

**An evaluation of an innovative waiting list initiative & collaboration with  
a Voluntary Sector Counselling Service**

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## **1. Introduction**

### **1.1 Mental health service waiting lists**

The BBC News (2017) reported mounting and intolerable pressure on NHS mental health services with patients waiting up to two years for psychological treatment. The British Medical Association (BMA) also reported extensive waiting times of up to a year and a half for patients to access psychological talking therapies (Matthews-King, 2018). Even though there is increasing concerns regarding waiting times of mental health services, little is known about the impact that these times have on those waiting accessing the service. However, speculation does suggests that it could lead to poorer health outcomes (Reichert & Jacobs, 2018). Reichert and Jacobs analysed routinely collected outcome data from patients waiting to access early intervention services (EIP) across England to explore the impact of waiting times on patient outcomes. A Linear regression model was used to analyse data collected between April 2012 and March 2015. Results showed that longer waiting time was significantly associated with a deterioration in patient outcomes (Reichert & Jacobs). In addition, outcomes deteriorated further if the waiting exceeded 3 months. The results of this study highlight the damaging effect of excessive wait times for those waiting to access EIP services. Such results can be used to inform and motivate more timely and innovative approaches to managing and reducing mental health waiting lists. However, as the study focused on solely EIP services and patients with psychosis, the results are less generalisable to other mental health conditions and services and therefore should be applied with this in mind.

A report published by the 'We Need to Talk' campaign (2017) also explored the impact of psychological therapy waiting times. The report highlighted that those waiting to access psychological therapy through the NHS were unsure of the length of time they would need to wait and reported being unsure about how to access help in the meantime. The report also acknowledged that long waiting times impact on the likelihood of patients attending and engaging in therapy and can increase and prolong the use of medication.

In 2014 the '5 Year Forward View' set out new standards to bridge the gap in waiting standards and accessibility between physical and mental health services. These new government standards outline that 75% of patients referred for talking therapy should be seen within 6 weeks and 95% in 18 weeks

(NHS England, October 2014). The government aspired for these standards to be reached by all mental health services by 2020 (NHS England, October 2014). These waiting time standards hope to tackle the national variations in waiting times for talking therapies and work towards parity of esteem between physical health and mental health services (NHS England, October 2014).

## **1.2 The Third Sector**

The term 'Third Sector' refers to not-for-profit voluntary organisations, community groups and charities which re-invests their profits into their social purpose (NAO, 2013). Third sector organisations approach supporting the health needs of communities from a holistic and person centred stance (NAO, 2013). With the rising pressure on NHS mental health services, it is thought that third sector mental health charities can help ease pressure and offer local-community base services (Weeks, 2015). Third sector organisations are well established in effectively providing mental health support to their local communities outside of clinical NHS services, nevertheless, this is often overlooked (Weeks, 2015). It has been argued that third sector organisations are well established in effectively providing mental health support to their local communities, although the evidence supporting this claim for effectiveness is unclear (Weeks, 2015).

The Five Year Forward View acknowledged the importance of third sector organisations in supporting the NHS face the challenges of the health and social care system. The report highlighted that for this collaboration to be successful the working relationship between these different sectors needs to be strengthened. The Five Year Forward View hopes that this joint mission is the start of equal power and the development of strong working relationships between the different sectors. NHS England (2015) also promotes new and integrated models of working, for community mental health services to support those with severe mental health conditions. However, Sackett, Strauss and Richardson (2000) argued that third sector organisations struggle to demonstrate their effectiveness and therefore are less likely to sustain their funding.

Bach-Mortensen and Montgomery (2018) conducted a systematic review to evaluate the barriers and facilitators of the evaluation of third sector organisations. Twenty-four studies, using a range of methods, were appraised and analysed using thematic analysis. The review included studies that used

various research designs and methods to investigate the evaluation process of third sector organisations. Results highlighted that the barriers for these organisations to evaluate their effectiveness included: lack of financial resources, lack of technical capability and challenges identifying evaluation systems and outcome indicators. Facilitators of these organisations were highlighted as: accessing the appropriate support, culture which supports evaluation and motivation to be accountable to stakeholders. Bach-Mortensen and Montgomery suggested that the challenges identified in this study can be addressed using evidence based methods and strategies and draw upon their facilitators in order to develop evaluation processes. However, the ability of the third sector to do this is questionable due to their lack of material and financial flexibility and resources.

### **1.3 Integrated Care Provision**

The Kings Fund (2010) argued that the main purpose of integrated care should be to improve the quality of care and experience for patients. The paper, 'Where next for integrated care organisations in the English NHS' published by the Kings Fund (2010), discussed the many forms that integrated care can take. This included multiple providers collaborating to provide care and the formal merger of multiple organisations (Powell, Williams, Larsen, et al. 2008). The report suggests that all approaches to integrated care can improve health outcomes and patient satisfaction when multiple organisations are involved in an individual's care as oppose to just one single source. However, Fulop, Mowlem and Edwards (2005) proposes that there is weak evidence for the benefits of organisational integration and therefore organisations should remain independent but collaborate to deliver health services. Lewis, Rosen, Goodwin and Dixon (2010) proposed various ways in which organisations can work more collaboratively. This included; co-location, shared standards of care, goals and priorities, information systems and education and training. Other benefits included a shared budgets and funding which can produce cost effective services. However, there is no empirical evidence to support the above theories and therefore it would be beneficial to conduct a thorough evaluation of such methods of integrated care prior to their application.

#### **1.4 Service context**

The NHS Bradford Community Mental Health Psychological Therapy service (CMHpS) offers psychological therapy for individuals with severe and enduring mental health problems who are accessing support for their mental health in secondary health care. CMHpS employs a range of Psychological Therapists to provide this psychological therapy (clinical psychologists, cognitive therapists, counsellors, psychotherapists and EMDR therapists, as well as assistant psychologists), embedded within 5 locality based CMHTs. CMHpS, like many psychological services nationally, has had excessively long waiting lists as demands have exceeded capacity for many years.

Various waiting list initiatives have been developed in the past 6-12months that are seeing waiting lists reducing in size. The initiative that this project evaluates is the sub-contracting of 4.0 whole time equivalents (6 individual counsellors) voluntary sector counsellors from Bradford Counselling Service (BCS) to work within CMHpS for 1 year to see individuals on the waiting list in order to widen capacity and tackle waiting times. Counsellors were operationally managed by BCS and clinically supervised by CMHpS Psychological Therapists.

Prior to the counsellors commencing their posts in CMHpS, there were approximately 181 people on the CMHpS waiting list in January 2018. This list ranged from individuals who had been referred and were awaiting screening to having been assessed and awaiting a start of psychological treatment. A cross sectional review of data on those waiting at that point in time suggested; 1% had waited over 2 years, 9% waiting 1-2 years, 44.5% waiting 18 weeks to 1 year and 45.5% waiting 18 weeks or less.

#### **1.5 Psychological Therapy and Counselling**

Within the academic literature, psychological therapy and counselling are regarded as significantly different approaches to talking therapy (Moorey, Green, Bliss & Law, 1998; Bower, Byford, Sibbald, Ward, King et al, 2000; Pybis, Saxon, Hill, & Barkham, 2017). Psychological therapy is defined as an active problem-orientated model of therapy, which includes models such as Cognitive Behavioural Therapy

(CBT), and is often offered as the front line intervention for those experiencing mental health difficulties (Pybis et al). Whereas counselling is seen as a non-directive listening approach (Moorey et al) and Pybis et al suggested that it is only recommended when other treatment options have failed. Pybis et al stated that the effectiveness of counselling as a talking therapy has also often been questioned. However, the literature provides a range of results regarding the effectiveness of counselling and thus providing inconclusive evidence to whether psychological therapy is more effective (Moorey et al 1998; Bower et al 2000; Pybis et al 2017).

## **2. Aims of the Service Evaluation Project (SEP)**

The aim of this project was to evaluate the effectiveness of joint working between the NHS and the third sector, as an innovative approach to managing a talking therapy waiting list. In order to evaluate this the project will:

1. Examine the impact that the initiative had on the CMHpS waiting list
2. Examine the clinical outcome of the clients that the BCS counsellors worked with
3. Explore the experience of BCS counsellors, CMHpS therapists and the BCS and CMHpS managers

## **3. Ethical considerations**

Ethical approval was granted by the University Of Leeds School Of Medicine Ethics Committee on 14<sup>th</sup> March 2019. Information was offered about the study to ensure subjects were able to provide informed consent prior to participation (Appendix 1).

Once the survey had been submitted, participants could not withdraw their responses; as these were anonymous they could not be traced back to individuals. The data was collected anonymously and asked for no identifiable information. Therefore, confidentiality and anonymity was upheld. The collected data was stored in line with the General Data Protection Regulation (2018). There was no potential risk of harm to those who participated in the study. However, if the study caused any psychological distress contact details were provided for support to be accessed. No deception was part of this study; all

information was clear and accessible to the participants. All participants were provided with the project lead's contact details. This allowed them the opportunity to ask any questions or arrange a debrief session if needed.

## **4. Methodology**

### **4.1 Design**

This evaluation was a mixed method design so contained both quantitative and qualitative elements, as described below.

#### ***Quantitative Data***

Data was taken from the CMHpS database and SystemOne regarding service waiting times from March 2018 to May 2019. Data was also collected from the CMHpS database which holds outcome data routinely collected by clinicians. Outcome measures are collected in order to meet service targets and demonstrate service user outcomes. Outcome data consisted of data collected from the Clinical Outcome Routine Evaluation (CORE-34). The CORE-34 is a self-reported measure of psychological distress using 5 point Likert scale measuring symptoms frequency.

***Clinical Outcomes in Routine Evaluation (Core -34)*** (Evans, Connell, Barkham, Margison, McGarth, Mellor-Clark & Audin, 2002)

The Core-34 is a 31 itemed self-reported measure which measures psychological distress by assessing 4 components: subjective wellbeing, problems/symptoms, life functioning and risk (to self and others). Items are answered on a 5-point scale ranging from 'not at all' to 'all or most of the time'. It is recommended that the Core-34 is used at the beginning and end of treatment. All domains had Cronbach Alpha scores of 0.75-0.95 showing that the measure has appropriate internal reliability as Cronbach alpha score above 0.7 is considered as satisfactory. The measure also had test-retest stability of 0.87-0.91 at 95% confidence interval and convergent validity has been established with 7 other measures (Evans et al). Overall the Core-34 is a reliable and valid instrument which is sensitive to change (Evans et al).



### ***Qualitative Data***

An online survey was created to collect data on the views of BCS counsellors, CMHpS therapists and BCS and CMHpS managers (appendices 2, 3 & 4). The survey aimed to collect feedback on staff experience of the initiative. The survey gathered feedback on the project using a SWOT analysis framework to capture the strengths, weaknesses, opportunities and threats of the project. Survey questions covered the following aspects of staff experience: the recruitment process, workload, CPD opportunities, supervision and spilt operational and clinical management.

### **4.2 Sample**

The online survey was emailed to all 6 BCS counsellors and to 30 CMHpS psychological therapists, who worked in the service at the time of the project. Project managers from both organisations (BCS and NHS) were also contacted by email to gather their feedback on their experience of joint working.

Overall, data was collected from: 6 out of the 6 BCS counsellors sub-contracted, 6 out of the 30 CMHpS therapists and 1 manager from both BCS and 1 manager from CMHpS.

### **4.3 Data collection**

All potential participants were emailed advertising the survey which contained the link to the online survey. Three reminder emails were sent to all potential participants three weeks apart to encourage completion. The first page of the Survey showed all relevant information about the project. Participants who agreed to take part provided consent by explicitly clicking onto and completing the survey. The survey took approximately 15-20 minutes to complete. The survey remained open for three weeks after each invitation email had been sent. The quantitative data was collected from the service's COREnet and System1 database; data was stored securely on password protected NHS computers.

#### **4.4 Analysis**

##### ***Quantitative Analysis***

Waiting list times were compared to assess the impact of the counsellors being in post on service wait times. Waiting list data was compared before, at the start and at the end of the counsellors' contracts. Routinely outcome measure data was analysed using a pre-post design. Data collected at the beginning of treatment with the counsellors was compared to the end of treatment to assess if clients had objectively experienced any improvement from their treatment.

##### ***Qualitative Analysis***

Qualitative data was analysed using thematic analysis (Braun & Clark, 2006). Braun and Clarke (2006) described thematic analysis as a flexible and theoretical approach to analysing qualitative data. It is a method of identifying, analysing and reporting themes within the set data. Themes represent important reoccurring features within the data. Braun and Clarke (2006) defined thematic analysis as a six-step process (*Table 1*). Firstly, the data was read thoroughly multiple times. Then, identification of initial codes within the data was systematically created from separate survey responses. The codes were then organised and allocated into themes. Afterwards the themes were named and reviewed to ensure they reflected crucial features of and linked directly to the data. The final themes were supported by quotations from the data and used as evidence in the analysis.

The identified themes were then structured using a 'Strengths, Weaknesses, Opportunities and Threats' (SWOT) framework. Gurel and Tat (2017) described a SWOT analysis as a strategic process which highlights internal and external factors which contributes to supporting the organisation or project achieving its overall aim. The use of a SWOT analysis allows for the development of appropriate strategy and action plans through exploration of a project's current impact (strengths and weaknesses) and future developments (opportunities and weaknesses) (Gurel & Tat). Even though SWOT is used widely through strategic and organisational planning and academia, there is minimal evidence outlining its emergence and efficiency.

Table 1: Key stages of thematic analysis taken from (Braun & Clark, 2006)

Stages	Description
1	Familiarisation with the data
2	Generation of initial codes
3	Identifying themes amongst codes
4	Review themes
5	Define and name themes
6	Report production

## **5. Results**

### ***Quantitative Results***

#### **Waiting list times**

Figure 2 and Figure 3 illustrates a decline in the number of clients on the CMHpS waiting list and also in the time that clients are waiting to see a therapist. The results show that before the counsellors started work with CMHpS (Oct 2017 to April 2018) a total of 142 clients were waiting to access CMHpS and 137 of these clients were due to wait between 18 weeks to over 2 years to commence psychological therapy. When the counsellors started (April 2018) a total of 120 clients were waiting to be seen and of these 113 clients were due to wait between 18 weeks to over 2 years to commence psychological therapy. The results demonstrate that during the time when the counsellors were in post (April 2018 to April 2019) the waiting list significantly decreased. In April 2018 a total of 52 clients were waiting to access therapy and only 15 of these were due to wait between 18 weeks to 1 year. No clients on the waiting list were expected to wait any longer than this.

Table 3. Overview of CMHpS waiting times before (Oct 17–Mar 18), at the start (Apr 18) and at the end (Apr 19) of BCS counsellors commencing contracted work with CMHpS

	<b>18 weeks</b>	<b>18 weeks up 1 year</b>	<b>1 year -2 years</b>	<b>Over 2 years</b>	<b>Total</b>
<b>Oct 17</b>	11	60	42	4	117
<b>Dec 17</b>	25	84	74	13	196
<b>Jan 18</b>	24	73	76	8	181
<b>Feb 18</b>	15	72	78	14	179
<b>Mar 18</b>	5	64	64	9	142
<b>Apr 18</b>	7	57	46	10	120
<b>May-18</b>	3	49	35	3	90
<b>Jun-18</b>	4	44	36	4	88
<b>Jul-18</b>	7	18	25	6	56
<b>Aug-18</b>	7	18	25	6	56
<b>Sep-18</b>	7	19	30	7	63
<b>Oct-18</b>	9	19	21	6	55
<b>Nov-18</b>	15	18	16	0	49
<b>Dec-18</b>	14	8	2	0	24
<b>Jan-19</b>	23	14	2	0	39
<b>Feb-19</b>	24	16	1	0	41
<b>Mar-19</b>	40	11	3	0	54
<b>Apr-19</b>	37	15	0	0	52

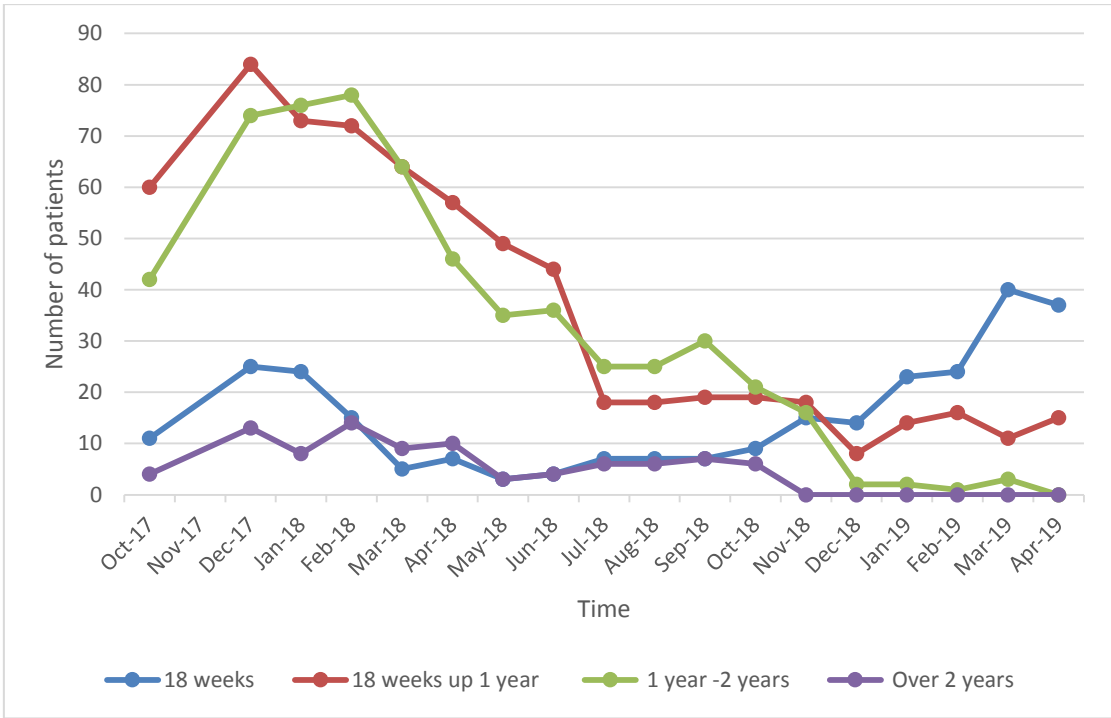


Figure 2. CMHps waiting times throughout the duration of the project

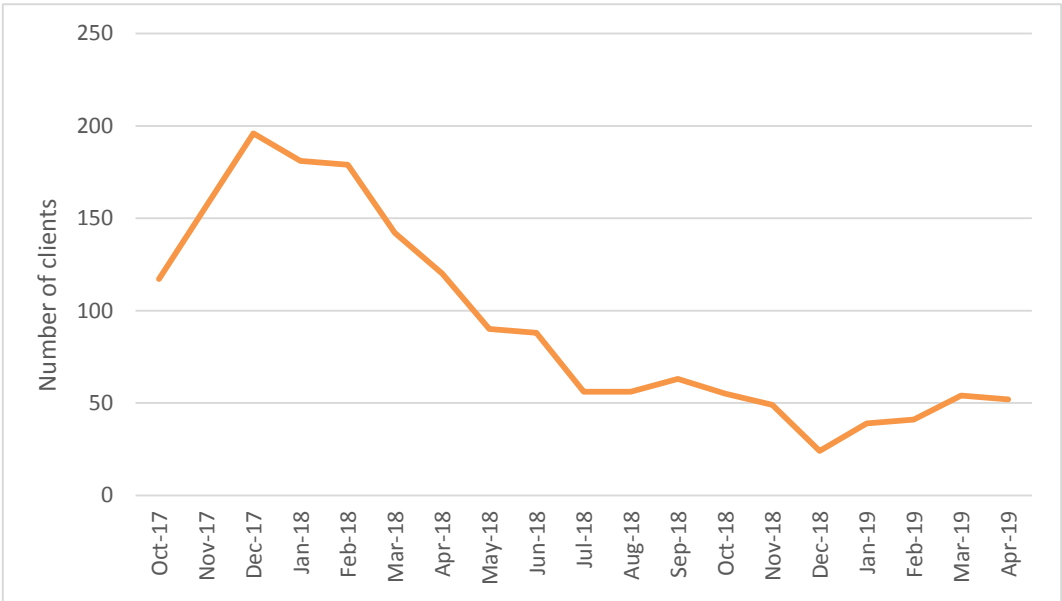
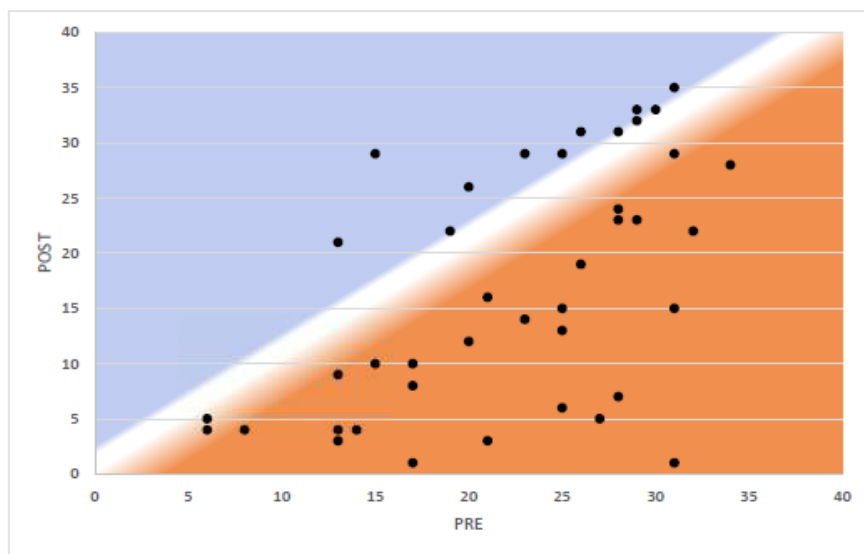


Figure 3. Waiting list total throughout the duration of the project

### Clinical Outcomes in Routine Evaluation (CORE-34)

Client data was routinely collected through the use of the CORE-34 and was analysed using a pre-post design. Data was collected from clients at the beginning and at the end of their treatment with the counsellors. The data was compared at these time points to assess if clients had objectively experienced any improvement from their treatment. Waiting list times were also compared to assess the impact of the counsellors being in post on service wait times. Waiting list data was compared before, at the start and at the end of the counsellor's contracts. Whilst the counsellors were in post they saw a total of 114 clients.



	Count	Percentage
Improvement	41	71%
No change	0	0
Deterioration	17	29%
Total	58	100

Figure 1. CORE-34 change for clients who received treatment from BCS counsellors

Figure 1 shows that overall the majority of clients (71%) who received treatment from BCS counsellors experienced an improvement in their symptoms of psychological distress. However, Figure 1 also highlights that 29% of clients experienced deterioration in their symptoms.

## Qualitative results

Overall, eleven themes were generated from the data. These were structured using a SWOT framework (Gruel & Tat, 2017).

Table 2. Overview of themes included in the SWOT analysis

<b>Strengths</b>	<b>Opportunities</b>
Responsive supervision Training and development Systems and processes Relational support Outcomes	Service quality Workforce enhancement
<b>Weaknesses</b>	<b>Threats</b>
Systems and processes Expectations of counsellors	CP professional Identity NHS and BCS conflict

## Strengths

The SWOT analysis highlighted that the majority of the themes identified in the data were strengths.

### 1. Responsive supervision

The quality of the supervision was emphasised as a real strength of the collaboration. BCS counsellors all expressed satisfaction with the supervision provided by CMHpS therapists. Supervision was described as responsive in meeting the needs and skills of the counsellors. Supervisory relationships were also described as supportive and responsive. Counsellors expressed that supervision sessions were planned, well managed and tailored to their caseloads and responsibilities.

- *“I felt as though my workload was manageable. I had quite a challenging year and this was taken into account. I was very grateful for that.”*
- *“I was allocated cases where I had valuable experience. E.g. sexual abuse.”*
- *“My supervisor was thorough and knowledgeable. I felt a gained a lot from us working together. She helped me and ultimately my clients. She was very approachable.”*
- *“I had access to weekly supervision especially in the beginning of the role. I could contact my supervisor if I had an issue. We worked very well together.”*



## **2. Training and development**

The provision of CPD training and development opportunities by CMHpS improved the confidence of the counsellors working in a different setting as it developed and optimised their skills. These opportunities were described as meeting the needs of the counsellors and therefore provided them with a positive experience of the collaboration through consideration of their training and development needs.

- *“I took advantage of a number of the CPD training events and found them useful.”*
- *“The experience I have had in the CMHpS has been undoubtedly helped me to improve my skills, knowledge and confidence within my role.”*
- *“Allowed knowledge to be further developed as well as learning new skills within a larger organisation.”*

## **3. Systems and processes**

The Counsellors felt that CMHpS were prepared for their arrival as all equipment was pre ordered and ready to use when they commenced their role within CMHpS. This enhanced the counsellors' experience as they felt considered. The split in managerial and supervisory responsibilities between CMHpS and BCS was described as balanced and that communication between and with CMHpS and BCS clear and was responsive. This again allowed for the counsellors to feel supported throughout the initiative.

- *“All my equipment worked well, if I had a problem I was able to get it sorted quickly. I felt well supported by Admin and IT etc.”*
- *“X has always been very supportive. I feel I can contact him at any time... He was very understanding about how I felt and how much on I had at home. Likewise X was open to me to returning to work when I felt ready.”*
- *“Good communication between organisations via email, phone. Collaboration between organisations seemed to work well with no issues evident.”*
- *“All of the laptops were pre ordered before they arrived”*

## **4. Relational support**

The counsellors also described feeling part of a team and supported by all CMHpS staff: supervisors, administrative staff and other members. This highlights the importance and significance of working relationships when separate sectors are joint working as it enhances the experience of all staff involved.

- *“The teams, both CMHps and CMHT have been incredibly welcoming, inclusive and supportive.”*
- *“I felt my CLM and supervisor was very supportive. I also felt part of a team working at Airedale Hospital. The team they are fantastic. They made me feel very comfortable and helped me in any way they could.”*
- *“I personally found the team to be very supportive. I felt able to raise any issues at regular team meetings or contact individuals direct.”*
- *“I felt well supported by Admin and IT etc.”*

## **5. Outcomes**

The CMHpS staff and counsellors acknowledged the benefit that the employment of the counsellors had on the service’s waiting times; demonstrating that the initiative fulfilled its purpose and initial aim of reducing the CMHpS waiting times for accessing psychological therapy.

- *“Patients were seen more quickly and matched with a suitably experienced therapist.”*

### **Weaknesses**

Even though the initiative was overall a positive experience for BCS and CMHpS staff, aspects were highlighted which hindered staff experience of the project.

## **6. Systems and processes**

Dissatisfaction was described about the support service received from the IT and HR department. Some problems were experienced with accessing the computer systems and IT equipment which created a sense of frustration and impacted on the experience of the staff involved.

- *“Lack of communication between departments, resulted in a lot of wasted time for all parties involved.”*
- *“The induction process seemed slow and cumbersome. I was waiting to have access to systems etc for a couple of weeks.”*
- *“That is always difficult - HR, IT etc. are rubbish*

## **7. Expectations of counsellors**

Counsellors and CMHpS staff both described a lack of certainty regarding each other’s roles and skills.

This had a potential impact on allocation of cases, training opportunities offered to the counsellors and

CMHpS' ability to optimise employment of the counsellors in the most effective and efficient ways to benefit the initiative.

- *"Identifying appropriate cases was difficult in the team and often made it hard to know what types of disorders a counselling approach would be used for."*
- *"...the role of counsellors was better promoted within CMHT settings and having a better referral pathway, information leaflet and idea of what counselling entails as this seemed not be set up as well as it could have been"*

### **Opportunities**

Overall, respondents felt positive about future joint working between CMHpS and BCS and identified various opportunities of joint working.

#### **8. Service quality**

Continuation of joint working would potentially improve service quality by reducing waiting times and creating a workforce with a larger skill mix. Service integration and collaboration would allow for the service to become more robust and be flexible, responsive and adaptive to the needs of clients.

Therefore, improving the quality of the service being delivered.

- *"Patients were seen more quickly and matched with a suitably experienced therapist."*
- *"A closer working relationship between the NHS and VCS should also lead to a more cohesive mental health service for the public,"*

#### **9. Workforce enhancement**

Future joint working would also provide more opportunities for staff. A larger workforce could also offer a supportive team environment and more diversity amongst staff which has the ability to enhance the experience and workplace wellbeing for the workforce.

- *"This also allows counsellors from primary care to work as part of a large team and to take these skills back to their organisation."*
- *"More collaborative re understanding our respective services and how they might meet the mental health needs of the local population. Need to give consideration to skill mix of staff needed in secondary care – ensure that the clinical needs of those referred into CMHpS can be met by the skill mix of Psych therapists."*

- *“Sharing expertise, knowledge- in both directions, maybe more flexible referral pathways. Vol sector training- eg where they have expertise- eg DV, CSA.”*

### **Threats**

Even though respondents felt positive about collaborative working as a prospect, a number of barriers were identified.

#### **10. Professional identity**

Concern was expressed for the professional identity of Clinical Psychologists and the impact this may have on their job role and clinical opportunities. Concerns included Clinical psychologists having less clinical time due to movement into leadership and management roles whilst working with counsellors who have primarily clinical responsibilities.

- *“Further erosion of jobs and pay for CPs. Or being pushed into managerial and supervision and service development and not client work because cheaper people (e.g. Counsellors)”*
- *“There is a conflict here for me as a CP wanting to protect my employment rights and specialisms whilst at the same time recognising that other professions have things to offer”*

#### **11. NHS and BCS conflicts**

The difference between how the NHS and voluntary sector services operated was acknowledged and participants were uncertain on how this would be managed in future joint working. These differences included: policies, legal and governance standards, service values and ethos.

- *“Different policy guidelines and lack of continuity especially in relation to clients could hinder the therapeutic relationship.”*
- *“In some areas the NHS work to higher than statutory required standards. For example in the area of facilities, NHS accommodation standards are higher than those set out by health and safety legislation. It would increase costs significantly to VCS if their buildings were subject to NHS standards”*
- *“From the NHS perspective, maintaining clinical governance standards may be seen as a weakness when working alongside VCS organisations*
- *“NHS process tends to be more complex and therefore take more time, there is a risk that this can cause delays to VCS and then put them at risk.”*

## 2 Discussion

The mounting pressure on mental health service has been well documented throughout the literature and also in the national news (Reichert & Jacobs, 2018; BBC News, 2017). Reichert and Jacob evidenced concerning results regarding the impact of long waiting times on patients waiting to access mental health services. These results included less successful outcomes and also a decrease engagement and attendance for psychological therapy. Such results highlight the need for timely and innovative ways to manage and reduce NHS mental health service waiting times. This SEP provides both quantitative and qualitative evidence for the effectiveness of NHS and third sector collaborative working in order to reduce NHS wait times for psychological therapy. The data illustrates a reduction in the number of clients on the waiting list from when the counsellors came into post in addition to a decrease in the time which clients were waiting to start therapy. Prior to the counsellors commencing their posts, there was over a 2 year wait to access psychological therapy. By the end of the counsellors' contract, this had halved as clients were predicted to wait around 18 weeks, with a much smaller percentage (29) waiting longer than this target. This approach brings the services waiting list in-line with the national standards outlined in the 5 Year Forward View (NHS England, 2014).

As discussed, there is a mix of evidence comparing the effectiveness of psychological therapy and counselling (Moorey et al 1998; Bower et al 2000; Pybis et al 2017). However, the outcome and waiting list data from this SEP illustrates that BCS counsellors are able to provide effective psychological therapy to CMHps clients. Nevertheless, it is important to take into consideration that data was only available for fifty-eight out of the one hundred and fourteen patients. Therefore, conclusions made from the data are informed by an incomplete data set and are therefore limited in terms of generalisability and validity. Furthermore, no comparison data was available for those who were seen by psychological therapists over the same time period.

Weaks (2015) argued that third sector organisations can help ease the increasing pressure placed on NHS services. The Five Year Forward View also supported this argument and acknowledged the

importance of third sector organisations in supporting the challenges faced by the NHS. New and integrated models of working are becoming more common in order to enable the NHS to provide timely services to those with mental health difficulties (NHS England, 2015). The main aim of such integrated working is to provide and improve care provision for patients (The Kings Fund, 2010). There are various ways that services and sectors can start to integrate to provide services to the community. One way includes multiple providers collaborating to provide care. Such collaboration includes; co-location, shared standards of care, goals and priorities, information systems and education and training. Some of which has taken place in the project that this report evaluates. As outlined in the results section of the report, the SWOT analysis highlighted the strengths and weaknesses of the innovation and also opportunities and threats of future joint working. Overall the effectiveness of collaborative working between the NHS and the third sector as an approach to managing waiting lists is supported. However, there are opportunities to develop and improve future collaborations. The findings of the project demonstrate an innovative way in which national mental health waiting lists targets can be met. The project also evidences the benefits and opportunities of working with and improving relationships between the NHS and third sector which is identified as essential in the 5 Year Forward View (NHS England, 2014).

Even though this report demonstrates the effectiveness of joint working there are a number of limitations which are not accounted for which impacts the validity and reliability of the findings:

- The capacity of the CMHpS workforce is not accounted for throughout the initiative. The size of the permanent workforce also increased over this time frame, also influencing the size of the waiting list. Therefore, the waiting list reduction evident may in part have also been caused by an expansion in the CMHpS workforce.
- The services offered to the CMHT also developed over this time frame with the introduction of a coping skills group, which may have invited new referrals and/or reduced the need for individual therapy.

- Service referral, discharge and engagement rates were unavailable for analysis and therefore the impact this will have had on the waiting list was not considered. We do not know whether these varied between the counsellors and permanent staff or were particularly different to usual during the study.
- Closer working relationships with CMHT practitioners may have also impacted referral rates. The increased provision of indirect support for the wider workforce, e.g. through case consultation may have impacted on referral rates and/or the levels of appropriate/inappropriate referrals for therapy.

In conclusion, it is evident that collaboration with voluntary sector counselling services is a useful, effective and innovative approach to managing NHS psychological therapy waiting lists. However, any future collaborative projects between these sectors would benefit from taking into consideration the weaknesses, barriers and confounding variables discussed in this report. It is also worth noting that prior to the SEP CMHpS routinely employed predominantly CBT therapists and clinical psychologists to deliver therapy. However, since the project ended CMHpS have commenced employing counsellors on NHS contracts due to the valued contribution that the results of the SEP displayed.

## **6. Strengths and limitations**

There are several strengths and limitations of this SEP which should be considered.

The main strength of this evaluation is that it used a mixed method design to collect data to establish the effectiveness of the waiting list initiative. Collecting both qualitative and quantitative data means that a broader data set is collected providing a richer insight and thus stronger evidence. This design has provided evidence for the effectiveness of employing third sector counsellors to manage NHS waiting lists. This has been complimented by qualitative insights into the experiences of CMHpS staff and BCS counsellors who were involved directly with the initiative. The results from this mixed methods design can therefore better inform any future collaborations between CMHpS and BCS.

Even though the collection of qualitative data is a strength of this evaluation it is important to be mindful that there was no reliability check of the themes reported. As this evaluation was conducted by one researcher there was no opportunity for additional checking of themes identified which lowers the reliability of the results. However, in order to manage the impact of this the identified themes were discussed within supervision to reduce the potential for unreliability.

The BCS counsellors and CMHpS therapists who completed the survey were self-selected. Therefore, a limitation of this sample is that they may have been biased towards their perception and experience of the initiative which is what motivated them to complete the survey. This means that the findings are not representative of all those who were involved in the initiative and are therefore skewed which impacts the project's validity and reliability. Finally, the author's prior involvement with CMHpS and the commissioner of the project may have also influenced how the data and themes were reported.



## 7. Recommendations

The following recommendations have been made to the service managers with the aim of improving any future joint working between CMHpS and third sector organisations:

- Collaborations between NHS and VCS are encouraged to address pressures associated with capacity and demand within statutory services.
- Clinicians involved should develop a better understanding of one another's roles in order to improve working relationships, allocation of clients and management of waiting lists, e.g.
  - Information about various roles could be provided to clinicians involved prior to the start of any future joint working.
  - Tailored workshops could be set up to facilitate better insight into different clinician skills.
  - A buddy system between BCS counsellors and CMHpS therapists could also facilitate this and also provide informal support.
- Clinical Psychologists reported concerns regarding their professional identity and fear of losing clinical time and cases to counsellors whilst being pushed into management and leadership roles, commensurate with their banding and training background. Clear job plans detailing the balance of direct and indirect work for all clinicians would be helpful.
- Further consideration is needed regarding the conflicting regulations and standards of third sector organisations and the NHS. This is a potential barrier for future joint working. However, in this project supervision was provided by CMHpS therapists and line management by BCS was reported to have worked well.
- Any future evaluation projects may benefit from exploring the experience of service users and the possible impact of referral, discharge and engagement rates on the waiting list. This would add a different dynamic and insight into the project's findings.

## **8. Dissemination**

This report has been presented at the University of Leeds D.Clin.Psychol SEP conference and will be available on University of Leeds D.Clin.Psychol website. There are plans to disseminate an adapted version of the report for circulation within Bradford District Care NHS Foundation Trust.

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## Appendices

### Appendix 1 – Information for participants

## Participant Information Sheet

### An evaluation into collaborative working with a voluntary sector organisation as a waiting list initiative.

#### Why complete the survey?

We would like to hear your thoughts on the employment of counsellors from Bradford Counselling Service (BCS) in CMHpS as an initiative to tackle waiting list and gain insight into collaborative working between the NHS and the voluntary sector organisation BCS.

#### Why am I being asked to take part?

You have been asked to take part because you are a member of staff working in CMHpS where the initiative took place.

#### What will I be asked to do?

If you choose to take part, you will participate in an online survey. The online survey will guide you through a series of questions in the form of likert scales and free text comment boxes. The questions about your experience of the initiative including: workload, access to supervision, CPD opportunities, team support. The study takes around 15-20 minutes to complete and once your responses are submitted you won't need to do anything else.

#### Will my data be identifiable?

The online study is anonymous and no one will be made aware that you have chosen to take part.

All responses will be kept confidential, anonymous and therefore unidentifiable. The data will be stored securely and only the project lead (Hannah Cartmell) will have access to the data.

#### Do I have to take part?

No, your participation is completely voluntary. If you agree to take part you may withdraw from the study at any point before submitting responses on the final screen. By submitting your responses you consent to the information being used in this study. Once you have submitted your responses, it won't be possible to withdraw your data. There will be no consequences if you choose not to take part or withdraw from the study. This is an anonymous survey and responses cannot be linked back to you.

#### Will I be paid for taking part?

Unfortunately not however, your participation will be very much appreciated and will be essential to the developmental of future initiatives and collaborative working.

### **What will happen to the information collected?**

All information provided will be kept confidential and will be handled strictly in accordance with the consent that you have given and also the General Data Protection Regulation (2018).

### **What will happen to the findings of this study?**

The study will take a minimum of 9 months to complete and at the end of the study a final report will be produced. The final report will be shared with Senior Management of both BCS and CMHpS. The findings of the study will also be presented as a poster presentation at the University of Leeds and written up as an academic report. Direct quotes from participants responses will be used in the reports and presentation.

### **Who has reviewed the study?**

Ethical approval has been sought and granted by University of Leeds Research Ethics Committee.

*If you would like any further information or have any concerns about this project feel free to contact:*

#### **Project Lead:** Hannah Cartmell

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#### **Appendix 2 – Introduction page of the survey**

## First Page of Survey

### An evaluation into collaborative working with a voluntary sector organisation as a waiting list initiative.

We would like to hear your thoughts on the employment of counsellors from Bradford Counselling Service (BCS) in CMHpS as an initiative to tackle waiting list and gain insight into collaborative working between the NHS and the voluntary sector organisation BCS.

This online survey will guide you through a series of questions in the form of likert scales and free text comment boxes. The questions about your experience of the initiative including workload, access to supervision, CPD opportunities, team support. The survey will take around 15-20 minutes to complete and once your responses are submitted you won't need to do anything else.

The online study is anonymous, and no one will be made aware that you have chosen to take part. All responses will be kept confidential, anonymous and therefore unidentifiable. The data will be stored securely and only the project lead (Hannah Cartmell) will have access to the data.

If you agree to take part, you may withdraw from the study at any point before submitting responses on the final screen. By submitting your responses, you consent to the information being used. Once you have submitted your responses, it won't be possible to withdraw your data. There will be no consequences if you choose not to take part or withdraw from the study. This is an anonymous survey and responses cannot be linked back to you.

Results from the survey will be shared with Senior Management of both BCS and CMHpS. The findings of the study will also be presented as a poster presentation at the University of Leeds and written up as an academic report. Direct quotes from participants' responses will be used in the reports and presentation.

To complete the survey please click the button below.

**Appendix 3 – Survey distributed to BCS counsellors**

**SEP Counsellor Survey**

Did you have access to a balanced work load? (*this includes the nature of the work and number of cases*)

Always      Very often      Sometimes      Occasionally      Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
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Did you have access to regular clinical supervision?

Always      Very often      Sometimes      Occasionally      Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
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Did you have access to CPD opportunities, training and development opportunities?

Always      Very often      Sometimes      Occasionally      Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
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Did you have access to a supportive team environment? *(this includes both the CMHpS and wider mental health teams)*

Always          Very often          Sometimes          Occasionally          Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

How did you experience the spilt in operational management and clinical supervision being provided by different organisations?

Excellent          Good          Average          Fair          Poor

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

How did you experience the recruitment, interview and induction process?

Excellent          Good          Average          Fair          Poor

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better</i></p>
--

How did you experience the support systems? (*this includes obtaining laptops, mobile, record system*)

Excellent

Good

Average

Fair

Poor

*Please comment on what worked well:*

*What could have been better:*

How did you experience the placement in relation to your career as a counsellor? (*e.g. helped or hindered*)

Excellent

Good

Average

Fair

Poor

*Please comment on what worked well:*

*What could have been better:*

What do you think the **opportunities** are of joint working between the NHS and voluntary sector organisations in the future?

What do you think the **threats** are of joint working between the NHS and voluntary sector organisations in the future?

**Appendix 4 – Survey distributed to CMHPS staff**

**SEP Staff Survey**

Did the counsellors have access to a balanced work load? *(this includes the nature of the work and number of cases)*

Always          Very often          Sometimes          Occasionally          Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

Did the counsellors have access to regular clinical supervision?

Always          Very often          Sometimes          Occasionally          Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

Did the counsellors have access to CPD opportunities, training and development opportunities?

Always          Very often          Sometimes          Occasionally          Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

Did the counsellors have access to a supportive team environment? (*this includes both the CMHpS and wider mental health teams*)

Always          Very often          Sometimes          Occasionally          Rarely Never

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

What do you think of the spilt in operational management and clinical supervision being provided by different organisations for the counsellors?

Excellent          Good          Average          Fair          Poor

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

What do you think of the recruitment, interview and induction processes for the counsellors?

Excellent          Good          Average          Fair          Poor

<p><i>Please comment on what worked well:</i></p>  <p><i>What could have been better:</i></p>
---

What do you think of the support systems offered to the counsellors? (*this includes obtaining laptops, mobile, record system*)

Excellent

Good

Average

Fair

Poor

*Please comment on what worked well:*

*What could have been better:*

What do you think of the placement in relation to the counsellor's profession and career? (*e.g. helped or hindered*)

Excellent

Good

Average

Fair

Poor

*Please comment on what worked well:*

*What could have been better:*

What do you think the **opportunities** are of joint working between the NHS and voluntary sector organisations in the future?

What do you think the **threats** are of joint working between the NHS and voluntary sector organisations in the future?