

National Specification for Psychological Services and Psychological Therapies

Staff survey and engagement events April to May 2022

Staff survey background and content

Background

The Scottish Government is developing National Quality Standards for Psychological Services and Psychological Therapies in Scotland. To inform these standards, a survey developed by the Scottish Government was carried out and a series of stakeholder engagement events were held across the country. The survey was sent via email to staff involved in psychological therapies across Scotland. ACP-UK was commissioned by the Scottish Government to assist in the analysis of the resulting data.

Survey instructions and content

Participants were then given the following instructions:

Under the following section regarding the leadership and governance followed by the 7 Key Principles, please select which statements you agree with that should be included and expanded upon in the National Quality Standard for psychological services and psychological therapies. If you have anything further to add e.g. key areas for improvement or an example of what 'good' looks like then please add to the free text box. If you feel strongly that something should not be included, please provide more detail so that we better understand how this might be unhelpful to enable best practice.

The survey contained the following sections:

Employer/professional group/service area/specialist services/level of psychological therapy.

Leadership and Governance of psychological services and psychological therapies (10 statements, 1 free text box for comments).

Key Principle 1 - How do we ensure that people experience high quality care and support that is right for them? (17 statements, 1 free text box for comments).

Key Principle 2 - How do we ensure people are fully involved in decisions about their psychological care and treatment? (14 statements, 1 free text box for comments).

Key Principle 3 - How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them? (17 statements, 1 free text box for comments).

Key Principle 4 - How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered? (9 statements, 1 free text box for comments).

Key Principle 5 - How can we ensure people are fully involved in the planning and transition of psychological care? (7 statements, 1 free text box for comments).

Key Principle 6 - How can we fully involve peoples carers/supporters in planning their Psychological care? (10 statements, 1 free text box for comments).

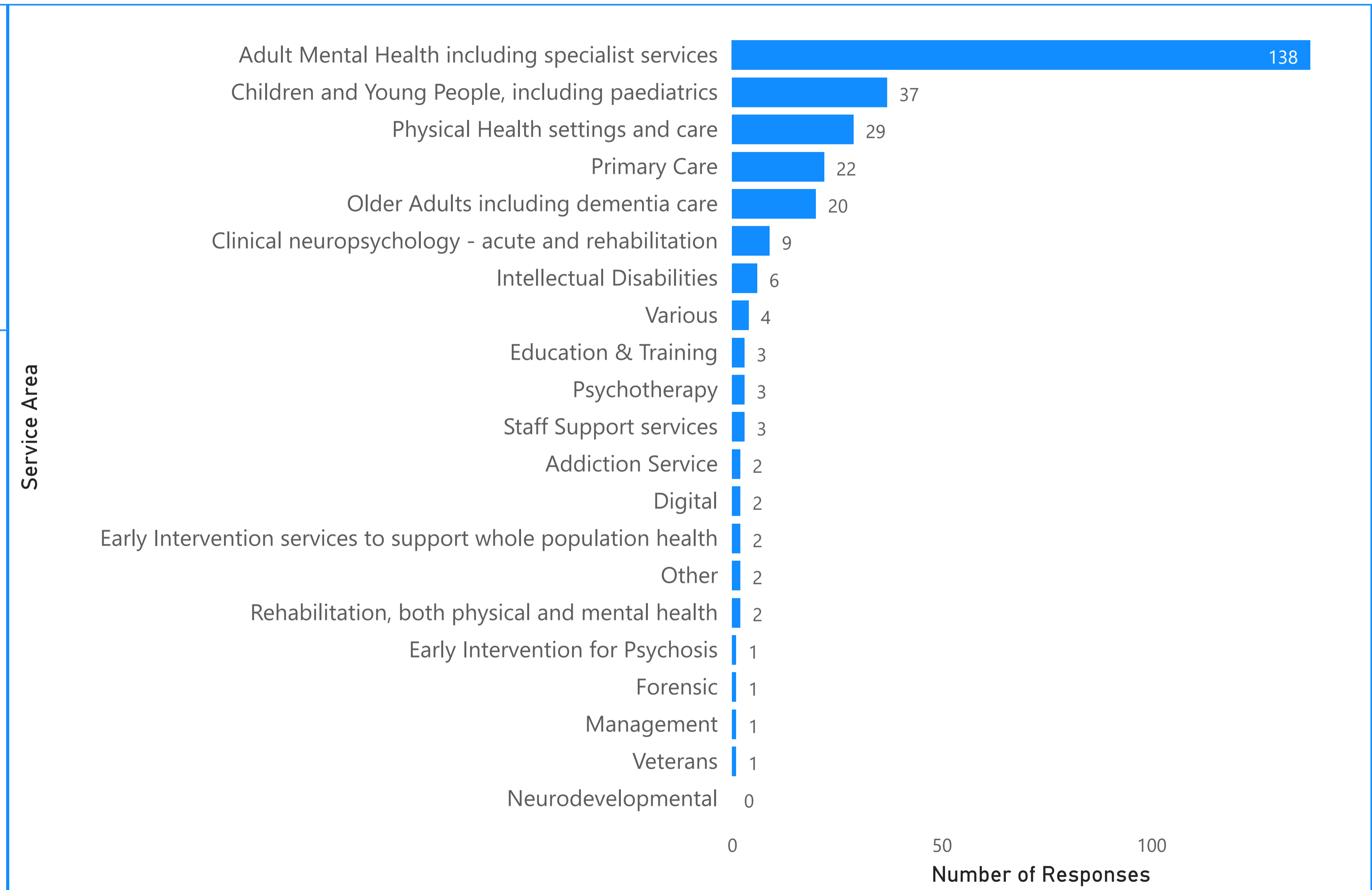
Key Principle 7 - How can we ensure people have confidence in the psychological services and therapies staff that support them? (11 statements, 1 free text box for comments).

Final question for additional comments.

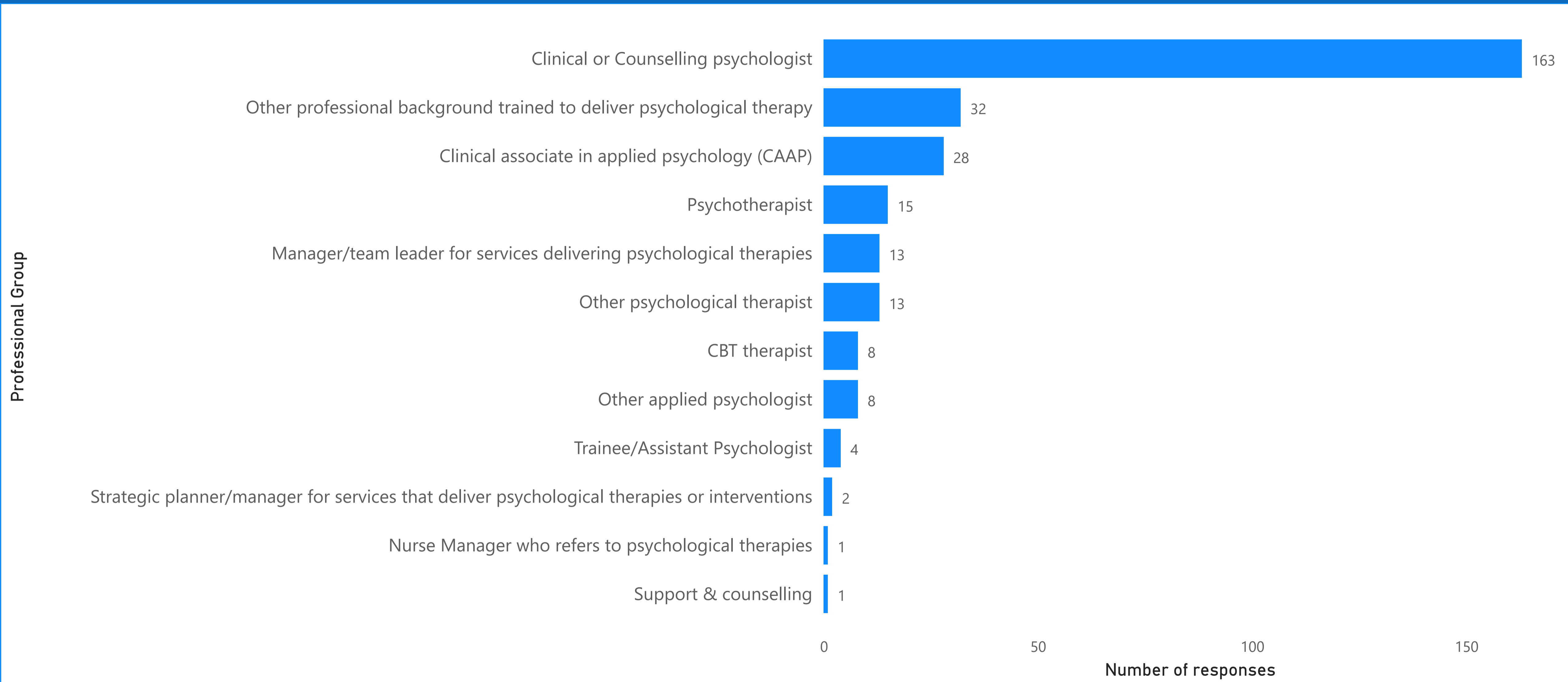
Number of survey respondents by employer and by service area

Employer	Number of Responses
NHS	269
National Organisation	8
Third Sector	4
HSCP	2
Independent Sector	2
Local authority	2
University Training Provider	1
Total	288

Adult mental health specialist service	Number of Responses
Specialist trauma services	28
Eating disorders	21
Substance use	20
Forensic services	18
In-patient care	18
Psychosis	14
Psychotherapy	14
Maternity and perinatal	13
Crisis support	11
Gender identity	7
Neonatal	4
Clinical health	3
Personality disorder	3
Homelessness	1
Total	175

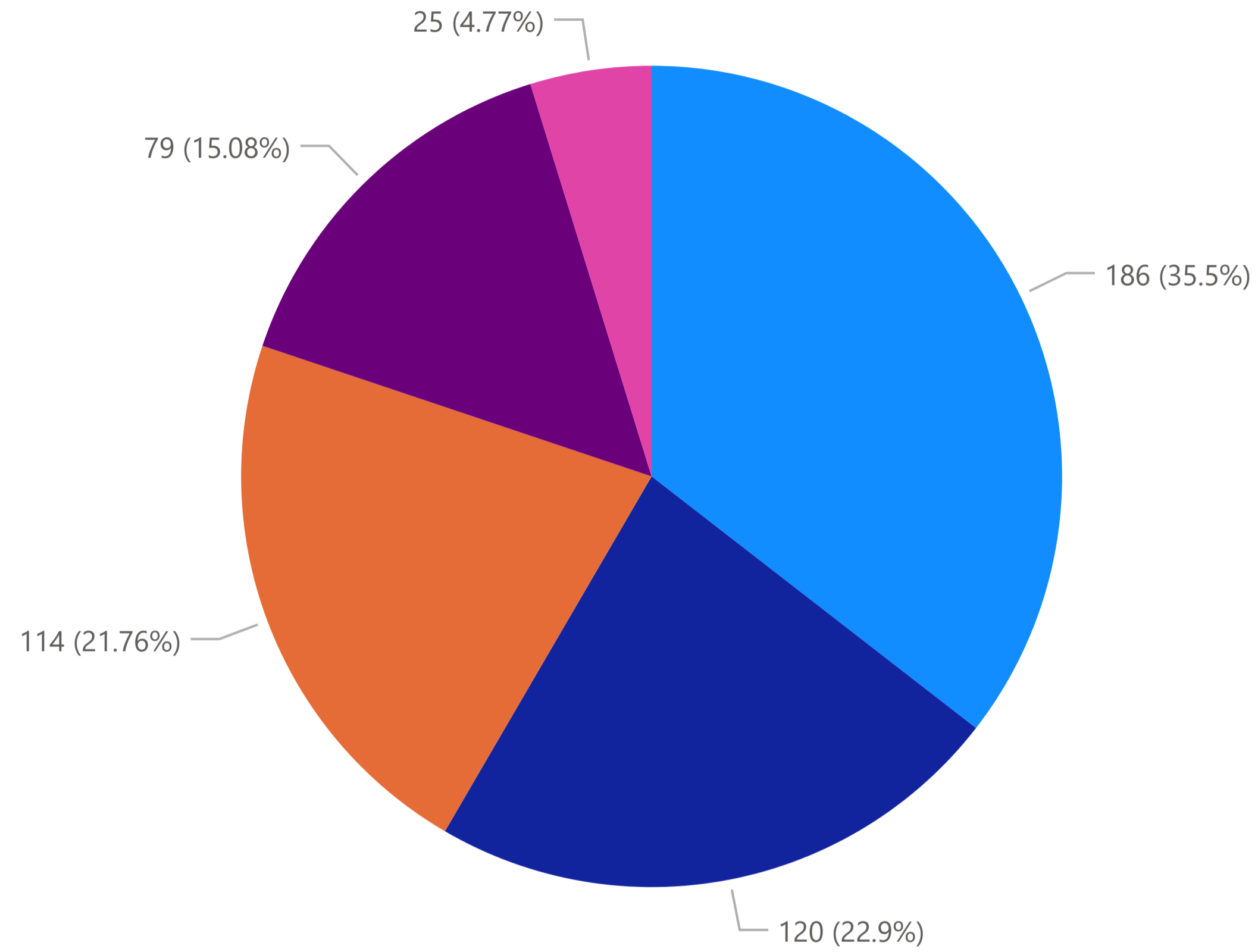


Number of survey respondents by professional group



Note: leadership may be under represented here, as some respondents may have selected their professional group, e.g. clinical psychologist and not manager or team leader.

Number of respondents by level of intensity of psychological therapies delivered



● Highly Specialist psychological therapies ● Specialist psychological therapies ● High Intensity psychological therapies ● Low Intensity Evidence Based Therapy ● High Volume Guided Self-Help

127 (44%) respondents delivered more than one level of intensity of psychological therapies.

92 (32%) delivered highly specialist psychological therapies **only**.

28 (10%) delivered high intensity psychological psychological therapies **only**.

13 (5%) delivered specialist psychological therapies **only**.

23 (8%) delivered low intensity evidence based therapy **only**.

Engagement events overview

Staff attended Engagement Events where they were asked to discuss the following questions:

How do we ensure effective implementation and governance of Psychological therapies?

How do we ensure that people experience high quality care and support that is right for them when accessing Psychological Services and Therapies?

How do we ensure people are fully involved in decisions about their psychological care and treatment?

How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them?

How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered?

How can we ensure that people are fully involved in the planning and transition of psychological care?

How can we fully involve people's carers/supporters in planning their psychological care?

How can we ensure that people have confidence in Psychological Services and Therapies staff that support them?

Location	Number of Events
Ayrshire & Arran	2
Borders	2
Fife	1
Forth Valley	4
Grampian	2
Greater Glasgow & Clyde	3
Highland	2
Lanarkshire	2
Lothian	4
NHS Education for Scotland	1
Orkney	1
Western Isles	1
Total	25

More than 181 attendees attended across 21 events.

Adult Mental Health, Arts Therapies, CAMHS, Clinical Health, Eating Disorder Service, Forensic, Health Psychology, Learning Disabilities, Older Persons Services, Oncology and Pain management Services, Personality Disorder Service, Neuropsychology, Older People, Substance Use and Specialist Trauma Service.

Note: 4 of the events did not provide data on number of attendees. This data has been requested and will be updated in an Appendix.

Professional groups/job titles of those that attended included: consultant clinical psychologists; consultant medical psychotherapists, head of programme, heads of psychology speciality services, lead clinical psychologists, director of psychology, clinical director, charge nurses, nursing team lead, occupational health manager, project manager, project lead, primary care manager, medical psychotherapist, clinical psychologists, clinical associates in applied psychology, health psychologist, learning disability nurses, primary care mental health nurses, nurse therapists, occupational therapists and trainee health psychologist.

Data analysis and layout of results

Data analysis

The categorical data was analysed using frequencies and percentages to describe the responses to each question. Responses to the free text response questions were analysed using thematic analysis by coding data line by line and organising into common themes for each section of the survey. For each section (or 'Key Principle') of the survey, those statements which had the most free text comments associated with it and/or those statements with the most 'disagree' responses were presented alongside the relevant common themes. In addition, survey free text comments and engagement events data were also coded for general feedback about the survey and engagement process. This also resulted in a number of themes.

The staff engagement event data was received in the form of Word documents with key themes and notes that had been collated by the facilitators of the sessions. This data was analysed separately for common themes under each of the questions discussed at the engagement events.

Layout of results

In the following pages the results of the data analysis are grouped under each of the seven staff survey sections which also correspond to the questions asked at the staff engagement events.

Firstly, the bar charts are displayed which detail the percentage of respondents who agreed and disagreed with each statement under that section of the survey. This is followed by the presentation of key themes that emerged from the free text comments in the survey. These themes are specific to the statements that received the most comments and/or most disagreement. A selection of quotes from respondents that reflect the key themes are also presented here. The themes from the engagement events are then displayed.

On the final page, themes from general survey and engagement event feedback are displayed.

Overview of survey free text comments

The following tables detail the number of free text comments and the number of words provided for each topic area/key principle and also the number of standards respondents' provided comments on.

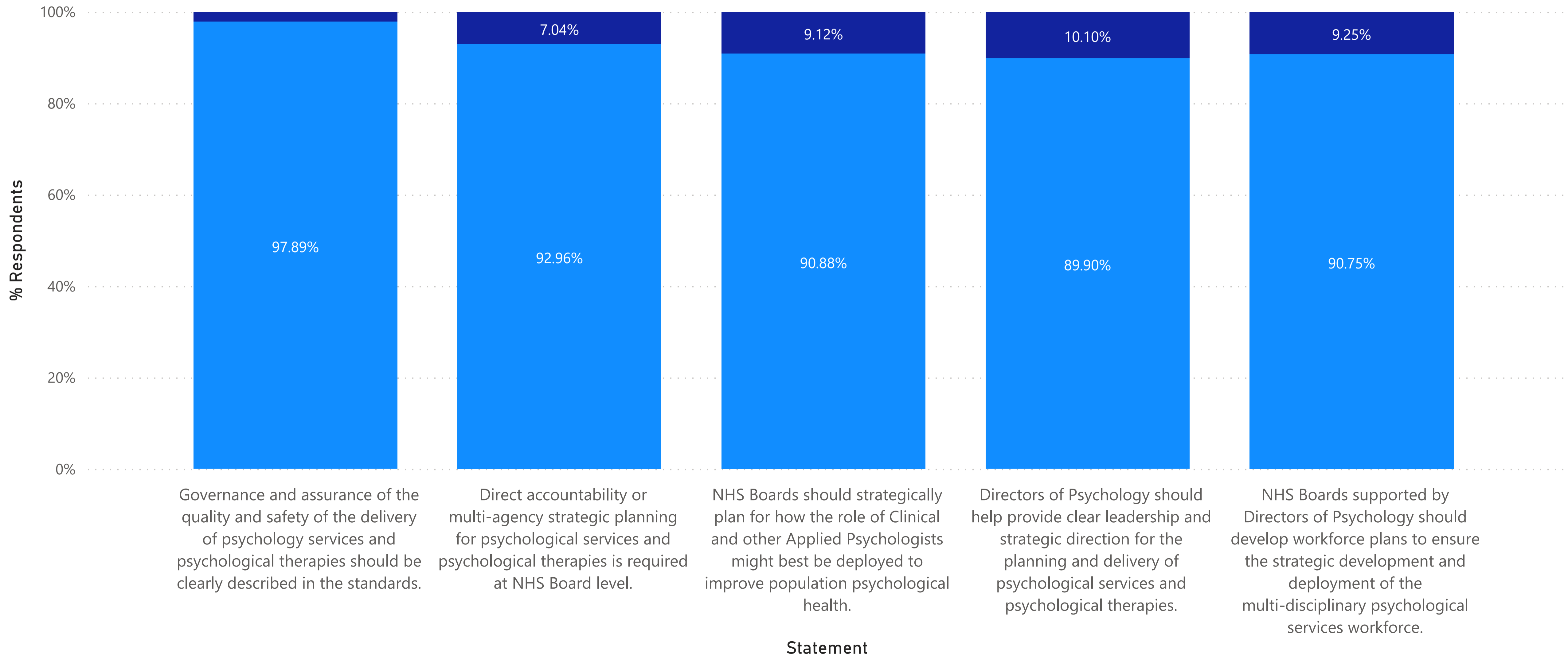
Topic/Key Principle Area	Number of comments	Number of words
In relation to the leadership and governance of psychological services and psychological therapies, which statements should be included in the standards?	125	8640
How do we ensure that people experience high quality care and support that is right for them?	120	5933
How do we ensure people are fully involved in decisions about their psychological care and treatment?	101	5601
How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them?	88	5585
How can we ensure people have confidence in the psychological services and therapies staff that support them?	72	2416
Final text box for additional comments	68	5470
How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered?	51	2352
How can we fully involve peoples carers/supporters in planning their Psychological care?	44	1783
How can we ensure people are fully involved in the planning and transition of psychological care?	40	1450
Total	709	39230

709 free text comments were provided by 186 (65%) respondents, totalling 39,230 words.

Number of standards with comments provided by respondents	Number of Respondents	% of Respondents
Did not provide any free text comments	102	35.40
Commented on one standard only	39	13.50
Commented on two standards	32	11.10
Commented on three standards	30	10.40
Commented on four standards	23	8.00
Commented on seven standards	15	5.20
Commented on five standards	14	4.90
Commented on six standards	13	4.50
Commented on all standards plus final question	11	3.80
Commented on all standards	9	3.10
Total	288	99.90

In relation to the leadership and governance of psychological services and psychological therapies, which statements do you agree should be included in the standards?
 Percentage of respondents who agreed and disagreed with each statement.

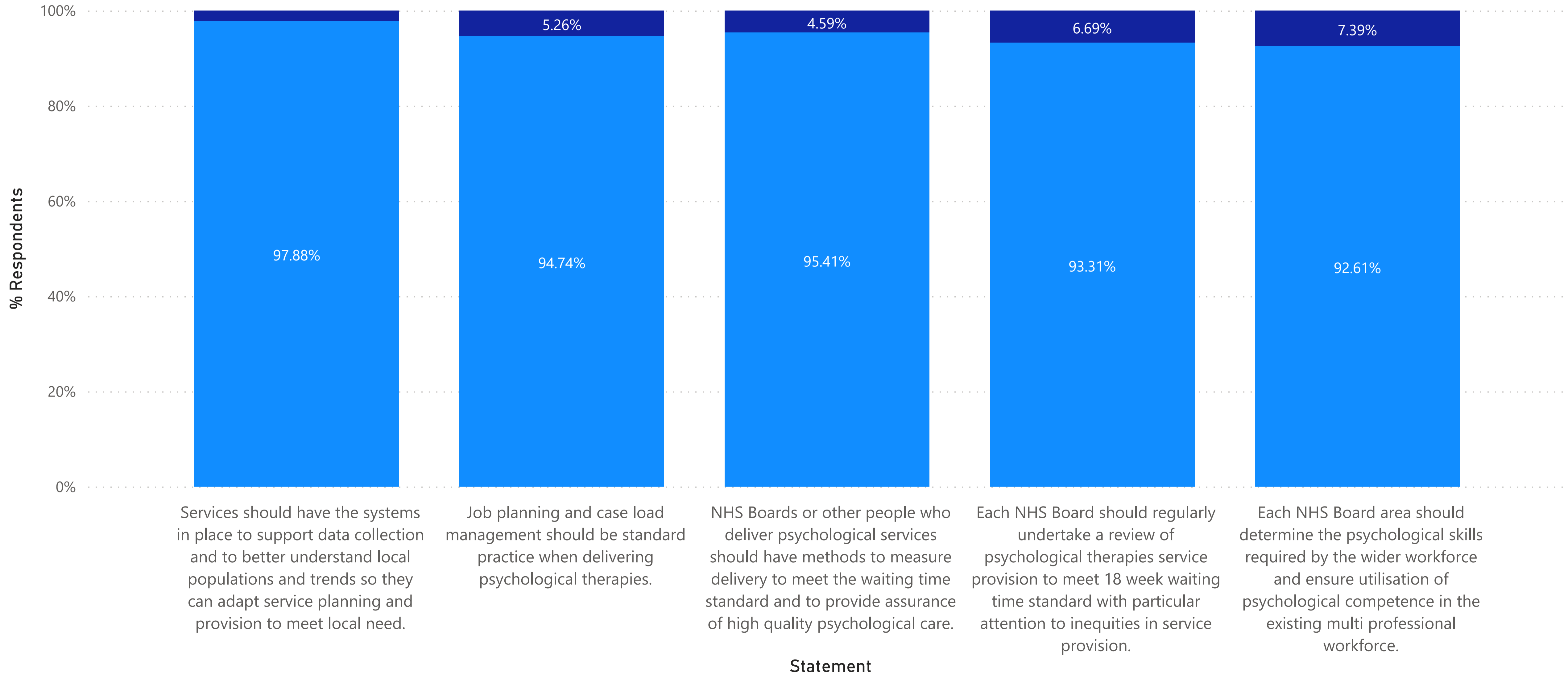
● Agree ● Disagree



In relation to the leadership and governance of psychological services and psychological therapies, which statements do you agree should be included in the standards?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



In relation to the leadership and governance of psychological services and psychological therapies, which statements do you agree should be included in the standards?
Themes from survey free text comments about specific standards.

Direct accountability or multi-agency strategic planning for psychological services and psychological therapies is required at NHS Board level.

Also consider having a psychologist directly involved at this level who can advise with their authority and experience.

NHS Boards should strategically plan for how the role of Clinical and other Applied Psychologists might best be deployed to improve population psychological health.

Workforce planning must also take place in alliance with local teams/Professional Leads/Director of Psychology, who can talk about the needs of local populations and local teams and therefore issues impacting service delivery.

Services should have the systems in place to support data collection and to better understand local populations and trends so they can adapt service planning and provision to meet local need.

Suggestion that data collection should be qualitative as well as quantitative; IT systems to support data collection and analysis is crucial; Process should be streamlined to ensure it is not a barrier to providing quality psychological intervention.

Each NHS Board area should determine the psychological skills required by the wider workforce and ensure utilisation of psychological competence in the existing multi professional workforce.

Concerns about health boards making these decisions; Would prefer a broader national approach that may be more inclusive of the different professions that deliver psychological therapies (and not only clinical psychologists).

"Staff wellbeing should be included as central to leadership and governance in psychology services. Well supported, valued, healthy staff who feel safe are absolutely key to the service."

"Decisions about psychological therapy and service delivery should be made by those with expertise in these matters, ie. psychologists and other psychological therapists, not operational managers from other professional backgrounds."

How do we ensure effective implementation and governance of psychological therapies?

Key themes from stakeholder engagement events.

Supervision and Training

CLEAR STRUCTURES AROUND TRAINING AND SUPERVISION STRUCTURES: ensure that governance is a requirement of delivering psychological therapies; supervision of supervisors; transparent supervision structures in place.

SUPERVISION DELIVERED BY APPROPRIATELY SKILLED INDIVIDUAL: Supervision delivered by individual experienced in the intervention being delivered (rather than generic supervision).

CAPACITY: resources and staff numbers required for supervision and training (staff often feel too busy).

NEED FOR HIGH QUALITY SUPERVISION: expert supervision needed for certain modalities of therapy; role for other professions as well as clinical psychologists.

SUPERVISION TRAINING: ensuring a base level of training and competent supervision for those delivering interventions; certified courses and also intervention/modality specific courses; capacity in system to support training and supervision and reflective practice for modality leads.

Leadership Qualities

LEADERSHIP TRAINING: provision of good career development opportunities; include in regular personal development plans; ongoing programme of leadership training available.

SHARED VALUES: Shared views with colleagues on what is valuable, service pressures, and being flexible regarding leadership implementation.

COMPASSIONATE LEADERSHIP: to have compassionate leadership and draw on leadership research; enabling teams to provide high quality services, feel engaged, creative and flexible, ensuring psychological safety within psychology teams and widely across services.

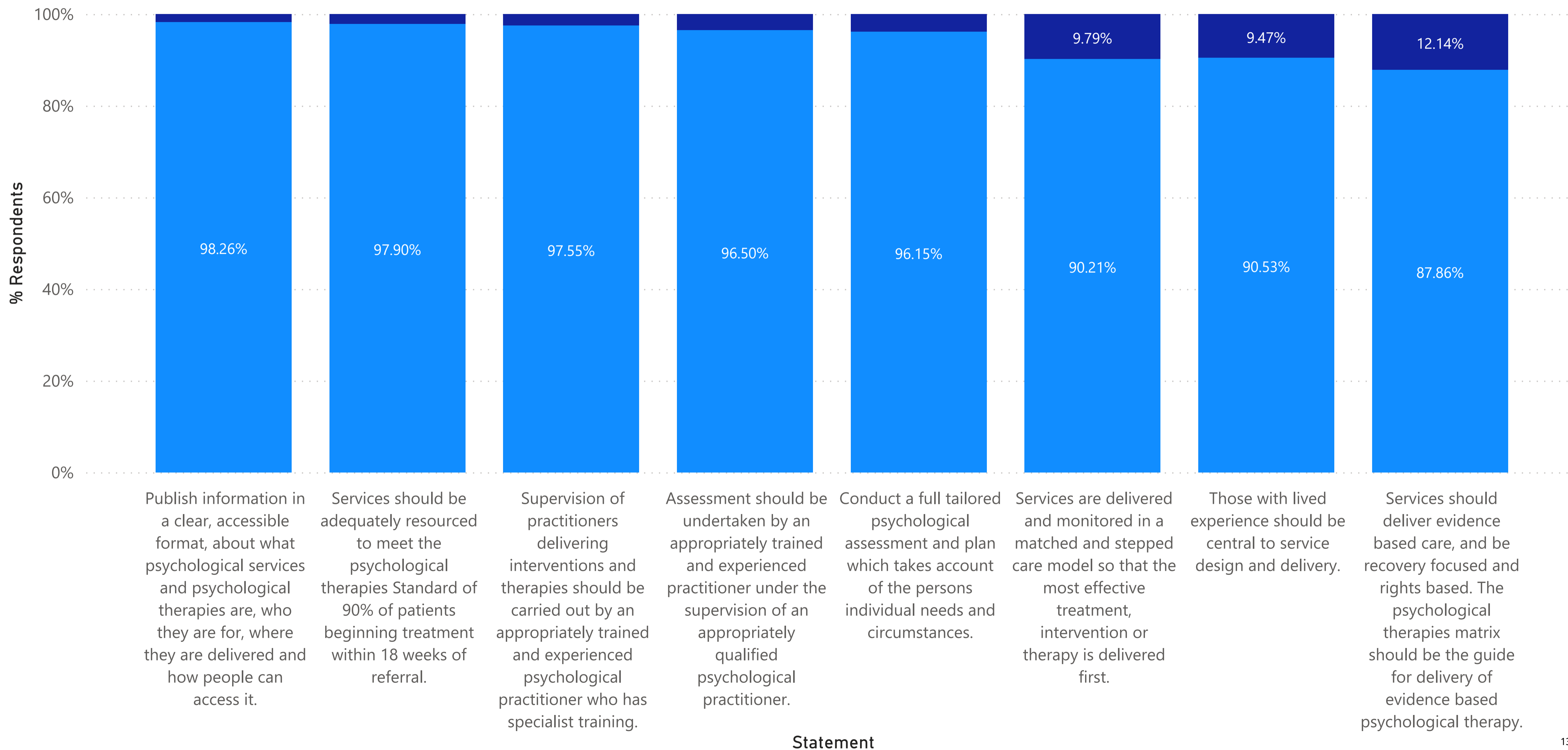
COMMUNICATION: listens to colleagues; effective leadership standards should consider clear, consistent and timely communication and information to staff so that they are informed of strategic plans.

RECRUITMENT: Ensure right leaders are in place via national assessment process; ensure national assessors scheme is fit for purpose; concerns about promotions into leadership positions without leadership competencies already in place; good succession planning in place.

How do we ensure that people experience high quality care and support that is right for them?

Percentage of respondents who agreed and disagreed with each statement.

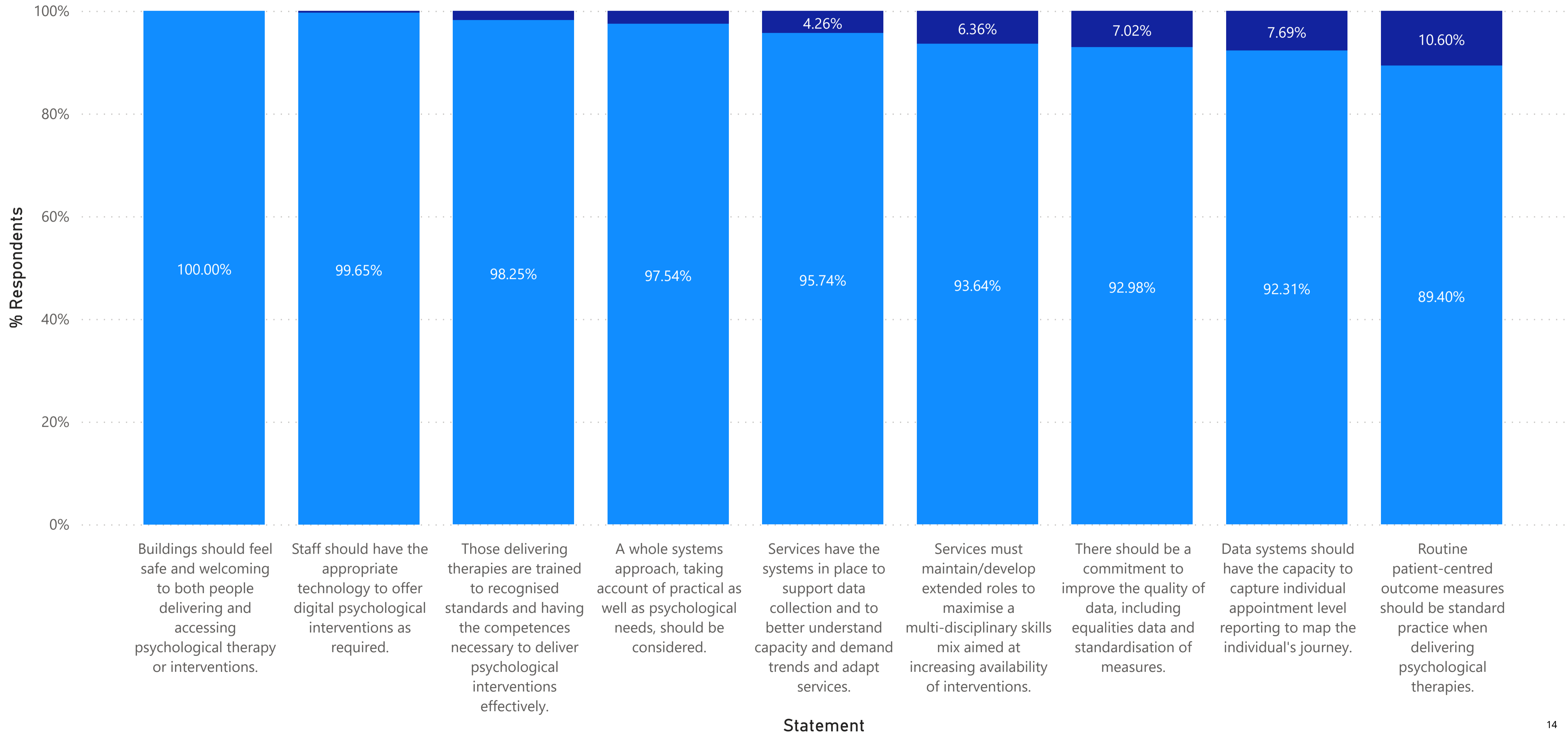
● Agree ● Disagree



How do we ensure that people experience high quality care and support that is right for them?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How do we ensure that people experience high quality care and support that is right for them?

Themes from survey free text comments about specific standards.

Those with lived experience should be central to service design and delivery.

Expectations must be clear;
Compensated appropriately (not volunteers);
Other factors must also be considered equally;
Would need lived experience representation from all specialities.

Services should deliver evidence based care, and be recovery focused and rights based. The psychological therapies matrix should be the guide for delivery of evidence based psychological therapy.

Evidence outwith the Matrix should also be considered;
Evidence base is limited for some services (LD, older adults etc);
Some effective therapies lack an evidence base due to difficulties in measuring;
The Matrix is CBT focused.

Services are delivered and monitored in a matched and stepped care model so that the most effective treatment, intervention or therapy is delivered first, only stepping up to more intensive or specialist services as required depending on the level of need or distress.

Model not appropriate for some services (e.g. trauma; specialist surgical assessment services);
There are times when a higher level of intervention is needed first;
Lack of resources - e.g. not enough low intensity workers/smaller services.

Routine patient-centred outcome measures should be standard practice when delivering psychological therapies.

"Routine" would need to be defined. Outcome measures should be considered carefully and used specifically and appropriately in context, not applied indiscriminately;
Needs to be appropriate outcome measure for intervention.

"As an example, I could not deliver standard outcome measures to patients with brain injury who are aphasic and behaviourally disturbed [...] standardised measures do not capture the effectiveness of what is often a complex intervention."

"The psychological therapies Matrix is a useful starting point but the lack of time and resources for clinically relevant research means that it does not adequately reflect current best practice."

How do we ensure that people experience high quality care and support that is right for them?

Key themes from stakeholder engagement events.

FEEDBACK & OUTCOME MEASURES: satisfaction feedback; patient case reviews; measures must be meaningful; qualitative data should also be collected; how do services react to feedback/evaluation? - quality improvement required.

APPROPRIATE REFERRALS: clear referral pathways and referral criteria; close working between referrers and mental health services; correct initial referrals allow more time for initial assessments and communication of formulation.

EFFECTIVE COMMUNICATION: providing patient with clear information about how long the process will take from waiting list to treatment; explaining terminology used; ensure the methods of communication are appropriate.

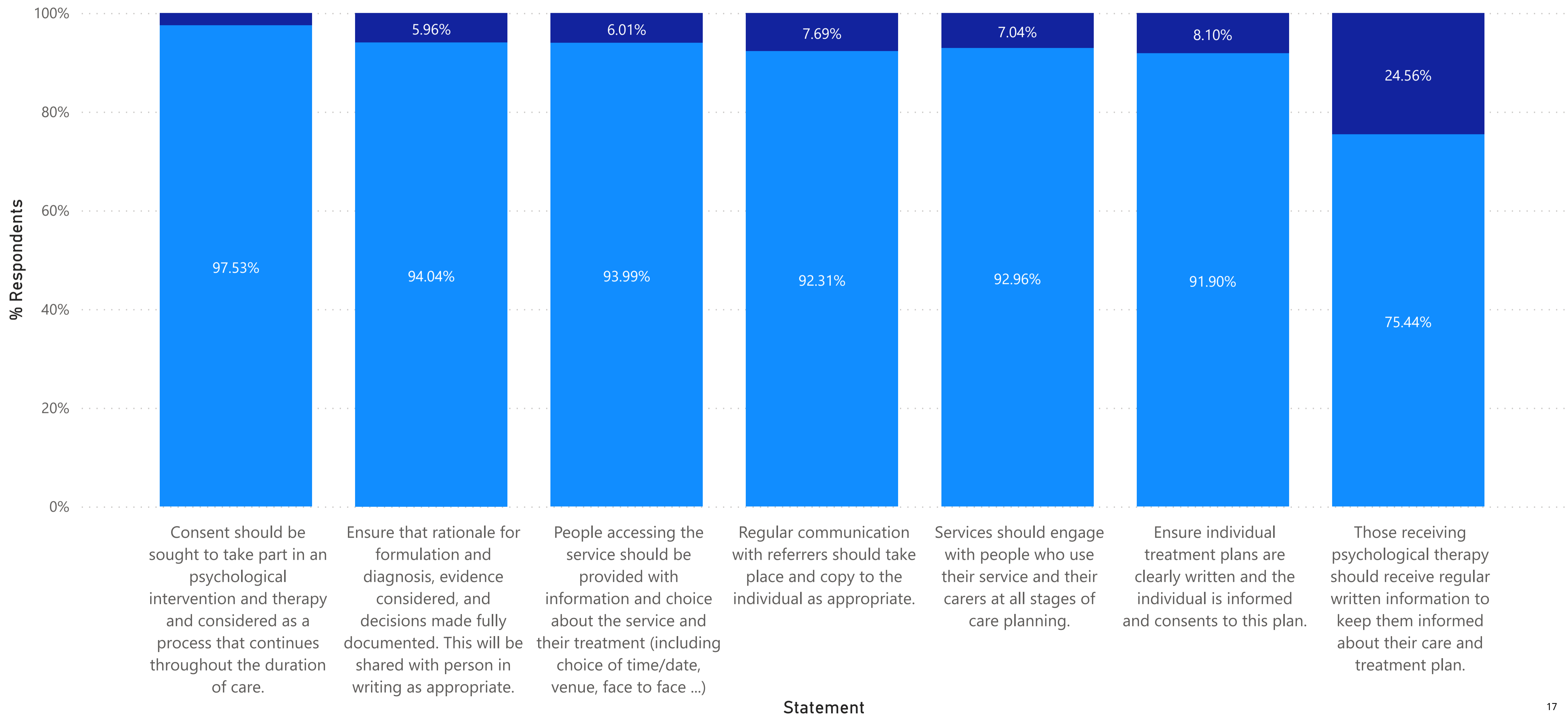
BARRIERS TO ACCESS OF PSYCHOLOGICAL THERAPIES: access can be difficult for forensic/prison population; some services are less 'trauma friendly'; marginalised populations such as homeless and substance misusing are not accessing services well – need to address this gap.

PSYCHOLOGICAL FORMULATION: key for including and involving people. Question about how to involve people in formulation and treatment decisions when the delivery of care is indirect through others.

How do we ensure people are fully involved in decisions about their psychological care and treatment?

Percentage of respondents who agreed and disagreed with each statement.

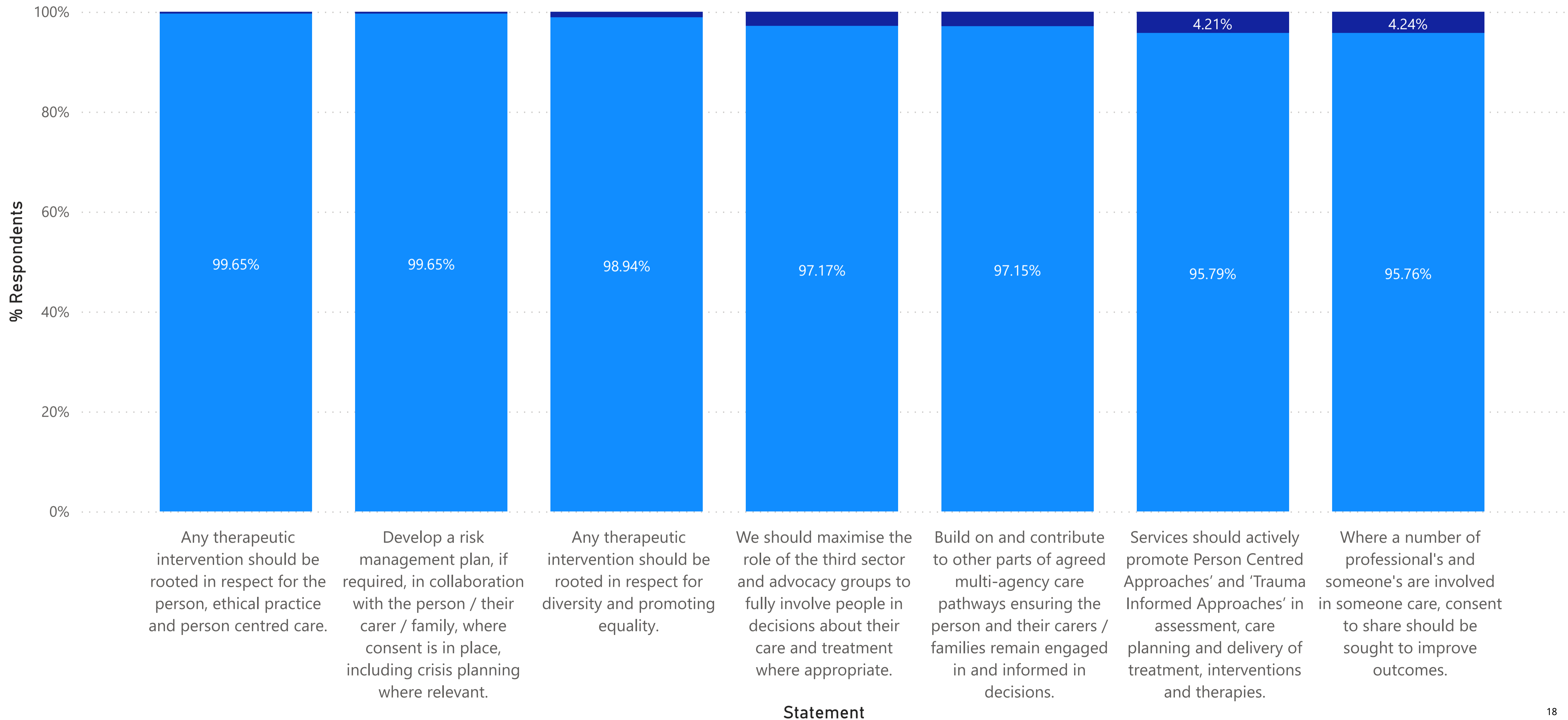
● Agree ● Disagree



How do we ensure people are fully involved in decisions about their psychological care and treatment?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How do we ensure that people are fully involved in decisions about their psychological care and treatment?

Themes from survey free text comments about specific standards.

Those receiving psychological therapy should receive regular written information to keep them informed about their care and treatment plan.

Agree in principle but job plans need to incorporate admin time;
Agree with updates but should also be option of verbal updates;
Not always appropriate (client doesn't want it/risk reasons);
Only at meaningful time points (not a 'tick box' exercise).

People accessing the service should be provided with information and choice about the service and their treatment (including choice of time and date, venue, face to face or technology enabled, and access to other language other than English).

Choice should be tailored, e.g. technology enabled therapy may maintain mental health difficulties for some;
Choice depends on resources - some services do not have the capacity to offer choice on venue due to lack of rooms. Also depends on services being adequately staffed.

"Written communication to patients needs to be considered carefully to be meaningful and sensitive as there are risks this could become a bureaucratic paper exercise."

"How can we offer a choice of venue when we can't even get routine clinic rooms? We can't offer what we're not resourced to deliver."

"Communication - verbal, recorded or written. It is about a means that works for the person in front of you."

How do we ensure people are fully involved in decisions about their psychological care and treatment?

Key themes from stakeholder engagement events.

SHARED FORMULATION: treatment goals guided by this; supporting other agencies with this through consultation; building relationship with multi-agency colleagues will support this.

DIVERSITY: Need for sufficient staff diversity to be able to offer choice (e.g. gender of therapist); consider having diversity champions; assistance from third sector agencies in accessing people who are excluded due to social disadvantage.

TRANSPARENCY: being clear to patient about the level of intervention they will receive and level of expertise of therapist; providing patients with reasons behind decision making about access to services and types of therapies offered to them; copying correspondence to patients.

PERSON CENTRED CARE: goal-based measure from outset; identify other areas that can be addressed while awaiting treatment; pathway and action plan is jointly developed with patient; self-referral pathways; joint approach with patient to discharge planning.

SERVICE USER INVOLVEMENT (SUI): at a national level with Boards reporting to government on how SUI is driving services; not tokenistic; actively seeking anonymous user-friendly feedback and satisfaction data: IT system needed to support this; service user forums; seeking SUI for new/expansion of services; service users presenting at meetings more often; acting on SUI and sharing with service users how their input will be used.

CHOICE: provide a choice of treatments where there is more than one evidence-based treatment; patient can choose from options such as group, computerised support or 1:1 in line with matched stepped care system; in CAMHS patients are given a leaflet with all therapeutic approaches listed and explored with patient; however be clear that choice depends on what is locally available and resources.

INFORMATION & EDUCATION: easy to read documentation for patients prior to treatment; informing the patient regarding the various levels of the intervention that is being offered; group information sessions for patients about what psychological therapy involves (e.g. short videos); educating referrers and wider MDT about what psychological services offer.

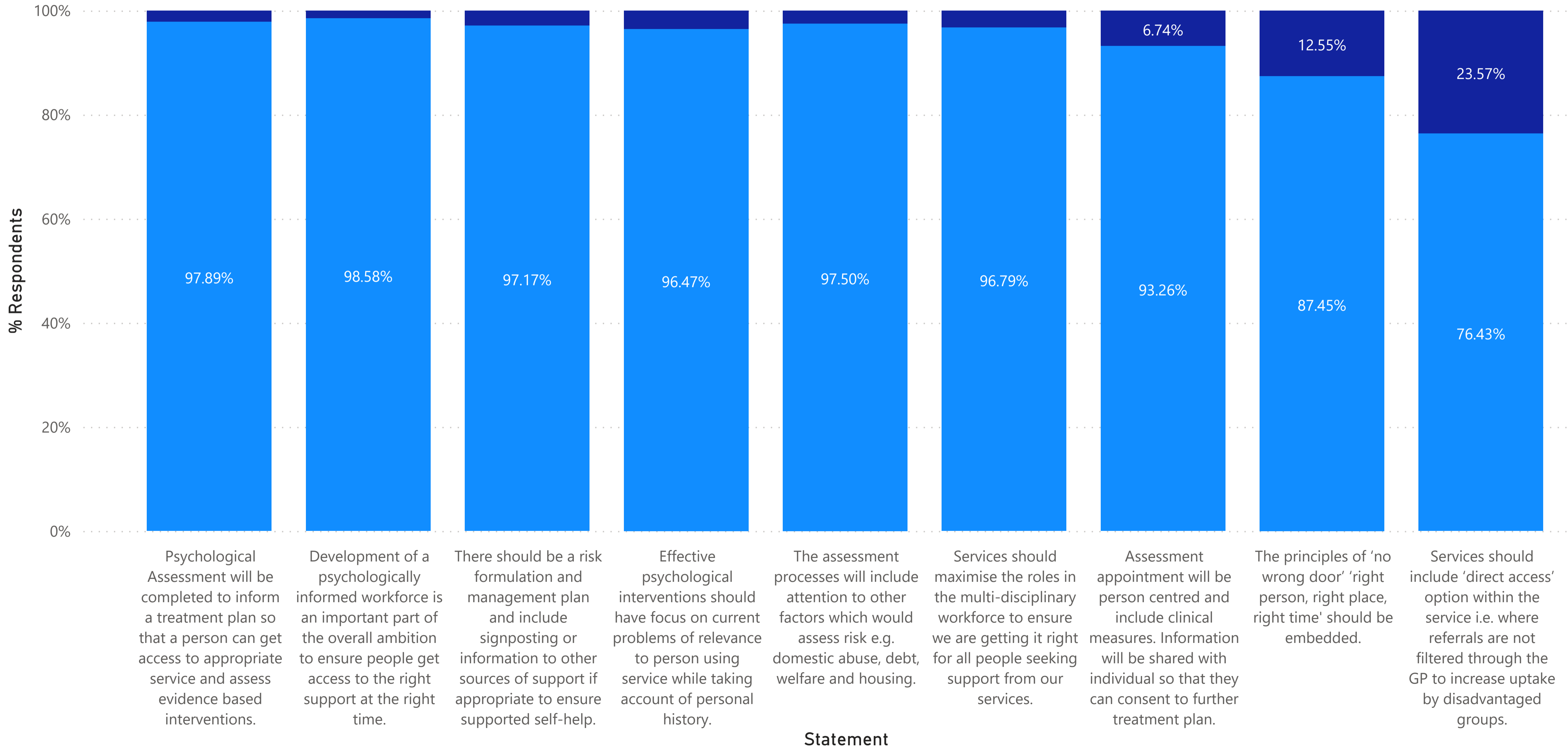
CONSENT: ensuring informed consent and supporting patients to make decisions within their capability; where there are capacity issues encouraging and supporting individuals to be involved in decisions wherever possible and to whatever level they can be.

INEQUALITY OF ACCESS: standards / targets around numbers of appointments, waiting list management etc can impact on access for marginalised groups; review how third sector agencies can support improvement of access for marginalised groups; find out why people disengage with services.

COMMUNICATION: including patients in communication between professionals and referrers; quality conversations around consent, clear explanations around what's happening, care plan etc; take into account individual patient needs (e.g. neurodiverse, cognitive difficulties).

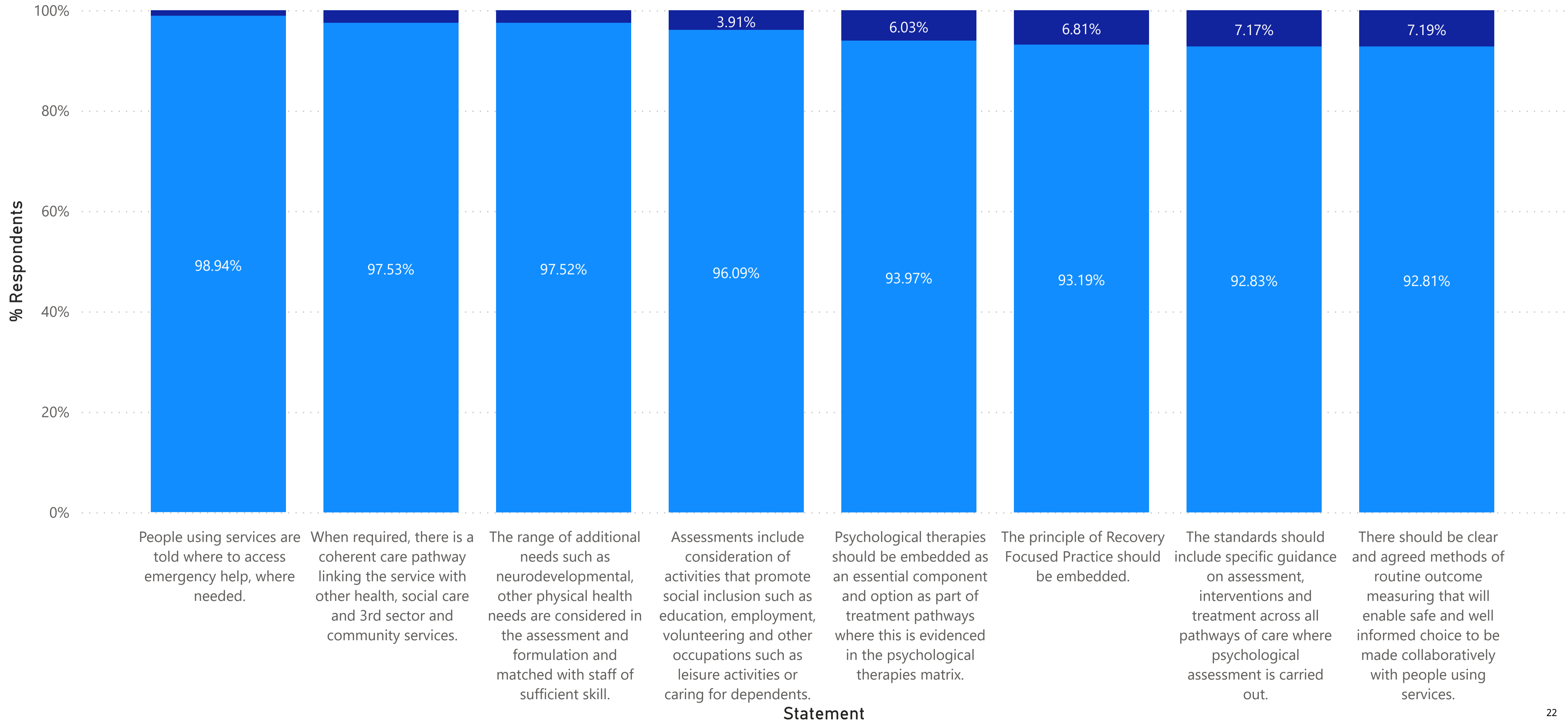
How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them? Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them? Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them? Themes from survey free text comments about specific standards.

The principles of 'no wrong door' 'right person, right place, right time' should be embedded.

Lack of understanding; needs to be defined further;
Good standard in theory but difficult to implement in practice;
It should be recognised that not all clients benefit from psychological therapies.

"The "no wrong door" principle sounds good in theory but naïve. It can be a very complex process to get clients to the right service."

"A direct access option would be great ideally but how on earth would this be provided for when waiting lists are enormous already if this leads to a big influx of referrals, whether suitable or not."

Services should include a 'direct access' option within the service i.e. one where referrals are not filtered through the GP to increase uptake by disadvantaged groups or groups who face additional barriers to access.

Agree in theory but potential for high levels of inappropriate referrals;
Impacts on waiting lists and times for other patients – clearer guidance on how direct access pathways could be set up;
Could increase risk – improving primary care access safer option;
Could also be achieved through consultation sessions with stakeholders/referrers and may present a more cost effective way of matching care;
Less appropriate for some specialist services to offer a 'direct access' option;
Depends on patients being well-informed on what therapy they require.

"Experiments with self and guided referral in my own board were not successful, and led to services being swamped with inappropriate self-referrals. Once again, there needs to be clarity about what is actually being proposed here."

How do we ensure people experience high quality psychological assessments, interventions and treatments that are right for them? Key themes from stakeholder engagement events.

COLLABORATIVE ASSESSMENT: with multi-disciplinary team; with different specialities where relevant; group supervision/consultation; good practice example – all clinical psychology assessments are discussed at weekly meeting with all staff welcome.

THE MATRIX: issue that complex transdiagnostic patients don't meet evidence table requirements; evidence tables can be restrictive/outdated; guidelines should be updated in line with emerging research and models of good service delivery in other areas.

OUTCOME MEASURES & DATA COLLECTION: measuring meaningful outcomes (e.g. CORE-10 not meaningful for many patients) – LD populations need appropriate outcome measures; consistent measurement of outcomes for services; data needs to be routinely collected and acted on.

CONSISTENCY & SHARING RESOURCES: sharing resources (groups/interventions) nationally via NES to ensure consistency.

RECOGNITION OF WIDER SOCIETAL ISSUES: poverty, homelessness, lack of support impact on whether therapy/interventions would be useful and/or what can be offered in assessment; other agencies should support before and after any psychology input.

FEEDBACK: Consider standardised feedback forms to ensure consistency across services; LD Service use CARE 5 to get feedback about particular sessions remotely; ensure service users are aware of the range of feedback mechanisms available and these are accessible and in a range of formats.

QUALITY of ASSESSMENT: sufficient information from referrer required; formulation led; work around engagement; assessing clinician requires knowledge about different tiers of service that can be accessed; high level of skill in formulation led assessment.

TRAUMA INFORMED: difficulties with patients having to tell story numerous times; build confidence in workforce for routine enquiry regarding trauma experiences from first point of entry to services.

STAFF WELLBEING: ensuring that the workforce is supported to continue to provide psychological services

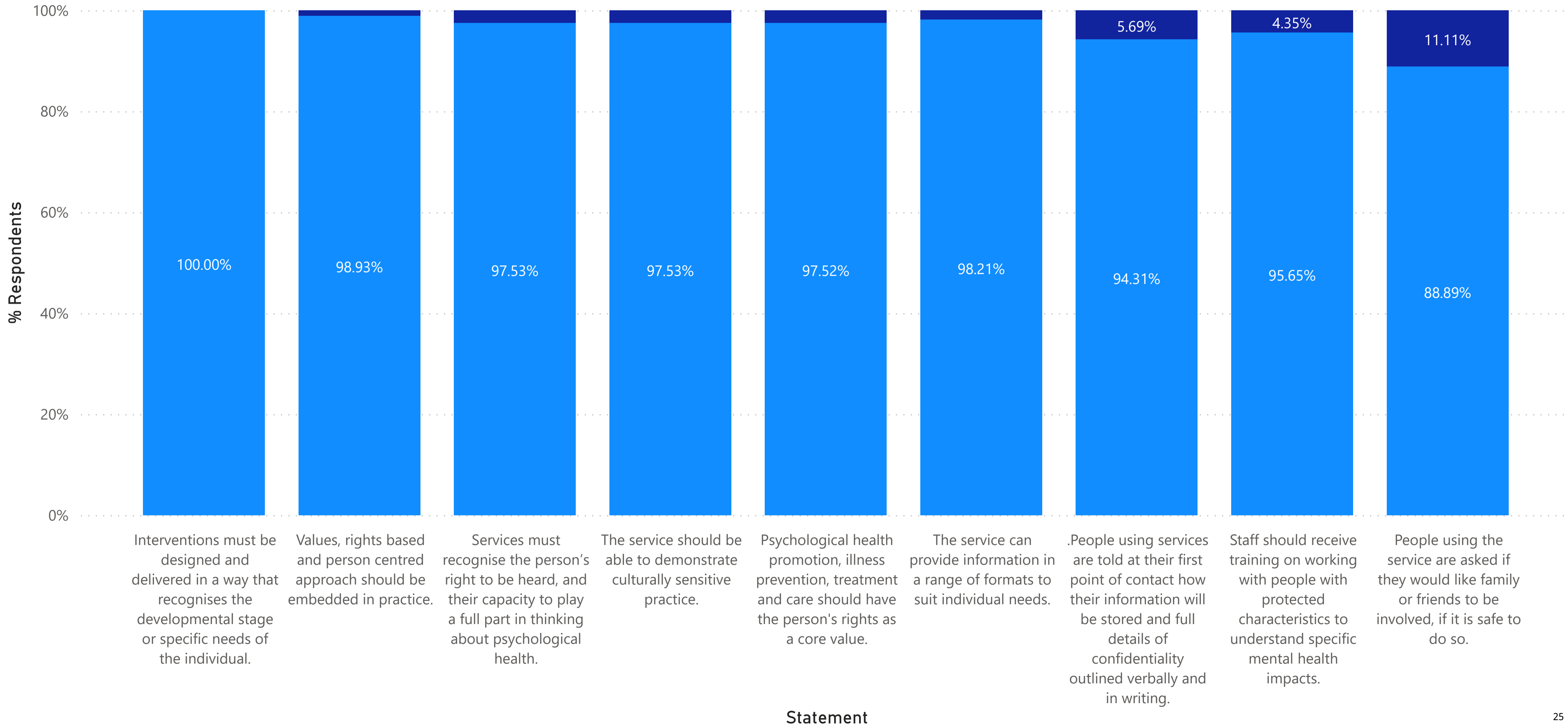
COMMUNICATION: use of therapeutic letters, summarising formulation; discharge summary letters should be written to patients and have referrer copied (and not vice versa); increased written communication to patient; open conversations about options, risks and benefits of proceeding with therapies/interventions.

PERSON CENTRED: model of intervention should be flexible enough to be adapted to specific patient; ensure service users deemed not to have capacity are still encouraged to be involved in their care plans, decisions, etc; ensure information is in an accessible format that is right for the individual ; allowances for missed appointments where appropriate.

TRIAGE/ASSESSMENT CLINICS: Consider assessment clinics; offer early triage and clinical discussion following assessment between professionals – reduces waiting times as inappropriate referrals excluded early on.

How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered? Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered? Themes from survey free text comments about specific standards.

People using the service are asked if they would like family or friends to be involved, if it is safe to do so.

Not appropriate for all services, eg. psychodynamic;
Consent for family involvement must be reviewed during the intervention;
Could undermine autonomy and increase risk for patient in some cases.

People using services are told at their first point of contact how their information will be stored and full details of confidentiality (and limits of this) outlined verbally and in writing.

For some patients too much information about data storage and processing would be overwhelming at the first appointment;
Questions over why it is needed **both** in writing and verbally.;
Questions over what should be prioritised at the first appointment.

"I agreed with point 'people using the service are asked if they would like family or friends to be involved, if it is safe to do so.' However, I would note that there is often absolutely no provision or training around working with families and wider systems. Working with a family takes experience and skill for it to be a helpful and not harmful experience, so I feel training and resources would need to be available."

"There is a risk of 'mission creep' when considering whether certain things should be mandated in speech with patients; what else should we consider as equally or more important to mention to patients at first appointment? How much of the first appointment becomes a bureaucratic exercise where we provide lists of legal disclaimers to patients?"

"I don't think this needs to be provided in writing, [how information will be stored] other services don't outline this so specifically."

How do we ensure people are able to realise their rights and that these are acknowledged, respected and delivered?

Key themes from stakeholder engagement events.

STRONG INDEPENDENT ADVOCACY: especially for those lacking capacity, detained people, families & carers; recognising that psychological therapists hold power and can advocate for patients; clear guidance around therapists' roles in advocacy; provide all service users with contact details of independent contact.

TRAINING: Need whole system awareness/training around rights/relevant legislation and protected characteristics - in LD services staff are trained to be very aware of capacity and consent issues and to embed this knowledge into interactions with the patient group.

EMPOWERING PATIENTS: self-referral options; using empowering language; communicating clearly to patients that they have the right to make requests in order to make therapy as safe a space as possible, e.g. request gender of clinician; emphasise choice at first contact – e.g. they do not have to attend further assessment/contact.

ACCESSIBLE INFORMATION: in different formats, languages; on various mediums – websites, social media etc; availability of interpreter.

CONSENT & CONFIDENTIALITY: informing patients that there are additional factors that may affect confidentiality, e.g. in acute medical settings where other medical professionals have access to clinical portal; being clear with patients about where information is stored; consideration to storing very detailed trauma information within a 'more private system' available within EMIS.

SIGNPOSTING: referrers signposting to third sector services where appropriate; signposting to Advocacy services where appropriate.

EDUCATION: ensuring patients know their legal rights; develop an easy read charter for service users with support from speech and language therapy; make existing charters more accessible, e.g. easily found on website.

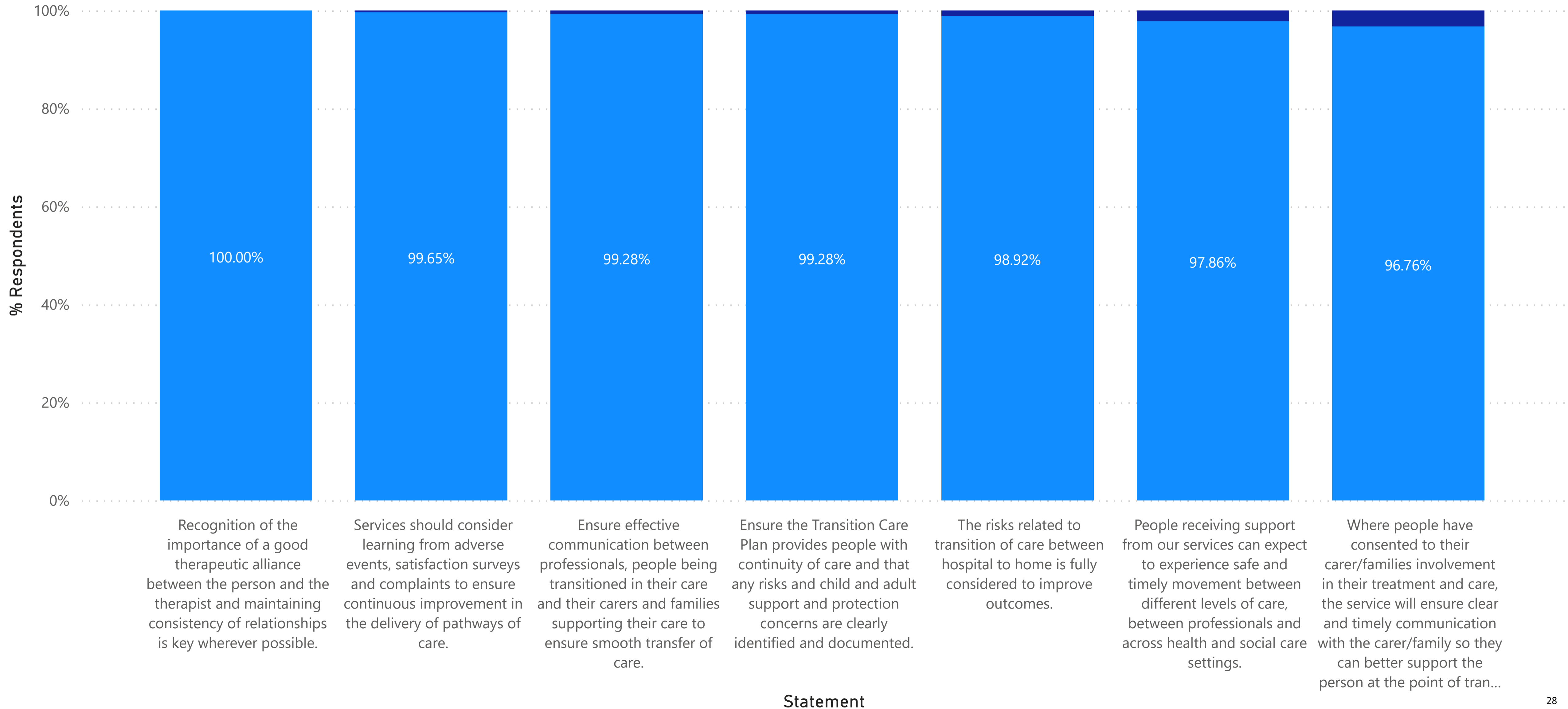
HEALTH INEQUALITIES: complex health inequalities issues with some areas of excellence and others underfunded; marginalised populations often struggle to access NHS however they have a right to treatment – consider how systems can be set up to be more accessible to these groups; same level of service should be available in all areas of country.

SERVICE USER ENGAGEMENT: if service users have concerns about their rights, there should be clear accessible guidance about what they should do next; collaboration with service users on service design; have regular review of standards and 'the charter' by service users.

How can we ensure people are fully involved in the planning and transition of psychological care?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How can we ensure that people are fully involved in the planning and transition of psychological care? Themes from free text comments about specific standards.

People receiving support from our services can expect to experience safe and timely movement between different levels of care, between professionals and across health and social care settings.

"Timely" is not always possible due to resource issues.
Difficult when not all services use same IT systems.

Services should consider learning from adverse events, satisfaction surveys and complaints to ensure continuous improvement in the delivery of pathways of care.

Consider changing to Services **have a duty to learn** from adverse events, satisfaction surveys and complaints to ensure continuous improvement in the delivery of pathways of care.

"This is a highly important area. In my experience sometimes the resource is just not there to do this in the way we would like. Proactive transitions are essential."

Ensure effective communication between professionals, people being transitioned in their care and their carers and families supporting their care to ensure smooth transfer of care. Complete information will be provided at the time of a person transitioning into their care.

Time needed in job plans to arrange and engage in meetings related to transition of care;
Communication with service person is transferring allows for realistic expectations of what new service can provide.

"Through-care support (from prisons, secure hospitals, etc), including communication between different services/agencies, should be a priority for improvement."

"We can certainly aspire to be as safe and timely as can reasonably be done within our resources, but this is a different this to believing our patients should 'expect' these things. It's common knowledge the NHS has its limitations, and that particularly at times of crisis (serial crises, in fact), standards do change."

How can we ensure that people are fully involved in the planning and transition of psychological care?

Key themes from stakeholder engagement events.

INFORMATION PROVISION: managing expectations and providing information at outset, e.g. those moving from child to adult services can have certain expectations; copying patients in to correspondence.

CLEAR PATHWAYS: clear pathways for transitions, for example from CAMHS to adult services already have a framework for transition in place; clear guidance about who provides care at specific timepoints; good service specifications and clarity over referral pathways.

KNOWLEDGE OF OTHER SERVICES: knowledge of services outwith own remit; importance of having knowledge of other options that can be used to support someone, for example community based resources to help embed a recovery focus in treatment planning.

COMMUNICATION BETWEEN SERVICES: good communication at transitional points of care including highlighting relevant information about previous patterns of engagement and barriers to engagement; good relationships between services; clear communication structures; shared information system between services.

SERVICE USER FEEDBACK & INVOLVEMENT: provide opportunities for service users to discuss their concerns about transitioning to another service; invite patients to review meetings; gather feedback from those people who have already transitioned to services; informed consent in place to transition to services.

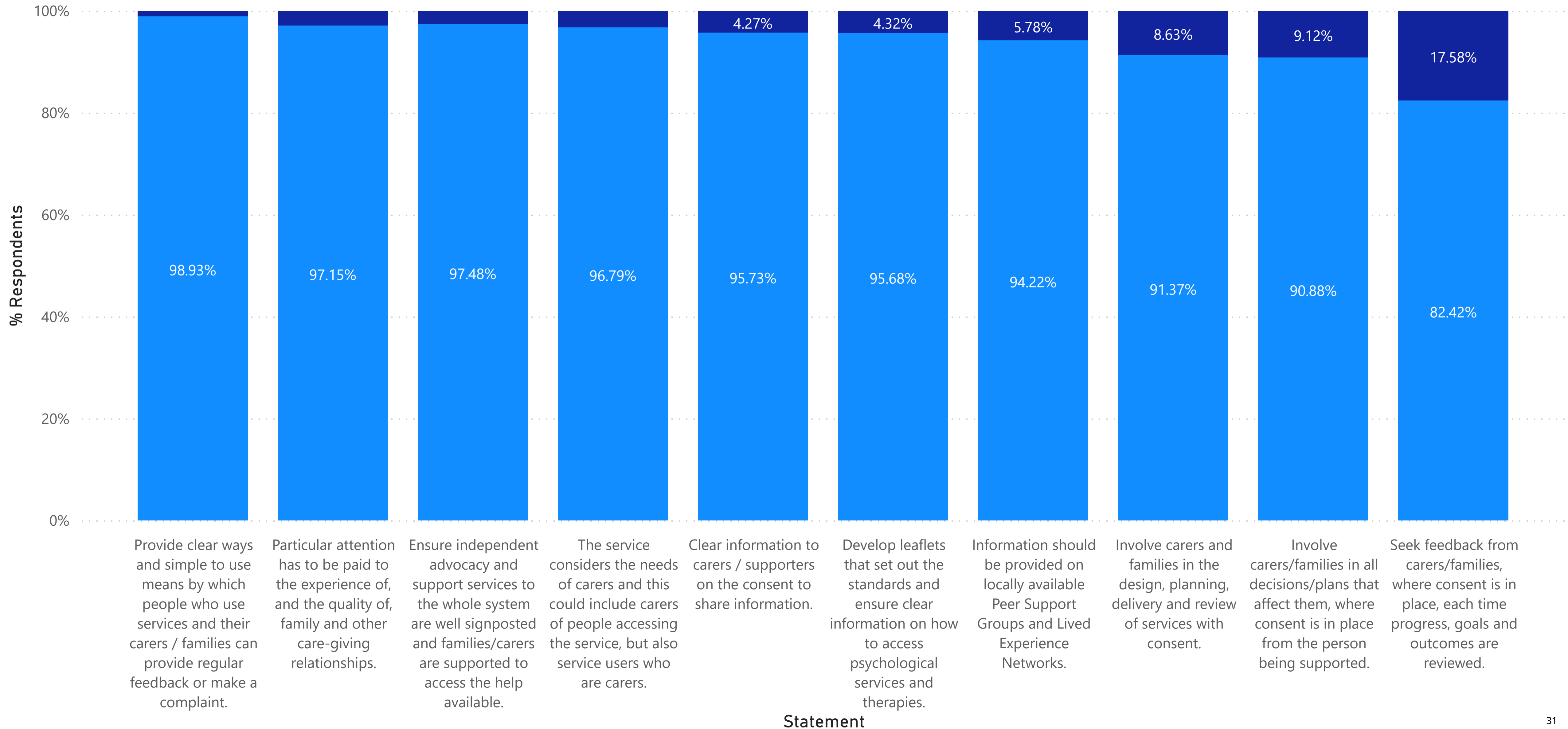
ROLES & RESPONSIBILITIES: named clinician to handle transition process and communicate throughout; clear processes and procedures around planning, transition and communication; clarity around governance and who holds duty of care.

RISK ASSESSMENT: ensure appropriate risk assessment in place and updated at transition points; ensure that required procedures are in place as specified on risk assessment; flexibility in system/teams that recognises that the transition process can increase risk.

How can we fully involve peoples carers/supporters in planning their Psychological care?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How can we fully involve peoples carers/supporters in planning their Psychological care? Themes from survey free text comments about specific standards.

Seek feedback from carers/families, where consent is in place, each time progress, goals and outcomes are reviewed.

This would need to be appropriate to the therapeutic approach;
This statement should include "where appropriate" as not always in best interest of service user;
Does not always meet the needs of carer to have involvement;
Depends on the individual preferences and rights of the service user.

Information should be provided on locally available Peer Support Groups and Lived Experience Networks.

Statement is vague - what type of information and/or networks?;
Consideration of signposting to recommended digital resources and online support should also be considered;
Only if we have enough information on these groups to trust that they are credible and safe.

"Need to refer to 'where appropriate' as sometimes families and carers do not have their relative's best interests at heart and may engage in abuse and/or exploitation."

"Peer support, informational support is also available online and this method is increasingly used by people in relation to health problems - the quality of this information is crucial."

"In learning disability settings often these methods of working are standard practice but accessing written information and digital poverty will impact certain client groups in being able to interact with this information. I feel it is very important in the process of developing standards to ensure that these applicable across all specialities."

How can we fully involve people's carers/supporters in planning their psychological care?

Key themes from stakeholder engagement events.

CONFIDENTIALITY: concerns around confidentiality bearing in mind issues such as domestic violence and elder abuse.

COMMUNICATION: patients should understand that they can have someone in their appointment with them; patient should understand the extent of their carer's involvement.

INVOLVE CARERS IN MEETINGS AND APPOINTMENTS WHERE APPROPRIATE: Offer these appointments from the outset of engagement with patient.

FEEDBACK: requesting regular feedback from carers/supporters, e.g. through focus groups.

ADDRESSING CARERS' NEEDS: provide carer support groups for all services; signpost to peer support groups; even when it is not appropriate to involve carers in treatment we attempt to meet needs, e.g. by signposting to other services.

ONLY INVOLVE CARER WHEN APPROPRIATE: when there is consent; when both carer and patient want this involvement; when it is not detrimental to therapeutic process; careful planning around consent as if families/carers present, then client may not share information relevant.

EDUCATION: Have clear information for patients and their caregivers, in a range of different formats about the care that is on offer; greater transparency about what psychological therapies are/involve for carers/supporters.

FLEXIBLE SERVICE: flexible clinic times and mode of appointment for carers (e.g. face to face/remote); promote digital inclusion; be open to having people coming along to sessions if consent is provided by patient.

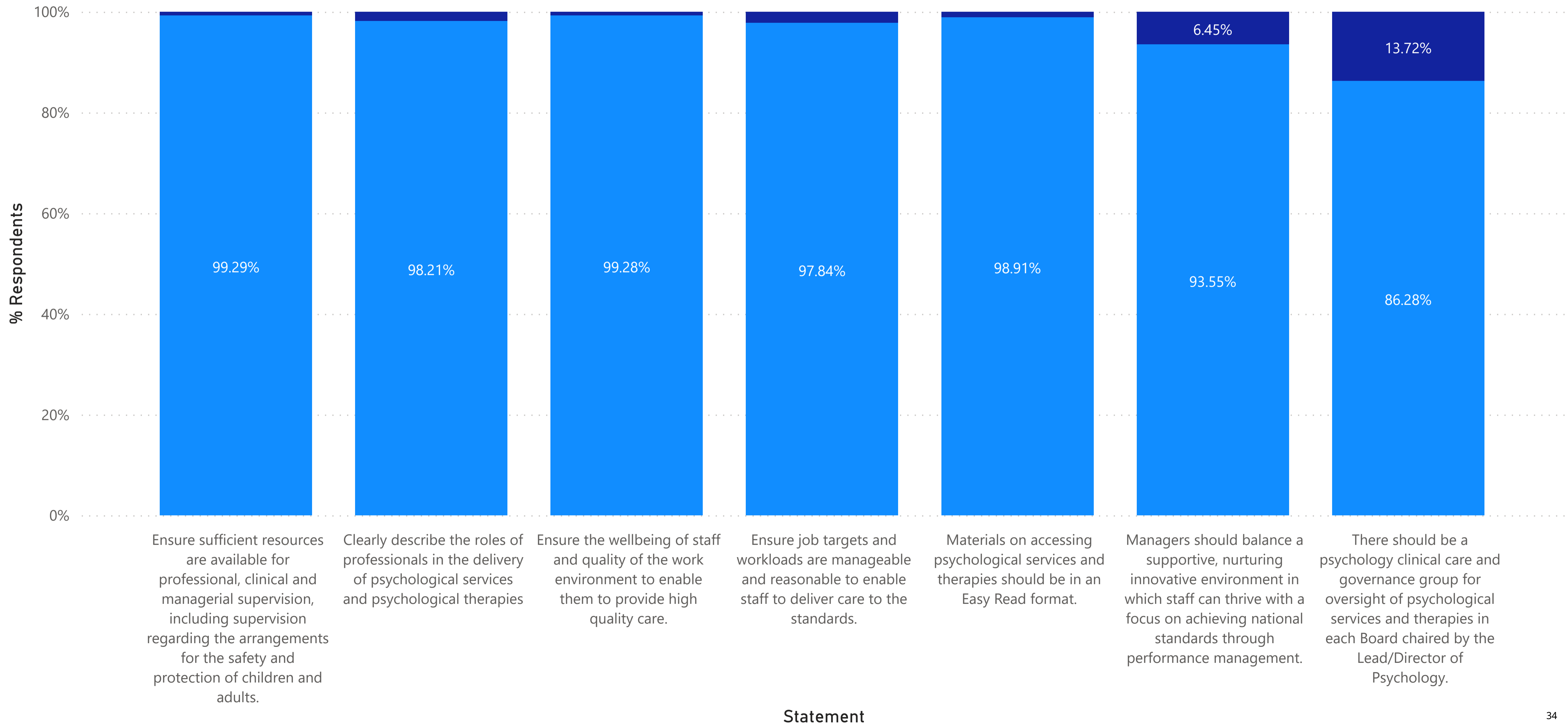
TRAINING/SYSTEMIC WORK WITH FAMILIES: Training to support workforce to be able to work more systemically with families and broader systems around the client (e.g. socioeconomic, education) with their consent.

FAMILY THERAPIES PROVISION: Investing in Family/carer sensitive practice – good practice shared by Inpatient team, who suggested service level investment in Behavioural Family Therapy and other formal carer support programmes.

How can we ensure people have confidence in the psychological services and therapies staff that support them?

Percentage of respondents who agreed and disagreed with each statement.

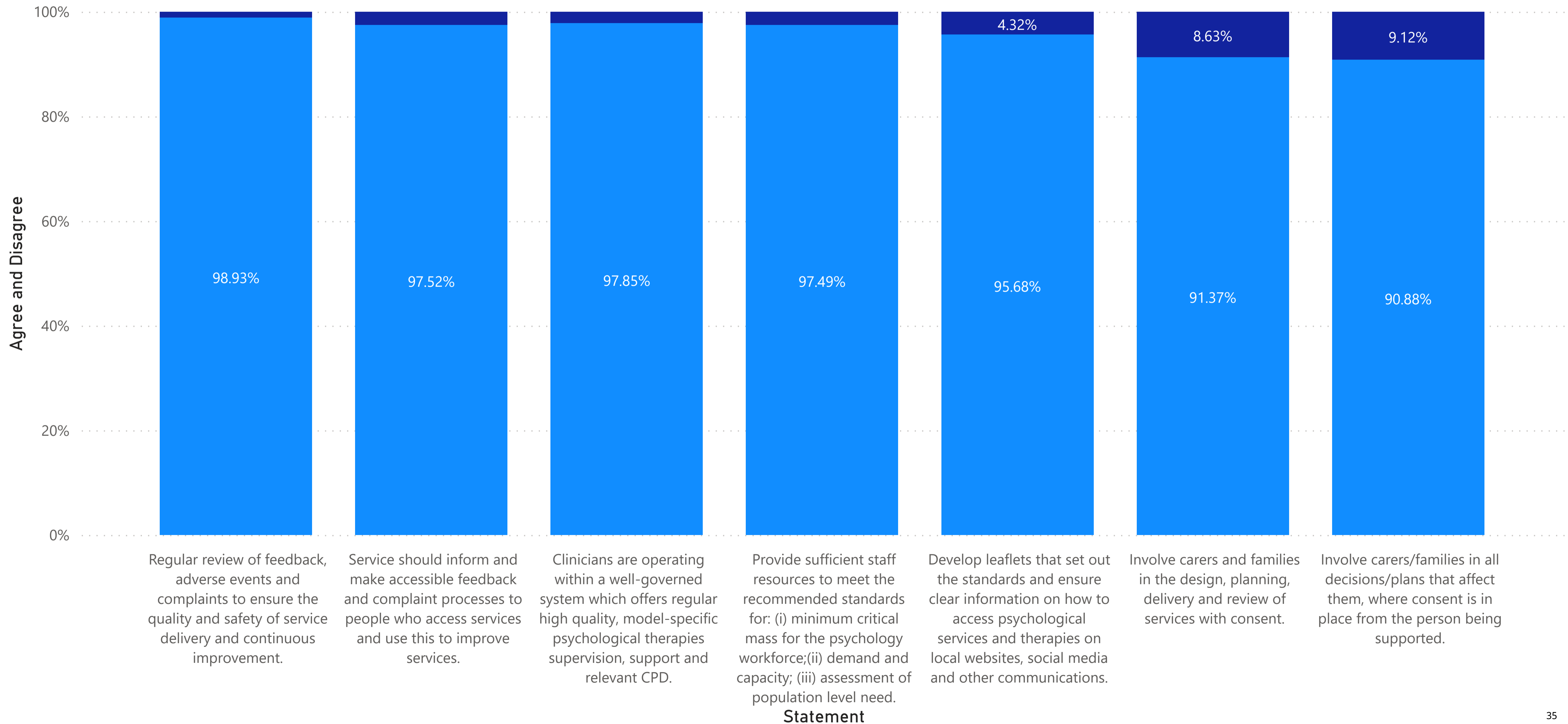
● Agree ● Disagree



How can we ensure people have confidence in the psychological services and therapies staff that support them?

Percentage of respondents who agreed and disagreed with each statement.

● Agree ● Disagree



How can we ensure that people have confidence in Psychological Services and Therapies staff that support them? Themes from survey free text comments about specific standards.

There should be a psychology clinical care and governance group for oversight of psychological services and therapies in each Board chaired by the Lead/Director of Psychology.

Some disagree and stated that Lead/Director of Psychology does not need to chair this group;
Other professions involved in delivering psychological services should be considered for the role of Chair;
The role of Chair should be based on skills/experience for role – not necessarily a Lead/Director of Psychology.

"I agree that there should be a psychology clinical care and governance group, but I don't agree that it should be chaired by the DoP. I actually think the DoP should be accountable to this board rather than leading the board - especially so that the board can act as a monitor and check on psychological standards, that the DoP should be delivering."

"Governance needs to have proper regard for the voices of senior therapists both from within psychology and also from other trainings. Psychologists are not the sole arbiters of Psychological Services."

Managers should balance a supportive, nurturing innovative environment in which staff can thrive with a focus on achieving national standards through performance management.

Performance management needs to be defined and elaborated on;
Sufficient training opportunities needed;
Complex issue involving various aspects of governance.

Ensure the wellbeing of staff and quality of the work environment to enable them to provide high quality care.

Agree that this should be included and should also be considered throughout the other standards;
A specific standard about staff accessing support services should be included.

"Given that this is an isolated statement on wellbeing it comes across as disingenuous...also wellbeing in the context of the previous 100+ questions doesn't really seem a prime concern."

How can we ensure that people have confidence in Psychological Services and Therapies staff that support them? Key themes from stakeholder engagement events.

MANAGEMENT OF LONG WAITING LISTS: keeping communication open; early intervention/initial appointment arranged; provision of triage; self help materials; keep waiting lists low (dependent on resources).

TRANSPARENCY: Explain honestly how decisions are reached; clear explanations about pathways; clear communication with referrers about services that can be provided; clear communication to service users about the role of each clinician they have contact with; openness to feedback and showing how we have acted on that feedback.

RELATIONSHIPS: good relationship between therapist and service user; if relationship is not good, then acting on this appropriately; trusting therapeutic relationship; having awareness of what can undermine the relationship between therapist and service user.

EDUCATION: raise awareness about what the psychology service offers; educate on difference between psychology and psychiatry.

MANAGE EXPECTATIONS: Explain clearly at outset to patient what the service can offer; indicate the anticipated length of treatment; assess patient expectations and ensure they are realistic; if all patient goals cannot be met, then signpost appropriately.

COMMUNICATION: build trust by communicating with patients before meeting them; patients should receive copies of all correspondence in appropriate format.

General feedback - key themes from survey free text and engagement event data.

Short time frame for survey and engagement events was problematic - this was a key theme reflected across survey free text comments and engagement data.

Engagement widely in the development and shaping of survey would have been useful.

Content of survey was vague – yes/no answers unlikely to elicit meaningful information.

Length of survey - many people gave up before completion because they felt the survey was too long. It follows that the survey responses may not be reflective of the wider workforce.

Psychotherapy was not represented in the drop down box on the online survey and there was more general feedback that Psychotherapy services did not feel represented in this consultation process.

Concerns that Quality Standards will be rigid or prescriptive and therefore will not translate to acute settings.

There should be an awareness of the impact these standards may have on workload.

Standards must be realistic and achievable in context of public funding and limited resources.