2013/19

**REPLY BY THE MINISTER OF
THE SOCIAL SECURITY DEPARTMENT AND
THE MINISTER OF THE HEALTH AND SOCIAL SERVICES DEPARTMENT
TO QUESTIONS ASKED PURSUANT TO RULE 6 OF THE
RULES OF PROCEDURE BY DEPUTY A. H. ADAM**

Preamble

Over the past 18 months there has been a pilot project where psychological or talking therapies have been offered within the community, in General Practices. The impetus came from the considerable cost, both to the individual and to the community, when stress or anxiety led to individuals being unable to work and claiming sickness benefit. The service has now been running for 18 months and the pilot is due to end in September.

Question 1

What have the Departments done to assess this service?

Answer

At the outset of the project, a Steering Group was established including staff level representatives of the Social Security Department ('SSD'), the Health and Social Services Department ('HSSD'), the Queens Road Medical Practice, Healthcare Group and L'Aumone and St Sampson's Practice (referred to jointly as 'the three medical practices') and MIND Guernsey. The purpose of the Steering Group is to plan and oversee the delivery of the Service in addition to monitoring quality and performance.

The Steering Group receives quarterly reports on the performance of the Service and evaluates these against clinical and non-clinical standards. The reports include statistical information and commentary on the following factors:

- Number of referrals
- Opt-in rates
- Waiting times
- Number of interventions
- Outcomes:
    - Clinical
    - Employment
    - Prescribing
    - Client satisfaction
    - Impact on secondary care referrals
- Performance against KPIs (see appendix 1)
- Feedback on the Service from the three medical practices
- Plans for next quarter

The reports are also submitted to the political boards of SSD and HSSD and to the Primary Care Committee for information.

This process of continual monitoring and assessment has enabled the Service to react quickly and flexibly to issues as they have arisen, thereby contributing to its success.

Question 2

What are the results; what are the benefits; what are the savings, both in cost of benefit, and to the individual?

Answer

The pilot programme outcomes, as at 31 December 2012, were reported in the first Annual Report of the PCMHWS, which was considered by SSD on 19 February 2013 and by HSSD on 20 February 2013. The following extracts are taken from the report:

> Clinical outcomes
> "Effective clinical outcomes can be measured in a number of ways. The IAPT [Improving Access to Psychological Therapies] standard which was adopted by the PCMHWS was that three measures are completed at each attended clinical session, two of which are validated assessment tools for anxiety and depression, with recognised 'cut-off' scores, a score above which is considered to fall within a clinical range. Each measure also has defined ranges for 'mild', 'moderate' and 'severe' cases. Thus, paired pre- and post- mean scores for first and last sessions can be compared for significant difference, in addition to any shifts in the proportion of cases falling in particular severity ranges. The third scale (Work and Social Adjustment Scale) is designed to assess the impact of any mental health symptoms experienced on daily life functioning in various domains, e.g. relationships, work, social activities. Thus, these measures capture not only the experience of the symptoms of anxiety and depression, but also the impact these symptoms are having on day-to-day functioning. This is important, as some people may continue to experience some ongoing symptoms of depression and/or anxiety, but through appropriate psychological intervention, learn key skills which help them to better manage the impact those symptoms have on their lives.

As shown… [in figures 1 to 3], there have been significant positive improvements on all three measures, including the impact of functioning scales. Most people who were in the moderate or severe ranges at the time of referral are not in the depressed/anxious categories at discharge.

Overall, the recovery rate for the Service in its first year of operation is 50%. This exceeds the IAPT programme (now in its fourth year of reporting) current mean recovery rate of 41%. The IAPT comparable figure for the first year of operation is 30%. Given the difficulties in establishing new services in Guernsey due to economies of scale and recruitment issues this is a significant achievement.".

Figure 1 - Depression outcome data

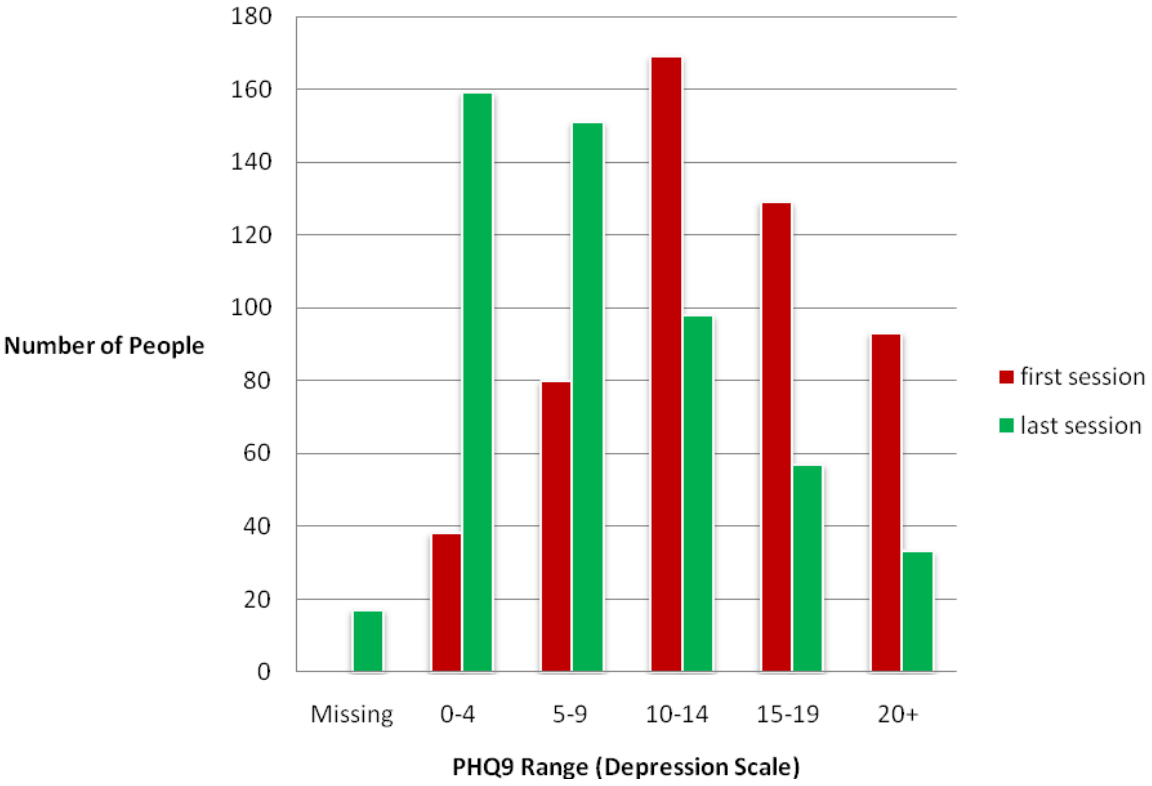
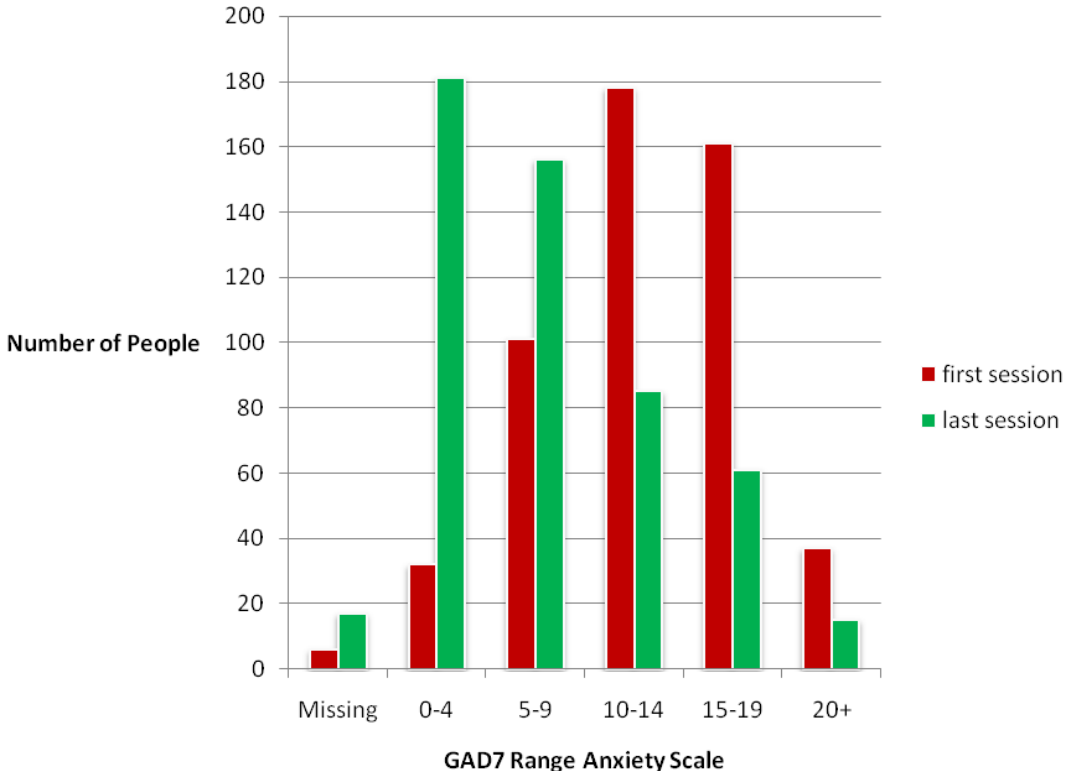


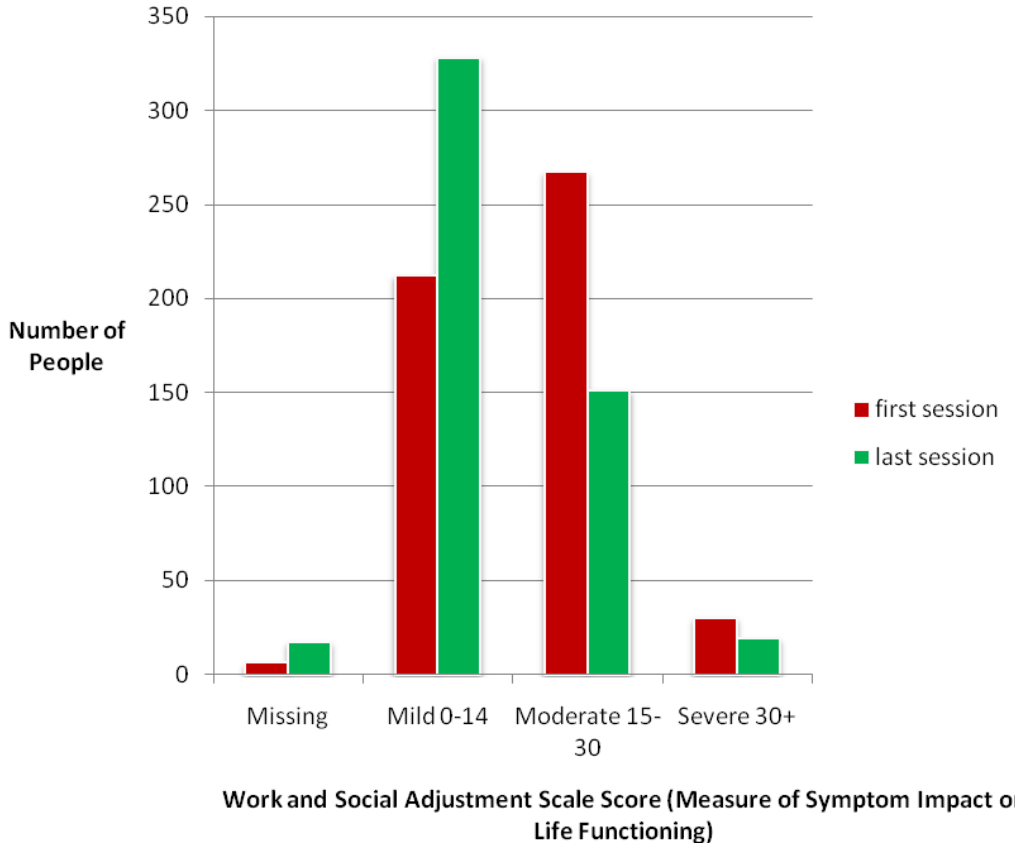
Figure 2 - Anxiety outcome data



Explanatory note: Most people attending the PCMHWS were assessed as falling in the moderate to severe ranges of the depression scale (figure 1) and the anxiety scale (figure 2) (i.e. to the right of the scales) at their first session. By their last session, most people's scores

had reduced (shifting to the left of the scales), meaning that they had less symptoms, with most having less than clinical scores at discharge from the Service.

Figure 3 - Impact on functioning outcome data



Employment outcomes

"Full evaluation of the employment outcomes of all people who have been seen within the PCMHWS is currently in progress. While this is a 'work in progress', early indications suggest that the PCMHWS has enabled the vast majority of people who were in work at the start of treatment to retain this employment at discharge and beyond. Most people who were referred to the PCMHWS were in work (75% in full or part time).

Initial analysis has indicated that "in the first year of operation, 96 people were claiming benefits at the time of referral to the PCMHWS. At one month post discharge from the PCMHWS, this figure had decreased to 35 people continuing to claim benefit. Further analysis is underway to investigate the effect of treatment with the PCMHWS, e.g. on duration of benefit claims.".

Prescribing outcomes

"Primary care prescribing data has been made available by the Prescribing Advisor. The data for previous years clearly reflects the increasing prescribing rates by GPs for common mental health disorders. As the data is extracted via the UK NHS database, there is a time lag of a quarter before the data is made available. Therefore, the latest data available is for the third quarter of 2012.

Since the introduction of the PCMHWS, there has been a *6% decrease* in the prescribing of anxiolytic/hypnotic items in Primary Care. Impact of the

introduction of the PCMHWS on the prescription of antidepressants is more difficult to analyse as psychological therapies are recommended in conjunction with antidepressants for more severe forms of depression, and also GPs are more likely to prescribe certain antidepressants for treating chronic pain (instead of opiate-based medication) than they used to. Nevertheless, the increase in prescribing has been less in the first three quarters of 2012. Further analysis of this data, including yearly totals will help investigate this potential trend in the data and what are the contributing factors to this change.".

Impact on Secondary Care Mental Health Services

"The impact of this service upon the secondary care mental health provision can be seen in the following four ways:

i. Improved relationships with GP practices. This is as a result of having a presence in each of the practices and a better method of referral between Primary Care and Mental Health Services.
ii. An eradication of rejecting GP referrals in to Mental Health Services. Prior to this service being established around 10 referrals per month were sent back to GPs as "inappropriate referrals". This resulted in frustration on the part of the service user who could not access services.
iii. Reduction in waiting list times in Secondary Care. Prior to this service there was a waiting list of up to two years to access psychological therapies and there is currently no waiting list to access Secondary Care.
iv. Increased choice in being able to offer service users the most appropriate treatment setting and intervention depending upon their needs. This has meant that significant numbers of individuals have been able to access help in non-stigmatising settings and a greater range of treatment options have been able to be developed within Secondary Care.

These improvements have been assisted by the significant reconfiguration of Adult Mental Health Services into more functional teams and therefore it is not possible to attribute this decrease totally to the introduction of the PCMHWS. It is also important to note that service users can be stepped up to secondary care from primary care if needed without a re-referral from the GP. From a service user point of view, the treatments they receive following such a recommendation is seamless.".

What has the Service cost?

The budget for the two year pilot project was £495,365 excluding a contingency sum of £40,000. Total expenditure to 31 December 2012 was £391,774 . This figure includes set-up and operational costs for 16 months. However, it should be noted that some on-costs are not included in this figure, including the cost of rooms at doctors' surgeries, which have been provided free of charge during the pilot period, the cost of administration and other management costs.

The average cost per service user to date is £430.

Question 3

Will it be continued?

Answer

During the next few months, the pilot scheme will be assessed against a series of key performance indicators which were agreed between SSD, HSSD and the three medical practices at the outset of the pilot period, in order to inform SSD and HSSD's decision regarding the long-term future of the Service.

Question 4

How will it be funded?

Answer

If it is decided to establish the Service on a permanent basis, consideration will need to be given to how to fund it.

The pilot programme is funded by SSD from the Guernsey Health Service Fund ('the Fund'), as provided for under Section 1(3)(a)(ii) of the Health Service (Benefit) Guernsey Law, 1990, as amended ('the Law')[1]. However, the Law does not currently permit the Fund to be used to finance the Service on a permanent basis. The Law could be amended to introduce the PCMHWS as a new benefit.

At the time that the service was introduced, the SSD's Uprating report (Billet XX of 2010, paragraph 80) stated:

> *"The cost of the pilot programme is £265,000 per year in 2010 terms. The Department intends to run the pilot programme for 2 years, with evaluation starting at the end of the first year. During the second year of operation, and informed by the evaluation, the Department will either develop proposals to convert the pilot programme into a permanent benefit, adjusted as necessary in the light of experience, or decide to terminate the pilot programme at the end of 2 years without replacement. The Department, however, believes that there is great potential in this initiative to make a positive contribution to the mental health of the community and to reduce social security costs by way of sickness benefit and supplementary benefit."*

The future funding of the service will be discussed between SSD, T&R and HSSD.

In the event that the long-term funding mechanism is not in place by the end of the two year pilot period (early September 2013), SSD and HSSD will need to consider whether to terminate the Service or extend the pilot period until such time as the necessary funding is in place.

Question 5

Where will the savings be made?

Answer

Funding the Service through savings is one of the options that will need to be evaluated in the coming months if it is decided to make this service permanent.

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[1] *"1(3) There shall be paid out of the Fund – (a) all sums payable in respect of – (ii) such research and development activities (including pilot programmes), as the Authority may determine, for the purpose of establishing the need for, and most effective method of providing, any other benefit which may be specified under this Law."*

Question 6

If such a scheme was shown to be cost effective, would this not be considered under the FTP as a spend-to-save project?

Answer

As with the previous answer, this is indeed a funding option.

Date of Receipt of the Question: 15th March 2013

Date of Reply: 28th March 2013

Appendix 1

KPIs for the Primary Care Mental Health and Wellbeing Service

KPI	Measure	Frequency of reporting to Steering Group	Party responsible for monitoring
People clinically "recovering" after treatment (i.e. not requiring further treatment)	A count of all those who at initial assessment achieved 'caseness' on the *PHQ9* (10 or more) or *GAD7* (8 or more) and at the final session scored less than these cut-offs. Additional disorder specific measures will be used for Social Phobia, OCD, and PTSD.	Initially after 6 months and quarterly thereafter	HSSD
Increase in reported emotional well-being.	Measured by use of the *Warwick Edinburgh Mental Wellbeing Scale (7 item short version)* (subject to Electronic Copyright permission having been granted).	Quarterly	HSSD
Service users' satisfaction levels maintained (GP and patient)	Assessed via the use of service-designed satisfaction questionnaires.	Quarterly	HSSD/MIND
Decrease in GP attendance.	For each patient referred, a count of the number of doctors' attendances 12 months before and 12 months after referral.	Annually	The three medical practices
Reduction in the rate of increase of GP prescribing for common mental health problems.	Assessed via comparison of trends in local prescribing for anti-depressant and anxiolytic/hypnotic medication prior to commencement of the new service and at regular intervals thereafter.	Quarterly	SSD and the three medical practices
Decrease in the number of referrals to Secondary Care Mental Health Services	Extracted from data collated by the Secondary Care Mental Health service.	Quarterly	HSSD

(CMHT/Psychiatry) bounced back to GPs.			
Average waiting time for initial appointment	PC-MIS report	Quarterly	HSSD
Decrease in average (mean) weekly benefit paid to service users. [10% target].	Benefit rate will be recorded by SSD on database during the week of each session. Therefore, mean pre and six month post intervention benefit rates can be readily compared.	Quarterly	SSD
Close collaboration with SSD's Work Rehabilitation team to maximise return to work outcomes.	Views of all stakeholders across SSD and Service teams. (Indicators include evidence of appropriate referrals; percentage of clients referred for Work Rehabilitation; pro-active development of joined-up working; working towards shared understanding; readiness and quality of communication).	Quarterly	SSD
Percentage of service users signed unfit for work at time of first PWP session that have ceased claiming Incapacity benefit or have a box ticked on medical certificate, one month after discharge from Service. [10% target].	SSD to identify claim / tick box status as at one month after discharge for claimants who were in receipt of benefit at time of first PWP session and comparison made. Database data to be cross referenced with SSD tick box spreadsheets.	Quarterly	SSD
Percentage of service users who were in employment at time of first PWP session that are still in employment six months after discharge from Service. [75% target].	Before and after percentage comparison of work status from database.	Quarterly	SSD