ITEM No …10…..……

REPORT TO: **PERFORMANCE & AUDIT COMMITTEE – 29 MAY 2018**

REPORT ON: **PSYCHOLOGICAL THERAPIES WAITING TIMES**

REPORT BY: **CHIEF FINANCE OFFICER**

REPORT NO: **PAC33-2018**

1.0 PURPOSE OF REPORT

To brief the Performance & Audit Committee on those specialities within the hosted Psychological Therapies Service currently failing to meet Health Improvement, Efficiency, Access & Treatment (HEAT) targets and the actions being taken to address the same.

2.0 RECOMMENDATIONS

It is recommended that the Performance & Audit Committee (PAC):

2.1 Notes the current position and reasons for certain specialities currently failing to meet HEAT targets as outlined at 4.3, 4.4, 4.6, 4.7 and 4.8 of the report.

2.2 Notes the actions already being taken within the Psychological Therapies Service (PTS) to address the current waiting time challenges as outlined at 4.12 of the report.

2.3 Notes the intention of the service to adopt alternative means of providing planned cover arrangements given the demographic of the workforce and level of demand for psychological therapy services as outlined at 4.8 and 4.9 of the report.

2.4 Notes the intention of the service to review current psychology service models within General Adult Psychiatry service as outlined at 4.7 of the report.

2.5 Notes the requirement for more detailed modelling of demand, capacity and potential impact on future financial resources within Clinical Neuropsychology as outlined at 4.11 of the report.

3.0 FINANCIAL IMPLICATIONS

None.

4.0 MAIN TEXT

4.1 The current Psychological Therapies National standard is that 90 per cent of patients should commence treatment within 18 weeks from the point of referral. At December 2015, the NHS Tayside Psychological Therapies Service saw over 96% of patients within this time frame. (ISD Psychological Therapies Waiting Times in Scotland: Quarter Ending December 2015). Current aggregated Information Services Division figures are much less accurate consequent to the transition to the new Trakcare patient recording system but show that the overall HEAT target is not being met.

4.2 The Psychological Therapies Service comprises a number of specialities. Within the HEAT return report, all specialities are aggregated. This masks that a number of specialities are currently meeting the HEAT target. These are:

- ✓ Angus Adult Psychological Therapies Service
- ✓ Tayside Eating Disorder Service

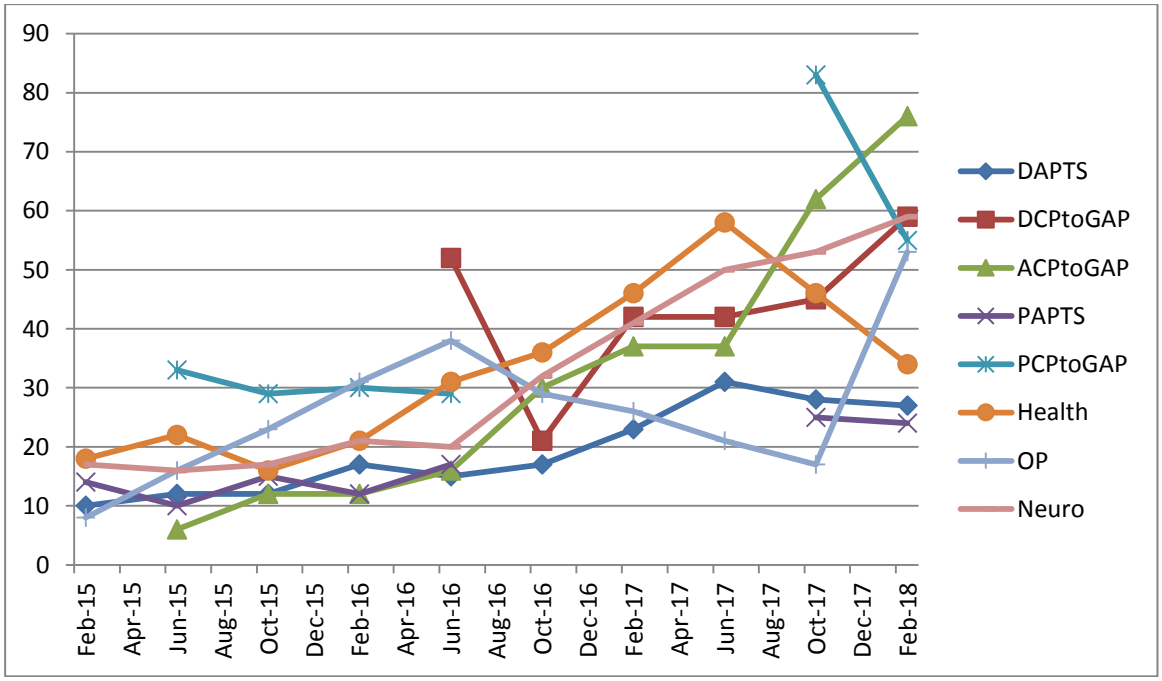
- ✓ Addictions Psychology
- ✓ Learning Disability Psychology
- ✓ Older People Services in Angus and Dundee
- ✓ Secure Care
- ✓ Tayside Forensic Court Service

The specialities not meeting the HEAT target at present are:

- Dundee Clinical Psychology to General Adult Psychiatry (DCP to GAP)
- Angus Clinical Psychology to General Adult Psychiatry (ACP to GAP)
- Perth Clinical Psychology to General Adult Psychiatry (PCP to GAP)
- Dundee Adult Psychological Therapies Service (DAPTS)
- Perth Adult Psychological Therapies Service (PAPTS)
- Clinical Health Psychology (Health)
- Older People Services in Perth & Kinross (OP)
- Clinical Neuropsychology (Neuro)

4.3 The performance of the services not currently meeting the HEAT over time are shown below:

Chart 1 – Longest time waiting referral to first appointment*



*There is some missing data from this legend consequent to changes in models of service delivery. Perth services have a period of missing data during 2017.

4.4 Important in understanding this information is the total number of patients currently waiting for the services breaching HEAT:

Table 1:

	DCPtoGAP	PCPtoGAP	ACPtoGAP	DAPTS	PAPTS	Health	OPPerth	Neuro
Longest Wait (weeks)	59	55	76	27	24	34	53	59
TOTAL waiting	130	73	86	555	545	325	47	361
Total >18 weeks	78	40	22	97	84	123	5	233

4.5 Table 1 above outlines the improved position of Older People Perth Psychology. Although still breaching, the numbers involved are now small and it is expected the HEAT target will be met again within the next quarter when the current Lead Clinician returns from maternity leave and the clinician covering that role at present will resume a higher level of clinical duties.

4.6 The decreasing performance over time needs to be understood within separate clusters.

4.7 The first of these is the "Clinical Psychology to General Adult Psychiatry" services across all three localities. These services provide high intensity assessment and treatment to individuals receiving treatment with Community Mental Health Teams (CMHT). This includes both individual and group treatments. Additionally, training and supervision of other disciplines providing lower intensity treatments is provided by this staff group. Previously, this speciality worked to a model of service delivery where the psychological resource within each CMHT was targeted to those *most* likely to benefit. That is, when a new case could be allocated to treatment the CMHT would prioritise patients and decide who they wished to be seen. However, following the advent of the HEAT target, this model caused difficulties for Consultant Psychiatrists and the services moved to a "conventional" model where all patients considered to require psychological assessment and treatment were referred. The rate of referral has consistently overwhelmed the capacity of the service. The age and gender profile of the service mean that maternity leave is an additional significant challenge in terms of workforce planning. The staff numbers within these services is currently small and the position of these services is unlikely to improve without investment and/or significant service remodelling.

4.8 The second cluster is the Adult Psychological Therapies Services (APTS) of Perth and Kinross and Dundee. Angus APTS is currently still meeting the targets. These services have a high volume of referral (for example, Dundee APTS consistently accepts between 110 and 130 referrals each month) and both have a demonstrated history of being able to meet the HEAT target from the given staffing level. However, APTS services have experienced high levels of maternity leave and delays in recruitment have an adverse effect on throughput. When fully staffed, APTS services are well balanced with regard to demand and capacity. The current additional issue for these services is the size of the "backlog" caused by the above. To address the backlog (that is, *all* the patients waiting) the service would require in the region of five whole time equivalent (wte) additional staff in each locality for a period of 12-18 months. To achieve a position of meeting the HEAT target, two wte additional staff in each locality for a period of 12-18 months would be required. The PTS is considering what options might be available within current limited financial resources.

4.9 Clinical Health Psychology should be considered as similar to APTS services in, that when fully staffed, demand and capacity are well matched. The service has also experienced maternity leave and delays in recruitment which has resulted in a large volume of people now waiting for a first appointment. To deal with all the patients waiting (using similar models to above) would require 3.0 wte additional staff; 1.6 wte additional staff to restore services to consistently meeting the HEAT target.

4.10 At the present time, no additional resource is being requested for APTS or Clinical Health Psychology services. These services illustrate, however, the impact on waiting times of loss of one or more staff members for a prolonged period. As the PTS has an extremely low rate of staff sickness, this impact is largely attributed to planned maternity leave. In a workforce that is over 80% female at a National level, this is a recurrent issue across all specialities**.** It is intended that models for planned cover to minimise the impact of this that are adopted elsewhere are considered for Tayside**.**

4.11 Clinical Neuropsychology (CN)

4.11.1 The remaining service is that of Clinical Neuropsychology (CN). CN is based with the acute hospital setting and accepts referrals mainly – but not exclusively – from secondary care providers such as hospital Consultants, Older People Psychiatry and other clinical psychologists. There is little scope for skill mix in CN.

4.11.2 CN was subject to improvement work and investment approximately six years ago. This enabled CN to meet the HEAT target ahead of the original trajectory and the final phase of planned increased staffing was withheld and lost to savings. However, in the period since there

has been a significant and sustained increase in the rate of referral to the service at a time where the service has also been subject to maternity leave. The annual referral rate (taking a three year average moving point to smooth peaks and troughs) from 2010 to present has been 247, 297, 334, 371, 438, 541, 726, 772. That is over a 300% increase in referral in an eight year period.

4.11.3 The volume of patients now awaiting a first appointment, together with the limited options available for skill mix means this service would benefit from more detailed modelling of demand and capacity and any associated financial support.

4.12 In addition to the above, the PTS have implemented a series of time-limited actions across *all* specialities including increasing the number of clinics offered by each clinician, cessation of all but mandatory continuing professional development activities, withdrawal of all teaching and training activities that do not directly enhance the delivery of psychological therapies to support that enhanced clinical activity. It is recognised that these measures will have only limited impact and some are not sustainable if we are to maintain a safe, effective and professional service.

5.0 POLICY IMPLICATIONS

This report has been screened for any policy implications in respect of Equality Impact Assessment. There are no major issues.

6.0 RISK ASSESSMENT

Risk 1 Description	Patient safety. People with identified mental health needs are experiencing delays in accessing appropriate care and treatment. Within Clinical Neuropsychology, delays in diagnostic assessment may result in failure to treat patients appropriately at an early stage resulting in worse clinical outcomes.
Risk Category	Governance
Inherent Risk Level	Likelihood 4 x Impact 4 = Risk Scoring 16
Mitigating Actions (including timescales and resources)	The Psychological Therapies Service has implemented a number of improvement measures including increasing the number of clinics each clinician is offering. To make this possible, there is no continuing professional development within the service, no secondments and no teaching and training which does not directly impact on HEAT target delivery. The PTS has also withdrawn its support from Undergraduate and Masters teaching at the University of Dundee. Alternative means of providing planned cover across the Service being pushed, and in some areas more detailed capacity/demand analysis being undertaken to support future workforce needs.
Residual Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Planned Risk Level	Likelihood 2 x Impact 3 = Risk Scoring 6
Approval recommendation	Given the moderate level of planned risk, the risk is deemed to be manageable.

7.0 CONSULTATIONS

The Director, Deputy Director of Psychology, Chief Officer and the Clerk were consulted in the preparation of this report.

8.0 BACKGROUND PAPERS

None.

Dave Berry
Chief Finance Officer

DATE: 4 May 2018

Arlene Mitchell
Locality Manager

Linda Graham
Consultant Clinical Psychologist