MasterMind

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Committed Regions Final Feedback

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This document details the Committed Regions, their membership and initial communications

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Executive Summary

This document provides information on the Committed Regions managed in Work Package 4. It details the management and operation, while providing information on the various organisations and regions currently participating in the MasterMind project as Committed Regions.

It also provides a summary of the key areas of information and learning that are being shared between members of the MasterMind consortium and the Committed Regions.

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1 Introduction

1.1 Purpose of this document

As part of the work in Work Package 4 of the MasterMind project, links were established with regions and organisations across the EU with an active interest in the implementation of cCBT and ccVC that currently were not partners in the MasterMind consortium.

Regions and organisations had the opportunity to exchange information, knowledge, and learning with the MasterMind consortium by becoming Committed Regions.

Committed Regions may come from research, clinical, and technical backgrounds and agreed through an MoU (Memorandum of Understanding) to disseminate information on MasterMind amongst their professional networks while they in turn benefit from the knowledge generated in the project.

This deliverable provides details and analysis of the Committed Regions in relation to their management, operation, and shared learning within MasterMind.

1.2 Glossary

cCBT	Computerised Cognitive Behavioural Therapy
ccVC	Collaborative Care Video Conferencing
ICT	Information and Communication Technologies
MoU	Memorandum of Understanding
PHQ-9	Patient Health Questionnaire
VC	Video-conferencing
WP	Work Package

2 Purpose of Committed Regions

2.1 Role of the Committed Regions

Committed Regions are organisations and regions that have a key interest in the implementation and the outcomes of the MasterMind project. The regions may be actively involved in running cCBT or ccVC services, be at the point of implementation themselves, or have a research interest.

Regardless of their interest, Committed Regions had an important role in a number of areas in MasterMind:

- They acted as a conduit between MasterMind and regions, communities, and countries not inside the consortium partnership.
- They were a vehicle for sharing and exchanging information beyond the MasterMind project, and thereby increased its impact and relevance in the implementation of technologically enabled services within mental health.

The exchange of information helped in the planning and strategic development used to expand the applicability, acceptability, and success of cCBT and ccVC across Europe.

2.2 Exchange of information

Throughout the project, consortium members have been actively engaging with regions outside of the current partners of MasterMind. This engagement has taken place through email correspondence, face-to-face meetings, and attendance and presentation at conferences. During these interactions, dissemination and an exchange of learning has taken place that allowed for a richer understanding of the key barriers and facilitators to be developed and shared.

3 Management of Committed Regions

3.1 Responsibility

Committed Regions are managed by NHS 24, a specialist health board within NHS Scotland. They are also supported by a linked consortium member, the link established during the recruitment process.

3.1.1 About NHS 24

NHS 24 is responsible for the delivery of clinical assessment and triage, health advice and information by telephone and online services to the population of Scotland, 24 hours a day, 365 days a year. NHS 24 is also Scotland's provider of national telehealth services.

NHS 24 works in partnership with local health services provided by NHS Boards, NHS staff organisations, and local communities, supporting health improvement agenda across Scotland adding value to services where and when required.

3.2 Operation

Communication with the Committed Regions was maintained throughout the project by email and by direct contact with members of the consortium. Every six months, the Committed Regions were updated on the progress, key developments, and outcomes from the MasterMind project. If appropriate, they were also supplied with any supporting documentation such as project deliverables.

Recruitment of Committed Regions was a continual process occurring throughout the duration of the MasterMind project. When identified, the relevant consortium member would contact the Committed Regions co-ordinator who provided information on the project, negotiated the MoU, and provided updates throughout the project.

4 Membership of Board

4.1 Recruitment

The recruitment process was ongoing and occurred continually throughout the lifecycle of the project. Partners in the MasterMind consortium could at any point identify regions or organisation from within their networks that had an active interest in the MasterMind project, cCBT, and/or ccVC. All potential regions must have the willingness to participate, sign an MoU and meet key criteria that include:

- Have an interest and involvement in cCBT or ccVC activity.
- Be well networked and able to disseminate information in their respective regions.
- Be able to review and identify the most appropriate information and learning from MasterMind, and disseminate this widely at local and national levels.
- Where required, respond to any request for information that may arise from the Work Package Leaders, trial sites, or members of the MasterMind consortium.
- Provide comment, where applicable, on aspects of MasterMind.
- Share useful information, reports, or learning from their own local activities or other information and learning that they believe is relevant or useful to the MasterMind project.

When a region met the criteria and wished to become a Committed Region, the Committed Region Co-ordinator (NHS 24) established contact and worked with the organisation to define and complete their MoU, specifying the key objectives and the sharing agreement.

For a number of regions where it was impractical to sign an MoU, dissemination of MasterMind and continued contact was still maintained and learning shared. However, this process was limited to only non-sensitive materials.

4.2 The Committed Regions

A total of 21 Committed Regions have been recruited across organisations that participate in a number of activities including; research, healthcare provision, charity, and technical organisations. The table below has details of the regions that have been activity engaged with MasterMind.

Region	Description
e-Resater	A programme whose major aim is the development of innovation networks about e-Health and e-Inclusion in the rural areas in Europe, especially SUDOE regions.
Autonomous University of Madrid	A small research group which has developed different online cCBT programmes.
Zamora Province	Running a cCBT trial using all the indicators and protocols used in MasterMind.

Region	Description
Solentra	A small, highly specialised, non profit organisation, closely related to the Child Psychiatry department of the University Hospital in Brussels.
Action on Depression	A national Scottish charity running cCBT services in parts of Scotland.
NHS Tayside	NHS Health Board that runs a long established cCBT service as part of matched care model of psychological therapies service delivery.
Madrid Hospital	Interested in implementing the cCBT service.
Poland (SWPS)	University interested in the research outcomes of the project.
Antakalnis Clinic and Lithuanian Health Science University	In the process of creating a project on computerised self-help programmes for depression and stress management for young people.
Mayden (England)	Commercial company with strong links to IAPT in England, looking to set up cCBT services on behalf of NHS England.
Psychiatric Hospital of Aita Menni	Research aligned hospital, interested in development of cCBT services.
NHS Dorset Clinical Commissioning Group	NHS service commissioning group based in Dorset.
Making Space	A mental health charity working nationally across England, provider of cCBT services.
NHS Health Boards Scotland	Eight regions within Scotland currently in the process of implementing cCBT services using the MasterMind approach.

5 Dissemination

5.1 Dissemination activities

Dissemination activities occurred regularly throughout the lifecycle of the MasterMind project. The activity was co-ordinated at local levels between the MasterMind consortium partner and the Committed Region.

In addition to this, information on the project was compiled by the Committed Region Co-ordinator (NHS 24) throughout the year and sent to regions providing updates in relation to key developments, learning points, and results:

- Regular updates through the MasterMind project website: https://mastermind-project.eu/.
- Posts and feedback through Facebook and Twitter pages.
- Introduction pack including project information, Market Place Report, and Scientific Protocol.
- Information packs sent throughout the project duration including progress reports and key deliverables; last sent July 2016.

6 Feedback

6.1 Shared learning

Through the interactions between the Committed Regions and the MasterMind consortium, a number of topics have been regularly discussed. These topics highlight some of the key areas of concern and interest when implementing cCBT and VC services; although the range and styles of organisations differ, the topics remained the same. These topics have included:

- Selection of cCBT package and its impact on service implementation.
- Implementation model.
- Logistics of service.
- Data Exchange and governance.
- Engaging clinical staff.
- Patient engagement.
- Evaluation.
- Funding.

6.1.1 Impact of cCBT package

One of the first decisions that an emerging cCBT service needs to make is the selection of an appropriate cCBT software package.

Through the interactions with the Committed Regions, the importance of this initial decision has become apparent. The software selected will shape the therapy, its duration, and patients' engagement with the treatment. It also has implications on the funding requirements. Funding appears to be one of the key aspects when making this decision; as well as its acceptability to the funders, how does it fit in with reimbursement structures and clinical service delivery models.

The technical requirements of the software and their implications are also a key discussion point, with a number of aspects of the programme being taken into consideration when selecting the package. These include:

- Where the patients can complete the treatment, in their homes or in a healthcare setting.
- If the programme is delivered online, broadband availability, especially in rural areas.
- Interactivity of the programme.
- Use of case studies.
- Clinical governance.
- Evidence base.

Another consideration is the use of multiple software packages in the same service to provide greater choice and flexibility in treatment of patients. Software packages can be used to target different conditions and in different contexts or treatment styles, for example as standalone treatments or used in conjunction with face-to-face therapy.

6.1.2 Implementation model

Through discussions with the Committed Regions and in the experience of MasterMind, it is clear that there are many different ways in which technologically enabled services can be applied and implemented within mental health.

There have been a number of discussions surrounding the benefits of using eMental Health services as a blended approach when treating patients, i.e. used in conjunction with face-to-face therapy, and the potential reduction of required face-to-face sessions when cCBT is used in this way. This also applies to the efficiency of patient access when using ccVC.

The topic of using cCBT as a guided or unguided treatment was also discussed. In some areas, cCBT is used as an unguided form of treatment. However, the results show that patient engagement suffers, and completion rates go down when there is less direct contact with the patients. This is a common finding across all regions using cCBT in the treatment of patients with depression.

Key to the successful implementation is to ensure the safety of the patients. Some cCBT programmes contain inbuilt clinical governance mechanisms that allow risks to patients to be quickly and easily identified. More important than these inbuilt mechanisms is the infrastructure, policies, and protocols that guide staff when the risk is identified, in particular in those regions using cCBT as a stand alone, unguided treatment. In addition to this, there is a high level of emphasis placed on the direct support offered to patients when completing this type of treatment, and the security of the technology used by clinical staff, which can directly impact on willingness to refer.

When discussing the service models for cCBT and ccVC, a balance needs to be created between developing a clinically safe service without hindering the potential scale and impact of the technology. This occurs when too many clinical safety / governance barriers are present within the service model, e.g. overly restrictive referral guidelines and/or complex assessment prior to treatment. The primary issue in this case appears to be trust. Specifically, trust in the cCBT programme or VC technology, and of referrers making good decisions relating to the selection of patients.

In relation to the process of implementation, it was recognised that a phased approach should be preferred with the development of a robust service with the required funding to ensure that the appropriate evidence of clinical outcomes and cost effectiveness can be gathered. The phases should be designed to systematically increase the scale of service, with clearly defined incremental steps. In addition to this, cCBT can be extended beyond the traditional referring groups of GPs, mental health services, and psychology through the creation of multiple referral routes from acute services, social care, and older people's services.

A specific aspect of the implementation that has been discussed is self-referral. Self-referral is used successfully in a number of cCBT services across the Committed Regions. The key to these services is the ease of access for patients, and an assessment process or electronic system that is able to identify and match the needs of the patient to the appropriate service.

6.1.3 Data exchange and governance

A key desire in particular within cCBT services is to electronically link the cCBT software package to an electronic patient record, providing an up-to-date record of the patient progression through their treatment. Barriers to this process include:

- The technical requirements needed to make the link from one system to another.
- The involvement of commercial companies.
- The time it has taken to develop this link.
- Variations of patient managements systems across healthcare services, e.g. between acute and primary care services.
- Complexity of network access, firewalls, and ICT security protocols.
- Data ownership.

In addition to this, there is an inherent need to ensure that across all cCBT and VC services the patient, data are stored securely and remain confidential.

6.1.4 Engaging Clinical Staff

One of the biggest barriers to the successful implementation is the negative perception held by many clinicians of technologically enabled services. This has been found not only within MasterMind, but across the majority of the Committed Regions. Many clinical staff feel that services such as cCBT are in some way inferior to more traditional treatment, that the patient-therapist relationship will be reduced in some way, or in the views of more junior staff that the introduction of technology-based treatment services may lead to a reduction of their role and perhaps a replacement for these roles.

A key part of the exchange between the Committed Regions and MasterMind has been the shared learning of how the engagement with clinical staff has taken place across the implementation sites. There is a need for a strategic approach that delivers key messages about the services and their benefits, while providing access to the evidence showing the clinical value of services developed within the MasterMind project.

6.1.5 Patient engagement

For those Committed Regions that are directly involved in the implementation of services, one of the key identified issues is to firstly ensure the appropriate levels of referral, and secondly to ensure that patient engagement is maintained throughout the course of their treatment.

The feedback and shared learning has emphasised the need for personal contact prior to and during the treatment. Personal contact has been identified as a key component to increase the completion rates of treatment and reduce drop-out. In conjunction with this, it is important that the patients' expectations of their treatment are managed through the provision of good information about the services.

6.1.6 Evaluation

One of the enduring areas of interest is in the evaluation of services and their implementation taking place within MasterMind; this interest relates to both the outcomes of the MasterMind project as well as the methods of day-to-day evaluation of the services within routine practice. The feedback from the Committed Regions highlights the importance of continually collecting evidence and evaluating the success of both cCBT and ccVC services, and the dissemination of these results locally. This importance appears to be to a greater degree than with more traditional face-to-face services, the implication being that technologically enabled services continually need to prove their value and worth to clinical and managerial staff within healthcare.

6.1.7 Funding and sustainability

Through the sharing of information between the Committed Regions and MasterMind, by far the biggest barrier that has been identified to the implementation of cCBT or ccVC is funding. In particular, the initial funding required to invest in the technology and dedicated personnel needed to set up and deliver eMental health services.

One of the key learning points from the interactions with the Committed Regions is that an additional investment with a direct focus on the implementation of cCBT or ccVC provided through a project such as MasterMind is needed to increase the chances of a successful implementation. Without the accountability and additional funding provided through a project, it is difficult for services to be developed within existing healthcare structures and budgets, and for the funding and staff resources to be diverted from the existing services to enable the dedicated implementation process that is required.

7 Conclusions

7.1 Barriers and facilitators

Throughout the interactions and sharing of information between the Committed Regions and the MasterMind consortium, a number of key barriers and facilitators have been identified:

Barriers

- Lack of initial funding to enable the development of cCBT or ccVC services.
- Negative clinical attitudes towards the use of cCBT or VC within the context of mental health.
- Patient engagement and generation of referrals.
- Patient safety when using technologically enabled services.
- Limited selection or choice of cCBT software packages.

Facilitators

- External project funding.
- Appropriate evaluation, collation, and dissemination of evidence.
- Correctly phased implementation approach and service model.
- Strategic approach to clinical engagement.

7.2 Conclusions

Sharing knowledge between MasterMind and the Committed Regions, while being a valuable method of dissemination, has also shown that one of the key barriers to the setting up and sustaining of cCBT and ccVC services is not one of clinical engagement, patient acceptability, or the implementation process. While these undoubtedly have an impact, the biggest barrier appears to be getting the right levels of investment that will cover the additional funding for the infrastructure, staffing, and technology required to set up and run eMental Health services. It is important that the funding provides enough time and scope within the implementation process to ensure that the evidence can be gathered and the evaluation of service completed to show the real benefits and value of cCBT and ccVC in local and national contexts.