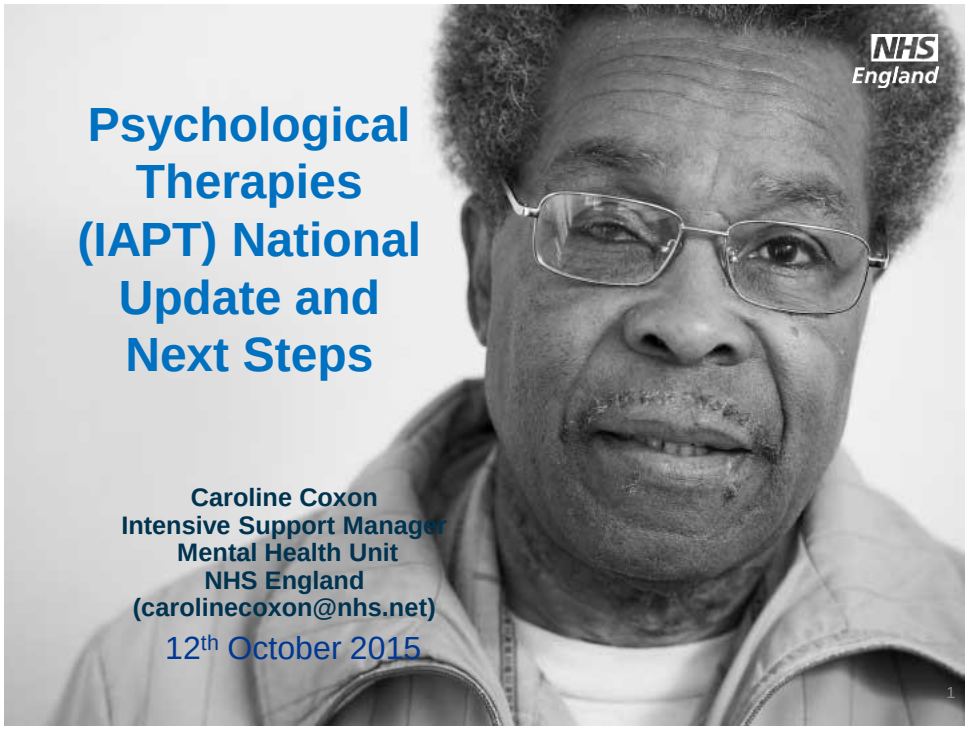


NHS Mandate – 2015/16

3.9 …….extending and ensuring more open access to the Improving Access to Psychological Therapies (IAPT) programme, in particular for children and young people, and for those out of work, and to continue planning for country wide service transformation of children and young people's IAPT. NHS England will work with stakeholders to ensure implementation is at all times in line with the best available evidence. NHS England will maintain the commitments that at least 15% of adults with relevant disorders will have timely access to IAPT services, with a recovery rate of 50%. In addition, NHS England will ensure that by March 2016, 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.

Referrals and Access

Achieving and Sustaining Access Rates

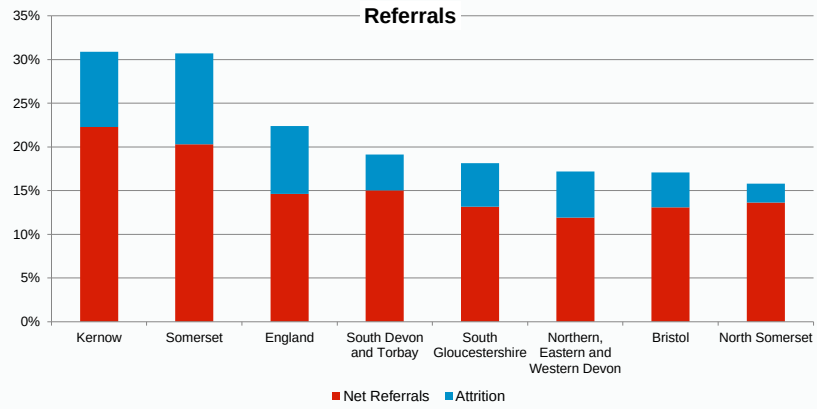
Q: Are your referral rates sufficient to deliver 3.75% access rates each quarter taking into account known attrition rates?

- Nationally 35% of patients referred do not enter treatment.
- CCGs may not have sufficient referrals (net of attrition rates)
- Evidence suggests that long waiting lists suppress referrals and in particular keep out the mild to moderate anxiety and depression.

Q: Do you have a clear longer term strategy with immediate priorities and a marketing plan which include:

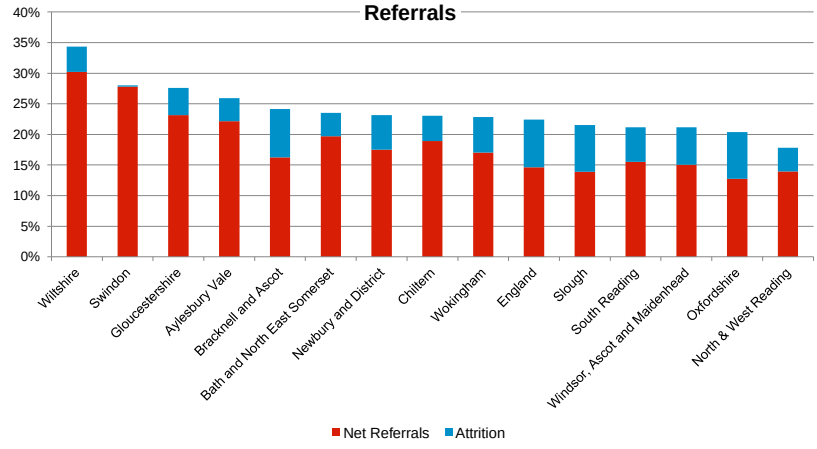
- Simplified access and self referral routes
- Truly primary care and not medically led
- Links with physical health
- Early intervention and valuing the benefit Step 2 therapy can make to wellbeing of the population including specialisation of PWPs
- Maximising older people access and BME Access

Referrals – South West



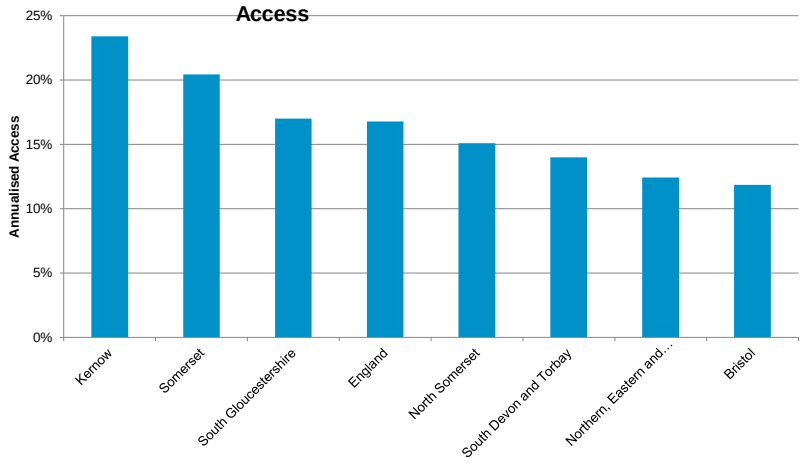
Source HSCIC June 2015 IAPT data.

Referrals – South Central



Source HSCIC June 2015 IAPT data.

Access Rates – South West



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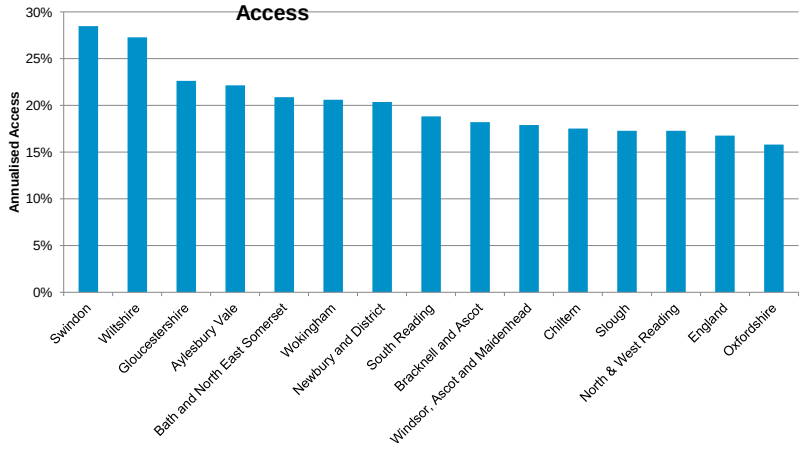
Access Rates – South Central



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South West - Summary

Commissioner	Referral Rate	Attrition	Self Referrals	Access
England	22.4%	34.7%	44.6%	16.8%
Bristol	17.1%	23.3%	89.6%	11.9%
Kernow	30.9%	27.9%	67.5%	23.4%
North Somerset	15.8%	13.6%	65.2%	15.1%
NEW Devon	17.2%	30.8%	72.6%	12.4%
Somerset	30.7%	33.8%	35.6%	20.4%
South Devon and Torbay	19.1%	21.3%	81.5%	14.0%
South Gloucestershire	18.1%	27.5%	87.5%	17.0%

Source HSCIC June 2015 IAPT data.

South Central - Summary

Commissioner	Referral Rate	Attrition	Self Referrals	Access
England	22.4%	34.7%	44.6%	16.8%
Aylesbury Vale	25.9%	14.7%	50.7%	22.1%
Bath and North East Somerset	23.5%	16.3%	91.3%	20.9%
Bracknell and Ascot	24.1%	32.8%	50.8%	18.2%
Chiltern	23.1%	18.0%	63.0%	17.5%
Gloucestershire	27.6%	16.1%	32.0%	22.6%
Newbury and District	23.2%	24.4%	63.4%	20.4%
North & West Reading	17.8%	21.9%	71.9%	17.3%
Oxfordshire	20.4%	37.4%	67.5%	15.8%
Slough	21.5%	35.3%	62.7%	17.3%
South Reading	21.2%	26.7%	71.1%	18.8%
Swindon	28.0%	0.8%	92.5%	28.5%
Wiltshire	34.3%	12.0%	88.0%	27.3%
Windsor, Ascot and Maidenhead	21.1%	28.8%	63.5%	17.9%
Wokingham	22.8%	25.5%	70.6%	20.6%

Source HSCIC June 2015 IAPT data.

Recovery and Reliable Improvement

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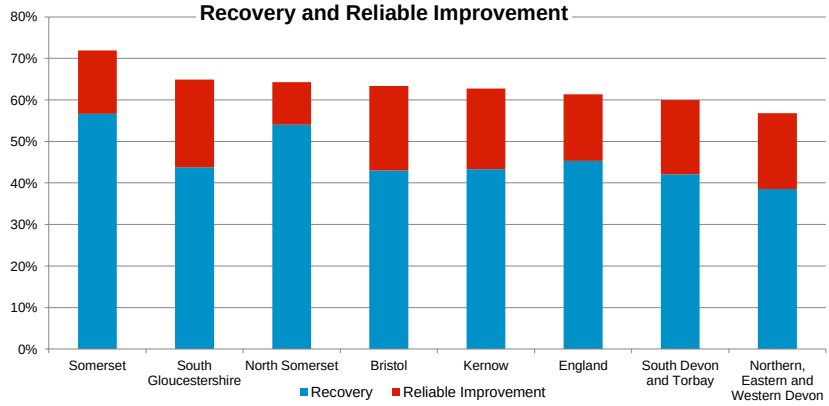
Recovery and Reliable Improvement

- For 2015-16 the KPI is the 50% Recovery.
- However, Reliable Improvement is also important as they measure different things and services need to understand how their performance varies from the national average on both.
- Commissioners and providers need to understand through sound audits or root cause analysis why the recovery rate is not being reached so that the cause can be addressed.
- On reliable improvement, services below average equally need to be understood through audits why high numbers of patients do not show reliable change/improvement.

Recommendations

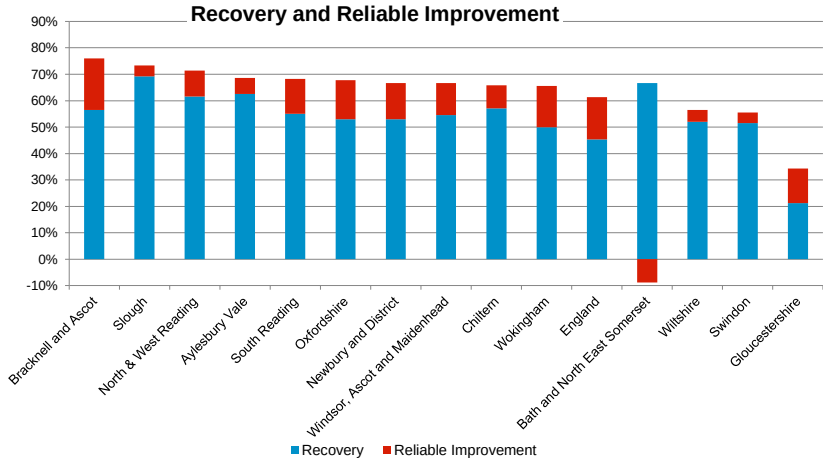
- Monitor both together at all times
- Data, data, data
- Make the link between presenting condition/diagnosis during treatment, NICE guidance for that condition and therapy offered
- Understand outcomes by Step, by Team, by modality, by therapist
- Offer choice of therapy by commissioning the full range of NICE Recommended modalities so that it meets the needs of your population

Outcomes – South West



Source HSCIC June 2015 IAPT data.

Outcomes – South Central



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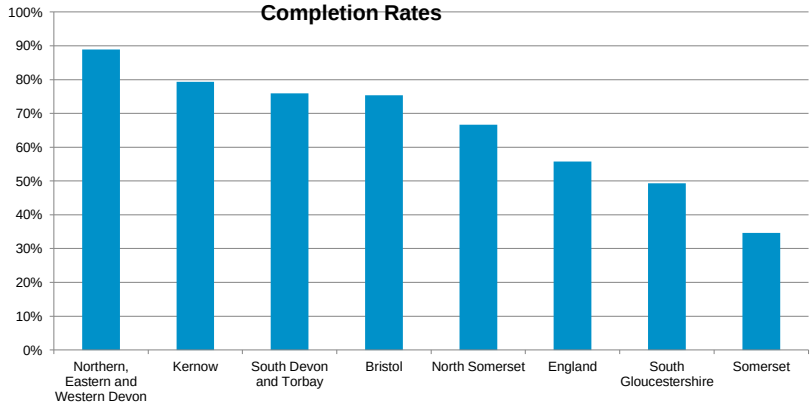
Source HSCIC June 2015 IAPT data.

Completion Rates – South West



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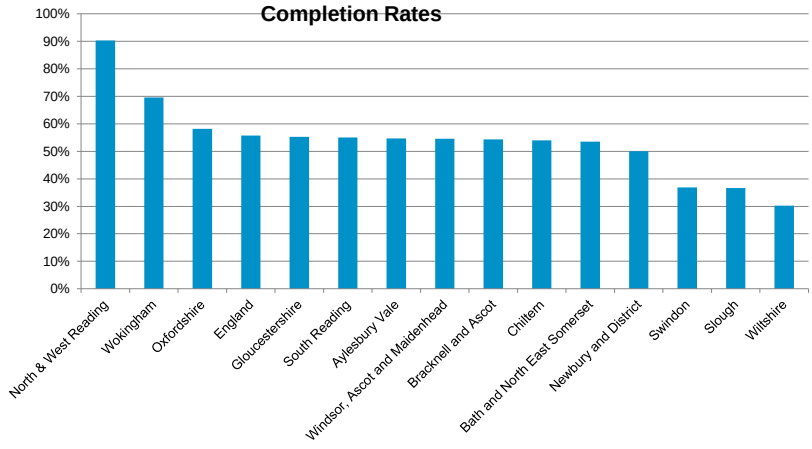
Source HSCIC June 2015 IAPT data.

Completion Rates – South Central



Source HSCIC June 2015 IAPT data.

Summary – South West

Commissioner	Recovery	Reliable Improvement	Completion Rate
England	45.3%	61.4%	55.7%
Bristol	43.0%	63.4%	75.4%
Kernow	43.3%	62.8%	79.4%
North Somerset	54.1%	64.3%	66.7%
Northern, Eastern and Western Devon	38.5%	56.8%	88.9%
Somerset	56.7%	71.9%	34.6%
South Devon and Torbay	42.1%	60.0%	75.9%
South Gloucestershire	43.8%	64.9%	49.3%

Summary – South Central

Commissioner	Recovery	Reliable Improvement	Completion Rate
England	45.3%	61.4%	55.7%
Aylesbury Vale	62.5%	68.6%	54.7%
Bath and North East Somerset	66.7%	57.9%	53.5%
Bracknell and Ascot	56.5%	76.0%	54.3%
Chiltern	57.1%	65.9%	53.9%
Gloucestershire	21.2%	34.3%	55.2%
Newbury and District	52.9%	66.7%	50.0%
North & West Reading	61.5%	71.4%	90.3%
Oxfordshire	53.0%	67.7%	58.1%
Slough	69.2%	73.3%	36.6%
South Reading	55.0%	68.2%	55.0%
Swindon	51.5%	55.6%	36.9%
Wiltshire	52.0%	56.5%	30.2%
Windsor, Ascot and Maidenhead	54.5%	66.7%	54.5%
Wokingham	50.0%	65.6%	69.6%

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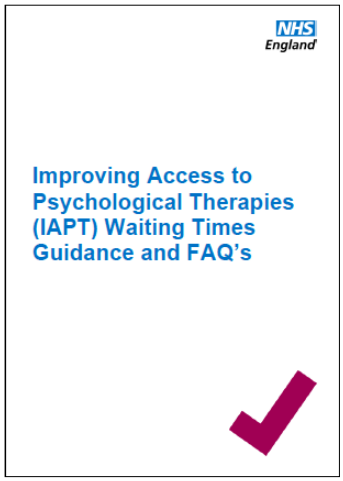
Waiting Standards

Improving Access to IAPT – Waiting Times



Measurement of the standard

- Guidance was published on 20 February to support measurement of the new waiting time standard.
- The new national indicators will measure waiting times from referral date to the start of a course of treatment – i.e. for those people who have two or more treatment sessions.
- Local areas will also be required to capture and monitor waits from referral to first treatment appointment for all people who enter the service and this should include people who receive a single treatment session.
- 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.
- A number of additional measures will be captured in national reports to guard against the introduction of perverse incentives into local commissioning arrangements

• The waiting time standards calculations and FAQs can be found at:
http://www.england.nhs.uk/wp-content/uploads/2015/02/iapt-wait-times-guid.pdf

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IAPT Waiting List Funding

£2M Bids allocated pro rata to all CCGs irrespective of long waits that was used for waiting list validation or process improvement

£6M Allocated for Waiting List Initiatives.

- Bids received from 147 CCGs
- A thirds of CCGs described long waits to first treatments
- Two thirds are already meeting the national waiting standards but described long waits for 2nd or subsequent treatments
  - 12 CCG - mean wait of over 20 weeks at step 3
  - Longest waits reported were over 6 months (50 CCGs) but were over 12 months for 2 CCGs
- 90 CCGs were supported

Central resource available to support local programmes that develop Leadership and Transformation skills; Good Waiting List Management; Capacity& Demand Training; Analytical reporting Skills(aimed at team leader, service managers, analysts)

IAPT Waiting List Initiative Learning

- Lack of Clarity on Costs- both commissioner and provider spend and how this relates to each other
- Many Providers with emerging secondary (hidden) waits
- Some CCGs were over-reliant on their providers for information on identifying gaps in services and where the backlogs are
- Lack of clarity about the real 'size of the problem'
- Some commissioners lacking understanding about pathways, Access and Flow through the service
- Some commissioners acknowledging reliance on their provider(s) – due to ever stretched capacity of commissioners

What is First Treatment ?

Local Accountability for 'getting it right for patients' is clear in NHS statutes

- Local ownership and Board accountability for what is being reported, clock starts, clock stops etc.

FAQ 13: How is first treatment defined?

- Treatment decision must be clinically-based and supported by agreed pathways that have senior clinical sign off in the organisation – *(and ultimately Trust Board and Commissioner approval)*
- The final decision on whether treatment has started is determined by the individual therapist for each intervention/appointment supported by written local pathway guidance. It should not be a blanket definition
- Does the patient think their treatment has started or would they say they are waiting for something else?

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What is not first treatment.

- A first contact by admin staff even if they collect PHQ/GAD scores
- Triage/assessment only where the outcome is to direct patients to an appropriate step/service or another assessment (including Step 4)
- Transfer to another IAPT Provider
- Signposting to another service unless it is part of an agreed pathway that continues to be monitored in your service and outcomes continue to be recorded and additional therapy is offered as required (i.e. the patient is not discharged)

Access & Waits -operationalisation

There should be no perverse incentive into local delivery or commissioning such as:

- Reduction in average number of sessions ⟺
- Increase in the proportion of patients discharged from a single session ⟺
- Selecting a lighter casemix ⟺
- Artificial treatment starts introduced where patients have an early appointment but are then put on an 'internal' waiting list. ⟺

Local monitoring required but nationally contextual indicators are being introduced in 2015-16 that set the historical context and determine variance

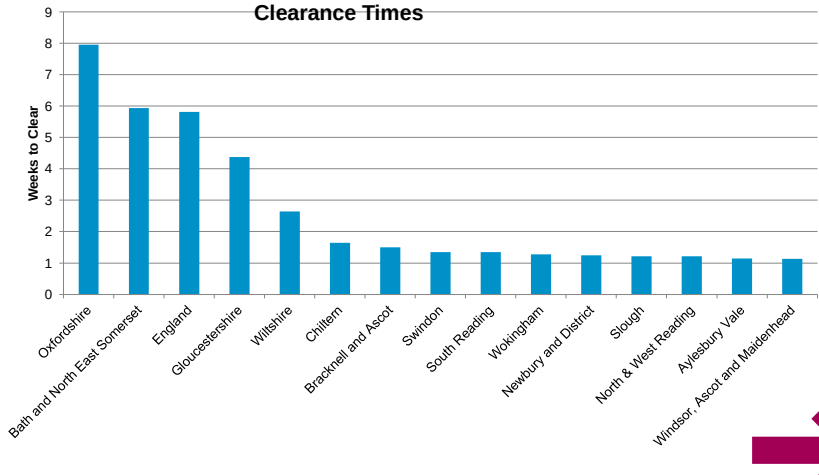
- Mean and median number of sessions
- Numbers completing treatment as a percentage of those who entered
- Case mix variance from provisional diagnosis and severity of symptoms
- Waits between first and second appointment to visualise long waits 'hidden' from nationally reported waits

There is local responsibility to monitor these and other factors to guard against poor decisions and assure the quality of service provision.

Clearance Times – South West

HSCIC June 2015 IAPT

Clearance Times – South Central



HSCIC June 2015 IAPT

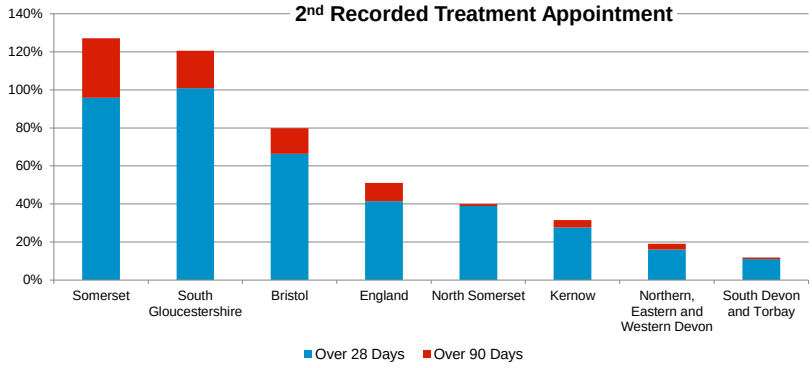
Summary – South West

Commissioner	6W All	18W All	6W KPI	18W KPI	Clearance
England	81.8%	95.7%	79.8%	96.4%	5.8
Bristol	91.0%	100.0%	91.1%	99.0%	6.2
Kernow	96.8%	100.0%	95.4%	100.0%	3.2
North Somerset	90.5%	98.4%	92.9%	97.6%	1.9
Northern, Eastern and Western Devon	95.4%	100.0%	90.6%	100.0%	3.6
Somerset	91.4%	99.5%	92.2%	100.0%	5.9
South Devon and Torbay	94.9%	100.0%	91.7%	100.0%	4.2
South Gloucestershire	92.0%	100.0%	94.6%	100.0%	5.7

Summary – South Central

Commissioner	6W All	18W All	6W KPI	18W KPI	Clearance
England	81.8%	95.7%	79.8%	96.4%	5.8
Aylesbury Vale	98.4%	100.0%	97.1%	100.0%	1.1
Bath and North East Somerset	73.2%	98.6%	89.5%	100.0%	5.9
Bracknell and Ascot	100.0%	100.0%	100.0%	100.0%	1.5
Chiltern	98.7%	100.0%	100.0%	100.0%	1.6
Gloucestershire	91.1%	99.6%	89.5%	98.6%	4.4
Newbury and District	97.2%	100.0%	100.0%	100.0%	1.2
North & West Reading	100.0%	100.0%	96.4%	100.0%	1.2
Oxfordshire	74.4%	96.3%	67.7%	93.5%	8.0
Slough	97.6%	100.0%	100.0%	100.0%	1.2
South Reading	100.0%	100.0%	100.0%	100.0%	1.3
Swindon	98.4%	100.0%	97.8%	100.0%	1.4
Wiltshire	96.1%	100.0%	95.2%	100.0%	2.6
Windsor, Ascot and Maidenhead	100.0%	100.0%	95.8%	100.0%	1.1
Wokingham	97.8%	100.0%	100.0%	100.0%	1.3

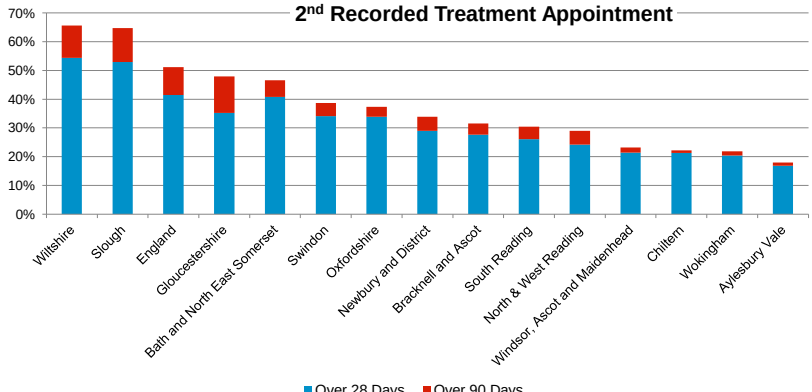
Waits to 2nd Treatment – South West



Caution: Experimental data
Waits between first and second treatments.
Patients who had a second treatment in the month (>28 and >90 days since first treatment) as a percentage of pts who completed treatment in the month i.e. the number of discharges that had a second treatment

Source HSCIC June 2015 IAPT data.

Waits to 2nd Treatment – South Central



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Source HSCIC June 2015 IAPT data.

Summary – South West

Commissioner	28+ 1st–2nd	90+ 1st–2nd	Completed Treats	28+ Ratio	90+ Ratio
England	18,525	4,290	47,594	41.5%	9.6%
Bristol	320	65	505	66.4%	13.5%
Kernow	250	35	980	27.6%	3.9%
North Somerset	70	*	210	38.9%	*
Northern, Eastern and Western Devon	135	25	960	16.0%	3.0%
Somerset	305	100	320	95.8%	31.4%
South Devon and Torbay	30	*	300	11.0%	*
South Gloucestershire	180	35	185	100.9%	19.6%

Summary – South Central

Commissioner	28+ 1st–2nd	90+ 1st–2nd	Completed Treats	28+ Ratio	90+ Ratio
England	18,525	4,290	47,594	41.5%	9.6%
Aylesbury Vale	30	*	175	16.8%	*
Bath and North East Somerset	70	10	190	40.8%	5.8%
Bracknell and Ascot	35	5	125	27.6%	3.9%
Chiltern	45	*	205	21.3%	*
Gloucestershire	250	90	715	35.2%	12.7%
Newbury and District	30	5	90	29.0%	4.8%
North & West Reading	25	5	140	24.2%	4.8%
Oxfordshire	145	15	465	33.9%	3.5%
Slough	45	10	75	52.9%	11.8%
South Reading	30	5	110	26.1%	4.3%
Swindon	75	10	225	34.1%	4.5%
Wiltshire	195	40	310	54.4%	11.2%
Windsor, Ascot and Maidenhead	25	*	120	21.4%	*
Wokingham	30	*	160	20.5%	*

What Next?

Adult IAPT What Next?

- Address Variation – Access, Recovery, Equity
- Improve Choice – Provider & Treatment
- Achieve Waiting Time Standard
- Integrate provision with physical health care pathways
- Improve access within mental health care pathways
- Introduce an outcomes based currency and tariff
- Improve employment support

Inequality

- Continue the promotion campaign run by Age UK to promote IAPT services to older people
- Older Peoples curriculum updated, and available for this coming academic year
- Mapping IAPT services benchmarking tool with a focus on demography, ethnicity of workforce, engagement, adaptions to clinical work, training and outcomes.
- Using more comprehensive data to monitor difficult to reach groups on access and outcome.
- Focus on improving BME engagement and promotion of services. Look into variability of access and outcomes

Long Term Conditions

- Commissioning Curricula on LTC training in following areas:
  - General LTC training for use in IAPT services
  - Three specific training packages for IAPT therapists who will be located in Cardiac, Diabetes and Lung disease clinics
- Working with Royal Colleges to take forward the mental health and physical health work to provide integrated care.
- The curricula will be completed in spring 2016 for use in the academic year 2016/17 starting in September 2016.
- Spending Review Decision awaited on the future of Psychological Therapies in Physical Health
- Complete the Pathfinder Site evaluation.

IAPT for SMI

- Transform existing services to provide NICE approved and evidence based psychological therapies as a frontline treatment to people with bipolar disorder, personality disorders and psychosis
- No new workforce, focus on competence, education and training of existing workforce and outcome measurement
- Six sites demonstrating that the provision of psychological therapies can support positive outcomes for patients, staff, the NHS & the wider economy, started in November 2012 and are funded to run until March 2016
- Working to inform the Access & Waiting Time targets for Early Intervention Services and wider provision across primary care and secondary care mental health services.

IAPT Currency Implementation

Strategic Vision: 5 year forward & Mental Health Task Force

- Move from “unaccountable block contract” arrangements to “new commissioning approaches” predicated upon:
  - effective payment systems which drive the delivery of high quality, evidence-based care; and,
  - assessment of need and which do not create perverse incentives
  - the quality and availability of data;
  - transparency in commissioning and outcomes;

- The aim of changing the payment system is to support improved access to excellent care and drive improved outcomes for people with mental ill health.

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Monitor / NHS England’s Objectives for Commissioners

By April 2015 all contracts to be underpinned by an understanding of need, evidence-based responses to need and expected outcomes

By April 2016 all contracts to include clear incentives for the delivery of outcomes. Outcome and quality driven payment models will have been introduced in a limited number of areas AND have robust data on cost, activity, quality and outcomes

By April 2017 a wholesale shift to outcome-focused contracting

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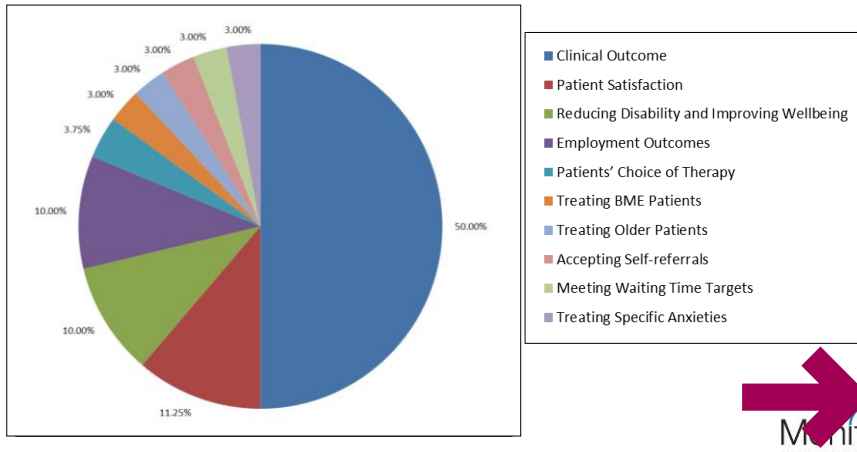
Overview of Currency Model - Outcomes

10 Outcome Domains incentivised and the nominal percentage of the price paid for meeting targets



Monitor
Making the health sector work for patients

NHS England

Any Questions?

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