Dundee Health & Social Care Partnership

**ITEM No …8……..**

**REPORT TO:** **HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD – 21st AUGUST 2024**

**REPORT ON:** **PSYCHOLOGICAL THERAPY SERVICES - ADHD**

**REPORT BY:** **CHIEF OFFICER**

**REPORT NO:** **DIJB48-2024**

## 1.0 PURPOSE OF REPORT

To outline the current challenges in providing care and treatment to people presenting with Attention Deficit Hyperactivity Disorder (ADHD) and to seek approval to use Transformation finance to address current waits and achieve alignment between current provision and the emergent Tayside wide model of care for Neurodevelopmental Disorders.

## 2.0 RECOMMENDATIONS

It is recommended that the Integration Joint Board (IJB):

2.1 Notes the contents of this report.

2.2 Notes the transformational nature of this proposal and its contribution to the strategic aims of the Neurodevelopmental Disorder Workstream within the Tayside Whole System Change Programme.

2.3 Approves the release of funding from ring fenced IJB Transformation Reserves to the value of £508,204 (as detailed in Section 4.16 of this report).

2.4 Instructs the Chief Officer to note the direction as attached at Section 8 of this report.

## 3.0 FINANCIAL IMPLICATIONS

3.1 The proposal to create a more protected service function for ADHD as outlined in this report for a period of up to 18 months will cost £101,641 in Year 1 and £406,563 in Year 2. It is proposed that the IJB utilises ring fenced Transformation Reserves to support this work. This timescale will allow Dundee to bridge across to any new service model with less people waiting than at present. The model to be utilised is designed to mirror key aspects of the model likely to be used in the longer-term and should therefore also help build a skilled workforce in advance of the establishment of a specialist Neurodevelopmental service.

## 4.0 MAIN TEXT

4.1 Referrals for ADHD are currently sent to one of two locality-based Community Mental Health Teams (East and West). Most people are seeking formalised assessment and, if diagnosed as having ADHD, access to evidence based supports and treatments. National Institute of Clinical Excellence (NICE) Guidance outlines that people should have access to structured discussions about the likely impact of ADHD on their life, advice with regard to making environmental modifications and, where necessary, access to medication.

4.2 In reality, most people are seeking medication which can only be initiated by someone with expertise in ADHD and there is a requirement for monitoring physical state over this period. A Shared Care Agreement with Primary Care means that people can be handed back only when stabilised on treatment and, even then, there is a requirement for CMHTs to provide annual reviews. This annual review must be with “a specialist” who reviews the efficacy and the physical impact of the medication and advises accordingly.

4.3 The rates at which people have presented to services requesting formal assessment for ADHD has increased significantly in recent years. This is in keeping with the National picture. For example, the National Institute for Health and Care Research (2023) reported findings from University College London’s analysis of the IQVIA Medical Research Data (a UK primary care database) indicating:

- The rate of new ADHD diagnoses increased from 2000 to 2018 in both males and females
- By 2018, the proportion of ADHD diagnoses for adults, was 74.3 per 10,000 in men and 20 per 10,000 in women
- This represents a 20-fold increase in ADHD diagnoses
- There was a 50-fold increase in ADHD prescriptions in men aged 18-29
- ADHD diagnoses were about two times higher in the most deprived areas.

The rates are recognised as having continued to rise since then but have not been studied in such a systematic way.

4.4 Within Dundee CMHTs, referrals are largely made on electronic systems. These electronic referral systems do not allow one to differentiate the reason for referral. However, separate analysis suggests that over the course of a year, each CMHT is receiving between 220 and 250 new referrals for ADHD. That is, around 500 new requests for treatment each year.

4.5 As referral for ADHD assessment is classed as "routine" care. Those cases triaged as requiring emergency and urgent care are prioritised, meaning that waiting times are disproportionate in comparison to other clinical problems. This issue has been added to over the last 6 months by National shortages in ADHD medication which has meant people being taken off medication (and therefore re-titration is necessary) and an agreement to stop all new assessments until the supply chain became reliable again. Together, this has resulted in a situation where more than half the people waiting for first appointments within CMHTs are waiting for assessment for ADHD. There are significant differences in the numbers waiting on each side of the City, but the proportion of ADHD waits are similar. In total, there are approximately 1000 people currently waiting for ADHD assessment.

4.6 CAMHS has experienced similar increases in referrals rates. They do not differentiate between neurodevelopmental conditions (mainly for Autism Spectrum Conditions and ADHD) but for the last three financial years, the rates of referral have been 2206, 1772, 1255 respectively. These people will graduate to adult services in due course and it is clear from CAMHS trajectories that a significant number will pass their 18th birthday whilst waiting to be seen (i.e. will be passed over without assessment being completed).

4.7 The current model of service delivery is almost entirely reliant on assessment by Consultant Psychiatrists and a thorough clinical review, using standardised assessments and gathering corroborative information from family/significant others, can take up to six hours work. As this part of the workforce remains unstable, there is a need to transform the delivery of services to people who consider that they may have ADHD.

4.8 The demand/capacity issues in responding to ADHD and the impact of this in responding to other common clinical problems managed within CMHTs, resulted in the setting up of a specific Workstream within the Tayside Whole System Change Programme to look at Neurodevelopmental Disorders (NDDs). The most common NDDs are Autism Spectrum Conditions and ADHD. These commonly co-occur with some studies suggesting that 65% of adults presenting at a specialist NDD services (innovation site) score positively for both ADHD and ASD irrespective of reason for referral. In those referred for ASD assessment, 81% scored positively for both and in those referred for ADHD assessment, 44% scored positively for both.

4.9 Given the above, the emergent model for management of ADHD, is to remove this from direct delivery within CMHTs and create new Neurodevelopmental Disorder Services which remove the emphasis on diagnosis and, instead, provide support based on need. Crucially, the model is likely to recommend a shift in the balance of care away from a having a health focus, to one which seeks to de-medicalise NDDs and the approach taken to them. This will likely include commissioning NDD specific services to provide needs based help and advice and low intensity supports and interventions. There will also be a move to systematically collect information (within a framework of 'tell my story once') which moves with a person should they require formal diagnosis and/or specialist higher intensity treatment approaches.

4.10 These emergent models increase overall capacity, decrease reliance on any single professional group and ensure that tasks are completed by someone with the relevant skills and competencies. A multi-disciplinary review of cases requiring diagnosis can achieve efficiency not possible within current models.

4.11 Given the above, increased capacity needs to be created within CMHTs. This increased capacity should be structured in ways which begins to mirror the emergent Tayside model of

NDDs. Early transformation to a new model means that Dundee will be well positioned in allowing service users a more seamless journey and will have allowed the 'growing' of a workforce interested in working with people with NDDs. Crucially, it will allow improved parity between NDDs and other common mental health problems. The work will remain housed within CMHT structures to ensure access to wider supports such as Duty Worker and preserve current referral routes.

4.12 Work can be conceptualised as having three distinct phases: Pre-diagnostic work; Diagnosis and Initiation of Medication; and Health Monitoring (annual checks).

4.13 Pre-diagnostic work will be undertaken by nursing, Occupational Therapy (OT), Assistant Psychologists and Peer Support Workers. This phase will allow structured information gathering, needs based advice and support and the provision of NICE recommended advice on environmental modifications.

- 1 wte Band 4 Peer Support workers
- 3 wte Band 4 Assistant Psychologists (plus 0.1 Band 8b for supervision)
- 0.6 wte Band 7 Community Mental Health Nurse (CMHN)
- 0.6 wte Band 7 OT

4.14 Diagnosis & Initiation of Medication with be undertaken by more specialist staff reviewing the structured information already gathered in above. Use will be made of the existing psychiatry resource where required but with a greater emphasis on alternative prescribers.

- 0.6 wte Band 7 Advanced Nurse Practitioner (ANP)
- 0.5 wte Band 7 Pharmacist

4.15 Health Monitoring. This will provide a more systems based approach to annual reviews in addition to the health checks required when medication is increased. Again, the existing psychiatry resource will be used for those tasks that can only be undertaken by them.

- 0.4 wte Band 7 CMHN
- 0.4 wte Band 7 ANP
- 0.5 wte Band 5 Pharmacy Technician

4.16 Costs

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| Year 1 (part year to March 2025): | £101,641 |
| Year 2 (April 2025 to March 2026): | £406,563 |
| Total Transformation Sum requested: | £508,204 |

4.17 The transformation of services will operate as a significant test of change and be monitored through the Mental Health & Learning Disability Clinical Care and Professional Governance Group with work delegated as appropriate to the Clinical Improvement Group. It is anticipated that this will reduce pressure on CMHTs and therefore also reduce the likelihood of hospital admission. This will need to be considered within a whole system financial framework.

## 5.0 POLICY IMPLICATIONS

This report has been subject to the Pre-IIA Screening Tool and does not make any recommendations for change to strategy, policy, procedure, services or core funding and has not been subject to an Integrated Impact Assessment. An appropriate senior manager has reviewed and agreed with this assessment.

## 6.0 RISK ASSESSMENT

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| **Risk 1 Description** | Patient safety. People with identified mental health needs are experiencing significant delays in accessing appropriate care and treatment. Demand outweighs clinical capacity and issues with lack of skill mix means that there is unnecessary demand on the most senior clinicians. |
| **Risk Category** | Governance |
| **Inherent Risk Level** | Likelihood 4 x Impact 4 = Risk Scoring 16 |

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| **Mitigating Actions** (including timescales and resources ) | Implementation of the recommendations outlined above. The resource will begin to address the longest clinical waits and provide support to the core ADHD work within CMHTs. |
| **Residual Risk Level** | Likelihood 3 x Impact 4 = Risk Scoring 12 |
| **Planned Risk Level** | Likelihood 2 x Impact 2 = Risk Scoring 4 |
| **Approval recommendation** | Given the moderate level of planned risk, the risk is deemed to be manageable. |

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| **Risk 2 Description** | Best use of resource. There is currently a lack of appropriate skill mix in the approach to ADHD. Whilst a prescribing resource is required, the approach to support and diagnosis can be transformed, meaning any medical time can be better utilised. |
| **Risk Category** | Governance |
| **Inherent Risk Level** | Likelihood 4 x Impact 4 = Risk Scoring 16 |
| **Mitigating Actions** (including timescales and resources ) | Phased-approach to service delivery with skill mix matched accordingly. |
| **Residual Risk Level** | Likelihood 4 x Impact 3 = Risk Scoring 12 |
| **Planned Risk Level** | Likelihood 3 x Impact 3 = Risk Scoring 9 |
| **Approval recommendation** | Given the moderate level of planned risk, the risk is deemed to be manageable. |

**7.0 CONSULTATIONS**

The Head of Health & Community Care, Chief Finance Officer and the Clerk were consulted in the preparation of this report.

**8.0 DIRECTIONS**

The Integration Joint Board requires a mechanism to action its strategic commissioning plans and this is provided for in sections 26 to 28 of the Public Bodies (Joint Working) (Scotland) Act 2014. This mechanism takes the form of binding directions from the Integration Joint Board to one or both of Dundee City Council and NHS Tayside.

| Direction Required to Dundee City Council, NHS Tayside or Both | Direction to: | |
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| | 1. No Direction Required | |
| | 2. Dundee City Council | |
| | 3. NHS Tayside | X |
| | 4. Dundee City Council and NHS Tayside | |

**9.0 BACKGROUND PAPERS**

None

Dave Berry
Acting Chief Officer DATE: 25th July 2024

Linda Graham
Clinical Lead for Mental Health & Learning Disability
Interim Director of Psychological Therapies Services

**DIRECTION FROM DUNDEE CITY INTEGRATION JOINT BOARD**

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|---|---|---|
| 1 | Reference | DIJB48-2024 |
| 2 | Date Direction issued by Integration Joint Board | 21 August 2024 |
| 3 | Date from which direction takes effect | 21 August 2024 |
| 4 | Direction to: | NHS Tayside |
| 5 | Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s) | No |
| 6 | Functions covered by direction | Dundee Community Health Teams |
| 7 | Full text of direction | To implement the additional service provision as set out within this report |
| 8 | Budget allocated by Integration Joint Board to carry out direction | £508,204 |
| 9 | Performance monitoring arrangements | Through HSCP management team arrangements |
| 10 | Date direction will be reviewed | March 2026 |