing the same stepping stones outlined in the first strategic plan. We reconfirm our commitment to the vision of a future health and care system.
Also included is the feedback from engagement events asking stakeholders to identify, where the Health and Social Care Partnership (HSCP) currently sits in relation to the stepping stones.

3.1.5 **Policy Context**
Providing an overview of the policy landscape at the local and national level. Summarised, the review highlights the need for the partnership to work more collaboratively with local people, build resilient and supportive communities and address the significant inequalities in North Ayrshire.

3.1.6 **Finance**
This section details the financial context of the HSCP, highlighting the challenges we face and the strategy for response.

3.1.7 **Workforce Planning**
In line with the financial strategy, the Workforce Planning section will provide an overview of the challenges facing the partnership from a staffing perspective and the opportunities to influence and shape the health and social care workforce of the future.

3.1.8 **Partnership working**
Highlighting the partnership landscape and how we compliment the wider role of the Community Planning Partnership (CPP). Underlines the people of North Ayrshire are also partners and details findings from 'What Matters to You' (WMTY).
This section also includes the work of the Locality Planning Forums in engaging and empowering local people, accompanied by mini-locality profiles.
Also provides details on the forthcoming Partnership Engagement Strategy.

3.1.9 **Strategic Priorities**
Broken down by each of the 5 strategic priorities:

- Tackling Inequalities
- Engaging Communities
- Bringing Services Together
- Prevention and Early Intervention
- Improving Mental Health & Wellbeing

For each section, the plan identifies:

- Why this is a priority
- What have we previously done under this priority
- What Matters to people about the priority (taken from WMTY)
- What are we planning to do in future to address the priority

3.1.10 **Action Plan**

To be completed.

In consultation with stakeholders and service areas, specific actions will be identified to support the implementation of the new plan. These will be compiled into an operational action plan. This work will take place during the public consultation period.

3.2 **Anticipated Outcomes**

Through implementation of the Strategic Plan we anticipate that we will continue to improve services, information and advice and ultimately the health and wellbeing of the people of North Ayrshire.

We will continue to progress positively against the 9 national health and wellbeing outcomes.

3.3 **Measuring Impact**

Partnerships are required to provide an Annual Performance report, measuring the impact of services against the 9 National Health and Wellbeing Outcomes.

Further, the new Strategic Plan will be measured through provision of updates on the associated Action Plan and Performance Frameworks. Quarterly performance reports will be submitted to the established scrutiny groups (e.g. Integration Joint Board (IJB), Performance and Audit Committee (PAC) and the All Service Performance Information, Review and Evaluation (ASPIRE) performance process.

4. IMPLICATIONS

Financial :	The new plan intends to take full cognisance of the Partnership's Budget. The plan make clear the financial challenges that the HSCP face.
Human Resources :	Human Resource implications arising from the new plan are referenced within the Workforce Planning Section, which is a reflection of the Workforce Planning Strategy.
Legal :	Not Applicable
Equality :	A full equality impact assessment will be completed on the new strategic plan. The plan contains reference to the newly adopted Shared Equality Outcomes Further, throughout our engagement process we will be actively seeking views on how our services impact on protected groups.
Environmental & Sustainability :	Not Applicable
Key Priorities :	The new plan will maintain the 5 key strategic priorities set out in the plan for 2015-18. Consensus is that these priorities are still very relevant to the work of the Partnership. Work to be undertaken as a result of the plan will be aligned to the 5 priorities.
Risk Implications :	It is vital that our plan is complimentary to those across Ayrshire. Throughout the development process, we will seek to engage with our colleagues in the East and South Partnerships and the acute sector to ensure plans are complimentary.
Community Benefits :	Not Applicable – no tendering or procurement implications.

Direction Required to Council, Health Board or Both *(where Directions are required please complete Directions Template)*	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5. CONSULTATION

5.1 A series of stakeholder engagement activities have been ongoing since the beginning of October:

- 2nd Oct – Plan presented to SPG
- 12th Oct – Plan focus of IJB workshop
- 17th Oct – Plan provided for distribution to service area senior managers
- 2nd Nov – SPG Meeting to focus on plan
- 7th Dec – Staff engagement event

5.2 A public consultation on the new plan is required. It will take place from December 2017 to February 2018.

6. CONCLUSION

6.1 The first draft of new Strategic Plan for 2018-21 has now been completed.
The draft sets out the current situation and challenges facing the HSCP and our development intentions going forward.
We will now engage and consult with stakeholders to gather feedback that will help us further refine the plan before public consultation.

For more information please contact Scott Bryan on 01294 317747 or sbryan@north-ayrshire.gcsx.gov.uk

Integration Joint Board
14 November 2017
Agenda Item 11

Subject:	**Peer support, recovery and employability support services for people with mental health problems in North Ayrshire**
Purpose:	To seek IJB approval to redesign and re-commission mental health peer support, recovery and employability support services in North Ayrshire
Recommendation:	That IJB approves the development of an integrated support service with 3 key elements

Glossary of Terms	
IJB	Integration Joint Board
PSMT	Partnership Senior Management Team
HSCP	Health and Social Care Partnership

1. INTRODUCTION

1.1 North Ayrshire Council at the direction of the NAHSCP has to date commissioned a mental health support service called *Positive Steps* (provided by Scottish Association for Mental Health) via a 'block funding' contract. The value of this contract is £279k and the contract will end 30 June 2018. The service now requires to be re-commissioned.

1.2 Based on a full service consultation and review carried out in 2014 (involving staff, service users and referrers), the key outcomes for a future peer support and employability service were established.

1.3 The statutory community mental health service is under review and in the process of integrating its local authority and NHS functions. This review includes the range of commissioned mental health services to ensure a comprehensive 'network' of support for people with mental health problems. The new service will be an integral part of this network.

1.4 Emerging evidence about recovery and the contribution of *Recovery Colleges* towards people's recovery from mental health problems has been considered by the service. Utilising short term funding from the NAC Challenge Fund, a pilot will be undertaken to develop a Recovery College in North Ayrshire. This will commence in January 2017 for 6 months. The findings will be used to inform the recovery college element of this service.

2. CURRENT POSITION

2.1 Positive Steps is currently commissioned to deliver a range of mental health supports to people in North Ayrshire via 1:1 support and group activities:

- Information and signposting
- Peer support
- Employability support
- Volunteering
- Social Connections
- Individualised Placement Support (IPS – see below)

2.2 **Performance of Current Service**

SAMH Positive Steps service received a total of 177 referrals during the last 12 month period, with an average of 83 service users accessing the service at any one time. During this time, they were funded for 6 frontline posts (with one vacancy for most of the period) which resulted in each member of staff working with approximately 17 service users (including one-to-one and group support).

The service has been able to deliver on some aspects of the current service specification. This has included providing information and signposting as required as well as volunteering opportunities, either arranged directly by the service or through collaboration with The Ayrshire Community Trust. They have also been able to deliver on the employability aspect of the service, which is now delivered through the IPS model. This service has been up and running since June 2017 and there have been two job outcomes since that time.

During the consultation with service users and carers in 2014, it was identified that activity groups would be an central part of the new service. Positive Steps planned to provide this through the peer support aspect of the service. The difficulties with this role have impacted significantly on the ability of the service to fulfil this requirement of the service. Over a one year period, the service has met the minimum requirements for the provision of group activities (four per week) on a weekly basis for only 33% of the time. The inability to fulfil the requirements of the contract in this area appears primarily to have been related to difficulties sustaining the peer support worker role.

2.3 Peer support in a mental health context starts with informal and naturally occurring support, which is also usually the bedrock of service user groups. In essence, service users use their own knowledge and expertise to help both themselves and others. Peer support is the support that peer workers offer to others who have shared experiences in common and:

- Share their personal experiences of recovery in a way that inspires hope
- Have a way of being in a relationship that shows people that they have the power to recover
- Offer help and support as an equal

2.4 Following the review of Positive Steps in 2014 and in response to feedback from people with lived experience, a peer development role was introduced, with the aim of setting up and running peer support activity groups. Unfortunately this aspect of the service has proved difficult to sustain, largely due to challenges with recruitment and retention of peer workers in the role. There is therefore currently no peer support in place within the service. This proposal to commission a specific peer support service will resolve the issue of sustainability because it will be integrated within a larger service including a Recovery College (see options appraisal below).

2.5 Individualised Placement Support (IPS) is a specialised intervention model which supports people with mental health problems gain paid work. It forms a highly evidence based intervention which is manualised and has a fidelity scale. The fidelity scale is a tool used to determine the extent to which any existing employment service meets the standards for an IPS service (Centre for Mental Health 2015). The key goal is competitive mainstream employment. This model is now recognised as the most effective and efficient way of supporting people who experience moderate to severe mental health issues into competitive employment.

2.6 Following the review of Positive Steps in 2014, employability and employment for people with mental health problems were identified as key service outcomes. SAMH recruited an employability worker in 2016 and then an IPS worker in March 2017. Additionally, SAMH delivered a successful 18 month IPS pilot in North Ayrshire concluding in 2015. Continuity of the IPS role is a key element of the service moving forward given the evidence of successful employment outcomes.

2.7 Recovery colleges provide “empowering and transformative recovery-based education to anyone with an interest in mental health recovery. Taking a co-production approach, the work of the recovery college is informed by a combination of recovery, adult education and community education principles” (Dublin Recovery College). The learning environment within a recovery college is intended to be a creative and safe space where students can improve their knowledge of mental health, learn self-management techniques, and receive and provide peer support. The approach promotes recovery in a range of ways, including improving self-esteem as people identify as students rather than patients, enabling people to actively learn about and manage their own health rather than being passive recipients, and having a focus on strengths and abilities rather than deficits.

2.8 A scoping exercise into Recovery Colleges was undertaken in North Ayrshire in June 2017. The scoping exercise found that the development of a recovery college would encompass peer support and co-production as well as promoting recovery and providing an alternative to traditional, medical-model approaches to mental health. Direct access to a recovery college for people with mental health problems would also provide a way of reducing the pressure on GP and mental health services that are already under significant strain. As the potential benefits of a recovery college are significant and relevant to the current challenges faced by mental health services in North Ayrshire, the scoping exercise recommended that a recovery college pilot was set up to enable evaluation of the impact on a local level to take place.

2.9 **Options Appraisal**

An options appraisal was undertaken in relation to the future commissioning model for a peer support, recovery and employability service in July 2017. The three options identified were:

1. Status quo – re-tender utilising the current service specification
2. Re-tender as one service specification with the addition of the recovery college
3. Re-tender each aspect of the service specification separately: peer support, employability and recovery college

Option 1 – Status Quo

Strengths	**Weaknesses**
Established referral routes Continuity for service users and referrers Variety of interventions available through a single service provider Single monitoring return	General support role is duplication of other services Dilutes the delivery of the 'specialist' areas Lack of clarity in relation to specific pathways e.g. peer support and employability Same challenges in relation to recruiting single peer support worker Restrictive referral criteria No recovery college development
Opportunities	**Threats**
Re-development of peer support role with a new provider (only if new provider appointed) Flexibility of services – people can access the service at whatever point they wish	Reliance on a range of expertise being present with one provider / service Provider might deliver better on one aspect of the service and not all If one aspect of the service is not delivered then whole contract would require to be reviewed

Option 2 – Add Recovery College to Single Service Specification

Strengths	**Weaknesses**
Variety of interventions available through a single service provider Single monitoring return Reduces pressure on primary and secondary care mental health services Wide referral criteria and open referrals Addition of recovery college – potential wider influencing role	Dilutes the delivery of the 'specialist' areas Potential loss of focus on any one area Potential confusion for service users if multiple support services offered More complex monitoring – each strand needing covered Recovery college aspect is new – no scope to test the market first with this option
Opportunities	**Threats**
Single access point to a range of services One provider may bring expertise in all 3 aspects of the service – economy of scale Recovery college brings recovery focus – wider impact in North Ayrshire in relation to stigma and mainstream services	Reduction in number of providers who would tender due to the range of specialist experience required Provider might deliver better on one aspect of the service and not all If one aspect of the service is not delivered then whole contract would require to be reviewed Reliance on a range of expertise being present with one provider / service Risk to recovery college aspect of service as untested – may not sit well with rest of service

Option 3 – Develop Separate Service Specifications

Strengths	**Weaknesses**
Allows a focus on each of the specialist service areas Allows recovery college scoping to be undertaken first (separate timescales allow this) Measuring specific outcomes Service users access specific service with single provider = clarity If one aspect of the service fails it does not impact on the others	Monitoring arrangements may be more time consuming (may be linked but ultimately separate) Access to separate services may be restricted if they don't work together and develop clear pathways Untested market for all of the specialist areas required – may not attract providers
Opportunities	**Threats**
Potentially attracts specialist providers with experience in the separate strands – bigger market Opportunity to develop a 'network' of inter-related services and integrate over time New way of delivering services – evaluation and learning will be new Recovery college brings recovery focus – wider impact in North Ayrshire in relation to stigma and mainstream services	Individual service aspects small (with a small resource attached) and may be unattractive as a result Recovery college is untested, peer support service is untested and there is a risk that they won't deliver within this model

The conclusion following the options appraisal was to go with option 3 and commission each of the 3 parts of the service separately. On balance, based on the challenges with the existing service specification delivering on 2 service aspects and the fact that the recovery college is currently still being scoped, option 3 has less risks attached to it than options 1 and 2.

2.10 The existing contract with Positive Steps will end in June 2018. It is anticipated that the impact on individuals using the service will be minimal because Positive Steps work on a short term basis with people and the new peer support and employability service will be in place by that time. However, individual transitional support plans may be required for any existing service users still accessing the service towards the end of the contract – these will be undertaken jointly by the Positive Steps service and mental health services to ensure a smooth transition and support as required.

3. PROPOSALS

3.1 That IJB approves the development of an integrated peer support, recovery and employability service with the 3 key elements described above:

- A commissioned peer support service
- A commissioned IPS and employability service
- A commissioned Recovery College

3.2 That IJB approves the phased commissioning of the integrated service as follows:

Activity	Timescale	Start Date
Commission Peer Support Service	Week commencing 3 October 2017	1 July 2018
Commission IPS and employability Service	Week commencing 3 January 2018	1 July 2018
Recovery College Pilot (funded through Challenge Fund)	Week commencing 3 January 2018	3 January 2018
Commission Recovery College based on pilot	Week commencing 1 April 2018	1 October 2018

3.3 **Anticipated Outcomes**

People will mental health problems in North Ayrshire are supported through this service to:

1. Experience recovery in terms of improved mental health and wellbeing
2. Access and sustain paid work
3. Access and contribute to a recovery based education programme
4. Be involved with the future development of mental health services

3.4 **Measuring Impact**

The peer support, employability and recovery service will measure impact in a variety of specific ways based on which part of the service the individual is engaged with. Measures will include:

1. Increase in numbers of people accessing and sustaining paid work
2. Increase in number of peer support opportunities for people with mental health problems
3. Increase in access to mental health related education programmes
4. Increase in levels of self-reported recovery
5. Reduction in the use of statutory mental health services over time
6. Increase in levels of co-production between mental health services and people who use mental health services

4. IMPLICATIONS

Financial :	There are no financial implications to the Partnership at this stage as funding for the proposed service is part of the core NAC Mental Health Service budget.
Human Resources :	There are potential HR implications for the Council in relation to the IPS aspect of this proposal if, for example, the IPS post were to be brought in house rather than commissioned. An impact assessment will be undertaken involving Legal and HR colleagues following the scoping exercise to determine the best commissioning route for this aspect of the service.
Legal :	The Procurement will be carried out in line with the Public Contracts (Scotland) Regulations 2015 and North Ayrshire Council's Standing Orders.
Equality :	There are positive equality impacts in this proposal as the service is targeted at individuals with mental health problems and will support recovery and employment prospects.

Environmental & Sustainability :	There are no environmental implications in connection with this proposal.
Key Priorities :	Improving mental health and wellbeing Prevention and early intervention
Risk Implications :	There is a potential risk to the level of funding allocation for this service in that it is being considered as part of the overall HSCP savings exercise. This risk is being impact assessed alongside the risks to community mental health services in the separate HSCP savings exercise currently underway.
Community Benefits :	

Direction Required to Council, Health Board or Both *(where Directions are required please complete Directions Template)*	Direction to :-	
	1. No Direction Required	
	2. North Ayrshire Council	√
	3. NHS Ayrshire & Arran	
	4. North Ayrshire Council and NHS Ayrshire & Arran	

5. CONSULTATIONS

5.1 Consultation took place with service users carers and staff in 2014 to re-design the Positive Steps service – the results of this consultation have formed the basis of the integrated service model.

5.2 A scoping exercise into Recovery Colleges took place in June 2017 involving key stakeholders. A steering group is now in place to oversee the Recovery College pilot.

5.3 Consultation and options appraisal has taken place with a range of stakeholders through an Advisory Group for the service commissioning process including colleagues from North Ayrshire Health and Social Care Partnership and 'critical friends' from other services in Scotland.

6. CONCLUSION

6.1 NAHSCP requires to commission a peer support, recovery and employability support service to meet the needs of people with mental health problems in North Ayrshire.

6.2 Therefore, it is recommended that IJB:

1) Note the requirement to re-commission this service;
2) Approves the development of an integrated peer support, recovery and employability service with 3 key elements:
    - A commissioned peer support service
    - A commissioned IPS and employability service
    - A commissioned Recovery College

For more information please contact Dale Meller, Senior Manager Community Mental Health on 01294 317790.