# SCHEDULE 2 – THE SERVICES

1. **Service Specification**

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| **Service Specification No.** |  |
| **Service** | IAPT – Increasing Access to Psychological Therapies |
| **Commissioner Lead** | Patrick Otway |
| **Provider Lead** |  |
| **Period** | 1 August 2018 – 31 March 2020 |
| **Date of Review** | Annually |

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| **1. Population Needs** |
| * 1. **National**

According to the National Mental Health Strategy (Feb 2011), ‘Talking Therapies’ (which includes IAPT) contribute to improved outcomes, wellbeing and recovery for:* Children and adolescents
* Older people
* People with severe and enduring mental illness
* People with long-term physical health conditions
* People with medically unexplained symptoms

The Five Year Forward View for Mental Health (FYFVMH, Oct 2016) re-emphasizes the ability of IAPT services to provide support for people with depression and anxiety disorders that can be managed effectively in a uni-professional context. IAPT services remain a key focus of FYFVMH in delivering the improved outcomes aspired to by linking mental health and physical health. FYFVMH sets out a commitment to expanding IAPT services with a view to increasing access to psychological therapies for an additional 600,000 people with common mental health problems each year by 2020/21.As IAPT services expand they are expected to increase access to treatment for people who also have long term physical health conditions by recruiting and deploying appropriately trained staff in IAPT services where psychological and physical treatment are co-located (i.e. IAPT-LTC). Such services should also have a focus on people distressed by medically unexplained symptoms, to help this group of people achieve better outcomes. * 1. **Local context**

The evidence is clear that mental health/psychological symptoms are common in the adult population, affecting up to 1 in 3 people at some point in their lives. **Numbers of People Resident in Barnsley, ONS Mid-2015 Population Estimates**

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|  | **0 to 15** | **16 to 64** | **65+** | **Total** |
| Male | 22,500 | 75,100 | 20,600 | 118,200 |
| Female | 21,600 | 75,400 | 24,200 | 121,200 |

(Source: ONS Mid-2015 Population Estimates) Figures are rounded to nearest hundred.About half of those with symptoms (i.e. 1 in 6 of Adult population) will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalized anxiety disorder and mixed anxiety and depressive disorder.Applying this rationale to Barnsley’s population would suggest that at any one time 26,343 people could be suffering from one of these symptoms.The latest data collected for Barnsley’s Mental Health profile (Appendix 1) covers the year 2015/16 and shows that during that period, Barnsley’s rate for the diagnosed prevalence of depression (10.3%) was significantly higher than the rate for England (8.3%). This represents 21,035 people aged 18+ living in Barnsley who have been diagnosed with depression. Unsurprisingly, during the same time period, Barnsley’s spend on antidepressants per 1,000 weighted population was £7,251, significantly higher than the England rate of £5,656.Barnsley’s Joint Strategic Needs Assessment (JSNA - Appendix 2) shows that the health of Barnsley residents is generally poorer than the national average. This affects the quality of life for Barnsley residents and creates growing pressures on health services, social care, informal care, supported housing and other services. Barnsley’s IAPT service provider will need to work with local health and social care commissioners to develop a Step 2 and Step 3 IAPT service which is able to meet the needs identified within Barnsley’s JSNA.Risk Factors for Common Mental Health DisordersThere is an interrelationship between physical and mental health. Mental Health problems are much more common in people who have long term physical illness. Compared to the general population, people with diabetes, hypertension and coronary heart disease (CHD) have double the rate of mental health problems, and those with chronic obstructive pulmonary disease, cerebrovascular disease (CVD) and other chronic conditions have triple the rate. People with severe mental health disorders, such a schizophrenia and bipolar disorders and depression are more likely to develop long term conditions such as diabetes or CVD.Due to high levels of deprivation (Appendix 3 a & b IMD 2015 data) and higher levels of risk factors for long term conditions (such as high rates of smoking and obesity levels and low levels of physical activity) it is likely that the levels of many long term conditions will be higher in Barnsley than nationally.The latest data (from the 2011 Census) shows that 97.9% of Barnsley’s resident population were from a white ethnic background, 0.7% were from mixed/multiple ethnic groups, 0.7% were Asian or Asian British, 0.5% were Black/African/Caribbean or Black British and 0.2% were from other backgrounds. Since these figures were collected the Barnsley population has experienced changes due to international migration but there are no recent data sources available to evidence this.In July 2016 the Gypsy, Roma and Traveller Census that took place showed that there were 130 adults and 89 children (aged under 16 years) who were known to Barnsley Council to be currently living within a small group of static and mobile encampments within the Barnsley borough.There are however, groups within the population for whom we do not have accurate and up-to-date information.The number of Lesbian, Gay, Bisexual and Transgender (LGBT) residents in Barnsley is unknown and very difficult to estimate, not least because there are no agreed definitions or mechanisms for routinely gathering this information. Estimates of the size of the LGBT population vary, but national surveys designed to capture sexual orientation and behaviour show 5% - 7% of the population is LGBT (Department of Trade and Industry, 2014), which is the figure the Government uses when undertaking equality impact assessments. Taking 6% as the mid-point we can reasonably estimate that Barnsley’s LGBT population is approximately 14,400.* 1. **Vision**

The vision for Barnsley is for the borough to have an IAPT service with exemplary delivery characterized by a warm, person-centered approach tailored to the needs of the individuals and staff who exude passion for making a difference to the people they serve and to constantly develop the service.Upholding the principles of service delivery developed within the Virginia Mason Institute of continuous improvement we expect the utilization of agile and lean approaches with effective performance leadership to maximize client facing time of all practitioners and preventing waits for access to the service developing, noting service responsibility to ensure wrap around support if a wait is incurred. We would also anticipate the prioritisation of relationship building with Primary Care Clinicians, particularly through the evolving neighbourhoods (appendix 4).The intention is to significantly improve the mental health and wellbeing of the residents of the borough. To achieve this we need to:* Improve psychological wellbeing and support the prevention of mental health problems;
* Invest in early intervention;
* Promote self-management of mental health problems;
* Focus on recovery;
* Ensure services are delivered appropriately to meet both the physical and mental health needs of the local population, including those residents who fall within the 9 protected characteristic groups (as referenced in the 2010 Equality Act);
* Ensure service user and carer participation in everything we do.

A good IAPT service is key to achieving this vision since services are delivered using a stepped-care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs first. Many people with mild to moderate depression or anxiety disorders are likely to benefit from a course of low-intensity treatment delivered by a psychological wellbeing practitioner (PWP). Individuals who do not fully recover at this level should be stepped-up to a course of high-intensity treatment. NICE (National Institute for Health and Clinical Excellence) guidance recommends that people with more severe depression and those with social anxiety disorder or post-traumatic stress disorder (PTSD) should receive high-intensity interventions first.NICE- recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment. A core IAPT service will provide treatment for people with the following common mental health problems:* Depression;
* Generalised anxiety disorder;
* Social anxiety disorder;
* Panic disorder;
* Agoraphobia;
* Obsessive compulsive disorder (OCD);
* Specific phobias (such as heights and small animals);
* PTSD;
* Health anxiety (hypochondriasis);
* Body dysmorphic disorder;
* Mixed depression and anxiety.

In addition, the IAPT service will provide employment support to people where appropriate, and will be expected to work closely with South Yorkshire Housing Association, who are piloting an employment support service in Barnsley from April 2018, known as ‘Working win’, which will be overseen by the Sheffield City Region team.The evidence base for the use of psychological therapies for the treatment of depression and anxiety disorders has been regularly and systematically reviewed by NICE since 2004. NICE-recommended psychological therapies (shown below) form the basis of IAPT interventions to optimise outcomes.**NICE-recommended psychological interventions** |
|  | **Condition**  | **Psychological therapies**  | **Source**  |
| **Step 2: Low-intensity interventions** *(delivered by PWPs)* | Depression  | Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme  | NICE guidelines: CG90, CG91, CG123 |
| Generalised anxiety disorder  | Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT  | NICE guidelines: CG113, CG123  |
| Panic disorder  | Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT  | NICE guidelines: CG113, CG123  |
| Obsessive-compulsive disorder  | Guided self-help based on CBT  | NICE guidelines: CG31, CG123  |
|  | **Condition**  | **Psychological therapies**  | **Source**  |
| **Step 3: High-intensity interventions** | Depression *For individuals with mild to moderate severity who have not responded to initial low-intensity interventions*  | CBT (individual or group) or IPT Behavioural activation Couple therapyd Counselling for depression Brief psychodynamic therapy *Note: psychological interventions can be provided in combination with antidepressant medication.*  | NICE guidelines: CG90, CG91, CG123  |
| Depression *Moderate to severe* | CBT (individual) or IPT, each with medication |
| Depression *Prevention of relapse* | CBT or mindfulness-based cognitive therapye |
| Generalised anxiety disorder  | CBT, applied relaxation  | NICE guidelines: CG113, CG123  |
| Panic disorder  | CBT  | NICE guidelines: CG113, CG123  |
| Post-traumatic stress disorder  | Trauma-focused CBT, eye movement desensitisation and reprocessingf  | NICE guidelines: CG26, CG123  |
| Social anxiety disorder  | CBT specific for social anxiety disorders  | NICE guideline: CG159  |
| Obsessive-compulsive disorder  | CBT (including exposure and response prevention)  | NICE guidelines: CG31, CG123  |
| Chronic fatigue syndrome  | Graded exercise therapy, CBT\*  | NICE guideline: CG53  |
| Chronic pain  | Combined physical and psychological interventions, including CBT\* and exercise  | NICE guideline: CG88 Informal consensus of the ETGh  |
| **Condition**  | **Psychological therapies**  | **Source**  |
| Irritable bowel syndrome  | CBT\*  | NICE guideline: CG61 Informal consensus of the ETG  |
| MUS not otherwise specified  | CBT\*  | Informal consensus of the ETG  |
| The IAPT service will need to develop strong relationships with professionals across a broad range of mental health care pathways, as well as social care, to ensure that people with needs that are either not appropriate or too complex for IAPT services receive the necessary care in the right place. Strong links with the social prescribing service in Barnsley, **My Best Life**, delivered by South Yorkshire Housing Association, would be viewed as a key relationship.  |
| **2. Outcomes** |
| **2.1 Expected Outcomes**The service will be expected to measure and demonstrate positive impact in the following areas according to the targets identified within this specification:* Recovery from common mental health problems;
* Clinically significant change in common mental health problems;
* Achievement of outcome goals jointly determined by the patient and clinician;
* Sustained recovery from common mental health problems, post intervention;
* Mental wellbeing amongst those with common mental health problems;
* Patient satisfaction with the service offered (quality, choice, timeliness, accessibility, appropriateness, transition from other services, transition to other services);
* A flexible service by ensuring a blended model of service delivery which incorporates the use of online services to deliver support and treatment;
* Improved health and well-being through reducing stigma, increasing understanding of common mental health conditions and promoting the ability to self-care by providing self-directed support and recovery packages and self-help activities;
* A patient centred service by offering patient choice of therapy, delivery method, location and therapist, appropriate to individual need;
* A caring service demonstrated through patient feedback, friends and family test, complaints;
* A safe service demonstrated through appropriate use of step up and down options, reported incidents and clinical audit.

**2.2 Patient- and clinician-reported outcome measures**The following patient-reported outcome measures are recommended for routine use in IAPT services. **Recommended outcome measures for IAPT-LTC services**

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| **Main mental health problem (primary problem descriptor)** | **Depression measure**  | **Other recommended symptom measure (ADSM/MUS)** | **Further option, only used if ‘other recommended symptom measure’ is missing** | **Measure of disability** |
| **Depression** | **PHQ-9** | **GAD-7** |  | WSAS |
| **GAD** | **PHQ-9** | **GAD-7** |  | WSAS |
| **Mixed anxiety/depression** | **PHQ-9** | **GAD-7** |  | WSAS |
| **No problem descriptor** | **PHQ-9** | **GAD-7** |  | WSAS |
| **Social anxiety** | **PHQ-9** | **SPIN** | GAD-7 | WSAS |
| **PTSD** | **PHQ-9** | **IES-R** | GAD-7 | WSAS |
| **Agoraphobia** | **PHQ-9** | **MI** | GAD-7 | WSAS |
| **OCD** | **PHQ-9** | **OCI** | GAD-7 | WSAS |
| **Panic disorder** | **PHQ-9** | **PDSS** | GAD-7 | WSAS |
| **Body dysmorphic disorder (BDD)** | **PHQ-9** | **To be agreed by IAPT’s Education & Training Committee** | GAD-7 | WSAS |
| **Irritable bowel syndrome (IBS)** | **PHQ-9** | **Francis IBS Scale** | GAD-7 | WSAS |
| **Chronic fatigue syndrome** | **PHQ-9** | **Chalder Fatigue Questionnaire** | GAD-7 | WSAS |
| **Chronic pain (in context of anxiety/depression)** | **PHQ-9** | **GAD-7** |  | WSAS |
| **MUS not otherwise specified** | **PHQ-9** | **PHQ-15** | GAD-7 | WSAS |

***Note*:** Recovery, reliable improvement and reliable deterioration rate calculations should be based on the pair of measures highlighted in bold. When the measure in bold in the third column is missing, the recovery calculation is based on the combination of PHQ-9 and GAD-7, if this is different. ***Key and cut-off scores:*** PHQ-9 – 10 and above; GAD-7 – 8 and above; Obsessive Compulsive Inventory (OCI) – 40 and above; Social Phobia Inventory (SPIN) – 19 and above; Agoraphobia-Mobility Inventory (MI) – above an item average of 2.3; Impact of Events Scale - Revised (IES-R) – 33 and above; Panic Disorder Severity Scale (PDSS) – 8 and above.**2.3 Public Health Outcomes**The service will also be expected to demonstrate, as part of regular service evaluation, positive performance amongst individuals in contact with the service according to the following outcomes associated to the Public Health Outcomes Framework:* Employment;
* Diet;
* Smoking prevalence;
* 16 – 18 year olds not in education, employment or training;
* sickness absence;
* utilisation of green space for exercise / health reasons;
* hospital admissions as a result of self-harm;
* proportion of physically active and inactive adults;
* self-reported wellbeing;
* improve access to psychological intervention for people with the first signs and symptoms of common mental health problems;
* deliver a service for people with common mental health problems, according to a public health approach, according to known needs intelligence and as part of community engagement to reduce barriers and inequalities;
* develop the health and wellbeing agenda to support self-care/management through preventative / early identified initiatives and clearly defined pathways;
* target services more equitably and focus on mental and physical health needs, particularly amongst those people within the 9 protected characteristic groups (as referenced in the 2010 Equality Act).
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| **3. Scope** |
| **3.1 Aims and objectives of service**The Improving Access to Psychological Therapies (IAPT) is an NHS programme of talking therapy treatments recommended by NICE which support front-line mental health services in common mental health disorders (see <http://www.iapt.nhs.uk>).The service will provide:* evidence-based psychological therapies, as approved by NICE, for people with depression and anxiety disorders;
* access to services and treatments by people experiencing depression and anxiety disorders from all communities living within the Barnsley borough;
* increased health and wellbeing, with at least 60% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition;
* patient choice regarding modality and location and high levels of satisfaction from people using services and their carers;
* timely access, with people waiting no longer than locally agreed waiting time standards;
* improved employment, benefit and social inclusion status including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living.

**3.2 Service Description****Referral and Assessment****Step 1** To adopt a stratified approach to engaging people in the service, through a single point of access (SPA) team via multiple access points thereby ensuring that regardless of what step a referrer thinks the patient is at, they will go to the assessment team to ensure that they are then assessed accurately and access the right service, at the right time, every time.**Step 2**Will provide low-intensity service and will include the components below. It will be provided through individual and group sessions (as recommended by NICE Guidance) and will include both face-to-face contact and telephone support. Key elements will include:Use of interventions detailed below (number of sessions not to exceed NICE recommendations):* Education;
* Bibliotherapy;
* Behavioural activation;
* Signposting – Guided cognitive-behavioural self-help;
* Problem solving – Guided self-directed exposure therapy;
* Referring to various services including social services and exercise referral;
* Introduction to services – this will require the worker to accompany the client to the required service if support is needed;
* Computerised CBT (8 sessions);
* 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 face-to-face sessions).

**Step 3**Will provide a high-intensity service and will include the following components:* Individual CBT (8 – 20 sessions, average 12 sessions over 6 months);
* Group CBT (6 – 10 people, up to 12 x 2 hr sessions).

Therapy sessions should be supplemented by guided self-help when appropriate materials are available.Concomitant medication advice and support for patients receiving antidepressant medication. Telephone ‘collaborative care’ support for patients on antidepressant medication.The service provider(s) will be responsible for case management and communicating with the service-users’ GP, including referral to higher steps (specialist services outside the IAPT service, CMHT’s, in-patient care). Step 3+/Step 4 are to be directly referred to the most appropriate service.It is expected that where a client is signposted on to another service after initial assessment that the reasons for this are communicated back to the clients GP. This will help to ensure better quality, future referrals into the service.**3.3 Accessibility**The service will accept adult (16+) referrals. The service will work with people who are registered with a Barnsley GP. The service is open to people with ‘sub-threshold’ conditions and, as such, formal diagnosis is not a requirement for access. The service will not provide support to people under the age of 16 or to adults with active severe mental illness, e.g. psychosis, or for those at a high level of risk of suicide, self-harm or harm to others.Where there are co-morbid difficulties including (but not exclusively) Substance Misuse, Eating Disorders, Learning Difficulties and Personality Disorder, the service will make reasonable adjustments to ensure the delivery of services. Clients will only be excluded on the basis of: other factors indicate risk levels are above those considered appropriate for management within IAPT Step 2 or Step 3; the mental health needs are caused solely by their use of substances; use of substances is chaotic or unmanageable, or where the risks associated with use of substances are too high to be safely managed.The service will directly accept self-referrals or referrals by a GP or other health and social care professionals and staff, including the third sector. Referral routes will be actively promoted (see 4.1.2) and will not be reduced or restricted by service re-design or pathway re-designs in any aspect of the local system. The service provider(s) will determine hours of operation based on identified demand and the need to improve accessibility but it is envisaged that the service will be available during core office hours of 8am – 8pm with a number of evenings and weekend sessions as required.The service will engage with mental health services across all steps of intervention, including those provided by public, private and voluntary organisations. Patients will be stepped up or down dependent upon need. The service will also engage with community services focused on health and lifestyle and support patients to access these (e.g. Live Well Barnsley), either upon discharge or parallel to intervention by the service, as appropriate.The service will be responsible for providing detailed information, awareness and training on appropriate decision-making regarding access to wellbeing and mental health support to those that refer or signpost to the service. Domiciliary visits and telephone support will be provided where people are unable to attend health and community venues.**3.4 Interdependencies**The Provider will have the necessary systems in place to step patients up or down, working with other parts of the system as part of a seamless care pathway for IAPT services.It is expected that to develop adequate choice of services for people with common mental health problems, the IAPT service will develop robust collaborative working arrangements with current service providers, across sectors that contribute towards the social, psychological, health and welfare needs of people accessing the service. The provider will keep up to speed with local service developments and will ensure that appropriate partnership opportunities are identified and established.The service will provide dedicated support to those people looking to retain and/or gain employment and will have strong links to the ‘Working Win’ employment trial to be delivered in Barnsley from April 2018 by South Yorkshire Housing Association.The Provider will be expected to demonstrate on-going engagement from key stakeholders, specifically patients and their carers, in understanding and prioritising the needs of people with common mental health problems.The aim of partnership arrangements will be to achieve the best outcomes for patients. The principles of partnership arrangements will be set out formally in partnership arrangement policies and agreements. These principles will include detail such as referral systems, joint working arrangements and feedback and communication systems where appropriate. The Provider(s) is expected to work particularly closely with the following partners:* General Practice;
* Mental Health Services;
* Substance misuse services;
* Employment services and employers e.g. ‘Working Win’;
* Offender services;
* Public health lifestyle / wellness services;
* Community and voluntary sector organisations e.g. My Best Life;
* The Provider will demonstrate robust and meaningful involvement of service users and those who care for them in the development and delivery of services, reaching each of the 9 protected characteristic groups (as referenced in the Equality Act 2010). In addition, the service will engage with people/groups who may inequitably access the services or who are at risk of poor mental health or who face barriers to accessing support.

These population groups include (but are not exclusive):* Military veterans;
* Perinatal mental health and new parents;
* Older people living in isolation;
* People living in deprived circumstances;
* People with long term conditions (LTC);
* The Deaf Community;
* People with Learning Disabilities.

Service delivery will be tailored to meet the needs of these population groups. Therapists will be trained and competent in understanding the complexities of each group and will have access to specific supervision in the provision of a service responsive to the diverse needs of local communities. Service delivery settings and information provided by the service will be responsive to the needs of these population groups and outcomes will be monitored routinely to establish the most effective model of working with specific communities.  |
| **4. Service Model** |
| **4.1.1 Service Model**1. The Service will focus on early intervention and promote self-directed support and recovery. There will be a culture of raising awareness, promoting positive choices and empowering service users to control their own recovery.
2. A stepped care model will be utilised in order to ensure that people receive the least intensive intervention for their needs. The stepped care model will ensure that the local care pathways:
	1. promote self-directed support;
	2. provide the least intrusive, most effective intervention first;
	3. have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway;
	4. do not use single criteria (such as symptom severity) to determine movement between steps;
	5. monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed;
	6. promote a range of evidence-based interventions at each step in the pathway;
	7. support people in their choice of interventions.
3. There will be seamless transition between low intensity and high intensity interventions within the stepped care model regardless of who is delivering the interventions.
4. There will be seamless transition between the IAPT Service and other mental health provision and this will be clearly documented, regularly reviewed and communicated to all relevant professionals.
5. The Service must have capability and capacity to safely manage severe and complex cases where required.

**4.1.2 Access & referrals**1. The Provider(s) will ensure that entry into the service is simple, prompt and via multiple access points which take account of the geography and demand across the District.
2. The Service will seek to expand **guided self-referral** as the primary route into the service.
3. Proactive promotion and marketing to different sections of the community will include working with the agencies/pathways identified in section 3.4 to ensure that service users are appropriately signposted into psychological therapies.
4. Promotion and marketing to achieve the outcomes and targets will be the financial responsibility of the Service Provider(s) and must take place on at least a quarterly basis. This will be monitored.
5. Referrals to the Service will be possible from other professionals including statutory and third sector agencies.
6. The Service will be expected to be able to receive referrals through:
	1. Online/website;
	2. Email;
	3. Telephone;
	4. Post;
	5. Drop in, e.g. via a talking shop.
7. There will be prompt access and equity of access for the harder-to-reach local community, such as those identified in section 3.4 above.
8. Where a service user requires additional support to access the service, the Provider will ensure that provision is made, within the value of the contract. Such support services might include, but are not limited to:
	1. Translation services;
	2. Easy read;
	3. Sign language/BSL – the service needs to maintain access to a deaf practitioner.
9. Opt-in processes are not a mandatory requirement and the Service will ensure that access by people with common mental health problems is unhindered by complex patient opt-in or confirmation systems. The Service will make strenuous efforts to assertively contact both new referrals and those service users for whom the service has lost contact during a treatment episode.
10. The Service must monitor the drop out between referral and assessment and take proactive steps to minimise this.
11. High risk individuals that have presented to the Service will be urgently referred to the appropriate service and supported to receive the appropriate care.
12. Where it is initially unclear which service is best to meet the needs of the individual, the Provider(s) must ensure that proactive dialogue is made with all relevant agencies and a solution identified.
	* 1. **Assessment**
13. **Ideally initial assessments will be undertaken face to face.** Alternative modes, such as by telephone or by video/web based conferencing with or without prior collection of relevant client information, will be acceptable if this is the clients’ choice.
14. The assessment will focus on the presenting problem, a basic risk assessment and referral on to other agencies, if appropriate.

This will include the following elements: * 1. Prior to the start of treatment all service users will receive a comprehensive ‘person centred’ assessment that clearly identifies the full range and impact of their mental health problems and any linked employment, social and physical health issues;
	2. Risk (suicide, harm to self or harm to others) will be assessed at initial contact and at each contact thereafter;
	3. All service users must have their clinical, work and social outcomes assessed using the recognised standardised measures that are appropriate to the conditions being treated;
	4. Key measures will be given at each treatment session so that a clinical end point is available even if the service user finishes treatment early.
1. Where an assessment is undertaken the assessor will discuss the range of options/therapies available (that are appropriate for the clinical presentation) and offer choice wherever possible. The treatment options available to the client should be made clear to them and realistic expectations outlined.
2. The Service must monitor the drop out between assessment and treatment and take proactive steps to minimise this.
3. People assessed as requiring Step 4 intervention should be referred on to the appropriate specialist/secondary care service and a referral protocol will be established with the secondary care provider to support this.
	* 1. **Treatment**
4. Service users will receive information about their condition and be encouraged to identify self-help activities.
5. Service users will have a choice of interventions/therapy and a choice of how it is delivered (e.g. face to face, via telephone or on-line). Increased use of digital technology would be expected to enable the expansion of on-line therapy (not just CBT) where this would be appropriate.
6. Service users will have a choice of when and where to be seen and arrangements will be mutually agreed between patient and therapist as part of good care planning.
7. Treatments will be evidence based, offered in the appropriate dosage by a trained and accredited workforce.
8. The Service will include access to online therapy and support via structured courses, audio and video consultation and live chat.

The Service will provide a range of interventions and treatments, in a range of locations to meet the identified demand (maximising use of borough estates coverage across the six neighbourhoods (appendix 4) as identified in section 7). * + 1. **Discharge**
1. When a patient has completed treatment and/or is discharged from the service a patient experience questionnaire will be given to them. This data will be collated and provided to the Commissioner. A minimum response rate of 75% must be achieved from all patients that complete treatment or are discharged.
2. Consistent arrangements for liaison with GPs at discharge and routine follow up where indicated must be in place.
3. In all instances, the Service will ensure that the relevant GP practice has been informed about the referral, assessment and treatment within 10 working days.
4. The service will ensure that discharged patients understand how they can self-refer for advice/treatment should they require it in the future (regardless of how they entered the service initially).
	* 1. **Outcomes data collection**
5. A minimum of 90% data completeness for pre/post treatment scores must be achieved from all patient contacts.
6. A secure cloud based IT system must enable therapists and service managers to have prompt access to outcomes data and to generate service reports.
7. Routine outcomes data measurement must be used to inform regular clinical supervision and to improve service quality and accountability.
8. To effectively operate a stepped care service it is essential that patients can be tracked through the full stepped care pathway through an, ideally interoperable, electronic patient record.
	1. **Population covered**

The service will work with patients registered with a NHS Barnsley CCG General Practice. For patients without a GP registration who self-refer, the Responsible Commissioner guidance applies.The service will meet the needs of people aged 16 and over, and will not discriminate on the basis of age, gender, race, religion/belief, sexual orientation or disability. * 1. **Service eligibility**

Eligibility criteria include people presenting with at least one of the following conditions, either as a sole or co-morbid diagnosis, where a psychological therapy intervention would be appropriate:

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| **Depression** (CG90[[1]](#footnote-1)) *(including that relating to antenatal and postnatal mental health* (CG192[[2]](#footnote-2))*):*Mild Depression (4 ICD-10 symptoms and/or PHQ-9 score of 5-9)Moderate Depression (5-6 ICD-10 symptoms and/or PHQ-9 score of 10-14)Moderate – Severe Depression (7 ICD-10 symptoms and/or PHQ-9 score of 15-19) |
| **Anxiety** including*:*Generalised anxiety disorder (GAD) (CG113[[3]](#footnote-3))Post-Traumatic Stress Disorder (CG26[[4]](#footnote-4))Obsessive Compulsive Disorder & Body Dysmorphic Disorder (CG31[[5]](#footnote-5))PhobiasPanic Disorders (CG113) |
| **Other Disorders**Anger Patients with psychological problems consequent to long term conditions (LTC) or presenting with somatisation disorder Bereavement or other life events resulting in any of the aboveRelationship issues |

The above list is not exhaustive and it recognises that there may be cases that fall outside the above definitions, however, these patients may still benefit from psychological interventions.The service will typically work with people in mental health care clusters 1-3:**Care Cluster 1:  Common Mental Health Problems (Low Severity)** - This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms.**Care Cluster 2:  Common Mental Health Problems (Low Severity with Greater Need)** - This group has definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.**Care Cluster 3:  Non-Psychotic (Moderate Severity)** - This group has moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).* 1. **Exclusion criteria and thresholds**

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. People suffering from acute psychosis or who are actively suicidal and those who have a pre-existing diagnosis of unstable severe mental illness are **not** suitable for the Barnsley IAPT Service. Such individual’s needs are best met via specialist or secondary community mental health teams and associated services. Similarly those individuals who have a **significant** impairment of cognitive function (e.g. dementia); or **significant** impairment due to autistic spectrum problems or learning difficulties are best served by specialist services. This also includes patients who need to be primarily referred for forensic or neuropsychological assessment. Individuals for whom drug and alcohol misuse present as their primary problems are best referred to substance misuse services. However, where the individual has the ability to engage in therapy they will be supported to access the Service, potentially via shared care arrangements. The principle of inclusion must apply.It is expected that in all cases where a person is not suitable for IAPT services, the provider will work proactively with other providers and agencies to ensure that the right care is secured for the individual. This will be monitored. |
| **5. Applicable Service Standards** |
| **5.1 Expected Standards**To achieve Barnsley’s ambitions to significantly improve the mental health and wellbeing outcomes of its boroughs residents the IAPT service should achieve the standards set out within the CQC’s framework (and shown below) highlighting the principles of a good IAPT service:

|  |  |
| --- | --- |
| **CQC domain**  | **Key features of a better performing IAPT service**  |
| **Well-led**   | * **Effective leadership**: creating a culture of shared leadership through staff engagement, effective teamwork and accountability, with patients held firmly at the centre
* **Values driven**: leaders displaying the values of the NHS through their behaviour, engaging stakeholders, delivering person-centred coordinated care and focus on staff wellbeing
* **Clear strategic direction**: delivering an inspiring vision and alignment of objectives at every level
* **Outcomes-focused**: ensuring a high-quality service providing the best possible standards of care for everyone in the local community
* **Engage and empower others**: able to hold the key characteristics of the national IAPT programme whilst meeting local need within rapidly changing landscapes and working within the wider system to empower communities
* **Value for money**: Focusing on productivity. Balancing effective, efficient service delivery with recovery focused compassionate care
* **Building leadership capability**: Inspiring leadership development through promoting attendance at NHS leadership courses, IAPT regional leadership workshops and local leadership development forums
* **Focus on innovation, research and the digital agenda**: to design service models that deliver best practice within evidence-based interventions and offer more choice, allowing staff to thrive within an innovation environment.
 |
| **Effective**   | **The right therapy:*** A choice of evidence-based, NICE-recommended therapies based on accurate problem descriptors. For depression, the choice of therapies extends to beyond CBT approaches to include interpersonal therapy, brief psychodynamic therapy, couple therapy, and counselling for depression4
* Following a prompt and good assessment, allocation to an appropriate low-intensity or high-intensity treatment. Progress should be carefully monitored with people being stepped up from low-intensity to high-intensity treatment if the initial response is inadequate. National data indicate that 37% of patients receive low-intensity treatment only, 29% receive high-intensity only and 34% have both.32 This means that 71% of people have low-intensity treatment at some stage during their care episode and 63% receive high-intensity treatment at some stage in the care episode. However, there is considerable local variation in these figures
* Services should have written good practice guidelines for staff to support clinical decision-making and appropriate stepping between treatments
* **Session-by-session outcome measures** are a key characteristic of an IAPT service and provide an outcomes framework for performance management to drive quality improvement. This level of transparency helps commissioners to understand how effective the IAPT service is, as well as identify contracts that provide good value for money.

**Meeting the national standards:** * Achieving recovery rates of at least 50%
* Meeting the access standard set locally and the minimum national standard of 15% increasing to 25% by 2020/21
* Achieving the waiting time standard of 75% of people starting their course of treatment within 6 weeks of referral and 95% within 18 weeks
* Minimum of 90% data completeness for pre/post-treatment scores for both depression and anxiety/MUS measures.

**Best practice:*** At least two in three patients achieve reliable improvement
* Most patients seen in the service go on to have a course of treatment (2 or more treatment sessions)
* Problem descriptors are identified for at least 80% of patients who have a course of treatment
* Most patients have their outcomes assessed with ADSMs or MUS measures, when the problem descriptor indicates that such measures are appropriate.

**Continuous quality improvement:** * Data-informed service level reflective practice. Curious about data, analysing themes and patterns and using this intelligence to improve outcomes
* Local quality improvement strategies implemented, based on local areas of development identified through qualitative and quantitative data
* Engaging staff and patients in shaping quality improvement
* Improving equality of access and outcomes for all
* Ensuring national reports reflect local performance through data quality validation including national and local data alignment
* Research active and good relationships with local universities
 |
| **Safe**  | **The workforce:** * Key focus on staff wellbeing
* Appropriate number of trained staff
* Appropriately qualified supervisors delivering outcomes-focused weekly supervision
* Staff receive personalised feedback benchmarked against the service average or other clinicians
* Tailored CPD
* The right skills mix and level of experienced clinicians
* A diverse workforce that reflects the local population and is culturally competent
* Professional registration and accreditation
* Workforce stability, retention and sustainability planning

**Supporting safe therapy:*** Robust local systems that enable analysis of all outcomes, including reliable deterioration
* Ensuring a good assessment to support the right evidence-based therapy is chosen in line with the accurate problem descriptor, using outcome measures, supervision and review as a corrective function

**Integrated governance:** * This should be supported by effective data management systems that facilitate routine data collection and analysis. Data analysis should support timely feedback at an individual, clinician and service level, with service-level outcomes published
* Performance management systems are important to ensure accountability, productivity and improving outcomes
* Services should develop their own standard operating procedures to ensure data quality and validation (as local and national data must be aligned)
* Local reporting capability is essential for reflective practice at individual, team and service level to promote a culture of enquiry
* Local missed appointment policies and best practice guidance on attrition, as services should make strenuous efforts to assertively contact both new referrals and people that have lost contact during a treatment episode
* Use of audit
 |
| **Caring**  | **The person held firmly at the centre of care:** * Focus on holistic care with a commitment to empowering patients at the centre, to improve mental health and wellbeing, social inclusion and employment, improved choice and access and improved patient experience

**Patient feedback and engagement:** * Individual feedback after each session through completion of PEQs
* Implementing changes and learning from feedback and complaints
* Engagement in service design, service development and service improvement
 |
|  | **Focus on staff wellbeing:*** A culture of shared and compassionate leadership providing high levels of support to staff
* Clear objectives should be set for all staff, encouraging accountability and leadership at all levels
* Development opportunities should be provided, accompanied by a high level of supervisory support
* Provide and review training opportunities, tailored CPD and weekly outcomes-focused supervision
* Special interest groups to enhance skills
* Provide career development opportunities: senior PWP posts and lead PWP post
* Team building to support effective teamwork
* Wellbeing champions to promote wellbeing activities
 |
| **Responsive**  | **Accessibility:** * Simple and direct access that is not hindered by complex patient opt-in or confirmation system
* GP referral and self-referral, as demographics for self-referral are more representative of the local population
* Seek to engage hard to reach groups to improve access and outcomes for all
* Choice of location and able to offer home visits where appropriate
* Clear and continuous publicity for the service to promote access: user-friendly and engaging websites, service leaflets, posters and other promotional materials developed and regularly updated

**Importance of choice: flexibility to fit with individual need** * If treatments are similarly effective a choice of therapy should be offered in line with NICE guidelines
* Choice of how therapy is delivered (one-to-one, group or blended therapy) where appropriate
* Choice of gender, ethnic or cultural background, and/or religion of the clinician, where this is practical. It should be possible, at the clients request, for the practitioner to be changed where the assigned practitioner is not deemed to be the ‘best fit’ for the client. The provider will ensure the client has access to an interpreter or BSL signer when requested and this should not delay commencement of treatment.
* Flexibility in terms of appointment times and location as well as contact via telephone, internet and email. From a service user survey carried out in Feb/March 2018 we know that the residents of Barnsley prefer to access these services ‘local’ to them, in community venues (libraries, community centres, pubs, cafes etc) and GP Surgeries. The CCG expect the Provider(s) to maximise NHS Estates, in line with the local Estate Strategy.
* Have **built-in flexibility** around working times and when and where to offer additional appointments, such as evening and weekend clinics

**Working with the wider system:** * Shaping integration within the wider system to improve a person’s experience and outcomes at a local level.
* Integration within primary care and GP champion
* Links with other services, such as housing, debt, social care, third sector and charitable organisations
* Employment advisers in the team to support individuals who are receiving treatment, and employment co-ordinators who work with employers to help people gain or retain employment
* The services should offer psychological therapies for complex cases, but have the skills to identify when other support should be brought in
* Connected, as part of a whole pathway approach, with the wider system, to facilitate a positive experience of care throughout
 |

The provider will ensure that all staff are trained and competent to deliver services. Services are required to offer supervision and support to agreed professional standards; these can be found on the IAPT website <http://www.iapt.nhs.uk/workforce/> The service should carry out training with partner agencies in the identification of common mental health problems, will work (in conjunction with others) to educate universal and other services available to the general public on mental health and wellbeing issues relevant to the client group. The service will conduct research where appropriate on issues relevant to the service area and client group and will contribute to Local, Regional and National networks linked to the IAPT programme.**Workforce**The service should have an appropriate skill mix within their team. Assessment should always be provided by an appropriately trained member of staff. Treatment can be provided by accredited staff or staff working towards accreditation but supervised by a registered practitioner (i.e. appropriately trained, qualified and experienced).In terms of training and development:* All staff should be appropriately trained to undertake procedures within the scope of their job role;
* Staff should be culturally competent and able to respond to a range of diverse experiences and identities of clients. Through adaptation, the service should strive to meet the diversity of life experiences, lifestyles and backgrounds clients have (as outlined at <http://www.iapt.nhs.uk/equalities/culturally-competent-practice/>);
* All staff should be able to demonstrate Continuing Professional Development activity;
* Staff should participate in peer review networks, appraisal and Professional Development Plans.

Providers must ensure compliance with national standards where these apply. This includes (but is not limited to) the following NICE guidance:* [CG 90 Depression in Adults](http://www.nice.org.uk/guidance/cg90)
* [CG113 General Anxiety Disorder & panic Disorder in Adults](http://www.nice.org.uk/Guidance/cg113)
* [CG123 Common Mental Health Disorders](http://www.nice.org.uk/guidance/CG123)
* [CG91 Depression in Adults with Chronic Physical Health Problem](http://www.nice.org.uk/guidance/cg91)
* [CG31 Obsessive Compulsive Disorder](http://www.nice.org.uk/guidance/cg31)
* [CG26 Post Traumatic Stress Disorder](http://www.nice.org.uk/guidance/cg26)
* [CG16 Self-harm](http://www.nice.org.uk/guidance/cg16)
* [CG45 Antenatal and Postnatal Mental Health](http://www.nice.org.uk/guidance/cg45)
* [CG78 Borderline Personality Disorder](http://www.nice.org.uk/guidance/cg78)

 Providers must also comply with IAPT requirements, including the Information Standard and Key Performance Indicator (KPI) technical guidance: * <http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf>
* <http://www.ic.nhs.uk/iapt>

(or most up to date version)**5.2 Applicable local standards****Waiting Times Management**In order to support improved access to the service, waiting list information should be made available to commissioners via weekly (Patient Tracking Lists) PTLs. In order to achieve Barnsley’s ambitions, the following local targets will be set:* Increase access to IAPT as a minimum in line with FYFVMH recommendations i.e. to 25% of the relevant population by 2020/21;
* 95% of people referred to the IAPT service will be seen for assessment within 2 working days;
* 80% of people referred to the IAPT programme commence treatment within 4 weeks of referral;
* 98% of people referred to the IAPT programme will commence treatment within 16 weeks of referral.

**Facilities**Venues and facilities should be accessible both in terms of public transport links and parking facilities and compliant with all relevant local and national laws, regulations and service requirements. Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face cultural or language barriers. The service should make adequate and reasonable adjustments and provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.**5.3 Proposed Investment**It is evidenced, for a population the size of Barnsley, that the desired outcomes from an IAPT service could be delivered at a cost of £75 - £85 per head of the relevant population |
| **6. Applicable quality requirements and CQUIN goals** |
| * 1. **Applicable quality requirements (See Schedule 4 Parts A-D)**
	2. **Applicable CQUIN goals (See Schedule 4 Part E)**
 |
| **7. Location of Provider Premises** |
| The IAPT service will be delivered from a range of community venues across Barnsley. Barnsley is divided into 6 Wards (areas) and to reflect this locality models (neighbourhoods) for community services have evolved which largely mirror the wards. Appendix 4 lists the 6 neighbourhoods and constituent GP Practices. In line with the local Estate Strategy there is an expectation that Provider(s) would maximise use of NHS Estates. To help facilitate this local working arrangement Barnsley CCG are prepared to offer, on a free of charge basis, accommodation in CCG LIFT Buildings. Barnsley CCG will not be liable for any costs associated with the take up of this offer, e.g. removal expenses, cancelling of existing lease arrangements, ongoing utilities and service charges etc. Please see Appendix 5 for a list of potential accommodation. |

1. NICE Clinical Guideline 90 <http://www.nice.org.uk/guidance/cg90> [↑](#footnote-ref-1)
2. NICE Clinical Guideline 192 <https://www.nice.org.uk/guidance/cg192> [↑](#footnote-ref-2)
3. NICE Clinical Guideline 113 <http://www.nice.org.uk/guidance/cg113> [↑](#footnote-ref-3)
4. NICE Clinical Guideline 26 <http://www.nice.org.uk/Guidance/CG26> [↑](#footnote-ref-4)
5. NICE Clinical Guideline 31 <http://www.nice.org.uk/Guidance/CG31> [↑](#footnote-ref-5)