Report for GP Leadership Project in Community Psychological Health

Introduction:
Wellbeing is rising on the personal, societal and political agenda. The absence of wellbeing manifest usually as depression and anxiety are on the rise in the community and is increasing GP workloads. Of the estimated 280 million consultations that take place in one year, about 30% are related to mental health issues but a far smaller number (<20%) of those consultations are referred on. Many of these patients do not meet local referral criterion for secondary care services (i.e. severe or enduring mental illness). These patients are currently be managed in primary care, although some do not cope well of the myriad of medications being offered to them. Although traditionally counselling has been one way to express psychological distress, it is not necessarily the most effective way to manage these conditions based on the recently updated national guidance (NICE, October 2009). Given this evidence based knowledge, policy altered to create a service which provides simple, easily accessed form of psychological therapy. Cognitive-behavioural therapy (CBT) is theory that separates thoughts, feelings, behaviours and symptoms that patients experience and given therapy a mechanism for individuals to understand themselves and regulate their own internal processes. These new services launched under the title of Improving Access to Psychological Therapies (IAPT) has been rolled out but individual PCT catchments and branded accordingly (although retaining overall IAPT branding). Talking Therapies (TT) is the branded names for IAPT services in West Berkshire PCT area.

Evaluating My Learning & Role in Talking Therapies about the Whole System, Whole Person and Whole Self:

i) The CBT model of therapy through the IAPT Programme
I began by spending time with the therapist in the first few weeks, so see what type of therapy was offered and how this was delivered. I observed the therapist in various roles including not only being therapist, but also assessors (initial screenings), completing electronic notes, producing letters for GPs regarding their patients, arranging meetings, reviewing complicated cases and team support. This was a wonderful opportunity as person who was extra to the system to observe how things ‘flowed’. Through my learning sets and the LEAN workshop I was able to map a patient’s journey through the system which became useful in my later work during my six month placement.

The teaching about NLP helped me during meetings when I met with the organisational thinkers at the PCT and SHA. It helped me listen to their experiences and interpret the body language when discussing the future vision of the services. I was able to reflect back in language that matched either a visual, auditory or physical experience according to their account. I achieved an understanding of where they saw the TT going both on a local and national level.

ii) The Referral System
TT is a relatively new system in terms of a service delivering therapy on a regular and systematic basis based on the national criteria. The notion was new to primary care and therefore there was an automatic role of establishing the TT brand and developing communications with GP. By virtue of being a GP in training, I was granted
permission to accessing GPs on both an individual and group basis at certain strategic meetings. I was granted access to the iaptus system (the NHS database of clients) which allowed me to start tracking the referrals by practice and the numbers. This gave me a spread of referrals and automatic targets (both low referrers initially but later high referrers too). Through the PDSA cycle I was able to strategically plan to visit busy GPs and inform them about the TT services targeted to the things they want to know about. This was a win-win because it helped them to help TT. I tailored my talks according to the needs that I could identify both from referral but also conversations over the phone in arranging these practice meetings.

iii) The Referral Form.
The referral form was inventive and initially met the services need although it became apparent that some key details were often not being completed. It also became apparent to me that the form was not necessarily easy for the GP to use and as the referred numbers began to increase, the referral form was becoming clunky and cumbersome without giving the information needed. Too many calls were being made to general practices. I helped redesign the form and pilot it my own practice for usability before we released on mass to practices. This was as part of using the PDSA learning cycle and from that evaluation I was able to tweak the referral form. I was instrumental in design a form which met both the services needs but also read in a way that a GP could easily complete even without having knowledge of services. I also helped design the opt-in section that met with the national aim of allowing an opt-in service.

iv) Producing Reports.
TT was relatively new and the manpower went into completing business of meeting therapy needs of the clients. I was able again to use the knowledge I had gained from the learning sets to be able to look at TT on an organisational basis both in meeting national targets but also interesting work in its own right. I learned how to make the iaptus system work for me in producing various reports which I have listed below along with key findings. Sometimes the data from the system had to be compared against other databases, so for instance ethnicity data need a base to compare against which I managed to ascertain through contacting the Office of National Statistics and using the extrapolated census data.

Reports produced:
- Substance Misuse and level of Psychological Input: those needing high intensity therapy were x4 more likely to be drinking alcohol over the government’s recommended limits, x2.5 likely to be smoking, x3 more likely to be using substances at the time of assessment. Causality could no be associated from the type of analysis.
- Failure to Engage rates: a difficult piece of work by its very nature, for although approximately 28% of clients failed to engage with TT the majority it did not want to be contacted. 17/69 patients were willing to talk to me and their reasons helped us to make therapy more accessible in location, more flexible in times and less formalised letters.
- Ethnicity Report: showed that white, mixed, Asian, black, and other ethnic groups were 89.3%:2.6%:4.0%:0.7% iaptus vs 89.6%:1.9%:4.3%:2.4%:1.8% extrapolated census figures respectively. It implied that the TT services were getting through a population representative of the expected figures and ethnic
minority groups were accessing services (although not to the quite the same extent e.g. over-representation of mixed and black groups compared to Asian and other ethnic minority groups)

- Age figures showed >65yrs to 0-65yrs were 3.6%:92.2%. This helped to create a baseline from which we could improve when the service became fully established and older age groups could be targeted.
- Analysis into mode of therapy showed that group therapy was most the efficacious compared to individual and computerised CBT programmes.
- A report analysing the employment status of people who underwent therapy showed that unemployment fell by 10% although some of this came from changing to other categories and did not confer to a corresponding rise in employment.

v) The Referral Rates.
An analysis from my beginning of my attachment showed that 8/30 Reading GP practice were not referring in the first six months (before my placement). By the time of reanalysis midway through my placement, all practices were referring. More importantly, all referral rates had risen by on average 14.5 fold (range 2-108 fold increase). I think this was a combination of both the tipping point when the majority of practices began utilising the service but also strategic targeting of non-referring practices and finding the people in the practice who would influence others.

As the numbers began to swell, it was found that the service was growing too fast for its then present capacity (a good proportion of the workforce were working as therapists whilst studying at the university, as detailed in the national IAPT training programme). It then became necessary to look at the throughput and working of the system. In conjunction with the seniors of the team, a triage service was introduced to begin screening the appropriateness of the referrals. The higher intensity therapists’ assessments slots were radically reduced to focus more on therapy time (the triage service screening referrals to minimise inappropriate referrals being assessed by high intensity therapists). We also scheduled a series of meeting to begin opening up the channels of referring to other services (i.e. secondary care systems such as the CMHT and crisis teams) in order not to ‘reject’ a referral per se back to the GP, but screen to get the patient to the most appropriate services. We felt this was in keeping with the
joined up thinking of the stepped care model. This again was from a result of evaluating the system as a whole. These changes have only recently been implemented by the waiting time for therapy already seems to be falling.

I was also allowed to assess some of the more complex patients. I had a good working knowledge of both psychology (from studying my BSc in psychology with biomedical sciences during my medical degree) and my psychiatry experiences as a doctor. This allowed to me to get some hands on experience of the type of clients, the challenges of the assessment process, and the quality of referral from the GP. As a result I managed to formulate a series of GP letters as templates for the staff. I also began a document so that useful information about other services could be stored and could be utilised by all (we all had access to the shared drive).

**vi) Future Design of Services.**
From the referral data and combining it with census data, deprivation indices and projecting forwards for the areas of Berkshire to come online (Reading was the pilot scheme that was 15 months ahead of Wokingham and Newbury), I was able to model the expected future rates of referrals which has been submitted to plan workforce capacity for each area.

**vii) Electronic Means of Communicating with General Practices.**
I helped establish a complete a working database of emails for each practice from which I was able to send an electronic version of the referral forms so that practice could upload the form and integrate the forms onto their systems. This gave the TT a means to communicate back directly with referring practices with any problems such as incomplete data on forms, or the use of old referral forms. It has also been means to communicate back to GPs about complex cases. This has been highly effective and the responses back from GPs states that they appreciate a service which appreciates the demands of general practice and is working with them in a dynamic and holistic manner.

**viii) Teaching.**
By being medical trained, I have encouraged the service to utilise any knowledge which would be to benefit to them. From a series of small conversations with individual therapists and utilising the pre-existing monthly team meeting, I regularly have a period of time for teaching about medical topics which may be relevant to the therapists. I have helped formulate information sheets about assessing suicide risk and medication as examples.

**ix) The National Agenda**
The most recent area were I have helped through my work has been the agenda were there are potential cost savings for the NHS for patients with long-term conditions (LTC) to have CBT therapy when there are signs of anxiety and/or depression. The commissioner who agreed my senior registrar post had the insight to introduce to me to the health information analysts at the PCT. After some negotiation I was again granted access to the PCT’s health numerics system. This allowed me to start to track some of the patients with a LTC and combine it with the iaptus data (both using the NHS number). It was then possible to produce reports to help the commissioner justify the process for continued investment into the iapt programme. It also gave an
insight to scope for potential cost savings to see if CBT did reduce health expenditure (currently underway).

x) Working with the Private Sector.
I was introduced to a pharmaceutical representative who was a former community psychiatric nurse. This lead to idea of formulating a template that could be used in general practices to help streamline consultations, assess risk and refer on to the appropriate speciality as necessary and in accordance with NICE guidance. This is being piloted in the practice I used to work in as part of this senior registrar training period (by virtue of the links with that practice and its partners).

Summation
Overall the senior registrar scheme was a wonderful opportunity to develop as GP-in training, to develop a natural interest in a specialism and to continue to learning through the learning sets. I think I was fortuitous in the position I held as I was able to work, learn and develop as a person, a GP and organisational thinker.

The opportunity arose by virtue of being in a learning set with registrar who specialisms was medical education, to pilot some reflective cards. These were meant for use in practice. It was an interesting pilot and in some ways helped me harness a reflective process in which I already routinely completed on a daily basis. Essentially, for me it became the next step in reflection in actually leading me to a process of action rather then just reflecting. The actions helped construct my thoughts in a useful manner. Another way in which the ‘R cards’ was to also think about positive experiences in practice and appreciate my work – a thing I must admit I had rarely done up until that point. I think it has helped maintain my resilience to face some of the daily challenges in general practice and continue in supporting my positive outlook.

In growth as a person, I feel I became more self-aware in terms of my role as a trainee, as an embryo GP, as an analyst, and as person. The training helped me take on a role and grow with a service. I was wise to achieve a balance between medic and a medical perspective in a service, working with rather then against the management. The six month placement required for me to learn to manage my time effectively and appreciate my workload realistically. Previously I was too eager to agree to take on everything in order to be helpful, but I learned that taking on the right amount to keep myself active and challenged whilst tempering with realism was the best path for a successful career. I have changed in terms of integrity with my patients too – no longer trying to put a positive perspective with everything that the patients present with. Sometimes patients present to share the difficulties of their lives and I now appreciate that sometimes all I can do back is share it with them.

Another area in which I have developed by virtue of this post was to develop the ways I work with others. I was taken out of the safety zone in which I was accustomed (the medical world) and challenged by working with non-medics. It was inspiring and difficult at times and most importantly fun. It is difficult to describe how good it feels to find a way to communicate at an appropriate levels, for instance in the group teaching to the other therapists. I had no real appreciation of the extent to which I used medical jargon so very fluently and that it bewildered others who had not a clue in which language I spoke. My group teaching sessions are much more appropriate. I
have maintained my ability to know when other are stressed or dissatisfied and remain an attentive, safe person to feedback to management. I understand the dynamics of the team model and am able to help particularly at moments when the workload stretches all to their limits.

I feel in these six months I have grown to become aware of a service which is becoming established in the community. I have worked with strengths as a GP in training and developed communication channels which did not exist previously with GPs, community nurses, health visitors, midwives, hospital consultants. I have formulated an updated risk policy to ensure that TT works as safely as possible at all times. I have also by my analysis into certain areas (such as the failure to engage rates) managed to listen to the views of those most dissatisfied with the services.

Organisationally I feel I have been helpful in creating an environment that is able to objective measure it processes and evaluate the TT service. I come from a solid medical background where evidence is sought to justifying changing something either via a report or personal experience. I am now able to identify key stakeholders who are able to bring about change, which is not necessarily management. Sometimes it is about getting the majority of staff onboard too. I think it is important to have a mechanism for feedback to the service so that changes (and its after-effects) can be fed back for review too (and I have this independence by being directly employed by the commissioner and not the commissioned service). My role has been very successful; so much so that the commissioner went on to create a post for me. There was already GP IAPT lead in post so I became and GP associate IAPT lead. I was very honoured and am privileged to have my work valued to such a degree that it went on to create me a job after I qualified which I have taken up and continued to date. This wonderful post would not have been generated without the experience of senior registrar post. If I had any influence on the teaching structure, I would make it mandatory for all developing GPs as a culmination of their training. Although I appreciate the screening process was necessary to ensure the motivation is present especially for the self directed learning so think the current system in place is excellent as run by Marion Lynch.

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