# Planning for delivery in 15/16 for the Dementia and IAPT Ambitions

24th March 2015

## Welcome to the planning WebEx: Dementia and IAPT delivery in 2015/16

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- If you don't receive a call back via the WebEx system call: 0800-9171950, using participant code 436 997 52
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## Agenda

1. Introduction
2. The ambition for 2015/16 and its measurement
3. Key headlines from 2015/16 plans
4. Expectations of commissioners
5. Tools and support

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# Dementia

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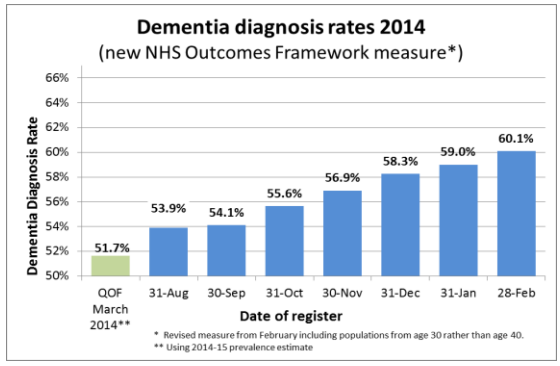
# Current performance

The national dementia diagnosis rate as at **end-February was 60.1%,** compared to 59.0% at end-January; an increase of 1.1 percentage points in a month




In the last 6 years, dementia diagnosis rates have increased **annually** between **1.5 and 3.5 percentage points**.

The rise in diagnosis rate to 60.1% is a continuation of the trend in **monthly increases ranging from 0.7 to 1.5** percentage points since September 2014.

An additional 7,388 people were added to dementia registers in the last month, with the count of additional diagnoses needed to reach 66.7% (diagnosis gap) falling from 51,815 at end-January to 44,427 people at end-February.

At the end of February there were an estimated 405,985 people recorded on dementia registers.



# Tools and support

A range of actions, support tools developed and commissioned by the central support team to support dementia diagnosis rates in 14/15.

| Tools and support | Description | Proposed action in 15/16 |
|---|---|---|
| **Monthly letter to CCGs** | Letter to CCGs communicating diagnosis rates per practice, register to diagnosis gap benchmarked at local area level. It also highlights support available to practices. | Regular communications to CCGs on diagnosis rates and other metrics will continue in 15/16. |
| **Harmonisation of clinical records**- tools developed to enable cleansing of GP registers but who do not currently appear on the Dementia QOF, supported by CSU and pro-active call centre. | **Dementia Quality Toolkit** (DQT): The DQT consists of a series of reports and queries run directly on GP systems to identify patients who may have dementia.<br>**Secondary Uses Services** (SUS): The provision of secondary care data (SUS) to GP practices, for cross checking of clinical records to update their dementia registers, estimated to add an additional 20 diagnoses per practice.<br>1964 (34.5%) DQT downloads<br>3179 (40.4%) of SUS secondary care data downloads. | The DQT will remain available to practices to download from the North of England Commissioning Support Unit (NECS) website. Practices may continue to run automated (DQT) and non-automated searches to update GP practice dementia QOF register. Call centre will be discontinued after end of March. |
| **Dementia Identification Scheme Enhanced Service** | • A scheme consolidating all tools and initiatives for case finding with an additional requirement for case finding in care homes. **Recent estimates of uptake by CCGs is at 5569 (70.8%).** | To be discontinued after the end of March. |
| **Recovery actions:**<br>• **Intensive support to high risk CCGs**<br>• **Dementia recovery plan returns** | Returns to the central support team to enable tracking of progress of recovery actions and further support actions required. | To be continued by regions as appropriate. |
| **Dementia Ambassadors** | A network of clinicians providing specific clinical advice, targeted support, tools and resources and work closely with regional teams and strategic clinical networks. | A review of the intensive support teams across MH and the provision of dedicated clinical support to the NCD is underway. |
| **Additional Alzheimer's Society Support** | Provision of support in some CCGs areas which includes public awareness activities, supporting diagnosis in care homes and improving post-diagnostic support with more Dementia Advisers. | Will continue. |

# What is the standard?

The planning guidance states that an increase in the dementia diagnosis rate to **66.7 percent** should be **achieved by March 2015, and sustained through 2015/16**.

**The work to improve the care of people with dementia and their carers should continue for everyone** and not just those practices who have already achieved a two-thirds diagnosis rate.

A timely diagnosis enables:

- people living with dementia, and their carers/families to access treatment, care and support, and to plan in advance in order to cope with the impact of the disease.
- primary and secondary health and care services to anticipate needs, and working together with people living with dementia, plan and deliver personalised care plans and integrated services, thereby improving outcomes.

The 15/16 plans will be based on the new method of estimating dementia prevalence (CFASII).

The initial CCG15/16 plans are showing that:

- The majority of CCGs are planning to start the year in April 15 with a diagnosis rate of at least 66.7 and maintain this throughout the year to the end of March 2016.
- There are a few CCGs (10) who are achieving diagnosis rates at a level of at least 5% above the ambition who are in effect planning to underachieve through next year as we move to maintain the ambition level.
- A number of CCGs (44) anticipate starting below 66.7%, of which 4 are forecasting that this will not improve by March 2016.

Based on the most recent data for 2014/15:

- 43 (27%) CCGs are already achieving the ambition with recovery actions in place for 51 CCGs.

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# Prevalence estimation in 15/16: CFAS II

The second Cognitive Function and Ageing Study II (CFASII) is a UK Medical Research Council study of the prevalence of dementia in individuals aged 65 years and older in three geographically defined areas of England.

CFAS II is considered the most accurate information currently available to estimate the number of people who need dementia care. There has been extensive consultation with clinicians and key stakeholders, which heard the overwhelming majority agreeing that CFAS II had considerable advantages over the Delphi consensus estimates in the Alzheimer's Society reports.

Monitoring of CCG dementia diagnosis rates in 2014-15 will continue to be against the Delphi 2007 prevalence estimates as set out in the planning round at the start of 2014. From 1st April 2015 we will use the CFAS II estimates of dementia prevalence and these will form the basis of 2015-16 dementia diagnosis rates for planning and monitoring purposes. When we require dementia prevalence estimates for people aged under 65, we will use the 2014 Delphi prevalence estimates for people aged 30 to 64.

In all 209 CCGs the estimated prevalence in 2015-16 will be lower than in 2014-15 (under the NHS Outcomes Framework measures); the 2015-16 prevalence estimate is lower than the current DPC estimate in 194 CCGs. The size of the fall in any particular CCG will depend on the local demographic mix and the amount by which the total list size exceeds the size of the local population.

**Dementia prevalence and diagnosis rates under different studies**

(dementia registers as at end-February 2015):

| Study | Notes | Prevalence Estimate | Register | Diagnosis Rate |
|---|---|---|---|---|
| Alzheimer's Society 2007 | (2014-15 NHS OF measure) | 675,617 | 405,985 | 60.1% |
| Alzheimer's Society 2014 | | 702,734 | 405,985 | 57.8% |
| CFAS II (65+) & AS 14 (30-64) | | 644,119 | 405,985 | 63.0% |
| CFAS II (65+ only) | (2015-16 measure) | 624,278 | 384,427 | 61.5% |

Estimate of people aged 65+ on dementia registers

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# Expectations of commissioners

- Achieve and maintain the National Ambition that 2/3 of people with dementia have a diagnosis and provide a focus on access to post diagnostic support throughout 2015/16.
- Delivery priorities for 2015/16 include maintaining and improving access to memory services and ensuring that care plans (including advanced care plans) are used to support post diagnostic care.
- The focus will be improving health services to people with dementia in regards to **post diagnostic support**, in the following areas in particular:
  - Risk reduction
  - Care homes
  - End of life care
  - Mild cognitive impairment
  - New models of care
  - Focus on particular patient groups
  - General hospital admissions
  - Antipsychotic use

To support delivery a suite of economic evaluations which will inform the 5-year transformation implementation plan that will deliver good post-diagnostic services across England. This will form part of the next steps following from the publication of the National Mental Health Plan, due to be published in Summer 2015.

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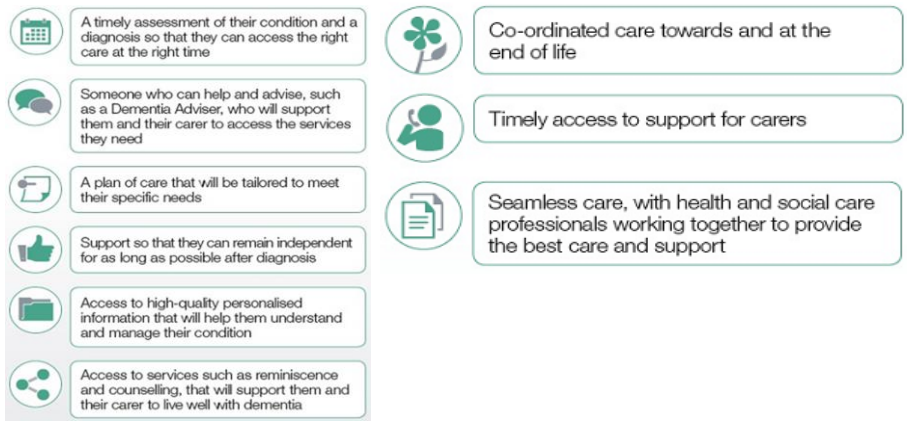
# The vision for post diagnostic support

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# Questions

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# IAPT

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# What is the standard?

1. **Maintenance of IAPT access and recovery ambition**

**IAPT access**

In 2015/16 assessment will be based on a run rate of at least 3.75% of the local prevalence of people with common mental health conditions entering psychological therapy services in each quarter of 2015/16.

**IAPT recovery**

Maintenance of at least the recovery rates achieved at the end of 2014/15. Ongoing improvement is anticipated where a rate of less than 50% was achieved.

2. **IAPT waiting times**

- 75% of people referred to the Improved Access to Psychological Therapies programme to be treated within 6 weeks of referral
- 95% to be treated within 18 weeks of referral



# Key headlines from 15/16 plans

**Maintaining the IAPT access and recovery ambition**

The initial CCG plans submitted for 2015/16 show that:

- The vast majority of CCGs (198) are planning to start with a run rate of 3.75% per quarter and maintain this throughout the year.
- 11 plan to start with a lower run rate, 5 which will not improve by March 2016.

Based on the most recent data for 2014/15:

- A number of CCGs are **already achieving** the IAPT access (**54** CCGs) and recovery rate (**57** CCGs) ambitions.
- There are a number of CCGs forecasting that they are unlikely to achieve the 3.75% access rate (48 CCGs) and the 50% recovery rate (70 CCGs) in Q4 2014/15; recovery plans are in place for this group of CCGs.

# Expectations of commissioners

Achieve sustainable delivery of IAPT access and recovery rates by ensuring the following has been considered:

| Key Issues | Considerations |
|---|---|
| 1. Has the necessary investment been made? | Between £58 and £64 per head of CMHD prevalence is required to achieve 15% access and 50% recovery and is based on these assumptions:<br>- An average of around 6 sessions of therapy at, combined Step 2&3,<br>- 20 clinical contact hours delivered per WTE therapist per week<br>- 20% overheads<br>The IST capacity and demand checker: http://www.england.nhs.uk/wp-content/uploads/2014/04/capacity-model-checker-iapt.xls |
| 2. Is the service productive? | -Are there sufficient staffing levels matched to planned activity?<br>-Are commissioned IAPT services maximising clinical contact hours?<br>-Are the full range of NICE compliant treatment options being deployed?<br>e.g. on-line therapy, a range of group therapies, all NICE recommended modalities. |
| 3. Are there sufficient referrals? | - Are referral rates sufficient to deliver 3.75% access rates each quarter taking into account known attrition rates? **Nationally 35% of patients referred do not enter treatment.**<br>- Are referral rates being monitored at GP practice level?<br>- Is there a clear marketing strategy to increase referrals including simplified access, maximising older people access and self referral routes?<br>- Is the waiting list being effectively managed? There is good evidence that long waiting lists suppress referrals. |
| 4. Recovery rates and case mix | Ensure the following:<br>-The IAPT service provides for mild to moderate as well as moderate to severe anxiety and depression<br>-Fidelity to NICE guidance –treatment appropriate for the presenting conditions without a cap on dosage<br>-Severe enduring mental illness (Clusters 5 and above) are managed on appropriate pathways which can include IAPT brief therapy<br>-Maintain a focus on individual therapist outcomes so that patient outcomes are maximised at all times |
| 5. Reliable data reporting and submission | -Does the local data match with the HSCIC national data?<br>-Are all NICE compliant IAPT activity within the CCG area being captured? (e.g. primary care based counselling)<br>Are there ongoing data reporting/submission issues in the services provided in the CCG area? |

# Prevalence estimation in 2015-16

Prevalence has been locally determined in CCG annual plan since 2013-14.

A national guidance table is available based on the 2000 APMS Census converted from PCT/CCGs and adjusted nationally for 2006 population changes.

**Key points**:
The advantage of locally determined prevalence is the ability to make local adjustments for population changes and CCG boundary changes, making the prevalence more 'current' and meaningful than the 2000 survey.

The expectation is NOT that CCGs carry out a survey of their own, but that they extrapolate local prevalence from the national Psychiatric Morbidity Survey 2000 as part of their needs assessment.

Any adjustments CCGs make need to be fair and honest so that the needs of the local population are met. There is a responsibility for all affected CCGs involved to agree gains and losses so that the overall prevalence for the wider area remains at least in line with the 2000 APMS.

Further guidance can be found at:
http://www.england.nhs.uk/wp-content/uploads/2014/03/prevalence-cmd.pdf

# Prevalence adjustments

Example of potential unmet need within a CCG area:

| CCG | Tool (National - 2000APMS) | CCG Declared Prevalence 14/15 | Prevalence Variances 14/15 | Tool (National - 2000APMS) | CCG Planned Prevalence 15/16 | Prevalence variances 15/16 |
|---|---|---|---|---|---|---|
| CCG1 | 85539 | 79345 | -6194 | 85539 | 75508 | -10031 |
| CCG2 | 25136 | 25136 | 0 | 25136 | 28934 | 3798 |
| CCG3 | 34027 | 34027 | 0 | 34027 | 34027 | 0 |
| CCG4 | 54406 | 54406 | 0 | 54406 | 54406 | 0 |
| CCG5 | 21645 | 21645 | 0 | 21645 | 21645 | 0 |
| CCG6 | 28833 | 28833 | 0 | 28833 | 28833 | 0 |
| CCG7 | 29277 | 29277 | 0 | 29277 | 29702 | 425 |
| | | | | 278864 | 273055 | -5809 |

Example of appropriate prevalence adjustments made within a CCG area:

| CCG | Tool (National - 2000APMS) | CCG Declared Prevalence 14/15 | Prevalence Variances 14/15 | Tool (National - 2000APMS) | CCG Planned Prevalence 15/16 | Prevalence variances 15/16 |
|---|---|---|---|---|---|---|
| CCG1 | 10276 | 10276 | 0 | 10276 | 10276 | 0 |
| CCG2 | 29274 | 29482 | 208 | 29274 | 29482 | 208 |
| CCG3 | 36356 | 36356 | 0 | 36356 | 36356 | 0 |
| CCG4 | 26011 | 25803 | -208 | 26011 | 25803 | -208 |
| CCG5 | 37913 | 37913 | 0 | 37913 | 37913 | 0 |
| | | | | | | 0 |

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# New: IAPT waiting times standard

# What is the standard?

IAPT is to be the **first mental health** mandated waiting standards to be introduced:

- 75% of people referred to the Improved Access to Psychological Therapies programme to be treated within 6 weeks of referral
- 95% to be treated within 18 weeks of referral

It is being introduced in shadow form in15/16 with the expectation of full implementation from 16/17 and will be monitored over the next financial year with delivery expected in Q4 2015/16 and thereafter.

The standard applies to patients finishing a course of treatment (completing 2+ treatment appointments).

Measurement from receipt of referral to entering first treatment. Monitoring is expected of all patients (including single sessions).

A number of additional measures will be captured in national reports to guard against the introduction of perverse incentives into local commissioning arrangements.

Patient-initiated delays will not be taken into consideration when calculating the IAPT indicator. Tolerances have been built into the IAPT standard to allow for such delays.

Further guidance can be found as follows:

- Technical indicator definitions can be found in the Forward view into action 2015/16 http://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf
- Frequently asked questions (FAQs) can be accessed via the Unify system.
- Improving Waiting times for Psychological Therapies (IAPT) Guidelines and FAQs, http://www.england.nhs.uk/2015/02/13/mh-standards/

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# Expectations of Commissioners

Commissioners will need to agree service development and improvement plans (SDIPs) as part of their 15/16 contract with providers setting how they will prepare for and implement the new standards during 2015/16 and achieve these on an ongoing basis from 1 April 2016.

CCGs will be also be required to submit plans setting out how they will meet the new waiting time standards. These will be monitored throughout the year with compliance assessed in the final quarter of 2015/16.

From the initial submissions CCGS are planning to meet the IAPT access waiting times overall, with planned performance currently showing that in Q4 15/16:

- 78.2% will be achieved for the 6 week wait.
- 98.3% will be achieved for the 18 week wait.

The following actions are required when planning delivery of the waiting time standards:

- A good understanding of the sustainable position i.e. the run rate, number of referrals and number of opt ins / first treatments to achieve at least 15% of prevalence accessing the IAPT service(s)
- The necessary capacity to deliver the run rate (3.75% each quarter), should be funded with performance monitoring and contract levers put in place to ensure that volume of patients is being delivered, separate from any discussion on clearing backlogs.
- Agree with providers the backlog to be cleared that will achieve the national waiting standards i.e. the reduction in numbers waiting for first treatment (incomplete pathways) with time scales, and identify whether this will be achieved within existing resources or requires additional funding.
- **NOTE OF CAUTION: At first glance very few CCGs have made the connection between reducing backlog and access rates that will ensure sustainability in their plans**

**NHS England is considering how the £10m implementation fund will be used** 1). Waiting list validation i.e. activity to confirm the accuracy of current waiting lists, 2). Additional or enhanced capacity i.e. in order to provide assessments / treatments, 3) transformation support

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# Tools and Support

- A range of recently recorded WebEx's are available on request, addressing key issues which are often the cause of underperformance in meeting the IAPT ambition.
- Support will continue through Strategic Clinical Networks and emerging IAPT Leadership Programmes.
- Commissioner only workshops to SCN/regions that request it in March/April and will cover:
  - Good commissioning for IAPT
  - Good practice (e.g. older people, social marketing)
  - Investment and Sustainability
  - Contract performance management
  - PbR Next Steps
- Support for the delivery of new waiting standards, embedding an understanding of bottom up capacity and demand modelling and waiting list management.

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# Questions

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