Creating a patient centred mental health service
Swindon fashion in the city of Brighton and Hove

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1 Recommendations to the city’s Health and Wellbeing Board (HWB)

a) Clarify with Government departments (see paragraph 3) that the terms of reference of the HWB is to take full responsibility in future for all aspects of public health, and all the services provided by the local Clinical Commissioning Group (CCG), including the signing off the Joint Health and Wellbeing Strategy (JHWS) and other plans, such as the Royal Sussex County hospital improvement for £420 million.

b) Instruct health commissioners to incorporate into the JHWS a nationally acclaimed best practice, patient centred mental health service similar to LIFT (Least Intervention First Time) Psychology (see www.lift.awp.nhs.uk) and commission it to pass the Care Quality...
Commission (CQC’s) 5 new questions (see paragraph 7) as an opt-in, no assessments, free access system (see paragraph 9) instead of Sussex Partnership Foundation Trust’s (SPFTs) provider centred system, which will fail those CQC questions.

2 The Joint Health and Wellbeing Strategy (JHWS) for Brighton and Hove

This JHWS report (about 200 pages in total) is on the agenda as item 20 of the HWB meeting on 11.9.13. In it’s own words, it is virtually the same as last year’s. However, the purpose of the HWB is not to continue with business as usual, but to improve services. The following paragraphs (3.1 and 3.2) are reproduced verbatim from page 20, with my emphasis italicised:

‘3.1 The Health & Social Care Act (2012) obliges each local HWB to publish a JHWS. Neither the legislation nor the statutory guidance concerning the JHWS is particularly prescriptive: in essence, local areas are free to agree their own JHWS, providing the JHWS reflects the major partnership health and wellbeing priorities across the area, proposes plans to improve outcomes in these areas, and is clearly evidence-based.’

On page 28 the five high priority areas are listed, and mental health is one. I, (together with many others, including GPs) have been complaining for years that the mental health service provided by Sussex Partnership Foundation Trust (SPFT) is not worthy of the name ‘service’, because of excessively long waits for talking therapies. For example, for Cognitive Behaviour Therapy (CBT) it is over 1 year, unless you are suicidal, and for mindfulness courses it is over 20 years. GPs therefore have no treatment to prescribe except drugs, whose side effects can make patients worse, leading to complaints of over-medicalisation.

The LIFT Psychology model adopted by Wiltshire is recognised as the national leader in talking therapies, as it saw over 16,000 patients last year with waits of only a few weeks, at less cost. The purpose of this report is to describe their model, and recommend that it be incorporated into the city’s JHWS, and implemented throughout the city and Sussex as soon as possible.

‘3.2 Locally, council commissioners and the CCG agreed that the JHWS should be a succinct, evidence-driven document focusing on the core health, public health and social care issues which had the greatest impact on city residents, and where there was a real opportunity to improve outcomes via better partnership working.’

The JHWS as drafted is anything but ‘succinct’ as it is about 70 pages of report plus 130 pages of Economic Impact Assessment, plus about 400 pages of Joint Strategic Needs assessment (JSNA). It does not focus on the core health, public health and social care issues which have the greatest impact on city residents. Furthermore, it ignores the ‘real opportunities to improve outcomes via partnership working’, for which I have been campaigning loudly for over 4 years.

By contrast, the outcomes achieved by LIFT Psychology in Swindon and Wiltshire (see paragraph 8) are dramatically better than those currently achieved in Sussex, and community partnership working in Scotland (see paragraph 13) which is why I recommend that these models should be incorporated into the JHWS.

3 Public health warning: does the HWB have the legal responsibility to sign off the JHWS, and if so, to improve services?

However, the JHWS document contains on page 27 the following warning, probably written by the director of public health, Dr Tom Scanlon, who is a GP:
‘Remit of the HWB
The core focus of the Brighton & Hove HWB will therefore be on the priorities identified via the JSNA (Joint Strategic Needs Assessment, which is about 400 pages) and embodied in the JHWS. However, it is becoming increasingly apparent that Government departments have adopted a maximalist approach to HWBs, effectively assuming that the local HWB is the key health and social care partnership for the area, and consequently requiring various plans, strategies and bids for funding/support to be signed off by HWBs. This will require the HWB to take on responsibilities additional to those identified in the JHWS, although the degree and range of these responsibilities is not yet clear.’

This statement arrogantly implies that the director of public health advises the HWB to take it’s responsibilities (effectively it’s terms of reference) from the minimalist approach that is written in the JHWS by officers such as himself.

I hope that I am not alone in thinking that they should take them from legislation as interpreted by Government departments, who see (as I do) the HWB as responsible for specifying measures to improve services, and signing off the JHWS rather than perpetuating the status quo of sub-standard NHS services.

This seems to me to be a blatant case of the tail (officers) wagging the dog (elected councillors). However, it merely reflects the historical officer led way that the NHS has been managed for the last 65 years. This is how the democratic deficit has always worked, and nobody should be surprised that officers like Tom Scanlon try to perpetuate it, as that has been his job for decades.

Health has never been properly scrutinised, as the Health Overview and Scrutiny Committee (HOSC) never did any real scrutiny. I tried for years to get issues addressed, and never got acknowledgements to my reports, still less any engaged discussion. Now at last, there are real councillors elected and appointed to take responsibility for what the local NHS does, assuming that they agree to take it, as I suggest, and do not listen to Tom Scanlon.

Even if they do, as portrayed in ‘Yes, Minister’, officers traditionally try to pull the wool over elected members’ eyes by obscuring the key issues of decisions in hundreds of pages of waffle, as in the 600 pages of JHWS referred to above. Councillors on the HWB have not had time to get their feet under the desk, so it is not surprising that they haven’t rumbled him yet. Dr Scanlon seems to have persuaded Cllr Rob Jarrett to listen to him, rather than to me, as Rob has hitherto ignored what I have sent him, and sent officer drafted replies to my deputation.

My impression is that he has been told to regard me as a crank, whose communications do not even deserve to be acknowledged, let alone acted upon. The reality is that I am a former councillor who is trying to alert him and the HWB to the changes in the law since 1.4.13.

4 The Health and Social Care Act is a revolution which turns the old NHS on its head
The people who pay for the NHS want a patient centred NHS, rather than the provider centred service they have had for the last 65 years. This is known politically as ‘filling the democratic deficit in health’.

The changes brought in by the Health and Social Care Act, (which came into effect on 1.4.13) represent a revolution in thinking about democracy, power to the people. This is cosmological energy caused by hard astrological aspects of Uranus and Pluto, so is felt worldwide. The UK’s crisis in the NHS corresponds to the civil wars misnamed the ‘Arab spring’, as both revolutions started several years ago, and will last for at least 3 more years, not just a season.
I have attended HWB meetings in the public gallery, and to me the chairman and members seem to regard themselves as casual bystanders, simply watching what the NHS as it goes about business as usual, aided and abetted by the officers. In defence of both officers and elected members, for 65 years, the NHS has been a law unto itself, immune from criticism. No local council or councillor previously ever had any say over what it did. Nor did any MP, or even the Health Secretaries, who got increasingly frustrated, hence the 12 reorganisations which it has had.

I happen to know about it because I have followed the privatisation policies for nearly 4 decades, particularly the passage of the Health Act through Parliament, and attended many conferences about it. I know that I am interpreting it correctly, because I have had e-mails thanking me from Andrew Lansley and Earl Howe, who led it through Parliament.

This legislation does not just change the structure of the NHS, as the previous 11 reorganisations did. It represents a fundamental culture change (a paradigm shift) in the peoples’ attitude to health, which was reflected by the Government changing the NHS from provider centred to patient centred.

This legislation completes the Thatcherite privatisation agenda, and is just as radical as the privatisation of the dozen public utility monopolies 20-30 years ago, which also converted them from provider centred to consumer centred. A good account of this from a Socialist perspective (with which I agree) is given in a report ‘Defending our NHS’ by Martin Rathfelder see http://www.sochealth.co.uk/2013/09/06/defending-national-health-service/

To give Tom Scanlon his due, he has been director of public health for more than 20 years, and has led the local system that we have today, but which now has to change by law. He naturally want to keep the status quo of an officer led NHS, which requires an officer led HWB. However, his above warning, (which is buried in scores of pages of waffle, which he hopes that no-one will notice) covers his back in case somebody says: ‘why didn't you tell us what we are supposed to do?’

His warning implies that the chairman and members of the HWB do not yet realise that the prime intention of the Health and Social Care Act was and is to fill the democratic deficit in health, and that the prime function of their HWBs is to take the responsibility for signing off all strategic documents, including the JHWS, and all other strategic NHS plans.

5 The wastefulness of a provider centred NHS
After 65 years of provider centred NHS we have become so used to it that we regard it as normal, and don’t even realise that it is different to consumer centred services. An example of this is in waiting times for A&E, which have exceeded 12 hours in our local hospital, and many others, but ours is the worst. A statement has recently been made that ‘no patient has waited more than 12 hours since April.’ This implies that the new target waiting time has been increased from 4 to 12 hours, and that our hospital has met the new target, which is a cause for celebration.

This approach misses the point that waiting times for all other services (like buses, trains, plumbers) are not measured in hours but in minutes. Provider centred services set their own standards, to suit the providers, rather than the customers. I can remember (30 years ago) when you could have any telephone as long as it was a black dumbbell, and you waited 3 months for it. Also, although the line known as Thameslink between London Bridge and Blackfriars had been there for the previous century, British Rail did not bother to open it to through traffic between Brighton and Bedford until the M25 was opened in the 1980s.
At its meeting on 12.6.13, the HWB heard a presentation on the plans for the £420 million extension for the Royal Sussex County hospital. It was for information only, and there was no vote, although the Healthwatch representative (Robert Brown) complained about the disruption to patients from a decade of being treated on a construction site, and Cllr Geoffrey Bowden asked what it would do for his mentally sick constituents? I would have liked to have asked what it would do for waiting times in A&E, but of course the answer is ‘nothing.’

I would therefore argue that the HWB should also take full responsibility for signing off those plans, as £420 m is more than a whole year’s budget for the CCG. If I was on the HWB I would argue against this project being signed off, as it is gold plated, over-development, and largely unnecessary. The only justification for the destruction of the 1828 Barry building is that it is nearly 200 years old. So what? So is the Royal Pavillion. The new NHS will care for more patients in the community, which is where they want to be treated. Fewer hospitals will be needed, which is just as well, as too many patient catch bugs such as MRSA and C.Diff in the overcrowded conditions.

The officers and members of the HWB can continue to ignore what I say and write, but I have the legal right to say it under Patient and Public Involvement. The law has a long arm, and will catch up with them eventually, as it did at mid Staffs, (thanks to Julia Bayley) and the 11 hospitals now in emergency measures.

I have no doubt whatsoever that the ‘maximalist’ approach of Government departments referred to by Tom Scanlon is right, and his ‘minimalist’ approach is wrong. I have said this publicly in my deputation to the Council on 18.7.13, and written it in various reports, which I sent to all members of the HWB, including to Tom Scanlon, and neither he nor anybody else has yet challenged my view.

At last we local people have been given the legal right and power to determine how the taxes we pay for the NHS are spent, through our elected representatives on the HWB. We should use this power by lobbying them to take the responsibility given them by Parliament. Yes, it is an onerous job, and yes, it’s members may not have realised that they were statutorily appointed to do it when they agreed to sit on the HWB. If so, tough.

Whether those members realise it or not, this is the reality, and the sooner they get it, the better for them and the people they serve. If they do not believe me, they should clarify this issue with the Government departments referred to as a matter of urgency, as it affects everything that they do in the HWB. This is why I have made this clarification my first recommendation (see paragraph 1 above).

6 What is wrong with the mental health service provided by SPFT?

I should disclose that I have not been a service user of SPFT myself, but I have attended many meetings over the last decade organised by MIND and others to get feedback from service users. From about 2006-9, these were held quarterly under the Improving Access to Psychological Therapies (IAPT) programme until the funding was stopped. Since then I have attended meetings called: ‘Listen to the Voice of Experience’ (LIVE) which were held quarterly until the end of 2011, and about twice per year since. They used to be attended by NHS commissioners Margaret Rooney, Anne Foster etc, and were organised by Julie Wright of MIND under a contract for community mental health support.

My impressions from all those meetings were that the service was very poor, as few service users had a good word to say about it. These impressions were confirmed by local GPs who I have met socially. The main complaint was the excessive waiting times to be seen, assessed, and treated.
When they were eventually treated (sometimes years after having fallen ill) the general complaint was that they were over-medicated with drugs because there was nothing else on offer, as the waiting time was excessive for talking therapies.

Until 2011 the waiting time for CBT was sometimes 2 years or more. This was reduced when 40 new CBT therapists were recruited by SPFT in 2010 under the IAPT programme, but it is still much too long at about a year unless you are suicidal. I kept requesting more mindfulness courses, as prior to 2011, only one part time facilitator (Robert Marx) was commissioned to run 4 course pa for up to 20 patients per course (up to 80 patient places pa) for 160,000 depressed patients in Sussex. The waiting time was therefore 2,000 years then, and it caused a laugh when I said it publicly. Robert has recruited and trained about 20 more mindfulness facilitators in 2011, but the waiting time is still over 20 years, so you can have an appointment for a course in 2034.

The SPFT seem to be suffering from the same crisis as the rest of the NHS, as reported in the media. Reports such as the LSE (July 2012) on the failure to treat 750,000 mentally sick patients, the Francis report (Feb 2013), the Geogh report (July 2013) which took 11 hospitals into emergency measures.

Staff morale is said to be at an all time low, and A&E departments are overwhelmed. There seems to be a ‘glass wall’ between the public and staff, as neither can talk freely about this to one another. There is an ‘elephant in the room’. Everyone knows that it is there, but it is politically incorrect to mention it, in this culture of fear for one’s livelihood.

7 Tightening up of regulation of providers, such as the CQC

The good news is that the crisis in the NHS has already resulted in a much needed tightening up of health regulation. Previously, all the health regulators (totalling over 35) seemed to be on the side of the providers. This perpetuated the provider centred service we have had for 65 years, rather than bringing in the long promised patient centred service, which has had all party support for decades.

However, the Care Quality Commission (CQC) who are responsible for inspections, and were shown up by the Francis report (Feb 2013) as negligent have at last got the message, and have become patient centred. A recent (Aug 2013) consultation document says: ‘We are on the side of the people who use services, making sure they are respected and listened to.’ (p6) They also say: ‘We make sure that directors or leaders of organisations have made legal commitments to provide safe and high quality care, and are personally held to account for it.’ About time too.

When the CQC inspect providers in future, their 5 main questions will be: 1. Is it safe? 2 Are they doing what they should? 3 Are they caring? 4 Do they change to meet peoples’ needs? 5 Is it well led? (p14)

When the CQC inspect SPFT (assuming the inspection is conducted with integrity, and they also inspect the PCT/CCG who commissioned them, and awarded them a block contract), I believe that their mental health service would fail most of these questions, for the following reasons:

1. Is it safe? No, treatments are massively over-medicated with drugs with harmful side effects, which often make patients worse.
2. Are they doing what they should? No, they are provider centred, and over assess patients, finding reasons why they cannot treat them. This is mainly because they do not provide
nearly enough talking therapies, particularly courses, which are far more cost effective than one to one sessions.

3. Are they caring? No. A more appropriate description for many of the stories I have heard from service users would be ‘callous disregard’.

4. Do they change to meet peoples’ needs? Occasionally, yes, as they trained about 20 more mindfulness facilitators in 2011, but this is not nearly enough for all Sussex, with 1.5 million people, of whom 160,000 are diagnosed depressed. They, and their commissioners are generally highly resistive to change.

5. Is it well led? Maybe the leadership is doing their best according to the old provider centred NHS, but in no way could SPFT or the PCT/CCG commissioners be described as having a patient centred approach to service.

By comparison, when CQC inspect the LIFT Psychology service, I believe that it will pass, being patient centred, opt in, no assessments. This is why I recommend the HWB to commission this type of system for the future mental health services in the city, in place of SPFT’s provider centred system.

8 Context of this report – Swindon has shortest wait for mental health courses

An item on Channel 4 news on Tuesday 20.8.13 featured Swindon NHS as having the highest access rate and shortest waiting time (only a few weeks) in the country for talking therapies if you are depressed or anxious. Hearing this made my day, as I have been complaining that in Sussex, waiting times are over a year for Cognitive Behaviour Therapy (CBT) (unless you are suicidal) and over 20 years for a mindfulness course. These differences indicate a post code lottery, which was not supposed to happen under the old regime of Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs), which were replaced with Clinical Commissioning Groups (CCGs) on 1.4.13.

A news report by Barack O’Brian showed a mindfulness course in progress in Swindon, and interviews with the following people. Mary, a patient, who seemed relaxed because she can get support whenever she needs it by phoning her counsellor. Manager Barbara Stapleford said that this service costs less than talking therapies in other places with longer waits. Health minister, Norman Lamb said that mental health is his highest priority, and that commissioners should apply for £400 million which is available to improve mental health services in the way portrayed.

I telephoned NHS Swindon, and spoke to therapist Geoff Windle. He invited me to an open day presentation that they were running on Tues 3.9.13, which I attended, together with Nesta from Norfolk and Suffolk, and Valery and Becky from Lichfield. The speakers were Liz Howells, the founder of the service in 1993, for which she was honoured in 2010 with an OBE, Barbara Stapleford, manager since about 1999, Alex Stirzaker, a clinical adviser nationally on severe psychosis to IAPT, who formerly worked for the SHA, and Jon Freeman, who is managing a pathfinder site for the Improving Access to Psychological Therapies (IAPT).

The following information was taken from what they said and gave us on the day, and from their website, but the interpretation is mine. Although I have sent them this report, I have not asked them to take responsibility for verifying it’s contents.

9 The Least Intervention First Time (LIFT) Psychology mental health service in Swindon, Wiltshire and Avon
a) What is LIFT?

LIFT Psychology (see www.lift.awp.nhs.uk) is a high quality service that includes traditional IAPT interventions plus additional services. It is an in-house, community based, primary care service provided directly by Avon and Wiltshire Mental Health Partnership (AWP) NHS Trust, serving a total population of 1.3 million. This includes Swindon (171,000), Bath and NE Somerset (161,000) Bristol (408,000) S. Glos (200,000) etc.

AWPT seems similar to the Sussex Partnership Foundation Trust, (SPFT) who provides mental health services throughout Sussex, with a population of 1.5 million. They receive a grant of about £220 mpa under a block contract, which was renewed in April 2012. They employ about 5,000 staff, of whom about 1,000 are clinical.

Least Intervention First Time (LIFT) Psychology, was founded by clinical psychologist Liz Howells in 1993 when she worked for 6 GP practices in Swindon. It’s mission statement is ‘Lift anxiety, Lift mood, Lift depression.’ She pioneered Primary Care Psychology services, with the philosophy (attributed to Jeremy Bentham) of ‘the greatest good for the greatest number’, or colloquially ‘providing buses for patients, rather than Rolls Royces’.

It has a reputation as an award winning national leader in the delivery of psychological therapies, which is why it was interviewed by Channel 4. It is an opt-in service, teaching anyone who wants to come how they can manage their stress and mood. It does not waste time on any assessment or triaging, so is inclusive and empowering irrespective of diagnosis, and has quick and easy access. Their aim is to keep patients out of secondary care, in which the cost per patient treated are enormous. (typically £30,000 over a decade for psychosis patients according to SPFT) It became part of the Improving Access to Psychological Therapies (IAPT) programme when that started in 2008.

LIFT Psychology expanded steadily over the years, first throughout Swindon by 2005, then throughout Wiltshire by 2009, and since Oct 2012, including Bristol and South Gloucestershire. They have been asked to quote for providing this service in other areas, including Margate in Kent, but they have no ambitions to go so far.

They continue to innovate to better meet the needs of their clients. In 2011 they won four out of a possible eight regional IAPT awards, were short listed for a Health and Social care award, and took part in a BABCP conference panel. They have a strong user representation which steers the services.

The LIFT service is (and has always been) part of the local mental health service, directly employing NHS clinicians and administrators. These now total about 300, who are not specialists. They say: ‘everyone does everything.’ It is not unusual for therapists to teach 3 courses in the day and 1 in the evening, as school teachers do.

Most patients are referred through their GP, but they can also self-refer, and come back anytime, which is what is meant by: ‘opt in’. This is the same as the GP service, and it gives patients confidence that the system is there for them whenever they need it.

b) Comparison with SPFT in Sussex.

The LIFT staff don’t suffer from burn out because they walk their talk, and support each other. This supportive energy was palpable, the moment that I walked in the door, and was greeted by...
the receptionist (Linda) Although only 100 miles away from Sussex as the crow flies, I felt that I was on a different planet. Everyone talked freely from the heart, and there was none of the usual awkward silences, fearfully watching what you said in case it is is judged politically incorrect.

Their present budget is around £10 million pa, which pro rata Sussex would amount to about 5% of the mental health budget for the counties of Avon and Wiltshire of comparable populations. However, they see over 16,000 patients pa, which is more patients than the rest of the service does, presumably in secondary care, and costing disproportionately more. What we will never know is how many patients they save from needing secondary care, thereby saving the taxpayer?

This system contrasts markedly from the assessment system used almost exclusively by SPFT in Sussex. This often excludes patients from treatment, because they are judged either too ill, or not ill enough to access it. This makes them feel rejected, which makes their mental health worse, not better. If and when they are finally accepted for CBT, it is limited to say 6 sessions, which pressurises them and the therapist.

This SPFT system is provider centred, and is not conducive to healing for either the patient, or the therapist. Therapists tend to burn out, being overwhelmed by Medically Unexplained Symptoms (MUSs) and lack of job satisfaction through feeling powerless to help.

c) Steps
LIFT’s step 1 is a one to one appointment within 2 weeks of asking. The session is for 30- 45 minutes with a professional wellbeing psychologist (PWP), in the patient’s GP surgery. This is not an assessment, but a discussion of what their next steps could be, such as watchful waiting, a change of lifestyle, or to attend a course.

The statement in the flier is: 'We will concentrate on steps that you can take yourself to help you tackle your difficulties.' This approach empowers the patient, because it gives them choice, trusts them that they know best what they need, and puts them in charge of getting it. In short, it encourages them to take responsibility for their own health.

Step 2 is to choose any course they like from a menu of 34 different courses, rolled out in up to about 15 different venues. This is more patient choice than any other psychology service in the country. Patients can attend as many courses as often as they like, and repeat them as often as they wish. This helps them to take responsibility for how they spend their time. LIFT’s access rate is 25% of the depressed population, compared to the national average of 15%. About 90% of patients take step 2.

Step 3 is usually one to one sessions, such as CBT, and is only accessed by about 10% of patients. The open day hardly mentioned this, as I guess it is standard throughout the country.

d) Comparison with SPFT’s assessment system in Sussex
What SPFT’s access rate is I have never been told, nor seen written in any report, but guess that either they do not measure it, or if they do, are not proud of it, so do not publish it widely. My perception is that SPFT’s provider centred system wastes time and energy in assessing patients. This is a fruitless exercise, because patients’ moods can swing violently from manic to depressive
from one moment to the next, so is not a reliable guide to their condition on which to make a
diagnosis.
The prevalent culture of trying to assess patients puts the therapist superior, (on a pedestal), and
the patient inferior (on their knees, begging). This is often popular with both, as it gives a
secondary gain to both. It is an ego trip for the therapist. It allows the patient off the hook of
responsibility for their lifestyle, and gives them someone to blame for the continuation of their
condition, which becomes 'long term'.

However, this is an illusion, and a slippery slope, which stigmatizes and disempowers both. The
therapist tends eventually to be overwhelmed and burn out (as described in paragraph 12 below)
The patient gets worse not better, as the side effects of drugs often compound the problem, and
feels let down in their hour of need. Both becomes disillusioned with the system, because it tends
to prevent, rather than promote healing. This defeats the purpose of the NHS, which has become
highjacked by the drug companies.

This is the reason why 1.3 m staff have a morale at an all time low, and 15 m patients with long
term conditions have lost confidence in the NHS, and are forced to the desperate measure of
going to A&E as a last, and fruitless, resort. The remedy is to change this monster provider
centred, over medicated system to a patient centred one, as the Government has enacted, and as
describe in this paper.

e) How do LIFT market their services?

The following paragraphs have been copied from the LIFT website www.lift.awp.nhs.uk .
‘The LIFT Psychology services are for anyone with common emotional, communication and
mental health difficulties, registered with a GP practice within Swindon or Wiltshire. (There is
another website for the new service in Bristol etc)

Around 1 in 4 people will experience some kind of mental health difficulty in their lives. Most
commonly these are depression and some form of anxiety. Everyone will feel low from time to
time and everyone has something that they feel anxious about, but it's when these very normal
emotional experiences have unhelpful effects on day-to-day life that they can be termed a
common mental health problem.

The service ranges from self-help therapies, to psycho-educational courses and one-to-one
support, and is based on a Stepped-Care LIFT (Least Intervention First Time) model. This means
that we offer our services in a tiered approach where we recommend trying the most commonly
helpful support first.

We aim to see people quickly and have the shortest waiting times in the region. We also try to
make coming to an appointment as convenient as we can. You can book an appointment at your
local GP in Swindon and Wiltshire. In Salisbury please phone our administration base who can
book an appointment.’

f) Menu of courses offered
All courses provided by LIFT can be easily booked through their website, (www.lift.awp.nhs.uk) or by post or phone. They are all free at the point of use, although they ask for donations to pay for beverages provided in the 15 minute break. Sessions last for 2 hours, and most courses last for 6 sessions on consecutive weeks, although some are for 3, 4 or 5 weeks. Courses are provided on weekday mornings, afternoons, and evenings from 630-830pm. A few courses are run on Saturdays. Class sizes are up to about 40, but the average class size is 8, and the minimum number is 3. There are always 2 facilitators, so that they can support each other if difficulties arise.

Their core course is called: ‘Stress and mood management’, which introduces the principles of Cognitive Behaviour Therapy (CBT) They also provide an ‘Introduction to mindfulness’, but they do not provide the full 8 week Mindfulness Based Cognitive Therapy (MBCT) course.

The following is a list of some of their courses, to show the extensive range: ‘ Beating Low Self-esteem, Managing panic, anxiety and worry. Principles and Practice of relaxation, Anger awareness, Coping with depression, Moving on from separation and divorce, Effective Relationships and good communication, Handling stress at work, Building Confidence, Open doors (wanting work) Developing skills in assertiveness, Managing sleep difficulties, Managing fits and faints, Eating Action Group, Managing Asthma, Coping with obsessive compulsions, Living well after strokes, Cardiac stress, and bespoke courses on managing specific long term conditions, such as: weight and lifestyle, type 2 diabetes, pain and anxiety, bereavement, depression, Multiple sclerosis, chronic fatigue, fibromyalgia, wellbeing after baby, Irritable Bowel Syndrome (IBS) A new course called: ‘Dementia’ has just been introduced.

Courses also include interactive computer programmes, such as computerised CBT (CCBT), but they are given collectively in a class setting, with support. (I have heard complaints in Sussex of patients just being given a CD, and told to get on with it at home. This seems to me more like a cop out than a service, because no support is given with the CD)

However, LIFT also provide a ‘Books on Prescription’ service. This is a leaflet with a reading list of about 20 books, which can be borrowed on prescription from the local libraries. The flier says: ‘Reading well books on prescription helps you manage your wellbeing using self help reading.’ This programme is NICE recommended, and is supported by some Royal Colleges of Medicine and Psychology. However, I am not aware that it is provided like this in Sussex, and it should be, as it is extremely cost-effective way of educating people who are sufficiently literate to look after themselves and their families. The essential point is that the patient (not the theorist) decides whether the patient is sufficiently literate to use this service, so it is not used by the provider to fob off the patient.

The venues for LIFT’s courses are held in the following 12 towns: Swindon, (4 different venues) Salisbury, Bristol, Devizes, Melksham, Chippenham, Amesbury, Corsham, Warminster, Marmsbury, Trowbridge, Tidworth, Westbury, but some courses are run in other towns and villages.

g) Statistics for Wiltshire, extracted from LIFT’s annual report April 2012 to March 2013.

‘Last year the LIFT service saw 16,641 patients in Wiltshire.'
There were 10,211 new patients, of which 4,647 (46%) were in recovery at their last appointment. 54% had Mixed Anxiety and Depression, 11.4% had Generalised Anxiety Disorder, 36% had one or more Long Term Conditions. 1.8% were ex armed forces.

Nearly 20% of the 1441 patients who entered the service on sickness pay and benefits were back in employment by their last contact.

LIFT ran 193 psycho-educational courses across the county, attended by 1,540 people. 42% of patients scored 15 or more on the PHQ9 at the first session, indicating moderately severe to severe low mood.’

10 What is IAPT?
As LIFT Psychology operates under the principles of the Department of Health’s national IAPT service, I reproduce these below, which were taken from the summary dated Nov 2012 on their website www.iapt.nhs.uk.

'Originally launched in 2008, the Improving Access to Psychological Therapies (IAPT) programme is a large-scale initiative that aims to significantly increase the availability of NICE-recommended psychological treatments for depression and anxiety disorders, within NHS-commissioned services in England.

IAPT is currently helping to deliver the government mental health strategy, "No health without mental health", by supporting Clinical Commissioning Groups and Health & Well Being Boards in completing the roll out of the adult programme, as well as extending benefits to children and young people, older people, those with a severe mental illness, personality disorders, long term physical health conditions.

"The support and advice I was given during my step-by-step sessions have given me the strength, motivation and self-belief to work through my mental health issues head-on. I was provided with a safe environment, free from judgement or pressure, where I felt listened to and understood. Step-by-step played an important role in my journey back to good health and happiness, enabling me to lead a fulfilling and enjoyable life.”

Emma, IAPT service user

No health without mental health
At least one in four people will experience a mental health problem at some point in their lives. This places a significant burden on the individual’s wellbeing and their family, as well as the NHS and the wider economy.

To combat this, in 2011, the government launched its mental health strategy, "No health without mental health", which aims to improve the mental health and wellbeing of the population, by making high-quality services equally accessible to all. This cross-government outcomes strategy committed more than £400 million over four years (up to 2014/15), to further improve equitable access to talking therapies.

1 HM Government and DH, No health without Mental Health, February 2011

IAPT’s successes
Key successes of the programme in the first three full financial years to March 2012 include:
- Over 1 million people entering treatment
- 680,000 people completing treatment
Recovery rates consistently in excess of 45% and 65% significantly improved
Over 45,000 people moving off sick pay and benefits
Nearly 4,000 new practitioners trained
A major transformation of Child & Adolescent Mental Health Services initiated.

"Before using the service I was in"

**Plans for a healthier future**
By March 2015, access to high quality evidence-based psychological therapies, capable of delivering recovery rates of 50% or more, is expected to be available for at least 15% of the adult population. The scope of IAPT is also expected to have been extended to other groups in need. In order to achieve this goal we will be:
- Continuing to monitor patient satisfaction, safety and clinical effectiveness, using greatly enhanced data and information systems
- Training a further 2,000 practitioners to meet service demands
- Evaluating which models deliver evidence-based services in the best way to support sustainable investment
- Expanding services to address local needs on an equitable basis
- Extending the scope of the programme to specific groups at risk, including: Children & Young People; People with a severe mental illness or personality disorder; People with a long term physical health conditions and / or medically unexplained symptoms.

**11 Antidepressant prescribing**
I am much in favour of IAPT, and believe that it should be rolled out much more widely (which I why I am writing this) However, I should point out that the headline banner under which it was launched at a mental health conference in May 2006 by Health Secretary Patricia Hewitt MP was: ‘The end of the Prozac nation.’

Since then the number of antidepressant monthly prescriptions has nearly doubled from 30 to 50 million. This is despite banner headlines in 2010: ‘Prozac doesn’t work.’ I believe that antidepressants may help people to cope with an emergency. However, they are addictive, and so become worse than the original disease. My cousin’s wife was a GP, who became addicted to Prozac aged about 50, and died at 67.

Overall, they are massively over-prescribed, (as are all drugs) NHS England should recognise and publicise the fact that we have become a nation of prescription drug addicts, and have a national target to halve this number to 25 million by 2018, and to halve it again to 12 million by 2023.

**12 What the LIFT website says about it’s involvement with IAPT**

'IAPT has marked its first 3 years in operation with a conference and awards ceremony where AWP’s primary care psychology teams won recognition for their work.

For the layman, IAPT is part of a Department of Health three year initiative designed to train people to deliver Cognitive Behavioural Therapy (CBT) interventions. Before the IAPT project began, it was felt by that there was a clear gap in provision, leading to demand from patients and GPs for increased access to talking therapies as an alternative to psychotropic medications.
Random controlled tests have shown CBT is – in many ways – as good a treatment as medication, and can also be a way of teaching new skills and ways for a person to manage depression and anxiety disorders.

Swindon was a first-wave site for the IAPT project, with money provided to PCTs to develop services, and Wiltshire a third and final wave site. The south west region now leads the rest of the country in the amount and range of primary care based psychological services available through the NHS.

To mark the first three years of IAPT, the South West Development Agency recently held a conference and national awards ceremony in Taunton, at which teams and individuals working within Swindon and Wiltshire Primary Care Psychology service were recognised for their work across four distinct areas. The areas were:

- **Community involvement**: linking with local groups and communities to develop ways of supporting people to deal effectively with common mental health needs
- **Leadership**: an individual award presented to Liz Howells by...Liz Howells (see below for why!)
- **Working together**: As the open access courses need not only clinicians but administration staff to enable them to run at a sufficient frequency to match demand (i.e. around 450 participants and course session each week), this award recognises where the close working relationship of the two has helped to achieve goals.
- **Personalisation and choice**: Reflects the ethos of the service which encourages self-help, patient choice and empowerment.

13 What Wellbeing Therapies are provided under AQP for in Bristol and South Glos?

As part of the April 2012 NHS initiative to give patients and service users more choice about their treatment, the Any Qualified Provider (AQP) scheme means that patients can choose from a range of approved providers, all of whom meets NHS standards.

AQP is about empowering patients and carers, and improving their outcomes and experience of services. Patients can choose a service based on what’s important to them – perhaps one that is closer to home, has a shorter waiting list or better outcomes. These services will remain free for patients to use and access to them will be based on clinical need, in line with the NHS Constitution.

LIFT Psychology Bristol and South Gloucestershire are the gateway to all the AQP providers for primary care mental health in the area. During your initial assessment we can talk you through the providers that are most appropriate for you, and you will have the choice of which provider you want for treatment.

Many people go through periods of difficulty in their lives, which can leave them feeling stressed, anxious, depressed or unable to cope. Sometimes talking about these problems can help. We call these Wellbeing Therapies.

For contact details please follow this link
The Wellbeing Therapies service is run by trained practitioners who listen and discuss your problems with you. They can also help you to find ways of tackling or coping with them. Wellbeing Therapies are suitable for a variety of problems, including: depression, anxiety/panic, work related stress, obsessions, anger difficulties, relationship difficulties, eating problems, loss/bereavement, long term physical health conditions.

**What we can offer you?**

The support you will receive is generally short term. Wellbeing Therapies focus on helping you move forward. This type of service is know as “stepped care”. This means we start with the least intensive option and step up to further options if needed. We will concentrate on steps that you can take yourself to help you tackle your difficulties.

You will be initially offered an assessment and a foundation course. The course is run by LIFT Psychology. As the courses are taught, there will be no pressure for you to talk. You will not have to stand up, introduce yourself and tell everyone why you are there. We aim to teach you ways of coping with the situations in your life that are causing you problems. People often find that the foundation course is enough to clarify difficulties and explore more helpful ways of coping. However, if after trying this option you feel you need more help, you can make a further appointment where we will review your next steps. There are a range of additional, more in depth therapies that will be discussed with you if required.’

**14The Scottish Recover Unit model of community partnership working**

The following is copied from their website, [www.scottishrecovery.net](http://www.scottishrecovery.net) and gives many examples of how partnership working with the community should be incorporated into our JHWS.

**Community-led solutions for recovery focused services**

Wednesday, 28 August 2013

In the next of our series looking at best practice, Heidi Tweedie argues that co-produced, community-led services are going to be key to the future of recovery oriented mental health services in Scotland.

Scotland’s mental healthcare system, despite embracing and investing in the importance of recovery approaches, is still far from having recovery at its beating heart. Change to best support what have been described as the most common elements of mental health recovery – [Connectedness, Hope, Identity, Meaning and Empowerment](http://www.scottishrecovery.net) (a.k.a. ‘CHIME’) – requires a future system that may look very different from today’s familiar model.
Michael Perera, Mental Health Projects Manager at Highland Health and Social Care Partnership, agrees service provision needs to change: “The way services are set up is often not what people would choose. A recovery approach requires a more social care package rather than medical solutions. We need to move toward a flexible approach; equally who is best to provide this is an important avenue for exploration.”

Future services that embody recovery principles by offering such flexibility could be provided through statutory, voluntary or private organisations, but deciding on who is best to address a particular recovery need can only come from engaging with the service-using community. This in turn lends itself to a particular style of organisation – one that is community-led.

“People don’t value just being handed things on a plate,” emphasises Susan Scott, Development Manager at PLUS Perth. She is clear that ownership both nurtures recovery and is key to a service’s long-term success: “If it’s something they [the service-using community] have built up from the beginning, it means much more to them and they are more likely to take responsibility for it.”

Creating a workforce comprised of individuals with personal recovery experiences leads the way in promoting social inclusion. Such community-led services have the potential to become recovery leaders in their field, building more responsive, flexible and suitable mental health services. By making best use of personal experiences, peer working and mutual aid principles, all sections of CHIME are addressed. Additionally, creating a workforce comprised of individuals with personal recovery experiences leads the way in promoting social inclusion in communities beyond those directly involved, creating services that potentially cross the longstanding employment and community engagement barriers experienced by many with mental health issues.

Many voluntary sector services may feel they already address this, but the key difference is utilising the power of peers from the top to the grassroots. Graeme
Nisbet of Borders-based New Horizons has been one of the people who has overseen the organisation’s change toward a fully community-led recovery oriented service. He is frank about their past where users of services were consulted rather than leading the service: “Our committee was once a nodding shop, but now members, like myself, truly lead our work; it’s not tokenistic.”

Existing services should not fear adopting community-led approaches, provided they realise that both structure and staff will change. A good example of this is the Canadian ‘alternative business’ Out of This World Café. Based in a Toronto psychiatric hospital, it previously operated as a traditional social firm; staff assumed management responsibilities and clients attended to gain vocational skills. Following a period of reorganisation, its management and ownership is now entirely peer-led, with appropriate pay provided and positions filled by people who hold suitable professional experiences alongside personal recovery. Despite an uncomfortable process for many professionals and clients involved, it has ultimately blossomed into a successful social enterprise with recovery principles running throughout.

To seed similar initiatives in Scotland we should build on the success and credibility gained by existing investment and Government support in key recovery technologies, including the accreditation of peer support workers and the growing evidence base for WRAP. This will also promote balance in mental health culture, moving toward a situation where professional and personal experiences are equally respected and remunerated.

This leap forward could promote much needed growth, de-stigmatising skilled individuals with lived experience and recognising them for their full range of transferable skills. This might in turn facilitate fresh leadership and increase the pool of expert workers, vital to cultivate innovative community-led services for the future.

Such progress would be welcomed by Susan, who found her leadership and knowledge of the local mental health system vital in supporting the ‘Bridges’ enterprise. This project is an innovative example of what a community-led service can become; outpatients of the Murray Royal Hospital have become service providers within the hospital, offering mutual support and information to patients before they leave. However, despite Susan’s repeated attempts to maintain the project’s autonomy, NHS staff continued to contact her, viewing a ‘worker’ as someone of authority preferable to approaching the group directly. Such red tape and short-sighted institutional views only stymie progress and disempower communities.
This is why creating an even playing field between key players – statutory and voluntary services, and the communities who access these – is so vital. It promotes co-production, sharing of vision and resources, thus realising true equality, change and innovation. Funding is the key issue here; currently the voluntary sector struggles for funding security in comparison to relatively well-resourced and protected statutory services. Public bodies need to move beyond an established fear of risk and sense of superiority and invest appropriate levels of finance, gold standard rather than pennies – avoiding stifling caveats and micro-management practices that suffocate innovation.

Nurturing the service-using community

Attempting an innovative approach to co-production service creation is Forth Valley College, supported by Stirling Council, who linked with local mental health services to design a capacity building programme. Giving participants knowledge and expertise in business skills, it resulted in the creation of Route 9, an umbrella social enterprise organisation created by a group of students.

Graeme Nisbet is frustrated by current limitations: “What there needs to be is trust from funders – they need to just water it and see how it grows!” This fresh, and potentially alarming, concept for funders may also mean reapportioning some of the estimated £930 million the NHS receives for provision of mental health services. Rachel Perkins, recovery champion and academic, provides a strong supporting case for such change: her view is that making best use of specialist treatment requires stripping back treatment services so that they might focus on their areas of greatest expertise and redirecting resources to skill up individuals and communities to support ongoing recovery and connectedness.

Any discussions about moving resources are of course controversial and sensitive but in some quarters there is an appetite for reflection. “The potential to think differently about using the entire resource exists now we have integrated health and social care,” suggests Michael Perera. “Informed by models of care from around the world, we can make the best use of money. It’s a challenge to statutory services to be flexible with funding, but resources locked in to services with 20-year-old thinking behind them could be redirected.” Such redistribution is also in line with the 2011 Christie Commission report, which emphasises the requirement for community input rather than top-down control.
Achieving such vision requires all partners to commit to change. Statutory services could refocus their strengths and emphasise their expertise as medical specialists, as well as making funding accessible and appropriate. Existing and start-up voluntary sector services need to link with good practice such as New Horizons and the ‘Bridge’ to avoid reinventing the wheel and to promote sector growth. As Graeme explains: “Organisations need to be both user-led and business minded to secure funding.” This includes giving consideration to new markets and funds, such as Self-directed Support, social enterprise funding and even novel approaches such as crowd-funding.

Community-led service inspiration
Possibilities for new Scottish community-led start-ups include recovery colleges in the model of the Dorset Recovery Centre, or perhaps a peer-led version of brokering service Texas Self-Directed Care Project.

Equally, as Graeme points out, for community-led services to be successful, “ultimately they need to have strong vision.” Because, as exciting and interesting as these novel examples are, they are far from well supported or rewarded. Enthused members of the service-using community, willing to navigate the responsibility of service provision and tapping in to personal recovery experiences to inspire others, may well become disenchanted if we do not push for radical change in funding accessibility and culture. We need to nurture the growth in community-led solutions to create a truly recovery focused mental health system in Scotland.

Useful information:

- Recovery in Scotland: Beyond service development

Support for community-led start-ups:

- Business Gateway
- Voluntary Action Scotland
15 The need to improve the health and wellbeing of GPs, and other NHS staff

At the time that Steve Boorman reported in 2009, NHS staff absence averaged about 5%, which was more than double the average in the private sector, which is about 2%. If the NHS can't keep their own staff healthy, what chance have us patients got? The old adage is: 'physician heal thyself', which seems to have been forgotten.

The target of reducing NHS staff absence by 1% to about 4% was adopted by Government 4 years ago, but I have never seen any figures published since, so I guess that it has got worse as stress levels have increased. The news (8.9.13) that A&E staffing levels are 10% below what they should be indicates that staff health is a serious problem, which should be addressed in the JHWS.

The LIFT Psychology courses could improve the mental health and wellbeing of NHS staff so that they walk their talk, so they should be commissioned and provided as priority, and staff given time off work to attend them. GPs have now been given the additional job of managing 2/3 of the NHS budget in the CCGs, but are burning out, as worryingly reported in the College of Medicine website www.collegeofmedicine.org.uk, and reproduced in part below.

'Creating resilience: preventing burnout in GPs and patients.'

GP burnout is reaching epic proportions, and disturbingly some of those most affected are younger doctors. What can we do to restore their resilience - and their empathy for patients?

Burnout...

Last year, Dr Chris Manning of the College of Medicine's Mental Health Faculty worked with Pulse and Prof Clare Gerada of the Royal College of General Practitioners to create a survey on GP burnout. Among the first 2,000 GPs to complete the survey on Pulse's website, the results are disturbing:

- 41% experienced high levels of depersonalisation, 27% moderate, 32% low
- 72% had high levels of emotional exhaustion, 18% moderate, 10% low
- 97% reported low levels of personal accomplishment, 2% moderate, 1% low

Speaking to Pulse one GP who eventually took early retirement said "The stress would pile up and by 10am you've already reached rock bottom. I was very sad I couldn't express my care for patients how I used to. I didn't like what I was doing any more. I thought 'What's the point?' I didn't want to become one of those doctors who doesn't listen to their patients any more and reaches for the prescription pad."

Read the pages from Pulse about our Resilience survey.

...and Resilience

So what are the solutions? Dr Alastair Dobbin spoke about his successful scheme for improving mental health, both for GPs and patients. He set up the Foundation for Positive Mental Health,
which has developed a simple mental health programme which can be used at home - based on a reorientation of material used by Olympic athletes since the 1960s. The programme can be taken in two afternoons and is based on recorded tracks which tap into hypnotherapy and physical and mental relaxation techniques. The course also teaches good breathing and builds positive emotion. A GP can explain it to a patient during a ten minute consultation.

But increasingly, Dr Dobbin found that GPs were using the programme to manage their own stress. The programme has since been trialed in occupational medicine in GP services Scotland, has been studied at two universities and was accredited by the Royal College of General Practitioners in 2012. 850 staff have now been trained to teach the techniques. Further research has showed that using these techniques, GPs have been able to recover feelings of empathy, compassion and generosity.

The Foundation for Positive Mental Health carries basic breathing exercises on its website that anyone can use - patient, GP or Olympic Athlete - to help you tap into your inner resources and begin to feel better straight away.

The following motion was tabled in the Scottish parliament on 29.4.13 by Richard Simpson, supported by 20 MPs: ‘That the Parliament welcomes the findings of a recent King's College study in which a GP-supervised, audio-based resilience programme, Positive Mental Training, was demonstrated to be more cost effective in treating moderate and severe depression than any other economically evaluated psychological treatment; recognises the work of the Scottish charity, the Foundation for Positive Mental Health, in promoting the use of this programme, and urges the Scottish Government to adopt this approach as a frontline measure for GPs, who treat 90% of depression in the community, to reduce antidepressant use and, by reducing demand, help achieve the 2014 target to see all psychological referrals within 18 weeks.’

16 Conclusion and recommendation – clarify responsibilities, and adopt best practice

The director of public health (Dr Tom Scanlon) is right when he says in the draft JHWS (see paragraph 4 above): ‘it is becoming increasingly apparent that Government departments have adopted a maximalist approach to HWBs, effectively assuming that the local HWB is the key health and social care partnership for the area, and consequently requiring various plans, strategies and bids for funding/support to be signed off by HWBs. This will require the HWB to take on responsibilities additional to those identified in the JHWS, although the degree and range of these responsibilities is not yet clear.’

The highest priority of the HWB is to clarify the degree and range of those responsibilities. I believe that they are the same for public health and the NHS as they are for all other council committees (such as social care, education) namely they are statutorily responsible for how the budget is spent. About £400 mpa is allocated to the new CCG is, so I believe that the HWB should regard it as their budget, and oversee the whole of that expenditure, signing off all reports and contracts as with any other council committee. Together with the council budget of around £700 mpa, this brings the total to over £1 bnpa.

Discharging that responsibility requires looking around for best practice, (such as LIFT Psychology in Swindon and Wiltshire, and in Scottish Recovery) and adopting it into their plans (JWBS) and commissioning it by letting new contracts to provide it. That is what I recommend HWBs to do about mental health services.