Item: 7.2

Report to:	NHS Hull CCG Board Meeting Part II
Date of Meeting:	23 November 2018
Title of Report:	Depression and Anxiety Service for Hull (DASH) – Contract Extension Decision
Presented by:	Joy Dodson, Deputy Chief Finance Officer -Contracts, Performance, Procurement and Programme Delivery
Author:	Joy Dodson, Deputy Chief Finance Officer -Contracts, Performance, Procurement and Programme Delivery Colin Hurst, Engagement Manager Toni Yel, Head of Commissioning - Integrated Commissioning

STATUS OF THE REPORT:

To approve	X	To endorse	
To ratify		To discuss	
To consider		For information	
To note			

PURPOSE OF REPORT:
The purpose of this report is to provide a summary of the engagement work undertaken and the feedback received as well as the latest performance information to determine whether the current Depression and Anxiety service meets the expectations of the general public, service users, GPs and the provider and inform the decision whether or not to exercise the option for a 2 year extension that is available within the current contract.

RECOMMENDATIONS:
The CCG Board is requested to approve the 2 year contract extension option to be exercised.

REPORT EXEMPT FROM PUBLIC DISCLOSURE No ☐ Yes ✓

If yes, detail grounds for exemption

CCG STRATEGIC OBJECTIVE *(See guidance notes on page 4)*

Vulnerable people

Short summary as to how the report links to the CCG's strategic objectives

- Five Year Forward View for Mental Health, NHS England, February 2016 - *"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services*";
- Mental health problems are widespread, at times disabling, yet often hidden. One in four adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year
- Public Health England estimate the current prevalence of eating disorders within Kingston upon Hull City Council area is 6.4% (2012).

IMPLICATIONS: (*summary of key implications, including risks, associated with the paper*),

Finance	There are no financial implications beyond the ongoing current expenditure of service contract.
HR	There are no HR implications specifically in this report.
Quality	Service user experience is included in this report.
Safety	There are no safety implications specifically in this report.

ENGAGEMENT: (*Explain what engagement has taken place e.g. Partners, patients and the public prior to presenting the paper and the outcome of this*)

- General public
- Service users
- Carers
- GPs
- Let's Talk Framework Sub Providers

LEGAL ISSUES: (*Summarise key legal issues / legislation relevant to the report*)

There are no specific legal issues with regard to the engagement work undertaken. The legality in relation to signing off contracts and incurring expenditure is a clear part of the procurement process so there are no issue to report in relation to this area.

EQUALITY AND DIVERSITY ISSUES: (*summary of impact, if any, of CCG's duty to promote equality and diversity based on Equality Impact Analysis (EIA).* ***All*** *reports relating to new services, changes to existing services or CCG strategies / policies* ***must*** *have a valid EIA and will not be received by the Committee if this is not appended to the report*)

	Tick relevant box
An Equality Impact Analysis/Assessment is not required for this report.	√
An Equality Impact Analysis/Assessment has been completed and approved by the lead Director for Equality and Diversity. As a result of performing the analysis/assessment there are no actions arising from the analysis/assessment.	
An Equality Impact Analysis/Assessment has been completed and there are actions arising from the analysis/assessment and these are included in section xx in the enclosed report.	

THE NHS CONSTITUTION: (*How the report supports the NHS Constitution*)

The NHS Constitution, "The NHS belongs to us all" (March 2012), outlines 7 key principles which guide the NHS in all it does. These are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and the public.

These are:

1. The NHS provides a comprehensive service, available to all.
2. Access to NHS services is based on clinical need, not an individual's ability to pay.
3. The NHS aspires to the highest standards of excellence and professionalism
4. NHS services must reflect the needs and preferences of patients, their families and their carers'.
5. The NHS works across organisational boundaries and in partnership with other organisations in the interest of patients, local communities and the wider population.
6. The NHS is committed to providing best value for taxpayers' money and the most effective, fair and sustainable use of finite resources.
7. The NHS is accountable to the public, communities and patients that it serves.

This Constitution establishes the principles and values of the NHS in England. It sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All NHS bodies and private and third sector providers supplying NHS services are required by law to take account of this Constitution in their decisions and actions.

This report specifically supports Key Principles 6 and 7.

The Five Year Forward View for Mental Health (FYFV MH) was published in February 2016. The report sets out the vision to improve the mental health of children, young people, working age adults and older people. The majority of the recommendations are focused on commissioners and other NHS arms-length bodies (e.g. the CQC, Health

Education England), but there are also recommendations that relate to the Government and local government.

The report addresses a number of areas:

- Commissioning for prevention and quality care
- Good quality care for all 7 days a week
- Innovation and research to drive change
- Strengthening the workforce
- A transparency and data revolution
- Incentives, levers and payment
- Fair regulation and inspection
- Leadership inside the NHS, Government and in a wider society

DEPRESSION AND ANXIETY SERVICE FOR HULL (DASH) – CONTRACT EXTENSION DECISION

1. INTRODUCTION

The purpose of this report is to provide a summary of the engagement work undertaken and the feedback received as well as the latest performance information to determine whether the current Depression and Anxiety service meets the expectations of the general public, service users, GPs and the provider and inform the decision whether or not to exercise the option for a 2 year extension that is available within the current contract.

2. BACKGROUND

IAPT services are nationally mandated by NHS England and provide support for adults with depression and anxiety disorders that can be managed effectively in a uniprofessional context.

The national IAPT programme began in 2008 and was developed as a systematic way to organise and improve the delivery of, and access to, evidence-based psychological therapies within the NHS. It has transformed treatment of adult anxiety disorders and depression in England. The Five Year Forward View for Mental Health has committed to expanding services further, alongside improving quality.

IAPT services provide evidence-base treatments for people with depression and anxiety disorders, and comorbid long-term physical health conditions (LTCs) or medically unexplained symptoms (MUS). IAPT services are characterised by three key principles:

- ***Evidence-based psychological therapies at the appropriate dose***: where NICE recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes
- ***Appropriately trained an supervised workforce***: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive weekly outcomes-focused supervision by senior clinical practitioners with the relevant competencies who can support them to continuously improve
- ***Routine outcome monitoring*** on a session-by-session basis, so that the person having therapy and the clinician offering it has up-to-date information on the person's progress. This helps guide the course of each person's treatment and provides a recourse for service improvement, transparency and public accountability

NHS Hull CCG undertook a full OJEU Open procurement process for the Depression and Anxiety service with the contract commencing on 1 October 2014 for a contract term of five years with the option to extend for a further two years. City Health Care Partnership CIC (CHCP) were successful in being awarded the contract to be the Lead Provider and deliver the service under the branding of 'Let's Talk'. This service specification meets national requirements for Improved Access to Psychological Therapies (IAPT) with additional enhancements; this is sometimes referred to as 'IAPT-Plus'. CHCP as Lead Provider maintain a framework of accredited sub-providers to offer choice for patients.

The current contract of 5 years comes to an end in September 2019. A decision is required on whether to exercise the 2 year extension.

3. CURRENT SERVICE PERFORMANCE

A summary of the latest *published* data (August 2018) of key national quality standards is shown below:

KEY NATIONAL QUALITY STANDARDS

E.H.1_B1 The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period

Target 75% **Actual August 2018 60.7%**

E.H.1_B2 The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period

Target 95% **Actual August 2018 99.8%**

E.A.S.2. The proportion of people who complete treatment who are moving to recovery

Target 50% **Actual August 2018 54.25%**

E.A.3 measures the proportion of people that enter treatment against the level of need in the general population (the level of prevalence addressed or 'captured' by referral routes).

Target 19.0% **Actual August 2018 18.6%**

Additional activity and performance information is received and monitored locally.

The service has undertaken considerable work since July 2018 to tackle the persistent high number of service users that Do Not Attend (DNA) their first assessment appointments. This is proving to be successful because DNA rates had regularly been reported well in excess of 30% and over recent months have steadily been reducing with October local data reporting a DNA rate of around 11% which allows the service to preserve capacity and improve waiting times.

During 2017 the Lead Provider and the CCG jointly invited NHS Improvement's Intensive Support Team to visit Hull and provide guidance towards improving recovery rates which were below the national target. The outcomes of the visit have been embraced by CHCP as the Lead Provider and embedded within their framework of sub-providers who collaborate through an active clinical network. Recovery rates have been achieving the target for almost 12 months.

4. ENGAGEMENT ACTIVITY

The attached Appendix A 'Engagement Findings Summary' provides the details of the engagement undertaken and the feedback received.

There are many positive aspects from all stakeholders that can be drawn from this engagement work.

The key issues to be addressed are:

- Improving waiting times for assessment and support; this is already making good progress through the reduction in DNAs and is anticipated to improve still further although opportunities for telephone assessment/triage will be explored.
- Review and modify the delivery model and branding of the Stress Control Group; this will be done collaboratively by the CCG and Lead Provider within the scope of the contract.
- Clarity over the number of therapy sessions to be offered; the Lead Provider and sub-providers will be encouraged to use consistent messages with service users.
- Improved clinical communication with primary care, particularly at discharge; the Lead Provider is committed to doing this and will facilitate the change through the established clinical network.

5. OPTIONS APPRAISAL

The CCG has two options available:
1. Exercise the 2-year extension in the current contract
2. Do not extend the contract and re-procure the service.

Review of the improving performance data and the comprehensive engagement feedback, the CCG can feel assured that the current service provision is largely meeting the expectations of service users, along with delivering contractual requirements to a reasonable level. The issues to be addressed would be put in place swiftly where they remain currently outstanding.

On this basis the preferred option would be to extend the contract for a further two years (1 October 2019 to 30 September 2021).

6. RECOMMENDATIONS

The CCG Board is requested to approve the 2 year contract extension option to be exercised.

Joy Dodson, Deputy Chief Finance Officer
Toni Yel, Head of Integrated Commissioning
Colin Hurst, Engagement Manager

November 2018

APPENDIX A

Depression and Anxiety Service – Let's Talk
Engagement Findings Summary

Introduction

The existing depression and anxiety service, Let's Talk, is run by City Health Care Partnership; the contract term is approaching. The CCG needs to determine if the service should be re-procured or the contract extended with some service improvement. Over the course of the exisiting contract the service has developed to respond to the changing behaviour and needs of service users, with particular focus on reducing the high DNA rates the service experiences.

Goals

The goals of this engagement exercise are:

- To gauge professional experience and views of the service, both working with and for the service.
- To use the experience and views of people accessing the service, to identify the valued aspects of service and areas for improvement.
- To use public views and experiences of mild to moderate mental health issues to give insight into what people may require from services in the future.

Methodology

Three online questionnaires were developed, one for each of the following stakeholders; general practitioners, patients and the public. The public facing questionnaire was promoted on Facebook using two promoted posts, one general post and one aimed at men. The public questionnaire asked if people had accessed the Let's Talk Service, if participants had and agreed to be involved further they were sent the patient questionnaire. The patient questionnaire was also completed in service waiting areas using iPads. The GP questionnaire was promoted using the GP newsletter, Council of Members and direct email.

Additional work was undertaken with professionals who interact with the service; a table top discussion with GPs was facilitated at the CCG's council of members meeting on 13th September 2018, and semi-structured interviews were conducted with subcontractors of the existing service.

Engagement Reach

578 people have taken part in this engagement exercise; 489 members of the public, 46 service users and 23 GPs completed their respective questionnaires. 20 GPs took part in the table top discussion and 9 subcontractors were interviewed.

The table below gives social media interactions on Facebook:

	Advert 1 (Male)	Advert 2	Total
People reached	11,919	11,068	22,987
Engagements	334	746	1,080
Link clicks	38	294	332
Comments	11	16	27
Shares	48	88	136
Likes, loves, interactions	88	85	173

Results

Chart 1

How would you rate the Let's Talk service? (n=41)

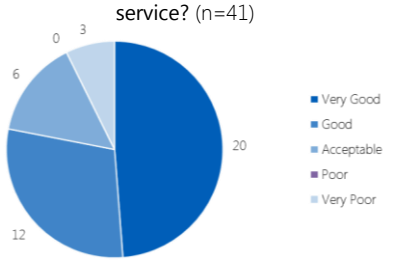


Chart 2

Would you use Let's Talk again? (n=41)

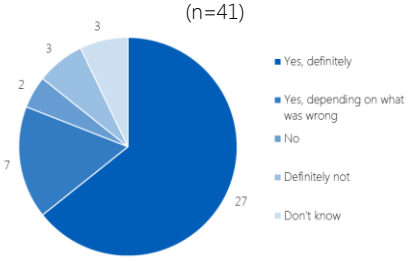


Chart 3

How convenient were the appointment session times? (n=41)

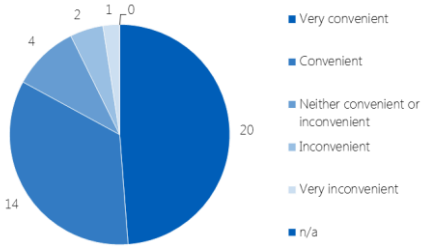


Chart 4

How did you feel when your support came to an end? (n=30)

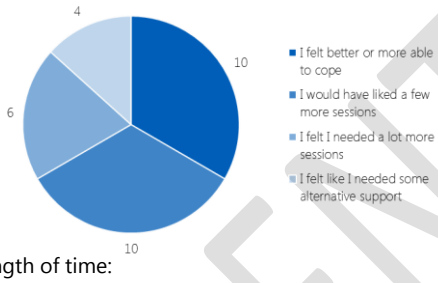


Chart 5

How would you rate the length of time: (n=41/42)

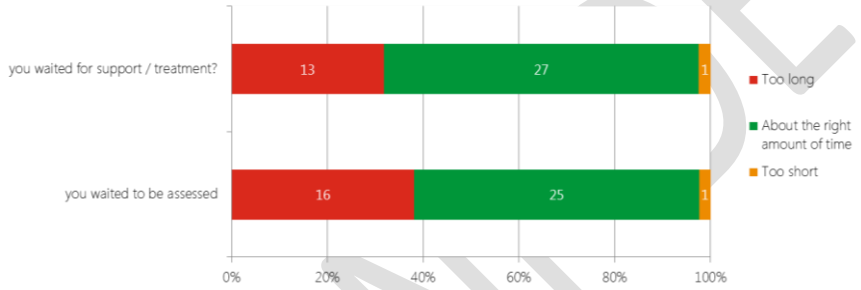
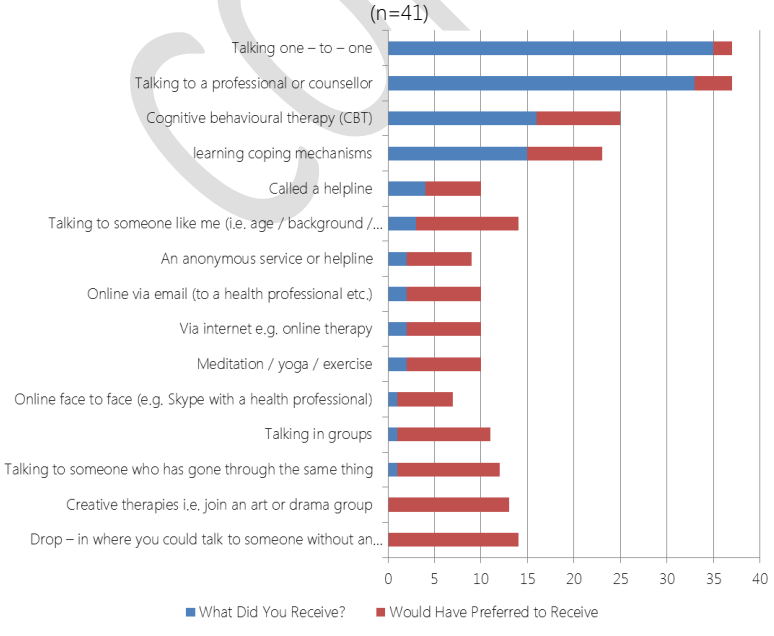


Chart 6

What support did you receive, and would prefer to receive? (n=41)



Service Users

Charts 1 and 2 show that service users value the existing service, with over three quarters rating it good or very good (n=32) and three people stating that it was poor or very poor; two thirds saying they would definitely use the service again (n=34), an only five people saying they would not use the service again.

The majority of respondents felt the length of time they waited to be assessed, and to receive support, was about the right amount of time; however about a third felt that they waited too long (chart 5). Only three people completing the survey felt that the appointment or session times were inconvenient.

Two thirds (n=26) of respondents were given a choice of the type support they received, however about a quarter (n=11) felt they were not offered a choice of support (chart 7). The majority of participants felt the support they received worked, only a fifth saying that they would have preferred different support or that it did not work for them (chart 8).

Chart 7

I was given a choice of types of support? (n=42)

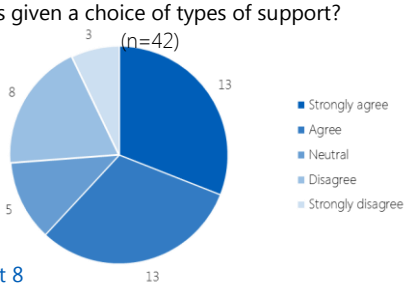


Chart 8

How would you rate the type of support you received? n=40)

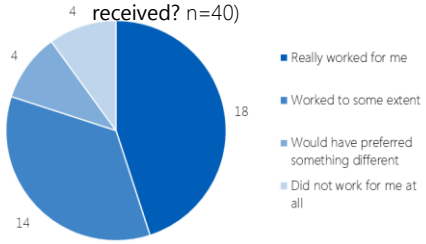


Chart 6 shows the type of support people received, and support that they would have preferred to receive, although this may give an indication of other forms of support that could be considered, it gives some indication of other services or community groups e.g. social prescribing that might be appropriate to refer to.

Chart 4 shows how people felt when their support came to an end, a third felt better and more able to cope in the future, another third felt that they needed a few more sessions, and the remaining third required notably more support either through a number of further sessions or alternative services.

General Practitioners

All of the GPs taking part in the table top discussion, and taking part in the online survey had heard of the Let's Talk service; and had referred, or told their patients to self-refer, into the service.

Chart 9

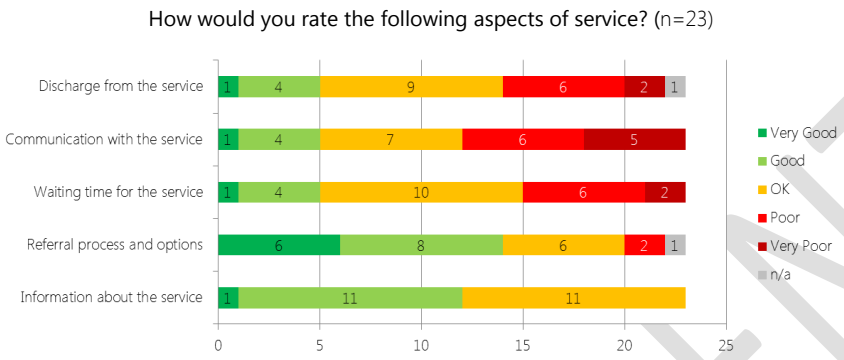


Chart 9 shows that GPs are positive about the information relating to the Let's Talk service, and the referral process and options. The majority of respondents felt that waiting times were OK or Poor, in almost equal measure, only a quarter felt the waiting time was good or very good (n=5). There is similar feeling for the discharge process. The majority of respondents feel that the communication with the service is poor or very poor (n=11).

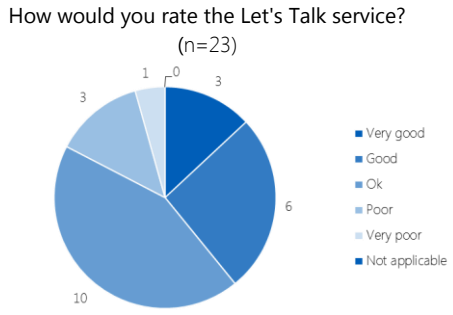
These findings were almost exactly mirrored at the table top discussion session. The discussion session gave more insight into issues with communication and discharge.

There was concern that the service appeared to have a limited number of sessions, rather than tailoring the number of sessions to the individual, reviewing periodically; there was a feeling that this was set at 6 sessions. Some GPs raised concern that after the 6 sessions the patient was sent back to the GP to be referred into service again.

Two different groups were concerned that the Let's Talk service did not refer people onto secondary care mental health services at the assessment stage, instead returning the patient to the GP to refer; this causing a delay that they felt could be avoided.

All the groups raised discharge letters as a concern; this was mirrored in the free text comments in the questionnaire. GPs felt that the letter, although prompt, did not really give them useful information in what support their patient had received; they felt this inhibited their ability to support the patient following the interventions from Let's Talk.

Chart 10



Just over a third of GPs rate the service as good or very good, whereas almost half rate it as OK.

GPs were asked if they could think of any particular reason why the service experiences high DNA rates. Although they thought this could be mainly attributed to the waiting time, some thought that the patient may have recovered from their period of mental ill health.

Members of the public

Chart 11 shows that 70% of members of the public were aware of the Let's Talk Service, and that just under 40% had access the service. Chart 12 shows people's experience of mental ill health, the 6 people have most experience of are all catered for within the Let's Talk service. Chart 13 shows the type of support that people would seek out a number of the popular settings are provided by Let's Talk.

Chart 11

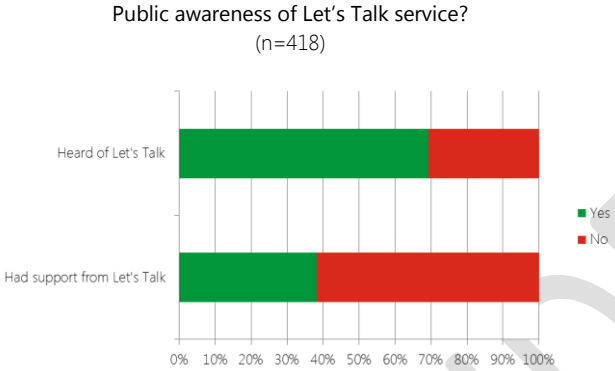


Chart 12

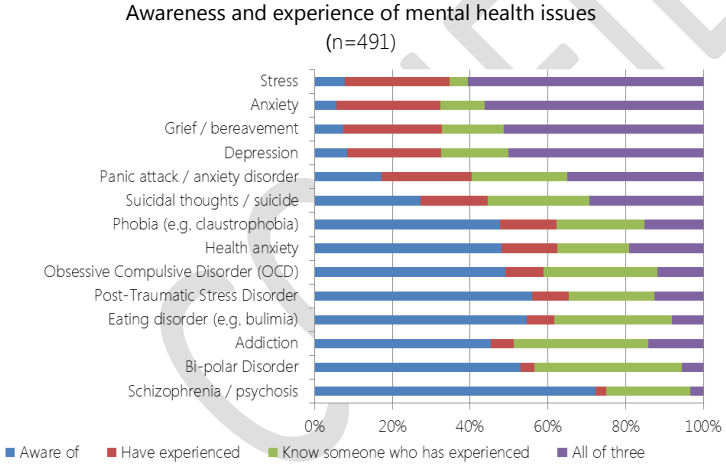
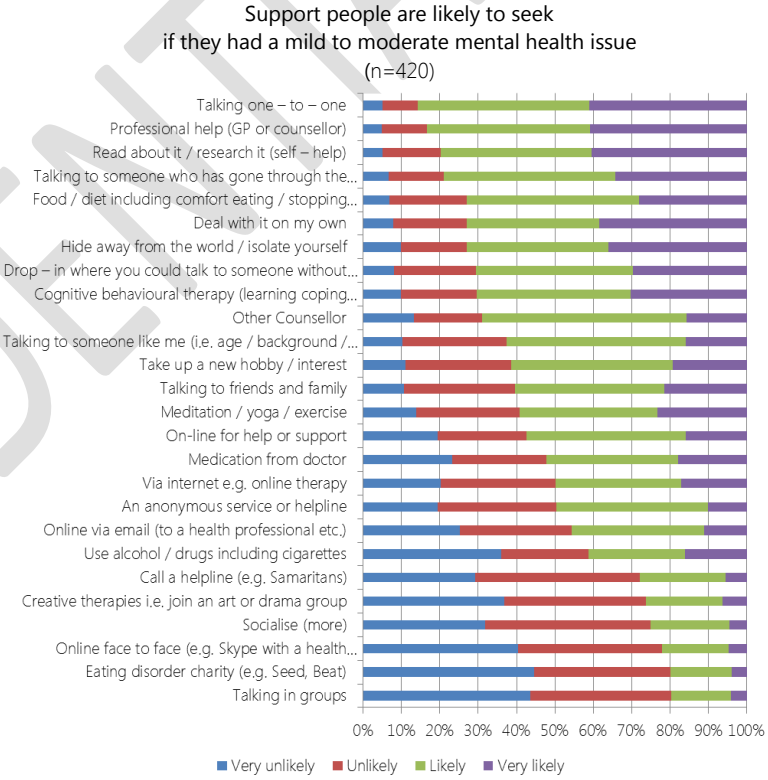


Chart 13



Sub-Providers

10 of the 11 subcontractors that provide the interventions offered by Let's Talk took part in semi-structured interviews. The general consensus around the referral process was considered 100% good or very good and reported to work seamlessly. The transfer of information process was rated 100% good or very good with positive comments around the system itself and the information provided by the team.

Generally waiting times didn't have much impact on the sub providers as they fill capacity with referrals as soon as they have them however there was awareness amongst the network that there have been times of significant backlog but felt this was now recovering. This process was rated 89% good or very good by the providers as they didn't feel they had enough information on the situation to low rate it.

Many of the providers said there hadn't been any specific concerns raised by service users however some had decided to bypass the waiting time and engaged privately.

The process of discharge was largely the same for all providers with the exception that some therapists did this individually themselves and others their office admin team were instructed to do this. All confirmed it was a standard letter on the system which could be tweaked to circumstances of engagement and was required to be sent to GPs within 48 hours.

All providers were very happy with the communications between CHCP and their own organisation and find the contract review meetings and clinical network meetings work very well. All point of contacts are very responsive and in a timely manner. They feel listened to for recommendations on elements such as training and speakers. It is also useful that a number of data is provided across various items. It was mentioned a number of times that the IAPTUS system is very useful and helps make things run smoothly. It was expressed that being allocated a nhs.net email account would also assist in identifying to others that they are part of this NHS service to the outside world as this sometimes comes with confusing factors when giving out own provider registered email addresses.

The providers were asked to feedback on the stress control group which they confirmed has had mixed feedback from service users. It was felt generally that this wasn't really a place that people with anxiety would go and don't feel it is that beneficial to the therapy most will undertake. They did recognise that some people may find it useful and it could help those to reengage with people socially that are dealing with loneliness, however for the majority they didn't feel it was a necessary or mandatory step as most people just want to start dealing with the initial crisis. It could perhaps work as a step down into post crisis as part of a sustainability option. Most providers felt it didn't describe what it was and it needed a different name and clarification on what the person will expect when they attend.

It was felt that the network of providers worked well together and they had good opportunities to meet up and discuss/share opinions, they would like more of this like the recovery rates workshop which they felt was very beneficial. It was felt that the network had a balanced and complementary framework of providers and although there were some elements of competitiveness they get on well with each other.

The key themes summarised:

- Happy with how the service is managed and how the network work together
- DNA's are not as much an issue once a person starts in treatment
- Some confusion amongst users over the stress control group; isn't for everyone and this could be better placed
- Relevant length of time in treatment for clusters vs defined number of sessions with options to extend where required. Service users prefer to know how many sessions they will receive

CONCLUSIONS

- Awareness of the Let's Talk service is good, with all GPs who have taken part stating that they are aware of the service, and 70% of the general public stating that they have heard of the service. None of the GPs taking part rated information about the service as poor or very poor.

- The Let's Talk service is valued by patients, and although this engagement exercise has highlighted some areas where the service could be improved, these issues do not appear severe enough to warrant significant service change.

- The Let's Talk service currently offers support for mental ill health that people have most experience of. Although patients suggested alternative methods of support may be preferred, none surpassed the methods currently offered. A number of the preferred support settings identified by the general public are currently provided by the Let's Talk service. This suggests that what the service offers is meeting the needs of patients, but some alternatives or links with organisations or services should be considered.

- The subcontractors report to operate well together and it is felt the network approach is supportive; no issues with service processes but some refinements required in relation to stress control

- The key service issues seem to be:
  - Waiting times for assessment and support: Although the majority of patients feel the wait is about right, about a third feel the waiting time is too long; GPs feel that the waiting time to access the service is too long and that this contributes to the high DNA rate the service experiences.
  - The number of sessions offered: The way this is determined needs to be reviewed, as there is a perception that a limited number are offered; this was highlighted by GPs and about half of patients taking part in this exercise felt they needed more sessions when their intervention came to an end.
  - Clinical Communication: Based on the feedback from GPs, this needs to be improved particularly at discharge. The GPs main concern relates to the information they receive but also relates to how the Let's Talk service refers on to other services.