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Improving Access to Psychological Therapies



IAPT Programme Review

December 2011

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1. Introduction

The Improving Access to Psychological Therapies (IAPT) programme was set up in May 2006 and funded by CSR2007. It aims to improve public access to a range of NICE-approved psychological therapies for depression and anxiety disorders through:

- provision of an appropriately trained workforce,
- delivering therapies to specific quality standards,
- routine monitoring of patient reported outcome measures,
- defined care pathways (characterised by a stepped care model) and
- flexible referrals routes (including self-referral by potential patients).

One in six adults is known to suffer from mental ill-health characterised by symptoms of depression and anxiety. The programme aims to expand access by treating 900,000 people per annum (15% of prevalence), with over 50% of those completing treatment recovering and most achieving reliable improvement with a smaller proportion achieving improved employment or social outcomes.

In line with Ministerial commitments, detailed SR2010 announcements, and the publication of *No health without mental health*, the programme aims to extend the benefits of improved access to talking therapies to a wider range of groups:

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

In parallel, the programme will aim to complete the roll out of IAPT services for adults, ensuring equitable access for under-represented groups such as older people from black and minority ethnic communities, and aiming to confirm sustainable implementation of services to cover 100% of the population. There are also requirements in related policy areas to support implementation of payment by results for talking therapies and developing services to meet the needs of particular groups such as military veterans.

Scoping work has been initiated using expert reference groups to cover the new practice domains (LTCs, MUS and SMI). This will lead to the adaptation of relevant IAPT quality standards, for example clinical (e.g. outcome measures and competency frameworks) and organisational (e.g. referral routes and funding streams), with implementation guidance to follow. New workstreams and governance arrangements are anticipated in order to secure benefits (across the NHS) related to full roll out and any new practice domains. The programme's governance structures will effectively integrate with the Ministerial Advisory Group which oversees delivery of *No Health without Mental Health*, and associated DH oversight arrangements. Programme workstream activities will also be organised to work effectively with the Department's QIPP, Choice and PbR workstreams.

The programme workplan will also include activities to support transition of the programme to the new architecture to be enacted following assent of the Health & Social Care Bill (2011).

2 Programme Outline

2.1 Programme Purpose

The **aims** of the IAPT programme as set out in the 'Four year Plan of Action'¹ are to:

- Complete the roll out of IAPT services, and
- Expand access to IAPT in specific areas of need, where talking therapies have been estimated as an efficient and effective aid to patient recovery²

2.2 Programme Objectives 2011/12

Objectives for 2011/12 include:

- 'Hardwire' IAPT quality standards (Appendix A) into DH and NHS performance management frameworks, including the NHS Operating Framework for 2011/12.
- Provide guidance and support to regional teams and other NHS and non-NHS colleagues to deliver the objectives of IAPT in the NHS Operating Framework 2011/12
- Produce plans to assure equitable access to IAPT services for the adult population and through service transformation extend access for children and young people, for people with severe and enduring mental health problems and for people with "Medically Unexplained Symptoms" and/or co-morbid mental and physical health long-term conditions
- Update the IAPT service model and associated quality standards, with a particular focus on care pathway development guidance (especially relevant to new practice domains), workforce integration, routine outcome measurement and reporting (including deployment of the IAPT Data Standard), and commissioning and employment support.

Established programme quality standards provide a framework for continuing delivery of IAPT and for expansion to the new practice domains.

The programme will continue to promote defined quality standards for IAPT service delivery in performance management, regulatory and commissioning systems, of the DH, NHS and external bodies such as CQC.

Current performance management frameworks include³:

1. Operating framework; measures and controls agreed with DH Performance management and reporting team, to monitor the development of PCT plans, baselined to performance data provided by IAPT central team Q2 2010.
2. Programme KPIs designed to measure progress in delivery of programme benefits and also used to support operating framework commitments in 2011/12.
3. Inspection regimes of the Care Quality Commission (CQC) and Monitor;

¹ 'Talking Therapies: A four-year plan of action'; DH, February 2011.

² *Impact Assessment of the expansion of talking therapies services as set out in the Mental Health Strategy*, IA No 7026, 24/01/11

³ 'Performance Management Framework', IAPT Programme Board paper, March 2011:

4. Commissioning and monitoring policies and controls of the NHS Commissioning Board.
5. Outcomes frameworks: NHS Operating Framework and Outcomes Framework 2012/13, Public health and other outcomes framework as relevant to the IAPT programme in its expanded form

2.3 Programme Benefits

A range of benefits have been shown from delivery of talking therapies using IAPT principles and quality standards. These are summarised in the Impact Assessments for the Plan of Action, and Mental Health Strategy, the latter citing potential benefits from extended roll out to people with MUS, SMI and specific LTCs. The value of benefits will be measured using established key performance indicators (KPIs). These are based on numbers of patients moving through IAPT services and rates of recovery.

Work will be undertaken in 2011/12 to extend the KPIs to cover new practice domains and so measure the value and progress in rolling out IAPT-configured talking therapies to specific groups of people. The core data set (The 'IAPT minimum data set') will be extended in support of programme KPIs. The IAPT Data Standard provides an infrastructure for capturing the minimum data set using automated processes. The Data Standard will greatly enhance the efficacy of data in IAPT for patients, commissioners and the programme, strengthening the basis for measuring benefits of service delivery and providing an objective basis for understanding service configuration. The Data Standard will be deployed by April 2012, by which time implementation across all IAPT services should be possible.

3. Planning Assumptions

3.1 Morbidity Estimates

In consultation with SHA colleagues and a range of expert opinion the DH central IAPT team has agreed an annual minimum "run rate" for a mature national IAPT service of 900,000 patients receiving treatment. This is based on the assumption that in any given health economy of 100 people with depression or anxiety only 50 will seek treatment, of these only 25 will be diagnosed and of these 80% with anxiety and 68% with depression will opt for a psychological therapy. In broad terms therefore this represents 15% of the total estimate of 6m people with common mental health disorders.

It is recognised that this is an overall estimate and will need to be reviewed particularly as the scope of the programme extends to Children and Younger People, those with long term conditions, medically unexplained symptoms and people with severe and enduring mental illness.

3.2 Service Targets & Milestones

Each SHA in England has agreed a share of the overall estimated numbers who should be entering treatment. This is indicated in the table below based on relative deprivation and assumed prevalence.

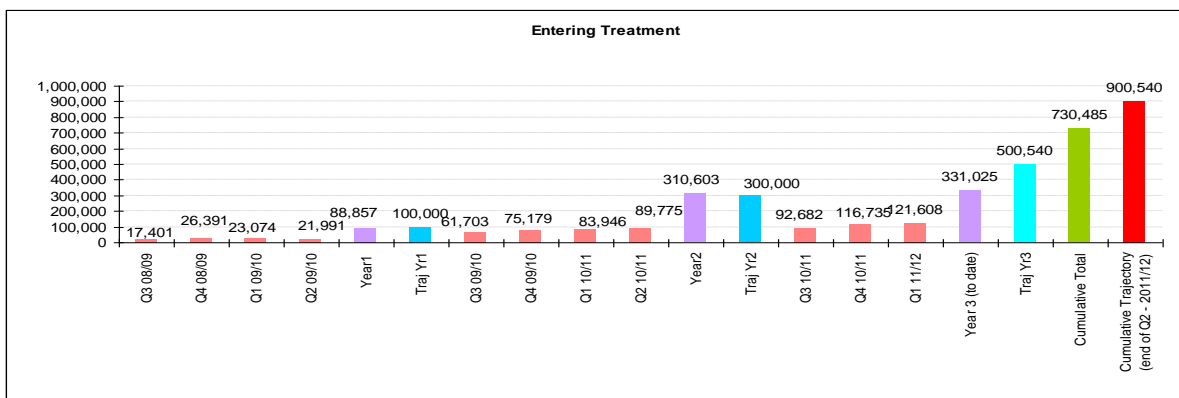
SHA	Prevalence	2015 Entering treatment	2015 Completing treatment	2015 Recovery Rates	2015 Moving off Sick Pay & Benefits
East of England	684,797	92,509	61673	30836	2570
East Midlands	431,814	75,619	50413	25206	2101
London	1,018,112	137,683	91789	45894	3825
North East	330,385	51,179	34119	17060	1422
North West	1,004,581	133,390	88927	44463	3705
South Central	411,454	61,432	40955	20477	1706
South East Coast	448,619	70,020	46680	23340	1945
South West	613,546	86,310	57540	28770	2398
West Midlands	568,463	97,363	64909	32454	2705
Yorkshire and Humber	620,772	94,495	62997	31498	2625
Totals	6,132,543	900,000	600,000	300,000	25,000

The table also provides an outline of the remaining key targets that can be projected based on data collected to date:

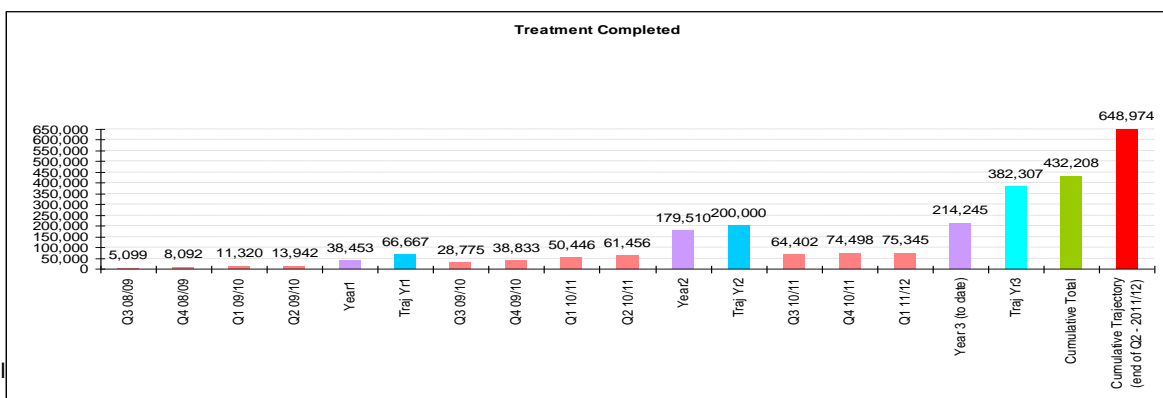
- Completing treatment – 66% of those entering treatment (estimated from KPI returns 2008/09- 2010/11 -to be reviewed for 2012/13)
- Recovery rates – 50% of those completing treatment
- A proportion of the national total of individuals moving off sick pay and benefits

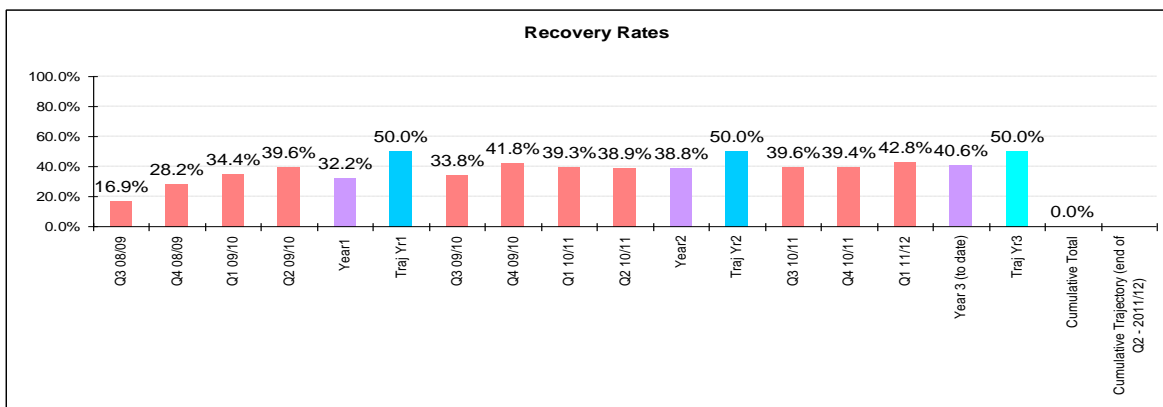
3.3 Current Performance

A summary of the latest performance at Q1 of 2011/12 is indicated below. National numbers accessing treatment are at agreed trajectory levels although substantial variation both at SHA and PCT levels is evident alongside increasing waiting times and in the case of 6 PCTs no IAPT service was operational in the quarter.

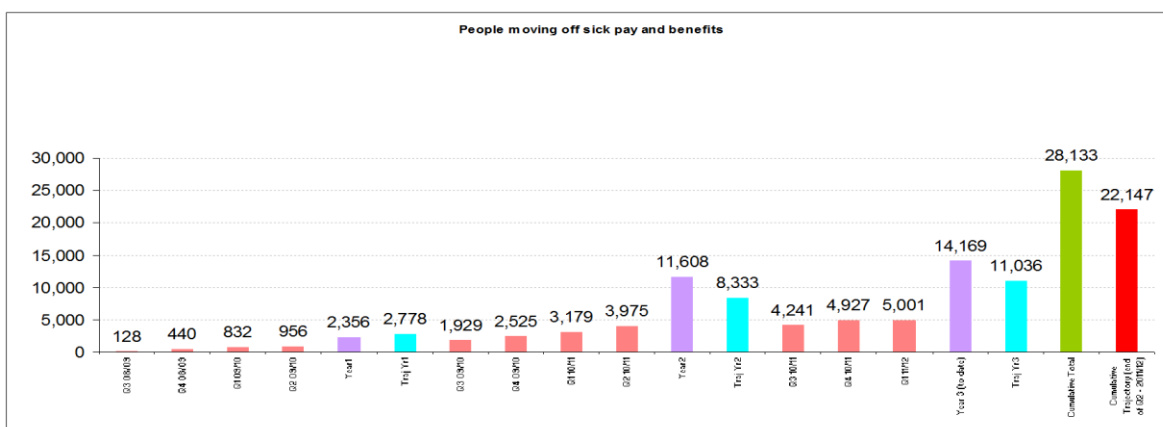


The numbers of individuals completing treatment appears to be stalling and it looks likely that the Yr 3 target for the programme will not be reached.





On the other hand a “step change” is evident in the rates of individuals achieving recovery., Whereas this figure had remained below 40% for the previous 7 quarters, a rate of 42.8% was achieved.



Further positive progress is evident in the reduction of those claiming benefits and the target of 25,000 people has already been achieved for the first phase of the programme.

Variations in performance and clarification including recovery plan development and implementation is being addressed in partnership with the DH Performance Delivery Team via the SHA and IAPT regional structures.

3.4 Developing performance frameworks

From Q1 2011/12 IAPT KPIs will be used to support the NHS Operating Framework. Two IAPT indicators are included in the NHS Operating Framework to measure improvement in;

- The proportion of people entering treatment against the level of need in the general population, and
- The proportion of those entering treatment against the number referred.

It is expected that SHA IAPT teams responsible for monitoring performance against the Operating Framework will, with the support of the IAPT central team, look to identify PCTs where:

- Incomplete KPI data is returned
- the numbers entering treatment fails to improve in line with planned trajectories
- the numbers entering treatment consistently falls below 60% of referrals
- Other causes for concern arise, for example in recovery rates

In addition to compliance with agreed performance trajectories the central IAPT team also intends to support SHAs in making progress by using the Operating Framework for 2012/13 and other aspects of the overall performance framework for example:

1. Inspection by The Care Quality Commission (CQC) and Monitor; expected to assume regulatory roles from October 2012
2. Commissioning and monitoring policies and controls developed by the NHS Commissioning Board subject to amendments to the Health Bill and resource allocations.
3. Outcomes frameworks particularly the NHS Outcomes Framework 2012/13

As another means of support to SHAs the DH central team has commissioned a number of related pieces of work supported by the NHS Confederation MH Network, & other agencies focusing for example on system levers. Connections are also being made at national level with the development of Payment by Results for Mental Health, the Choice Commitments team with regard to the Any Qualified Provider (AQP) initiative and also the Quality, Innovation, Productivity and Prevention (QIPP) programme.

3.5 Workforce Targets & Milestones

In order to fully support services providing care to 900,000 people, in the region of 6,000 additional therapists are estimated as being required. By mid-2011 around 3,600 new therapy workers will have completed their training. Further funding is available in 2011/12, via the national Multi-Professional Education & Training (MPET) arrangements. Training plans are currently in development for 11/12 and the present position is indicated below:

Table 1: New CBT trainees for 2011/12

SHA	HI	PWP	TOTAL	EXPECTED	DIFFERENCE
East Midlands	9	19	28	66	- 38
East of England	8	16	24	83	- 59
London	52	35	87	123	- 36
North East	16	12	28	45	- 17
North West	57	51	108	117	- 9
South Central	25	40	65	56	+ 9
South East Coast	40	25	65	63	+ 2
South West	7	46	53	78	- 25
West Midlands	32	35	67	86	- 19
Yorkshire & Humber	5	5	10	82	- 72
Total	251	284	535	799	- 264

Table 2: Replacement CBT trainees ('turnover')

SHA	HI	PWP	TOTAL
East Midlands	22	17	39
East of England	27	28	55
London	6	15	21
North East	26	16	42
North West	5		5
South Central	12	34	46
South East Coast	3	9	12
South West	11	26	37
West Midlands	4	10	14
Yorkshire & Humber	20	25	45
Total	136	180	316

Table 3: Non-CBT trainees

SHA	Couple Therapy for Depression	Counselling for Depression	DIT (Brief Dynamic Interpersonal Therapy for Depression)	IPT (Interpersonal Psychotherapy for Depression)	Supervisor Training Places
East Midlands	2	5	5	13	67
East of England	5	5	5	5	60
London	24	0	15	15	90
North East	0	0	0	22	74
North West	5	10	5	10	49
South Central	12	35	9	20	78
South East Coast	2	0	3	10	15
South West	8	11	4	15	40
West Midlands	6	2	2	2	20
Yorkshire & Humber	5	5	1	20	60
Total	69	73	49	132	553
Target	60	60	60	60	260
Variance	9	13	-11	72	293

The establishment and retention of an effective workforce is crucial to the success of the IAPT programme. It is of concern that at this stage, for 2011/12, excluding replacement posts, current plans do not reconcile to the overall requirements for a net increase in the workforce. . It is also of concern that in some cases there appears to be divergence in service and education commissioning strategies with the potential for newly trained therapists not being able to secure employment in future IAPT services.

These matters are being addressed through routine SHA liaison meetings.

4. Resources Available

In addition to baseline funds for the initial programme of £173m as part of CSR2007, as noted above in CSR 2010 over £400m has been prioritised against this policy area. The largest proportion of these funds has been included in PCT baselines. An assumed distribution of these funds to the programme overall is included below but it should be noted that actual spend in each year is determined at local level.

Policy	2011/12	2012/13	2013/14	2014/15
Completing roll out of IAPT	43	88	133	133
Talking therapies for children and young people	8	8	8	8
Piloting talking therapies for those with MUS/LTCs	2	tbc	tbc	tbc
Total	53	96	141	141

A break out of these funds for 2011/12 indicates:

- Further training & education commissions - £32m
- PCT costs associated with employment support - £11m

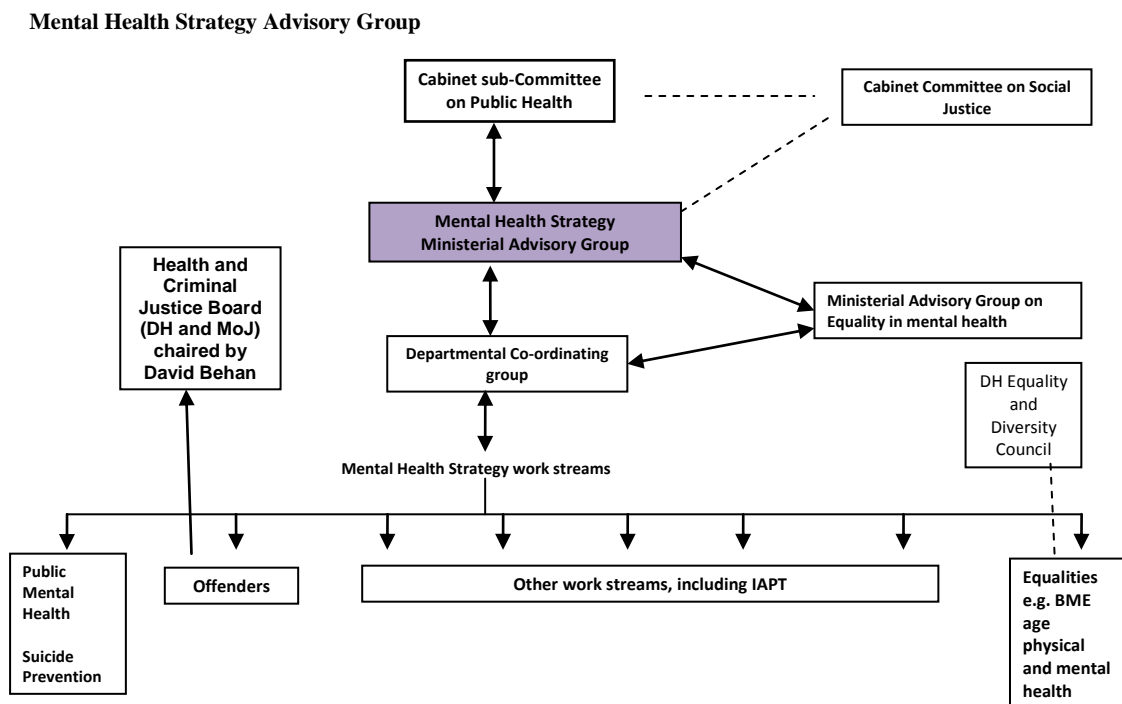
In addition for 2011/12 only, within the SHA “bundle” provision is made for:

- IAPT Central Team Costs - £1.5m
- SHA IAPT Team & other costs - £3.5m

The figures for the remaining financial years of the current CSR are not confirmed. The workplan for subsequent years of the 4 Year Plan of Action will be devised in light of progress, funding bids and resource availability

5. Programme Plan & Governance

The IAPT programme is a key workstream in the implementation of the national Mental Health Strategy – *No Health without Mental health*. The programme governance arrangements sit within the context of the overall governance for implementation of the wider strategy as indicated below.



For IAPT an overall Programme Board oversees the activities of the programme and ensures alignment with the wider corporate agenda within the directorate, other parts of DH and Government. An executive (more operational) role is taken by members of the Programme Management Group for adults. Responsibility for the Children & Young People’s IAPT project is assumed by an Expert Reference Group. Revised governance structures are shown at Appendix B. Proposed terms of reference and membership for the Programme Board and Programme Management Group are available separately.

The following management roles have been defined in the transition structure for the IAPT central team:

- National Programme Director
- Finance, Operations and Delivery Lead
- Programme Management Office Manager

The above will form a Senior Management Team within the central team to provide overall leadership to the programme with support from other resources e.g. in finance, analytics, communications or other resources as required.

Key outcome areas for the programme with indicative status as at October 2011 are set out below:

Outcome	Projects/ activities:	Status
Embed IAPT in NHS performance frameworks	<ol style="list-style-type: none"> 1 Contribute to development of the NHS Operating Framework for 12/13, emergent Commissioning Outcome Framework and SoS Mandate 2 Establish relationships with the NHS Commissioning Board and agree transition arrangements/timescale 3 Establish clear performance data flows with the Information Centre, relationships with the DH Performance Delivery Team and Workforce policy team & use effectively to assure service & workforce commissioning delivery <p><i>Primary workstream: IAPT SMT</i></p>	Amber
Establish the IAPT data standard	<p>In partnership with SHA leads assure compliance by individual services with the revised Information Standards Notice including encouraging early adoption in advance of 2012/13</p> <p><i>Primary workstream: Informatics</i></p>	Amber
Extending IAPT scope	<p><u>For 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</p> <p><u>For 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.</p> <p><i>Primary workstream: New Projects Development</i></p> <p><u>For Children & Young People (C&YP)</u> - Progress identification and mobilisation of national collaboratives - including Higher Education Institutes and local services- to develop and test models of outcome based service delivery.</p> <p><i>Workstream: C&YP IAPT (standalone programme)</i></p>	Green
Payment system for talking therapies	<p><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.</p> <p><u>Any Qualified Provider</u> - Continue to work with the National Choice Commitments team on the inclusion of primary care psychological therapies</p> <p><i>Primary workstream: Commissioning and provider development</i></p>	Amber

The programme will be delivered via two main groups of workstreams as follows:

- Main Workstreams

- Completing Roll Out – including ensuring equitable access for older people, BME communities
- Long Term Conditions, Medically Unexplained Symptoms, Severe & Enduring Mental Illness (New Projects Development)
- Children & Young People
- Supporting Workstreams
 - Workforce
 - Informatics & Outcomes
 - Commissioning ie currency development and AQP
 - Communications – tbc
 - Employment - tbc

A number of project management roles have been identified within the central team paired in most cases with National adviser posts as follows:

- The Finance Operations & Delivery Lead will have responsibility for workstream activities involved in the delivery of the main adult programme to full roll out. This will require very close working with SHA IAPT, Mental Health & Education Commissioning colleagues to ensure good practice in securing effective roll out is identified, analysed and shared and poorer performance addressed.
- The PMO lead will have responsibility for assisting in the design of individual workstreams, monitoring overall progress, identifying and reporting variations and supporting project managers in planning and implementing remedial actions.
- The New Project Development Lead will have responsibility for co-ordinating expansion of IAPT to people with Long Term Conditions, Medically Unexplained Symptoms and Severe Mental Illness.
- The Children & Young People project seeks to improve access to talking therapies for CAMHS service users (tiers 2 and 3) and others under 18. The project will seek to apply IAPT quality standards to the CAMHS operating environment to facilitate the delivery of suitable therapeutic interventions, and will assist in the clarification of referral routes for those under 18 needing access to talking therapies.
- The Commissioning & Provider Development Manager will have a particular focus on developing the PBR pilot proposals and rolling these out to services as a potential outcomes based alternative currency. This should promote enhanced choices of psychological therapy provision through extension of Any Qualified Provider procurement. This post-holder will also update commissioning guidance in order to emphasise the savings that effective delivery of IAPT can produce in the health and wider economies.
- The Workforce & Education project manager will undertake specific project work and activities to promote adherence to clear quality standards in workforce development planning. The key stakeholder is likely to be the Centre for Workforce Intelligence.
- The Outcomes and Informatics project manager will lead on KPI data collections and validations, IAPT Data standard implementation and support KPI development and outcome measurement for the extension in IAPT scope. Status reports against programme KPI trajectories will be produced in the informatics workstream.

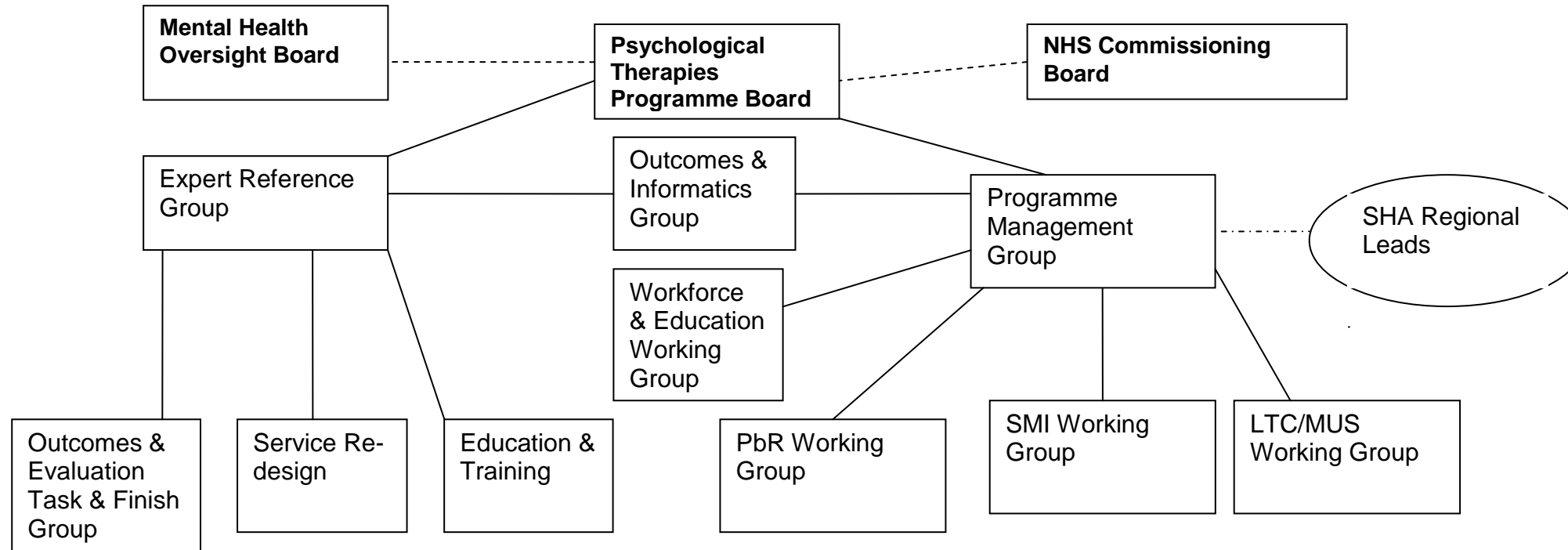
Appendix A- IAPT Headline Quality Standards

IAPT is a set of service quality standards that the existing programme continues to promote and will look to establish in the NHS including:

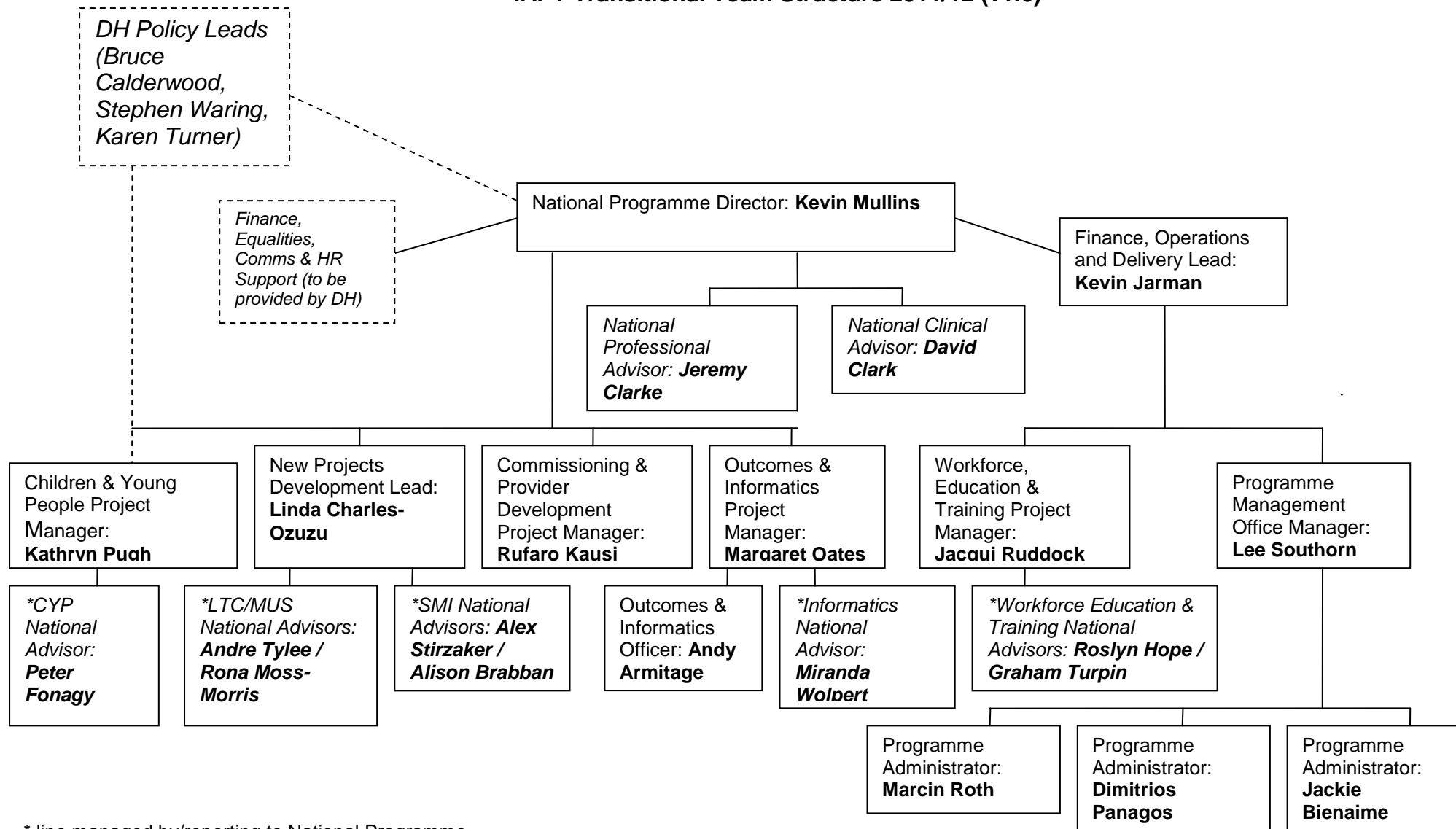
- I. NICE guidance for the treatment of depression and anxiety in a stepped care model (and associated development of appropriate pathways),
- II. The sessional collection of patient reported outcomes and adherence to the IAPT Data Standard, building the evidence base and informing service improvement
- III. The development of a suitably qualified, accredited workforce.
- IV. Universal equitable access, referring to IAPT outcome metrics, local analyses of the impact on equalities, IAPT workforce capacity tool, and Joint Strategic Needs Assessments (covering common mental health problems).
- V. Agreed referral and access protocols which define the scope of a service, stepped care protocols and waiting list policy
- VI. Integrated employment support interventions

The above standards are subject to regular review in the light of service evaluation. Programme KPIs and other measures are structured to measure performance against key quality standards. KPIs for 2011-12 relate to access and throughput, recovery rates, and impact on employment outcomes.

Appendix B: IAPT Programme Governance 2011/12



IAPT Transitional Team Structure 2011/12 (v1.6)



* line managed by/reporting to National Programme Director
 IAPT Programme Review December 2011 v2.1 September 2011

