Executive Summary

This paper presents the psychological services strategy for the next three years. The paper is divided into three volumes. Volume one presents the essential elements of the strategy, identifying nine strategic aims for the development of psychological therapy services in the Trust and an associated thirty-five action points to ensure delivery of the strategy over a three year period. Volume two provides a comprehensive summary of psychological therapy services provided by the Trust and benchmarks these services against quality indicators. Volume three addresses the growth and development of psychological therapy services in Camden and Islington, focussing upon workforce development, business growth, research and development and staff support.

Recommendation to the Board

The Board of Directors is requested to:

- approve this strategy, including its incorporated action points.

Trust Strategic Priorities Supported by this Paper

Excellence

- Continually improve the quality and safety of service delivery, service user experience and improving outcomes.
- Delivering the highest level of quality and financial performance.
Innovation

- Rapidly adopt best practice and maintain a culture of innovation in service development.

Growth

- Pursue organic and inorganic growth opportunities through strategic partnerships and research and development.

Risk Implications

Failure to implement the strategy jeopardises the provision of a comprehensive programme of accessible NICE compliant therapies and the development of a psychologically informed workforce that is equipped to deliver positive outcomes and cost-effective services.

Legal and Compliance Implications

None.

Finance Implications

Many elements of this strategy, such as workforce development, R&D, staff support and staff training, are cost-neutral or involve only a marginal increase in expenditure, and may ultimately deliver cost-savings through increased efficiency and effectiveness of services. The implications of the ‘Opportunities for Growth’ section are that we will need to invest to create a more substantial business team that can operate effectively in a competitive health market. Similarly we will need to invest to develop an IT infrastructure that enables the delivery of a broad range of digital therapies that offer service users the range of choice, access and quality that they expect. The three year aspirations for increased resources for psychology services have significant cost implications. In the climate of reduced funding for secondary care services much of this will be difficult to achieve other than through service re-design that is compatible with new investment in primary and integrated care.

Single Equalities Impact Assessment

N/A

Requirement of External Assessor/Regulator

This report is not related to any specific requirements of any external assessor or regulator.
Camden & Islington Psychological Services
Strategy
2015-2018
Volume 1:
STRATEGIC OVERVIEW
Jeff Halperin
Head of Psychology and Psychotherapy Services
Camden and Islington
Mental Health NHS Foundation Trust
September 2015
CONTENTS

1.0 Introduction to the strategy documents 4

2.0 Psychological Services in C & I NHS Trust 4

3.0 The local and national context 5

4.0 The strategy 7

References 14

Appendix: Action Plan 15
1.0 Introduction to the strategy documents

The Camden and Islington NHS Trust Psychological Services Strategy 2015-2018 is comprised of three documents, the second and third of which provide the information and background that has informed the development of the strategy.

1. Volume I: The Psychological Services Strategy Overview provides a local and national context for the development of the psychological therapies strategy for the Trust. It then identifies the key elements of the strategy, and the action points to enable delivery of the strategy.

2. Volume II: The Description of Psychology Services and Quality Indicators provides a comprehensive description of all the psychological services in the Trust, and benchmarks them against key indicators of quality in the NHS: effectiveness, accessibility, service user participation, carer experience, and the morale and wellbeing of the workforce.

3. Volume III: The Growth and Development of Psychological Services focuses on:
   - Advancement and innovation in the Trust's psychological services.
   - Fostering a skilled and effective psychological therapies workforce.
   - Developing an effective psychological therapies training strategy for the Trust.
   - Forging opportunities for improving our commercial position and share in the healthcare market.
   - Building a more resilient workforce.
   - Driving forward research and collaboration with academic partners to develop cutting-edge services.

2.0 Psychological Services in Camden & Islington NHS Trust

Historically, psychological therapies have thrived in Camden and Islington, and have been well supported by the Trust. The psychological therapy services have a professional lead carrying responsibility for psychology and psychotherapy services within the Trust, and reporting to the Director of Nursing and People. The therapies are well represented in all the Divisions of the Trust, and each Division has a psychology lead contributing to strategy and planning for that Division and providing professional leadership.

The full range, scope and staffing of psychological services in the Trust is described in Volume II of the strategy documents.

It is important to stress that while this strategy focuses on our specialist psychological therapy staff, it also takes the perspective that all Trust staff are part of our psychological therapy services.
3.0 The local and national context

The profile of psychological therapies has risen significantly over the last five years. The development of Improving Access to Psychological Therapies (IAPT) has seen an unprecedented expansion of psychological therapy provision for common mental health disorders.

The increasing evidence base for psychological therapies across the spectrum of mental health presentations also means that the psychological therapies have become fundamental to service planning. The culture shift towards evidence-based interventions, and the resulting focus on outcome and effectiveness, sits well with psychological models of intervention.

The psychological therapies can make a difference both to individual patient experience and to the overall functioning of the healthcare system by, for example:

- Reducing bed-days and re-admissions, and the unnecessary use of A&E and GP resources
- Improving outcomes with long-term conditions.
- Moving people with chronic and treatment resistant presentations towards recovery.
- Providing effective interventions for the large population with common mental health disorders.

With the imperative to create a mental health workforce that has the skills to deliver positive outcomes, psychology has a key role to play in enhancing staff capacity to work with psychological formulation and also to be able to deliver direct, brief psychological interventions.

The current economic climate presents a major challenge. The growth in NHS spend in the early years of this century has been replaced by annual efficiency savings that are impacting on core services, and this is likely to continue for the foreseeable future.

Despite the investment in, and creation of, some excellent local services, London boroughs such as Camden and Islington still face the task of tackling high mental health need. The population is transient and diverse, and is characterised by high unemployment, poor housing, economic and social deprivation, and very disruptive levels of substance misuse.

There is an over-reliance on secondary care support, a sub-optimal interface between primary and secondary care, severe pressure on acute beds, and waiting lists in some areas are still too long for psychological therapies. At the interface between mental and physical health psychological, morbidity continues to contribute significantly to poorer health outcomes for many people with long-term conditions.

Yet there are many opportunities for growth and innovation. Recent government publications provide a manifesto for action for mental health services (see Refs.1, 2, 3 & 4), and the government has committed to “parity of esteem” and “closing the gap” between the standards and quality of delivery for physical and mental health care.
Further, the re-design of services required to meet efficiency savings necessitates a review of skill mix, and more creative and effective use of existing resources. As we look ahead, we can be optimistic about several areas of development for the psychological therapies:

- IAPT continues to attract government support and good performance is being incentivised. There are also the recent IAPT developments for people with severe mental illness (IAPT-SEMI), older adults, children and young people, and for people with medically unexplained symptoms (MUS)/long-term conditions.
- The new Integrated Practice Unit (IPU) for people living with psychosis provides an opportunity for advancing NICE guideline interventions on psychology.
- The recent emphasis on psychological therapies will be reinforced by waiting list targets for mental health, which will highlight areas of need and may inform funding priorities.
- The digital revolution in healthcare has already impacted on psychological therapies, and promises further opportunities for investment in innovative approaches to accessing and delivering therapies and managing care.
- Patient Choice offers genuine opportunities for service growth, notably targeting people who commute to work in central London.
- There is investment in transition services for young people making the difficult move from child and adolescent services to adult provision.
- New contracts will continue to come up for tender, notably for IAPT.
- There is commitment to increasing and improving acute and crisis care services – notably, early intervention services (EIS) – and the need to develop models of care that ensure prompt and high-quality care for those in most urgent need.
- As traditional models of long-term support evolve into interventions that emphasise recovery and social inclusion, inventive and transformative solutions are required that emphasise wellbeing and resilience.
- The move to integrated and primary care provision promises a revolution in service delivery. The divide between primary, secondary and social care has been a barrier to personalised and co-ordinated health services, and is being deconstructed. The new primary care services will challenge mental health professionals to develop the requisite skills for the new task. It will also see a move of resources from secondary to primary care services, and an emphasis on the effective management of mental health and long-term physical conditions in the community. Services will be driven by co-production, with service users identifying goals that reflect their needs, aspirations and sense of personal significance. This presents an opportunity for psychology to promote models of resilience and wellbeing, to design management and crisis plans that can be delivered by primary care staff, and to provide training to staff to deliver these services and support service users on this journey. There will be the task of deciding what are the specialist therapies that might sit in secondary care, and what is best delivered in primary care (this must reflect, of course, the evidence base), and of creating an effective stepped care pathway between the two. IAPT already has an excellent and very effective presence in primary care, and will be an essential part of this new configuration. There may also be a need to re-organise secondary care specialist services and create more of a centralised resource in the interests of economies of scale – though not at the expense of the successful
integration of specialists and core services that we have been developing, such as in personality disorder (PD) and complex depression, anxiety and trauma (CDAT) services.

- The re-development of the St Pancras site will provide opportunities for new and creative collaborations, especially with research partners that may be co-located, and for psychology to develop a high profile in delivering and evaluating cutting-edge interventions and offering highly specialist assessments.

In summary, the context of rapid change and service redesign in the NHS provides an opportunity for psychological therapies to be leaders in innovation and development, working with our local academic partners to offer quality and choice to service users.

This requires psychology to have a higher profile in forming and advancing Trust strategy, and to actively support the development and growth of Trust business.

The task for psychological services is:

- To be genuinely effective, flexible, lean, and affordable.
- To drive forward the outcomes and recovery agenda.
- To engage pro-actively with the corporate and strategic life of the Trust as it meets the challenge of re-shaping healthcare delivery.
- To embody the core values of healthcare, as described in the 2013 Francis Report on the public inquiry into Mid Staffordshire Foundation Trust (see Ref.5), reflecting the humane, as well as the economic, imperatives of the NHS.

4.0 The Strategy

This psychological services strategy supports the Trust clinical strategy in striving for excellence, efficiency, quality and innovation, driving forward the recovery agenda and offering service users the best possible experience of care. The nine key elements of the strategy are summarised in the text boxes below. Each box describes an element of the strategy, and the action points to support the strategy. Psychology service leads in each Division will use the strategy to inform their annual service objectives, and progress against action points will be monitored as part of an annual appraisal conducted with the Trust Head of Psychology and Psychotherapy and the Divisional Clinical Directors. The action points for each psychology service will also be addressed in the Quality Forums for that Division.

Each section of the document identifies action points, and these are listed in full in the Appendix, with page numbers indicating where they can be located in the documents, and the timescales and responsibility for implementation.

**ACTION POINT 1**
The Action Plan will be the basis for an annual review of the psychology service in each Division.
STRATEGY 1

To drive the delivery of high-quality, NICE-concordant psychological assessment and therapy services.

- Deliver effective services with good outcomes.
- Support the recovery agenda.
- Facilitate access to psychological therapies.
- Enhance service user experience, and support the co-production of services.
- Improve support to carers.
- Reduce waiting times for assessment and treatment.
- Support psychological therapy service plans for growth within each Division.

ACTION POINTS

1. Psychological therapy services to develop a consistent approach to collecting and reporting outcomes.
2. Psychological therapy services to promote the use of outcome measures across all services in their Division.
3. Psychology leads to have a stronger engagement with the commissioning process in relation to decisions about outcome reporting.
4. Each psychology service to develop a coherent and consistently applied service user strategy, and to report on service user engagement as part of the annual service appraisal.
5. Develop a carer's support policy for all psychology services.
6. Psychology services to develop business cases for increased resources as appropriate. (Individual service need identified in volume two.
7. Increase availability of evening and weekend clinics for psychological therapies.
To build a modern psychological therapies workforce that is accountable, flexible and cost-effective, and with the necessary skill-mix to deliver positive outcomes.

- Effective workforce planning.
- Increase diversity in the workforce.
- Increase the accountability of the workforce: Job Plans and 360° feedback.
- Develop leadership and management skills.
- Update continuing professional development (CPD) modules for newly-qualified staff to build competencies for new service configurations.
- Develop and maintain skills through supervision and training.
- Creative job design across Divisions to support career progression and staff retention.

**ACTION POINTS**

1. Convene a working group to devise a protocol for Job Planning.
2. Convene a working group to establish a system for 360° assessment and feedback.
3. Develop a learning set on leadership and management for staff at Band 8b and above.
4. Re-launch the learning set on leadership and management for Band 8a staff.
5. Design psychology posts with sessions in clinical governance.
6. Create business development roles for psychologists within Divisions.
7. Psychological Therapies Training Strategy Group (PTTSG) to review CPD modules to reflect new evidence and emerging roles for psychological therapy staff.
8. Review recruitment strategy for psychological wellbeing practitioners (PWPs) to explore the possibility of creating a more stable workforce.
9. Psychology leads to revise/review job designs and create more posts that facilitate a broader range of skills development, and to collaborate around development of cross-division posts.
STRATEGY 3

To develop leadership and management skills that bring psychology into the heart of the organisation.

- Re-launch the business and management learning set for Band 8a staff.
- Develop a learning set on business & management for staff at Band 8b and above.
- Identify talent and encourage and support management and leadership training.
- Design psychology posts with sessions in clinical governance.
- Create business development roles for psychologists within Divisions.
- Ensure the full integration of Psychology Divisional Leads in the development of the strategic work of their Division.

ACTION POINTS

1. Develop a learning set on leadership and management for staff at Band 8b and above.
2. Re-launch the learning set on leadership and management for Band 8a staff.
3. Identify talent, and encourage and support management and leadership training.
4. Design psychology posts with sessions in clinical governance.
5. Create business development roles for psychologists within Divisions.
STRATEGY 4

To enhance, through training, the capacity of all Trust staff to provide psychologically-informed care that promotes the recovery and wellbeing of all service users across the Trust.

- Work in partnership with L&D and Divisional and professional leads to develop workforce training plans.
- Maximise the delivery of NICE-concordant specialist Type 3 psychological therapies.
- Maximise the delivery of Type 1 and Type 2 interventions in each of the Divisions.
- Maximise the delivery of psychologically-informed care across all Divisions.
- Provide reflective practice and skilled supervisory support to Trust teams.
- Support professional training.

ACTION POINTS

1. Develop a Behavioural Family Therapy (BFT) training post in the Trust to support Type 3 therapy provision.
2. Prioritise training in Type 1 and Type 2 competencies in each Division.
3. Develop training in group-work skills across the Trust.
4. Explore the application of structured case management across Divisions.

STRATEGY 5

To lead in the development of new models of care in the context of major service redesign and redistribution of resources to primary care.

- Ensure the full engagement of Psychology Divisional Leads in the development of strategic work, within and across Divisions.

ACTION POINTS

1. Create business development roles for psychologists within Divisions.
2. Ensure the full integration of Psychology Divisional Leads in the development of the strategic work of their Division.
STRATEGY 6

To grow the psychological therapy services and develop our commercial position and share in the healthcare market.

- Bid for stand-alone psychology services.
- Bid for local funds to increase resources.
- Exploit Patient Choice.
- Exploit the market potential of specialist services.
- Explore the local private employment market.
- Deliver our products to other service providers and institutions.
- Develop Digital Solutions to service delivery.
- Develop new partnerships with voluntary sector and other key providers.

ACTION POINTS

1. Bid for stand-alone psychology services.
2. Bid for local funds to increase resources.
3. Explore the patient choice agenda.
4. Exploit the market potential of specialist services.
5. Explore local private employment market.
6. Provide consultation, training, teaching and service support to other provider services and educational institutions.
7. Establish links with University College London (UCL) and other research agencies developing digital solutions to service delivery.
8. All new service design should consider digital innovation as part of service configuration and delivery.
9. Extend the use of existing digital solutions in services.
10. Psychology services to play significant role in the development of a Trust-wide approach to the development of a digital technology program for psychological therapies.
**STRATEGY 7**

To pro-actively support and develop strategies and interventions to promote resilience in the Trust workforce.

**ACTION POINTS**

1. Contribute to the development of a Trust-wide approach to staff support and within-team analysis of points of stress.

**STRATEGY 8**

To develop new partnerships with research institutions that will raise our profile in developing innovative therapies that offer quality and choice to service users and strengthen our position in the healthcare market

- Develop lead posts within each Division to enhance research links with local and national academic institutions, and promote research funding applications.
- To exploit the potential collaborations that will follow the development of the new St Pancras site.

**ACTION POINTS**

1. Establish links with UCL and other research agencies developing digital solutions.
2. Development of more research posts to enhance research links with local and national academic institutions, and promote research funding applications.
STRATEGY 9

To embody the core values of healthcare as described in the Francis Report, reflecting the humane, as well as the economic, imperatives of the NHS.

- Deliver services with genuine quality.
- Support the wellbeing of staff charged with the challenging role of delivering high-volume/low-cost services to people in distress.

ACTION POINTS

1. Psychology leads to revise/review job designs, create more posts that facilitate a broader range of skills development, and collaborate around development of cross-division posts.
2. Contribute to the development of a Trust-wide approach to staff support and within-team analysis of points of stress.

References

2. Closing the Gap. The Department of Health 2014
4. NHS England: Five Year Forward View
7. Quality in the new health system, National Quality Board 2013
8. The Triangle of Care. The National Carers Strategy, Carers Trust 2010
## APPENDIX: ACTION PLAN

**Camden and Islington NHS Trust**

**Psychological Services Strategy 2015-2018**

<table>
<thead>
<tr>
<th>Action Point No.</th>
<th>Reference</th>
<th>Action Point</th>
<th>Responsible person</th>
<th>Involved others</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Volume 1 Page</td>
<td>The Action Plan will be the basis for an annual review of service in each Division</td>
<td>Head of Psychology &amp; Psychotherapy</td>
<td>To review with Divisional Clinical Directors</td>
<td>Annually</td>
</tr>
</tbody>
</table>

### Increasing Accountability of the Workforce


### Developing leadership and management skills

| 4 | Strategies 2,3 & 9 Volume 3 Page | Develop a learning set on leadership & management for staff at Band 8b and above. | Head of Psychology & Psychotherapy | TBC + L&D | January 2016 |
| 5 | Strategies 2,3 & 9 Volume 3 Page | Relaunch the learning set on leadership and management for Band 8a staff | Head of Psychology & Psychotherapy | TBC + L&D | April 2016 |
| 6 | Strategy 3 Volume 3 Page | Identify talent, and encourage & support management and leadership training. | Psychology Divisional Leads | | Ongoing |
| 7 | Strategies 2 & 3 Volume 3 Page | Design psychology posts with sessions in clinical governance | Psychology Divisional Leads | Clinical Governance leads | Ongoing |
| 8 | Strategies 2, 3 & 5 Volume 3 Page | Create business development roles for psychologists within Divisions | Psychology Divisional Leads | Divisional Directors | Ongoing |
| 9 | Strategy 5 Volume 3 Page | Ensure the full integration of Psychology Divisional Leads in the development of their strategic work of their | Psychology Divisional Leads | Head of Psychology and Psychotherapy | Ongoing |
### Developing and maintaining skills

|   | 10 | Strategy 2 Volume 3 Page | Psychological Therapies Training Strategy Group (PTTSG) to review CPD modules to reflect new evidence and emerging roles for psychological therapy staff. | PTTSG Chair | PTTSG | Ongoing |

### Career progression and staff retention

|   | 11 | Strategy 2 Volume 3 Page | Review recruitment strategy for PWP’s to explore possibility of creating a more stable workforce | IAPT Lead | Ongoing |

|   | 12 | Strategies 2 & 9 Volume 3 Page | Psychology leads to revise/review job designs & create more posts that facilitate a broader range of skills development & to collaborate around development of cross-division posts. | Psychology Divisional Leads & Head of Psychology and Psychotherapy | Ongoing |

### Demonstrating effectiveness

|   | 13 | Strategy 1 Volume 3 Page | Psychological therapy services to develop a consistent approach to collecting and reporting outcomes | Psychology Divisional Leads | Divisional Directors | September 2016 |

|   | 14 | Strategy 1 Volume 3 Page | Psychological therapy services to promote the use of outcome measures across all services in their Division | Psychology Divisional Leads | September 2016 |

|   | 15 | Strategy1 Volume 3 Page | Psychology leads to have a stronger engagement with the commissioning process in relation to decisions about outcome reporting | Psychology Divisional Leads | Divisional Directors |
## Service user involvement

<table>
<thead>
<tr>
<th></th>
<th>Strategy</th>
<th>Volume</th>
<th>Description</th>
<th>Psychology Divisional Leads</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>Strategy1</td>
<td>3 Page</td>
<td>Each psychology service to develop a coherent and consistently applied service user strategy and to report on service user engagement as part of the annual service appraisal.</td>
<td>September 2016</td>
<td></td>
</tr>
</tbody>
</table>

## Supporting carers

<table>
<thead>
<tr>
<th></th>
<th>Strategy</th>
<th>Volume</th>
<th>Description</th>
<th>Psychology Divisional Leads</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Strategy 1</td>
<td>3 Page</td>
<td>Develop a carer’s support policy for all psychology services.</td>
<td>September 2016</td>
<td></td>
</tr>
</tbody>
</table>

## Improving access to services

<table>
<thead>
<tr>
<th></th>
<th>Strategy</th>
<th>Volume</th>
<th>Description</th>
<th>Psychology Divisional Leads</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>18</td>
<td>Strategy1</td>
<td>2&amp;3 Page</td>
<td>Increase availability of evening and weekend clinics for psychological therapies.</td>
<td>TBC Estates</td>
<td>January 2016</td>
</tr>
<tr>
<td>19</td>
<td>Strategy1</td>
<td>3 Page</td>
<td>Psychology services to develop business cases for increased resources as appropriate. (Individual service need identified in section 5).</td>
<td>Psychology Divisional Leads</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>

## Opportunities for growth

<table>
<thead>
<tr>
<th></th>
<th>Strategy</th>
<th>Volume</th>
<th>Description</th>
<th>Psychology Divisional Leads</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Bid for stand-alone psychology services</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>21</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Bid for local funds to increase resources</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>22</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Explore the patient choice agenda</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>23</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Exploit the market potential of specialist services</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>24</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Explore local private employment market</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>25</td>
<td>Strategy 6</td>
<td>3 Page</td>
<td>Consultation, training, teaching and service support to other provider services and educational institutions</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>26</td>
<td>Strategies 6 &amp; 8</td>
<td>3 Page</td>
<td>Establish links with UCL and other research agencies developing digital solutions</td>
<td>TBC</td>
<td>January 2016</td>
</tr>
<tr>
<td>Strategy 6</td>
<td>Volume 3 Page</td>
<td>All new service design should consider digital innovation as part of service configuration and delivery</td>
<td>Psychology Divisional Leads</td>
<td>IT Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------</td>
<td>--------</td>
</tr>
<tr>
<td>28</td>
<td>Strategy 6 Volume 3 Page</td>
<td>Extend the use of existing digital solutions in services</td>
<td>Psychology Divisional Leads</td>
<td>IT Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>29</td>
<td>Strategy 6 Volume 3 Page</td>
<td>Psychology services to play significant role in the development of a Trust-wide approach to the development of a digital technology program for psychological therapies.</td>
<td>Head of Psychology and Psychotherapy</td>
<td>IT Department + TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

**Training Strategy**

<table>
<thead>
<tr>
<th>Strategy 4</th>
<th>Volume 3 Page</th>
<th>Develop a of Behavioural Family Therapy (BFT) training post in the Trust to support Type 3 therapy provision</th>
<th>R&amp;R Psychology Divisional Lead</th>
<th>Head of Psychology and Psychotherapy</th>
<th>April 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Prioritise training in Type 1 and Type 2 competencies in each Division</td>
<td>Psychology leads</td>
<td>In liaison with divisional leads and L&amp;D</td>
<td>January 2016</td>
</tr>
<tr>
<td>31</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Develop training in group-work skills across the Trust</td>
<td>Psychology Training lead for group-work</td>
<td>Head of Psychology and Psychotherapy + PTTSG</td>
<td>Ongoing</td>
</tr>
<tr>
<td>32</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Explore the application of structured case management across Divisions</td>
<td>Psychology Lead (PD)</td>
<td>Trust Divisional Leads TBC</td>
<td>September 2016</td>
</tr>
</tbody>
</table>

**Staff Support**

<table>
<thead>
<tr>
<th>Strategies 7 &amp; 9</th>
<th>Volume 3 Page</th>
<th>Contribute to development of a Trust-wide approach to staff support and within-team analysis of points of stress.</th>
<th>Psychology Leads</th>
<th>Collaboration with L&amp;D and Occupational Health</th>
<th>January 2016</th>
</tr>
</thead>
</table>

**Research and Development**

| Strategy 8 | Volume 3 Page | Development of more research posts to enhance research links with local and national academic institutions & promote research funding applications | Divisional Psychology Leads | R&D Committee | Ongoing |
Camden & Islington Psychological Services Strategy 2015-2018

Volume 2: Psychological Therapy Services and Quality Indicators
Jeff Halperin
Head of Psychology and Psychotherapy Services
Camden and Islington
Mental Health NHS Foundation Trust

September 2015
CONTENTS

Introduction 4

Section 1 4

The Psychological Therapy Services: A Description of Services by Division
1. Services for Ageing and Mental Health Division (SAMH) 4
2. Learning Disabilities Service 6
3. Substance Misuse Services (SMS) Division 9
4. The Acute Division 10
5. Rehabilitation and Recovery Division (R&R) 12
6. Community Mental Health Division 14
   6.1 Improving Access to Psychological Therapies (IAPT) 14
   6.2 Complex Depression, Anxiety and Trauma (CDAT) .... 16
   6.3 Traumatic Stress Clinic (TSC) 17
   6.4 London Veterans Service 18
   6.5 Personality Disorder Service 20
   6.6 Clinical Health Psychology 22
   6.7 Psychodynamic Psychotherapy Service 24
   6.8 Camden and Islington Transitions Services 28
   6.9 Camden Parents Wellbeing Service 30
   6.10 Islington Parents Mental Health Service (Growing Together) 31
   6.11 The Gangs Projects 32
   6.12 Other Community Services with Psychology input 33

Section 2 35

Benchmarking Services against Quality Indicators 35
1.0 Demonstrating effectiveness 35
2.0 Service User Experience and Co-Production 37
3.0 Supporting Carers 40
4.0 Facilitating Access to Psychological Therapies 41
   4.1 Waiting Times for Assessment and Treatment. 42
   4.2 Service Location 43
   4.3 Access for BME and under-represented Groups 43
Introduction

Section One provides a comprehensive description of the psychological therapies services offered by each Division of the Trust. This includes an account of the aims, scope and staffing of each service, the merits and deficiencies in service performance and plans for the development of each service over the next three years.

Section Two benchmarks the services against key indicators of quality in the NHS: effectiveness, accessibility, service user participation, carer experience, and the morale and wellbeing of the workforce.

The appendix at the end of the document presents a summary of all the action points supporting implementation of the psychological services strategy.

Section One

The Psychological Therapy Services: A Description of Services by Division

The psychological therapy services have a professional lead carrying responsibility for psychology and psychotherapy services within the Trust. Each Division has a psychology lead, who is professionally accountable to the Head of Psychology and Psychotherapy, and who contributes to the strategy and planning of services and provides professional leadership within their Division. These relationships are represented in the structure chart below. A similar structure chart is presented for all of the services described in this section.
1. Services for Ageing and Mental Health Division (SAMH)

Aims of the Service

- To provide high-quality, evidence-based psychological therapies to service users and carers in SAMH. This includes people with dementia and those with functional mental health needs, including depression, anxiety and psychosis.
- To be active participants at all levels of service activity (e.g. from Divisional Management Meetings to MDT meetings) to ensure the delivery of psychologically-informed practice across the division.
- To enhance the psychological care of older people and their carers through supervision, training and consultation

Scope of Service

The SAMH psychologists deliver sessions to the Islington Memory Assessment and Treatment Service (MATS), Camden Memory Service (CMS), Camden and Islington Community Mental Health Teams (CMHTs), the In-Patient Wards and the Community Recovery Service for Older People (CRSOP). In the memory services, psychologists lead on delivery of Cognitive Stimulation Therapy (CST) for people with dementia, a manualised intervention for carers of people with dementia – the Strategies for Relatives (START) project (see Section 2 no.2) – and neuropsychological assessment. Elsewhere in SAMH, psychologists offer a range of interventions for complex presentations, including challenging behaviour to individuals, families and groups.
The psychologists in SAMH have developed a strong culture of systemic practice. The model informs their work with older people and their carers, and is applied to consultation with staff teams (e.g. in residential care and in-patient services) and to staff training. It underpins the delivery of “Tree of Life” groups (see below), work with service users, and the management of referrals.

(Tree of Life therapy enables people who have experienced disadvantage and distress to draw their own “tree of life”, in which they get to speak of their “roots”, where they come from, their skills and knowledge, their hopes and dreams, as well as the special people in their lives. The participants then join their trees into a “forest of life” and, in groups, discuss some of the “storms” that affect their lives, and ways that they respond to these storms, protect themselves, and each other).

The Next Three Years

The service is looking to fill several gaps in provision and resourcing:

- At present, there is no psychology resource for two recent service developments – the Home Treatment Team (HTT) and Care Home Mental Health Liaison Team. Both teams would benefit from a half-time senior post (B8a) as they involve a significant level of indirect work and staff consultation.
- Camden has a shortfall (relative to Islington) of resource for START (at B4 and B7 staff levels). The CMHT in Islington would benefit from an Assistant Psychologist, as there is in the Camden CMHT
- The psychology service would benefit from a specialist post to provide neuropsychological supervision and training. This expertise could be funded across the Divisions and offer a resource to all services.
- The existing Community Recovery Service for Older People Post (CRSOP) is only funded at 0.2 whole time equivalent (wte). This post would be more effective if it was expanded.
2. Learning Disabilities Service

Aims of the Service

To enable adults with learning disabilities to lead as fulfilled and independent lives as possible through support provided directly to service users, their family and paid carers, and by enabling mainstream services to make reasonable adjustments to meet their needs.

Scope of Service

The psychologists in the Learning Disabilities Service provide sessions to the Camden Learning Disabilities Service (CLDS), Islington Learning Disabilities Partnership (ILDP), Acute Admissions In-Patient ward (specialist LD beds on Dunkley ward) and other wards, as appropriate. Planned developments include the delivery of a clinical service to Alexandra College – the first London-based Further Education provision for young people with special education needs and disabilities, scheduled to open in September 2015, and eventually providing 50 places – and a short-breaks respite service to people aged 16-25 who have profound LD and/or Autistic Spectrum Conditions.

The psychologists in the Learning Disabilities Service (Islington) have developed a strong culture of systemic practice. The model informs their work with people affected with learning disabilities, their carers and wider networks. It is applied to consultation with staff teams (e.g. in residential care and in-patient services) and staff training, in the delivery of network meetings, and to their work with service users who have learning disabilities, and their networks.
The Next Three Years

- There is lack of clarity in service arrangements for people aged 16-18 with LD.
- There is a need for service development for adults with Autistic Spectrum Disorder, in the absence of global LD.
- To enhance Positive Behavioural Support (PBS) approaches across LD services in both boroughs.
- To contribute more to enabling other Trust services and agencies to make reasonable adjustments to meet the needs of people with learning disabilities.
- To continue to strengthen the integrated health and social care approach to providing services for adults with LD.
- To enhance the local community services for people with LD and mental health problems to best ensure that people do not need admission, especially to out-of-borough Assessment and Treatment (A&T) units – in line with Winterbourne View Joint Concordat and Improvement Plan.
3. Substance Misuse Services (SMS) Division

Aims of the Service

Improving outcomes through the delivery of evidence-based psychosocial interventions, directly to service users and also indirectly through supervision and training for our services in Camden, Islington and Westminster. The role is comprehensive, involving the provision of direct (face-to-face) and indirect clinical services through consultancy, training, and supervision. Specific priorities are:

- Guiding the referral process through participation in multidisciplinary team meetings (usually weekly) to ensure service users who are likely to benefit from psychological interventions are seen promptly.
- Delivering a range of evidence-based psychological interventions spanning the spectrum of cognitive behavioural, systemic and acceptance and mindfulness approaches.
- Provision of specialist neurocognitive psychological testing.
- Ensuring audit and service evaluation is completed in accordance with Foundation Trust standards and requirements. Senior staff are responsible for this on a borough-wide basis, with more junior staff involved in data collection and analysis.

Scope of Service

Psychologists work in all the core teams:

- South Camden Drug Service (SCDS)
- North Camden Drug Service (NCDS)
- Integrated Camden Alcohol Service (ICAS)
- Islington Drug and Alcohol Specialist Services (IDASS)
- Islington Alcohol Specialist Services (ISATS)
- South Westminster Drug and Alcohol Service (SWDAS)

The psychology team is skilled in most cognitive behavioural therapy (CBT) variants, including Acceptance and Commitment Therapy (ACT) and Mindfulness. The team has specialist neuropsychological skills, and is active in supervision and training with the workforce. Psychologists have been at the forefront of efforts to comply with key performance indicators of sustained recovery by a specified proportion of service users. The psychology service has taken a Trust-wide role providing training to staff in fostering "resilience", managing substance misuse in the context of serious or enduring mental health difficulties, and supervising staff on the in-house cognitive behaviour therapy course.

The Next Three Years

The most important gap is in providing sufficient support to other Divisions in the collaborative management of substance misuse problems. Given the well-documented high level of substance misuse associated with admission to acute wards, this is a high priority and needs to sit with more effective care pathways to the acute services. The SMS service will also be tendering for contracts in both boroughs, and will need to adapt to meet the new specification.
4. The Acute Division

Aims of the Service

- Prompt access to evidence-based psychological intervention (CBT, DBT, MBT and Behavioral Family Interventions) for service users in acute crisis (within one week of referral).
- Reducing acute distress and likelihood of re-occurrence.
- Reducing the length of stay and rates of re-admission.
- Training staff in core therapeutic skills and basic psychological interventions.

Scope of Service

The service offers intervention to the Trust’s ten acute wards, four crisis teams, two crisis houses, and two acute day units. The limited psychology resource means that there is no psychology resource for Drayton Park Women’s Crisis Centre, perinatal services, or the liaison teams at the Whittington, Royal Free or UCLH hospitals. The service is currently developing policies and a strategy with the Traumatic Stress Clinic (TSC) for providing emotional support after critical incidents within the Trust.

The Next Three Years

The psychology service for the Acute Division is under-resourced against the standards set by Accreditation for Inpatient Mental Health Services (AIMS) – see below. The staffing comprises 4wte, and these posts are spread across 17 services. There are several adverse consequences:

- The standard model of service delivery is two sessions per ward, and so the capacity to meet service demand is very limited and many service users will not have access to
evidence-based psychological therapies. The Trust Service User surveys have indicated that service users want increased psychology service on wards and in community teams.

- The psychology service is unable to deliver a full consultation, supervisory and training role to the Division – for example, low-intensity psychological interventions, basic engagement skills, and care planning/goal setting for non-psychology staff.
- The psychology team cannot contribute sufficiently to service development, project management, audit, the development of local research projects, and direct support for carers.
- The psychology team is unable to develop a full group programme for service users.
- The sustainability of jobs for staff with such multiple split-roles is a documented concern.

**Accreditation for Acute Mental Health Inpatient Services Service Standards (AIMS)**

To achieve accreditation, AIMS requires participating wards to provide a minimum amount of evidence-based psychological therapy and staff training. Mandatory standards of access to psychological therapy will come from the Home Treatment Accreditation Service (HTAS) – the sister accreditation service for crisis teams. The Care Quality Commission is looking to incorporate AIMS and HTAS standards in its regulatory strategy. As the Trust seeks to accredit its acute services via AIMS and its sister accreditation services, the psychology service will need to expand in order to achieve the minimum mandatory standard set. The Service Lead has prepared a business case for the expansion of psychological resources for the service. Increased staffing – including a broader skill mix – would help to remedy the service deficiencies identified above – particularly staff development with respect to the provision of low-intensity psychological therapies.
5. Rehabilitation and Recovery Division (R&R)

Aims of the Service

To provide psychological assessment, treatment and consultation for service users with psychosis and bi-polar disorders. The service aims to have minimum waiting lists, full staffing, incentives for staff retention, and a balance of interventions available in line with NICE guidelines – including family interventions.

Scope of Service

- The service offers psychology sessions to all of the Trust recovery and outreach teams (other than Focus, the Homeless Outreach Team) and the following rehabilitation wards and community units: Malachite Ward; Tile House; Cornwallis and Islington Re-ablement team; Montagu Ward and IST/Camden Re-ablement team; Hanley Gardens and Caledonian Road; 154 Camden Road; Aberdeen Park & Highview; Sutherland and Ward and the Islington Community Rehabilitation Team.
- The service provides the award-winning Kidstime project to support young people who have parents with mental illness. The project runs a monthly multi-family workshop for parents and children, where children are helped to better understand and live with their parent’s illness through a creative mix of education and drama. A recent evaluation provided evidence that the groups significantly diminish the children’s level of distress and improve the quality of caring by parents.
- The service is successfully building a rolling programme of group-work. A bipolar group for service users from the four recovery and two Early Intervention Service (EIS) teams is in place, and a successful programme of ACT (Acceptance and Commitment Therapy) in psychosis groups for service users from the four recovery teams has also been developed. Further, three CBT groups in EIS (psycho-education, mood management, managing distressing beliefs) have been run over the last year, and continue as a rolling programme.
- The psychology service has recently appointed a systemic family therapist, and has now established a referral pathway for systemic family therapy and consultation within the Recovery and Rehabilitation (R&R) Division.
- The service has contributed to the streamlining of the Meridian process (to improve service efficiency) for R&R, working with non-psychologist managers to draw up realistic job plans across the different disciplines.

The Next Three Years

Waiting list for CBT and Behavioural Family Therapy (BFT) for Psychosis in the Recovery and EIS teams

The service is benefiting from waiting-list funding that has enabled it to appoint 3.1 wte additional staff, and this has been renewed for a second year. The waiting list had stood at an unacceptable 10 months average for psychological interventions in these teams.
However, this additional resource is only half of the additional funding that was required to clear the waiting lists, and the service aspiration in the longer term must be to increase the substantive staffing by six wte posts. There is a strong evidence base for this work with the IAPT-SMI (Increasing Access for Psychological Therapies for people with Severe Mental Illness) pilot sites across the UK, demonstrating positive results and recommending a minimum of 16 CBT sessions and/or 10 BFT sessions provided by psychologists or other suitably trained staff. Recent research suggests a possible evidence base for six-session low intensity (LI) CBT interventions, providing behavioural activation for low mood and exposure treatments for anxiety for service users with psychosis. This could be delivered by non-psychologists in the teams to broaden the scope of psychological intervention in R&R, but would not be a replacement for a standard CBT intervention. The provision of formal CBT across the R&R services by care co-ordinators is still very limited, needs development (??see section 6), and requires ongoing supervision by psychologists to make it work.

**Focus (Homeless Outreach Service)**
The Focus service continues to be the one R&R team without psychology input. A bid for funding for a 0.5 wte band 8a post has recently been made to the Camden Prevention Challenge Fund administered by London Borough of Camden, and a decision is awaited.

**Rehabilitation Psychology Service**
The psychology service will contribute to the bid for the new Tredgold Ward as this will need specialist psychology provision.

**Family work: Systemic Interventions and BFT**
The service now has one Family Therapist in post (0.5 wte across the two boroughs) to provide family therapy interventions and consultation, and has established a care pathway for family therapy referrals. The service is looking to pilot, on a very small scale, the use of the Open Dialogue approach (through Network Meetings) with a small number of complex cases over the next year. This will need substantial buy-in by management if it is to have a significant impact upon services.

Several members of the service have now been trained in BFT, and have ongoing external supervision. However, the Trust has no dedicated trainer in BFT, and it is not realistic for this role to be taken on by an existing member of the service. BFT is a key component of NICE guidelines for psychosis and bipolar, and is also recommended for a number of other conditions covered by other divisions in the Trust. The need to develop such a position is discussed in (see volume 3, section 3.1) on the training strategy for the Trust.
6. Community Mental Health Division

6.1 Improving Access to Psychological Therapies (IAPT)

Aims of the Service

The IAPT service provides NICE guideline compliant treatments for common mental health disorders (anxiety and depression). The service operates a stepped care model that is predominantly based in primary care. The low intensity treatments (delivered by Psychological Wellbeing Practitioners (PWPs) comprise: guided self-help; computerised CBT; medication adherence support; a wide range of psycho-educational groups; support with accessing community resources (including employment); Exercise on Prescription; Books on Prescription; and supported web-based psycho-educational courses. The high intensity interventions (delivered by Clinical and Counselling Psychologists, and Psychological Therapists) include: CBT (individual and group); interpersonal psychotherapy; couples therapy; counselling; short-term psychodynamic psychotherapy; Mindfulness for recurrent depression and Eye Movement Desensitisation and Reprocessing Therapy (EMDR) for PTSD. The services work in close collaboration with key stakeholders, including training and employment agencies, and, in Camden, the Trust has a sub-contract relationship with four voluntary sector partners, with the Trust as lead provider. The Trust IAPT services have an excellent reputation for delivering inclusive, accessible, effective and innovative services.

Scope of Service

C&I Trust runs the IAPT services for Camden, Islington and Kingston. The services are required to meet a target of seeing 15% of the local population with common mental health problems every year, and 11,400 service users in the last year entered treatment across the three boroughs. In Camden, the service is run with two other providers, and some of the service falls under Any Qualified Provider (AQP).
The Next Three Years

- **The development of IAPT as part of a primary care network**
  The aim is to develop an integrated and well-functioning primary care mental health service in Camden, Islington and Kingston. IAPT will be a key component, and the service will also meet the needs of a broader range of people with more complex problems who are also managed in primary care. This will require a multidisciplinary approach, with more access to social work and psychiatry.

- **More development of Long-Term Conditions (LTC) work**, with stronger links with LTC pathways and possible specialist roles in LTC – for example, Health Wellbeing Practitioners (HWPs) – and an emphasis upon collaborative care for people with LTCs and depression.

- **Greater use of technology through use of “blended therapies” – e.g. computer-aided therapies, APPS, and providing Skype therapy where appropriate.**

- **Improving access by providing more out-of-hours and weekend clinics.**

- **Increasing the limited availability of evidence-based therapies provided beyond individual and group CBT – e.g. Interpersonal Therapy, couples therapy, Dynamic Interpersonal Therapy, counselling – and reducing the waiting times for these therapies.**

- **Developing more specialist skills within IAPT teams, including working with older people, young people, and people with Mild Learning Disabilities and Long-Term Conditions.**

- **Increasing the efficiency of administrative functions in the teams, so that more administrative tasks are taken from clinicians in order to increase their clinical time and reduce waits for assessment and treatment.**

- **Further development of PWP roles (including HWPs, as mentioned above), and adoption of new Low Intensity (LI) interventions as they are developed.**

- **Model of continuing skills development for all staff.**

- **The embedding of research in the service to improve clinical outcomes.**

- **A staffing plan that takes into account annual or predictable fluctuations to reduce periods of staff shortages – due to training cycles/maternity leave – that have an inevitable impact on key performance indicators (KPIs).**

- **More emphasis on mental health promotion, and possibly funding this role as part of some PWP posts within IAPT.**

- **Developing systems for supporting other services that are offering support for people with longer-term difficulties – e.g. peer support projects.**

- **Greater specificity in identifying outcomes for different cohorts in IAPT, and so enabling development of more focused and tailored interventions.**

- **Ensuring we are able to meet the new KPIs and waiting time targets.**

- **Retaining the contract for Camden IAPT service when the contract goes out to tender (probably 2017).**

- **Developing new and leaner models of service delivery compatible with winning contracts at a time of reduced funding.**
6.2 Complex Depression, Anxiety and Trauma (CDAT) Service

Aims of the Service

To lead and develop a psychological approach in CDAT, providing evidence-based psychological therapy in conjunction with psychologically informed case management of complex cases, and devising innovative and sustainable models of care, including enhancing self-care.

Scope of Service

The CDAT team is psychology-led, and psychologists embedded in the team provide:

- Supervision of other team workers’ case work.
- Co-facilitating and supporting specialist group interventions within CDAT.
- Assessment and formulation of cases.
- Direct clinical intervention.
- Training of team members.
- Evaluation of care plan outcomes.

The Next Three Years

The CDAT service experiences very high levels of demand, and is slowly building a psychology resource from a very low base. In order to deliver a comprehensive psychologically informed service for all service users and direct clinical interventions to those who require them, the service will need the following structure and resourcing:
Home-Based Treatment Interventions

- Intensive Behavioural Activation for depression, requiring 3-5 visits per week for 2 weeks, fading to 2-3 for 2 weeks, then weekly (30 cases per year).
- Exposure and Response Prevention for OCD, requiring daily or twice daily visits for up to a month, and then phased out.
  
  **Staffing required:** 3 wte

Formulation-Based Psychological Therapies

20-30 session model and groups for 120 new patients a year.

**Staffing required:** 3wte

Systemic and Family Interventions

Systemic consultations for team, networks and family treatments for 20 cases per year.

**Staffing required:** 1 wte

Supervision, Training and Development

**Staffing required:** 1 wte

An effective service will require a mix of very well-trained and experienced clinical leaders and supervisors, along with some strong practitioners and trainees. The majority would be accredited psychological therapists, but a variety of professional backgrounds would be appropriate. The skill mix for the total resource of 8 wte would be a minimum of one 8b, two 8a posts, two B7s and three B5 Psychology Assistants/Psychological Wellbeing Practitioners. Some treatment would be provided by clinical psychology trainees, honoraries, psychiatric trainees and other members of the MDT under supervision. The predominant treatment model would be CBT, but supported by systemic interventions for complex family presentations.

Other Service Developments

- Development of digital-based care planning, and self-care platform/enhanced care platform (see volume three, section 2.7).
- The development of a clear step-down model to primary care.
- The development of closer collaboration with UCL around development of new treatments and supporting new research (see volume three, section 5.0).

**6.3 Traumatic Stress Clinic (TSC)**

**Aims of the Service**

Delivery of highly specialised evidence-based treatment for complex Post Traumatic Stress Disorder (PTSD), and the building of capacity across the Trust for managing and working with trauma. The service has a national reputation for excellence, hosted the London Bombings Project, and has won the contract for delivering care to veterans.
Scope of Service

- Provision of evidence-based treatments, including EMDR and Narrative exposure therapies for service users with PTSD, and multi-disciplinary input, including medication reviews and case management. The service attracts a large number of referrals and waiting lists have been problematic. In response to this, the service developed Phase One brief interventions to provide early symptom relief to those on waiting lists. The service has also been successful in attracting new funding, and several new posts have been created to address the waiting list problem.
- Training, supervision and support of IAPT staff in managing PTSD in primary care, and to facilitate cross-referrals in line with a stepped care model.
- Liaison with CDAT and the PD services to provide a joined-up package of care for service users with PTSD and with multiple and complex psychosocial needs, including those who may require access to CDAT/PD interventions.
- The provision of regular supervision, training and support to CDAT and IAPT and health psychologists at the Royal Free Hospital.
- The service is currently developing policies and a strategy, with the Acute Division, for providing emotional support after critical incidents within the Trust.
- Psychologists in the service are working closely with colleagues leading on Safeguarding and Vulnerable Adults, in relation to training staff around assessing for Female Genital Mutilation (FGM), as this has become a mandatory requirement for services.

The Next Three Years

- A lack of opportunity for career progression jeopardises the retention of experienced staff. This may, in some part, be compensated for by creative job design, involving split-posts with broader-based jobs developing care pathways with other Divisions.
- The development of expertise in addressing the needs of childhood sexual abuse survivors and dissociative disorders.
- Managing the waiting list continues to be a priority. The service needs to lobby for retention of the recently-funded posts.
- The development of more integrated treatment packages for survivors of trauma with comorbid substance misuse and chronic pain.
- Managing the needs of service users with sub-threshold personality disorders who do not meet criteria for PD service, but who struggle to make use of our treatment model because of difficulties with emotion regulation and self-harming.
- Ensuring more medical input is provided to the TSC service.

6.4 London Veteran Service (LVS)

Aims of the Service

The service was established in response to Murrison’s 2010 report, “Fighting Fit”, recommending an increase in NHS care for veterans. The LVS is one of 10 regional specialist NHS services for ex-service personnel in the UK. The service provides a comprehensive mental health assessment, formulation and assertive treatment advocacy service for veterans across London.
Scope of Service

- Open access, accepting referrals from GPs, any NHS service, veterans’ charities, families, and self-referrals
- Provision of comprehensive mental health assessment within a multidisciplinary team and a clear formulation, medication advice and treatment plan; active liaison and follow-up of onward referrals.
- Provision of evidence-based treatment for PTSD and therapy issues that do not fit neatly in exiting services, or where appropriate treatment is not available locally.
- Provision of group and one-to-one support for partners and family members.
- Training and awareness-raisin raising to build capacity in the region across multiple sectors, including criminal justice, IAPT services, and veteran charities.

The Next Three Years

- In partnership with the South London and Maudsley NHS Foundation Trust (SLaM), the LVS is piloting an outreach project in Wandsworth prison, and hopes to expand into other prisons.
- Expand the service to meet the needs of reservists, and to target specific issues of transition.
- The LVS is a very small team, so the service is seeking further funding to expand the team to enable it to deliver case management and veteran-specific therapeutic interventions.
- The LVS is working with Big White Wall – digital service that supports people experiencing common mental health problems – with a view to delivering live therapy for veterans, as well as contributing to step 1 and 2 interventions. This is being supported by NHS England.
6.5 Personality Disorders (PD) Service

Aim of the Service

Personality disorder is defined as a pervasive pattern of instability in interpersonal relationships, self-image and emotional state. People with borderline personality disorder – who comprise a significant number of our service users – are very impulsive and will often self-harm through cutting, suicide attempts, risky sexual behaviour, and substance misuse. They will generally be extremely sensitive to environmental circumstances, and may respond with intense fears of abandonment and anger. These patterns of behaviour are inflexible and pervasive across a broad range of personal and social situations and typically leads to significant impairment at work and in interpersonal relationships, and the development of anxiety and depression. The onset can often be traced back to early adulthood or adolescence.

The aims of the PD service are to enable people to function independently and more successfully in the community by:

- Reducing self-destructive behaviours.
- Identifying realistic life goals to create “a life worth living”.
- Developing problem-solving skills.
- Developing skills around regulating emotional reactions and tolerating distress.
- Creating crisis plans to prevent problems escalating.
- Developing more of a theory of mind, so that better understanding of other people’s behaviour will make people with PD less likely to assume the worst, or to react
impulsively in response to feeling abandoned and angry, and will give relationships a better chance of success

Scope of Service

The PD service is psychology-led and comprises a community team and specialist therapy services.

The PD Community Team is trained to use the structured clinical management (SCM) model. This provides clinicians with a psychologically informed best-practice framework to guide service users towards meeting their goals, and offers case management, advocacy, the development of problem solving skills, active crisis planning and medication. The flow of referrals from the R&R teams and medical out-patients following the reconfiguration in 2012 has been exhausted and the service receives 30 referrals a month from the assessment team and other secondary care services and the team caseload stands at around 360.

The Specialist Therapy Services are delivered by a team of clinical and counselling psychologists to the more stable and higher functioning service users, who are better placed to manage the demands of working with a formal course of therapy. Following assessment, all service users referred to the specialist therapies will be offered a weekly pre-treatment blended therapy group that offers an innovative mix of Mentalisation-Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT), and which targets the development of emotional regulation skills. Service users then move into one of the three specialist therapy pathways: MBT, DBT, or Schema Focused Therapy. The latter is designed to help those with a presentation of mixed personality disorder and is offered on a one-to-one basis.

A fourth and developing element of the specialist service is Psychologically Informed Consultation and Training (PICT). This is described fully in volume three, section 3.3 on the psychology training strategy for staff.

The Next Three Years

- Following the reconfiguration in 2012, the PD service started with a low base of staffing. A recent independent consultation exercise (Meridian) identified the need for a further 20 staff –10 each for the PD community team and specialist therapy service. Although the PD service has now obtained funding for a further seven workers (soon to be appointed) this still leaves a very significant shortfall, and securing adequate resourcing for the service will continue to be a priority in contract negotiations with commissioners.
- The development of primary care mental health teams means that more service users will be managed in the community, and this will impact where PD service providers will be located. The configuration of services and thresholds for referral to secondary care will be a focus for the next couple of years.
- The service is looking to develop Schema Focused Therapy groups as part of the specialist therapy teams.
- It is an aspiration to develop an Emerging Personality Disorder (EPD) service. This plan is described in this section under the Camden Transitions Service.
- PICT is clearly a growth area for PD services (see volume three, sections 2.6 & 3.3).
6.6 Whittington Clinical Health Psychology Service (Including the Islington Community Rehabilitation Team)

Aim of the Service

The Whittington-funded Clinical Health Psychology service provides psychological assessment and treatment services for people with physical health problems and their families and carers. The service aims to mitigate the impact of psychological factors on the course of physical illness and to improve wellbeing and adjustment to physical illness. There is a good evidence base for the effectiveness of psychological interventions and NICE guidance support for the establishment of effective psychological services across the health domains covered by the service (see below). The Islington Community Rehabilitation Team is a community-based, multidisciplinary service providing specialist neuro-rehabilitation for the adult residents of Islington. The service provides neuropsychological assessment to enhance understanding of cognitive strengths and difficulties in order to monitor progress, guide rehabilitation programmes, and develop strategies to manage difficulties. Psychological intervention is provided to enhance the emotional wellbeing of individuals with neurological conditions. In addition, psychology can provide a functional analysis and management guidelines for challenging behaviours that can occur in neurological conditions.

Scope of Service

This service is delivered across the following specialties:
General Medicine on-referral (mostly Cardiology and Diabetes) ; Women’s Health; Oncology; Sickle Cell and Thalassemia; Respiratory Medicine; Pain Management; Life Force (Community – a Paediatric Palliative Care and Bereavement Service ); and Islington Community Rehabilitation Team (neuropsychological assessment and rehabilitation service).
The Next Three Years

The service is under review by Whittington Health and it is uncertain whether it may go to tender, be taken in-house, or if the existing contract with C&I will be re-negotiated. A recent stakeholders’ review indicated that the quality of clinical input is highly valued at the Whittington. However, there is a need for improvements in terms of productivity, cost-efficiency, and service modernisation. A significant problem is that the service has grown, over the last 10 years, in an incremental fashion across a range of specialties. This has produced a high proportion of part-time staff, and a difficulty in providing cover and avoiding gaps in service.

In preparation to bid for the new contract, all vacancies over the last year have been filled with temporary contracts terminating in December 2015. A skill-mix review for the service is being undertaken, and concerns are being addressed about waiting lists, productivity, and outcome reporting. There is the potential to create a new model of service delivery that incorporates, for example, LI interventions in physical health delivered by PWPs. This could be married to collaboration with a research initiative at UCL, and guided by new competencies being developed for interventions in Clinical Health Psychology. The new integrated care initiative also means that Clinical Health Psychology will need to articulate care pathways between hospital and community, and to seize opportunities – such as in relation to behaviour change in managing long-term conditions. The funding for the service is being reduced, and a significant challenge will be to identify sources of funding in the acute health sector to build a comprehensive service that genuinely meets national recommendations for psychological service input. Finally, a significant problem with the existing service is that it is not located on the Whittington site. This compromises service access and service integration, so re-location of the service on the Whittington site is a priority for the re-negotiated contract.
6.7 Psychodynamic Psychotherapy Services

Aims of the Service

Psychodynamic Psychotherapy is a therapeutic process that helps service users with psychological disorders understand and resolve their problems by increasing awareness of their inner world, and its influence over past and present relationships. The therapy enables service users with psychological disorders to understand and change complex and often unconsciously-based emotional and relationship problems, thus effecting deep-seated change in personality. The therapy has a developmental emphasis, exploring past experiences and identifying recurrent patterns and themes, and identifying dysfunctional defensive strategies used to avoid distress. The therapeutic relationship is seen as a crucial element in the work. In a process described as transference, unconscious patterns in the service user’s inner world become reflected in their relationship with the therapist. This process helps service users to gradually identify these patterns and to develop the capacity to understand and change them. The aim of therapy is to reduce symptoms and distress, to improve functioning, and to increase the service user’s sense of wellbeing and satisfaction with their lives.

As well as providing direct clinical interventions, mostly with service users falling into clusters 4-7, the service aims to increase understanding of a psychodynamic perspective on service user care across the whole care pathway by providing consultation, teaching and supervision. The appreciation of developmental and transference issues that impact on the service users’ pattern of relationships to individual care providers and services can inform
and improve case management, as well as the provision of briefer individual and group therapies.

Scope of Service

In 2015, the previously separate Camden and Islington Psychodynamic Psychotherapy services were merged and co-located. The combined service attracts around 550 referrals per year. Most referrals have complex presentations in and present with anxiety, depression and relationship problems that have proved resistant to briefer first-line psychological interventions in IAPT, or require longer-term interventions. Referrals come direct from primary care and from other services in the Trust. The service runs a Single Point of Entry system with the Tavistock Clinic (the other NHS provider of psychotherapy services in the area), and also has pathways to local voluntary sector providers of psychotherapy. This ensures that service users are able to access a wider range of interventions, and minimises possible waits for treatment. Following a comprehensive assessment, service users are offered a range of medium-term to long-term interventions. Individual Psychodynamic Psychotherapy (IPP) is mostly offered as a one-year contract of around 40 sessions, but the service now provides Dynamic Interpersonal Therapy (DIT) as part of a research trial, which is a 16-session therapy for individuals with depression and interpersonal problems.

A significant feature of the service is the provision of group therapies. The service employs two consultant group analysts who provide placements for trainees from training organisations and offer high-quality supervision. This enables the service to run a very extensive and comprehensive Psychodynamic Psychotherapy group programme. The service usually has about 15 groups running, with a total of 120 service users attending weekly groups. The groups range from the traditional slow open groups (two years) to a range of thematic groups – for young people, for women, for refugees’ “where is home group”, for survivors of childhood sexual abuse, for those presenting with complex and long-term personality problems, and a group designed specifically for service users from CDAT.

These groups vary in length from six months to two years. There is also a 12-week “group-experience group” for people unsure of whether group work is the right option. Apart from the group’s therapeutic benefits in its own right, it also reduces drop-out rates for those then graduating into the longer-term groups offered in the service.

The service is small, comprising just 2.7wte medical staffing and 2.5wte non-medical staffing, made up of psychologists and group analysts. All permanent staff are fully accredited and have undertaken robust training. The service is sustained by honorary and trainee psychotherapists attached to local and British Psychotherapy Confederation and UKCP training courses for individual and group psychotherapy. There are generally around 30 honoraries engaged with the service, and an additional 10 to 15 medical students on the Student Psychotherapy Scheme (see below). The service is also part of the medical rotation scheme, and has junior doctors and Specialist Registrars on placement. It is the presence of this non-qualified training cohort – supervised by senior staff who have close working relationships with local training institutions – that enables the service to manage service demand and manage the waiting list.
**Medical Student Psychotherapy Scheme and Balint Groups**

The Psychodynamic Psychotherapy service has had a pioneering role in relation to development of the Medical Student Psychotherapy Scheme and Balint Groups, designed to improve the quality of doctor-patient relationship across all branches of medicine. Working in partnership with UCL, the service receives Service Increments for Teaching (SIFT) funding. This enables the Trust to employ a Consultant Psychiatrist in Psychotherapy (3PAs), supervisors for the medical students, and leaders for the Balint Group. At its current rate, SIFT money generates a considerable sum in excess of the funding needed for these posts.

The UCL Student Psychotherapy Scheme involves 10 to 15 medical students providing one year of weekly psychotherapy for a Trust patient, under supervision provided by medical staff in the psychotherapy service. The Balint Groups provide an opportunity for reflective practice in relation to their practice, and in particular a focus upon the doctor-patient relationship. The groups are run by accredited Balint Group leaders, with medical psychotherapists from the team. More than 50 students per year attend 11 groups per term for one year. Students can choose either the Balint Group or Student Psychotherapy Scheme as a “longitudinal” Student Select Component (SSC) during their fourth year of medical school training. This counts as a final year SSC.

These training schemes play a unique role in medical education, and this was highlighted by the recent publication “Learning about Emotions in Illness: Integrating Psychotherapeutic Teaching in Medical Education”, written by a member of the service. The Royal College of Psychiatrists (RCP) has set up a committee to develop these two schemes in all 34 UK medical schools as they are seen as key to improving recruitment into psychiatry and to developing a psychologically informed workforce.

**The Next Three Years**

Psychodynamic Psychotherapy services face a number of challenges. Commissioners may favour high-volume and accessible services that can provide evidence of rapid symptom reduction. The heavy investment and publicity around IAPT and manualised therapy has impacted on the perception of traditional long-term therapies, and on public expectations of what therapy will be like. Psychodynamic Psychotherapy services need to ensure that their unique and highly specialist contribution to service users and colleagues can grow and be sustained. The service will work towards the following goals:

- **Provide evidence of effectiveness:** The service now has access to CORE NET, a web–based information system for capturing outcomes in psychotherapy (focusing on recovery rates). The service needs IT support to maximise the benefits of this system and to be able to present compelling evidence of effectiveness. Traditionally, psychotherapy services have been slow to demonstrate outcomes, and a good evidence base is essential to the marketing of the service.

- **Retain senior posts in the service:** The pressure to reduce costs puts senior posts in jeopardy. In order to attract trainees into the service, it has to retain senior and experienced staff, without whom the service will not be able to offer the placements and supervision that make the service cost-effective. The retention of these posts must be a priority for the service.
Develop the range of medium-length individual and group interventions: It is important that the service continues to provide interventions that reflect the core principles of Psychodynamic Psychotherapy, while being mindful of the need to be cost-effective and manage waiting lists. Treatment interventions are being modified. The service now offers mostly one-year, rather than two-year, courses of individual therapy. This may restrict the service’s ability to work effectively with service users who have more complex presentations. The service also needs to balance the provision of longer-term interventions with an increasing use of medium-length therapies that are developing a good evidence base. DIT, although a 16-session manualised therapy, manages to distill the key elements of the therapeutic process into a brief and cost-effective intervention, and is beginning to demonstrate effectiveness in relation to the treatment of depression. The expansion of DIT, as well as the shorter and medium-term groups, mean the service can offer better access and more service user choice.

Service user and carer engagement: As noted in volume three, sections 2 & 3), the psychodynamic service needs to strengthen its position in relation to these two important benchmarks of quality. The small staffing resource of the service makes this a challenge, but the service needs to identify leads for these areas and look to making creative use of trainees and students to help support initiatives.

Primary Care: The new developments in primary care (e.g. Team Around The Practice) provide an opportunity for Psychodynamic Psychotherapy to promote a model of consultation, case formulation and short to medium-term intervention as part of the service delivery model for complex and challenging presentations. There are examples of successful application of this model in other areas of London.

Increase impact across the care pathways: The service, which has well-established close and collaborative relationship with other psychological therapy services, has been establishing effective care pathways to CDAT, and is working to raise its profile across the Trust. Some of this may be achieved through an expanded teaching and consultation role, such as via the new training sessions “From the Nursery to Psychiatric Intensive Care Units (PICU)” seminars that are being delivered in the Acute Services at Highgate Mental Health Centre and The Huntley Centre.
6.8 Camden and Islington Transitions Teams

Camden Transitions Team – Minding the Gap

Aims of the Service

The transition of young people from Child and Adolescent Mental Health Services (CAMHS) to Adult Mental Health Services (AMHS) is often problematic. The two services have very different cultures and some young people experience a loss of support, leading them to drop out of services. Late teens and early twenties are a critical period for personal and social development. For vulnerable young adults without support, there is a risk of developing maladaptive coping strategies and personality problems that will impact on the rest of their lives. There is also a high risk that they may miss opportunities for education, training, employment, and a positive experience of personal relationships. Research shows that some years later, in their later twenties and early thirties, these same young people are often referred into services with chronic mood and personality problems. The opportunity to provide early and preventive interventions has been lost, so the aim must be to bridge the gap between adolescent and adult services to ensure the best possible chances of a positive future for young people. It is also necessary to ensure that our adult services provide a friendly experience, and are accessible to all young people referred for help.

The Camden Minding the Gap (MTG) project, which began in December 2014, is psychology-led and has two elements.

First, a fortnightly MTG Transition Meeting is held, at which clinicians from local agencies can bring complex cases for discussion with senior managers from CAMHS and AMHS services. This team is provided in partnership with Tavistock and Portman NHS Foundation Trust, The Brandon Centre, London Borough of Camden, and C&I Foundation Trust. The meeting assists with planning transitions, managing the challenge of possible disengagement from services,
and preventing the bouncing of referrals between agencies. The meeting generates high-quality clinical discussion, and is making a significant contribution to closing the unhelpful gap between CAMHS and AMHS.

Second, there is a psychology-led clinical service comprised of a team of transitions workers located into four of our key adult services. These clinicians champion the needs of young people in those services, facilitating transfer from CAMHS to AMHS, reviewing policies and protocols to ensure services are young people-friendly, accessible and safe, and developing bespoke interventions for young people. Two of the workers are seconded from CAMHS to facilitate the optimum transfer of knowledge between the respective services.

Scope of Service

The transitions workers are located in Camden IAPT, Camden CDAT, Camden Assessment and Advice Team, and Camden Personality Disorder Service.

The Next Three Years

Demonstrating effectiveness of the service: The current deployment of staff in the MTG team will be reviewed in advance of contract renewal in January 2016. This may result in a different spread of MTG clinicians across the respective services. Demonstrating the impact of the service on transition between CAMHS and AMHS, and in the experience of young people using adult services, will be fundamental to the success of the project.

Working with the Integrated Youth Base:

The sister branch to MTG is the development of a Camden integrated youth base, named “Axis” and located at The Hive (the old Finchley Road Post Office). This is an innovative multi-agency project hosted by Catch 22 and in partnership with C&I, The Brandon Centre, The Tavistock and Portman NHS Foundation Trust, and The Anna Freud Centre. It will provide an outreach approach to engagement with, and support for, young people with mental health problems, and will have a strong social enterprise element. The Hive, scheduled to open in the late summer of 2015, will provide a two-way care pathway with C&I Trust services. It will comprise two small teams of young-people workers, each of which will be led by a mental health professional (one each employed by C&I and the Tavistock), and will be managed by a Programme Director. On site, there will also be workers specialising in employment, training, housing, benefits, and sexual health. This exciting development offers the genuine prospect of developing a whole-system approach to improving the wellbeing of young adults.

Emerging Personality Disorder: The project is new and the additional staffing in the four services is making a difference, but it is already apparent that there is a need for more resources for managing the volume of young people with very complex presentations and multiple morbidities. The Trust PD service has reduced thresholds to enable taking on young people with possible EPD, but this will not be sustainable without lengthening the waiting list, and also the CDAT service struggles with managing young people in whom some PD traits are present. There is further concern about the possible detrimental effect of young people attending a service where many of the service users have chronic disability. The fundamental aim of this service is to change the trajectory for young people with developing mental health problems, and the piloting of a small, specialist service – perhaps on the lines of the Helping Young People Early (HYPE) approach taken in Australia – may be a way
forward. The MTG service has now established a small working party to look to develop a business case for an EPD Service.

Islington Transitions Team

The rationale for the development of this team mirrors that for the Camden team described earlier in this section. The team comprises just one wte, with a CAMHS and adult psychiatrist, family therapist, psychologist and an administrator, each having two sessions – it is planned that the team will soon be supplemented by the appointment of a half-time psychology assistant to help with data collection and audit). The team, led by the psychologist, reviews cases where the transition of young people into adult services presents a significant difficulty. The team is not case-holding, but may offer an assessment of a young person as an aid to diagnosis and to the development of a management plan. An innovative feature of the team is the trialling of the use of personal health budgets with young people, as part of a more holistic approach emphasising that enabling young people to achieve their personal goals and aspirations is fundamental to improving wellbeing and mental health. The team has developed a transitions policy, to which all key stakeholders working with young people have signed up.

6.9 Camden Parents Wellbeing Service

The Parental Mental Health Project is a psychology-led and staffed service that was established in 2006 to work with parents of children known to Camden CAMHS and who
were identified as having sub-threshold mental health needs. In 2010, the project was expanded to accept referrals from adult services working with parents. The project provides clinical interventions for parents with mental health problems, using systemic and cognitive psychological approaches where it is felt that the parents' mental health difficulties are impacting on the wellbeing of their children. The parents are identified either by local adult mental health services (e.g. Camden IAPT), by children’s services (Camden CAMHS teams), or directly by GPs. The service is essentially outreach, seeing parents in GP practices, community centres and children’s centres. The Parental Mental Health Project provides regular workshops to multi-professional mental health workers on issues surrounding mental health and access to services, and provides liaison and consultation for both child and adult services.

6.10 Islington Parental Mental Health Service (Growing Together)

This new psychology service was developed in 2014 to provide direct mental health interventions to parents with children under the age of five, and in particular to those who do not meet thresholds for accessing statutory mental health services but who have problems that impact significantly upon the children’s wellbeing. The service also provides training and consultation to children’s social care teams (Families First, Children in Need, Troubled Families) around adult mental health issues, and around systemic factors that disrupt the consistency and co-ordination of multi-agency interventions. The service is a multi-agency collaboration between Whittington Health and C&I (with whom the staff have honorary contracts), and the Trust provides professional supervision for the team.
6.11 The Gangs Projects

Camden Positive Punch

Positive Punch is a highly innovative psychology-led (and C&I-led) multi-agency collaboration piloting the “Integrate” model developed by MAC-UK (a charity engaging with excluded young people that offers interventions for some of Camden’s hardest-to-reach young people aged 16-25). These young people are heavily invested in criminal, gang and antisocial activity, and have a major impact upon community safety. It is well documented that they experience a high level of unmet mental health need, and that gang membership is a health issue, as well as a criminal justice issue. The multi-agency partnership is comprised of C&I, Camden Council, The Tavistock and Portman NHS Foundation Trust, Employment and Training agencies, CAMHS, MAC-UK, and Camden police. The street-based project worked for three years with up to 60 young men, engaging through building relationships, providing activities and attracting young men via peer-referral. The project was evaluated by the London Centre for Mental Health, which identified the following outcomes:

- Successful mental health interventions based upon psychological formulation and street therapy.
- Moving 60% of young people into education, training and employment.
- Bridging young people into mainstream services.
- Reducing levels of serious youth violence.
- Improving community safety
- Developing governance structures needed to operate an effective and safe street-based gangs project. These governance structures are now being deployed by ??SLaM and Barnet Enfield and Haringey Trusts.

Based on the success of Positive Punch, plans were made to develop a second project in autumn 2015. This project is a cross-borough intervention working with a gang that straddles both Camden and Islington, and is currently of great concern to the local community. Funding has successfully been established from Catch 22 and from Camden and Islington Councils. An innovation is that this new project will provide a first for site for the training of youth and community staff in gang-related work. MAC-UK is developing an academy for the training of workers to use the Integrate model. The gang project will provide the placement opportunity for these workers, offering training and education, and at the same time providing a resource for staffing the project and, in the longer term, supporting the sustainability of the project.

Project Staffing:
The Positive Punch project was staffed by two Clinical Psychologists (team leader and deputy leader), with support from local youth and employment workers re-aligned by Camden council. It was also supported by MAC-UK contributing consultation and supervision. The new project is expected to have similar staffing, and will be managed from within the psychology service.
Islington Gangs Project

The Islington 18-24 Gangs and Serious Youth Violence Team is a multi-agency service that was established as a wrap-around response to young adults involved in gang-related offending violence. The team aims to reduce re-offending and gang violence by supporting young adults to exit gangs and offending lifestyles. As with the Camden project, the service was designed to provide a multi-agency approach, with health integrated into the service delivery model. Unlike the street-based peer referral project in Camden, the Islington team is based in the probation service, and receives referrals from that service. Psychology has played a significant role in the Islington Gangs project, and the emphasis within the MDT – which is led by a forensic psychologist – is on a psychologically-informed approach to working with gang members.

The Islington Gangs Transition Service has been highlighted as good practice by the Home Office and by the Centre for Mental Health. It has particularly attracted interest for its innovative approach to mental health when working with young adults involved in gangs and serious youth violence. The team is achieving positive outcomes with:

- Positive and sustained engagement with high-risk gang members who would not otherwise access mental health services.
- Engaging young women with severe anger dyscontrol, severe depression and relationship problems in mental health support, with improved outcomes for them and for their children.
- Reducing re-offending and violent behaviour.
- Increasing engagement in employment, education and training.
- Reducing re-offending and violent behaviour.
- Making savings to the partnership and wider community in relation to the cost and impact of offending on the young person and victims, as well as to support and health services.

6.12 Other Community Division Services with Psychology Resources

Neurodevelopmental Disorders Service (NDDS)

The NDDS provides a service to people with Autistic Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD). The ASD service is managed by a clinical psychologist, and psychologists contribute to the assessment and treatment function in ASD and ADHD. The services have attracted long waiting lists, but the introduction of new funding and more efficient practices has meant that the wait times are reducing, and the aspiration is
that the service will be able to offer a comprehensive treatment programme, including psycho-education groups and one-to-one psychological therapy.

**Primary Care Mental Health Teams**

The Trust has teams based in Barnet, Camden and Islington providing primary care mental health support to GP Practices. The aim is: to increase the number of people whose mental health support is appropriately managed within primary care; managing patients with complex presentations, and reducing their use of both primary and secondary care services. Psychologists are represented in all the teams (2.5wte across the teams), providing a combination of consultation, liaison and advice to GPs, working up case formulation, case management plans for GPs, and self-management plans for service users, as well as offering a number of brief therapeutic interventions. These new roles in primary care require the development of effective collaborative working with GPs around the best management of challenging and frequent-attending service users, and building the skills and confidence of GPs to work effectively with these presentations.
Section Two

Benchmarking Services against Quality Indicators

This section benchmarks the Trust psychological services against key indicators of quality in the NHS: effectiveness, positive patient experience, accessibility, service user participation, carer experience, and the morale and wellbeing of the workforce (ref.7 National Quality Board 2013). The psychology services are well supported in monitoring performance against these criteria by the support of more than 30 trainee psychologists undertaking annual small-scale research and audit tasks in each Division.

1. Demonstrating Effectiveness

“The failure to measure outcomes (other than survival) from mental health services represents a significant failure of English mental health policy.”
(No Health Without Mental Health: Developing an Outcomes-Based Approach, Mental Health Network NHS Confederation, 2011)

The need to demonstrate effectiveness has never been more compelling. The NHS faces an unprecedented economic challenge, and for services to justify their cost they will have to provide evidence of positive outcomes for service users. The logic of Payment by Results demands that we demonstrate the outcomes associated with each care cluster and package of care. The advent of Any Qualified Provider (AQP) and Patient Choice means that we will be expected to provide information to help service users choose between services, to demonstrate that our services really do deliver the help that people want and need.

However, as the quote from “No Health without Mental Health” indicates, mental health services are still well behind the curve in demonstrating outcomes. Psychology, with its strong tradition of scientist practitioner and research based service development, should be at the vanguard of outcome measurement both for psychology services and for general mental health service delivery.

Examples of Good Practice

IAPT services probably set the gold standard for monitoring the effectiveness of psychological therapies. Surely the most closely monitored and audited of all mental health interventions, IAPT service delivery requires the collection of sessional outcome measures that are captured electronically for Department of Health analysis against a range of key performance indicators, including activity and recovery rates. The data collected is subject to local and national scrutiny, and can attract penalties and rewards against performance – as well as carrying reputational implications for successful bidding for future contracts. The Trust has recently acquired IAPTUS – a new electronic patient record (EPR) system for IAPT services – so that it is possible to judge the service against national benchmarks.

R&R services have introduced outcome measures based on those used by the Severe Mental Illness (SMI) IAPT pilot sites. Measures are used at the beginning of therapy, every
fourth session (or less frequently if necessary, as agreed with the service user), and at the end of treatment. Scores are recorded on the recently-developed R&R psychology service database. The Acceptance and Commitment Therapy (ACT) Group for psychosis has adopted the same standard set of outcome measures. The Bipolar Group is using the Bipolar Recovery Questionnaire to evaluate outcomes. Research is looking at the effectiveness of the first three runs of the Bipolar Group, and at the sensitivity of the outcome measure used. In the two EIS teams, the service is collecting outcome data on the three psychology-led groups: “Understanding your experiences”, “Managing mood”, and “Managing distressing beliefs”. In relation to family work, the service is exploring the best outcome measures for use with Behavioural Family Therapy (BFT) and Systemic Family Therapy (SFT). The rehabilitation team psychologists have developed a list of outcome measures for individual psychological treatment and overall improvement through MDT work. The rehabilitation psychology service currently offers a significant amount of consultation and training to staff, and is developing a measure to gather feedback from staff teams on the effectiveness of this.

**SAMH** psychology service has an ongoing yearly audit of Memory Service activity, and is looking to introduce similar audit into Community Mental Health Teams and the new in-patient wards for older adults. The service is engaged with Division-wide discussion around suitable outcome measures for the service. The **TSC** uses routine collection and audit of outcome measures before, during and post treatment. It is intended to conduct follow-up at six months to one year to see whether gains have been sustained through qualitative interviews with service users, with regard to their perception of their treatment. The service is currently translating outcome measures into multiple languages so that they can be more effectively used across language groups. In **SMS**, the service contributes to achieving the statutory framework – “successful completions” as a percentage of those in treatment, and the service has made significant gains, moving from 8-9% to >15%. The psychology service itself is looking to capture further psychology-specific outcome data for mood rating.

In **CDAT**, the service is using standardised self-report questionnaire measures for all service users in psychological treatment, as well as global outcome scaling of all care plan goals. The Transition Team is piloting the use of Goal-Based Measures with young adults, and the **Clinical Health Psychology Team** is currently undergoing a review of all outcomes measures being used in the service. The **PD Service** is using electronic proof of delivery systems (PODS) to collect a wide range of outcome measures (symptoms, functioning and wellbeing) for specialist therapy (including pre-treatment groups) and for community teams. The service will be using the data to compare outcomes between the various specialist therapies.

The **Psychodynamic Psychotherapy Service** is using the CORE information management system for outcome monitoring and has access to CORE Net, a web-based system for capturing outcomes in psychotherapy. The service needs IT support to maximise the benefits of this system, and to be able to present compelling evidence of effectiveness.

**The Next Three Years**

The collection of good-quality outcome data is essential – but is not without complications. Data collection presents a significant burden to clinicians and is often resented, as it is
perceived as reducing time available for direct clinical work. There is mistrust about how data will be understood and used by management and commissioners. There are disagreements around what data should be captured, complaints that it is too reductionist, and at times little more than meaningless number crunching in pursuit of politically-driven targets.

In order to achieve effective sign-up to outcome-data collection, information systems are required that facilitate the capture of data. Service users should be involved in decision-making around which measures are used, so that consensus might be reached on what is relevant and meaningful. Closer engagement with commissioners is needed with regard to the purpose of outcome measures, and to avoid simplistic and statistically-flawed interpretation.

If outcome monitoring is done well, then it can incentivise clinicians by championing good and effective service provision. There are many examples of good practice in C&I services, and some of these in psychology have been highlighted above.

**ACTION POINT 13**
Psychological therapy services continue to broaden the use of outcome measures for all psychological therapy provision, and to make this data readily available.

**ACTION POINT 14**
Psychological therapy services promote the use of outcome measures across all services in their Division.

**ACTION POINT 15**
Psychology leads to have a stronger engagement with the commissioning process in relation to decisions about outcome reporting.

2. Service User Experience and Co-Production

Service user experience and satisfaction are fundamental elements of quality in health delivery. We are moving away from traditional models in which services were “done” to people and for people, to a situation where they are delivered with people as equals. The principle of “no decision about me without me” is fundamental, as service user’s needs, aspirations, experience, expertise and knowledge should be at the heart of what we do. Service user engagement is critical to the creation and delivery of high-quality services that are recovery-focused, relevant, de-stigmatising, and attractive to service users.

What does genuine service user involvement look like? How can we ensure that service user involvement doesn’t become tokenistic and little more than a tick-box exercise? The aspiration must be for service users to be genuinely engaged in the co-production of services, so that power is shared between provider and service user, and so that there are
clear mutual responsibilities and expectations. This means: engagement with the commissioning; design and planning of services; the recruitment and training of staff; providing ongoing feedback about service delivery; involvement in service evaluation and reporting this feedback to service providers; peer support; expert patient programmes; and mentoring of other service users. It also means that service user participants should be properly rewarded and reimbursed for their efforts to support our delivery of services.

**Examples of Good Practice**

All psychological therapy services enshrine the principle of collaborative working and information sharing as being fundamental to the philosophy of their service. The assessment and treatment plans offered to service users are developed collaboratively, and there will be a full discussion about the most effective and acceptable treatment plan that takes into account the service user’s preferences, goals and aspirations. Where appropriate, these plans will be agreed with a carer or family member.

The **PD Service** has an exceptional history of service user involvement. The service has a contract with the service user-led alliance group Emergence, and employs service users to develop and run a genuinely co-produced service. Emergence is involved in the co-facilitation of the pre-treatment groups, the delivery of workshops to carers, attendance at team meetings, the design and delivery of the service and staff training, and evaluation of services. **The CDAT and PD Services** have an ongoing joint service forum, and CDAT is developing a client satisfaction and health economics satisfaction service user form. CDAT is also planning to introduce routine service user feedback, and to involve service users in training. It has a long-term aspiration for service users to be involved in the co-production of an E-based care planning/self-care tool.

**SAMH Psychology Services** have a very strong record of service user engagement. There is a well-established service user group, the Advisory Group for Older People (AGOP), founded in 2008, and some of the founding members have become service “ambassadors”, contributing service user input to agencies beyond the Trust. AGOP comprises current and past service users from the CMHT, and meets every six to eight weeks. They are involved with service development, recruitment, advising on service leaflets, and they have developed a wellbeing discharge pack for service users and have commented on service evaluation forms. Some AGOP members have also contributed to the delivery of the “Tree of Life” intervention to service users. The SAMH psychology team is contributing to improving service user involvement of people with dementia.

**Camden Transitions Service** is a new and excellent example of genuine co-production of services. Young people have been involved since inception in the commissioning process, the planning Board, and now in the recruitment and training of staff and in providing service feedback. The service is supported by a Participation Officer, who has established a thriving young people’s service user group to advise and to provide feedback on all service development. The plan is for the group to be involved in designing young people’s therapy workshops, the wellbeing curriculum, creating posters for workshops, being part of interview panels, and attending team business meetings.
The IAPT service runs regular service user forums in Camden and Islington, seeks feedback from users of the service via the iCope website, and regularly seeks the views of community organisations and local people to improve the responsiveness of services. It uses the Friends and Family test in GP Practices in Islington, and gives the national IAPT Patient Experience Questionnaire (PEQ) to all service users at the conclusion of assessment and treatment.

The Veterans service in the TSC has developed user groups for service feedback, and also gets feedback on the service leaflets and website. Service users from the Veterans service have also made a presentation at an IAPT training conference, and have been involved in filming and media work. The development of service user groups has been less successful within the generic TSC service, perhaps because of the diversity of the client group and significant feelings of disempowerment and cultural barriers. The service needs to work more actively with trust-wide service user groups to see how this can be remedied.

Learning Disabilities Services have a long history of service-user and advocacy involvement in shaping and delivering services through formal Partnership Boards, engagement with family carer groups, and elected member (Councillors) forums. Service users and carers are directly involved in tendering and recruitment, as well as in co-producing and delivering training packages for staff. The R&R Psychology team is piloting the use of a patient experience questionnaire with all service users discharged from the Trust’s four recovery teams. This bespoke questionnaire, designed in-house, will capture quantitative and qualitative feedback from service users on their experience of individual and family therapy provided by psychologists. The psychology team has also engaged service users in the development and delivery of two Friends and Family workshops as part of the bipolar group initiative. The R&R Psychology Lead chairs the steering group for the ‘Recovery Project’, in which some clinicians work with service users to deliver workshops to teams across the R&R Division. The aim of the workshops is to help staff and service users come to an agreed definition of recovery. A leaflet will then be designed to describe the ‘Recovery’ agenda and will be given to all users who come into contact with the service.

In SMS, psychologists have taken a leading role in engaging service user representatives, and the Division Quality Forum is focused on service user perception and concerns. Service users are involved in some core skills development within the service, such as motivational enhancement, and join with psychologists to provide teaching on drugs and alcohol to service users in the Recovery College. Psychology has also promoted Recovery events in Camden, in which service users play a very significant role.

The Psychodynamic Psychotherapy Service has very little history of setting up service user groups. It has intermittently used service user satisfaction surveys with the assistance of trainees, but is currently developing a new strategy for collecting this data using electronic feedback.

Acute Service will need to identify resources to develop group therapy co-facilitation.
The Next Three Years

There are some excellent examples of good practice, but the psychological therapy services could do much more towards a systematic and consistent approach to service user engagement. Capacity is a problem, notably for some services that are already very stretched and have very limited resources. However, psychology services need to be consistent in developing practices that follow the principles of genuine co-production, where appropriate. Service users should be routinely involved in recruitment, service improvement projects, staff training, and the development of service materials. Service user groups should be established with particular focus on increasing access for under-represented groups, such as BME, LGBT and disabled people. We should be developing expert patient forums and, for IAPT, service user groups that meet in GP Practices. All services should be making routine use of service user satisfaction questionnaires. Finally, annual reports should be produced, summarising feedback from service users and presenting them, where appropriate, to management groups, stakeholders, service user forums, and commissioners. Service user engagement should be a part of the annual appraisal of each psychology service, and there should be a clear action plan, with expectations of delivery and achievement.

3. Supporting Carers

The Triangle of Care report (2010; Ref.8) makes a number of key recommendations with regard to carers that include: the early identification of carers; the engagement of carers in the development of care planning; supporting carers to enable them to maintain good mental health; the importance of training staff to be “carer-aware” and trained in carer engagement strategies; and the provision of a range of carer support services.

Examples of Good Practice

Examples of Good Practice

There are some examples of excellent practice in relation to carers in psychology services. Improving access to psychological therapies for carers is part of the national IAPT agenda (DOH, 2011), and NICE guidance recommends that psychological input for carers of people with dementia is a key component of high-quality care. Psychologists, in collaboration with SAMH, IAPT and UCL, are delivering START (Strategies for relatives), an eight-session manual-based coping intervention delivered by supervised Assistant Psychologists and graduate mental health workers to carers of people with dementia. This is delivered in Islington Memory Service and IAPT, and these are among the first sites to deliver the intervention outside of a research trial.

The SAMH psychology team also provide a Cognitive Stimulation Therapy (CST) workshop for carers of people with dementia, and if carers or patients are house-bound, the psychology team is piloting providing this at home. Workshops have been extremely well
received by carers. Treatment for carers also makes up a significant proportion of psychologists’ clinical work in the SAMH CMHTs and inpatient wards, and consultation and support is regularly offered to formal carers in nursing and residential care homes. Finally, psychologists lead on developing a carer’s care pathway, which is used to guide what interventions are offered to carers across the division.

The **Acute Division** Psychology Service recently ran and evaluated a series of Carers Support and Information Workshops for carers of service users in acute crisis. This pilot workshop ran for four sessions, each of two hours duration, and included guest speakers, psycho-education, information about services, and an opportunity to reflect upon the experience of being a carer in the context of group support. The workshops were well received by carers, and the aspiration for the service – resources permitting – is to run three such series of workshops per year for carers from across all the Acute Division.

The **TSC** runs a quarterly group for wives, partners and family members of clients using the Veterans service. The PTSD service has a leaflet for carers, involves carers in joint sessions with service users where appropriate, and has identified a need to develop carer support groups.

The **R&R** psychology has started a “Friends and Family Workshop”, which is a two-session group run for carers of bipolar service users who attended the Bipolar Group. Although NICE guidelines recommend carers groups for carers of people with psychosis, there are no such groups in R&R Division at present. Options for developing a programme of carers groups in R&R are currently being explored.

In the **Learning Disabilities** service, both Camden and Islington have long histories of engagement with family carer groups and involving carers in processes such as Service tendering and recruitment, as well as co-producing and delivering training packages. Islington Learning Disabilities Partnership also runs a weekly Systemic Forum offering couple, family and network-oriented approaches to carers and families.

The **Psychodynamic Psychotherapy** service is planning to establish a Carers psychotherapy group. The **TSC** has leaflets for carers, and involves carers in joint sessions with service users, where appropriate.

**The Next Three Years**

Despite the obvious areas of good practice, there is a lack of a consistency in approach to supporting carers across the psychological therapy services. The development of good carer support is a resource issue, and it is likely that this requires more focus as a strategic and business planning target for psychology services across all the Divisions.

**ACTION POINT 17**
**Develop a carers’ support policy for all psychology services.**
4. Facilitating Access to Psychological Therapy Services

Talking therapies are popular with service users, and a frequently-heard complaint over many years has been that there should be more psychological therapy. It is reasonable to argue that the situation is now much improved. Indeed, the recent Islington Borough User Group (IBUG) survey offered encouraging feedback that 73% of respondents had received talking therapies, and the same percentage indicated that they had found them helpful. The development of IAPT has certainly improved access, and the psychology service training strategy has produced more staff with specialist therapy skills. However, demand continues to outstrip supply, and we still face a challenge to provide therapies that are available promptly, in accessible settings, and which are user-friendly to cohorts that we have traditionally struggled to engage. This means that services need to be as efficient as possible to maximise the use of available resources and to be creative with regard to engagement strategies.

4.1 Waiting Times for Assessment and Treatment

The development of IAPT produced a massive expansion of the availability of psychological therapy services for common mental health disorders. The service is mostly delivered in primary care, and in Camden and Islington there is either a PWP or high-intensity therapist in over 90% of GP Practices. The IAPT service across Camden, Islington and Kingston is meeting the national target of seeing 15% of people with common mental health problems, and 11,441 people across the three boroughs entered treatment in the last year. The service is also required to hit waiting time targets, and while this is managed for LI interventions at Step 2, it is more of a challenge at Step 3. Waiting times from referral to treatment will, of course vary, but interventions for LI by PWPs at Step 2 tend to be very short (between 10 and 20 days across the three boroughs), while interventions for HI at Step 3 will be longer (between 44 and 64 days).

All services endeavour to operate as efficiently as possible, adopting various strategies to reduce missed appointments (DNAs), offering prompt assessments to ensure that service users are waiting in the right queue, and, where appropriate, designing low-intensity interventions that may afford some measure of symptom relief in advance of a full psychological intervention. Nonetheless, waits for specialist services continue to be a problem. The R&R and TSC services have benefited from waiting list funding, but waits in R&R are still running at between four and seven months, and at around five months in the TSC. The separately-funded London Veterans Service (part of the TSC) has waits of just four weeks for assessment, and between two and four weeks for treatment. The Islington Community Reach Team has waits of zero to four weeks for urgent referrals, and up to 12 weeks for routine referrals. The CDAT service assesses within four weeks, but service users can wait up to a year for a course of treatment. The Acute Service has a very limited psychology resource and brief lengths of stay, and so service access has to be rationed accordingly. The PD Service has been under great pressure, and waits for treatment often exceeded one year. The service has now been re-designed to reduce waits. At present, there is a three-month wait for assessment for the specialist therapy teams, and then a further six months wait to begin therapy. However, the service now offers a weekly pre-treatment skills development group for those on the therapy waiting list, and a monthly follow-up contact for those waiting for the pre-treatment group. The wait for the PD Community Team will be three months for routine assessment and a further three months for allocation to the team. However, this will be dependent on risk analysis, and those at risk and requiring priority will be fast-tracked to the team. The PD Service has recently won funding for a further seven posts: three posts and a team manager for the community team and three new posts for the specialist therapy teams. It is anticipated that this will further
reduce waits. The SMS service has very modest waits for all psychology treatments, with around three weeks wait as a maximum for all services. The Acute Service has a target of seeing all service users within one week of referral, but this is achieved only with priority referrals.
4.2 Service Location

While IAPT is mostly delivered in GP and primary care settings, other services are generally sited in team bases or in our hospital and community residential centres. The IAPT service offers some evening sessions and groups, and Saturday clinics in some GP Practices. The psychotherapy service offers individual and group therapy sessions in the evening. It is planned that the Camden IAPT and psychotherapy services will be moving to the St. Pancras Hospital site in the Autumn of 2015, and this centralisation of services will enable an increase out of hours work, by virtue of better reception and security support. The CDAT, PD and SAMH psychology services offer some home-based assessment and treatment for service users who are unable to travel for reasons of immobility, or for whom the therapy is best delivered at home – e.g. working with hoarding, severe agoraphobia, and OCD. The advance of digital solutions to service delivery will play a significant role in increasing service access, and this is discussed in volume three, section 2.7.

ACTION POINT 18
Increase availability of evening and weekend clinics for psychological therapies.

4.3 Access for BME and under-represented Groups

IAPT is probably the best example of positive action to increase access for under-represented cohorts. The service works with local community groups and voluntary sector organisations to maximise access for those across the whole demographic profile. Some specific examples of efforts to respond to local community need include:

- Targeting socially deprived areas of the borough by marketing services to local GPs and offering services in local employment organisations.
- Social marketing campaigns, using the service’s newly-designed website, and large-scale leafleting campaigns that reduce stigma and resistance to service uptake.
- Advertising services in a range of languages, including Bengali/Sylheti and Somali.
- Offering same-language and culturally-sensitive therapies through employment of Somali and Bengali/Sylheti-speaking PWP.
- Working with community groups to produce same-language materials (e.g. Khat booklet, self-help booklets).
- Engaging with Somali people by running groups in local cafés and community centres.
- Translating and adapting interventions – such as the “Feeling Good Groups” – so they can be delivered in Bengali and Turkish.
- Promoting wider access by providing interventions in libraries, children's centres and older people's resource centres.
- Addressing the needs of older people through joint work with Age UK Camden.
The TSC has a good representation of BME service users through its work with refugees and victims of trauma. The Gangs Projects work almost exclusively with young people who don’t access services. Other services, such as Psychodynamic Psychotherapy, may need to work with referrers with regard to increasing referrals to psychological therapy for the BME population. All services make use of interpreters as and when required.

The Next Three Years

Improving access means increasing volume, reducing wait times, and increasing engagement with BME and other hard-to-reach cohorts. It is, of course, resource-dependent to some extent, and services will continue to make the business case for increased staffing. However, this must be predicated on demonstrating that services are: making the optimal use of available resources; running the most appropriate service model and skill-mix; managing caseloads and throughput; demonstrating effectiveness; being creative with regard to engagement; using new technology to enhance access; and maximising the impact of the training of non-psychology staff to deliver therapies.

Action Point 19 – all psychology services
Psychology services will develop business cases for increased resources as appropriate. The needs of each service are identified in the service descriptions in.
References

2. Closing the Gap. The Department of Health 2014
4. NHS England: Five Year Forward View
7. Quality in the new health system, National Quality Board 2013
8. The Triangle of Care. The National Carers Strategy, Carers Trust 2010
### APPENDIX: ACTION PLAN

**Camden and Islington NHS Trust**  
**Psychological Services Strategy 2015-2018**

<table>
<thead>
<tr>
<th>Action Point No.</th>
<th>Reference</th>
<th>Action Point</th>
<th>Responsible person</th>
<th>Involved others</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Volume 1 Page</td>
<td>The Action Plan will be the basis for an annual review of service in each Division</td>
<td>Head of Psychology &amp; Psychotherapy</td>
<td>To review with Divisional Clinical Directors</td>
<td>Annually</td>
</tr>
</tbody>
</table>

**Increasing Accountability of the Workforce**

| 2                | Strategy 2 Volume 3 Page | Convene a working group to devise a protocol for Job Planning. | Head of Psychology & Psychotherapy | TBC + L&D | January 2016 |
| 3                | Strategy 2 Volume 3 Page | Convene a working group to establish a system for 360° assessment and feedback. | Head of Psychology & Psychotherapy | HR + L&D  | January 2016 |

**Developing leadership and management skills**

| 4                | Strategies 2, 3 & 9 Volume 3 Page | Develop a learning set on leadership & management for staff at Band 8b and above. | Head of Psychology & Psychotherapy | TBC + L&D | January 2016 |
| 5                | Strategies 2, 3 & 9 Volume 3 Page | Relaunch the learning set on leadership and management for Band 8a staff | Head of Psychology & Psychotherapy | TBC + L&D | April 2016    |
| 6                | Strategy 3 Volume 3 Page | Identify talent, and encourage & support management and leadership training. | Psychology Divisional Leads |          | Ongoing      |
| 7 | Strategies 2 & 3  
    Volume 3  
    Page | Design psychology posts with sessions in clinical governance | Psychology Divisional Leads | Clinical Governance leads | Ongoing |
|---|---|---|---|---|
| 8 | Strategies 2, 3 & 5  
    Volume 3  
    Page | Create business development roles for psychologists within Divisions | Psychology Divisional Leads | Divisional Directors | Ongoing |
| 9 | Strategy 5  
    Volume 3  
    Page | Ensure the full integration of Psychology Divisional Leads in the development of the strategic work of their Division. | Psychology Divisional Leads | Head of Psychology and Psychotherapy | Ongoing |

**Developing and maintaining skills**

| 10 | Strategy 2  
    Volume 3  
    Page | Psychological Therapies Training Strategy Group (PTTSG) to review CPD modules to reflect new evidence and emerging roles for psychological therapy staff. | PTTSG Chair | PTTSG | Ongoing |

**Career progression and staff retention**

| 11 | Strategy 2  
    Volume 3  
    Page | Review recruitment strategy for PWPs to explore possibility of creating a more stable workforce | IAPT Lead |  | Ongoing |
| 12 | Strategies 2 & 9  
    Volume 3  
    Page | Psychology leads to revise/review job designs & create more posts that facilitate a broader range of skills development & to collaborate around development of cross- | Psychology Divisional Leads & Head of Psychology and Psychotherapy |  | Ongoing |
### Demonstrating effectiveness

<table>
<thead>
<tr>
<th></th>
<th>Strategy 1</th>
<th>Volume 3</th>
<th>Page</th>
<th>Psychological therapy services to develop a consistent approach to collecting and reporting outcomes</th>
<th>Psychology Divisional Leads</th>
<th>Divisional Directors</th>
<th>September 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td>Psychological therapy services to promote the use of outcome measures across all services in their Division</td>
<td>Psychology Divisional Leads</td>
<td></td>
<td>September 2016</td>
</tr>
<tr>
<td>15</td>
<td></td>
<td></td>
<td></td>
<td>Psychology leads to have a stronger engagement with the commissioning process in relation to decisions about outcome reporting</td>
<td>Psychology Divisional Leads</td>
<td></td>
<td>Divisional Directors</td>
</tr>
</tbody>
</table>
### Service user involvement

| 16 | Strategy1 Volume 3 Page | Each psychology service to develop a coherent and consistently applied service user strategy and to report on service user engagement as part of the annual service appraisal. | Psychology Divisional Leads | September 2016 |

### Supporting carers

| 17 | Strategy 1 Volume 3 Page | Develop a carer’s support policy for all psychology services. | Psychology Divisional Leads | September 2016 |

### Improving access to services

| 19 | Strategy1 Volume 3 Page | Psychology services to develop business cases for increased resources as appropriate. (Individual service need identified in section 5). | Psychology Divisional Leads | Ongoing |

### Opportunities for growth

<p>| 20 | Strategy 6 Volume 3 Page | Bid for stand-alone psychology services | Psychology Divisional Leads | Business Development Team | Ongoing |
| 21 | Strategy 6 Volume 3 Page | Bid for local funds to increase resources | Psychology Divisional Leads | Business Development Team | Ongoing |
| 22 | Strategy 6 Volume 3 Page | Explore the patient choice agenda | Psychology Divisional Leads | Business Development | Ongoing |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Strategy 6 Volume 3 Page</th>
<th>Leads</th>
<th>Team</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>Exploit the market potential of specialist services</td>
<td>Psychology Divisional Leads</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>24</td>
<td>Explore local private employment market</td>
<td>Business Development Team</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>25</td>
<td>Consultation, training, teaching and service support to other provider services and educational institutions</td>
<td>Psychology Divisional Leads</td>
<td>Business Development Team</td>
<td>Ongoing</td>
</tr>
<tr>
<td>26</td>
<td>Establish links with UCL and other research agencies developing digital solutions</td>
<td>Psychology Lead TBC</td>
<td>TBC</td>
<td>January 2016</td>
</tr>
<tr>
<td>No.</td>
<td>Strategy 4</td>
<td>Volume 3</td>
<td>Page</td>
<td>Text</td>
</tr>
<tr>
<td>-----</td>
<td>------------</td>
<td>----------</td>
<td>------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>30</td>
<td>Strategy 4</td>
<td>Volume 3</td>
<td>Page</td>
<td>Develop a of Behavioural Family Therapy (BFT) training post in the Trust to support Type 3 therapy provision</td>
</tr>
<tr>
<td>31</td>
<td>Strategy 4</td>
<td>Volume 3</td>
<td>Page</td>
<td>Prioritise training in Type 1 and Type 2 competencies in each Division</td>
</tr>
<tr>
<td>32</td>
<td>Strategy 4</td>
<td>Volume 3</td>
<td>Page</td>
<td>Develop training in group-work skills across the Trust</td>
</tr>
<tr>
<td>33</td>
<td>Strategy 4</td>
<td>Volume 3</td>
<td>Page</td>
<td>Explore the application of structured case management across Divisions</td>
</tr>
</tbody>
</table>

**Staff Support**

<table>
<thead>
<tr>
<th>No.</th>
<th>Strategies</th>
<th>Volume 3</th>
<th>Page</th>
<th>Text</th>
<th>Lead</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>Strategies</td>
<td></td>
<td></td>
<td>Contribute to development of a Trust-wide approach to</td>
<td>Psychology</td>
<td>January</td>
</tr>
<tr>
<td>7 &amp; 9</td>
<td>Volume 3 Page</td>
<td>staff support and within-team analysis of points of stress.</td>
<td>Leads</td>
<td>Occupational Health</td>
<td>2016</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

**Research and Development**

| 35 | Strategy 8 Volume 3 Page | Development of more research posts to enhance research links with local and national academic institutions & promote research funding applications | Divisional Psychology Leads | R&D Committee | Ongoing |
Camden & Islington Psychological Services Strategy 2015-2018

Volume 3:
The growth and development of psychological services
## CONTENTS

### Introduction

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
</tbody>
</table>

### 1.0 The Psychological Therapies Workforce

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Promoting equality and diversity in the workforce</td>
<td>4</td>
</tr>
<tr>
<td>1.2 Increasing the accountability of the workforce</td>
<td>6</td>
</tr>
<tr>
<td>1.2.1 Introducing job plans for psychologists and psychotherapists</td>
<td>6</td>
</tr>
<tr>
<td>1.2.2 Introducing 360 degree feedback for psychologists and psychotherapists</td>
<td>6</td>
</tr>
<tr>
<td>1.3 Developing leadership and management skills</td>
<td>7</td>
</tr>
<tr>
<td>1.3.1 Continuing professional development for leadership and management</td>
<td>8</td>
</tr>
<tr>
<td>1.3.2 Developing new roles for psychological therapis</td>
<td>8</td>
</tr>
<tr>
<td>1.3.3 Approved clinician training</td>
<td>9</td>
</tr>
<tr>
<td>1.4 Developing and maintaining clinical skills</td>
<td>9</td>
</tr>
<tr>
<td>1.5 Career progression and staff retention</td>
<td>11</td>
</tr>
</tbody>
</table>

### 2.0 Opportunities for Growth

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Bid for stand-alone services</td>
<td>13</td>
</tr>
<tr>
<td>2.2 Bid for local funds to increase resources</td>
<td>13</td>
</tr>
<tr>
<td>2.3 Exploit the patient-choice agenda</td>
<td>14</td>
</tr>
<tr>
<td>2.4 Exploit the market potential of specialist services</td>
<td>14</td>
</tr>
<tr>
<td>2.5 Explore the local private employment market</td>
<td>15</td>
</tr>
<tr>
<td>2.6 Deliver our products to other service providers and institutions</td>
<td>15</td>
</tr>
<tr>
<td>2.7 Development of digital solutions to service delivery</td>
<td>16</td>
</tr>
<tr>
<td>2.7.1 Digital solutions: Where are we now?</td>
<td>17</td>
</tr>
<tr>
<td>2.7.2 How should we position ourselves in the E-Health movement?</td>
<td>18</td>
</tr>
<tr>
<td>2.8 Obstacles to growth and expansion of services</td>
<td>19</td>
</tr>
</tbody>
</table>

### 3.0 Training Strategy for Psychological Therapies

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Maximising the delivery of NICE-concordant specialist Type 3</td>
<td>20</td>
</tr>
<tr>
<td>psychological therapies</td>
<td></td>
</tr>
<tr>
<td>3.2 Maximising the delivery of Type 1 and Type 2 interventions within each Division</td>
<td>21</td>
</tr>
<tr>
<td>3.3 Maximising the delivery of psychologically-informed care across the care pathway</td>
<td>23</td>
</tr>
<tr>
<td>3.4 Other sources of reflective practice and skilled supervisory support within teams</td>
<td>25</td>
</tr>
<tr>
<td>3.5 Support for professional training</td>
<td>26</td>
</tr>
<tr>
<td>3.6 Problems in delivering staff training</td>
<td>27</td>
</tr>
</tbody>
</table>

### 4.0 Staff Support : How can we best support our staff?

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Staff Support Groups</td>
<td>28</td>
</tr>
<tr>
<td>4.2 Support Following Serious Incidents</td>
<td>28</td>
</tr>
<tr>
<td>4.3 Mindfulness</td>
<td>29</td>
</tr>
<tr>
<td>4.4 Resilience Training: Acceptance and Commitment Therapy</td>
<td>29</td>
</tr>
</tbody>
</table>
5.0 Research and Development 30
References 32
Appendix 33
Introduction

Volume Three of this Psychological Services Strategy focuses on:

- The advancement and innovation in psychological services in the Trust;
- Fostering a skilled and effective psychological therapies workforce;
- Developing an effective psychological therapies training strategy for the Trust;
- Forging opportunities for improving our commercial position and share in the healthcare market;
- Building a more resilient workforce;
- Driving forward research and collaboration with academic partners to develop cutting edge services.

The appendix at the end of the document presents a summary of all the Action Points supporting implementation of the psychological services strategy.

1.0 The Psychological Therapies Workforce

The Trust currently employs 114.63 wte Clinical and Counselling Psychologists (Bands 7-9), 14.11 wte Psychological Therapists or Senior Psychological Wellbeing Practitioners (Band 6), 36.63 wte Psychological Wellbeing Practitioners and Psychology Assistants (Bands 4-5), and 2.0 wte clinical psychologists who are employed as non-medical psychotherapists. The Trust also employs two family therapists (0.7wte).

Some two-thirds of the total workforce is located in Improving Access to Psychological Therapies (IAPT), serving Camden, Islington and Kingston. There has been a small percentage increase in psychologists employed by the Trust year on year, and it is anticipated that, with new service developments, this is likely to continue. This increase is largely attributable to the development of IAPT services, and masks reductions in psychological therapy services in other areas of the Trust.

The National Workforce committee continues to predict a small but steady increase in demand for psychological therapists over the next three years. The funding for training clinical psychologists, psychological therapists and psychological wellbeing practitioners (PWPs) remains stable, and the Trust has an excellent record of being able to fill posts as they become available.

The challenge is to sustain a skilled and effective profession, characterised by a clear sense of purpose and a strong morale, and which is:

- Adaptive to the changing demands of the NHS.
- Efficient, lean, and affordable.
- Promotes the delivery of psychologically-informed care by all Trust staff.

1.1 Promoting equality and diversity in the workforce

The diversity of the psychological therapies workforce is an important contributing factor in ensuring that service users are able to access services that reflect their culture and identity.
It is sometimes argued that psychological therapy services are rooted in Eurocentric assumptions about the family, social structures, and how symptoms of distress will be expressed. In some part this can be addressed through professional training, continuing professional development (CPD), and innovative practice.

Clinical Psychology training courses are now placing much greater emphasis on cultural sensitivity in service delivery, and making it mandatory that trainees work with service users from a range of ethnic backgrounds. IAPT services are required to meet commissioner-led key performance indicators for black and minority ethnic (BME) populations.

This concentrates the mind of service providers and, locally, we have seen a range of innovative developments to increase BME access and successful engagement with our services – including audits of recovery rates for different populations, service user feedback from the BME population, and the recruitment of Sylheti and Somali speaking psychological wellbeing practitioners (PWPs).

The large number of refugees in the locality means that there has been an imperative upon services to develop cultural knowledge and competence, and this is a very significant part of the work of the Traumatic Stress Clinic.

Notwithstanding these valuable initiatives, we are more likely to achieve a culturally-competent workforce if its composition better reflects the local demographic profile. An analysis of the ethnic mix of psychological therapy staff in the Trust is reveals that as many as 87% of Clinical and Counselling Psychologists are either White British or White Other. This in turn reflects the profile of clinical psychology trainees, for while the BME community is well represented at degree level in psychology, it struggles to gain access either to clinical psychology training courses or psychology assistant posts (a common route into training courses).

The explanations for this are complex and beyond the scope or focus of this document, however, despite various attempts to promote diversity within the workforce – including Trust-led initiatives to improve awareness and understanding of Clinical Psychology among BME undergraduates at University College London (UCL) – relatively little progress has been made (Ref.6).

However, there is evidence, that the workforce is moving in the direction of increased diversity. The development of IAPT has created a large number PWPs (also known as Low-Intensity Workers) and Psychological Therapists (also known as High-Intensity Workers). The sheer number of these posts, the less stringent academic standard, and the intent to recruit PWP staff from BME groups (noted above) has opened the door to a wider population. This is reflected locally, where the percentage of those of White UK or White Other origin among PWPs and Psychological Therapists falls to 69% and 63%, respectively. PWP posts are also a stepping stone for many into both Psychological Therapist posts and Clinical Psychology training courses.

There is, therefore, a realistic prospect that the psychological therapies workforce, across all services, will have a larger representation of ethnic diversity over the coming years.
1.2 Increasing the accountability of the workforce

Good governance requires that systems are in place to ensure that all staff are held accountable for their work. Psychology and Psychotherapy services have an excellent culture of accountability through one-to-one and group supervision, and all supervisors will have attended supervision training courses. Psychologists usually receive weekly supervision in the first year following qualification, moving to fortnightly/monthly thereafter (pro-rata against sessions employed), and an enthusiasm for supervision is evident.

The supervision is delivered by senior psychologists, either on a one-to-one basis or in small groups. All staff will also have, of course, an annual appraisal.

There has, however, been less focus on planning for the optimum use of clinicians' time and responsiveness to peer and service user feedback. It is proposed that accountability for psychological therapy staff is enhanced by two developments:

1.2.1 Introducing Job Plans for psychologists & psychotherapists

Psychology services need to be transparent in demonstrating that they are operating efficiently. This means ensuring that clinicians are making the best use of their time to maximise their contribution to the Trust, their teams and service users. Such planning supports professional accountability, improvement in service user care, and offers clarity around what can be achieved within the scope of a job.

The Job Plan should not just be seen as a weekly timetable, but as a device to improve service efficiency, service quality, and job satisfaction. The introduction of job planning may also provide objective evidence of service capacity.

The Job Plan will sit alongside the Trust’s existing appraisal process, which sets out objectives and learning needs and will detail: what work is being done; when it is done; where it is done; how much time the clinician is expected to be available for different types of work; and what flexibility there is around the weekly schedule to accommodate changing service needs.

The job planning meeting will be undertaken with the clinician’s line manager and professional supervisor as part of the annual appraisal. It will need to be carried out in the spirit of collaboration, and be signed off by all parties.

**ACTION POINT 2**
Convene a working group to devise a protocol for Job Planning.

1.2.2 Introducing 360° feedback for psychologists & psychotherapists

A modern psychology workforce needs leaders with well-developed leadership skills, and senior clinicians who are effective and functional in their relationships with their immediate colleagues, the Trust, and other stakeholders. Many psychology leads have had little
management training, and receive little or no formal feedback from colleagues as to their interpersonal and managerial skills.

**ACTION POINT 3**
Convert a working group to establish an electronic system for 360° Degree assessment and feedback.

The 360° Degree feedback tool is now widely used to enable NHS professionals in leadership roles to identify their strengths and weaknesses, and where their development needs may lie. The process involves getting confidential feedback from line managers, peers and direct reports. It offers the individual an insight into other people’s perceptions of their leadership abilities and behaviour.

It is planned to introduce this tool for all psychologists and psychotherapists on Band 8b and above. It is anticipated that the introduction will create a stronger sense of corporate engagement for staff, as well as increasing self-awareness and personal effectiveness.

Feedback will be managed with the psychologist's line manager and supervisor, and will form part of their appraisal. It is intended that senior staff engage with this process every two years.

1.3 Developing leadership and management skills

Psychologists and psychotherapists have had relatively little impact in terms of engagement with the corporate life of the Trust. It is probable that the training of clinical psychologists and psychological therapists has given insufficient weight to understanding the mechanics and infrastructure of the NHS. Coupled with a necessary emphasis upon developing clinical competence, this has meant that psychologists have rarely identified themselves with the corporate world, may lack the confidence to take on senior roles within their profession, and have sometimes viewed such roles as alien and bureaucratic.

This reinforces the traditional, and unhelpful, split between management and clinician, and is wasteful because psychologists can contribute analytical skills and psychological understanding at all levels of Trust life. With the development of the healthcare market, it is also imperative that psychologists understand their role within the wider system, the need to be efficient and effective, to improve access and to innovate, and to look to growing the Trust's market share in delivering psychological therapies. There is a need to build leadership and management skills in psychologists, and to strengthen the integration of the profession into the Trust.

There have been some positive developments. First, since the Trust reconfiguration in July 2012, psychologists have taken service lead roles in Personality Disorders, Complex Depression, Anxiety and Trauma (CDAT), IAPT, the Islington Learning Disabilities Service, and a psychologist held one of the Clinical Director roles in the Trust.

Second, clinicians have taken on more specific corporate roles and responsibilities. Psychologists are now on both the senior manager and Directors’ on-call rota, and are providing substantial input into the investigation of Serious Untoward Incidents and Complaints. This has increased awareness of some of the core problems impacting the
Trust, engaged psychologists with other senior colleagues in decision making around these issues and generally raised the profile of psychological therapy staff across the Trust.

Third, psychologists are now taking up part-time roles in clinical governance, as well as in a workforce development role with Health Education for North, Central and East London (HENCEL). This latter role with HENCEL has led to an appointment to a national role overseeing Health Education England’s Mental Health and Learning Disability education and training.

Finally, psychologists are routinely working with the Trust business team on bidding for new contracts.

1.3.1 Continuing professional development for leadership and management

The Trust provides First Line Management courses for staff entering management roles, and the psychology service has recently introduced a new and similar course for band 8a psychological therapists. The aim of the eight half-day sessions, designed in collaboration with Learning and Development, is to provide an introduction to business and corporate life of the Trust.

The sessions have focused upon NHS finances, commissioning and tenders, clinical governance, performance and capability management, leadership and management skills, and service development. The programme appears to have had a significant impact, and the time given to supporting the training by senior members of the Trust and local commissioners has been much appreciated.

Following consultation with senior psychologists in the Trust, a similar Learning Set for all psychologists at Band 8b and above has been designed. It will commence in 2016.

ACTION POINT 4
Develop a learning set on leadership and management for staff at Band 8b and above.

ACTION POINT 5
Re-launch the learning set on leadership and management for all staff at Band 8a.

1.3.2 Developing new roles for psychological therapists

There is a need to develop new roles for psychological therapists that engage with the corporate life of the organisation. Such posts – for example, in clinical governance – can be designed to enable psychologists to maintain their clinical skills while providing excellent experience for future managerial positions.

IAPT is seeking to create a part-time post to explore opportunities for business growth, and enabling the post-holder to work closely with the Trust business team. Senior psychology
leaders need to be actively encouraging staff with management aptitude and potential to pursue these positions, and to engage with management and leadership training.

**ACTION POINT 6**
Identify talent, and encourage and support management and leadership training.

**ACTION POINT 7**
Design psychology posts with sessions in clinical governance.

**ACTION POINT 8**
Create business development roles for psychologists within Divisions.

**ACTION POINT 9**
Ensure the full integration of Psychology Divisional Leads in the development of the strategic work of their Division.

### 1.3.3 Approved clinician training

The Mental Health Act 2007 introduced the new roles of Approved Clinician (AC) and Responsible Clinician (RC) for medical practitioners, psychologists, social workers, nurses, and occupational therapists. Under the Act, ACs have various responsibilities, including acting as the RC for detained and Supervised Community Treatment service users, and so carrying overall responsibility for their care.

The Act’s Code of Practice states: “A patient’s RC should be the available AC with the most appropriate expertise to meet the patient's main treatment needs. The choice of RC should be based on the individual needs of the patient concerned. Where psychological therapies are central to the patient's treatment it may be appropriate for a psychologist to act as RC.”

Clinical Psychologists have been reluctant to take on these roles – to a fairly large extent, because of limited capacity – and few have embarked on the additional training to achieve AC status.

It could be argued that taking on such a responsibility would again strengthen the position of psychologists in their corporate and clinical roles in the NHS. However, the direct provision of consensual and collaborative psychological therapy by an RC to patients subject to the Act would be difficult in many circumstances, due to competing duties of care. This would need to be carefully considered, given the Acute Division’s very limited psychology resource.

### 1.4 Developing and maintaining clinical skills

Consolidating staff skills and providing good CPD is fundamental to ensuring that the service delivers interventions that reflect the developing evidence base. The C&I psychology service
has an excellent reputation for providing CPD for recently-qualified psychologists, and this has made C&I an attractive proposition for psychologists seeking their first employment.

For many years, the service has been offering four CPD modules, each of which is run every second year, depending upon the number of new staff. Psychologists usually attend the courses within the first two or three years of their qualification, and by agreement with their managers on the basis of the relevance of the courses to the requirements of their job. The modules are described below.

**Systemic Therapy Course**
This course develops skills and competencies in delivering family and system-focused interventions. There are two modules of 40 hours and 35 hours each. Module One (40 hours – usually delivered two hours per week) is at foundation level and is attended by staff from a variety of professional backgrounds. Those completing this course can go on to the Intermediate course, Module Two, which is mostly attended by psychologists. These courses have been accredited for the past 10 years by the Association of Family Therapy (AFT). The Trust will accredit the courses internally from 2015 onwards.

**Group-Work Course**
This course, delivered across 8-10 half-days, provides teaching in the understanding of basic group processes, and the development and application of group-work skills. The course is mostly run for psychologists, but this year has been opened up to staff from other professional groups.

**Psychodynamic Psychotherapy Module**
The course, delivered over seven half-days, provides an introduction to some of the key concepts that underpin psychoanalytic thinking – such as, transference, countertransference, projection and projective identification, interpretation, and the centrality of mourning in human development and in the analytic process.

**Cognitive Behavioural Therapy (CBT) Module**
The Cognitive Behavioural Therapy CPD module is a 10-week course designed to give newly-qualified psychologists training in topics related to CBT, to help them consolidate and develop skills and knowledge learned on clinical psychology training courses. The module is delivered by experienced cognitive behavioural specialists, and the workshops are highly-interactive, focusing on CBT as applied to the types of complex cases seen within the NHS.

In addition to the four CPD modules for recently-qualified staff, the psychology service provides an ongoing programme of CPD events, which are advertised to staff via a quarterly newsletter. These will include the bi-annual District Psychology Workshops and four CBT Day Workshops, with guest speakers from around the UK.

The psychology service also provides ongoing supervision of family practice for clinicians working with families, and a supervision group for psychologists working with groups.

The CPD programme for psychologists is regularly reviewed at the Psychological Therapies Training Strategy Group (PTTSG) meeting every three months (reporting to the Trust Learning and Development Group).

The future structure and content of modules is currently under review, and will be informed by changes in service structure and demand – such as taking into account new roles for
psychologists in primary care, and the delivery of training and support for staff across the care pathways.

**ACTION POINT 10**
The PTTSG group to review CPD modules to reflect new evidence and emerging roles for psychological therapy staff.

### 1.5 Career progression and staff retention

Although it is generally the case that psychology and psychotherapy services continue to be able to recruit high-quality staff, there are difficulties with regard to longer-term retention of ambitious and able clinicians. Several factors have contributed to this.

First, the reconfiguration of services in 2012 resulted in the loss of a number of senior banded posts, and some staff – notably at Band 7 and 8a – feel that there are few opportunities within the Trust for career progression. Perhaps because C&I was one of the first Trusts to reconfigure services, there has been a loss of staff to other Trusts, where more senior posts continued to be available. It is disappointing to lose staff when the Trust has invested heavily in providing CPD and supervision to develop their skills, and it is to the detriment of service quality to lose experience and seniority. It is possible that, as other Trusts reduce the number of higher-banded posts (and there is evidence that this is happening), then this may be less of a problem, although there is now the risk of psychologists leaving the Trust to join rival private and third sector agencies that are able to offer more attractive salaries. Furthermore, some psychologists may be persuaded that a career working privately – at least for part of their working week – is more attractive than a full-time and less financially-rewarding career in the NHS.

Second, the psychology services used to offer split posts across specialisms, but the creation of Service lines posts means that these tend to be filled within Divisions, rather than across them. It would be desirable to create more attractive posts by providing clinicians with a varied experience that enables the development of a wider range of specialist skills, and that could also include more explicit training and research components. IAPT has developed several such specialist roles – such as in relation to long-term conditions, physical health and wellbeing, working with BME communities, working with older people and young adults – and so has enabled clinicians to develop a broader skill-set and areas of specialist knowledge. Further, if the Trust can sustain a position at the forefront of new service developments (such as in primary care services, CDAT, PD, Transitions and IAPT) then this will facilitate both recruitment and retention of staff.

Third, clinical psychologists, historically, could achieve bandings of 8a and above based on clinical expertise and specialist skills. However, since Agenda for Change clinicians are now required to take on management and leadership responsibilities to increase their banding, this may encourage some psychologists to take a more managerial and corporate route (at least as part of their role). However, it is also a source of dissatisfaction for those who wish to specialise exclusively as clinicians, and it may not be a good model for all staff.
While varied and attractive job design and service innovation may improve staff retention, it is a challenge to keep ambitious and highly-competent staff. Ultimately, lack of career progression could reduce the attractiveness of the psychological therapies as a career choice – although, at present, competition for training places remains as high as ever.

There are some limited, but worthwhile, strategies. In the IAPT service, for example, there is recognition that the vast majority of PWPs will have left the service after two or three years to pursue training as Psychological Therapists or Clinical/Counselling Psychologists. This is a significant loss of skill and experience, and we are endeavouring to retain at least some of our most talented PWPs by creating senior PWP roles at Band 6 to take on specialist and supervisory roles within the IAPT service (qualified PWPs are employed at Band 5).

Recruitment into PWP roles is almost exclusively dominated by graduates with one or more years’ experience in mental health, and who perceive the role as a route into a higher qualification in psychological therapy. This is both a strength and a weakness. The young staff are very able, highly motivated, and contribute energetically to innovative practice and the high volume of work required. However, the constant disruption and discontinuity in the late summer months (in advance of the new academic year commencing) is undesirable.

Ideally, the movement of staff might be balanced by identifying candidates – from a wider spectrum – who may be less likely to move on and who might also find roles facilitating the delivery of psychological therapies across other Divisions.

**ACTION POINT 11**
Review recruitment strategy for PWPs to explore possibility of creating a more stable workforce.

There is a further emerging problem when fixed-term contracts are attached to meeting key performance indicators (KPIs), such as waiting list funding. When filled by newly-qualified staff, there is an expectation of participating in our CPD programme described in volume three section 1.4. The considerable loss of time to CPD compromises productivity, and it has been necessary to limit CPD attendance to meet service demands. While this can be solved by flexible working practices and compromise, there is no doubt that it can foster discontent about lack of parity with permanent staff, and again can impact on retention.

A part of this problem may be that staff must adjust to a changing NHS culture, and it is important that training courses are preparing newly-qualified staff for the realities of working in a system under pressure. There is ongoing discussion between the Trust and our three local training institutions (University College London, University of East London, and Royal Holloway University) with regard to the best preparation for trainees for NHS employment.

**ACTION POINT 12**
Psychology leads to revise job designs and create more posts that facilitate a broader range of skills development and to collaborate around development of cross-Division posts.
2.0 Opportunities for Growth

Seven different strategies have been identified to address the question of how psychology services can grow and increase their market share:

2.1 Bid for stand-alone psychology services

IAPT represents the clearest opportunity. The C&I IAPT service has an excellent reputation for quality and innovation, notably in the area of providing a genuinely inclusive and community-based service, managing sub-contracting with voluntary sector organisations, delivering local and national training, innovative group-work, and increasing access to BME communities.

Although we won the IAPT service contract in Kingston, subsequent bids have been unsuccessful, and we face the major challenge that many of the IAPT contracts are so poorly funded that they preclude the delivery of a NICE-compliant service. If we decline to bid for these services, we run the risk of the risk of being squeezed out of the market. If we modify our model to enable us to deliver outcomes against small contracts, we run a reputational risk to our service quality, and the probability of failing to deliver against key performance indicators.

It is possible that the failure of providers to deliver against under-funded service contracts will produce a natural correction to the “race to the bottom” in contract size. This would favour services, such as C&I’s, that carry a good reputation for quality. It is also possible that the market for IAPT services will evolve and that, rather than stand-alone contracts, IAPT services will be tendered as a part of new primary care contracts.

Locally, we have the opportunity to build IAPT services as part of our primary care teams working hand-in-hand with GPs and having close links with specialist services. This is a rapidly-developing area, and we should be looking to use this model as an example of good integrated primary care services for future contract bids.

Alongside this, the service will continue – in collaboration with the Trust Business Team, and in partnership with voluntary and third sector agencies – to look for realistic opportunities to bid for IAPT stand-alone services.

ACTION POINT 20
Bid for stand-alone psychology services.

2.2 Bid for local funds to increase resources

The pattern of annual Cost Improvement Programme (CIP) savings – against which there is some compensation from new local funding for nationally-led initiatives – will continue over the term of this government. Psychology services have benefited from waiting list funding for the Traumatic Stress Clinic (TSC), CBT for psychosis and for IAPT services. There has also been funding for Transitions services, with the creation of several new psychology posts (as
described in volume two, section 6.8) and new funding for crisis services. There are likely to be continued opportunities for growth where services can demonstrate that the new funding will increase service reach and improve outcomes and access times.

**ACTION POINT 21**
Bid for local funds to increases resources.

**2.3 Exploit the patient-choice agenda**

Patient Choice, as exercised by service users through their local GP, provides a real opportunity for services to attract new business. As a central London Trust, C&I is well placed to exploit this business potential due to the fact that a large population of potential service users commute to London, and may wish to enjoy the convenience of availing themselves of services during their working day.

There are clear possibilities for IAPT and Clinical Health Psychology services working with long-term conditions, as well as the possibility of setting up specialist clinics for smoking cessation, and for therapies such as Mindfulness, Stress Management, Acceptance and Commitment Therapy (ACT) to develop resilience, and for wellbeing and lifestyle enhancement therapies.

**ACTION POINT 22**
Exploit the patient-choice agenda

**2.4 Exploit the market potential of specialist services**

Where we have developed highly-specialist psychological therapy services, there is the potential for marketing this to NHS and other service providers.

- The TSC attracts some Non Contract Activity (NCA), but this could be increased with a good marketing strategy, focusing upon our expertise in treating PTSD, working with childhood sexual abuse, and with refugees. There is also the possibility of developing a service to treat dissociative disorders, rather than purchasing this from other Trusts.
- The CDAT service is beginning to develop specialist clinics for working with treatment resistant depression and obsessive compulsive disorder (OCD).
- The Personality Disorder (PD) Services, which are also highly specialist, attracted very positive feedback from the Care Quality Commission (CQC) as being exemplars of good practice. The local expertise in Mentalisation-Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT) provides an opportunity for marketing, and we are currently exploring possible collaborations with other Trusts with regard to developing a comprehensive PD intervention service.
• The Camden Gangs Project (Positive Punch) provides a template for multi-agency psychologically-led interventions with gang members. C&I was the first NHS Trust to lead on the delivery of a gangs project, and has developed a clinical governance structure that we have already delivered as training to Barnet, Enfield and Haringey (BEH) Mental Health Trust. A new project (in collaboration with both Camden and Islington local authorities) will be launched in the autumn of 2015. The service will be delivered in conjunction with MAC-UK, an agency that is developing an Academy for the training of gang-workers. It is planned that the new project will provide placement opportunities for community workers in training with the MAC-UK Academy. This will contribute to the sustainability of the project by providing staffing and direct revenue in the form of placement fees. The Gangs Project has reputational advantage to the Trust, and may provide further marketing potential.
• Interventions to manage anti-social behaviour can be marketed to local authorities – for example, Psychologically-Informed Consultation and Training (PICT), and our local model of Gangs Intervention.
• In C&I, we are well placed to collaborate with local research institutions (notably through jointly funded posts) to develop new cutting-edge and effective new interventions that improve quality and patient experience. These developments clearly provide marketing potential.

ACTION POINT 23
Exploit the market potential of specialist services.

2.5 Explore the local private employment market

There are a number of possible options that could be explored. Step 2 and Step 3 IAPT interventions could be sold to local employers, as could other wellbeing and lifestyle interventions – including Mindfulness, ACT and stress management packages.

ACTION POINT 24
Explore the local private employment market.

2.6 Delivering our products to other service providers and institutions

There are several opportunities for commercial exploitation by delivering our existing products to other providers, including:

• The C&I PD Service has developed expertise in delivering PICT, and has won funding to deliver this in primary care, forensic settings, and working with troubled families. PICT has a good record of effective intervention, is well-received by non-mental health staff, and affords an opportunity for further expansion.
The Camden Gangs Project, described above, can offer funded placement opportunities to students.

CDAT and IAPT services could offer consultation – for example, with regard to hoarding – to fire and housing departments.

CBT supervision for complex presentations of psychosis.

The TSC and Acute Service “Staff Affected by Stress/Trauma at Work” service.

A number of Postgraduate diplomas in CBT are running in London, and some pay good rates for external supervisors. This is a possible market opportunity, although the impact of loss of staff (who would be difficult to backfill) needs to be balanced against income.

Psychotherapy services have an excellent reputation for the training of junior doctors on rotation, and could exploit this by providing Skype (or similar secure-platform communication) supervision for junior doctors working in Trusts outside London where there is a lack of medical psychotherapy expertise.

IAPT has been running an IAPT group-work course for IAPT staff across the UK, hosted by the Anna Freud Centre. This course is now under review, and the service is planning to re-launch it as part of a broader-based series of workshops for PWPs and High-Intensity Therapists that will be hosted within C&I and marketed across London or nationally.

C&I rehabilitation psychologists have developed training packages for delivery to rehabilitation teams in the Trust, and these could be delivered to other providers.

The Trust has recently won a small contract to deliver Schwartz Rounds – a practical tool that health and care providers can use to improve the culture of their organisation and to support staff – to Islington Community Services (mental and physical health providers).

ACTION POINT 25
Consultation, training, teaching and service support to other provider services and educational institutions.

2.7 Development of Digital Solutions to service delivery

The digital revolution demands a change in the way we think about the provision of mental health care, as it is through modern technology that we increasingly expect to receive and exchange information. It is estimated that 43% of people access healthcare information online, 94% of people have a mobile phone, and 83% of homes have internet access (Ref. 9). People now look to the digital medium to understand and manage their health, and to find support and solutions via developments such as social media chat sites on mental health and recovery.

This is not to downplay the importance of face-to-face relationships in healthcare. Indeed, much of the new technology will not be a replacement for one-to-one or group therapies, but is “blended-care”, offering an adjunct to existing interventions.

However, we need to emphasise that technology opens up new possibilities to improve public health through the dissemination of information, and by offering alternative and adjunctive models of care delivery.

Digital technology offers an opportunity to address some of the most significant problems of healthcare delivery. The NHS Mental Health Foundation estimates that, by 2030, more than
two million adults in the UK will have mental health problems. The challenge is to improve the mental health of the nation against a background of falling funding and the well-documented failure of the majority of people with mental health problems to access services. Although not a panacea, digital technology does present new ways to deliver services more efficiently and cost-effectively, to improve convenience and access, to empower patients and support self-management, and to have ready access to outcome data. The new technology is very fast-moving, with smartphones, wrist bands and glasses providing internet access, and health trackers monitoring bodily changes in health and functioning.

There are thousands of Health Apps, although less than a hundred are exclusively for mental health, and very few have been evaluated. The current range of mental health APPS provide information and signposting, advice about lifestyle and wellbeing (such as mindfulness practice), self-help support for specific conditions, and a few provide interactive therapy for common mental health problems – for example, The Big White Wall and Psychology On-Line.

Many of the current Apps address mild-to-moderate common mental health problems, but there are interesting possibilities for more ambitious interventions. We could, for example, utilise Apps for addressing behaviour change in long-term conditions where lifestyle impacts physical and psychological health.

In keeping with the integrated care agenda, we could be developing E-based care planning tools for people with complex physical, psychological and social needs. These would be shared with service users, and could be used by clinicians from different services to coordinate care. We could also exploit Apps such as “Mind of My Own” – being developed for young people in transition between child and adolescent and adult service.

These initiatives would require extensive collaboration with academics and the digital industry.

2.7.1 Digital Solutions: Where are we now?

The new technologies are beginning to find a place in some of our services. For example:

- Service users can make appointments by email in IAPT and the Psychotherapy service, and by text in IAPT.
- Telephone assessments and therapy with PWPs in IAPT.
- Computerised CBT (CCBT) for anxiety and depression and insomnia in IAPT.
- A web-based PODS system is being used for collecting outcome data and instant analysis in our Personality Disorder Treatment Teams (PDTA) and Assessment Services.
- We are making some use of email therapy in IAPT.
- We have just established a partnership with South London and Maudsley (SLaM) Trust for the delivery of psychological support via Skype to NHS staff working with humanitarian crises around the world.
- The head of the Trust CDAT service has developed a very successful website – “Down Your Drink” (DYD) – for providing digital screening and brief feedback to enhance the delivery of evidence-based brief interventions to people who drink hazardously, and who are at risk of experiencing significant harm through excessive alcohol consumption. The website was the first of its kind and has continued to evolve, so that it is still the first choice digital intervention for new research programmes in the field and also for service...
developments. DYD has spawned a family of derivative versions, including “Healthier Drinking Choices” and “Help Alcohol”.

- IAPT is currently involved in a study evaluating “blended therapy” – a mixture of face-to-face guided self-help, computerised programme, and phone App – for depression.

2.7.2 How should we position ourselves in the E-Health Movement?

- We cannot compete in terms of developing technology, but we can provide the clinical setting in which these innovations can be evaluated. We should be forging close links with the UCL Click Project and with other agencies with genuine expertise in developing digital solutions to healthcare delivery. This will enable us to offer the very latest in innovation to our service users, and to be at the forefront of evaluating effectiveness.

**ACTION POINT 26**
Establish links with the UCL and other research agencies with genuine expertise in developing digital solutions to healthcare delivery.

- All new service design should consider digital innovation as part of service configuration and delivery. This also provides a great opportunity for service user engagement, co-producing E-Health solutions and using social media to test out new ideas with young and old people alike.

**ACTION POINT 27**
All new service design should consider digital innovation as part of service configuration and delivery.

- We should be looking to extend the innovations in practice that have already been established. We could: extend the use of both Skype and email therapy across the psychological therapy services; the use of iPads for neuropsychological testing and for instant recording and analysis of outcomes across psychological services; consider introducing tele-care for older adults.

**ACTION POINT 28**
Extend the use of existing digital solutions in services

The culture is changing – but, arguably, the statutory health providers are not keeping pace. There is no doubt that we are on the cusp of a change in the way that services will be delivered and, if we are able to forge ahead now, we could place ourselves in an advantageous position in the marketplace. We should be clear that, with patient choice developing, service users may soon be choosing their own online provider.

There are, however, many challenges to developing E-Health solutions. How will the Trust manage the necessary culture change, assuming that there will be psychological resistance to changing how we deliver services? How will we fund and support the new IT infrastructure and staff training programme? We will need to develop governance structures to support the new technology, and to oversee inter-operability between digital tools and the Trust.
electronic patient record (EPR). We would need to bring in expertise to enable us to deliver these new systems.

The Mental Health Network NHS Confederation paper, “The Future is Digital”, published in 2014 (Ref.9), calls for a national approach, with NHS England taking a lead role, and for inclusion of digital developments in the NHS mandate for 2015-2016. It recommends that each organisation should have a programme director. It is anticipated that these recommendations will be made later in the year. In the meantime, we have an opportunity to position ourselves to take full advantage of this major shift in the culture of service delivery.

**ACTION POINT 29**
Psychology services to play significant role in the development of a Trust-wide approach to the development of a digital technology programme for the psychological therapies.

### 2.8 Obstacles to growth and expansion of services

There is much enthusiasm for growing and developing the market share for psychological therapy services. However, this is often frustrated by a lack of support and infrastructure. Bidding for tendered services is time-consuming, distracts senior staff from local service provision, and is mostly done outside normal working hours.

All of the potential initiatives described above require extensive consultation and relationship building, good marketing, and business planning. There is a need to invest in a stronger infrastructure for growth that frees-up (or imports) local expertise to enable us to realise our potential.

Where possible, it will be important to develop business expertise among clinicians within services. The proposed development of a part-time business development role (planned for late 2015) for a clinician in IAPT would be an important step in this direction.
3.0 Training Strategy for Psychological Therapies

How can we enhance the capacity of the Trust to provide psychologically-informed care that promotes the recovery and the wellbeing of all our service users? How can we increase system capability to deliver talking treatments, and ensure that service users get what is needed, when it is needed, and delivered by those who are best placed to provide it?

It is the responsibility of all staff to offer psychologically-informed care to service users. We must ensure that staff are competent and feel confident to offer therapeutic care – from the most fundamental but vital competences of good empathic communication to the delivery of more specialist interventions.

This section describes a range of approaches to staff training, identifies some of the problems and dilemmas of making training work, and advances some action points for the future.

3.1 Maximising the delivery of NICE-concordant specialist Type 3 psychological therapies

The traditional model of psychological therapy has been to offer stand-alone NICE-concordant therapies (described as Type 3), delivered by psychological therapy practitioners. While in principle it would be possible for the Trust to recruit more psychological therapists to deliver the necessary volume of NICE-concordant therapies, in reality this is likely to be extremely costly and impractical. Therefore, it is necessary to train in-house non-psychological therapy staff to a level of competence to deliver NICE-concordant interventions.

In 2013, the Trust Board accepted a psychology strategy paper providing a framework for a Trust-wide approach to achieving this goal, building on training programmes that had been in place since 2008. The paper clarified and formalised what is required for staff in the Trust to be considered competent in delivery of the main NICE-recommended psychological therapies relevant to the Trust’s services (CBT and family interventions).

There are five stages of training for each psychological therapy, requiring training over a likely minimum of 18 months. We have three specialist trainers (total 1.0.wte) delivering the training and supervision for the respective modules, and they are supported by psychologists offering supervision across the Divisions. The courses have been very successful in attracting trainees. The CBT course began in 2008, and a total of 193 non-psychologists have completed the five-day introduction to CBT course of whom 62 were nurses, 27 social workers, 17 occupational therapists, 16 support workers, 15 assistant practitioners, 15 substance misuse workers, eight graduate mental health workers, eight assistant psychologists, five clinical practitioners, two pharmacists, one medic, and 17 “others”. The 10-day advanced course has been completed by a further 55 staff.

The Systemic Foundation and Intermediate courses have been accredited for the past 10 years by the Association of Family Therapy (AFT), and have received high commendation at accreditation reviews. The Trust will accredit the courses internally from 2015 onwards.

Since 2009, the 40-hour Module 1 Foundation training has been completed by 213 practitioners (133 clinical psychologists, 25 nurses, 25 social workers, eight Occupational
Therapists, four psychiatrists, two psychotherapists, 15 other mental health workers, and one manager; 81 practitioners have completed the 35-hour Module 2 Intermediate training (56 clinical psychologists, 11 social workers, seven nurses, four Occupational Therapists, and three other mental health workers); 55 practitioners have received an accredited Certificate in Family Therapy by the Association of Family Therapy (40 clinical psychologists, seven social workers, five nurses, two occupational therapists, and one other mental health worker); 12 practitioners have been accredited as Systemic Practitioners by AFT at Diploma Level (two-year training), and a further three have gone on to qualify with external institutions as systemic psychotherapists, returning to offer training and supervision within the trust.

The Next Three Years

In the last year, the Trust has invested in training staff in Behavioural Family Therapy (BFT), a NICE-recommended family intervention (minimum 10 sessions) to be delivered by qualified mental health professionals. The five-day training programme was provided by Meriden to 30 staff (21 clinical psychologists, five nurses, two social workers, one occupational therapist, and one trainee wellbeing practitioner, with 17 coming from R&R, six from Services for Ageing Mental Health (SAMH), four from the Acute Division, and 1 from CDAT). The training is now supported by externally-provided monthly supervision.

If BFT is to become embedded in the Trust, we need to establish our own trainers and supervisors who have previously completed the systemic training in the Trust (or equivalent). We will be aiming to secure, in partnership with University College London Partners (UCLP), new funding from Improving Access to Psychological Therapy – Severe Mental Illness (IAPT-SMI) (see section 3.5) to develop a training post for BFT, to work alongside our trainers in systemic therapy. This will be a priority for the coming year. The Trust should also look to securing more funding from Health Education England (HEE) to support training in Type 3 therapies.

ACTION POINT 30
Development of a Behavioural Family Therapy (BFT) training post in the Trust to support Type 3 therapy provision.

3.2. Maximising the delivery of Type 1 and Type 2 interventions within each Division

The Psychology Training Strategy Paper (2013) delineated Type 1 and Type 2 interventions. Type 1 are the talking treatments that all service users receive as a core component of care (essentially, basic good listening and communication provided by all staff with treatment/care roles, at all bands). Type 2 are psychological interventions available within each service to help address more specific problems (e.g. motivational interviewing in Substance Misuse Services (SMS), sleep hygiene in SAMH, hearing voices groups in R&R).

These may be delivered by staff across a range of banding, with those at lower bands providing the interventions under supervision from more senior experienced staff. Type 2 interventions might also be described as including broader-based trainings that have application across the whole care pathway.
Most training for Types 1 and 2 interventions are probably best delivered within Divisions. Because the needs of Divisions are different, there is an advantage in focusing training using case examples relevant to the specific Division (dementia, psychosis, substance misuse), and for logistical reasons.

**Examples Of Good Practice**

An excellent example of a systemic theory approach to training is the mandatory programme provided by the psychology team to staff in SAMH. Staff receive 1.5-hour sessions dedicated to the principles of CBT, understanding anxiety, basic therapy techniques such as exposure and relaxation training, understanding depression, and techniques such as behavioural activation and activity scheduling, mindfulness and relaxation techniques, relapse prevention, assessing cognition, and the assessment and management of challenging behaviour.

The **Learning Disabilities Service** (LDS) runs awareness training across the Trust to enhance understanding of LD, and the need to make reasonable adjustments to meet the needs of people with LD. This is being run three times as a pilot, with the intention of developing it into a regular Learning and Development training on a quarterly basis. The service also offers autism awareness training, as well as specific training on issues such as bereavement and dementia in the context of LD.

**CDAT** has developed a comprehensive training package for all staff joining the service that is backed by ongoing individual and group supervision. Staff receive Type 2 training in the understanding of anxiety, depression and trauma, and learn about specific interventions – including activity scheduling, graded exposure, behavioural activation, normalising, psycho-education, and managing extreme emotions through grounding, distraction, attention switching and imagery.

The training package also includes managing the difficult elements of the relationship with service users, ruptures in the relationship, dependency and endings, and the importance of relapse and crisis plans.

Staff are trained in the basic principles of how to ensure each meeting with a service user has an agreed agenda, structure and sense of purpose, enabling service users to identify goals and aspirations and problems that are amenable to change. They also learn about formulating problems and identifying maintaining factors, understanding the impact of avoidance on symptoms and wellbeing, the importance of working collaboratively with clients, and the underlying principle of improving self-management.

**The Next Three Years**

There is the potential for psychology to contribute more to training in Type 1 and Type 2 skills. The plan is for Psychology Leads to liaise with Divisional Leads and the Learning and Development Team to prioritise competency training.

It is anticipated that this will begin with the Acute Division. It is also the case that many nurses start in Acute Services, and later move to community posts, so this would enable transfer of skills to other Divisions as their career progresses.

In the R&R Division, there is also the possibility of delivering training for care co-ordinators in low-intensity interventions for depression and anxiety in psychosis via one or two one-day
courses, supported by ongoing supervision from team psychologists. In addition, the R&R family therapist is piloting brief training for care co-ordinators in basic family work skills.

**ACTION POINT 31**
Psychology Leads to liaise with Divisional Leads and the Learning and Development Team to prioritise competencies training.

There are advantages to training delivered to Divisions and teams, rather than to individuals. The training can impact on the culture of the team, and new learning has a real chance of being embedded in practice when all the team are learning together. In contrast, when individual clinicians go outside their team for training, they may return to their team lacking confidence and in need of support to practice skills. If this is absent or little understood by colleagues, the newly-trained staff may quickly lose motivation. However, the logistics of providing team training courses are considerable and are likely to produce cost pressures on the service.

Another area of training that could be developed is in relation to group-work (a mix of Type 2 and Type 3 skills). Staff work with groups of service users in many settings. The Psychology CPD group-work module (see volume three section 1.4), run by a consultant group analyst, provides an excellent resource for learning about group dynamics and the use of groups as a medium of change. In the last year, the training has been opened up to non-psychologists.

**ACTION POINT 32**
Develop training in group-work skills across the Trust.

### 3.3. Maximising the delivery of psychologically-informed care across the care pathway

It is estimated that only 12% of service users with a diagnosis of Personality Disorder will receive a specialist therapy. Many will never be referred for a specialist therapy, and not all would benefit from a formal one-to-one or group intervention; they may be too overwhelmed with distress or too distracted by social care needs to commit to the routine and demands of formal therapy, and some may find the experience stressful and destabilising, rather than beneficial.

Similarly, a recent analysis of CDAT service users suggested that, at any one time, only around 15% would benefit from a specialist psychological Type 3 therapy – although more would be helped by some of the specific Type 2 interventions.

While many service users with such complex presentations may not be able to access specialist therapies, their care would be very much enhanced by a more psychologically-informed approach to the day-to-day management of their problems.

People with personality disorders and other complex and challenging presentations are highly represented in the health, social care and judicial care pathways, but are not able to benefit from our knowledge of best management of their condition. Therefore, we need to
complement the provision of training in Types 1, 2 and 3 therapies by increasing the skills of the workforce to deliver more psychologically-informed care across the whole care pathway for these very complex presentations.

Psychologically-Informed Consultation and Training (PICT)

The C&I Personality Disorder (PD) service has developed PICT, an approach based on learning from delivering Mentalisation-Based Therapy (MBT) and Dialectical Behaviour Therapy (DBT). PICT starts with the care pathway. Where is the service user with PD seen? How are their needs being met as they move around the system, and how enabled are staff to meet these needs?

The aim is to support the wider system to work more effectively with people presenting with personality disorder and other complex mental health presentations and challenging behaviours, and to enable our own mental health workforce to work with their service users in a more targeted, proportionate and effective way.

The PICT team consists of eight/nine psychologists who have specialist knowledge and expertise in understanding and working with adults with personality disorder. Although hosted by the PD Service, they are embedded within different care pathways to support those staff to work more effectively with service users presenting with personality disorder, which may not be diagnosed. Currently, PICT psychologists work in:

- London Borough of Islington (LBI) children’s social care to support the identification and management of parents with mental health problems, particularly PD or challenging behaviour.
- LBI’s 18 to 24-year-old gangs and serious violence transitions service.
- Primary Care and Crisis Pathway in Camden and Islington.

The PICT team delivers a model of intervention comprising the following elements:

- Case identification (the service users whose personality difficulties makes the task of supporting them more difficult).
- Case consultation and liaison, including signposting to a range of community support.
- Bespoke training.
- Joint working, where appropriate, to promote earlier and more informed assessment and formulation, and to role-model best practice.

The PICT psychologists do not carry a caseload of service users in the teams in which they are embedded, although they do carry a small caseload in the PD Service. This is in order to maintain their clinical expertise, and to support their professional development.

The PICT approach is based on the following assumptions:

- Most service users with personality disorder will never enter formal therapy services, for various reasons. They will be cared for in more mainstream settings, primary care, probation, housing support services, substance misuse services.
- The practitioners in these services will face challenges in providing care to people with PD because of their relationship difficulties and, therefore, require “upskilling” to be effective.
By equipping the workforce with the knowledge, skills and confidence to work more effectively with this group of service users, we can enhance the quality of psychosocial interventions and achieve sustainable benefits beyond the input from PICT.

PICT training to practitioners is customised for the recipient teams, but typically involves some or all of these elements:

- Understanding personality disorder and its causes.
- Clarification of roles and responsibilities.
- Motivational interviewing.
- Collaborative problem solving.
- Validation.
- Contingency management.
- Setting limits and boundaries.

This model of case management emphasises relationship skills (engagement, communication and validation) and also structuring skills (making the achievement of a positive outcome more likely through focused goal-setting and problem-solving). This model of care is used by the PD community team, enabling them to bring key elements of specialist therapies into the day-to-day management of service users with the most complex presentations.

The model provides staff with a clear sense of purpose in relation to each of their contacts with service users, improving the staff sense of efficacy, and providing a more structured and goal-focused experience for service users (an approach supported by the evidence base).

The application of the PICT approach in other services should be explored.

The Next Three Years

**ACTION POINT 33**

Explore the application of a structured case management across Divisions.

### 3.4. Other sources of reflective practice and skilled supervisory support within teams

The Psychodynamic Psychotherapy service provides reflective practice and consultation to a number of services across the Trust, including Recovery Centres, Islington Alcohol Services and the Risk Panel. The service also offers Balint Groups (aimed at better understand the clinician-patient relationship) for doctors on rotation (see volume two, section 6.7), monthly case discussion groups for consultant psychiatrists, and CPD opportunities for psychologists and other staff to take on a psychotherapy case under supervision.

In the last year, the Psychodynamic Psychotherapy service has developed training in psychodynamic principles for the Acute Service wards. This was piloted at the Highgate Mental Health Centre, and will be repeated at the St. Pancras Hospital site. The focus of the
seminars is a developmental approach to understanding service users and the impact of psychiatric disturbance on staff, aiming to deepen understanding of emotional pressure on individuals and teams, and to provide an interactive forum for discussion of issues raised and their clinical application.

### 3.5. Support for professional training

The Trust holds the contract with UCL, University of East London (UELP) and Royal Holloway University of London (RHU) for trainee clinical psychologists. This means that around 300 trainees will hold a contract with C&I and, at any one time, about 30 to 40 trainees will have placements in the Trust.

The Psychology Service also provides training placements for psychological therapists (CBT trainees at the Institute of Psychiatry (IOP) and for Personal Wellbeing Practitioners (PWP) in training at UCL. It also provides placements for counselling psychologists on local courses. In addition, a contract has been established with the University of Bath to provide placements for undergraduates, and several undergraduate students each year will have an eight-month placement in the psychology services, with some additional summer placements also being provided. These students are mostly located in IAPT, contributing significantly to audit, and the setting up and running of groups, but they have also worked in the Neurodevelopmental Disorders Service (NDD), the Trust Assessment and Advice Team (AAT) and the Trust Clinical Governance Team.

Formal CBT training is also provided by the Psychology Service for junior doctors on rotation, to meet their training requirement to deliver for a "short-case" psychological treatment (6-12 sessions). There is a one-session post per week post dedicated to organising this scheme, and it is delivered as a rolling programme of group supervision, with service users drawn from the IAPT service.

The Psychodynamic Psychotherapy service is integral to the training of psychiatrists, and is part of the core curriculum for general psychiatry AT1-6. All core psychiatry trainees are required by the Royal College of Psychiatrists to take on a psychotherapy case (under supervision from a consultant psychiatrist) and to participate in a weekly Balint Group.

The service offers training placements to trainees from many individual and group psychotherapy training courses, and in particular has very strong links with the Institute of Group Analysis. It also provides supervision for the "long-case" psychological treatment (usually about one year) for doctors on rotation, with supervision delivered by a medical consultant (GMC requirement) to a small group of doctors.

### 3.6 Problems in delivering staff training

We need to be able to demonstrate that training is of a high quality, has an impact on practice, and improves outcomes and service user satisfaction. However, despite the range and sophistication of our training strategy, there are problems.

First, team managers struggle to free-up time for staff to pursue elective training. The priority is to deliver a safe (and cost-effective) service, and their teams will often have been reduced
by annual efficiency savings. Staffing levels may take insufficient account of the demands of training – particularly given the increasing volume of mandatory training.

Second, when staff take up training opportunities they may struggle to find the space to practice new skills because their existing duties are so time-consuming. This has been demonstrably the case with family therapy training, where staff struggle to find time to undertake the work. This again raises the problem of staff leaving their teams for training, but then returning to a culture that may not be able to support and consolidate their new learning. New skills may soon be lost for want of opportunity to develop them.

It may be that offering briefer team or Division-based training – whether it be for Type 1 and 2 therapies or for group-work and systemic therapies – may be a more effective strategy. However, this has to happen within the context of workforce training plans within each Division that identify key component skills.

The Psychological Therapies Training Strategy paper (2013) identified conditions that would enable staff training in Type 3 therapies to be successful. Team managers would need to: release staff for training, and ensure they have time and are supported in seeing “training cases” as part of their regular duties; include delivery of NICE-recommended psychological therapies as part of staff job plans, include them in appraisals and monitor them routinely in supervision; ensure clinical supervisor time from within the division to provide clinical supervision during and after training; monitor the number and percentage of service users receiving psychological therapies by adequately trained staff; and, where a NICE-recommended psychological therapy is indicated, include this in service user care plans.

At present – and not for want of endeavour by hard-pressed team managers – we are still some distance from achieving these ambitious goals. This presents a challenge for the psychology training committee (the Psychological Therapies Training Strategy Group), working in collaboration with Learning and Development and senior colleagues across the Divisions, to implement workforce training plans in order to ensure the maximum benefit from our investment in staff training.

**4.0 Staff Support: How can we best support our staff?**

It is difficult to argue with the contention that jobs have become more challenging for a range of reasons. Teams face demanding Key Performance Indicators (KPIs) for volume and recovery; they may have lost senior posts that supported junior staff; individual and team performance are much more closely monitored via supervision and performance meetings; data entry demands have multiplied; and many staff have corporate responsibilities that put pressure on their clinical time – for example, investigating complaints and Serious Untoward Incidents.

In addition, the developing market in healthcare means that jobs feel less secure than previously, and an increasing number of staff are on fixed-term contracts.

Psychological therapy services can contribute to staff support though the following measures.
4.1 **Staff Support Groups**

Across the Trust, staff teams make frequent requests for support groups. If well-run, such groups can provide a space for staff to think constructively and cathartically about the emotional impact of the work on them as individuals and as a team. The group can relieve feelings of stress, reduce the likelihood of staff “acting-out” their feelings in their work, enhance team morale, and ultimately improve the quality of care for service users.

The Psychology and Psychodynamic Psychotherapy staff have offered several such groups across a range of services in the Trust, including Acute Wards, EIS and AOT, Crisis Houses, and SMS services.

However, our services do not have the capacity to meet demand without further investment, and the running of such groups is increasingly being out-sourced. This may be beneficial in bringing an objective and uncompromised perspective, but is sometimes unhelpful if the group leader is unfamiliar with the architecture of the organisation. In addition, the groups are not without risk, as they have the potential to degenerate into a spiral of negativity and complaint that aggravates splits between clinicians and management.

It is important, at all times, to question why the group is being requested, what problems need to be addressed, what outcomes we might want from such a group, and to undertake an evaluation of the impact of the group.

Finally, there can also be governance issues, as matters may be raised that indicate a risk to safety and team functioning that are not shared with management. A governance protocol is now being prepared for the running of staff support groups.

This is not to deny the value of such groups, but to emphasise the importance of clarity about when, where and why we might use this solution to staff stress, and how we can best ensure it works effectively and constructively.

4.2 **Support Following Serious Incidents**

The psychological therapy services have always met requests for team support following serious incidents in our services. Staff generally find the sessions very helpful, providing an outlet for many of the feelings of shock, despair, guilt and anxiety following a major incident.

In order to formalise this service, the TSC and Acute Division psychology leads are setting up a brief training programme for a panel of senior clinicians who will deliver this service.

4.3 **Mindfulness**

Mindfulness is becoming increasingly popular as a method of stress reduction for staff. CDAT run a daily Mindfulness session for staff before work in The Well, and the R&R psychology lead commissioned two eight-week courses on Mindfulness-Based Cognitive Therapy (MBCT) in 2014, and these were attended by 40 staff in total.
4.4 Resilience Training, Acceptance and Commitment Therapy

In SMS, the psychologists developed resilience training – delivered in three sessions over two months – emphasising the use of mindfulness, and developing a balance between managing unhelpful thoughts and feelings and moving forward in a valued direction. This was later extended to the whole Trust, and there have now been five courses, attended by more than 50 staff in total. The staff attending the training show a significant decrease in their General Health Questionnaire (GHQ) scores, and staff feedback for the course has been very positive.

The Next Three Years

The work stresses listed at the beginning of this section will not be eradicated, and so will have to be accommodated. The evidence of annual sickness rates (3.4%) and staff turnover rates (16%) places C&I firmly in the average range for London Mental Health Trusts. At the same time, it is clear from recent surveys that there is a national trend for staff in the NHS to be reporting increasing levels of absence from work for reasons of stress. The uptake for our local initiatives has been enthusiastic, as has been the call for more staff support groups.

The initiatives described previously are likely to be valuable in supporting the wellbeing of staff, and there is a need to develop some cohesion and policy with regard to these developments, as they have tended to grow in a rather ad hoc fashion.

Over and above this, there is a need for all services to drill down and determine what their service pressures are and how they can best be ameliorated, and for psychologists to be supporting this process.

For some teams, the stress may be around the sheer volume of expected activity. For others working with chronic and severe clients with multiple problems, the stress may be that staff need much greater clarity about their task, their agreed formulation and goals with each service user, the problem they are trying to solve, and the small steps by which this might be achieved. If the task is poorly-defined, it can seem impossible and overwhelming. Staff may feel that they don’t really know what they are doing, and may experience job stress and learned helplessness.

Attention to the frequency and content of supervision for all staff groups can also make an important contribution. Team leaders need to be encouraged to focus on staff morale as an ongoing concern, alongside their KPIs and cost-effectiveness. It is likely that a combination of support initiatives – combined with clear goal-setting, good quality supervision and intelligent job design – may improve long-term job satisfaction and wellbeing at work.

ACTION POINT 34
Contribute to the development of a Trust-wide approach to staff support and a within-teams analysis of points of stress.
5.0 Research and Development

The psychology services have well-developed engagement with local and national research programmes. IAPT has four research-funded posts (1.5 wte in total) and regular research meetings with UCL, a research seminar every term, and research leads in each of the four IAPT teams in C&I to facilitate research and co-ordinate research participation. Current research studies include:

- **Obsessive Compulsive Treatment Efficacy Trial (OCTET).** (F) An evaluation of two self-help treatments for OCD, in partnership with the University of Manchester and funded by the Health Technology Assessment (HTA) programme.
- **The Randomised Evaluation Dynamic Interpersonal Therapy (REDIT).** (F) Study involves both IAPT and Psychodynamic Psychotherapy, and is comparing outcomes for DIT with CBT for depression. This research is in collaboration with UCL and The Anna Freud Centre.
- **Compassion in Virtual Reality in Depression.** (F) This research is in collaboration with UCLP and funded by MRC.
- **Cardiovascular Risk and Depression.** An ERIC-D study, in collaboration with UCLP.
- **Anxiety Symptoms Prevention Intervention (ASPI) Study.** (F) An evaluation of workshops for parents with anxiety disorders, and funded by the National Institute for Health Research (NIHR).
- **Transcranial Direct Cranial Stimulation (TDCS) and CBT.** (F) An evaluation of whether TDCS can enhance the effect of CBT in depression, conducted in collaboration with UCLP and funded by MRC.
- **Trial of Sertraline versus CBT for Generalised Anxiety (TOSCA).** (F) Collaboration with UCLP and funded by NIHR.
- **Can-Talk Study.** (F) An evaluation of CBT for depression in enhanced cancer, in collaboration with UCLP and funded by NIHR.
- **Insomnia Trial.** An evaluation of CBT for insomnia groups in IAPT, in collaboration with UCL.
- **E-Compared Study.** (F) An evaluation of internet-supported CBT for depression (blended therapy), conducted in partnership with the London School of Hygiene and Tropical Medicine and funded by the EU.
- **The Adverse Effects of Psychological Therapy.** (F) It is planned for the IAPT service (and possibly the PD service) to become one of the research sites for a national study (in collaboration with UCLP and University of Sheffield) investigating the adverse impacts of psychological therapies.
- **Conman and Praise Trials.** (F) Use of contingency management in SMS.
- **Psilocybin and severe depression.** (F) MRC-funded study.
- **Reward and Punishment in Depression.** (F) Wellcome-funded study in depression.
- **MRC diagnostic study in Depression.** (F) Peter Fonagy (Director of the Anna Freud Centre)

*Note that all marked with an F attracted research capability funding.
CDAT has a Band 7 0.2 wte research facilitator post funded by North and Central London Research (NOCLOR), and the post is supporting the development of the following projects:

- The application for the “Loneliness Intervention Research Study” by researchers from the Mental Health and Social Care Division of Psychiatry at UCLP.
- A qualitative study with CDAT service users looking at feasibility and acceptability of an online support tool.
- Piloting a new self-report outcome tool in CDAT.

The SMS service is a partner in the Positive Reinforcement Targeting Abstinence in Substance Misuse (PRAISE) study, in partnership with SLaM and UCLP and funded by NIHR.

In addition to these funded research projects, the psychology service supports ongoing small-scale research and audit projects by clinical and counselling psychology trainees – usually at least 30 in the Trust at any one time.

**The Next Three Years**

Although there is considerable research activity, there is an opportunity to build on this, and for the psychological therapies in C&I to develop a position as leaders in innovation and development – working with our local academic partners to develop innovative therapies and offer quality and choice to service users. We should look to team-up with our colleagues in psychology and in psychiatry at UCL, and in the university’s Centre for Behaviour Change, and play a key role in the new Institute of Mental Health that will be based on the newly-developed St. Pancras site.

The development of the “Strategies for Relatives (START) work for carers is an excellent example of research collaboration turning into service delivery, and the DIT research programme is now providing training and supervision for DIT practitioners and the beginnings of the development of a DIT service. There are also exciting possibilities in relation to research around digital therapies, as discussed in volume three section 2.7.

It would be desirable for each Division to identify a psychology research lead, with (if possible) some funded time to promote research, develop close links with research agencies, and identify funding streams.

Staff in the psychological therapy service are active in publishing. In the last year, for example, members of the service have published books across such diverse subject areas as Acceptance and Commitment Therapy (ACT), the role of willpower in the management of substance misuse, the impact of the “anti-group” in group therapy, and systemic approaches to care with older people.

**ACTION POINT 35**

Development of more research posts to enhance research links with local and national academic institutions, and promote research funding applications.
References

2. Closing the Gap. The Department of Health 2014
4. NHS England: Five Year Forward View
7. Quality in the new health system, National Quality Board 2013
8. The Triangle of Care. The National Carers Strategy, Carers Trust 2010
### APPENDIX 1

**Camden and Islington Psychological Services**  
**Strategy 2015 – 2018**

**ACTION PLAN**

<table>
<thead>
<tr>
<th>Action Point No.</th>
<th>Reference</th>
<th>Action Point</th>
<th>Responsible person</th>
<th>Involved others</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Volume 1 Page</td>
<td>The Action Plan will be the basis for an annual review of service in each Division</td>
<td>Head of Psychology &amp; Psychotherapy</td>
<td>To review with Divisional Clinical Directors</td>
<td>Annually</td>
</tr>
</tbody>
</table>

### Increasing Accountability of the Workforce

|---|-------------|----------------|---------------------------------------------------------------|-----------------------------------|-----------|----------------|

### Developing leadership and management skills

<table>
<thead>
<tr>
<th>4</th>
<th>Strategies 2, 3 &amp; 9</th>
<th>Volume 3 Page</th>
<th>Develop a learning set on leadership &amp; management for staff at Band 8b and above.</th>
<th>Head of Psychology &amp; Psychotherapy</th>
<th>TBC + L&amp;D</th>
<th>January 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Strategies 2, 3 &amp; 9</td>
<td>Volume 3 Page</td>
<td>Relaunch the learning set on leadership and management for Band 8a staff</td>
<td>Head of Psychology &amp; Psychotherapy</td>
<td>TBC + L&amp;D</td>
<td>April 2016</td>
</tr>
<tr>
<td>6</td>
<td>Strategy 3</td>
<td>Volume 3 Page</td>
<td>Identify talent, and encourage &amp; support management and leadership training.</td>
<td>Psychology Divisional Leads</td>
<td></td>
<td>Ongoing</td>
</tr>
<tr>
<td>7</td>
<td>Strategies 2 &amp; 3</td>
<td>Volume 3 Page</td>
<td>Design psychology posts with sessions in clinical governance</td>
<td>Psychology Divisional Leads</td>
<td>Clinical Governance leads</td>
<td>Ongoing</td>
</tr>
<tr>
<td>8</td>
<td>Strategies 2, 3 &amp; 5</td>
<td>Volume 3 Page</td>
<td>Create business development roles for psychologists within Divisions</td>
<td>Psychology Divisional Leads</td>
<td>Divisional Directors</td>
<td>Ongoing</td>
</tr>
<tr>
<td>9</td>
<td>Strategy 5</td>
<td>Volume 3 Page</td>
<td>Ensure the full integration of Psychology Divisional Leads in the development of the strategic work of their</td>
<td>Psychology Divisional Leads</td>
<td>Head of Psychology and Psychotherapy</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
### Developing and maintaining skills

| 10 | Strategy 2 Volume 3 Page | Psychological Therapies Training Strategy Group (PTTSG) to review CPD modules to reflect new evidence and emerging roles for psychological therapy staff. | PTTSG Chair | PTTSG | Ongoing |

### Career progression and staff retention

| 11 | Strategy 2 Volume 3 Page | Review recruitment strategy for PWP's to explore possibility of creating a more stable workforce | IAPT Lead |  | Ongoing |
| 12 | Strategies 2 & 9 Volume 3 Page | Psychology leads to revise/review job designs & create more posts that facilitate a broader range of skills development & to collaborate around development of cross-division posts. | Psychology Divisional Leads & Head of Psychology and Psychotherapy |  | Ongoing |

### Demonstrating effectiveness

| 13 | Strategy 1 Volume 3 Page | Psychological therapy services to develop a consistent approach to collecting and reporting outcomes | Psychology Divisional Leads | Divisional Directors | September 2016 |
| 14 | Strategy 1 Volume 3 Page | Psychological therapy services to promote the use of outcome measures across all services in their Division | Psychology Divisional Leads |  | September 2016 |
| 15 | Strategy 1 Volume 3 Page | Psychology leads to have a stronger engagement with the commissioning process in relation to decisions about outcome reporting | Psychology Divisional Leads | Divisional Directors |  |
### Service user involvement

| 16 | Strategy 1 Volume 3 Page | Each psychology service to develop a coherent and consistently applied service user strategy and to report on service user engagement as part of the annual service appraisal. | Psychology Divisional Leads | September 2016 |

### Supporting carers

| 17 | Strategy 1 Volume 3 Page | Develop a carer’s support policy for all psychology services. | Psychology Divisional Leads | September 2016 |

### Improving access to services


| 19 | Strategy 1 Volume 3 Page | Psychology services to develop business cases for increased resources as appropriate. (Individual service need identified in section 5). | Psychology Divisional Leads | Ongoing |

### Opportunities for growth

| 20 | Strategy 6 Volume 3 Page | Bid for stand-alone psychology services | Psychology Divisional Leads | Business Development Team | Ongoing |

| 21 | Strategy 6 Volume 3 Page | Bid for local funds to increase resources | Psychology Divisional Leads | Business Development Team | Ongoing |

| 22 | Strategy 6 Volume 3 Page | Explore the patient choice agenda | Psychology Divisional Leads | Business Development Team | Ongoing |

| 23 | Strategy 6 Volume 3 Page | Exploit the market potential of specialist services | Psychology Divisional Leads | Business Development Team | Ongoing |

| 24 | Strategy 6 Volume 3 Page | Explore local private employment market | Psychology Divisional Leads | Business Development Team | Ongoing |

| 25 | Strategy 6 Volume 3 Page | Consultation, training, teaching and service support to other provider services and educational institutions | Psychology Divisional Leads | Business Development Team | Ongoing |

<p>| 26 | Strategies 6 &amp; 8 Volume 3 Page | Establish links with UCL and other research agencies developing digital solutions | Psychology Lead TBC | TBC | January 2016 |</p>
<table>
<thead>
<tr>
<th>Page</th>
<th>Strategy 6 Volume 3 Page</th>
<th>All new service design should consider digital innovation as part of service configuration and delivery</th>
<th>Psychology Divisional Leads</th>
<th>IT Department</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>28</td>
<td>Strategy 6 Volume 3 Page</td>
<td>Extend the use of existing digital solutions in services</td>
<td>Psychology Divisional Leads</td>
<td>IT Department</td>
<td>Ongoing</td>
</tr>
<tr>
<td>29</td>
<td>Strategy 6 Volume 3 Page</td>
<td>Psychology services to play significant role in the development of a Trust-wide approach to the development of a digital technology program for psychological therapies.</td>
<td>Head of Psychology and Psychotherapy</td>
<td>IT Department + TBC</td>
<td>TBC</td>
</tr>
</tbody>
</table>

### Training Strategy

<table>
<thead>
<tr>
<th>Page</th>
<th>Strategy 4 Volume 3 Page</th>
<th>Develop a of Behavioural Family Therapy (BFT) training post in the Trust to support Type 3 therapy provision</th>
<th>R&amp;R Psychology Divisional Lead</th>
<th>Head of Psychology and Psychotherapy</th>
<th>April 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Prioritise training in Type 1 and Type 2 competencies in each Division</td>
<td>Psychology leads</td>
<td>In liaison with divisional leads and L&amp;D</td>
<td>January 2016</td>
</tr>
<tr>
<td>31</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Develop training in group-work skills across the Trust</td>
<td>Psychology Training lead for group-work</td>
<td>Head of Psychology and Psychotherapy + PTTSG</td>
<td>Ongoing</td>
</tr>
<tr>
<td>32</td>
<td>Strategy 4 Volume 3 Page</td>
<td>Explore the application of structured case management across Divisions</td>
<td>Psychology Lead (PD)</td>
<td>Trust Divisional Leads TBC</td>
<td>September 2016</td>
</tr>
</tbody>
</table>

### Staff Support

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td></td>
<td></td>
<td>Psychological Leads</td>
<td>Collaboration with L&amp;D and Occupational Health</td>
<td>January 2016</td>
</tr>
</tbody>
</table>

### Research and Development

<table>
<thead>
<tr>
<th>Page</th>
<th>Strategy 8 Volume 3 Page</th>
<th>Development of more research posts to enhance research links with local and national academic institutions &amp; promote research funding applications</th>
<th>Divisional Psychology Leads</th>
<th>R&amp;D Committee</th>
<th>Ongoing</th>
</tr>
</thead>
<tbody>
<tr>
<td>35</td>
<td></td>
<td></td>
<td>Psychological Leads</td>
<td>R&amp;D Committee</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>