Scottish Borders Health & Social Care Integration Joint Board

Scottish Borders Health and Social Care PARTNERSHIP

Meeting Date: 15 June 2022

Report By:	Simon Burt, General Manager Mental Health & Learning Disabilities Services
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MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES	
Purpose of Report:	To present for noting the submission made to Scottish Government around the initial funding and implementation plan for improving Mental Health and Wellbeing Services within Primary Care.
Recommendations:	The Health & Social Care Integration Joint Board is asked to: a) **Note** for reference this 4-year programme.
Personnel:	A conceptual workforce plan is underway – however this will be informed through co-production, and flexible enough, to adapt to any iterations of the model.
Carers:	We are currently working with our Public Engagement and Communications teams to develop a 4-year strategy plan that will ensure we have the right expertise to facilitate and inform this critical part of this process.
Equalities:	HIIA is currently being conducted and will be annually reviewed.
Financial:	Scottish Government Mental Health Recovery and Renewal Fund - NRAC Allocation – see paragraph 14
Legal:	N/A
Risk Implications:	The following are a list of key risks that we feel are critical at this stage of submission to bring to your attention: • Recruitment and retention, particularly within the Mental Health sector in Scottish Borders, is at a challenging point and will impact implementation plans should recruitment campaigns take longer than anticipated • Patient care and safety must be considered above all else and therefore plans and models will need to be agile and iterative to support this • The remote and rural set-up of health care within Scottish Borders does pose additional challenges that we may not have anticipated yet due to infrastructure and limited

	funding • Financial allocation based on NRAC may be insufficient to support our deliverables of developing real change • Funding beyond 2024-25 is subject to approval by future Scottish Governments. Our intention to treat this funding as recurrent as and when plans are approved by Scottish Government on an annual basis presents a limited financial risk • Availability of infrastructure and space will impact the service roll out and will need to be accounted for as we further develop plans •
Direction required:	No Direction required

Briefing Paper

1. Initial funding had been made available to improve Mental Health and Wellbeing Services within Primary Care Services.

2. We are being asked to: '*work with Primary Care partners to improve capacity for mental health assessment, care and support within Primary and Community Care settings. This will build on examples of good practice already implemented through the Primary Care Improvement Plan, and through our work on Action 15 of the Mental Health Strategy. This will include the interface with specialist services to ensure that people receive the right care in the right place. This will ensure that there is a clear pathway to mental health services for those who need them*.'

3. The funding that being provided is to be used by Integration Authorities (IAs) to support the planning process for the establishment of multi-disciplinary MHWPCS, within GP clusters or localities, to provide assessment, advice, support and some levels of treatment for people who require mental health, distress or wellbeing support.

4. Building resilience within our Primary Care teams is pivotal for an integrated mental health system and key in developing and sustaining a system that supports the population with improved mental health and wellbeing. Our overarching vision is that wherever and whenever a person is in touch with the system - they will be listened to and helped to reach the most appropriate place for them - there is no wrong door.

5. For us to achieve this vision we have four key targets and supporting requirements. These are:

- Establish an ageless service
- Build on local services/successes through additionality
- Maximise the use of digital technology and resources
- Ensure inclusive access for all

6. Where we see the biggest unmet need in our Health Board, is the provision of Tier 2 Services for under 18s. We have a huge demand on our CAMHS service at present as there is a significant gap between what CAMHS can offer and that of the local commissioned services that supports children and young people. From our initial consultations, almost all agree that this area is where real progress and change can occur.

7. Our plan therefore will be implemented in two phases:
Phase 1 will focus on the Under 18s gap between Tier 2 and 3 Services where we feel the biggest unmet need and risk is; and will be our primary focus for Years 1 and 2. The development of a core service for under 18's (recognising a cohort of 16-25 transitions) closely linked to GP Practices and school will work with key stakeholders to further identify demand, establish care/treatment pathways, explore the use of technology, and build a clear picture of demand – this will be expanded within Year 3.

8. Phase 2 will look to address the gap between our Adult Primary Care service and our Secondary Care service and will be the focus across Year 3 and 4. Further stakeholder engagement will allow us to further define the gaps, demand and care/treatment pathways and the additional staffing model required. We envision that this will build on our current Renew service while addressing the gaps identified with people with more complex needs who present in primary care; the establishment of a trauma treatment pathway and supporting over 65s.

9. We believe that by developing our existing services, Scottish Borders will ensure equity and inclusivity to all ages looking to access mental health support for those with mild to moderate mental health conditions

10. NHS Borders prides itself in its co-production approach to service design and implementation. We know that collaboration with people with lived experience is key in understanding and evidencing what works. It will result in invaluable guidance; improved outcomes and a stronger evidence-based model of care/support. Therefore, we are currently working with our Public Engagement and Communications teams to develop a 4-year strategy plan that will ensure we have the right expertise to facilitate and inform this critical part of this process.

11. Using quality improvement principles, proper collaborative engagement (particularly with children and young people) and conducting a successful recruitment campaign will lay a solid foundation for years 2 -4 and the development of more detailed plans.

12. The additionality provided by our 2026 vision will be:
    1. Phase 1 will be to establish services in primary care to under 18's focussing upon anxiety and low mood. Scoping of demand and capacity will allow us to ensure that we provide the correct resource level, assessment, and support.
    2. Phase 2 will focus upon the gaps in support to over 18's and how we can redesign and coordinate effectively existing services to ensure that we meet unmet need. Our early consultation indicates that we will need to focus upon supporting those presenting frequently within primary care settings, those with neurodevelopmental disorders and increasing the take up of services for over 65's.
    3. Our mental health primary care services will be easily accessible and more streamlined, wherever possible providing a single point of access. We aim to provide no wrong front door and to ensure people reach the right place at the right time avoiding "rejected" requests for support.
    4. We will maximise the use of digital options and look to reduce the accessibility of these types of interventions. This will include digital hubs within localities and increased accessibility to online self-help and information resources.

5. Our model focussing upon a centralised resource, maximising digital access wherever possible, will allow us to flexibly meet demand, including the anticipated increased demand from deprived areas of the community.
6. Services will be strategically planned and evaluated effectively. Our local oversight group will continue to support us to plan services together with our stakeholders. We will be further developing engagement with people with lived experience to ensure meaningful involvement and co-production. Years 1 and 2 will include a strategic review of the existing landscape of services including those funded through action 15 and the PCIP to ensure that we provide an integrated and aligned range of service provision avoiding duplication and overlap wherever possible.
7. Our fundamental model for developing services will follow a quality improvement approach. This will be underpinned by effective gathering and analysis of data and the establishment and measurement of key outcomes targets/data.
8. Service delivery and accessibility will be delivered within a trauma informed framework as a minimum standard.

13. Funding is based on NRAC allocation and has been indicated as follows:

2022-2023	£204,537.20
2023-2024	£408,436.56
2024-2025	£823,676.85
2025-2026	TBC

Scottish Government have stated that ongoing funding beyond 2024-25 is "…subject to the approval of future Scottish budgets by the Scottish Parliament". As such we are treating funding as recurring for recruitment and planning purposes.

14. Next steps:
    a. Awaiting feedback from National Oversight Group on our submitted plan
    b. Planning and scoping of various workstreams e.g. Under 18s, Digital, Public Engagements etc
    c. Review of Current Primary Care Mental Health Provision (see Appendix 1 for supporting information)

Appendix 1 - The Renew Service – Report on the first 18 months

01 June 2022

Introduction

1. The Renew service was established in NHS Borders in October 2020 utilising funding from PCIP and Action 15 with the aim of offering a “see and treat” model for mild to moderate anxiety and depression using evidence based psychological therapies in primary care. The aim was to reduce GP Mental Health workload as well as increase the capacity and access to psychological therapies. This report outlines the service’s development, performance, current state, and development issues going forward.

Background

2. Historically psychological therapy and mental health services for adults in NHS Borders have been accessed via the Community Mental Health Team (CMHT) in secondary care. This has led to long waits, rejected referrals and GP’s needing to support people with mild to moderate mental health difficulties.

3. Changes to GP contracts and the PCIP have created the opportunity to revisit this and resulted in the development of an innovative collaboration between with GP’s, Mental Health, and Psychology Services to establish a centralised primary care mental health service where assessment and treatment is offered under one service.

4. This in itself is innovative, as traditionally models of mental health support in primary care are aimed at distress management with onward referral to other services e.g., psychology should this be needed.

5. Psychology Services in NHS Borders have been under resourced pre 2018 and had the smallest workforce per 100,000 for a mainland Board. Resource has been largely focused on secondary care services, but in adult mental health this resulted in very long waiting times and the inability to widen access to psychological therapies or meaningfully address these capacity issues or cater for people who needed evidence based psychological treatment for mild to moderate mental health issues, but who did not meet the criteria for secondary care services.

6. Through audit and discussions with GP’s, it became clear that many patients were seeing GPs on a regular basis who fell into the category of mild to moderate mental health issues with the only option GPs could consider being medication or wellbeing services which did not necessarily meet the treatment need.

7. Following discussions with GP’s it was agreed that to fill this gap and reduce the workload on GP’s, that offering a “see and treat” model of psychological intervention in situ, may be a solution.

Initial Pilot

8. It was agreed to pilot this approach in one GP Practice. This took place between October and December 2019 where referrals for mild to moderate anxiety and depression were assessed and treatment started “under one roof” as opposed to an initial period of distress reduction and then onward referral to psychology waiting lists. This approach proved popular and reduced GP return mental health referrals considerably.

Scaling Up

9. It was agreed to investigate scaling up the model in 2 GP Clusters in 2020. However, this did not come to pass due to Covid as well as logistical issues. It was agreed that Psychology Services would support primary care by offering psychological first aid training and enhancing the Wellbeing service during this time.

10. Following the first lockdown, in July 2020, an options appraisal to reconsider scaling up the primary care mental health service for adults took place. Of the options considered, the preferred option was for a centralised service offering a range of evidence based psychological interventions delivered digitally using a combination of PCIP and Action 15 funding.

11. A SLA was agreed and the Renew Service started in October 2020 with a much reduced staff complement while recruitment continued for CAAPs (Clinical Associates in Applied Psychology), Mental Health Practitioners and Assistant Psychologists. The service was at full staffing complement by April 2021.

12. Interventions offered include computerised CBT, internet enabled CBT (IESO), anxiety and low mood courses, guided self-help (121) and one to one psychological therapy. It was agreed that a comprehensive assessment would be undertaken a quickly as possible so that people could be directed to /choose the best treatment for them.

13. As mentioned earlier, the service was offered without a physical base, with all practitioners (except the admin team) operating from home using Near Me and telephone to offer interventions.

Performance

14. When the initial SLA was signed, 4 KPI's were agreed with the agreement that these would be reviewed annually. (It has not always been possible to collect data on all these KPI's which will be discussed.)

KPI 1: Demand for the service

15. Renew has been a popular service with all GP practices in the Borders using the service. Since the starting there have been over 5000 referrals which is a high referral rate. The following graphs outline referral numbers and sources.

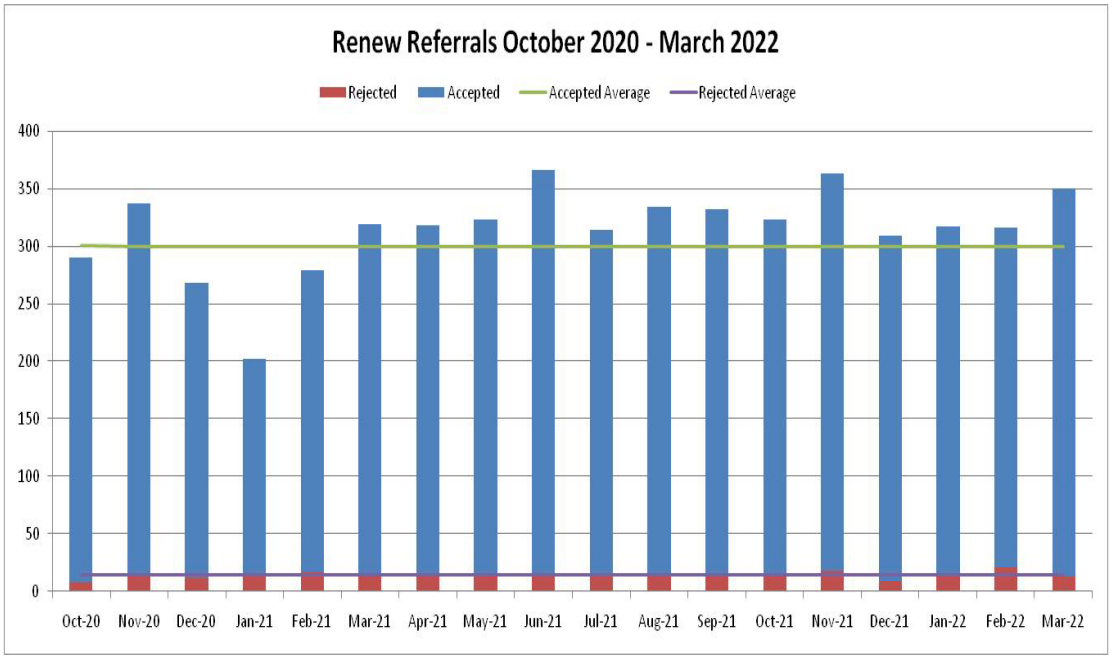


Figure 1: Renew Referrals October 2020- March 2022

16. All GP Practices in the Borders have referred to Renew, although some have referred higher numbers than others.

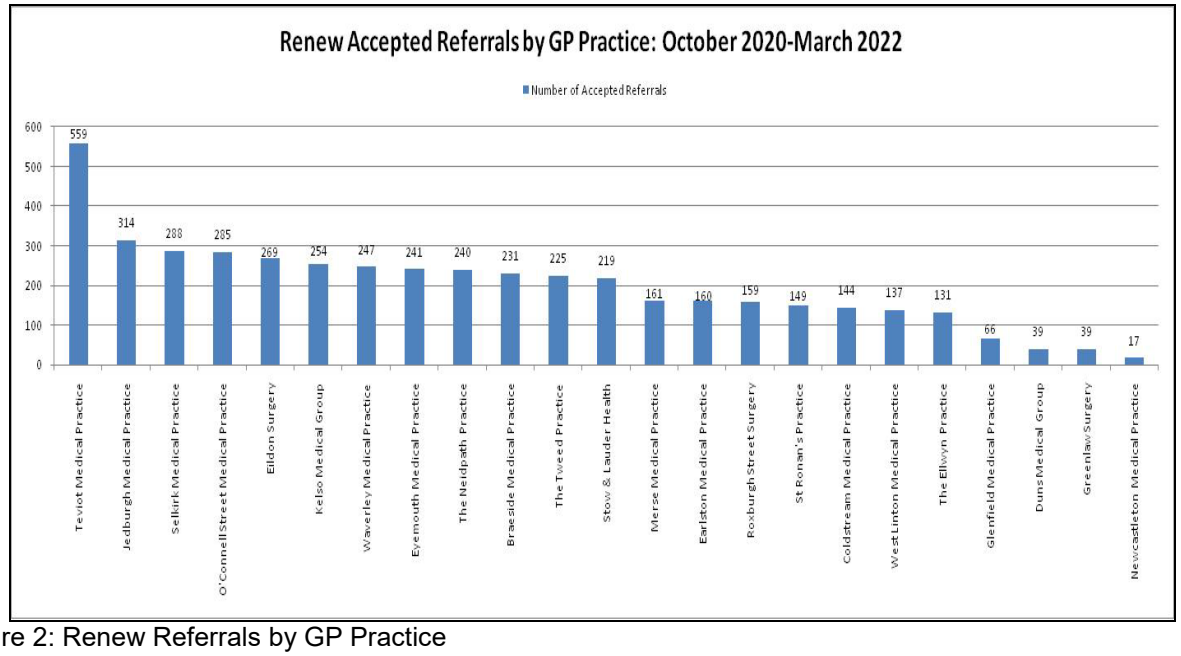


Figure 2: Renew Referrals by GP Practice

17. Renew accepts referrals from other services including Mental Health, DBI and Wellbeing.

Figure 3: Renew Referrals by Source: October 2020 – March 2022

KPI 2: Speed of Access/Service Efficiency to see and treat

a) Assessment

18. One of the initial priorities with Renew was to ensure that a comprehensive assessment takes place as soon as possible, and our target has been to assess new referrals within two weeks. On average we have completed 210 assessments per month and complete these assessments within an average of 12 days.

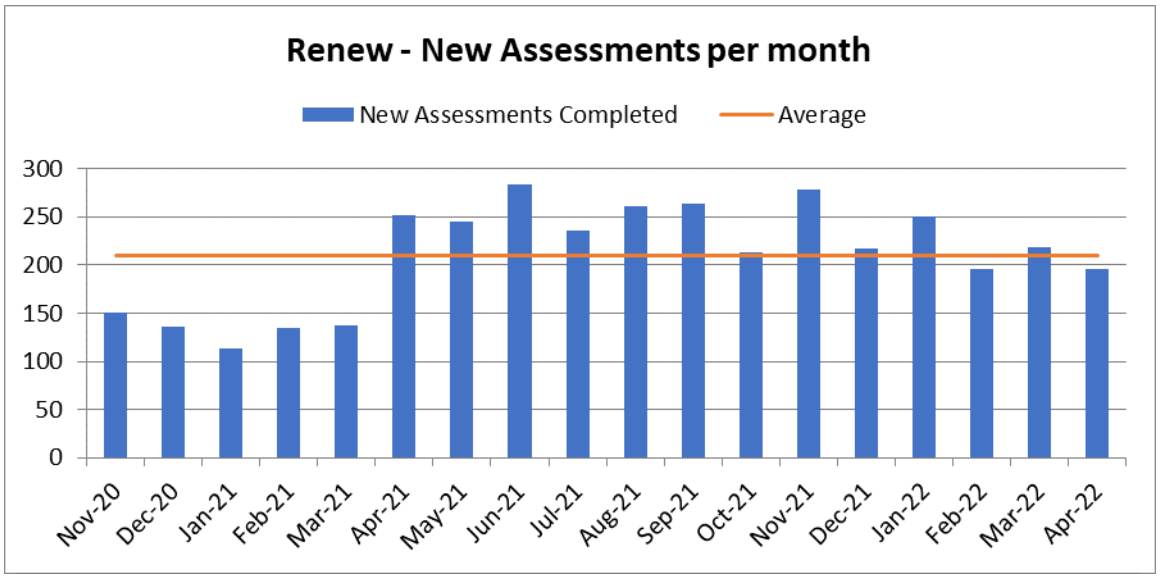


Figure 4: Renew Service – Number of Assessments completed per month, November 2020-April 2022

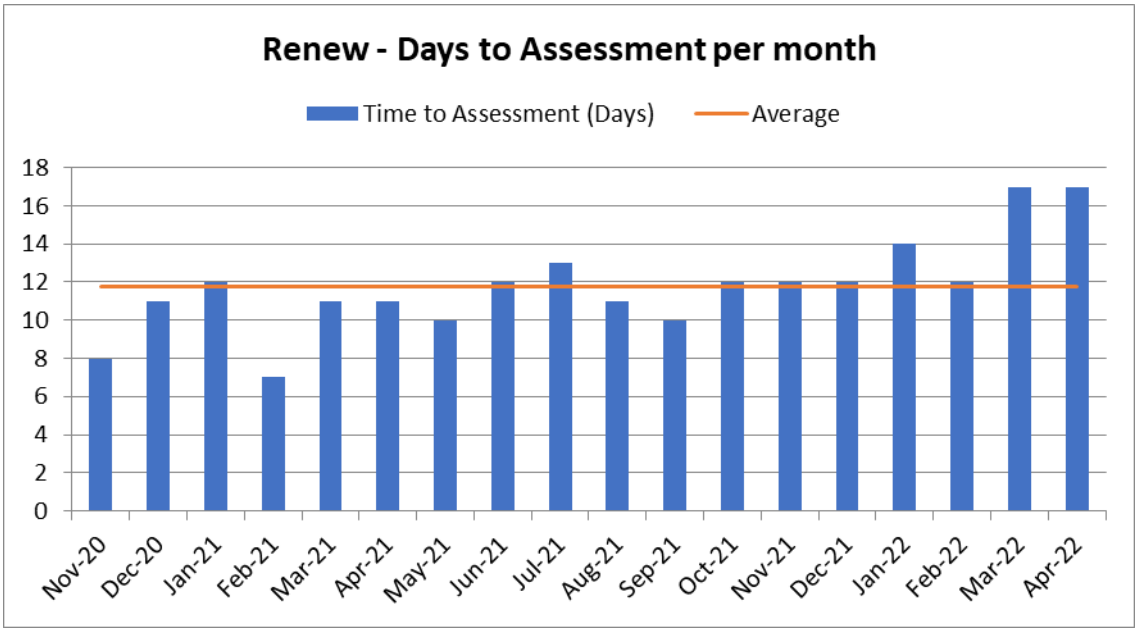


Figure 5: Renew Service -Time to Assessment per month November 2020- April 2022

19. Keeping assessments and treatments in balance is something we need to consistently monitor.

b) Treatment

20. For treatment, we aim to start treatment with the majority of people referred within 18 weeks and on average have 105 new treatment starts per month. It is clear from this data, that there has been some variance in terms of new treatment starts which is due to a number of factors, including data issues, shifting the main mode of treatment to courses that start every 8 weeks (from August 2021) and service adaptations during Covid to manage staff absence while maintaining flow.

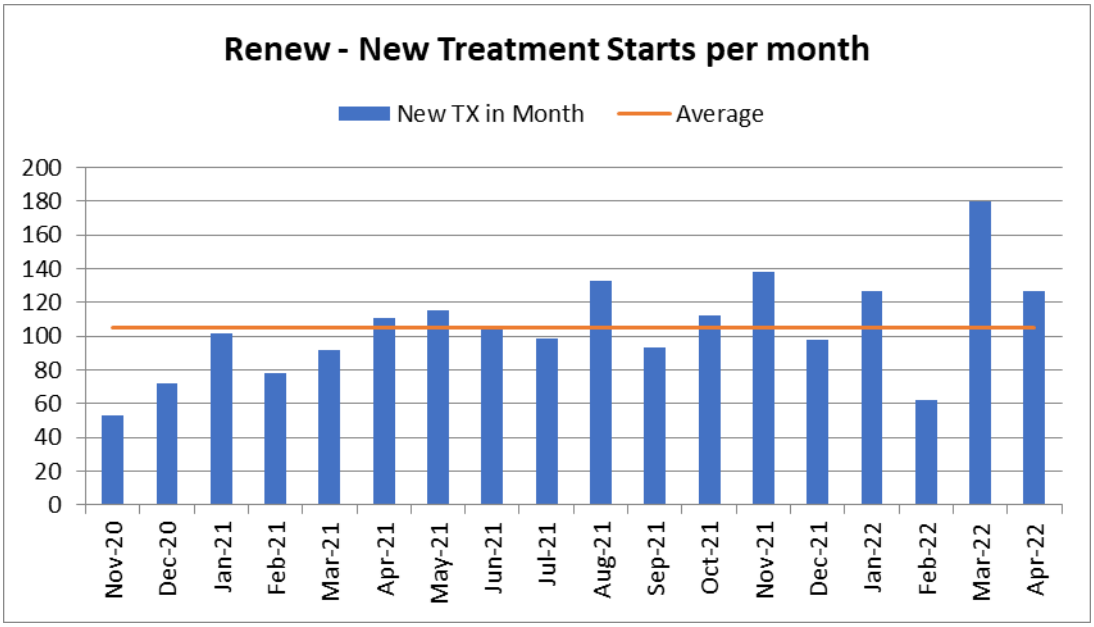


Figure 6: Renew: Number of new treatment starts per month November 2020- April 2022

21. In general, Renew has consistently started treatment for over 80% of all referrals within 18 weeks. Since October 2021 there have been a few delays which have been caused by staff sickness due to Covid and delays with courses or 121 treatment starts as the model has shifted to more courses. However, we monitor this closely and are currently working on plans to flow, reduce the backlog, and smooth out the courses schedule so that courses are offered more regularly than every 8 weeks.

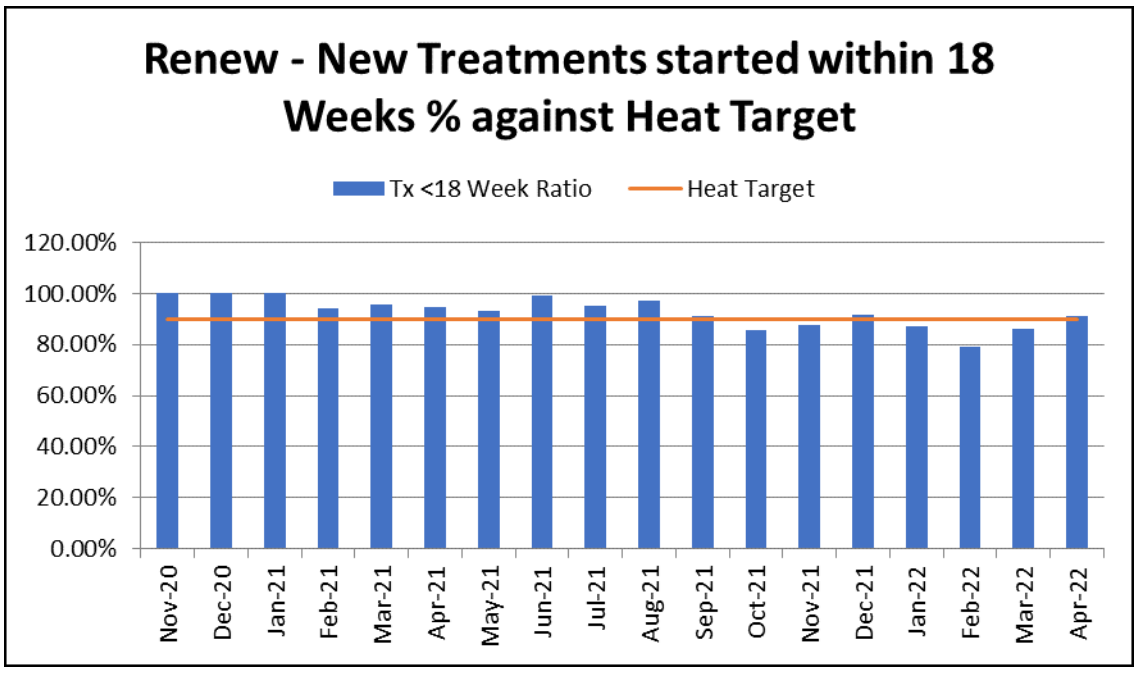


Figure 7: Renew: Number of new treatment starts within 18 weeks November 2020- April 2022

c) Current Waits

22. Renew started with a third of the agreed staff complement and inherited open cases and psychological referrals that were waiting to be seen as part of the enhanced Wellbeing Service were moved over to Renew in October 2020. Renew has therefore always had a “tail” and this coupled with strong demand has needed careful monitoring of the focus of capacity and treatment types to ensure flow through the system. We are currently reviewing our queue to focus on ways of reducing this “tail” and bringing the service into balance.

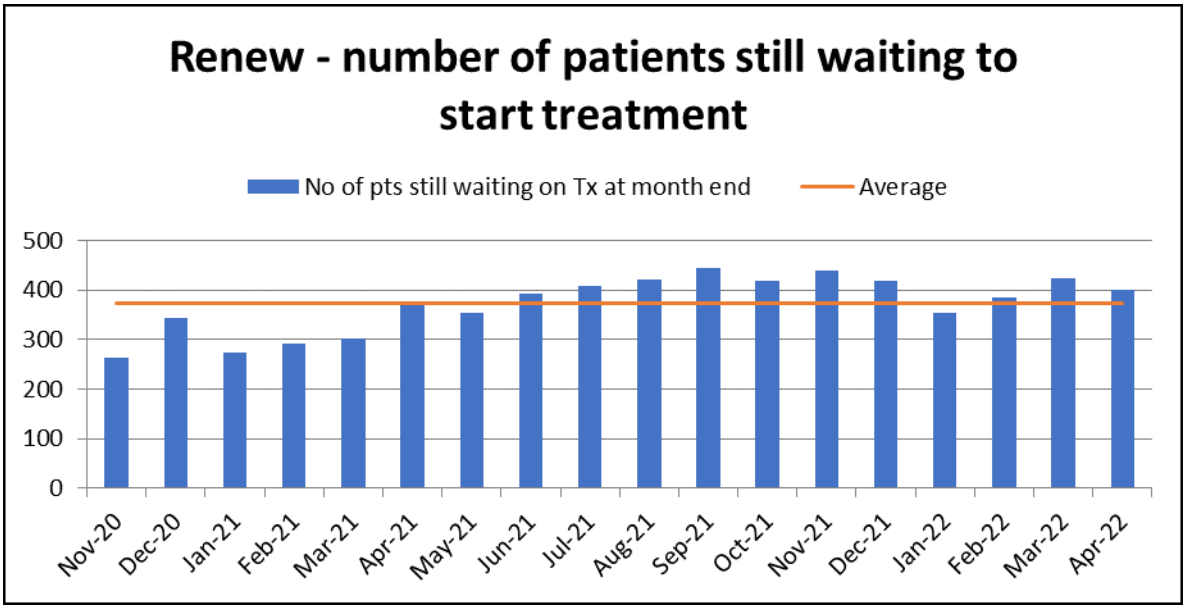


Figure 8: Renew: Number of new treatment waits 18 weeks November 2020- March 2022

KPI 3: Service Outcomes – service valued by GP's and patients and treatments effective

a) GP Satisfaction

23. All GP Practices in the Borders have referred into Renew and at a recent audit of GP satisfaction with Renew, results show that 35% GPs rated Renew as Excellent, 53 % Very Good, 8% Good, 4% fairly Good/Poor.

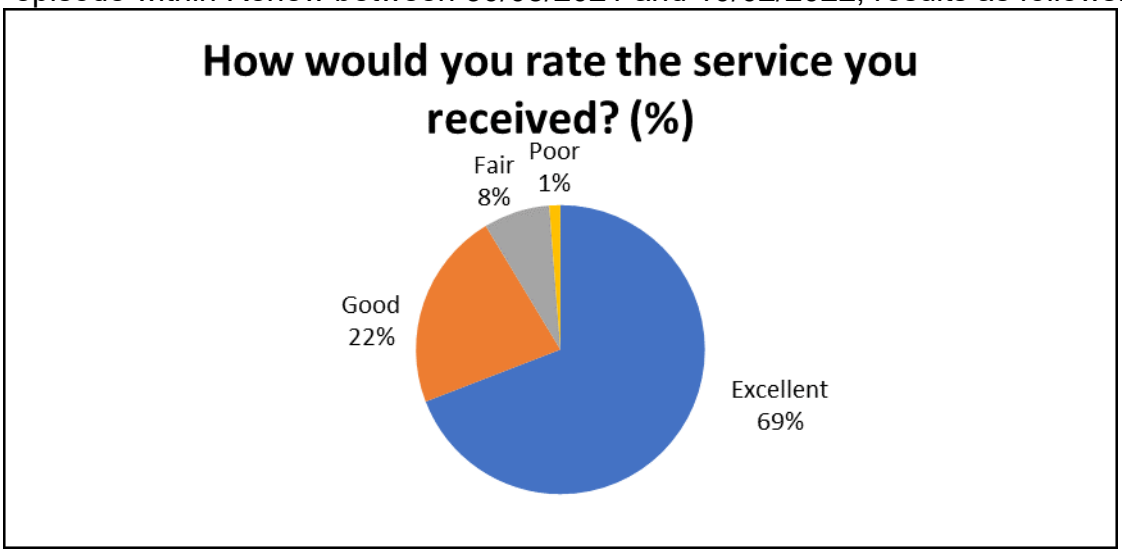
Some of their comments about the service are:

- *Encouraging lack of hoops for us to jump through - we can leave assessment to our more expert colleagues*
- *We previously had a massive gap in MH provision in Borders and I believe Renew has filled this gap well.*
- *Before it was very confusing to keep up with what services were still available and what were not.*
- *I found single point of referral for triage to different treatment modalities works really well.*
- *Patient feedback and I have also noticed that they have an initial consultation quickly to discuss problems and develop a plan about most appropriate approach and I think the patients find this discussion and choice helpful and empowering.*

b) Patient Satisfaction

24. We routinely collect data from people who have been through the service using the CSQ-8, a validated tool to assess patient feedback in primary care mental health services which provides us with both qualitative and quantitative data. Feedback from a sample of these is as follows:

25. Eighty-one patients completed the CSQ-8 following completion of their treatment episode within Renew between 30/08/2021 and 10/02/2022, results as follows:



84% *of all respondents received the kind of service they wanted from Renew*
93% *of respondents would recommend the Renew Service to a friend*
89% *of respondents were satisfied with the amount of help they received in Renew*

88% *of respondents felt that services they received within Renew had helped them to deal more effectively with their problems*
93% *of respondents would come back to Renew if they needed to seek help in future*

c) Efficacy of Treatment

26. We collect routine outcome measures throughout all our treatments. This has helped us to measure the effectiveness of the service in terms of symptom reduction, recovery, and client satisfaction.

27. To capture this data, we collected self-reported information each treatment session using the Patient Health Questionnaire-9 (PHQ-9) as a general measure of depression, the Generalised Anxiety Questionnaire-7 (GAD-7) as a general measure of anxiety, and other measures around specific phobias and functioning.

28. Data indicates that all treatment interventions are showing good efficacy in terms of symptom reduction.

KPI 4: Balancing Measures: Ensuring the effect of the service is positive and not creating more work for GP's or Mental Health Services.

a) GP Mental Health Appointments

29. When we did our test of change, an audit on one GP Practice, revealed that for every new GP Mental Health consultation, there were three times as many return appointments. This pointed to the "revolving door" where there was no effective, evidence-based treatment available and was one of the main reasons why we tested out and adopted a "see and treat" model as opposed to usual models of distress management in primary care.

30. With this KPI, we sought to measure whether by establishing Renew, those GP's who referred to Renew had a drop in mental health appointments, especially return appointments.

31. Unfortunately, in spite of extensive discussions, no mechanism has been found to be able to measure GP mental health appointments and as such we have not been able to measure this KPI and recommend we remove this as a KPI unless suitable technology is developed.

b) Anti-depressant Prescribing

32. Our assumption was that with different treatment options, that GPs would rely less on prescribing anti-depressant medication. We therefore proposed to monitor anti-depressant medication prescribing.

33. This however, also proved to be difficult on a number of levels. When we consulted experts in this area, the consensus was that even if there was a drop (or increase) in anti-depressant medication, there was not current technical ability to attribute this change to Renew. We therefore did not continue with this KPI and recommend we review this.

c) Impact on Mental Health Services

34. At the time, we considered a balancing measure to be that there was not an increase in referrals to other mental health services, namely the CMHT. In order to monitor this, we have looked at two pieces of data – total referrals from GP's to CMHT's and referral data between Renew and the CMHT.

d) Referrals from GP's to CMHT

35. Data shows that there has been a significant reduction of over 30% in referrals from GPs to the CMHT from 2020 to current times. This is an interesting trend to note, and clearly there has not been an increase in referrals to the CMHT from GP's since Renew was established. However, it is important to note that this period coincided with Covid which could have impacted on referral trends.

	Fin Yr. 2019/20	**Fin Yr. 2020/21**	**Fin Yr. 2021/22**
GP to CMHT	951	639	687

Table 1: Referrals from GP's to CMHT

e) Referrals between Renew and the CMHT

36. When Renew was established there was concern expressed from CMHT colleagues that this would result in an increase in their workload.

37. Data shows that referrals have been going either way from the CMHT to Renew with no negative impact on the CMHT. This data also shows the excellent collaboration between the CMHT and Renew to ensure that referrals get to the right treatment option and that this can be done without referrals having to go back to GPs for redirection.

38. It is also important to note that there is currently no mechanism for stepping up referrals from Renew to more advanced psychological interventions apart from referring via the CMHT. It is planned to address this, as this is creating unnecessary duplication in referrals and additional work for the CMHT.

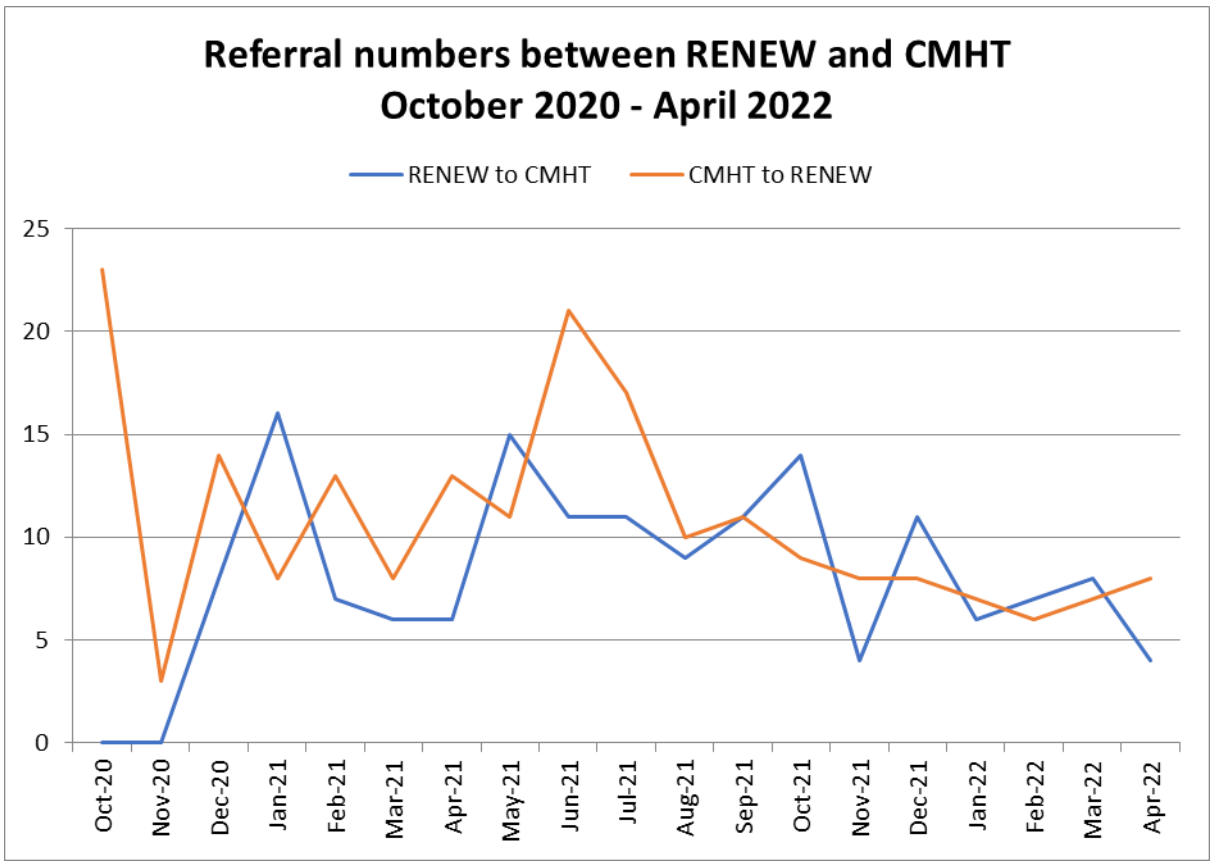


Figure 9: Referrals between Renew and the CMHT, October 2020 – April 2022.

	Mean	Median
RENEW to CMHT	8.4	8
CMHT to RENEW	10.8	9

Table 2: Mean and Median Referrals between Renew and CMHT

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
RENEW to CMHT	0	8	16	7	6	6	15	11	11	9	11	14	4	11	6	7	8	4	6	160
CMHT to RENEW	23	3	14	8	13	8	13	11	21	17	10	11	9	8	8	7	6	7	8	205

Table 3: Referrals by month between Renew and CMHT

Summary and Recommendations

39. In general, given its origins and the conditions it has operated under Renew has been a successful service. It is still relatively new and from a clinical perspective there is work to be done to ensure the model, flow and treatment options fit the demand.

40. The centralised model has worked well, especially with courses as previously there had been resistance to face to face courses or groups due to the rural nature of the Borders and people knowing each other – with the centralised model this ensures a wider group and mix of people attending the groups.

41. Given the Scottish Government's investment in primary care services, it is important to review and take learning from the Renew experience to help us in this wider development and ensure that we build on our successes, while continuing to allow Renew to develop and mature.

42. The following recommendations are proposed:

- Review Renew KPI's to ensure they are deliverable (especially KPI 4)
- Review SLA in the light of future primary care developments. Future service developments should not negatively impact on the delivery of psychological therapies and pathways.
- Continue to monitor flow and reduce treatment backlogs and ensure model, flow and treatments fit demand
- Consider how to meet gaps that have come to light between Renew and the CMHT e.g., trauma treatment
- Enhance the digital therapeutic offering (e.g., cCBT) by establishing a digital team
- Establish a more permanent administrative base, and scope out clinical options for Near Me Hubs
- Establish a website that will provide referrers and those referred with service details and links
- Review the pathway for GSH via Wellbeing
- Review and improve the pathway for ongoing referrals to other psychology services
- Collaborate closely with proposed primary care developments to ensure that pathways are improved, and developments work seamlessly.

Dr Caroline Cochrane
Clinical Lead: Renew
June 2022