Can a Deaf charity develop an effective relationship with over 200 CCGs?

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ABSTRACT

BSL Healthy Minds (BSLHM) is a national psychological therapy service in primary care that provides cognitive behaviour therapy (CBT) and counselling for deaf people who use British Sign Language (BSL). There are 211 clinical commissioning groups (CCGs) in England and BSLHM has the onerous task of developing a relationship with each one to set up a contract that would enable BSL users to have the same access to psychological therapies as the general population.
This article will consider the obstacles faced when negotiating the ever-changing face of the CCGs, the complex relationships with commissioners, the issues Deaf people face when accessing mainstream mental health services and specialist status. There are possible solutions to the immense difficulties BSLHMs experiences when considering commissioning and this article offers recommendations for changes within the funding structure for the future.

Key Words: Deaf • Third sector • Clinical commissioning groups • Choice

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BSL Healthy Minds (BSLHM) from SignHealth, a charity, is a national psychological therapy service for British Sign Language (BSL) users, delivering one-on-one therapies at Steps 2 and 3 of the stepped care model within primary care. The charity has to work with over 200 clinical commissioning groups (CCG) to provide a service to their local deaf population. This article reports on the obstacles that BSLHM face when working with CCGs.

There are over 800 000 people in the UK who are severely and profoundly Deaf (Action on Hearing Loss, 2011) and of those, 101107 are BSL users in England, according to the IPSOS MORI 2010 GP Survey. Not all the Deaf population will access mental health services, but using the national Improving Access to Psychological Therapies (IAPT) prevalence rate of 15%, it is calculated that the number of BSL users that would need to access these services is 7584 across England.

In April 2013, 211 CCGs replaced 152 primary care trusts (PCTs) and 10 strategic health authorities (SHAs). Prior to April 2013, BSLHM worked mainly with SHAs and a handful of PCTs who had regional control of their budget. There were no regional or strategic hub replacements in the new changes, which has meant that BSLHM has had to forge new relationships with 211 individual CCGs. This is an 80% escalation in the number of people they have to work with who all have different funding mechanisms and priorities.

Impact of changes in commissioning

The major overhaul from PCTs to CCGs, change of job roles, change in commissioning practices and change in contract choices have impacted on BSLHM resulting in the offer of only short-term or ad-hoc contracts in many cases. This has affected the sustainability of the service. Rees et al (2014) highlighted the third sector's relationship with commissioning and BSLHM identifies with many points in this report, in particular that 'developing alternative commissioning structures and appointing individuals to work with has caused a degree of chaos and delays in key decisions being made'.

BSLHM concurs with this as they spend a considerable amount of time identifying the right commissioner. CCGs and clinical support units (CSUs) took on the role of commissioning at such a pace that there have been many changes to processes and staff. Due to these changes, it has been difficult to identify commissioners with the knowledge base needed to make decisions relating to meeting the needs of the local deaf population.

There are many aspects of everyday life that Deaf BSL users can access without the need for a specialist service such as shopping, banking, leisure activities and public transport. However, when it comes to education, community services and health-care, the need for specialist provision becomes more apparent as they have specific issues due to their deafness that necessitate further support. They may have issues with reading and understanding English, may be unable to access health services because of insufficient communication or interpretation provision, or may experience cultural barriers when interacting with staff who lack competency in Deaf culture.

BSLHM: A specialist service

Deaf people experience the same proportion of mental health issues as the general population but have higher rates of common mental health problems (Fellinger et al, 2012) for which many need specialist support. A specialist service is generally described as one that focuses primarily on a specific area and usually consists of people who are highly skilled in a specific and restricted field. There are specialist Deaf services within the third sector and health field.

BSLHM is a primary care service that was developed to address the gap in primary mental health services as Deaf people have been unable to access these services mainly due to the lack of communication access and cultural competency. Within the Deaf mental health field, it is only secondary and tertiary services that are recognised as specialist and receive ring-fenced funding from the NHS England specialised commissioning body. Interestingly, Vardy (2014) identifies specialist services as those with 'a small number of patients, complex needs, high costs, and a high level of expertise and specialist knowledge.' BSLHM ticks all those boxes, but is considered non-specialist as its IAPT status falls under non-specialised services.

The Deaf community is small and geographically dispersed which means the numbers of people are smaller per CCG (Levine, 2014). Two of the main reasons that some CCG commissioners are not commissioning BSLHM are the high costs and low numbers. They are now starting to refer Deaf people who need therapy to mainstream mental health services with a BSL interpreter and not commissioning BSLHM. This is suitable for Deaf people who are able to cope using a BSL interpreter and a hearing therapist but what of those who are not? Choice or parity of esteem is not offered.

BSLHM has had discussions with NHS England with regard to the specialist status, and the latter said that BSLHM referral numbers are too high to be considered specialist and too low for CCGs to consider commissioning. It is clear that this vital and much-needed service does not fit into any commissioning category. Furthermore, collaborative commissioning (NHS Commissioning, 2012) looks to be a useful option for both BSLHM and CCGs as it brings the neighbouring commissioners together to do joint commissioning. This would reduce costs for the CCGs and increase the number of referrals.

Data recording has been a major problem in the Deaf field as there are inadequate tick boxes for Deaf people, particularly sign language users. There are no exact figures on how many Deaf

people there are in the UK and how many use sign language. There are many data recording systems that collect personal data for banks, employers, utility companies, telecommunication providers, and the national census to name a few. However, these do not highlight the language or culture of an individual.

By contrast, the health sector make many decisions based on the Joint Strategic Needs Assessment (JSNA), the main purpose of which is to 'accurately assess the health needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities' (NHS Confederation, 2011). Many services put Deaf people under the 'disability' category, and when pressed for a further breakdown they are unable to provide accurate details. BSLHM is one of the few psychological therapy services that retain a full data record of sign language users.

The Social Research on Deafness (SORD) team at the University of Manchester are currently in the first of a two-part stage looking into the possibility of setting up a randomised control trial to investigate the differences for Deaf IAPT users who access standard versus BSL services (SORD, 2015). Furthermore, at the University of Central Lancashire, the author is currently carrying out a small-scale study (at MSc level) into sign language users' experiences of psychological therapies that is in line with the intended research at the University of Manchester. Both of these studies are still in progress and it is hoped that their outcomes will shape the future of psychological therapy services for Deaf users—for example, through adding to the body of knowledge in this distinctive area, improving patient care and access, and making positive improvements to the lives of Deaf people.

Current policies

There are many policies and guidelines that outline what it ought to be like for a Deaf person accessing mental health services. Examples can be found in *No Health without Mental Health* (Department of Health, 2011); *Everyone Counts: Planning for Patients* (NHS England, 2013); *Commissioning IAPT for the Whole Community* (Department of Health, 2008); and *Choice in Mental Health Care* (NHS England, 2014). However, these policies are not being put to use as parity of esteem is not being addressed in practice, which is outlined in the *Sick of It* report (SignHealth, 2014).

As alluded to already, the most recent mental health outcome of emphasis is 'parity of esteem' which means 'valuing mental health equally with physical health', but to ensure this happens, mental and physical health services must be equal in access and quality (NHS England, 2014). According to *Sick of It*, Deaf people do not get equal access to physical health services (SignHealth, 2014). The study reported the poor quality of Deaf people's access to GP services—including problems with diagnoses and treatment, and a lack of accessible information. Physical symptoms are generally easier to treat than psychological ones, which makes accuracy and quality in mental health even more important. But parity of esteem does not yet seem to be reality for the Deaf community.

Do Deaf people have a choice?

Choice in Mental Health Care is probably the most effective policy for Deaf people in theory, and ironically, it falls on 'deaf ears'. BSLHM provides a cultural and linguistic appropriate service that produces high clinical outcomes where the recovery rate is 75%, compared to the national average of 44% (Hulme, 2014); it submits monthly data to the Health and Social Care Information Centre (HSCIC), is fully Information Governance (IG) compliant and follows all the standard guidelines and policies and yet these do not seem to be factoring influences on commissioner decisions. Most CCGs are referring Deaf people to generic IAPT services with a BSL interpreter and are not heeding the requests for a Deaf therapy service where the therapist is a culturally Deaf BSL user. BSLHM has received over 50 requests to access its service in the North West in the last six months and they were denied by the CCGs. To date, five of those have been accelerated to crisis intervention, which means stepping up to secondary and tertiary services at a cost of approximately £500 per day.

BSLHM has been considering ways of improving and developing new strategies to engage with CCGs. It has been raising awareness of the aforementioned issues with commissioning at local, regional and national level, including networking events and conferences, and by providing tailor-made mental health and Deafness masterclasses for commissioners and instigating a debate in the House of Lords.

As a consequence of this debate, it was suggested that a working party should be developed to explore the practicalities of one small service working with 211 CCGs. Unfortunately, this did not occur due to the election and change in government. An exciting partnership with the Royal College of Psychiatrists(RCPscyh) has been established. BSLHM and RCPsych are producing Joint Commissioning Panel for Mental Health (JCPMH) guidelines for commissioning mental health services for Deaf people in primary care, which is one way of raising awareness and supporting commissioners to make informed decisions.

In summary, the issues with commissioning are: insufficient deaf mental health awareness; a lack of distinct CCG mental health commissioner leads in some areas; inadequate supporting data to enable commissioners to make decisions about their local deaf population (JSNAs); the geographic dispersion of the deaf community; and a failure to refer and adhere to relevant policies within the sector. Substantial strides have been made, but more recognition is needed at the local and national level.

Recommendations

Can a third sector Deaf charity develop an effective relationship with over 200 CCGs? This is possible if the following recommendations are taken into account to enable BSLHM and CCGs to be more effective. First, the national funding route (one contract) is the ideal way forward but in the event that this is not a viable option; changes should be made within individual CCGs. Second, there needs to be one clear mental health lead per CCG, who can easily be identified on the local website. Third, all mental health commissioners need to receive mental health and Deafness awareness training to facilitate informed decisions. Finally, collaborative commissioning should be recommended and implemented as it benefits all parties—the commissioners, BSLHM and most importantly, the Deaf community. BJHCM

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