NHS
Lancashire &
South Cumbria
NHS Foundation Trust

PRIVATE & CONFIDENTIAL
Mental Health Action Group

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Dear Mental Health Action Group

Thank you for taking the time to share your concerns regarding Talking Therapies services, which was received on 21 August 2025.

I note that you have written to both ourselves and to the Lancashire and South Cumbria Integrated Care Board (ICB).

The Talking Therapies Leadership team has reviewed the points you raised in relation to our service provision and our responses to your questions are set out below.

> **In 2023-24 in Lancashire and South Cumbria ICB's NHSTT services, only one third of the total number of 51,220 referrals and only one half of the 32,755 who started therapy actually finished a course of treatment. Two-thirds of the people who applied for primary care talking therapies in Lancashire and South Cumbria dropped out.**

1. **Why is the dropout rate so high?**

A proportion of people disengage from any time-limited therapy service. The most common reasons we see are:

- **Clinical and personal factors:** anxiety/avoidance, fluctuating motivation, caring and work commitments, physical health issues, and life events that interrupt attendance.
- **Readiness and expectations:** some patients may not yet be ready for an active therapeutic intervention or had different expectations regarding the nature of support. We endeavour to set clear expectations as part of early sessions in the service, as well as in our written materials.
- **Waiting and timing:** the gap between assessment and treatment can affect motivation, and we are reducing waits and increasing waiting list contact.

- **Stigma and confidence:** worry or shame about seeking help can reduce engagement. Our engagement lead and clinicians regularly run community outreach workshops to normalise mental health symptoms and help-seeking.

What we are doing to reduce dropout:

- **Reduce waits:** expanding High Intensity capacity; offering remote options and "choose and book"; proactive rebooking after cancellations.
- **Clearer "what to expect"** written materials and discussions at the start of therapy.
- **Right care, first time:** stepped-care allocation to NICE-recommended treatments, including long-term conditions clinics where indicated.
- **Consistent approach to non-attendance:** our Operational Policy and LSCft Waiting Times & Access Policy set out responses to repeated DNAs/cancellations, with clinical judgment for vulnerable or at-risk patients.

2. What happens to the 34,000 people in Lancashire and South Cumbria who are looking for help but drop out of the service?

We do not have routine contact once someone is discharged or self-discharges, so we cannot reliably track individual outcomes. In practice, people who disengage typically:

- **Self-manage** via NHS or online resources.
- **Use community options** (voluntary sector services, peer support, social prescribing).
- **Seek support via primary care** for medication or review.
- **Re-refer** to Talking Therapies at a later point.
- **Access urgent help** via 111 option 2 or local crisis services if needed.

At discharge we provide tailored signposting and support patients to access a mental health app.

The adult community prevalence of common mental health disorders in the Lancashire and South Cumbria ICB area was around 234,150 in 2017. NHSTT gave access to 32,755 adults in 2023-24, i.e. 14% of the 2017 prevalence – well below the 25% target. And only about a quarter of this 14% recovered. ·

In the Lancashire and South Cumbria area, Talking Therapies apparently met the 75% waiting time target in 2023-24, of a maximum 6 weeks. However, the average wait between the first and second session was 50 days by which time half of its referrals had dropped out. 8,800 of the remainder waited over 6 weeks for a second session.

The recovery rate for Lancashire and South Cumbria ICB in 2023-24 was 48% of people who completed a course of treatment. However, the more meaningful statistic is for the recovery rate of people who entered treatment - less than 24%.

3. Why does NHS TT claim to meet its required targets when the claim is untrue?

LSCFT TT Business Intelligence Team accurately report to the ICB our progress toward targets, with all achievements assessed according to national guidelines.

In 2025/26, LSCFT remains 4% below the national benchmark for completed courses of treatment; however, this reflects a marked improvement compared to prior years, attributable to quality improvement efforts and the growth of the NHS Talking Therapies workforce.

LSCFT TT consistently meets both the six-week and eighteen-week waiting time standards.

Recovery strategies are actively being implemented to reduce in-treatment pathway delays so that fewer than 10% of patients wait longer than 90 days.

For 2024/25, the average percentage of in-treatment pathway waits was 22%, which is lower than the national mean of 24%. Additionally, LSCFT TT achieved a 50% recovery rate in 2024/25, meeting the established target.

4. **Why does it measure recovery in relation to completed treatment rather than treatment entry?**

Recovery outcomes are measured at the point of completed treatment rather than treatment entry because not all patients who are assessed for NHS Talking Therapies proceed to receive psychological therapy within the service. During the initial assessment, some patients may be found to not meet the clinical threshold (e.g. their symptoms may not be severe enough), or the service may not be well suited to their needs.

In such cases, patients are signposted to alternative support services that are more appropriate for their needs such as the Initial Response Service, Home Based Treatment Teams, Community Mental Health services, community health resources, social care, social prescribing, or voluntary sector support. Since these patients do not engage in a structured course of therapy within NHS Talking Therapies, it would be inaccurate and misleading to include them in recovery outcome statistics for the service.

Measuring recovery at the point of completed treatment ensures that the data reflects the effectiveness of the therapy provided. It captures symptom improvement among those who have received therapeutic interventions, allowing for a more valid and meaningful evaluation of service impact.

For those redirected elsewhere, while symptom improvement may still occur, it is outside the scope of NHS Talking Therapies and therefore not included in its performance metrics.

In 2023-24, the annual Talking Therapy funding for Lancashire and South Cumbria was £28 million. The average duration of a session that year was 53 minutes, and for a finished course of treatment 405 minutes or 6.7 sessions. If we divide the spend by the

number of people who finished a course of treatment (17,075), the cost per session was around £216.

If we use this admittedly crude measure, NHS TTs claim to cost efficiency does not hold water. There are over 320 qualified practitioners based in Lancashire alone who are currently offering counselling and psychotherapy for under £50 per session. By this comparison £216 could buy each patient over four times the number of sessions.

5. Why is there no independent audit of the TT service?

This is a valid concern and one that is best addressed by the national team responsible for overseeing NHS Talking Therapies.

At a local level, LSCFT does not currently commission an independent audit of the TT service. However, through the ICB it does rely on a robust set of tools and data sources to monitor and improve service quality, productivity, and efficiency. These include:

- NHS Benchmarking Data: This provides comparative insights across regions and services, helping identify areas of strength and opportunities for improvement.
- Mental Health Planning and Analysis Tool: Used to support strategic planning and resource allocation based on population needs and service performance.
- NHS Talking Therapies Maturity Tool: Assesses the development and readiness of services across key domains such as workforce, digital capability, and clinical outcomes.
- Internal Quality Audits: Conducted within the organisation and LSCFT TT service to ensure adherence to clinical standards, operational protocols, and patient safety measures.
- Patient Experience Questionnaires: These are routinely used to gather feedback directly from service users about their experience, including accessibility, communication, and perceived effectiveness of care. The insights help inform service improvements and highlight areas needing attention.
- Friends and Family Test (FFT): A national feedback tool that asks patients whether they would recommend the service to others. It provides a simple yet powerful measure of satisfaction and trust and is used to monitor trends in patient feedback over time.

While these mechanisms offer valuable oversight, they do not replace the objectivity and transparency that an independent audit could provide. Therefore, any decision to implement such an audit would need to be considered at a national level, potentially as part of broader policy or commissioning changes.

6. What is the average cost of a completed course of treatment?

The NHSE 2024/25 Mental Health Triangulation Planning Analysis Tool reports that the average cost of completed treatment in Lancashire and South Cumbria ICB was £1336, just below the national average of £1338.

In terms of the limitations of behavioural therapies, it is noticeable that a third of people who completed a course of therapy experienced no change or deteriorated. Why out of 3,000 courses of collaborative care was the contribution of talking therapy so small (455 courses)?

In Lancashire and South Cumbria NHS talking therapy services in the ICB area offer online talking therapy via Silvercloud. Silvercloud is in partnership with US based data and cloud companies developing fully automated conversational AI therapy using millions of recorded NHS sessions.

7. Why are only behavioural therapies offered by NHS TT?

NHS Talking Therapies primarily offer psychological treatments that are evidence-based and recommended by the National Institute for Health and Care Excellence (NICE). While the service is often associated with cognitive and behavioural approaches such as Cognitive Behavioural Therapy (CBT) it provides a broader range of therapeutic modalities tailored to different mental health needs.

Some differences exist between teams and services in LSCFT but the psychological therapy approaches include:

- Eye Movement Desensitisation and Reprocessing (EMDR): A structured therapy specifically recommended for patients experiencing trauma or post-traumatic stress disorder (PTSD).
- Interpersonal Therapy (IPT): Focuses on improving interpersonal relationships and communication patterns, particularly effective for depression linked to relationship issues or life transitions.
- Person-Centred Experiential Counselling for Depression (PCE-CfD): A person-centred approach that helps patients explore the underlying emotional causes of their depression, often used when CBT may not be suitable.
- Couples Therapy for Depression: Designed to support couples where one or both partners are experiencing depression, this therapy aims to improve relationship dynamics and emotional wellbeing.

These therapies are offered based on clinical need, patient preferences, and the presenting problem, and are delivered by trained clinicians within a stepped care model.

The emphasis on behavioural therapies like CBT often reflects their strong evidence base, cost-effectiveness, and suitability for a wide range of common mental health conditions such as anxiety and depression.

8. Why is there no longer-term therapy available for people who need it?

Therapeutic support is tailored to each patient's clinical needs and the severity of their symptoms. The length and intensity of treatment are guided by ongoing clinical assessments, ensuring that each

person receives care that is proportionate to their progress and presentation. Some patients may require more sessions than others, and this is determined on a case-by-case basis.

Longer term therapy may not always be available due to service capacity, resource limitations, and the need to prioritise access across the wider population. Services aim to deliver effective, evidence-based interventions within a framework that balances patient needs with fairness and accessibility. Where extended support is clinically indicated, alternative options such as stepped care approaches, community health, community mental health based services, or referrals to specialist providers may be explored to ensure continuity and appropriateness of care

Thank you for taking the time to contact the service to raise these themes, and I do hope we have provided a helpful and thorough response.

Yours sincerely

Tracy Cook-Scowen
Director of Operations – Central and West Locality