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National IAPT Director

An Update on the National IAPT
Programme
November 2012

Introduction

Programme Aims

- Complete the roll out of IAPT services
- Expand access to IAPT in specific areas of need

Deliverables

- an appropriately trained workforce,
- specific quality standards,
- session by session outcome measures,
- stepped care model
- flexible referral routes

Extended Scope

- children and young people,
- those with physical long-term conditions and mental health issues,
- those with Medically Unexplained Symptoms (MUS), and
- those with severe mental illness

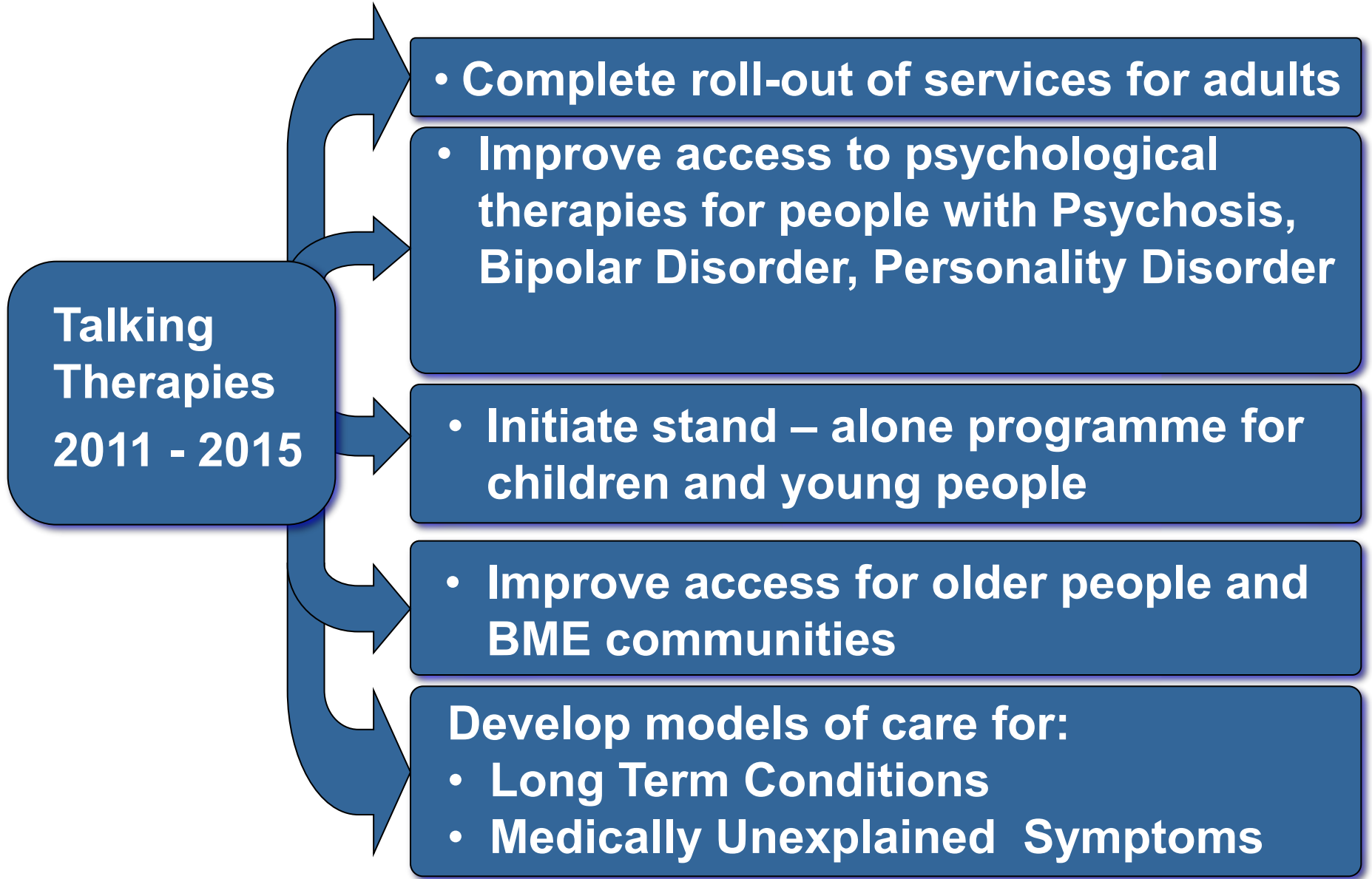
Outcomes

- improved access to evidence-based psychological treatments;
- improved mental health and wellbeing;
- more people with lived experience of these situations involved in leading the changes
- more people able to resume or start normal working lives

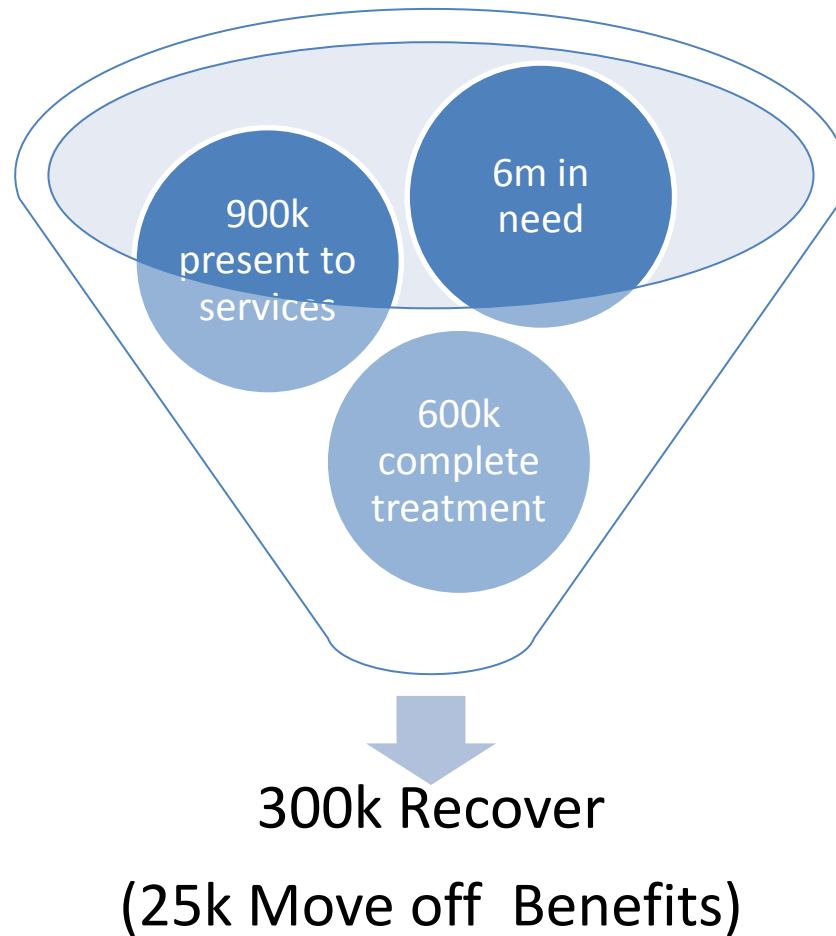
Benefits by 2015

- 3.2 million people able to equitably access effective therapies
- 2.5 million complete treatment
- 1.3 million helped to move to measurable recovery
- 75,000 get, retain a job, education, training or volunteer placement

Talking Therapies: four – year plan of action



Start Point & Planning Assumptions



Service Targets & Resources

SHA	Prevalence	2015 Entering Treatment (15% prevalence)
East of England	684,797	102,720
East Midlands	448,652	67,298
London	1,018,112	152,717
North East	330,385	49,558
North West	1,004,581	150,687
South Central	384,730	57,710
South East Coast	430,321	64,548
South West	613,546	92,032
West Midlands	568,463	85,269
Yorkshire & Humber	630,658	94,599
Totals	6,114,245	917,137

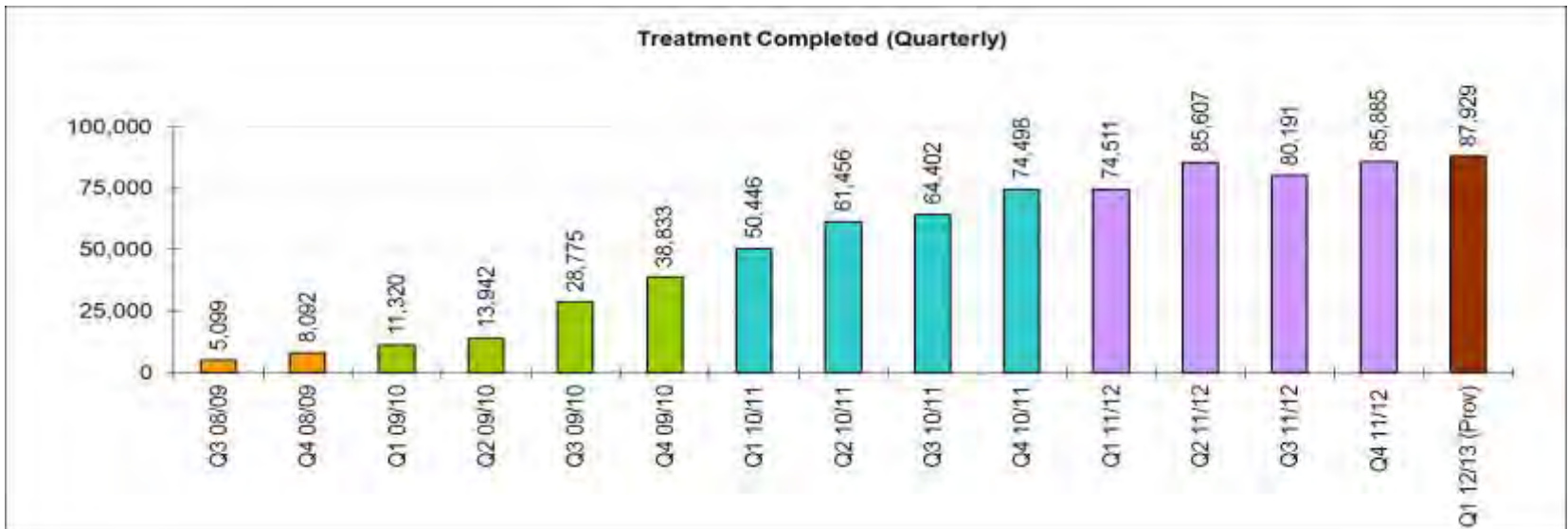
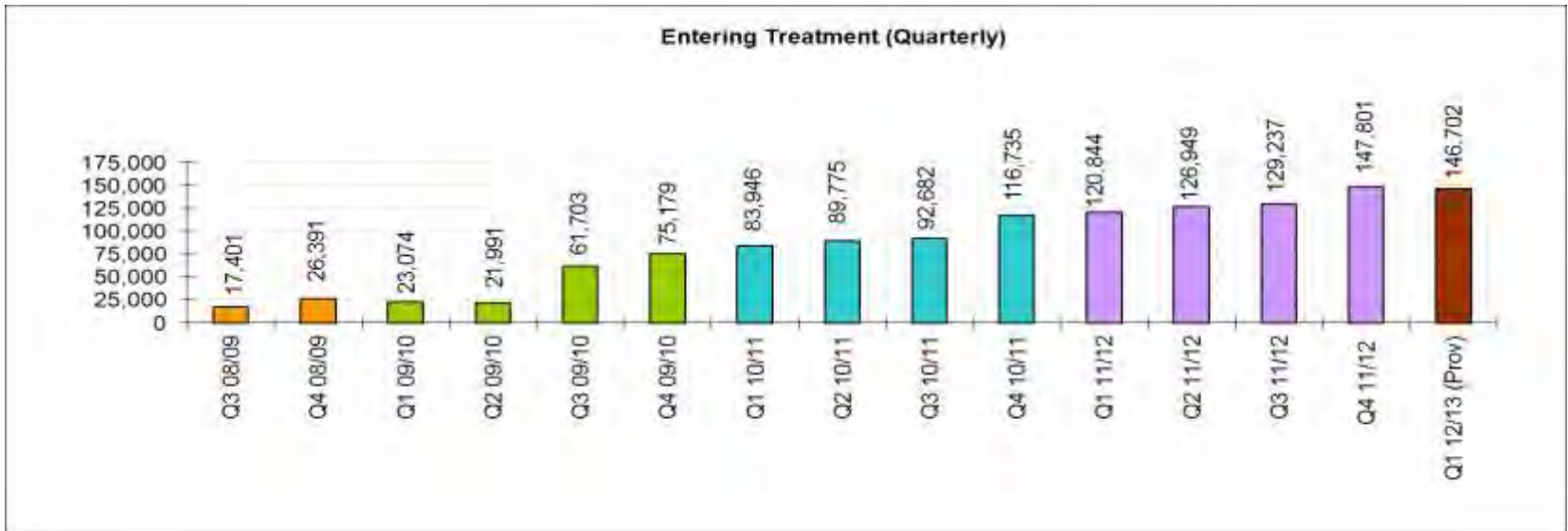
Performance Management

- NHS Operating Framework for 12/13
 - Access – full roll out by 2014/15 (BME & Older People)
 - Recovery – 50% in fully established services
 - Scope – SMI (inc PD) & LTCs

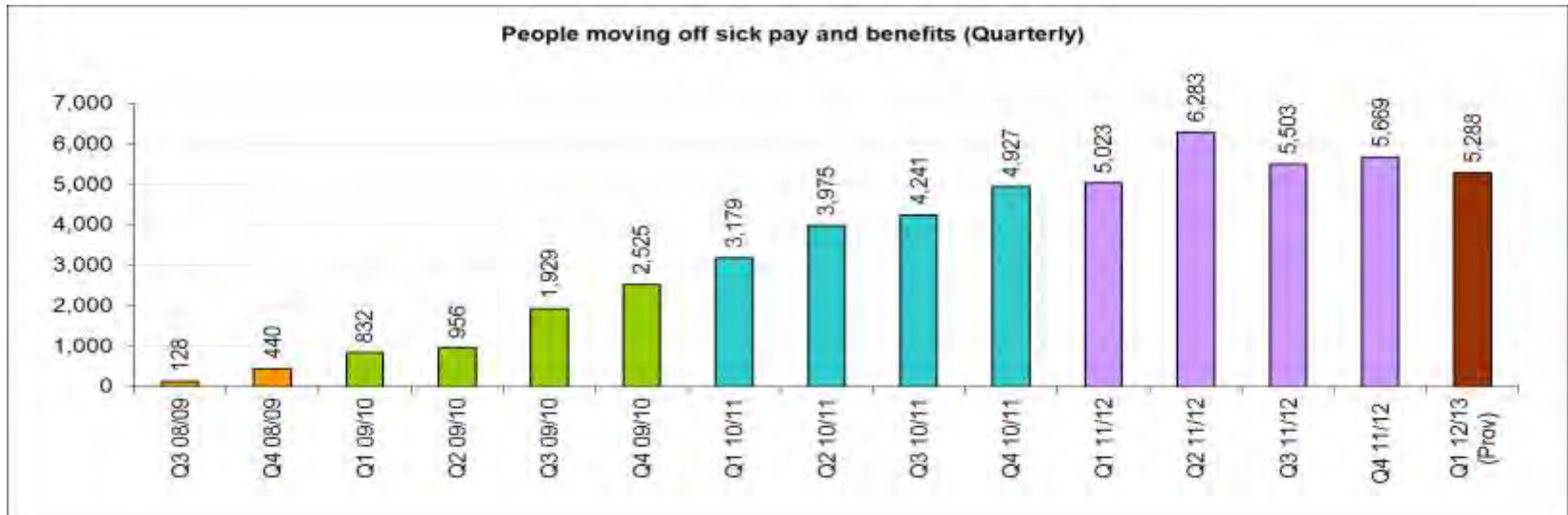
Performance Focus

- Incomplete KPI data is returned
- Access numbers below trajectories
- Treatment completers falls below 66% of those entering
- Recovery rates fail to improve
- Waiting lists increase

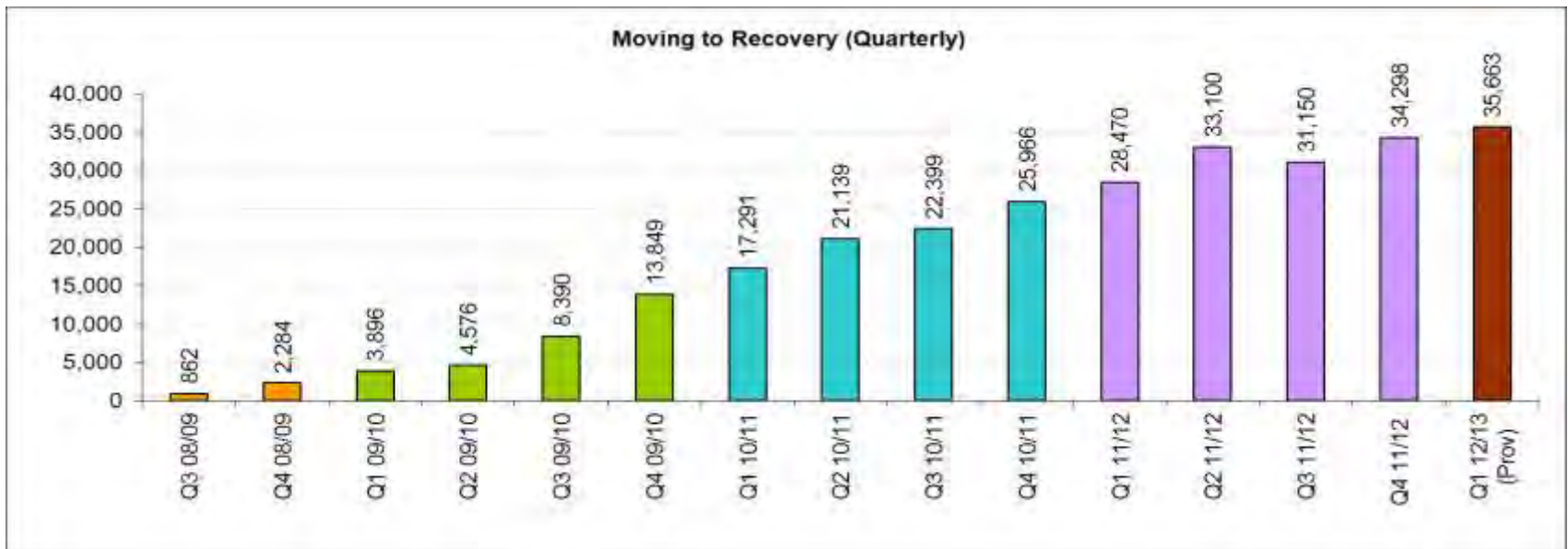
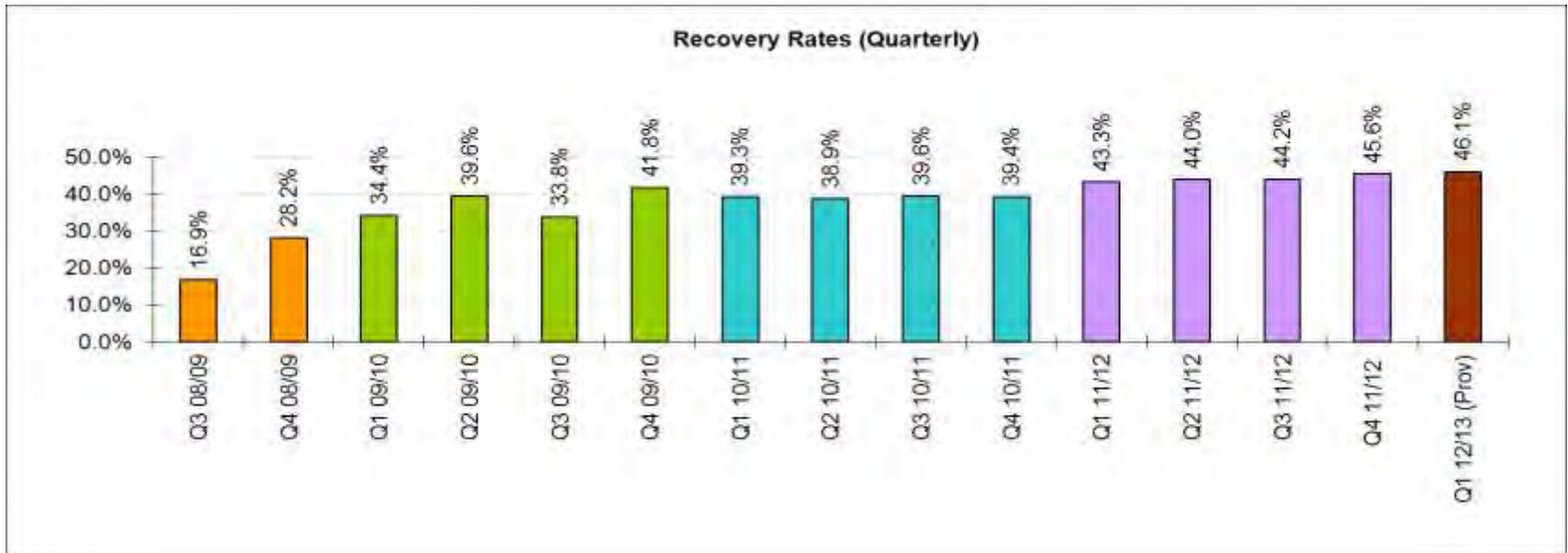
Performance – Q1 12/13



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Performance – Q1 12/13



National Training Summary Table

2011/13 (@ October 2012)

Training Type	2011/12		2012/13		Total	Deficit
	Expectation	Commissions	Expectation	Commissions		
HIT (High Intensity)	480 (79)	234 (57)	480 (150)	192 (113)	426 (170)	534 (59)
PWP (Low Intensity)	320 (247)	304 (232)	320 (300)	226 (177)	530 (409)	110 (138)
Counselling for Depression (CfD)	67	68	172	107	175	64
Couples Therapy for Depression (CTfD)	66	69	72	91	160	-
Brief Dynamic Interpersonal Therapy (DIT)	66	27	72	78	105	33
Interpersonal Psychotherapy (IPT)	66	82	80	113	195	-
Supervision	260	516	259	407	923	-
Total	1325 (326)	1300 (289)	1455 (450)	1214 (290)	2514 (579)	

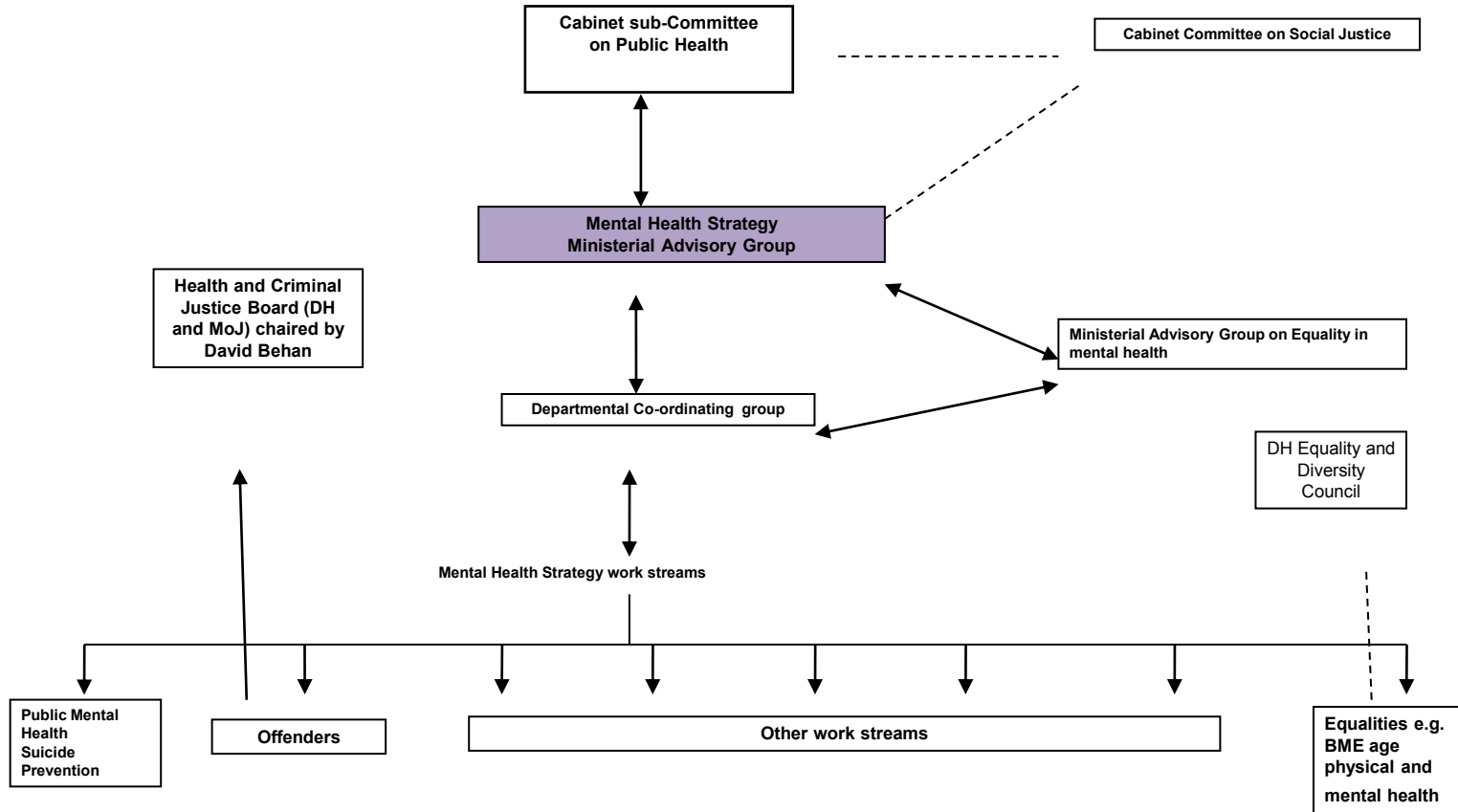
HIT and PWP numbers include both expansion trainees and replacement trainees. Replacement trainees appear in brackets

Resources Available

Policy	2011/12	2012/13	2013/14	2014/15
Completing roll out	43	88	133	133
Children & Young People Pilots	8	20	14	14
MUS/LTC Pilots	0	2	2	0
Total	51	110	149	147

Governance – MH Strategy

Mental Health Strategy Advisory Group



Improving Access to Psychological Therapies Programme Central Team 2012/13

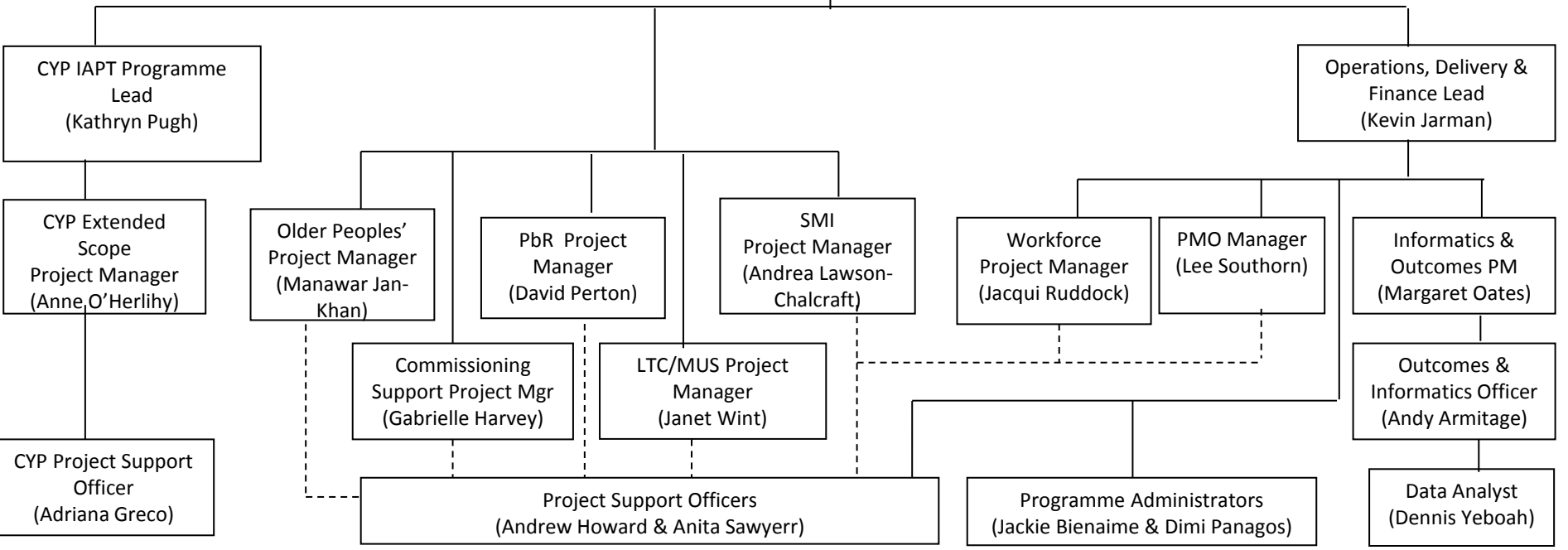
Programme Director – Kevin Mullins

National Advisors

CYP inc Additional Modalities – Peter Fonagy
 CYP Data & Informatics – Miranda Wolpert
 CYP Schools Counselling – Mick Cooper

Clinical Lead – David Clark
 Professional Lead – Jeremy Clarke
 LTC – Andre Tylee
 MUS – Rona Moss-Morris
 SMI – Alex Stirzaker, Alison Brabban
 Older People – Marie Claire Shankland

Workforce – Roslyn Hope
 Education & Training – Graham Turpin
 Data & Informatics – Nick McNulty



2012/13 IAPT Programme Outcomes; key products/activity areas

Outcome	<i>Projects/ activities 2011/12:</i>	Status	<i>Projects/ activities 2012/13</i>	Date
Embed IAPT to NHS performance frameworks to: •Make progress towards meeting 15% of need •Increasing workforce capacity and choice of modalities	1.Monitor PCT performance against Operating Framework ⁽¹⁾ 2.Continue to work with SHA/DH workforce colleagues to deliver MPET commitments <i>Primary Workstreams</i> •SHA IAPT Regional Leads •Workforce, Education & Training	Green Amber	Move focus of IAPT programme from DH to NHS CB and develop relationships with other parts of the new system, e.g. HEE and PHE Consolidate, re-fresh and develop focus of programme on achieving equitable access for particularly vulnerable groups via a specific workstream (Appendix 2a) Extend focus to include Older People Workstream developed by British Psychological Society	March 2013 March 2013 March 2013
Establish the IAPT data standard	1.Data standard implementation project, promote implementation of the standard in services 2.Use data to evaluate and shape future service design/delivery <i>Primary workstream: Outcome & Informatics</i>	Green Amber	Implement national reporting system based on IAPT Data Standard Issue next edition of the IAPT Data Standard based on PbR pilot site outcomes	April 2012 February 2013
Extending IAPT Scope	<u>LTC/MUS</u> - identify good practice through a review of current service models, including care pathways, patient centred assessment protocols, sessional outcome measures and KPIs. Agree processes for objective service evaluation and/or service pilots in order to promote service transformation <u>SMI</u> - establish consensus across a wide range of stakeholders on the costs and benefits of extending access alongside an assessment of potential service models. <i>Primary workstream:</i> New Projects Development Children & Young People (C&YP) - Progress identification and mobilisation of national collaboratives - including Higher Education Institutes and local services- to develop and test models of outcome based service delivery. <i>Workstream:</i> C&YP IAPT	Green Green Green	Issue best practice guidance in Long term conditions (LTC) and medically unexplained symptoms (MUS) Publish LTC / MUS costs calculator Develop competency framework for staff training in talking therapies for Severe mental illness Evaluate progress in collaboratives & extend phase 2 offer including additional collaboratives Finalise outcome measures for use in demonstration sites Finalise training and competency frameworks for CAMHS staff including additional modalities Progress service, professional and education accreditation proposals	Sept 2012 Sept 2012 Dec 2012 June 2012 Sept 2012 Nov 2012 Sept 2012
Commissioning IAPT Services	<u>Currency Development</u> - Use available IAPT performance metrics to determine the feasibility of aligning an outcome based PbR currency for psychological therapies with the main mental health clustering approach. Agree an outline currency model, data requirements and balance of quality incentives & outcome rewards. Pilot and evaluate the agreed approach across a broad range of services. <u>Commissioning Guidance</u> - Continue to work with SHA mental health leads, DH resources eg the National Choice Commitments Team re AQP on the development of the IAPT offer <i>Primary workstream:</i> Commissioning and provider development	Amber Green	Develop an outcomes based currency and pricing model for use across all psychological therapy services. Publish payment by results guidance for talking therapies Contribute to the development of an JCP/SHA Commissioning Pack and implementation plan	Ongoing March 2013 December 2012

Other work proposed for 2012/13

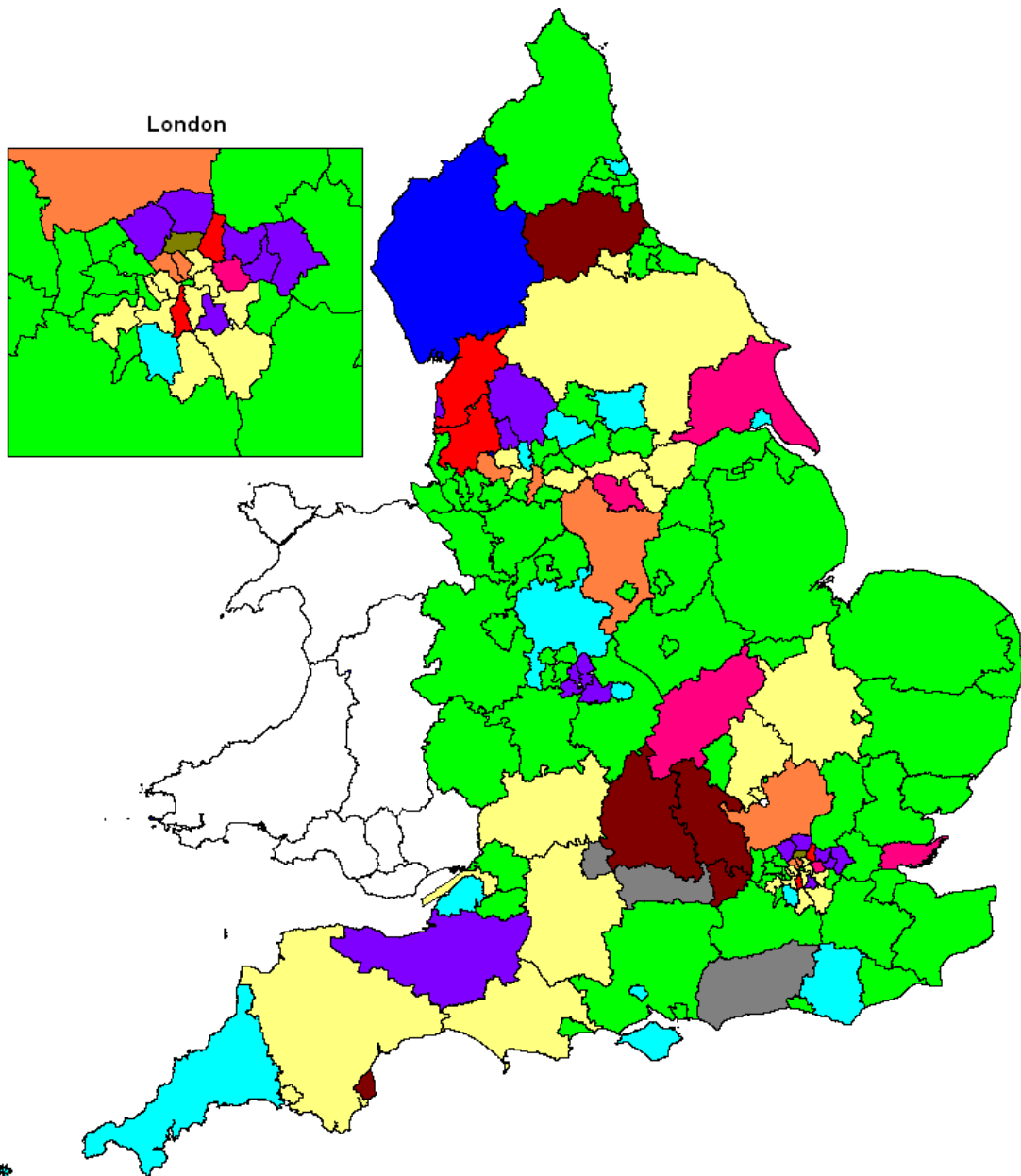
Older people's workstream

<ul style="list-style-type: none">•Publish a 'working with older people' module for existing IAPT training courses•Specialist older peoples module for supervision training.•Quality standards and commissioning guidance for commissioning services for older people•Revised outcome measures for older people•Engage with Alzheimers Society to extend psychological therapy to dementia carers•Engage with DH Dementia strategy team to verify approach to delivery of psychological therapies to those with early stage dementia	Sept 2012 Sept 2012 March 2013 March 2013 April 2012 April 2012
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Equalities

Publish revised positive practice (equalities) guidance	Dec 2012
Review and re-issue 'Being Fair. Including All- Equality Impact Assessment (EqIA) Guidance for Commissioners'	Dec 2012
Provide equalities guidance to workstreams	Ongoing
Review and implement actions from the EqIA for the Four Year Plan and the mental health strategy	Ongoing

Map showing PCT with IAPT Services & Projects



<u>KEY</u>
No IAPT Service
IAPT Service
IAPT Service + PBR
IAPT Service + LTC/MUS
IAPT Service + CYP
IAPT Service + SMI
IAPT Service + PBR + CYP
IAPT Service + PBR + SMI
IAPT Service + CYP + SMI
IAPT Service + CYP + LTC/MUS
IAPT Service + PBR + LTC/MUS + CYP
IAPT Service + LTC/MUS + CYP + SMI

Lessons Learned from Implementation

IAPT Minimum Quality Standards

Service Model:

- Services should offer a rigorous stepped care model as evaluations have found that services with a higher step-up among patients who had failed to recover from low intensity interventions had higher overall recovery rates.
- Services should have close links with employment advisors in order to realise improved non-clinical outcomes.
- Services should focus on relapse prevention in order to maintain and increase long term benefits of therapy including “top up” opportunities if required.
- Joint commissioning across services should allow for a seamless transition for patients to ensure patient satisfaction and clinical efficiency both between primary and secondary care services, and other organisations outside IAPT which offer step 3 and 4.
- Services should have a clear focus, capability and capacity to safely manage severe and complex cases, as these are the cases where the greatest clinical, and other returns, can be achieved.

Access:

- Services should focus on equity of access and ensure inclusion of marginalised groups, including older people, and those protected under the equalities act. This can be best achieved through regular analysis of care pathways and referral rates to identify and develop approaches to reduce inequalities affecting particular communities.
- Services should seek to expand self-referral in order to improve equity, clinical efficacy and outcomes as well as promote better access for different sectors of the community.
- In order to ensure effective patient choice and clinical engagement, multiple modes of delivery and choice of treatments should be offered including group telephone therapy and mobile phone communications.

Treatment:

- In order to provide effective and efficient clinical care, and in particular to provide NICE recommended and outcome focused treatments, service users should receive patient centered assessments (problems and goals, employment issues) plus a provisional diagnosis at intake.
- Treatments should be NICE recommended and evidence based as compliance is associated with better clinical outcomes eg:
- GAD and MADD patients who received CBT were more likely to recover than those who received other non-evidence based therapies.
- Psychological therapy treatments also have sustained benefits long term and patients are more likely to avoid relapse.
- In depression, guided self-help was associated with higher recovery rates than non-guided self help.
- If IAPT services offer pure self-help to patients with GAD they should ensure that the patients are followed up by the service and offered more intensive intervention subsequently needed.
- In order to optimise treatment outcomes, patients should receive an appropriate course of therapy with regular reviews of their progress.
- In order to optimise therapeutic alliances, patients should have treatment options and choice of therapy types discussed with them, and the final treatment course be made in consultation with both patient and therapist.
- Limited but consistent arrangements for follow up, eg. via primary care based “call and recall” systems, should be in place not only to continuously evaluate service and practitioner performance but also to support relapse prevention.

Outcomes Data Collection:

- In order to continuously evaluate the effective provision of services, a minimum of 90% data completeness should be achieved; pre and post treatment on all patients.
 - Clarifying and quantifying benefits of those who didn’t enter treatment and/or didn’t reliably recover (capture data around these & marry up with patient satisfaction).
 - In order to identify the full range of benefits achieved services should adopt the definition of “reliable recovery” as opposed to “caseness”.
- IT systems should enable therapists and service directors to have prompt access to outcomes data and to generate service reports.
- Routine outcomes data measurement should be used to improve service quality and accountability.
- Ensure IT systems are fully integrated.
 - To effectively operate a stepped care service it is essential that patients can be tracked through the full stepped care pathway; normally this means having an inter-operable IT system.

Staff and Training:

- As services with a higher proportion of experienced therapists have higher overall recovery rates, staff should be suitably trained and accredited by BABCP or other appropriate accreditation organisations.
- Staff should use IAPT accredited training providers.
- Therapists (trained and trainees) should receive appropriate outcomes informed regular supervision in order to maintain standards, problem solve and identify training and other issues.
- Services should provide education and training of staff and in particular support succession planning.
- Staff turnover should be monitored eg via “exit interviews” in order to ensure that any negative reasons are identified and addressed.
- In order to support equitable access and other factors services should aim to develop a balanced workforce in relation to local needs i.e. in terms of not only skill mix but also clinical background, gender, ethnicity etc.
- Services should have therapists trained to deliver both high intensity and low intensity treatments to ensure patients with more complex presentations of anxiety and depression are not excluded.
- Experienced therapists should maintain contact with some patients who only have mild and moderate symptoms to ensure their skill set is maintained [\[1\]](#)MCS

Lessons Learned from Implementation IAPT Minimum Quality Standards

- Direct Benefits
 - Service Model:
 - Access:
 - Treatment:
 - Outcomes Data Collection:
 - Staff and Training:
- Indirect Benefits
 - Supporting Behaviour Change:
 - Impacting on Key Public Health Outcomes:
 - Supporting a Life Course Approach:
 - Improving Health & Well Being of Those Recovering from Mental Illness:
 - Focus on Health Improvement Data:

Risks & Opportunities

- Mandate & Outcomes Framework(s)
- Commissioning Structures & Transition
- Information Standard Notice Implementation
- Payment By Results
- Any Qualified Provider
- Quality Innovation Productivity & Prevention
- Education & Service Commissioning