NHS Derby City and NHS Derbyshire County

Derbyshire County and Derby City Cluster Primary Care Trust's Review of Specialist Psychological Therapies.

Summary of the 3 Month Formal Consultation

FINAL REPORT

Purpose of the report

This report has been produced for the NHS Derbyshire Cluster and the Clinical Commissioning Groups to inform their decision making process regarding the formal review of Specialist Psychological Therapies. The report is a summary of the Consultation and the information gathered through the formal consultation period, which took place from 1st August to 31st October 2011.
The report contains an overview of the information and picks out some key themes and issues. Throughout the engagement period, these themes have been consistent.

NB. For consistency this report refers to "patients" although it is acknowledged that some organisations and patients prefer to be referred to as "service users" or "service receivers" and where appropriate the terms have been used inter-changeably

Background & Case for Change

Specialist Psychological Therapies (also referred to in this document, as specialist psychotherapies) concern those therapies that are delivered, usually over a longer duration, by expert clinicians, qualified in particular therapeutic modalities. Patients who require specialist psychotherapies usually present with the most complex and severe mental health problems for whom primary care services and standard secondary mental health services, e.g. input via recovery teams, have either not been effective or have been unsuitable.

Derby City and Derbyshire County specialist psychotherapy services have been in existence for around 30 years with much of the established services being based in Derby City.

In Derby City and South Derbyshire, patients have been able to access a range of specialist psychotherapies including long term psychodynamic psychotherapy (LTPP), cognitive behaviour therapy (CBT) and group therapy programmes (GTP). In the North of the County, access to discrete specialist psychotherapy services has been more limited, as there are no established specialist psychotherapy services - although there is a team of clinical psychologists trained to deliver dialectical behaviour therapy (DBT). Consequently there has been inequity across the entire County.

At the time of writing, the specialist psychological therapies services consist of:

Service	Base	CCG areas covered
Cognitive Behaviour Therapy service (CBT)	Rykneld, Derby City	Southern CCG, Erewash CCG
Psychodynamic Psychotherapy service	Duffield Road Derby	Southern CCG, Erewash CCG
Group Therapy Programme	Duffield Road	Southern CCG, Erewash CCG
Dialectical Behaviour Therapy service	North Derbyshire	North CCG, Hardwick CCG

* Clinical Psychology also offers specialised psychological services, available across all CCGs but as they offer a range of approaches, and not solely specialist psychotherapies, clinical psychology services is excluded from the review.

Specialist Psychological Therapy services, delivered by Derbyshire Healthcare NHS Foundation Trust (DHcFT), have been the subject of a number of reviews by the PCT since 2005. For example, the PCT commissioned a report by David Shapiro in 2005 to detail how psychological therapy services could be delivered across the entire County ***(See Appendix 1)***

Attempts to reconfigure services to equalise availability and accessibility and maximise efficiencies in terms of activity have been difficult to implement for a number of reasons, including, strength of feeling of patients, resistance by clinical staff and their union and flaws in engagement processes. A previous review was overseen by the Derby City Overview and Scrutiny Committee in 2008 and at the time the recommendation was to keep the services unchanged.

In 2011 an agreement was made to review the specialist psychological therapy services as part of the QIPP agenda and a joint agreement was made with DHcFT to undertake a service review which could realise £750K in efficiencies (out of a total budget of circa £2M) whilst making improvements in the quality. The aim was to reinvest the released resource in making services more equitable across the county.

A service specification delivery group was set-up by DHcFT with the remit of developing a service specification that eventually delivered NICE recommended therapies to the whole of the Derbyshire Population.

The specification drew on the work that NHS Nottinghamshire were also undertaking simultaneously and was reviewed and developed locally by clinicians employed by DHcFT and Mental Health Commissioners.

The draft service specification ***(See Appendix 2)*** represented an improvement in the availability of NICE recommended therapies and a reduction in long-term psychodynamic psychotherapies (LTPP) as there is less compelling evidence for this treatment approach. The reduction in the number of staff delivering this approach corresponded to the QIPP saving.

Consultation

At the point that it was agreed that the specification was ready to engage on, it was loaded on to the PCT home web page with a view to notifications being sent to key partners to comment (July 2011).

The Consultation followed guidelines set out under the National Clinical Advisory Team (NCAT).

Discussions were held between the PCT and Derbyshire County Council Overview and Scrutiny regarding the draft proposals with a view to formally presenting the plans to both the County and Derby City OSC committees.

However, prior to being able to carry this out formally, DHcFT sent letters to staff to inform them of the intention to engage on the draft specification. LTPP staff were also informed that notice would be served on their contracts as DHcFT managers had been under the impression that the service change would follow an indicative implementation timetable taking effect from October 2011. This led to the Unite Union raising this issue with Derby City OSC as staff felt that they had not had an opportunity to engage on the proposals and ultimately a recommendation to conduct a 3 month formal consultation commencing August 1st 2011 was made. DHcFT subsequently re-issued letters to LTPP staff informing them they would be at risk rather than that notice was being served on their contracts

Summary of the Consultation process

The PCT made a formal announcement on the PCT home page on August 3rd 2011 of the intention to go out to formal consultation with accompanying information that public and staff groups etc. could comment on. DHcFT also placed a similar notice on their Internet home page and the Intranet. The consultation has taken a number of forms including face-to face meetings and public events, web-based information and questionnaire, and via email and letter. Information has been made available throughout the process and we have responded to requests to improve the information, e.g. to simplify the service specification and make it user-friendly.

Key partners and stakeholders were informed and whilst this is not an exhaustive list, they include:

- Patients (service receivers) and public (Commissioners and Public Involvement Manager attending patient meetings.)
- Service User led support organisations, Derbyshire Voice (DV) and Mental Health Action Group (MHAG)
- On-line responses
- Clinicians
- GPs
- The Media
- Voluntary Sector organisations and community groups
- Members of the public
- Overview and Scrutiny Commission (Derby City and Derbyshire County)

The response has been excellent and commissioners have received many helpful comments that have helped to shape recommendations as a result of the consultation.

Feedback on the Consultation

The information provided is the aggregated information from correspondence sent to the Cluster PCT, engagement meetings with staff, public meetings and feedback from patients (service receivers) via a service user led organisation, Derbyshire Voice.
Responses from clinical staff, GPs, Unite the Union, Members of Parliament, the media and Overview and Scrutiny Commission is also included.
You will also see as an appendix **(3)** a report from the work Derbyshire Voice were commissioned to undertake on behalf of the Cluster in gaining feedback from those unable to attend the Public events.

Patient and Public Meetings

The Patient and Public Involvement Manager and the Primary Care Mental Health Planning Manager met with Derbyshire Voice and Mental Health Action Group to discuss the most appropriate format of Public meetings.

There was concern about the potential number of people wanting to be involved so it was decided that the venues should be of a reasonable size and spread across the Southern part of Derbyshire.

Invitations were sent out to a range of local stakeholders and information about the consultation was also sent to South Derbyshire Voluntary Sector Mental Health Forum (SDVSMHF) and North Derbyshire Voluntary Action (NDVA) who are a network of Mental Health support organisations.

Invitations also went to a wide variety of community groups. Derbyshire Voice and Mental Health Action Group also worked with their members to encourage people to attend.

People were asked to register to ensure that the rooms booked were big enough to accommodate and to ensure there were enough refreshments.

Unfortunately, due to very low numbers registering for the events, two of the events had to be cancelled.

The two events that took place were:

28th September 2011 6-8pm Derby City, YMCA

27th October 2011 2-4pm Belper Football Club

Attending patient meetings

The project team working on this consultation made several offers to go out and meet with patients in addition to the work that Derbyshire Voice was commissioned to undertake. There were two requests.

The Patient and Public Involvement Manager met with Derby Depression Club to talk through the presentation given at the consultation events and feed any comments back into the consultation.

The Primary Care Mental Health Planning Manager was invited to meet patients currently receiving group therapies at 63 Duffield Road in Derby.

Derbyshire Voice (DV)
Derbyshire Voice is a user led organisation and a registered charity and company. They support past and present receivers of mental health services to attend NHS meetings to represent the views of other service receivers.

For the purposes of this consultation they were specifically commissioned to gain the views of service receivers through supporting people to attend the consultation events and to offer an alternative supportive and independent way for people to feedback without attending the consultation events.

Derbyshire Voice have produced an independent report which can be found in ***Appendix 3***

Mental Health Action Group (MHAG)
MHAG is a service user led campaigning group who have offered patients support in attending and in supporting the views of patients. MHAG compiled a report in response to the consultation ***(See Appendix 4)***

Online Questionnaire

A draft service specification and online questionnaire were posted on the PCT internet site. All stakeholders that accessed the site for information had access to the questionnaire. There were 3 responses from patients, 1 from a support group or advocacy organisation and 4 from Clinical members of staff.

Consultation with Clinicians

Clinicians employed by DHcFT were involved in the development of the service specification and directed to information and details on how to consult via both the DHcFT intranet and the PCT home web pages.

Commissioners met with clinical staff on 2 separate occasions and also responded to letters and emails commenting on the consultation. A number of reports from staff commenting on the evidence base and suggestions for future service delivery were also received.

Clinical staff were directed to the intranet and invited to comment on the specification.

Consultation with GPs

GPs were contacted via letter and email on two separate occasions and were directed to the PCT home web page to comment on the consultation.

GPs were also invited to register attendance at a GP consultation event on October 11th organised to enable interested GPs to comment on the consultation. Only 6 GPs registered and so a small focus group and presentation was instead arranged.

The Media

The Derby Evening Telegraph was contacted by concerned members of public and as a result the PCT has been asked for a number of comments and interviews throughout the process. A number of letters from the public expressing their views have also been published.

Voluntary Sector and Community Groups

Key partners and stakeholders in the voluntary sector and representing the community were informed in writing of the consultation and asked to disseminate information to constituents and partners on how they could access information and contribute. The key organisations contacted were Southern Derbyshire Voluntary Sector Mental Health Forum and North Derbyshire Voluntary Action who were asked to disseminate information. PCT commissioners also met with Derby LINk and Derbyshire LINk to provide information on the consultation.

Overview and Scrutiny Commission

The PCT met with Derby City OSC, alongside representatives of Derbyshire County OSC who were also present as part of a joint process, at public meetings on two separate occasions (July 25th and October 6th). On both occasions the PCT outlined the purpose of the draft service specification and proposals to provide evidence based specialist psychological therapies service equitably across Derby City and Derbyshire County.

A third meeting, organised by OSC on October 31st to discuss the evidence base, was cancelled (by OSC) as the NICE representative that they had organised to attend was unable to keep the appointment. The Psychological therapies review was discussed at the October 31st Derby City OSC meeting (no members of the PCT were in attendance) and recommendations on the consultation were made to the PCT following that meeting.

Correspondence via Letter and Email

From Commissioners

Mental Health commissioners consulted with Derbyshire HealthCare NHS Foundation Trust (DHcFT) managers and clinical staff (via their manager) regarding the most appropriate means of informing the psychodynamic psychotherapy patient list that the consultation was taking place. As a result a suggested letter was drafted by PCT commissioners in order that this could be circulated as soon as possible.

The letter was shared with DHcFT managers and clinicians with a view to it being sent to every patient on the list immediately. However, clinical staff suggested that the most appropriate means was that they informed patients' directly as it was felt that a letter was too impersonal and would not allow patients to ask questions etc. DHcFT managers took on board the clinicians' request and agreed that staff would inform the patients face to face and also give the patients the letter in person. The feedback from service users (via Derbyshire Voice) was that it significantly delayed communication in some cases.

To Commissioners

Patient and public comments on the consultation were received personally (at meetings and consultation events), via email and letter and also via a report completed by Derbyshire Voice on the feedback that they had received. Mental Health Commissioners also received feedback from carers.

In total Mental Health Commissioners received emails and letters from 10 individual patients, 2 carers, and 4 individual members of the public although in the case of 2 members of the public multiple emails were received. A couple of patients also commented on a number of occasions via email. We also received a copy of a patient letter that had been sent to her MP.

The report developed by Derbyshire Voice reported on comments made by 115 patients (both current and previous receivers of psychodynamic psychotherapy).

A total number of 60 people attended the public meetings. However, we do not know how many of the attendees were existing or previous patients of the LTPP service. Approximately 20 patients attended a separate meeting with a commissioner at their request

In total there were at least 180 comments received

NB- As patients commented to both Derbyshire Voice and Commissioners some of the views may be from the same patients.

Feedback on the Consultation

Feedback on the consultation has been separated into 3 main themes;
a) Consultation processes
b) The evidence base
c) Impact on patient care/the service.

Each of these areas will be summarised individually.

a) Consultation Processes

Patient & Public feedback

A number of criticisms were received over communication with the draft service specification. It was evident, from feedback, that patients receiving psychodynamic psychotherapy felt that they had not been informed appropriately nor in a timely way about the consultation. Despite a letter being drafted immediately by commissioners, a decision by DHcFT managers and staff to attempt to undertake this via face to face meetings with patients meant that communication was significantly delayed and this did cause a degree of unnecessary anxiety among patients.
Error in quoting that Derbyshire Voice was in support of the proposals- There was a miscommunication by commissioners stating that Derbyshire Voice was in support of the proposed changes. This was rectified to say Derbyshire Voice was supporting people to have involvement in the proposed changes and a full apology was made to Derbyshire Voice and its members.
The Consultation events- There was consideration made in planning the consultation to ensure that patients had different ways to feedback. It had been expected from feedback that more people would have attended the events and therefore the smaller venues where people access services had been discounted. There were also concerns identified from patients about having to register for an event but it was felt to be important to ensure that rooms were large enough to accommodate attendees. It was also commented that information about the events had been late going out.
Lessons have been learned and future work with patients /service receivers will take these comments into account.

Several of the comments made by patients and public were related to concerns that the proposed service changes were linked to cutting costs and that decisions had already been made. There were also concerns about the means by which they had received details of the consultation and the level of information available. There was a great deal of feedback about the draft service specification and the lack of understanding of what the service would eventually look like. Patients commented that they did not fully understand what the proposals meant for existing or future service receivers.

The consultation events included a presentation explaining more about the draft service specification but feedback from these events still included comments that people did not fully understand what the initial proposals meant.
Some commented that the actual service specification was not easy to find on the internet site and even when it was located it was hard to understand.
Commissioners responded to these comments and put a user friendly version online but this was still felt to be inaccessible to some people.
Patients and public felt that the information was either very technical or that it was not made clear what they were being asked to consult on. There was also a feeling that this was another "hit" to mental health care (and budgets) with greater emphasis being placed on the more emotive physical health issues despite the great economic burden resulting from mental health problems in society.
Patients commented that public meetings were unsuitable for everyone, so therefore not inclusive.

Weighting of issues raised

- Concern that service changes due to cuts (25+)
- Lack of information and adequate communication about the consultation and the rationale for it. (20+)
- Information too technical and jargonistic (10+)
- Insufficient engagement and consultation with patients (10+)
- Concerns that decisions had already been made (10+)
- Anger related to cancellation of 2 public events (3+)
- Frustration that consultation was organised during holiday time (2+)

Clinician Feedback

Commissioners received comments from 8 clinicians employed by DHcFT (6 psychodynamic psychotherapists, 1 clinical psychologist and 1 consultant psychiatrist). We also received feedback from 2 Psychodynamic psychotherapists working for another NHS organisation and by 2 practice counsellors. Feedback was received from a Primary Care Mental Health Nurse attached to a Derby City GP practice and feedback from an IAPT provider.

In total – 14 clinical staff

There was a great deal of concern that the staff had initially been given letters of notice by Derbyshire Healthcare Foundation Trust and this unfortunately had a bearing on the messages that were given to patients, namely that as a result of being served notice on contracts that therapy would be ending in October 2011. Once commissioners became aware of this, service receivers were reassured that this that this had not been the intention and that there should be no change to services until after the consultation period had finished and a report had been written and recommendations considered. Staff being given notice letters led to many patients and staff believing that a decision had been made before the consultation took place.

Therapists felt they had not been adequately consulted with or given the opportunity to be involved in developing the service specification.
Clinicians also felt that the consultation was concerned with cutting costs rather than service improvement and that the service specification was unclear.

4 reports were received from clinicians and Union commenting on the service specification. The reports can be found in ***Appendix 5***

The key issues included:

- Being served notice on employment contracts prior to opportunity to consult
- Inadequate engagement with clinicians on the proposals
- Specification unclear and too focussed on CBT/DBT
- Problems in applying NICE Guidelines to very complex cases
- Reduced spend on services not made explicit
- Unclear how equity of service would be achieved
- Removal of choice

GP feedback – GP feedback was limited but despite letters going to all GP practices, the LMC commented that some practices had not been informed. The LMC expressed disappointment that they had not been directly notified of the consultation taking place. One GP emailed to report that the technical information was confusing for most.

OSC – OSC recommended the formal 3 month consultation and echoed concerns already raised by service receivers and clinicians about clarification on the proposals being consulted on. Following a meeting held by Derby City OSC on October 31st 2011, the members made recommendations, based on the information provided by patients, staff, UNITE and PCT Commissioners:

1. The Trust (DHcFT) retains psychodynamic psychotherapy services as part of a balanced treatment service.
2. That access to psychodynamic psychotherapy services is made fair and equitable across Derby and Derbyshire.
3. That the Trust (DHcFT) should seek to equalise rather than reduce the level and quality of service provision in Derby and Derbyshire.

NB. Commissioners were issued with the recommendations prior to the opportunity to report on the outcome of the consultation

b) The Evidence base

Patient's, public, and clinical staff questioned the validity of the evidence base as suggested by Public Health and NICE. Clinical staff submitted examples of research evidence which they felt to be in support of long term psychodynamic psychotherapy. There were concerns that the specification was too focussed on NICE evidence and that technical evidence did not take into consideration complexity.
OSC asked for independent comment on the evidence base.

Professor Diane Waller OBE who is a former member of steering groups working with the National Institute for Mental Health (NIMH) and Department of Health on the Improving Access to Psychological Therapies (IAPT) programme stated that she:

"… supports the PCT"s desire to improve access to psychological therapies across the county. Although some therapies do lend themselves more easily to the kind of research evidence on cognitive based psychotherapies, NICE is clear that its guidance cannot provide the full picture across the range of patient groups at any one time "

The case put forward by Public Health on the evidence base was supported by representatives of NICE who had also been asked by OSC to comment on the evidence base.

All information received from staff challenging the evidence base and all of the research reports and papers sent supporting their arguments were gratefully received and shared with the PCT Mental Health Public Health lead to review with the help of Knowledge Services.

Public Health Response to stakeholder views on the evidence base

The complexities of identifying evidence based mental health interventions are well understood by commissioners and this is acknowledged in the original Literature Review consultation document and the draft service specification. Psychological therapies encompass a broad range of interventions that are frequently tailored towards the needs of individual patients. Individual patients themselves may have a number of interrelated problems that make diagnosis problematic. Some of the challenges associated with accumulating robust evidence for effective treatment of mental health problems include the following;

- Therapist effects; the relationship between the therapist and patient has considerable influence over patient outcomes
- Heterogeneity: variation in fundamental characteristics of patients' symptoms and diagnoses make standardisation in research problematic
- Individual tailoring of therapies

- Disengaging of patients; high levels of disengagement from clinical trials or treatment regimens resulting in low numbers studied
- Multiple diagnoses / co-morbidities

We appreciate the time and effort taken by stakeholders in undertaking their own literature reviews; however anything published prior to the respective NICE Guidelines by condition will have potentially been considered in the relevant systematic reviews and meta-analyses informing NICE according to their criteria for inclusion.

During the consultation considerable concern was expressed with regard to patients with borderline personality disorder: NICE has recently finished (14th Nov) a consultation process on whether there is a need to update their Guideline (CG 78) and this decision will be announced in January 2012; see print out of the relevant area of the consultation summary below
"Summary CG78- Borderline Personality Disorder, review proposal consultation document [31st Oct to 14th Nov] 9 of 23
“For psychological treatment options in the management of patients with BPD, most of the studies and reviews looking at different forms of psychological interventions such as interpersonal psychotherapy (IPT), dialectical behaviour therapy (DBT), cognitive therapy (CT), cognitive behavioural therapy for personality disorders (CBT-PD) schema focussed therapy (ST), manual assisted cognitive therapy (MACT), and motive oriented therapeutic relationship, showed some form of effectiveness in managing symptoms including self- harm, suicidal ideation, improved overall functioning, improved quality of life, and reduced anxiety, of patients with BPD. But any form of psychological intervention is allowed to be used provided it suits the patient needs and the patient is happy to comply with it. Also, it should be used for no less than three months. Therefore, no new evidence has been identified that would change the current recommendations.”

The recommendation of the NICE review consultation document on borderline personality disorder is not formalised. On their website, NICE state “Note that the provisional review decision presented here does not constitute the Institute's formal decision on this topic. The decision is provisional and may change after consultation.” (http://guidance.nice.org.uk/CG78/ReviewProposal).
Therefore in this case we do have to wait until January 2012 for their decision, and we can’t assume that it will still be not to update the guideline

Post script note: Nice has decided not to update Guideline CG78

All the studies cited by stakeholders post NICE Guideline dates have been given due consideration. One frequently quoted study is a Leichsenring and Rabung paper “Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis” published in the British Journal of Psychiatry 2011, 199:15-22.

The Leichsenring & Rabung meta-analysis includes 10 studies comparing long-term psychodynamic psychotherapy (LTPP) to shorter term or less intensive interventions. Of these studies, only one (Bateman 2009) is covered by NICE’s review consultation document for CG78, and a further three are referenced in the guideline itself (Bateman 1999, Clarkin 2007 and Gregory 2008).

It may be the remaining six are excluded by NICE not because they are too recent, but because they don't match the inclusion criteria: two are on anorexia, two on depression and anxiety disorders, one on cluster C personality disorders and one is not an RCT.
So it looks like the difference between the reviews is the number of studies they consider relevant. It is possible that if Leichsenring & Rabung's inclusion criteria had been as strict as NICE's, they perhaps would not have been able to demonstrate any significant benefit. The authors acknowledge that they have been criticised in the past for "including heterogeneous populations and comparison conditions", but argue that this "increases the generalisability and usefulness of the results". They cite a BMJ editorial as evidence for this statement.
Leichsenring & Rabung reviewed no trials that NICE didn't at least have the opportunity to look at when writing their guideline. They make no specific claims for long term psychodynamic psychotherapy, only that their analysis suggests intensive psychiatric interventions are more clinically effective than less intensive ones.

Summary on the evidence base

Having given further consideration to the research evidence submitted by stakeholders, no changes are recommended to the conclusions of the original literature review posted for consultation. Commissioners should consider future NICE reviews and updates as they occur and continue to audit providers to ensure their interventions are in accordance with latest evidence.

The challenge remains to commissioners to ensure a full range of evidence based psychological therapies are available to Derby and Derbyshire residents which focus on outcomes and can be accessed according to population need.

c) Impact on patient care/the service

Patient and public feedback - The vast majority of comments made by patients were related to them valuing the service. Without doubt every service receiver who commented as part of this consultation had positive comments about the current psychodynamic psychotherapy service. Comments included statements such as:

'It has given me hope and I now see a future for me'

'Without this therapy I would not be writing this now'

Many comments were focused on retention of the long-term psychodynamic psychotherapy service along with the accompanying anxiety that they would be personally affected by any reduction in the availability of support or therapy. Patients on existing caseload were worried that therapy would be terminated prematurely and/or that they would no longer be able to access a service in future.

A common assumption was that other therapies indicated in the draft service specification, such as CBT and DBT, were short-term therapies for people with less severe and complex presentations. Value is therefore placed on the length of time in therapy, e.g. the longer the therapy the higher the quality of the service. Another common theme is the length of time it had taken patients to get to the "right therapy" and the fear that, if discharged, no other options would be offered in future (other than short term therapies).
For a significant number of patients, it had taken considerable time before they were able to access specialist therapies, in some cases years of being managed in different settings, by a range of different types of mental health worker or GP and by medication alone. In a few cases, the situation had got to crisis level before they were able to access therapy.

Other comments made by both patients and clinical staff were assumptions about the impact on other services should one aspect of the specialist services be reduced, e.g. greater burden placed on A&E services and in-patient care (there is limited evidence locally to back up this assumption)

Weighting of key themes

- Benefits of the service (60+)
- Retention of service (50+)
- Problems getting into specialist psychological therapy (20+)
- Impact on other services (15+)
- Direct impact on existing therapy – fears therapy will stop (10+)
- CBT and DBT are short-term therapies (10+)
- No other options if LTPP no longer available (10+)
- Other services patients had tried had not met needs (5+)
- NHS wouldn't pull the plug on physical treatments (5+)
- CBT and DBT lower quality (5+)

Clinical staff – had similar concerns in terms of the impact on patients as outlined above but their focus was also on the complexity of cases seen in LTPP services and accompanying fears that if the availability of LTPP was reduced then this would have a detrimental impact on patients and on other services. A proposal for future delivery was suggested.

"A way forward now would be to organise wider discussions involving the full range of stakeholders in order to develop more variable proposals ……to support a modern, comprehensive and high quality model of psychological therapy service provision for the people of Derbyshire"

Comment

The overwhelming response from the feedback received was that LTPP was valued, had benefitted those who commented and with little support, from those who commented, to reduce this element of the specialist psychotherapy services.

Whilst the comments received from patients were representative of those receiving both group and individual psychodynamic therapy, the responses were not representative of all patients receiving specialist mental health services nor representative of those currently not able to access specialist psychotherapies, e.g. patients residing in the North of the County. The response from clinicians was also representative of clinicians currently delivering LTPP in Derby City and South Derbyshire but not so representative of clinical groups delivering the other specialist psychotherapies as outlined in the service specification.

There was also a strong feeling that the pre-consultation period had not adequately sought the views of patients, the public and clinical staff, the PCT responded to the comments by commissioning patient support groups to offer advice on the patient consultation. The PCT also responded to requests to meet with patients, staff and the Union representatives to ensure that all stakeholders were consulted with during the formal consultation period.

One of the key themes emerging from consulting with patients was the value placed on longer term support as opposed to shorter term therapies, the perception being that longer term therapies are for more complex cases and are of a superior quality. This may be due to the fact that a few patients had received other therapies that had not been of benefit. There is also a commonly held belief that CBT and DBT are short-term therapies for people with less complex presentations. This may be partly due to the fact that CBT is now available in primary care for patients with mild – moderate mental health problems as part of the Improving Access to Psychological Therapies (IAPT) programme.

Key points patients' perspective are summarised below which Commissioners considered in developing recommendations for future service delivery:

1. Having therapy helped patients in other areas of their lives, e.g. maintaining relationships, remaining in employment
2. Patients had problems accessing therapies, experienced long waiting lists and inconsistent care pathways.
3. Patients' personal accounts suggest there is a need for services for people with more complex presentations and with troubled personal histories.
4. Patients like group therapies and feel there should be more of them.
5. Patients feel that CBT and DBT therapies do not work for everyone and are too short-term (although it was not clear how many of the patients who commented had experienced CBT (therapy in specialist service settings) and DBT).

**There was a general assumption and misconception that CBT and DBT were considered as "lesser" therapies based on assumptions of them being short-term and not necessarily specialist in nature.*

6. Patients valued the therapeutic relationship and support over the longer term

Acknowledgement

Commissioners would like to acknowledge the time and effort that patients and public have taken in responding to the Consultation - with special thanks to those patients who were able to share personal histories and experiences in putting their cases forward.

Options

When considering options for future service delivery the following choices have been considered in terms of delivery of specialist psychological therapy services and in light of the consultation:

1. Do nothing – i.e. keep the status quo

The argument for this option is that patients living in Derby City (in particular) but also in the South of the County would continue to get the same level of services currently available.

The argument against this option is that it doesn't meet the criterion of equity across the county, leaves the city without a full range of evidence-based therapies and doesn't meet the OSC recommendations. It will not correct the situation we heard about in the consultation in which patients sometimes bounce between services before being matched to a therapy effective for them. It also retains a non-team-based approach to therapies based on treatment modality groups. It will not improve the long waiting list problem. It does not meet the recommendation of the therapists for service-redesign. This may also not be affordable to Southern Derbyshire CCG as Derby City spends a great deal more per capita than does the County.

2. Do minimum – reorganise the way the existing service is delivered.

The argument for this is that the clinical staff delivering the service have been motivated to explore other evidence-based models of delivery being used in other areas. It may help to reduce both the waiting list and the length of therapy for some patients.

The arguments against this are similar to those for the 'do nothing' option. A minimal change to one service does not meet need across the county in a sustainable way in the long-term.

3. Do maximum – revise service to take account of what was learned at consultation

The argument for this is that resources would be directed to NICE recommended and evidence based (best evidence) therapies. It would enable a team-based approach based on diagnosis which would:

- ✓ Provide a service capable of directing patients to the right service first time and before they have self-harmed or their condition worsens
- ✓ Reduce waste when patients bounce between services which don't meet their need and use a resource which could have been effective for others
- ✓ Enable commissioners to provide the full range of services e.g. CBT, DBT, GPT, STTP, and LTPP equitably across the area.
- ✓ Meet the spread requirement of OSC
- ✓ Continue to offer a longer term service for individual patients where the need is demonstrated
- ✓ Provide a step-down service which does not require continuation of a highly qualified clinician longer term

The argument against this is that initially demand may not be met within current resources in the short term. It does not meet the OSC requirement to retain the LTPP in current form. It will require careful planning to match need to resource and capacity and will result in some disruption while changes are being made. Patients currently within the service will need to complete treatment which could delay any implementation.

Recommendations

The views expressed in the consultation by patients, the public, clinicians, the evidence base and recommendations of the OSC have been carefully examined and considered. The recommendations to be considered by the Cluster Board and CCGs are as follows:

a) Approve in principle a potential spread of workforce and modality resource across the CCG areas within affordability as each CCG has a limited resource to invest in the service. The aim will be to improve efficiency and achieve greater capacity within the existing financial limits in order to address unmet need.

b) (Option 3) Achieve this by working with CCGs, providers, clinical representatives and representatives of service receivers on a service model that enables a choice of NICE recommended therapies for the diagnostic groups identified in the service specification

If the recommendations are approved a further proposal will be drawn up and discussed with OSC in June 2012 in order to ensure all views have been considered.