SERVICE SPECIFICATION

Service	Improving Access to Psychological Therapies (IAPT)
Commissioner Lead	Medway CCG
Provider Lead	To be procured
Period	1st April 2016 – 31st March 2019 TBC

1.Executive Summary

A national programme for Improving Access to Psychological Therapies (IAPT) was launched in 2008. The core components of this service are contained within the IAPT implementation plan published by the Department of Health (DH) in February 2008[1].

The model of care for this service is based around a stepped care model, based upon the least intervention first time. The service can provide provision for Step 2 and Step 3 and 'online support and interventions' to work in Medway CCG'.

The IAPT 'Three Year Report – First Million Patients (November 2012)'[2] states that 'at least one in four people will experience a mental health problem at some stage in their lives. This can place a significant burden on that individual's wellbeing, their family, ability to hold employment status, the NHS and the wider economy. Recognising this, in February 2011 the Coalition Government highlighted its commitment to improving mental health in England through *'No Health Without Mental Health'*[3], a strategy that aims to achieve parity of esteem between mental health and physical health services'.

The report demonstrates that at the end of the first three full financial years of operation of the IAPT service (end of March 2012), more than 1 million people have used the new services across England, recovery rates are in excess of 45% and 45,000 people have moved off benefits.

1. Population Need

1.1 National Context and Evidence Base

It is estimated nationally that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder and at least 15% of those will enter Primary Care Psychological Therapy Services (PCPTS).

Across Medway the adult population of 18-64 year old is 198,816. Of these, 29,601 (15%) (*Mental Health Needs Assessment, 2014*), may have common mental health disorders and 4,441 (15%) may enter PCPTS.

The development of the IAPT Service has been undertaken considering the needs of the whole population including prevalence and incidence of common mental health disorders.

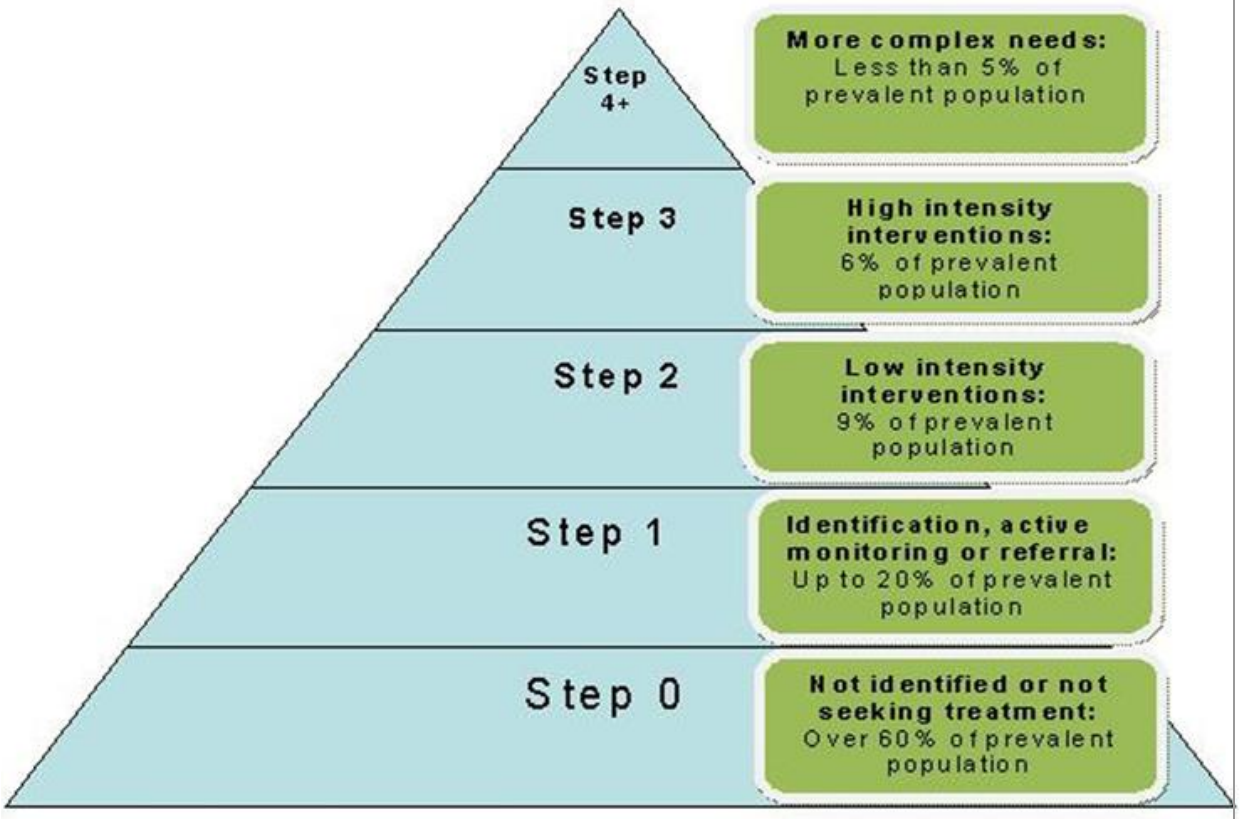
There is strong evidence that appropriate and inclusive services and pathways for people with common mental health problems, specifically depression and anxiety, reduce an individual's usage of NHS services whilst contributing to overall mental wellbeing and economic productivity[4].

Achieving parity of esteem between mental and physical health raises the importance of offering holistic interventions that impact on both health and mental wellbeing. It is therefore important that IAPT Services are designed to ensure that general health and wellbeing are also considerations in treatment.

The Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis (2014)[5] highlights the importance of early intervention service being in place to prevent crisis situations by having a single point of access to a multi-disciplinary mental health teams. It states that this access point should be available to agencies across the statutory and voluntary sectors.

'Talking therapies: a four year plan of action'[6] estimates that two-thirds of people with common mental health disorders have mild mental health conditions and so require low-intensity treatment at step 2. One-third have moderate or severe mental health disorders and so require higher intensity treatment at step 3, therefore it is expected that this is reflected in provider activity levels. The Provider will be required to have a workforce that reflects this need and provide interventions at these levels.

Figure 1 Estimated proportion of the prevalent population with common mental health disorders who will enter each step of care



- Cluster 1 = Signposting/Self-help/Public Health and Prevention
- Cluster 2/3 = IAPT interventions with possible integrated support with other community based provision
- Cluster 4 and above = Community Mental Health and Wellbeing Service provision or secondary mental health care services where appropriate

1.2 Local Context

Table 1 below details the population figures (based on estimates using National Benchmarking Tools) likely to meet the criteria for common mental health disorders (CMD) and of these, the number likely to enter psychological therapy treatment at step 2 and 3 within Medway.

Table 1: Local Populations meeting CMD criteria and likely to access step 2 or 3 services

Medway Population	Estimated population who would meet the criteria for CMD	Estimated population likely to access step 2 and step 3 services
198,816	29,601	4441

2. Scope

2.1 Aim of Service

The aim of the Improving Access to Psychological Therapies (IAPT) Service is to provide a universal primary care psychological therapy service for people registered with a Medway GP and suffering with depression & anxiety disorders which is integrated within current physical and mental health services. IAPT aims to relieve distress and transform lives by offering NICE-approved interventions and treatment choices for people with depression and anxiety disorders, and counselling and emotional support for people not primarily suffering from depression or anxiety disorders.

The IAPT Service will be provided across the Stepped Care spectrum, focusing particularly on the development of new low and high-intensity psychological therapy services in the early steps of the relevant NICE model of care (figure 3).

Stepped care is a system of delivering and monitoring treatments, so that the most effective, yet least resource intensive treatment or intervention is delivered to the service user in the first instance before providing more intensive treatment to those that do not improve with the first step.

The service will treat patients experiencing depression, panic disorder, generalised anxiety disorder, phobias, post-traumatic stress disorder, obsessive-compulsive disorder and body dysmorphic disorder.

In line with No Health without Mental Health the IAPT service will have a role in promoting public mental health and wellbeing in the Medway area, liaising with existing organisations and GPs and setting up accessible care pathways with a single point of access.

The link between satisfying work and better mental health is crucial and the longer people are out of work the greater the risk of depression or anxiety disorders developing or becoming unmanageable. The IAPT service will support and monitor people that are struggling in employment or who are unemployed to improve their mental health and wellbeing and return to work.

2.2 Objectives of Service

The key principles of an integrated IAPT Service is to:

- Provide a patient-centred approach to the delivery of IAPT taking into account socio-demographic characteristics, health co-morbidities and lifestyle factors
- Provide a single point of entry for receiving referrals so that patients experience a seamless, timely service that is appropriate to their needs
- Increase the proportion of people who are identified, provide early assessment for those entering psychological therapy treatment and deliver this in line with national targets
- Increase the proportion of people accessing the service to make a clinically significant improvement or recovery and deliver this in line with national targets
- Improve early access to and delivery of psychological therapies in primary and community settings as close to home as possible
- Ensure methods of communication are in place to keep General Practitioners well informed of the patients journey along their treatment pathway
- Reduce the need to re refer if extended treatment is required
- Reduce the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders
- Provide signposting information and support to facilitate access to a range of community based support services
- Improve service user choice and experience of mental health services
- Improve identification and awareness of common mental health disorders and promote onward referral or assessment and intervention
- Improve the interface between services for people with common mental health disorders
- Provide access to interpreters for people who do not speak English
- Improve access and support to maintain people in work, help them to return to work, help them into education or training and where appropriate help people to find a meaningful activity
- Provide a person-centred service and recognise the need for all health professionals to work in partnership with service users in a holistic and inclusive manner
- To provide a person centred service sensitive and responsive to all age groups
- Support families and carers in terms of assessment of their own caring (carer's assessment), physical, social, occupational and/or mental health needs and provide information on how

they can access relevant support groups and networks

- Provide high quality and flexible support to service users that maximises individual potential, which could include the use of multi-media technology (e-CBT) or home based interventions
- Provide follow ups at 3 and 6 months after discharge (Telephone or Face to Face)
- Provide a service that is evidence based and good value for money
- Provide access to information and other support for people who are referred, but who may not at present be eligible for the service.
- Use a system for data collection which supports the core requirements of the IAPT minimum data set, as stated in the IAPT Data Standard[7], and allows the evaluation of the effectiveness of the service based on pre and post treatment outcomes for all patients treated

2.3 Interdependencies

The NHS is committed to working jointly with other local authority services, other public sector organisations and a wide range of private and voluntary sector organisations to provide and deliver improvements in health and wellbeing (Extract from NHS Constitution). Accordingly, where collaborations or partnerships have been formed in order to deliver services an appropriate Service Level Agreement (SLA) or Partnership Agreement (see Appendix for example Partnership Agreement) should be agreed and in place within 1 month of commencing contract.

The Lead Provider is expected to operate with a formally agreed partnership agreement (example provided) that has been signed by the parties as part of their submission. The partnership members will allow full access to all information and operate in an "open book" manner that enables the main commissioning body or their appointed auditors to verify any element of the partnership activity to ensure that processes are robust, risks are managed and cost is verifiable. Information requests or verification can be undertaken without notice but notice will normally be given.

Partnership working and collaboration with a range of other health and social care services, residential and nursing care, employment support agencies, criminal justice agencies, well-being services (e.g. leisure services; health promotion) will be required. These partner agencies are likely to include a variety of statutory, voluntary and independent sector providers.

Sharing information with lead professionals as appropriate in order to support individual physical and mental health care planning and Multi-disciplinary team working. Information governance guidelines need to be followed and where necessary, reference made to the Caldicott Guardian[8]

Where necessary the service will develop shared care arrangements with other relevant services to ensure patients' needs are fully met, and all aspects of their care and treatment co-ordinated.

Where appropriate, the Service must work in partnership with colleagues working in specialist/secondary mental health services to ensure a smooth transition of care for individuals with more complex mental health needs.

The Children and Families Act 2014 requires Local Authorities to work in partnership with the NHS and other partners to carry out 'transition assessments' if a young person is likely to have need for some care or support on turning 18. These needs will be met under the Health and Social Care Act 2014[9] in advance of the child becoming or turning 18. There is an expectation on the provider and the partners to work in collaboration with the Child and Adolescent Mental Health Services (CAMHS), ensuring support and transition for the service user in Medway.

2.4 Service Description

The IAPT service will provide a single point of access to psychological therapies, offering a stepped care model of service, based on NICE Guidelines (see figure 3 below), whereby the least intensive intervention appropriate to a person's need is provided first. People can readily "step up or down" the care pathway in accordance with their changing needs and response to treatment.

In line with this stepped care model, the service will ensure that care pathways provide the least intrusive, most effective intervention first and monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed. The service will provide a range of evidence-based interventions at each step in the pathway and support people in their choice of interventions.

In accordance with NICE guidance some people e.g. those assessed with severe depression or anxiety disorders or Post Traumatic Stress Disorder (PTSD) will be routed straight to high intensity interventions rather than stepped first through low intensity interventions which would not be effective in meeting their treatment needs.

Figure 3: Stepped Care Model - Focus and Nature of Interventions

Step 3: High Intensity Interventions	Depression: moderate to severe	Cognitive Behavioural Therapy (CBT) or Interpersonal Therapy (IPT), each with medication
	Depression: mild to moderate for individuals with an inadequate response to initial interventions at Step 2	CBT or IPT Behavioural Activation (BA), a variant of CBT. [2] Behavioural Couples Therapy (*if the patient has a partner, the relationship is considered to be contributing to the maintenance of the depression, and both parties wish to work together in therapy*) Counselling[1] or short-term psychodynamic therapy[1] *(consider if patient has declined CBT, IPT, BA, or Behavioural Couples Therapy*)
	Panic Disorder	CBT
	Post Traumatic Stress Disorder (PTSD)	CBT or Eye Movement Desenstisation reprocessing Therapy (EMDR)
	Generalised Anxiety Disorder (GAD)	CBT
	Obsessive Compulsive Disorder (OCD)	CBT
	Social Phobia	CBT
Step 2 : Low Intensity Interventions	Depression	Guided Self-Help based on CBT, Computerized CBT, Behavioural Activation, Structured Physical Activity
	Panic Disorder	Self-Help based on CBT, Computerized CBT
	Post Traumatic Stress Disorder (PTSD)	None
	Generalised Anxiety Disorder (GAD)	Self-Help based on CBT, Psycho-educational Groups, Computerized CBT
	Obsessive Compulsive Disorder (OCD)	Guided Self-Help based on CBT
	Social Phobia	None
Step 1: Primary Care / IAPT service	Recognition of problem Moderate to Severe Depression with a chronic physical health problem	Assessment/Referral/Active Monitoring , includes careful monitoring of symptoms, psychoeducation about the disorder and sleep hygiene advice. Collaborative care (consider in light of specialist assessment if depression has not responded to initial course of high intensity intervention and/or medication)

1.NICE' Guidance on treatment of "Depression" and "Depression in people with a chronic physical health problem". The two guidelines are very similar. However, it should be noted that the "depression with a physical health problem" guideline does *not* recommend IPT, behavioural activation, counseling or brief dynamic therapy as high intensity interventions

2 Although the recent update of the NICE Guidance for Depression recommends Behavioural Activation for the treatment of mild to moderate depression, it notes that the evidence base is not as strong as for CBT or IPT.

3 PTSD NICE had not recommended low intensity treatments

4 Social Phobia - NICE has not yet issued guidance on the treatment of social phobia. However, there is a substantial body of evidence supporting the effectiveness of high intensity CBT. Low intensity versions of CBT are being developed by several groups around the world and are likely to play a useful role in the future. At least one trial has also demonstrated that IPT is effective

3. Service Delivery

3.1 Service Model

The service required is for a community-based Psychological Therapies service to deliver a range of services to people with common mental health disorders. These services should treat conditions that are covered by a traditional IAPT model, plus additional conditions where NICE guidance dictates, including:

- Adjustment depression or anxiety in adults with a chronic physical health problem e.g. chronic pain or medically unexplained symptoms
- Anger management
- Bulimia nervosa
- Generalised anxiety disorder
- Health anxiety (hypochondriasis)
- Mild learning disability or cognitive impairment
- Neurodevelopmental disorders such as autism/ADHD
- Persons in contact with the criminal justice system
- Mild depression and anxiety
- Obsessive-compulsive disorder
- Other co-morbid mental health conditions e.g. non-acute or stable psychosis where anxiety or depression-related symptoms are present
- Panic disorder
- Personality disorder (not severe and where anxiety and depression related symptoms are present
- Phobias (including social anxiety disorder)
- Post-traumatic stress disorder including working with military veterans

3.12 Assessment

Every person who is referred (or self-refers) to the IAPT Service will receive a comprehensive patient-centred assessment by a member of the psychological therapies team within 10 working days from receipt of referral. Individuals should be able to choose a worker of the same gender, ethnic or cultural background and religion, where this is practical, to conduct the assessment. The assessment should clearly identify the full range and impact of the individual's presenting mental health problems and any linked social and physical health issues. The assessment must include a robust risk assessment (suicide, harm to others, self-harm etc.) which should also be conducted at each contact thereafter.

The assessment should include as a minimum the PHQ9 and GAD7 outcome measures, plus the IAPT Phobia Scale and Worker & Social Adjustment Scale (WSAS) outcome measures where necessary. The results of the outcome measure assessments must demonstrate that the individual has an appropriate level of need to warrant entry into the service for treatment. Table 2 below indicates the appropriate level of need for each outcome measure:

Table 2: Outcome Measures

Problem area to be addressed	Recommended measure	IAPT data handbook appendix reference * **	Number of items	Cut-off score to demonstrate need
Depression	PHQ-9	D1	9	10 and above
General Anxiety	GAD7	D2	7	8 and above
Phobias	IAPT Phobia Scales	D3	3	4 or above on any item
Functioning	WSAS (Worker & Social Adjustment Scale)	D4	5	N/A

*Detailed information concerning this area can be found in the IAPT Data handbook Appendices in order to deliver this part of the specification. Where data is to be collected electronically / on line please ensure that sufficient data protection protocols are exercised.

**Please note that the Data Handbook is subject to change and that processes or procedures should be reviewed annually to ensure that changes are captured.

The assessor will discuss with the individual the range of options/therapies available (appropriate to the clinical presentation and in-line with NICE guidelines) taking into consideration gender, ethnicity and other diversity issues and offer choice wherever possible.

An individual's particular treatment pathway will be based on interventions to address their specific needs and will include, for example, NICE recommended treatments for anxiety and depression, as well as additional services to support functionality and social well-being (where required). Individuals should be offered the least intensive or burdensome intervention that is likely to result in clinical improvement.

Once an individual has been assessed, they should be allocated a practitioner at the step relevant to their needs. Individuals should be able to choose a practitioner of the same gender, ethnic or cultural background and religion, where this is practical, to conduct their treatment. Commencement of treatment should be within 10 working days from assessment for step 2 interventions and 28 working days for step 3 interventions.

If the outcome of the assessment indicates a requirement for referral on to specialist mental health services at step 4, providers must ensure that mechanisms are in place to facilitate this.

The additional outcome measures (table 3) should also be undertaken at assessment for patients where a specific anxiety disorder is present/identified:

3.13 Interventions

The service is comprised of a stepped approach to the delivery of equitable, holistic, integrated mental health services. The service will provide employment advice in partnership with other agencies or advisory services. The levels of support include:

Table 3: Anxiety Disorder specific outcome measures

Problem area to be addressed	Recommended measure	IAPT data handbook appendix reference * **	Number of items	Cut-off score to demonstrate caseness
Obsessive Compulsive Disorder	Obsessive Compulsive Inventory (OCI)	D5	42	40 and above
Generalised Anxiety Disorder	Penn State Worry Questionnaire- Short (PSWQ)	D6	16	45 and above
Social Phobia	Social Phobia Inventory (SPIN)	D7	17	19 and above
Health Anxiety	Health Anxiety Inventory – Short week version (SHAI)	D8.1	18 in total	15 or above for 14 or 18 items
Avoidance/ re-assurance	Avoidance/ re-assurance (health) questionnaires	D8.3	19 in total	Optional measures. No fixed cut-off
Agoraphobia	The Agoraphobia-Mobility Inventory (MI)	D9	52	Above an item average of 2.3
Post-Traumatic Stress Disorder	Impact of Events Scale (IES) – revised	D10	22	30 and above
Panic Disorder	Panic Disorder Severity Scale: self-report version (PDSS)	D11	7	8 and above

*Detailed information concerning this area can be found in the IAPT Data handbook Appendices in order to deliver this part of the specification. Where data is to be collected electronically / on line please ensure that sufficient data protection protocols are exercised.

**Please note that the Data Handbook is subject to change and that processes or procedures should be reviewed annually to ensure that changes are captured.

Step 1 - Low level intervention

This group of people have definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms. Many people at this level can manage with support from their GP. However the service will be responsible for providing advice to GPs on individual cases where necessary. The service will also be responsible for raising awareness and confidence among communities and GPs to identify and manage depression. As part of this the service will:

- Provide awareness-raising training for GPs and primary care nurses, delivered at appropriate times to ensure clinical engagement.
- Work with GPs on ensuring patients are referred early into services at step 2
- Provide training for primary care to use mental health promotion CDs and MP3 downloads, which are given to service-users as an early intervention and an adjunct to watchful waiting.
- Work with the MH Commissioning Lead, Public Health and the CCG Communications Team to arrange health promotion and media events, that raise awareness of common mental health

disorders, with an emphasis on building community resilience during difficult times.

The overall will form part of an annually agreed communication plan to ensure continuing engagement between the IAPT partnership and NHS professionals.

Step 2 – Low level intervention with greater need

This group of people have definite but minor or moderate problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Step 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.

This is generally a low-intensity service and will include the components below. It can be provided through individual and group sessions and will include both brief face-to-face contact and telephone/text support.

Short term (low intensity) psychological interventions (6-8 sessions including an assessment) will include:

- One to one therapeutic interventions
- Therapeutic interventions for couples
- Group interventions including 6 week stress control groups held during evenings to increase access
- Half day healthy-living workshops, focusing on guided self-help on issues such as managing anxiety, self-esteem and sleep disorders.
- Guided behavioural self-help (face to face, telephone and group)
- Prescribing e.g. books on prescription scheme, exercise referral schemes, eco-therapy
- Brief person centred/integrative counselling
- Problem solving
- Computerised CBT
- Concomitant medication advice and support for patients receiving antidepressant medication
- Telephone 'collaborative care' support for patients on antidepressant medication
- Individual CBT sessions with a therapist (6-8 sessions)
- Sign posting to alternative services/support

Alternative engagements that are ICT web-based solutions that can be run from home computers, smart phones, etc., would be encouraged as part of the therapeutic intervention.

The outcome measures as described in table 2 should be repeated periodically throughout the individual's treatment, with a copy to be received by the GP within 7 working days, until the individual is deemed recovered and ready for discharge.

If at any time the outcome measures indicate that step 3 interventions are required, the individual should be stepped up, and the GP informed within 7 working days.

Step 3 - High level Intervention

This group of people are characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

Step 3 services are generally high-intensity services and will include the interventions detailed below. They should be available as individual and group sessions and should be conducted via face-to-face contact. This high-intensity service includes the following components:

- Individual CBT (8-20 sessions, average of 12 sessions over 6 months)
- Group CBT (6-10 people, up to 12 x 2hr sessions)
- Therapy sessions should be supplemented by guided self-help when appropriate materials are available
- Medication advice and support for patients receiving antidepressant medication
- Telephone 'collaborative care' support for patients on antidepressant medication

The outcome measures as described in table 2 should be repeated periodically throughout the individual's treatment, with a copy to be received by the GP within 7 working days, until the individual is deemed recovered and ready for discharge.

If at any time the outcome measures indicate clinical improvements, the individual may be considered for stepping down to step 2 interventions if appropriate.

If at any time the outcome measures indicate that step 4 interventions are required, a referral should be made to specialist mental health services as follows:

- For an urgent need the referral should be made the same day and the individual's GP must be informed as soon as possible but no later than 2 working days from referral. Any verbal information/discussions must be confirmed in writing and be received by the GP within 7 working days.

- For a non-urgent need the referral should be made within 5 working days but only after consultation with the individual's GP. Any verbal information/discussions must be confirmed in writing and be received by the GP within 7 working days.

Step 4 – Severe non psychotic Disorders
This group of people will be severely depressed and/or anxious. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and/or self-harm and they may present safeguarding issues and have severe disruption to everyday living. Care for this group of patients will be co-ordinated by the Primary Care Mental Health Specialists aligned to the Care teams. However where indicated as appropriate and following a clinical risk assessment, the IAPT Service may be required to deliver some aspects of care to assist in their overall care plan. This will be provided in collaboration with treatment undertaken by specialists and this will be a rare occurrence.

Case Management
The provider will be responsible for case management of people receiving step 2 and 3 interventions and for communicating with the service users GP and the primary care Specialists regularly, including the need for referral to higher steps (specialist services outside the IAPT service, CMHTs, in-patient care). Case management must consider the following areas:

- Assigned accountability
- Role and remit
- Skills and support
- Case finding
- Targeting

- Caseloads
- Single point of access
- Care planning
- Continuity of care
- Self-care
- Communication
- Integration and collaboration (Kings Fund reference – case management 2011).

The provider will use an appropriate case management system that meets the NHS ICT standards[10]

3.2 Workforce Information

The IAPT Service will be staffed with an appropriately qualified workforce in the therapy they are delivering, competent to deliver interventions in accordance with NICE guidelines, receive supervision in line with professional standards and are kept up to date in regards to professional development. The workforce must demonstrate a range of skill mix that provides flexibility across evidence based and IAPT recommended psychological therapies, such as Cognitive Behaviour Therapy (CBT), Interpersonal Psychotherapy (IPT), Dynamic Interpersonal Therapy (DIT), Behavioural Couples Therapy, Counselling for Depression and Eye-Movement Desensitisation and Reprocessing (EMDR) and be accredited by the relevant professional bodies:

Cognitive Behaviour Therapists: British Association for Behavioural and Cognitive Psychotherapies (BABCP)

Clinical and Counselling Psychologists: Health and Care Professions Council (HCPC)

Counsellors: British Association for Counselling and Psychotherapy (BACP) or United Kingdom Council for Psychotherapy (UKCP)

DIT therapists: British Psychoanalytic Council (BPC)

EMDR therapists: EMDR Europe

IPT therapists: IPT-UK

Behavioural Couples Therapy: The Association for Behavioural Couples Therapy (ABCT).

Psychological Wellbeing Practitioners (PWPs) delivering step 2 low-intensity interventions, will be expected to have followed the national curriculum for PWP in order to become qualified and to comply with the IAPT PWP Best Practice Guide:

- National Curriculum For The Education Of Psychological Wellbeing Practitioners (PWPs) http://www.iapt.nhs.uk/silo/files/national-curriculum-for-the-education-of-psychological-wellbeing-practitioners-pwps-.pdf

- Psychological Wellbeing Practitioners Best Practice Guide http://www.iapt.nhs.uk/silo/files/psychological-wellbeing-practitioners--best-practice-guide.pdf

CBT therapists, clinical psychologists, counsellors, nurses, occupational therapists, experienced graduate mental health workers or psychotherapists undertaking step 3 high-intensity interventions.

- National Curriculum For High Intensity Cognitive Behavioural Therapy Courses http://www.iapt.nhs.uk/silo/files/national-curriculum-for-high-intensity-cognitive-behavioural-therapy-courses.pdf

- IAPT Workforce http://www.iapt.nhs.uk/workforce

The senior staff must demonstrate competence in clinical leadership, training delivery, governance, audit, evaluation, service design and improvement. They must commit to the ongoing clinical supervision and case management essential to setting up and managing stepped care systems.

Where providers or their partners are using volunteers to deliver aspects of the IAPT provision, it is expected that they will adhere to the Investing in Volunteers UK Quality Standard[11] and meet the nine indicators that comprise of the standard.

3.21 Supervision

Supervision from experienced accredited practitioners (e.g. clinical psychologists and other suitably qualified high intensity workers) is essential. The service provider must demonstrate that they have appropriate workforce supervision in place:

- Clinical supervisors should have a working knowledge and experience of the interventions they are supervising.
- Supervisors should have no more than five trainees (at any one time) to supervise individually for a minimum of one hour a week (for full-time staff), with sufficient time to undertake the role and access to peer/group support and continuing professional development.
- Supervision should review ongoing clinical cases every 2-4 weeks, looking at case management and individuals' outcome measures. All staff should also have routine professional and management supervision.
- High intensity (step 3) trainees should be able to receive additional in-depth supervision of training cases at college, usually in groups of two to three trainees for around 1.5 hours per week.
- PWP trainees should also receive individual and group supervision, for around an hour a fortnight, to discuss assessment, risk issues and clinical decisions to step up treatment to high intensity, discharge or refer on to specialist services.
- All providers and their partners need to demonstrate a clearly defined supervision policy.

3.3 Location of Services

The Service is required to be delivered from a range of community venues in an environment which is conducive to the needs of the individual, offering anonymity if required (e.g. in some cases of self-referral).

- Delivered close to a patient's home wherever possible (and in patient's own homes where they are housebound or have prohibitive mobility issues)
- Community settings could include GP practices, libraries, resource centres and employment settings
- Closely aligned with GP practices to ensure good integration with primary care
- Integrated within local health and social care systems
- Services need to be provided in easily accessible locations well-served by public transport

- Identified space for group interventions to be easily identified

All facilities need to be risk assessed as a safe place for both clients and those delivering the therapeutic intervention. All providers and their partners should have appropriate policies in place that promote safe working practices and the protection of staff, e.g., lone working, panic buttons, and smart phone enabled personal tracking.

3.4 Days/Hours of Operation

Operating hours of the service should be in line with demand and as agreed with the commissioner across the geographic area. This will include out of hours and weekend working as appropriate.

Opening the service on statutory public holidays is at the discretion of the provider; however there will be a requirement for providers to ensure patients are notified in advance of closures.

Service accessibility will form part of an annual submission to commissioners for approval. The submission should show how the service will be delivered over the coming year to enable challenge/discussion.

4. Referral, Access and Acceptance Criteria

4.1 Referral Process

Providers should have the ability to be able to receive referrals through the national NHS E referral (entry level with the ability to upgrade). Where a referrer (GP, other registered health professional or self-referrer) is unable to use E-referral Book, an alternative (i.e. paper) referral process should be accepted.

The provider will be expected to develop direct access for people to self-refer into the service, however following initial screening, the patients GP must be informed to validate the referral prior to full assessment and treatment commencing to ensure that the patient is not already on a contra indicated pathway.

There will be a single point of access to the integrated service with a stepped care approach. The service would be responsive with early assessment of need, and accessible with flexible working times to meet the needs of service users and deliver the required referral to treatment and access targets.

4.2 Acceptance Criteria

There are clear and explicit criteria for entry into treatment as detailed in Table 2, Section 3.12, whereby need must be demonstrated. If need is not demonstrated then the patient should be referred back to their GP and Primary Care MH Specialist with detailed information regarding why, and suggested options that will aid recovery, including alternative routes for therapy / treatment.

GPs or other registered health professionals should ensure that only suitable persons are referred into the service and will usually include a PHQ9/GAD7 outcome measure with their referral. When a patient self refers, the Service should undertake initial screening to seek preliminary caseness prior to any assessment. The patients GP must be informed prior to any assessment commencing, to ensure that other avenues of treatment which may be contra indicated are not already in place.

Services must be available to people aged 18 and over, who are registered with a GP in the Medway area, on the basis of need, irrespective of their gender, race, sexuality, cultural or religious beliefs, disability or financial circumstances. High risk groups such as homeless or travelling community can access the service on a basis of temporary residence.

4.3 Response times and prioritisation

The Service is required to meet an access standard of 10 working days from receipt of referral to assessment. Following assessment, commencement of treatment should be within 10 working days for step 2 interventions and 28 working days for step 3 interventions.

People that are identified to be at high risk (e.g. suicidal ideation, severe self-injurious behaviour, psychotic symptoms) should be referred to the appropriate step 4 mental health service, within the following timescales:

- For an urgent need the referral should be made the same day and the individual's GP must be informed as soon as possible but no later than 2 working days from referral. Any verbal information/discussions must be confirmed in writing and be received by the GP within 7 working days.

- For a non-urgent need the referral should be made within 4 working days but only after consultation with the individual's GP. Any verbal information/discussions must be confirmed in writing and be received by the GP within 7 working days.

4.4 Exclusion Criteria

Continuing management of people with psychosis/severe mental illness (as a primary condition) will be outside the scope of this service. However, when an individual with psychosis/severe mental illness is being stably managed and then presents with a secondary condition of depression or anxiety, then they may benefit from access to psychological therapies to address the depression or anxiety states and these individuals will be accepted by the service.

The IAPT Service is not targeted towards those who pose a high risk to themselves, risk to others or who are at significant risk of self-neglect. This may include "hard-to-engage" people who have consistently rejected various treatment options offered. Additionally those patients identified as requiring step 4 interventions are outside the scope of this service as previously stated unless specified within their care plan.

4.5 Rejecting Referrals

The provider must only accept referrals that meet the referral criteria covered by this specification.

Any inappropriate referrals received from a GP or other registered health professional (i.e. for individuals who meet the exclusion criteria and require step 4 services) should be referred onwards to step 4 services within the timescales detailed within section 4.3.

Sufficient feedback should be provided to the referrer (if not the GP) to minimise inappropriate referrals in future. Details of this occurrence should be logged and discussed at contract monitoring meetings to ensure continuous improvement and feedback.

Any inappropriate referrals received from a GP or other registered health professional or specialist

voluntary professional (i.e. for individuals where it is clear prior to assessment that they clearly do not meet the acceptance criteria of the service and require step 1 services) should be referred back to the GP with recommendations for step 1 intervention provision.

If the individual is not appropriate for the service for any reason and therefore does not require an assessment appointment, the GP should receive this information within 7 working days along with any recommendations for future management (i.e. step 1 intervention provision).

People who refuse or do not attend (DNA) two consecutive reasonable appointment offers for assessment following referral should be discharged back to their GP and PCMHS. This includes where the person has indicated a preference for telephone contact for the assessment.

Referrals that are rejected prior to assessment for the reasons described above will not be chargeable.

5. Discharge Criteria & Planning

5.1 Discharge from the service

Discharge will occur when:

- Treatment intervention has been completed and clinical outcomes met
- Patients have achieved their optimum level of function
- Patient has failed to engage in the service in accordance with the Did Not Attend Policy

Patients and their designated carer (if appropriate) will be involved in the discharge process, to minimise the likelihood of re-referral. Patients who require further treatment in an alternative service will be referred back to the GP to manage the onward referral.

5.2 Discharge process

Discharge plans must be developed with the individual and any other professionals involved in the individual's care and treatment.

Following completion of treatment, a discharge summary must be received by the GP and referrer (if not the GP) within 7 working days, with a copy to the individual. The discharge summary must include an outline of the treatment delivered, the contact time and the clinical progress (based upon the validated outcome measures described in tables 2 and 3).

Once treatment has commenced, where an individual declines further treatment or disengages from the service of their own volition, the GP and referrer (if not the GP) should receive a summary of the actions taken and outcomes provided in writing within 7 working days.

Once treatment has commenced, in the event of the individual being referred on to step 4 services, the GP and referrer (if not the GP) must be informed as soon as possible but no later than 2 working days from referral.

5.3 Evaluation/reassessment

Evaluation and where appropriate reassessment will take place:

- To enable patients and clinician to identify strengths and areas for development within the treatment plan
- To monitor efficacy of approach used for each individual
- To gain user feedback on the experience of using the service

6. Self-Care and Patient and Carer Information

Patients will be encouraged to be fully involved in all aspects of their care and encouraged wherever practicable and safe to self care. The service will provide a range of information for patients and carers to promote self care and support families in their role as carers. All patients will be made aware of the support networks available to them.

All information must be provided in a format that will meet the needs of the patient and their carers, for example language, makaton, easy read symbolic language etc.

7. Governance and Quality Assurance

The Care Quality Commission monitors evidence of compliance with a set of essential standards for quality and safety. The service is responsible for the appropriate gathering of evidence to support an assessment of achieving outcomes identified in the essential standards. The Service must act on any recommendation in any Care Quality Commission report that the Independent Regulator requires to be implemented or is otherwise agreed.

The service must be able to demonstrate that it is achieving the aims and objectives within the resources available. All assessments and treatments must be performed by staff with appropriate qualifications, training and experience and in line with the service specification.

All clinical staff receives regular personal development plans linked to their individual knowledge and skills framework and are encouraged to access clinical supervision and benchmarking to ensure quality of care delivery. All staff have a structure which provides support, advice and guidance on a regular basis.

7.1 Applicable National Standards

The providers must ensure compliance with national standards where these apply. This includes (but is not limited to) the following NICE guidance:

- Depression in Adults (Update) (CG90) http://guidance.nice.org.uk/CG90
- Anxiety (CG113) http://www.nice.org.uk/Guidance/CG113
- Common mental health disorders (CG123) http://www.nice.org.uk/guidance/CG123
- CMG41: Commissioning Stepped Care for People with Common Mental Health Disorders http://www.nice.org.uk/usingguidance/commissioningguides/commonmentalhealthdisorderservices/CommonMentalHealthDisorderServices.jsp

Providers must also comply with IAPT requirements, including the Information Standard:

- The IAPT Data Handbook http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf
- The Information Centre http://www.ic.nhs.uk/iapt

7.2 Audit

The Service will be expected to undertake a clinical quality audit of the care of clients on an annual basis. Service activity and any records requested must be made available to the commissioner on a quarterly basis.

The Service will have an established Clinical Governance programme which as a minimum covers the following:

- Patient, pubic and carer involvement
- Risk management, including incidents, near misses and complaints
- Staff management and performance, including recruitment, workforce planning and appraisals
- Education, training and continuous professional development
- Clinical effectiveness and audit
- Clinical appropriateness of the level of therapy offered i.e. step 2 or step 3
- Referrals not accepted
- Information governance
- Communication both internal and external
- Leadership at all levels of the organisation

7.3 Quality Indicators

Clinical outcome measures of depression and anxiety are completed pre-assessment, at initial assessment and at the end of treatment.
Patient satisfaction surveys are sent out to the patient at the end of treatment.
All staff received clinical supervision on a monthly basis.

7.4 Complaints
All providers will have a clear complaints policy showing how the stages of complaint are dealt with and how they are escalated through to the CCG. Information concerning complaints will form part of the Quality Indicators for assessing the service. The approach to complaints will always work on the basis of a no blame culture. This enables the complainant's issue to be heard and dealt with fairly, and for any lessons learnt from the complaint process to be embedded as part of an ongoing service improvement learning process.

8. Monitoring

The service will use a patient information/case management system to collect report and analyse data to ensure aims are achieved as agreed by commissioners. Services will routinely collect the outcome data. This will include monitoring the following:

- Accessibility
  - Ensuring waiting times and the range of interventions provided are appropriate
- Equity of access
  - Ensuring the service is available to all sections of the community, by means of a local equality impact assessment.

- Effectiveness
  - Obtaining pre and post-treatment outcome data for at least 90% of the people treated by the service.
  - Demonstrating reductions of symptoms for the conditions treated.
  - Demonstrating social inclusion and employment outcomes.
- Acceptability and quality
  - By monitoring satisfaction and choice amongst people who use the service, benchmarked against comparators nationally.
  - By monitoring supervision of trainees and qualified staff.
- Complaints
  - Received, resolved and actions.

Key Performance Indicators

National Key Performance Indicators	Threshold	Method of Measurement	Consequence of Breach
KPI1	The Number of people who have anxiety or depression	Quarterly Report	TBC
KPI3a	The Number of people who have been referred to psychological therapies	Quarterly Report	
KPI3b	The number of active referrals who have waiting more than 28 days from referral to first treatment/therapeutic session	Quarterly Report	
PHQ13_05	People who have entered treatment as a proportion of people with anxiety or depression	Quarterly Report	
KPI4	The number of people who have entered psychological therapies during the reporting quarter	Quarterly Report	
KPI5	The number of people who have completed treatment during the reporting quarter	Quarterly Report	
KPI6a	The number of people who are “moving to recovery” of those who have completed treatment in the reporting quarter	Quarterly Report	
KPI6b	The number of people who have completed treatment not at clinical caseness at treatment commencement	Quarterly Report	
PHQ13_06	Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session	Quarterly Report	
KPI7	The number of people moving off	Quarterly	

	sick pay or ill-health related benefit	Report	
PHQ13_01	The proportion of people that have depression and/or anxiety disorders who receive psychological therapies	Quarterly Report	
PHQ13_02	The proportion of IAPT service users who complete treatment who are moving to recovery	Quarterly Report	

Local Quality and Performance Indicators	Quality and Performance Indicator(s)	Threshold	Method of Measurement	Consequence of Breach
Service User Experience	User feedback on the experience of using the service is routinely collected and used to develop the service	A statistically relevant proportion of the population be surveyed annually	The survey will be undertaken in a manner which enables engagement and is accessible to all	TBC
Improving Service Users & Carers Experience	User feedback is incorporated into service developmental reviews leading to year on year improvement in service user experience	Evidenced improvement in outcomes delivered and movement along the pathway previously identified	The service will record outcomes achieved against personal plans and movement along the pathway	
Reducing Inequalities	Information on quality and activity indicators should be analysed by locality, age, gender and (where possible) ethnicity, so that inequalities can be identified	No provision shall be denied unreasonably by reason of unjustifiable discrimination for whatever reason	Activity indicators will be compared with wider population data	
Reducing Barriers	The service will ensure that it provides services to the whole population that needs services	The service will identify the proportion of eligible population to whom it is providing	Number of new referrals to the service	

		services		
Improving Productivity	The service will move people with learning disabilities along the agreed pathway to increased independence of services	Agreed baseline for number of people supported by the service	Annual audit of people using service and level of dependency / support	
Access	The service will be fully accessible to those needing the service providing the eligibility criteria are met	Nobody should be denied service through lack of accessibility	Number of new referrals to the service and those disengaging from the service	
Personalised Care Planning	The service will deliver care planning in line with principles identified in valuing people	People that use services will be provided with a personal care plan and , where appropriate, be supported to access individualised budget support solutions	Annual confirmation that everyone who uses services has personalised care plans.	
Outcomes	The service will deliver all of the outcomes identified	A baseline for performance will be established	Annual audit against agreed measures.	
Additional Measures for Block Contracts:-				
Staffing Establishment WTE		Baseline to be established	Monthly return	
Sickness Levels		Baseline to be established	Monthly return	
Patient Contacts per WTE and A for C Band		Baseline to be established	Monthly return	
Vacancy Rates		Baseline to be established		
Temporary Staff Usage		Baseline to be established		
Staff Turnover		Baseline to be established		

Activity

Activity Performance Indicators	Threshold	Method of measurement	Consequence of breach
Number of Referrals	TBC	Patient Information System	TBC
Number of patients in treatment by treatment type	TBC	Patient Information System	TBC
Comprehensive assessment completed	TBC	Patient Information System	TBC
Number of discharges	TBC	Patient Information System	TBC
Referral Source	TBC	Patient Information System	TBC
Referral to 1st intervention wait time	TBC	Patient Information System	TBC
Referral to subsequent intervention wait time	TBC	Patient Information System	TBC

ACTIONS TO AVOID SERVICE OVERTRADE

When appropriate referrals are discussed with the referring practitioner prior to being accepted and may be redirected to a more appropriate source.

Information about the service is sent to all potential referrers and includes information relating to the service referral criteria in order to ensure that referrals fall within the professional remit of the service.

If a patient does not attend two consecutive appointments without cancelling, they are discharged and the referring practitioner and GP is informed.

9. Continual Service Improvement Plan

The service should review its performance against the quality and performance indicators to determine plans for service improvements in patient care.

Providers are expected to work collaboratively with statutory and non-statutory stakeholders in activities that support continuous service improvement. Services must be able to demonstrate they have systems in place that are responsive to clinical and quality issues and that the use of audit and other forms of objective and subjective evaluation are being used to inform service

improvements.

The service should undertake an annual review in association with the CCG Commissioning Lead and departments.

Service user, referrer and commissioner feedback on the experience of using the service is routinely collected and used to develop the service.

10. Cost

TBC

Basis of Contract	Price
	£

References

1. Department of Health. *Improving Access to Psychological Therapies. Implementation Plan: National guidelines for regional delivery.* National Institute for Mental Health in England, 2008
2. Department of Health. *IAPT three-year report. The first million patients,* 2012
3. HM Government & Department of Health. *No Health Without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages, 2011.*
4. Department of Health. *Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy,* 2011.
5. HM Government. *Mental Health Crisis Care Concordat. Improving outcomes for people experiencing mental health crisis,* 2014.
6. Department of Health. *Talking therapies: a 4 year plan of action, 2011.*
7. NHS. *IAPT Data Standard*, 2012.
8. NHS Executive. *Caldicott Guardians,* 1999.
9. HM Government. *Social Care Act , 2014.*
10. NHS England. *Information Governance Policy*, 2014.
11. Investing in Volunteers. *Investing in Volunteers: Quality Standard: For organisations that involve volunteers, 2015.*

Appendices

Appendix 1 – Partnership Agreement

Template for Partnership agreement between Lead Partner and Project Partners

This document consists of a preamble, a Part A and a Part B:
-The preamble must be filled in the grey parts;
-**Part A is compulsory** for all partnership. This part cannot be amended by the partnership nor it can be limited by the contents.
-Part B is to be defined and detailed by the partnership and shall contain information on how to coordinate and implement activities and how to disseminate results. It must be negotiated between partners and tailored to the partnership's individual needs.

For the parts marked in grey in the preamble and for Part B, the JOINT COMMITTEE is not liable for completeness, correctness, up-to-date and full compatibility with EU and national law.