Bristol, North Somerset and South Gloucestershire IAPT Service Specification

Schedule 2 Section A

i. Introduction to this specification

This is the specification for the Bristol, North Somerset and South Gloucestershire (BNSSG) IAPT service.

i.i Approach

The causal connection between poverty, unemployment and social isolation and common mental health difficulties is well evidenced. Commissioners have therefore taken an innovative and positive new approach (see 3.1.1, Service ethos) that locates the mandated clinical IAPT interventions within the wider socio-economic context in which the service and its users exist.

It is expected that, through a strong outward-focus and the establishment of formal referral connections to and from a wide range of **existing external** (largely local authority funded) provision across the area, within limited resources, the clinical IAPT interventions will be better supported to maximize their effectiveness and sustainability and improve service user outcomes.

The outward-looking ethos of this service will require a holistic assessment that understands psychological issues in the wider context in which they exist. A wholly clinical assessment will not be sufficient to gain such an understanding of each person and could lead to failure to pick up on important factors that cause or influence the presenting issue.

i.ii Structure of the document

The expectations of IAPT's impact are extensive and cover a wide range of both core and issue/health/group-specific areas. This specification is therefore structured in sections that highlight these.

i.ii.i Delivery of the service's national and local outcomes

This specification is based on a set of strictly defined national requirements and outcomes, as well as sets of locally defined expectations and outcomes. While it does not strictly stipulate either the model by which the service ethos should be delivered, or exactly how the provider will measure the delivery, commissioners' expectations are ambitious. It crucially sets out an ethos and approach (above) that offers the opportunity to an innovative outward-looking and ambitious lead provider to draw on their experience, skills and connections to develop a delivery model to meet these requirements.

i.ii.ii Headings:

The document includes these key headings:

- *'Local defined outcomes':* This section lists the locally defined outcomes (in addition to the nationally mandated outcomes) to be achieved through this specification.
- *'Provider expectations':* Details the expectations that the provider will need to fulfil in terms of service standards and steps to be taken by them in their delivery of the contract.
- *'Key issues and tensions'*: These are included in all major sections and describe the particular issues and tensions that the provider will be expected to understand and take responsibility for continually working with dynamically in their service delivery.

They illustrate where such issues arise (with particular local resonances) variously due to, for example:

- Demographics, equality/under-representation, geography and/or mental health profile.
- The picture of primary/secondary services across the area.
- Conflicts inherent in different delivery decisions (which may/should change/flex over the contract period). For example, the balance of courses, groups and individual interventions; the use and range of digitally-enabled interventions; user choice vs short waiting times.
- National guidance and potential for service efficiency being at odds with key messages from local service user experience and preference.

Commissioners do not prescribe fixed delivery responses to these issues, but attempt to show an understanding of them and offer the provider the agency to work with and find solutions over the course of the contract.

i.iii The IAPT Manual

The national expectations of IAPT service delivery are documented in the IAPT Manual and further developed in the Positive Practice Guides. The reporting requirements of the MDS (Minimum Data Set) are provided on the NHS digital website.

These national documents must be used to inform the core delivery of the service. This specification does not rewrite the requirements and good practice guidance of these documents, but rather reinforces them and expects that they are used throughout.

The Manual describes the complexities involved in delivering an effective IAPT service, and Commissioners have built on it and the suite of Positive Practice Guides by integrating the learning from the three current (BNSSG) services and the public engagement/consultation process to construct this specification.

i.iv Note on navigation

This specification shows the inter-relatedness of its sections. In order that wording is not reproduced in multiple locations, where expectations/explanations are described elsewhere, they have been cross-referenced wherever possible.

Contents

SCHEDULE 2 – THE SERVICES

A. Service Specifications

Service Specification No.	TBC
Service	Improving Access to Psychological Therapies across Bristol, North Somerset and South Gloucestershire
Commissioner Lead	Ian Popperwell
Provider Lead	TBC
Period	10 years (with a 3 year break point)
Date of Review	TBC

1. Population Needs, evidence review and national IAPT priorities

1.1 Local context and evidence base

1.1.1 Background

There are nearly one million residents in BNSSG, and nearly half of the population live in Bristol. There are three acute hospital trusts, an ambulance trust, four providers of community services and a mental health trust, as well as 104 GP practices and supporting organisations including those from the voluntary and community sector.

Some people's mental health issues are recurrent, long-term conditions, while others' are short-term and temporary. Either way, they can occur alongside a range of physical and behavioural co-morbidities which can have a considerable impact on a person's life. Social, economic, relational and cultural factors also have a substantial impact on mental and physical health, and The Marmot Review (2010)[1] described and evidenced these social determinants.

Bristol and South Gloucestershire are home to two large universities (the University of Bristol and the University of the West of England, UWE) with a current joint student enrolment of circa 51,000 – around 5-6% of that of BNSSG (although not evenly distributed). There are

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[1] Marmot, M. Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010. The Marmot Review. 2010.

also a number of further education (FE) colleges which add greatly to the overall number of post-16 students. While the mental health of students is an important issue, estimates vary considerably as to its size and severity (a 2016 YouGov poll found 27% of students reported having a mental health problem of one type or another, while a 2015 National Union of Students survey found 78% of respondents said that they 'believed that they had experienced mental health problems in the last year'). Of particular relevance to IAPT is that, in both examples, depression and anxiety were by far the most prevalent mental health issues reported. Additionally, the NUS survey reported far higher than average levels of suicidal ideation.

Local authorities are required to meet national government targets in relation to house-building in order to meet the needs of the growing population. Their Core Strategy documents pledge to increase the local housing stock (from all sectors) as follows: Bristol a minimum of 26,400 between 2006 and 2026, North Somerset 20,985 for the same period, and South Gloucestershire 22,540 between 2013 and 2027. This represents an annual increase of nearly 4,000 dwellings until 2026 which will inevitably have an impact on the shape and demographics of neighbourhoods over the area.

Note that the three local authorities will update their JSNAs (Joint Strategic Needs Assessments) throughout this contract.[2,3,4] Sections of the latest versions are provided as Appendices D1 to D3.

Additionally the Bristol, North Somerset and South Gloucestershire Case for Change – Addressing the Health and Wellbeing Gap, provided here as Appendix-C (and also on the Bristol City Council website),[5] describes the local context, the changing health and care needs, and the key health and wellbeing challenges facing the BNSSG health and social care system.

1.1.2 Bristol, North Somerset and South Gloucestershire profiles

Bristol: Bristol is the major city of the South-West region, and the seventh largest city in England. In national policy terms it is one of the eight English Core Cities. Locally, it is the economic and cultural hub of the West of England (former Avon) sub-region. The unitary authority has a population of approximately 454,200 people (2016): roughly two-thirds of the greater Bristol conurbation. Bristol is part of the West of England Local Enterprise Partnership (LEP) area. On a city-wide scale, Bristol's status as the major regional centre attracts inward investment and national programming.

Bristol is a city of extremes of wealth and deprivation, sometimes such areas are in close proximity to each other, with the major areas of deprivation being in the north fringe area, south Bristol, and central/east inner-city Bristol. Under-achievement in education and low skill levels have been identified as key areas for improvement to enable the most deprived areas to benefit from economic growth. There are significant health inequalities and life expectancy gaps alongside economic deprivation. Patterns of disability mapped across the city broadly follow the geography of deprivation. The last Census recorded at least 16% of the population as having a "life limiting long-term illness or disability". However, this rate is considerably higher in the more deprived outer areas at over 20%, and there is an average 9 year gap in life expectancy between the most and least deprived areas of Bristol. However health on average is very good when compared with the other Core Cities, and the estimation of healthy life expectancy at age 65 is also good when compared with them.

Bristol's population is projected to increase by 2021 to roughly 473,000, largely being driven by rising birth rates and by migration. Unlike its West of England neighbours, Bristol's population is skewed towards a younger age profile, and the rising birth rate is due to an underlying high population of people in their 20s and 30s. Over the next 10 years Bristol's

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[2] Bristol City Council JSNA website.

[3] North Somerset Council JSNA website.

[4] South Gloucestershire Council JSNA website.

[5] Bristol, North Somerset and South Gloucestershire (BNSSG) Case for Change – Addressing the Health and Wellbeing Gap

population is expected to see growth in four areas (0-15s, 20-35s, 50s, and over 75s). The population of 0-15s will rise by 17.6% between 2010 and 2020, an increase of 12,700 children. The proportion of older people at 13% is, by contrast, much smaller than in the surrounding areas and when compared nationally, and is not projected to rise significantly, although the proportion of very old people - over 85s - is increasing significantly.

Bristol is the most culturally and ethnically diverse area in the South-west, and some areas now rival parts of London for the range of countries of origin and first languages spoken. By 2011, 15% of people were not born in the UK, 45 religions, 50 countries of origin and 91 languages were represented in the city. This diversity has expanded geographically over time particularly into north Bristol. The biggest groups arriving in Bristol recently have been white Eastern European, particularly since the expansion of the EU, and Black African, particularly from Somalia. Recent estimates put the Somali population at approximately 10,000. The other main area of growth in diversity is in mixed race or dual heritage, particularly amongst the young.

Bristol’s (and surrounding counties’) population of severe and profoundly Deaf people is estimated to be three times higher than the national average and second only to London, and is made up of British Sign Language (BSL) using residents, hard of hearing, deafened and deafblind people. Bristol therefore provides a focus for a strong BSL-using Deaf Community estimated to be nearly 500.

As the major regional centre, Bristol acts as a focus for a range of activities and services for marginalised or otherwise “hard to hear” groups, particularly the lesbian, gay, bi-sexual or trans-gender (LGBTQ+) communities. It is hard to establish figures but estimates suggest that there are roughly 26,500 LGBTQ+ people in Bristol.

Bristol has a range of household types - stand out features being a high proportion of adult households with no children (students, young professionals, etc), and a high percentage of people living on their own (38%), of whom a significant proportion are people over 65 (est. 21,000 people) (2012).

(Adapted from the Quartet Community Foundation’s 2014 Bristol Area Profile).[6]

North Somerset: North Somerset covers an area of around 145 square miles and has a population of 212,834 people. The main settlements include the town of Weston-super-Mare and the three smaller towns of Portishead, Clevedon and Nailsea. Over two thirds (67%) of people in North Somerset live within these four towns, with the remaining living in the villages and countryside.

There is a particularly high elderly population in comparison to both England and the South West. North Somerset has a high proportion of people over the age of 65, one in four which is higher than the average for England of one in six (ONS, 2017). Its population is projected to age quicker than the other West of England areas.

North Somerset is one of the fastest growing parts of the West of England with significant new housing developments outside Weston-super-Mare and Portishead, with more planned over the next twenty years.

Like its rural West of England neighbours North Somerset is not a deprived area overall but it has the third largest gap between the most and least deprived in the country. The most prevalent contributors to deprivation in North Somerset, and Weston-super-Mare in particular, are barriers to employment, and health and disability. The relationship between poverty and health is therefore a key issue for public policy in North Somerset. The take up of Incapacity Benefit (now Employment and Support Allowance) in particular is especially high in areas where other deprivation indicators predominate and is the main source of income for a significant proportion of households in these areas – rather than Jobseekers Allowance.

Overall the health of people in North Somerset is generally better than the England average. Life expectancy is similar to England at 84 years for women and 80 years for men, but this masks disparities within the area. Life expectancy is 9.9 years lower for men and 7.9 years lower for women in the most deprived areas of North Somerset than in the least deprived

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[6] Bristol Area Profile. Quartet Community Foundation. 2014.

areas and remains a significant priority for health and social care services.

Economic and administrative activity is focused on Weston-super-Mare, the county town, and the majority of voluntary and community sector organisations are also located there. With a coastline along the River Severn estuary, North Somerset is a tourist destination.

The population of North Somerset is less ethnically diverse than England and Wales with 97% of people living in North Somerset classifying themselves as belonging to a white ethnic group, a decrease of one percentage point since 2001. Of those from a black or minority ethnic group 44% classified themselves as Asian and a further 37% classified themselves as mixed race.

(Adapted from the Quartet Community Foundation's 2014 North Somerset Area Profile[7] and the North Somerset JSNA Population chapter (Appendix-D2.1))

South Gloucestershire: In the 2001 census, the population of South Gloucestershire was 245,641. By mid-2016, the population had increased to 277,600. South Gloucestershire is the 54th least deprived Local Authority in England (ranked 273rd out of 326). The area has relatively high levels of economic prosperity, with one of the highest levels of employment in the country.

South Gloucestershire has one of the fastest growing populations in the South West, and the area is the second largest of the four unitary authorities of the West of England sub-region. The area of Kingswood, which borders Bristol, was a mining area and suffered through the decline of traditional industry. South Gloucestershire unitary authority area was formed in 1996 following the merger of Northavon District, a mainly rural area, and Kingswood Borough, a mainly urban area east of Bristol. Much of the recent and projected growth is a result of the building of large new housing estates and the arrival into the area of large employers such as the MOD and Friends Life Insurance (formerly AXA). The voluntary sector has developed in recent years and CVS South Gloucestershire is now well established and supported by the Local Authority, and works in partnership with other statutory agencies and community anchor organisations to support groups across the area. South Gloucestershire is part of the West of England Local Enterprise Partnership (LEP) area.

South Gloucestershire Council and Partnership recognise that a few areas are significantly more deprived than average and define 6 areas as Priority Neighbourhoods for policy purposes. These areas were defined as areas where "higher numbers of people do not achieve their full potential, have poorer health outcomes, are employed in less well-paid jobs or are unemployed, and there are higher levels of crime". Although mostly small areas dispersed around the area, roughly 44,000 people live in these Priority Neighbourhoods, and the majority of them are located in the older urban areas bordering Bristol (with the exception of Yate/Dodington – an "expanded town" principally developed in the 1960s).

Of South Gloucestershire's 165 LSOAs (Lower Layer Super Output Area) only 19 are in the top 40% of the most deprived LSOAs nationally, representing 11.5% of the South Gloucestershire population. Nearly 68% of the South Gloucestershire population are among the 40% most affluent LSOAs in the country, indicating that areas of deprivation exist despite the area being generally seen as affluent. With much of South Gloucestershire benefiting from the protective effect of the areas general affluence, the poorer health outcomes of the more deprived may be missed when looking at South Gloucestershire as a whole. Income deprivation is a key component of poverty and deprivation as defined in local and national policy, and is widespread in South Gloucestershire both for children and for older people. Both groups follow the same geographic patterns, and they are broadly similar throughout the time period of the IMD (2004-2010). It is worth noting that 1 in 9 children in South Gloucestershire live in poverty, and two thirds of them live in areas outside the designated Priority Neighbourhoods.

South Gloucestershire is a more ethnically diverse area than its more rural neighbours - North Somerset and B&NES. The majority of people from Black & Minority Ethnic (BME) backgrounds live in the urban parts of the district. Overall the BME proportion of the

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[7] North Somerset Area Profile. 2014. Quartet Community Foundation.

population has grown to nearly 6% in the last ten years, and is as much as 8% (comparable with Bristol) in Bradley Stoke – some 21,600 people. The most common countries of origin are India and Poland according to GP registration records. 1 in 11 children are from a BME or mixed heritage background. South Gloucestershire has the highest population of gypsies and travellers, and the highest numbers of traveller pitches in the West of England. South Gloucestershire Council hosts the Ethnic Minority and Traveller Achievement Service on behalf of neighbouring authorities, and reaching out to these communities is a priority in South Gloucestershire.

There is a gap of 2.8 years in life expectancy between those that live in Priority Neighbourhoods compared to South Gloucestershire as a whole in 2014. There is a slight increase since 2006 that shows the inequality in life expectancy across South Gloucestershire is widening.

(Adapted from the Quartet Community Foundation's 2014 South Gloucestershire Area Profile[8] and the South Gloucestershire JSNA (Appendix-D3))

1.1.3 Overall levels of wellbeing and happiness

When asked, three out of four (75%) of people across England say that they have high or very high rates of happiness, compared to 71% in Bristol, 77% in South Gloucestershire and 78% in North Somerset. Feelings of people's lives being worthwhile were higher with 84% across England similar rates in North Somerset, 83% in Bristol and 86% in South Gloucestershire. Notably, responses for low levels of happiness decreased in Bristol (from 11.0% to 9.4%) and North Somerset (from 8.8% to 7.3%) between 2015/16 and 2016/17 and increased in South Gloucestershire (from 8.0% to 9.0%).

1.1.4 Health needs across BNSSG

The population of BNSSG is growing and the health needs are changing:

- The population is due to grow significantly in the next few years, with a large increase in people aged over 75. Indeed the BNSSG population is likely to rise at a greater rate than national projections as they do not take into account dwelling-led population growth. Local people are living longer and older people tend to have additional health needs related to complex multiple conditions.
- The health of the people in BNSSG overall is generally good, however there is great variation across the population.
- There are widespread inequalities across BNSSG, with stark health inequalities and high differentials in life expectancy (as above).
- The most common causes of premature death in BNSSG are due to cancer, heart disease and stroke, liver disease and injury. These main causes of early death are often preventable and amenable to public health interventions. Behavioural and lifestyle factors including smoking, excessive alcohol consumption and poor diets are linked to an increasing number of diseases and conditions.
- The prevalence of mental health problems disproportionately affect people living in the most deprived areas, with rates of self-harm proving to be a significant local issue.

1.1.5 Levels of mental health needs within BNSSG

Estimates suggest that just over 1 in 5 people who live in Bristol experience common mental health problems, higher than the rates in England (16%), North Somerset (17%) and South Gloucestershire (14%). See table below for more details and an outline of other mental health problems that are covered by the IAPT service.

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[8] South Gloucestershire Area Profile. 2014. Quartet Community Foundation.

1.1.6 Table 1: Estimated prevalence of persons with common mental health problems, SMI (severe mental illness) and learning disability across, Bristol, North Somerset and South Gloucestershire

Mental health condition	England (%)	Bristol (%)	N Somerset (%)	S Gloucestershire (%)
Common mental health disorders	16	21	17	14
Mixed anxiety and depressive disorder	9	13	10	8
Depression	9	10	11	9
Generalised anxiety	5	5	5	4
Post-Traumatic Stress Disorder	3	3	3	3
Obsessive Compulsive Disorder	1.1	1.1	0.7	0.9
Panic Disorder	0.7	0.8	0.6	0.5
SMI	0.92	0.98	0.84	0.57
Learning disability	0.5	0.5	0.5	0.4

Source: Public Health profiles

1.1.7 Self-harm and suicide rates

Deliberate self-harm is the act of deliberately causing harm to oneself by causing a physical injury, putting oneself in dangerous situations and/or self-neglect. Rates of emergency admission for self-harm are significantly higher in South Gloucestershire (210 per 100,000) and Bristol (290) than across England (185), whereas in North Somerset (176) the rate is similar.

The suicide rates for the BNSSG area between 2014 and 2016 were significantly higher in Bristol (13 per 100,000 population) than across England, similar to England in North Somerset (10) and significantly lower in South Gloucestershire (7).

1.1.8 Impact of mental health on employment

Employment is a primary determinant of health, impacting both directly and indirectly on the individual, their families and communities. Unemployment is associated with an increased risk of mortality and morbidity, including poor mental health and suicide.

Rates of Employment Support Allowance for people with mental health concerns are high in Bristol (34 per 1000 population) and North Somerset (31) when compared to England (28) but lower in South Gloucestershire (16).

1.2 Evidence review summary

Public Health, Bristol City Council (October 2017)

The full evidence review search notes are provided as Appendix-B.

Links to key related sections:

2.3 Measurement, evaluation and learning/development

1.2.1 Holistic models for IAPT delivery

- A particular concern for this evidence request related to information on "holistic models of IAPT delivery", i.e. models where IAPT was delivered in combination with a consideration for employment, social prescribing, physical health, and other factors.
- There was a lack of evidence on such holistic models of IAPT delivery. Such models could not be identified in the (limited) literature search undertaken (of both academic and grey literature). Services appear to focus on limited factors, such as employment or a particular health condition, instead of encompassing 'the person as a whole'.
- Some IAPT services refer to (or are linked to) services that appear to be more holistic in their approach – these include Life Rooms (Mersey Care) and Spring to Life (Birmingham).
- This lack of evidence does not indicate that such a holistic model would not work, but that it perhaps has not yet been tested, or that such evidence has not been made publically available.
- As this innovative model is being pursued across BNSSG for the IAPT service, it is very important that evaluation is built in to the programme from the start. This would be crucial in monitoring the development and success of any changes made, and would help to build a future evidence base for such a model.

1.2.2 Employment advice and other concurrent interventions

- IAPT guidelines have always expected teams to include one employment specialist per every eight therapists; however the current ratio nationally is 1:50.
- Evaluation evidence indicates that clients who see employment advisers appear to view this positively, however the quality of evidence is not particularly robust – it remains unclear how crucial such services are in relation to the outcomes claimed.
- Evidence is lacking on how to best implement or embed employment support into IAPT services.

1.2.3 Other associated connections

- Some other suggestions of services to incorporate with IAPT include money advice, nature-based interventions, and arts therapy.
- Early "integrated LTC IAPT" implementers seem to focus on specific physical health conditions, such as COPD or diabetes, in relative isolation.

1.2.4 Quality of evidence

- The difficulty in drawing conclusions from the general IAPT evidence base is that many studies and evaluations are not comparative. Where individual services have reported successes, it cannot be known whether such improvement would have occurred in any case.
- Additionally, lack of comparative evidence means we cannot say anything about whether an 'enhanced' model "works better" (or worse!) than a traditional model.

1.2.5 Lessons from well-performing IAPT services

- Oxford Academic Health Science Network (AHSN) has reported success in improving recovery rates in its region. A crucial part of this success is monthly collection and analysis of key performance data, with feedback provided to individual services. Based on the local data, additional staff training is provided (e.g.

on specific disorders) and services ensure that the NICE-recommended number of IAPT sessions is provided. (For full details, see search document).

- Swindon's LIFT Psychology model has reported access rates "well above 19%" consistently for more than two years.
- Islington's iCope IAPT service has reported improvements in recovery rates. It is staffed with a "larger force of step 2 workers" and offers a variety of interventions including computerised CBT.
- In terms of improving the access rates of BME populations, one element noted in the literature is the involvement of service users in the planning of services. Having link workers in GP practices has also been suggested as a useful approach.
- For further examples/case studies, refer to the full literature search document.

1.2.6 Large evaluations

- Some factors for success noted in the 2013 national evaluation of the first year of IAPT were a higher average numbers of sessions, larger proportion of experienced staff, and higher step-up rates for individuals who started with low intensity treatment.
- The 2011 interim evaluation of IAPT services in the South West emphasised service design factors such as a greater range of group based interventions offered, a greater proportion of step 2 workers, and multiple access methods to the service, as being associated with higher access rates.
- An audit in a London borough particularly noted the impact of session numbers and the amount of clinical contact time as impacting recovery rates.

1.3 National IAPT priorities

The provider will use the IAPT Manual[9] which will form the basis, and guide their delivery of the service.

The manual encompasses the following national priorities for IAPT service development and delivery:

- Expanding services so that at least 1.5 million adults can access care each year by 2020/21.
- Focusing on people with depression and/or any of the anxiety disorders. 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 (these are called 'IAPT-LTC services' in the manual). Such services should also have a focus on people distressed by medically unexplained symptoms, to help this group of people achieve better outcomes.
- Improving quality and people's experience of services. This includes improving the numbers of people who recover, reducing geographic variation between services and reducing inequalities in access and outcomes for particular population groups.
- Supporting people to find or stay in work, so that IAPT services can better meet a person's individual employment needs and contribute to improved employment outcomes.

2. Outcomes

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[9] The Improving Access to Psychological Therapies Manual. 2018.

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1	**Preventing people from dying prematurely**	✓
Domain 2	**Enhancing quality of life for people with long-term conditions**	✓
Domain 3	**Helping people to recover from episodes of ill-health or following injury**	✓
Domain 4	**Ensuring people have a positive experience of care**	✓
Domain 5	**Treating and caring for people in safe environment and protecting them from avoidable harm**	✓

2.2 National outcomes

Links to key related sections:

2.3 Measurement, evaluation and learning/development
3.1.3 Co-production and user involvement
3.2.2 Improving access to, and accessibility of the service
3.2.3 Timeliness of service
3.2.6 Recovery

2.2.1 Access standard

The access standard for IAPT services to achieve by 2015 was 15% of the community prevalence of depression and anxiety disorders (900,000 people nationally). The Five Year Forward View for Mental Health[10] sets out that this should rise so that at least 25% of adults with depression and/or anxiety disorders will be able to access IAPT services each year by 2020/21.

Locally this means that, in order to achieve a 15% access rate, the service needs 20,500 people presenting to it (referrals including self-referral). In order to expand the access rate to 25%, the service needs 30,000 people presenting to it (referrals including self-referral).

2.2.2 Waiting times standard

Of the referrals that have a course of treatment, 75% should have their first treatment session within 6 weeks, and 95% within 18 weeks (100% of pregnant women should have their first treatment session within 6 weeks of referral).

It is good practice for the waiting time standard to be applied to each of the initial interventions (low-intensity and high-intensity therapies) that are offered during a course of treatment. Services should also guard against hidden waits within a course of treatment. For example, this means that there should not be an excessive wait between the first and second appointment for a particular therapy. If the therapy sessions are generally meant to be weekly or fortnightly, then the gap between the first and second session should be similar. For people who are stepped-up between low-intensity and high-intensity therapies, the wait between the last low-intensity therapy session and the first high-intensity session should be minimised and certainly should not exceed the waiting time standard for the first intervention.

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[10] The Five Year Forward View for Mental Health. NHS England. 2016.

2.2.3 Recovery standard

The national recovery rate standard is that a minimum of 50% of eligible referrals should move to recovery.

It is critically important to ensure complete and accurate problem descriptors paired with the correct disorder specific measure, so that these can be counted in the recovery rate calculation.

2.3 Measurement, evaluation and learning/development

Links to key related sections:

1.2 Evidence review summary
2.2 National outcomes
2.5 Local defined outcomes
2.6 Provider expectations
3.1.2 Equality and equity
3.1.3 Co-production and user involvement
3.2.2 Improving access to, and accessibility of the service
3.2.6 Recovery
3.5.1 Primary and secondary mental health interface

2.3.1 Background

The national requirements for IAPT to report on the Minimum Data Set (MDS)[11] are clear and the IAPT Manual (and Positive Practice Guides) [12] provide thorough guidance.

Other documents included in the references provide further specific guidance in relation to particular issues and groups.

Over the course of the contract, this service will need to develop and adapt, shaping itself to meet changing need, demographics and national requirements. In order to be able to achieve this, a culture will need to be nurtured across the entire service that is flexible and enthusiastic about learning and improvement.

2.3.2 Key issues and tensions:

2.3.2.1 Continual measurement is a core component of IAPT services, however the time taken for it in each session can be misunderstood or not communicated clearly enough. It is essential that the reason for and importance of measurements in each session are explained from the point of assessment.

2.3.2.2 It is important that IAPT interventions have a sustained positive effect on the lives (and wider wellbeing) of their users. The MDS requires the collection of data at sessions but does not measure the service impact after discharge. A service that is committed to quality and improvement will expect to collect follow-up (hard and soft) data to be able to understand its lasting impact and use this learning to assess the effectiveness of, and shape its interventions.

2.3.2.3 Commissioners recognize that follow-up measurement can be practically challenging, as for example, there can be low response rates, there are often more responses from people whose improvement has not continued or who are dissatisfied with the service and it can demand specific resources. To manage this, the provider will need to develop its methodology and work through its co-

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[11] IAPT Data Set. NHS Digital.

[12] IAPT Positive Practice Guides.

production arrangements to achieve best results within its resources.

2.3.2.4 Equality and demographic data will be reported to NHSE as part of the MDS and for the whole service. However, providing whole service average figures can inadvertently serve to mask local under-representation (by being balanced out by areas with higher numbers) and misrepresent the true picture across this large and diverse footprint. It is essential that the provider understands and proactively responds to all of its demographic data on a local level to avoid this.

2.3.2.5 The Manual states that the IAPT national standards are not a goal in themselves. The service must be transparent and accountable. It is important for providers to remember that the standards are simply aids to help services achieve the goal of providing timely and effective treatment. Consideration of the wide range of IAPT measures (symptoms, disability, employment and patient experience) is the most appropriate way to determine whether those goals have been achieved. Service leads and clinicians should pay attention to the broader picture of patient benefit and guard against any temptation to report performance data for national standards inaccurately.

2.3.2.6 Data analysts have a crucial role within an IAPT service because data quality is a key feature of the success of the IAPT programme. Ensuring alignment of national and local reporting is an essential task since commissioners are performance managed on national, not local, reports. Providing more in-depth local reports for analysis can support staff and managers to understand and improve the quality of the service provided.

2.3.2.7 Issues of patient fragility and the influence of the therapeutic relationship can lead to inaccurate responses (e.g. people feeling pressure to provide a positive response).

2.3.2.8 It is expected that the provider will use ‘test and learn’ and other piloting approaches to help develop a service that works across the wide geographical area and that is based on the outward-focussed ethos. Some developments will work better than others, and some will be more appropriate to particular groups, demographics or areas/neighbourhoods than others. It will be important to understand what works best, in which areas and for whom. It will also be important to understand what doesn’t work and why in order that it can be modified or ceased. The detail of measurement will be crucial to aiding learning. These tests/pilots must be accountable, properly measured and developed/evaluated alongside service users (and their representative organisations).

2.4 Relationship with commissioners

This contract affords the provider the responsibility and agency to operate within the available financial resources across the whole service using its data to help it make decisions and inform continual developments.

This contract places expectations on the provider to make connections and to develop pathways/protocols across the wider system. It is acknowledged that these will not all be easily accomplished without the reciprocal agreement and co-operation of the partner agencies or the support of CCG and local authority commissioners, and the CCG Locality leads.

Where issues emerge, and/or gaps are identified in the wider picture of health provision, they will be highlighted to commissioners at regular service delivery meetings.

The provider’s relationship with the CCG through commissioners and Locality Leads must therefore be dynamic, collaborative and transparent in order to ensure the best outcomes for service users and meet national requirements.

2.5 Local defined outcomes

Links to key related sections:

2.3 Measurement, evaluation and learning/development

3.1.3 Co-production and user involvement

2.5.1 Service ethos

2.5.1.1 The effectiveness of the service approach/ethos is demonstrated through full service evaluations.

2.5.2 Equality and equity

2.5.2.1 No group should find it harder to access the service than any other.

2.5.2.2 The service’s workforce mirrors the population across the service area.

2.5.2.3 The picture of service use reflects the diverse demographics of need within all populations across the area.

2.5.2.4 Through user and public surveys, the service is widely understood and trusted across all communities.

2.5.2.5 People will receive the same IAPT service no matter where they live (associated other local provision will vary depending upon county boundaries).

2.5.2.6 Service users will be able to receive interventions at locations that are most convenient to their home or workplace.

2.5.3 Improving access to, and accessibility of the service

2.5.3.1 Demonstrate a continually increasing access rate from the prevalence population over the course of the contract.

2.5.3.2 Demonstrate that access rates reflect local prevalence across all population groups.

2.5.4 Timeliness of service

2.5.4.1 Of the referrals that have a course of treatment, 75% will have their first treatment session within 6 weeks, and 95% within 18 weeks (see 2.5.9 below for standards for pregnant women).

2.5.4.2 At least the national average rate of attendance of assessments and treatments is achieved and maintained (demonstrated through monitoring).

2.5.5 Assessment

2.5.5.1 The assessment process is experienced positively and therapeutically by service users.

2.5.5.2 The assessment results in the most appropriate programme of treatment including referral to other associated provision.

2.5.5.3 Low levels of re-presentation to the service are demonstrated (when compared to national benchmarks).

2.5.6 Recovery

2.5.6.1 At least the nationally mandated 50% recovery rate will be demonstrated.

2.5.6.2 Service users who receive step-2&3 therapy show sustained recovery after completing treatment (through follow-up qualitative measurement).

2.5.6.3 Recovery rates follow the nationally mandated 50% across the nine protected characteristics (Equality Act 2010)[13].

2.5.7 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

2.5.7.1 People with a long-term health condition (from an established IAPT-LTC pathway) who also have depression and/or anxiety and are eligible for IAPT, receive an integrated approach to their physical and mental health.

2.5.7.2 Health staff from the IAPT-LTC pathways established by the service demonstrate a greater level of confidence in addressing their patients' mental health needs.

2.5.8 Issue and group specific outcomes

2.5.8.1 People who present to this service with depression and/or anxiety, and who:

- Have a learning disability
- Are neuro-atypical (including those with Autism Spectrum Disorder ASD and Attention Deficit Hyperactivity Disorder ADHD presentations/diagnoses)
- Have dementia
- Have an eating disorder
- Have experienced domestic and/or sexual abuse and/or violence in childhood or adulthood
- Are refugees
- Are homeless
- Are misusing substances (alcohol or drugs)
- Are in, or have been involved in the criminal justice system
- Are serving or formerly serving service men and women and their family members

And meet its eligibility criteria:

- Are able to access the service.
- Receive assessment and treatments that are appropriate to their needs.
- Are offered connection to relevant associated services through formal pathways (where they exist).
- Gain sustained improvement to their mental health through the service working in partnership with other specialist/relevant organisations/agencies.

2.5.9 Perinatal mental health

2.5.9.1 Women with known or suspected mental health problems who are referred in the perinatal period (pregnancy through to one year from the child's birth) are assessed for treatment within 2 weeks of referral and provided with psychological interventions within 1 month of initial assessment [NICE CG192].

2.5.10 Younger people (16 years +)

2.5.10.1 'Young People Friendly' status is achieved by the service for its work with 16/17 year olds.

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[13] Equality Act 2010.

2.5.11 Psychosis, bipolar disorder or complex needs (including those with personality disorder diagnoses)

2.5.11.1 People with a diagnosis of psychosis, bipolar disorder and/or people with complex needs (including personality disorders) who are experiencing depression and/or anxiety receive appropriate and effective interventions by IAPT or another service, where such treatment is judged not to be detrimental to their mental health or other treatments.

2.5.11.2 People with psychosis, bipolar disorder and/or complex needs (including personality disorders) are able to gain support for their common mental health difficulties outside, but supported by, secondary mental health services where appropriate through receiving psychological therapies.

2.5.11.3 People who present to the service with complex needs (including the various personality disorder diagnoses) will be able to better:

- Pay attention to the present/live in the moment (achieve mindfulness).
- Regulate their emotions.
- Tolerate distress or conflict.
- Navigate relationships with other people.
- Achieve motivation to avoid unhealthy coping skills, e.g. self-harm.
- Evidence good recovery rates.
- Evidence positive change in other areas of their lives e.g. housing situation, employment, finances.

2.5.12 Employment and job retention support

2.5.12.1 People’s immediate and short-term needs for job retention and job search goals are addressed through adopting an integrated approach to employment within the service and strong external connections.

2.5.12.2 People receive effective and skilled support to maintain their employment.

2.5.13 Housing and homelessness

2.5.13.1 People who present to this service with a housing (or homelessness) issue will be referred at assessment to the appropriate LA or LA commissioned housing advice/allocation service.

2.5.14 Tobacco cessation & harm reduction

2.5.14.1 As part of a wider tobacco control action plan for the Public Health outcomes of reducing smoking prevalence in young people and adults (16 yrs+), and reducing the number of pregnant women who smoke at time of delivery, IAPT service users who smoke are:

- Offered a brief smoking cessation intervention

And/or

- Referred/signposted to local smoking cessation interventions.

2.5.15 Connections and referral pathways to and from other existing services and support

2.5.15.1 Service users’ recovery is supported through the contribution of surrounding agencies working collaboratively with IAPT interventions.

2.5.16 Workforce

2.5.16.1 A diverse workforce is recruited that is representative of local demographics where possible.

2.5.16.2 The service reflects the top 25% of levels of staff retention in IAPT services nationally through the implementation of a range of wellbeing promotion, training opportunities, career development and management of sickness absence.

2.6 Provider expectations

Links to key related sections:

2.2 National outcomes

2.3 Measurement, evaluation and learning/development

2.5 Local defined outcomes

2.6.1 Measurement, evaluation and learning/development

The provider will:

2.6.1.1 Establish a culture across the service that promotes interest in and commitment to continual learning and its relationship to service development.

2.6.1.2 Construct (or use an existing) means of measuring and reporting the effect of using this service's outward-focussed ethos on a) service users, and b) the service's nationally and locally required outcomes.

2.6.1.3 Promote understanding of the need for detailed monitoring and use of data in service development.

2.6.1.4 Collect the IAPT MDS and have IT systems in place for the automatic reporting of data to NHS Digital on a monthly basis via the Exeter Portal within national timescales.

2.6.1.5 Send the MDS and all local monitoring data to the BNSSG CCG differentiated by GP practice.

2.6.1.6 Agree and fulfil the terms of an information schedule with commissioners for the collection and provision of a defined and consistent set of both qualitative and quantitative information (in addition to the MDS) which must include the GP practice of each referral and service user (including self-referrals). The data set should be chosen in order to support a holistic and nuanced measurement of service users' presenting difficulties in order to understand how the service can best help and its impact on them differentiated across GP practices. All of this data should be fed into service evaluations when undertaken.

2.6.1.7 Use the IAPT Manual's recommended measures of depression and anxiety, along with those for disability, MUS and others that are either required or support service need over the course of the contract.

2.6.1.8 Put systems in place for collecting follow-up data in order to evidence the extent to which recovery rates and wider service impacts are sustained.

2.6.1.9 Ensure complete and accurate data is collected and reported for all equality categories (protected characteristics within the Equality Act 2010), and, in the analysis, pay particular attention to how groups are under-represented against local demographic prevalence/profiles across BNSSG. Note that in order to meet requirements in relation to women in the perinatal period, in addition to recording pregnancy, the provider should also include women who have a child aged under one year.

2.6.1.10 Administer Patient Experience Questionnaires as advised by the IAPT Manual, and use their feedback and experiences to drive service development.

2.6.1.11 Establish ‘test and learn’ and other means of piloting new approaches and practice, replicating it for the groups/demographics/communities that its efficacy is proven for.

2.6.1.12 Build on specific evidenced (local and other) good practice models.

2.6.1.13 Accurately capture and reflect geographical disparities across the service.

2.6.1.14 In partnership with commissioners, appoint an independent institution to conduct full service evaluations within 4 months of the end of the second, fifth, seventh and tenth years of the contract.

2.6.1.15 Additional to the ring-fenced ‘innovation fund’ (see 3.1.1.2), commission an independent academic body with a wide contextual understanding of mental health from the start of the contract to study the effectiveness of the service’s ethos through researching its innovative practices with the aim of securing academic validation.

2.6.1.16 Report to commissioners (in a timely manner) on any challenges to effective service delivery identified, how they have responded in order to resolve them, and, if unresolved, plans and timescales for mitigation/recovery.

2.6.1.17 Record the numbers of individuals accessing the service who:

- Have a learning disability
- Are neuro-atypical (including those with Autism Spectrum Disorder ASD and Attention Deficit Hyperactivity Disorder ADHD presentations/diagnoses)
- Have dementia
- Have an eating disorder
- Are pregnant or have a child in its first year
- Have experienced sexual abuse and/or violence in childhood or adulthood
- Are refugees
- Are homeless
- Are misusing substances (alcohol or drugs)
- Are in, or have been involved in the criminal justice system
- Are serving or formerly serving service men and women and their family members

At the earliest possible stage in their presentation (from self/professional referral to assessment).

2.6.1.18 (Re 3.4.2 Exclusions) Record and report on (by GP cluster) those people who are declined an IAPT service, or referred on to a more appropriate care pathway (without a concurrent IAPT service).

2.6.1.19 Understand and work with numerous tensions and conflicts inherent in delivering the service.

2.6.2 Service ethos

The provider will:

2.6.2.1 Understand and fully integrate the service ethos into the culture, delivery and development of the service.

2.6.2.2 Ensure that the service is properly connected with the CCG’s Integrated

Community Localities.

2.6.2.3 Establish a ring-fenced 'Innovation Fund' that is at least 2.5% of the contract value.

2.6.2.4 Use the Innovation Fund to conduct a range of 'test and learn', pilot projects and other small scale experiments in order to establish the most effective work practice underpinned by the service ethos across the different populations, demographics and geography of the area. They will then:

- Record the results of all such experimentation to inform the building of an effective service model.
- Implement the results of the learning across the service as appropriate.
- Communicate regularly with commissioners about the results of these pieces of work and the development of the service model.

2.6.2.5 Secure academic validation for innovative service interventions that promote the service ethos from an appropriate research institution throughout the contract period (seeking any funding opportunities available for this).

2.6.3 Equality and equity

The provider will:

2.6.3.1 Embed equality and inclusion principles values and best practice into all of its structure and culture.

2.6.3.2 Promote an outward facing anti-discriminatory approach to the service, understanding how the experiences of stigma and discrimination, and requirements of different protected characteristics (Equality Act 2010) can be similar, different and layered.

2.6.3.3 Pay attention to all groups who have protected characteristics under the Equality Act 2010 (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation) ensuring accessibility, and proactively acting to address under-representation and poor outcomes in all localities.

2.6.3.4 Demonstrate a commitment to continual development in relation to equality to inform its practice, service development and improve representation over the whole service.

2.6.3.5 Make continual use of the IAPT Manual, Positive Practice Guides and the relevant guidance to support service delivery.

2.6.3.6 Understand the demographics of the area and how they change, proactively and specifically outreaching to particular neighbourhoods and communities (including BAME/cultural [14] , LGBTQ+, Deaf people, older and disabled people, neighbourhoods with high socio-economic disadvantage) who are typically under-represented in IAPT services.

2.6.3.7 Develop and maintain strong relationships with a wide range of voluntary sector and community organisations that can provide (through formal arrangement e.g. sub-contracting, partnership agreements, referral processes and protocols) particular knowledge, interventions, support and/or therapeutic specialisms in order to enable the service to most appropriately deliver its outcomes.

2.6.3.8 Deliver a culturally competent and appropriate service across the entire area, ensuring that learning and expertise is quickly shared and utilised from where it is held as and when required.

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[14] IAPT Black and Minority Ethnic (BME) Positive Practice Guide. NHS. 2009.

2.6.3.9 Integrate an understanding of LGB, Trans and gender identity issues within the service that develops with wider thinking and as guidance is produced.

2.6.3.10 Take into account the elevated Deaf (BSL-using) population in Bristol and the surrounding area to ensure that the service is adequately targeted, and both linguistically and culturally appropriate to the level of eligible need.

2.6.3.11 Ensure capacity in relation to community language capabilities (including for Deaf people for whom British Sign Language is the first language).

2.6.4 Co-production and user involvement

The provider will:

2.6.4.1 Establish a range of inclusive and accessible means of ensuring that the experience of people who use and/or have used the service, along with that of groups that are known to be under-represented within it, shape the service in the following areas:

- Establishment.
- Design/operating model.
- Monitoring systems.
- Evaluation.
- Review.
- Future development.

2.6.4.2 Develop strong relationships with user organisations across the area.

2.6.4.3 Take advantage of the connections made with neighbourhood and community organisations/groups to ensure that the experience and needs of under-represented groups are gained and used to develop the service.

2.6.4.4 Use the principles and practices of the National Survivor User Network (NSUN) '4Pi National Standards'[15] (provided as Appendix M) and associated resources[16] in their co-production and involvement work in this service.

2.6.5 Improving access to, and accessibility of the service

The provider will:

2.6.5.1 Ensure that the service's access rates across all localities are fully representative of the diversity of the local populations across the service area.

2.6.5.2 Undertake full and early capacity planning and demand modelling, and use them to drive the service's development.

2.6.5.3 Undertake extensive widespread publicity about the service to ensure general mainstream improvement of access rates.

2.6.5.4 Provide locally-based IAPT interventions where everyone can receive a service within reach of where they live (or work) unless they expressly opt out, and/or opt in to an intervention elsewhere (e.g. a group).

2.6.5.5 Ensure that all locations where IAPT services are provided are near to main public transport routes/stops with appropriate parking adjacent.

2.6.5.6 Make provision for one-off home visits on a session by session basis but only in those exceptional circumstances where a person absolutely cannot leave their accommodation by any reasonable means.

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[15] 4Pi National Involvement Standards. NSUN. 2015.

[16] 4Pi national involvement standards website. NSUN.

2.6.5.7 Source a wide range of building locations (NHS, community, LA etc) that are physically accessible and compliant with current access standards for all disabled people in relation to entry/egress, manoeuvre around the building, communications and toilet facilities.

2.6.5.8 Offer choice of appointment location in order to maximise attendance (e.g. near home, work, college, children's school).

2.6.5.9 Offer multiple ways into the service (including formal referral pathways from professionals/services, self-referral and supported referral).

2.6.5.10 Ascertain at the earliest stage, the preferred means of communication for each service user (e.g. writing, text message, telephone, VoIP, email) and only use these methods to communicate with them.

2.6.5.11 Request and hold information about each service user's access requirements and ensure that these are fulfilled.

2.6.5.12 Offer flexibility of appointment times to fit around, for example, work, childcare or caring responsibilities, student term times (for non-residents of BNSSG), public transport availability, mental health issues.

2.6.5.13 Source venues that can be drawn upon when needed with crèche facilities in order to enable access by women in the perinatal period where they would not be able to attend otherwise.

2.6.5.14 Understand, and take steps to address the impact of inequality, including socio-economic disadvantage and poverty on people's ability to access the service.

2.6.5.15 Respond to and work with the particular barriers to accessing or engaging with the service that are known to be faced by people with learning disabilities with eligible need.

2.6.5.16 Adapt materials to be appropriate to different groups. This includes written communication and visually-based resources available for people who do not speak English as their first language and for people with learning disabilities.

2.6.5.17 Implement both online and telephone based self-referral and associated triage, allowing people to sign up for wellbeing, self-help and self-management groups, courses, online options and other support instead of or before an IAPT assessment.

2.6.5.18 Outreach to key neighbourhoods and communities promoting IAPT and its approach to good mental health and wellbeing – also modelling the helpfulness of group learning/support.

2.6.5.19 Seek out and use established and emerging practice guidance in order to support work on improving access.

2.6.6 Timeliness of service

The provider will:

2.6.6.1 Develop an 'attendance and cancellation' policy that clearly locates responsibility for them with the service, and positively promotes engagement and attendance. This should include:

- Clear explanations of the definitions of, and expectations in relation to attendance and non-attendance.
- Acceptable notice periods to be provided for cancellation by service users and therapists.
- Flexible guidance to manage both service user and therapist absences due to sickness, and their impact on courses of treatment.

2.6.6.2 Use the IAPT Manual's guidance to maximise engagement and minimise waiting times. For example sending automatically generated reminders for appointments.

2.6.6.3 With service user consent, gain the support of other agencies who might also be working with them in order to help promote their attendance.

2.6.6.4 Be transparent with commissioners about the range of reasons for non-attendance and their mitigations.

2.6.6.5 Ensure that therapists use the time made available by patient non-attendance effectively, and provide them with the IT equipment necessary to undertake administrative tasks (including updating appointments, writing notes and records).

2.6.6.6 Have in place clear monitoring systems that will support learning and service development including the coding of attendance/non-attendance and cancellations.

2.6.6.7 Exercise the principles of good capacity and waiting list management.

2.6.6.8 Work within the NHS waiting time standard and apply it to those people who move from an IAPT waiting list in another CCG area to this service, ensuring that their total waiting time does not exceed 18 weeks.

2.6.6.9 Minimise hidden waits within a course of treatment - e.g. between assessment and the start of therapy, or the first and second appointment for a particular therapy.

2.6.6.10 Have in place written pathways with senior clinical sign-off, with agreed waiting standards for assessment, first treatment and all subsequent treatments in line with national IAPT referral to treatment standards.

2.6.6.11 Have a clearly expressed waiting list exceptionality policy (the reasons why people in certain circumstances are fast-tracked through the waiting list). For example, mothers in the perinatal period (pregnancy and in the child's first year), people with life limiting illnesses who are close to the end of life and veterans (whose depression/anxiety results from their service in the armed forces, subject to clinical need) will always be exceptions.

2.6.7 Interventions and therapies

The provider will:

2.6.7.1 Use robust (evidence-based) clinical judgement about which treatment is most appropriate for each service user's presenting issues.

2.6.7.2 Through PHQ-9 and GAD-7 monitoring, work with commissioners to determine the most appropriate and efficient balance between mild-moderate and moderate-severe levels of need.

2.6.7.3 Maintain an up to date knowledge of current best practice and of new treatments and their evidence base, and implement, evaluate and review their effectiveness over the course of the contract.

2.6.7.4 Understand that generic (mixed) groups can present anxiety or inaccessibility for some people and types of issue, and therefore provide a range of group and psycho-educational interventions that recognize different need. This will include specifically targeted approaches for particular groups or experiences (see 3.1.2).

2.6.7.5 Have, or be able to immediately draw on the necessary interpretation resources (including community and telephone services, 'community Link workers' etc) in order to ensure that therapies are conducted in the language chosen by the service user, bearing in mind the issues about interpreters (see 3.2.4.5).

2.6.7.6 Follow NICE guidelines where psychological interventions are delivered in combination with prescribed medications (see the IAPT Manual).

2.6.7.7 Keep up to date with and procure digitally enabled therapies that are well-evidenced, of the highest quality, appropriately accredited and will meet service outcomes.

2.6.7.8 Ensure that online and digitally-enabled therapy options are offered in a diverse range of community languages.

2.6.7.9 Provide positive online materials to encourage/help family members/friends/supporters to understand and support their relative's work through the service.

2.6.7.10 Using the principles of the FYFVMH, the growing body of evidence, and in collaboration with service users, source a wide range of digital and online therapy products that are chosen to meet both general and specific needs across the entire service.

2.6.7.11 Positively promote digital and online therapy options to all, and specifically target them to the groups who are known to benefit most from, and prefer them.

2.6.7.12 Demonstrate specific understanding of self-harm and suicide, competence in working with these issues and clear mechanisms to ensure that potential suicide risks are assessed, immediately flagged and referred directly to appropriate mental health services (within local protocols) alongside IAPT treatment if appropriate.

2.6.7.13 Work with commissioners to participate in any appropriate multi-agency approaches to suicide across the three local authority areas.

2.6.8 Assessment

The provider will:

2.6.8.1 Put in place a pre-assessment triage process that can get people to the right help early on (including local voluntary sector helplines), and divert some from requiring a full assessment and IAPT service. This will include a mechanism for identification of anyone in a serious mental health crisis and potential referral to appropriate local crisis services.

2.6.8.2 Put in place a holistic person-centred assessment process to explore people's difficulties in the context of their self-defined goals, wider lives and other long-term health conditions (including learning disability/Autism Spectrum Disorder).

2.6.8.3 Ensure that all assessors have the experience and skills to recommend the most appropriate intervention/treatment for each service user straight away in order to enable the best outcomes and avoid unnecessary re-presentation.

2.6.8.4 Through robust and skilled assessment, ensure that individual therapies are available quickly to those with the greatest clinical need for them.

2.6.8.5 Wherever possible/appropriate combine the first therapy session with the assessment (ensuring this is made clear to the person and their consent is gained).

2.6.8.6 Where possible within capacity and resources, offer the assessment in an appropriate medium for the person at a time convenient to them (this is particularly important for people who have anxiety around telephone communication).

2.6.8.7 Ensure that, whatever medium the assessment is conducted in (telephone, VoIP, face to face etc, it offers the same level of skill, sensitivity and empathy).

2.6.8.8 Have, or be able to immediately draw on the necessary interpretation resources (including community and telephone services, 'community Link workers' etc) in order to ensure that the assessment is conducted in the language chosen by the service user, bearing in mind the issues about interpreters (see 3.2.4.5).

2.6.8.9 Ensure that each person who has an assessment receives a package of interventions and external support most appropriate to the needs they present with.

2.6.8.10 Integrate equality competence and understanding into the assessment process.

2.6.8.11 Ensure that people with (all forms of) learning disability receive a skilled assessment that recognises and responds to their particular issues in relation to depression and anxiety.

2.6.9 Communications

The provider will:

2.6.9.1 Communicate with its service users clearly and in a timely fashion in the format that they have indicated as their preference.

2.6.9.2 Develop a consistent identity and message across the entire service (including all partners and subcontractors).

2.6.9.3 Positively and confidently promote the service's range of treatment interventions.

2.6.9.4 Put out clear, consistent and applicable messages about the service, how it can improve wellbeing, what it is, what it offers, what is available and for whom.

2.6.9.5 Ensure that sub-contractors, partners etc understand their role in the whole service and communicate it accurately.

2.6.9.6 Ensure that potential referrers are well informed about the service, its remit and eligibility.

2.6.9.7 Have an understanding of how inequality can impact communication styles and mediums e.g. using online and other forms of communication to reach different communities.

2.6.9.8 Provide clear and welcoming outward-facing communications that positively and straightforwardly publicise all aspects of the service.

2.6.9.9 Pay particular attention to:

- The services' presentation and the impression it creates.
- Directing publicity towards existing organisations over the area including developing co-location arrangements where venues are accessible – e.g. GP practices and 'community centres and hubs' etc.
- Targeting advertising at the range of common places where people go, e.g. GP practices, libraries, leisure centers and gyms, faith communities, entertainment venues, shopping centers pubs etc.
- Its communication methods (e.g. by telephone, electronically, face-to face, BSL) and use of social media.
- Direct positive and tailored outreach into communities that are known to be under-represented.
- Undertaking widespread local media campaigns.
- Providing publicity in a range of accessible forms and formats using straightforward language.
- Use of community languages and BSL in service delivery where spoken English is not the first language.
- Linkages with surrounding mental health services.

2.6.10 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

The provider will:

2.6.10.1 In partnership with commissioners, undertake careful capacity planning to determine the possible numbers of embedded staff in LTC pathways, and put in place a process for implementing the most effective and efficient ways of managing co-location and integration of IAPT and LTC/MUS pathways on a scale that will achieve best results.

2.6.10.2 Work together with the LTC pathways (where IAPT staff are embedded) to jointly provide training to both the LTC and IAPT staff, in order to deliver the best integrated mental and physical health care.

2.6.10.3 In partnership with commissioners, help to collate details of the clinical psychologists that are located within non-mental health secondary care LTC services and develop an understanding of when it may be more appropriate (and timely) for a referral to be made to them instead of IAPT.

2.6.10.4 Work with and support existing condition-specific health care pathways through education resources and training programmes, to integrate a better understanding of mental health into their work.

2.6.10.5 Provide self-management, issue-specific and generic psycho-educational courses, therapy and self-help/support groups, online treatments and resources that cross over conditions/pathways.

2.6.11 Younger people (16 years +)

The provider will:

2.6.11.1 Ensure that staff undertaking interventions with younger people will:

- Be trained to work with under 18 year olds.
- Understand their developmental needs and the differences in presentation between children, young people and adults.
- Be aware of relevant legislation and safeguarding.
- Use outcome measures validated for this age group.

2.6.11.2 Adopt the necessary communication methods, publicity and interventions to achieve demographically appropriate representation of younger people (including from all groups with protected characteristics (Equality Act 2010)) across the entire service.

2.6.11.3 Work jointly with Off The Record's counselling service (in Bristol and South Gloucestershire) to put in place a pathway into services and a clear protocol (covering referral, triage and assessment of young people) to ensure clarity about what each service can offer, differences and therapeutic boundaries to avoid duplication. This will include communicating clear joint messages.

2.6.11.4 Ensure that connections are made with young people's (care leavers') Personal Advisers in order to ensure proper connection with other provision they may be accessing.

2.6.11.5 Forge strong connections with Kooth (in Bristol and North Somerset) including full information and links on the public-facing website and with Off the Record (or any other providers of services specialising in the support of young people over the course of the contract).

2.6.11.6 Establish strong connections (with joint protocols) with further and higher education colleges and specific student health services across the area in order to ensure referral pathways for eligible students.

2.6.11.7 Develop an agreed pathway into the service without duplication of functions from the children/young people's counselling services. This is currently Off the Record and they undertake a triage function.

2.6.12 Older people (65 years +)

The provider will:

2.6.12.1 Demonstrate access to the service by older people that is demographically representative of the local population.

2.6.12.2 Promote the service to older people's groups as well as neighbourhood and community groups/organisations across BNSSG to ensure that the issues faced by older people are integrated into the service.

2.6.12.3 Promote older people's access to, and treatment within the service and ensure that it is informed within the context of equality and equity (see 3.1.2).

2.6.12.4 Demonstrate that no lower expectations of sustained recovery are held of older people than others who use the service.

2.6.12.5 Contribute to the training programmes of other healthcare professionals to increase identification rates of depression and anxiety amongst older people, and ensure that skills in working with older people forms part of ongoing CPD for IAPT staff.

2.6.12.6 Conduct outreach to residential care homes, sheltered and Extra-Care Housing services in order that their residents with depression and anxiety are not inadvertently excluded by the service.

2.6.12.7 Work with the Dementia service providers across BNSSG to establish good connections for referral pathways for people with dementia and their family members who experience depression and anxiety within the service's eligibility criteria.

2.6.12.8 Engage with local implementation of the Dementia Strategy and Carers Strategy.

2.6.12.9 Use the range of flexibility and focussed targeting/publicity options (see 3.1.2 and 3.2.2) to enable the greatest access of older people.

2.6.13 Perinatal mental health

The provider will:

2.6.13.1 Ensure full integration with, and collaboration between services in and connected with the perinatal mental health pathway. This will include the specialist community perinatal mental health services, voluntary sector organisations, Health Visitors and social care.

2.6.13.2 Communicate clearly to midwives, health visitors and GPs (and other referring professionals and agencies) how they can get help for eligible patients within the perinatal period quickly and how the service can work with this cohort of women.

2.6.13.3 Ensure that parental mental health issues are captured at the first presentation to the service in order that parents with perinatal mental health issues (during pregnancy and in the child's first year) can get help quickly and that the mother is prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks.

2.6.13.4 Offer a range of evidence-based individual and group interventions for this cohort of women, including specifically tailored low and high intensity packages that can adapt quickly to need and its impact.

2.6.13.5 Pay attention and positively respond to the particular needs of women with young babies in relation to attending therapy – e.g. ability to attend with their baby, providing crèche facilities.

2.6.13.6 Offer one-off home visits on a session by session basis but only in those exceptional circumstances where a mother absolutely cannot leave her accommodation by any reasonable means.

2.6.13.7 Offer support for the mental health needs of fathers, same sex parents and others in a partner/care-giver role in the perinatal period.

2.6.14 Learning disability and neuro-atypicality (including Autism Spectrum Disorder ASD and Attention Deficit Hyperactivity Disorder ADHD)

The provider will:

2.6.14.1 Make reasonable adjustments (Equality Act 2010) to enable full and equal access to treatment by people with learning difficulties and people who are neuro-atypical.

2.6.14.2 Provide specific support for people with learning disabilities to engage in its therapies through, for example, making accessibility adaptations to course/group content, allowing for more time in groups.

2.6.14.3 Ensure that it provides accessible ways in to external services and pathways rather than assume that people with learning difficulties can only be supported by specialist services.

2.6.14.4 Work positively and proactively to develop referral pathways with associated information sharing and joint working protocols to and from learning disability, ASD and ADHD services in the three local authority areas.

2.6.14.5 (Referring to section 3.5.1) Ensure strong connections and protocols with primary care, (NHS) secondary mental health and secondary learning disability provision.

2.6.14.6 Work in partnership with learning disability, ASD and ADHD services to increase their awareness of each other's services and skills in working with the cohorts.

2.6.15 Domestic and sexual abuse and violence

The provider will:

2.6.15.1 Provide high levels of generic awareness and capability across the service in relation to domestic abuse/violence including recognition of its signs and associated indicators.

2.6.15.2 Develop a procedure for clear decision-making at assessment for extending (individual and group) therapy where appropriate for people presenting with these issues.

2.6.15.3 Draw on skilled specialist therapists to provide IAPT interventions for people presenting to the service with depression/anxiety who have experienced domestic abuse/violence (and meet IAPT eligibility).

2.6.15.4 Draw on skilled specialist therapists to provide IAPT interventions for people presenting to the service with depression/anxiety who have experienced childhood or adult sexual abuse and/or violence (and meet IAPT eligibility).

2.6.15.5 Build strong relationships with the SARC and other local provision for people who have experienced domestic and/or sexual abuse/violence, establishing robust referral pathways, to ensure seamless and connected interventions and avoid duplications or fractures/gaps in provision.

2.6.16 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)

The provider will:

2.6.16.1 Be clear about the interventions it can provide and which presentations they are appropriate for (noting that people using secondary mental health services, and those with complex needs and personality disorders, are entitled to access IAPT where it provides treatments appropriate to their eligible needs).

2.6.16.2 Undertake and promote close locality–based joint working between GP practices and secondary mental health services to support the development of flexible interventions and greater awareness/understanding of the eligibility for, potential of and limits of each level of intervention. This will include:

- Joint training between primary care, IAPT and secondary mental health staff.
- Holding jointly facilitated (by IAPT and secondary mental health staff) groups in GP practices.
- Knowing what other services (see 3.2.14.2) across BNSSG for these cohorts can and cannot provide.
- Forging strong links with secondary mental health services through the Primary Care Liaison services (and the Complex Psychological Interventions (CPI) service in Bristol), in order to be clear about who the service can and cannot work with.
- Seeking advice from secondary services as appropriate, on the potential benefits and/or risks of IAPT therapies for these cohorts.

2.6.16.3 Ensure that assessors have the levels of understanding, skill and competence to identify the particular presentations of people with complex needs (who have a personality disorder diagnosis), and to recommend the most appropriate evidence-based treatment programme for them.

2.6.16.4 Provide a range of evidence-based individual and group therapies to meet the needs of people from these cohorts presenting to the service – including trauma-informed interventions specifically aimed at them.

2.6.16.5 Provide specifically designed self-help resources (that can be offered prior to or concurrent with therapy) for these cohorts.

2.6.16.6 Ensure that, from referral and assessment, these groups have the same access to the external referral pathways in relation to support for socio-economic/housing/homelessness/long-term health conditions/etc.

2.6.16.7 Through the assessment and review processes, collect data (where possible) on the unmet needs of people with a PD and report it to commissioners.

2.6.16.8 Connect with CCG work undertaken over the course of the contract to develop a PD pathway over BNSSG and ensure its full integration into the service to increase access and recovery of this cohort.

2.6.16.9 Ensure that opportunities for additional funding made available for work with this cohort are taken advantage of over the course of the contract.

2.6.17 Employment and job retention support

The provider will:

2.6.17.1 Ensure that the service maintains a strong recognition of people’s right to work and of the support they might need to maintain their employment during their use of IAPT.

2.6.17.2 Maintain timely communications with GPs in relation to job retention work within IAPT in order that they can work supportively with fit for work notes, phased returns etc.

2.6.17.3 Develop referral pathways/protocols to and from existing national and local agencies that support disabled people (including people with mental health difficulties) to find or remain in work.

2.6.17.4 Establish specialist employment advisor posts embedded in teams who can quickly capture live employment issues that have impacted on service users' presentations of anxiety and depression, intervening at any stage from referral and complementing therapists' work. They will:

- Promote an awareness of employment (and unemployment) throughout the service, supporting therapists to understand how it might impact upon their clients.
- Use job retention support skills, working with the employee and their employer to prevent job loss.
- Work directly with individuals to establish basic job search goals and work on connecting people into job search programmes or employment support.

2.6.17.5 Provide person-centred support to assist people to set and meet their own employment-related goals.

2.6.17.6 Connect with Local Authority led programmes promoting mental health in workplaces and work to counter stigma and discrimination.

2.6.18 Poverty, debt and benefits advice

The provider will:

2.6.18.1 Develop robust connections with referral protocols to welfare rights and debt advice services across the area.

2.6.18.2 Recognise and refer people (to appropriate local services) who present with a financial difficulty either instead of, or concurrently with IAPT therapies.

2.6.19 Housing and homelessness

The provider will:

2.6.19.1 Publicise itself clearly to homelessness services across the area to promote understanding of IAPT, its purpose, remit and eligibility.

2.6.19.2 Establish robust connections and clear referral protocols to and from the three (across BNSSG) local housing departments and homelessness services/pathways.

2.6.19.3 Shape the service in relation to new housing developments across the area, understanding the associated demographics and prevalence of depression and anxiety.

2.6.19.4 Record the number of individuals accessing the service who are also homeless or in homeless pathways accommodation.

2.6.20 Tobacco Cessation & Harm Reduction

The provider will:

2.6.20.1 Ensure that service users who smoke are:

- Offered brief advice and brief intervention [17] in accordance with NICE guidance quality standards[18] and related guidance including smokers with COPD[19]; and pregnant women who smoke.[20]

And/or

- Referred/signposted to local smoking cessation interventions.

2.6.20.2 Work collaboratively with local Public Health teams and smoking cessation services to support their delivery of smoking cessation/harm reduction.

2.6.20.3 Nominate a proportion of PWP staff to receive the initial 2 day smoking cessation advisor training and subsequently attend at least one update session per year in accordance with NICE guidance (NG92)[21] and quality standards[22].

2.6.20.4 Provide monthly data to commissioners and appropriate local Public Health leads electronically on smoking cessation activity (for example via Quit Manager www.bristolquitmanager.co.uk in Bristol).

2.6.20.5 Actively promote tobacco control campaigns and provide advice including on smokefree homes and vehicles to prevent harm to children and young people from secondhand smoke. (A training module is available from Bristol Public Health (Health Improvement Team) or via the National Centre for Smoking Cessation and Training). [23]

2.6.20.6 Support and engage with innovative research proposals that support the tobacco cessation/harm reduction agenda at a local level (e.g. the current IAPT research at the University of Bristol), and where they evidence particular efficacy, integrate them into the service.

2.6.21 Substance misuse

The provider will:

2.6.21.1 Work positively and proactively to develop referral pathways with associated information sharing and joint working protocols to and from substance misuse services in the three local authority areas.

2.6.21.2 Ensure that IAPT eligibility is not restricted for people using alcohol or drugs through access thresholds, including those based on methadone dosage and requirements of periods of abstinence.

2.6.21.3 Take appropriate steps to overcome any barriers to accessing or engaging with the service for people with coexisting mental health and substance misuse needs, recognising that they are at higher risk of not using, or losing contact with services.

2.6.21.4 Work in partnership with substance misuse services to increase their awareness of each other's services and skills in working with the cohort.

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[17] Stop smoking interventions and services. NICE guideline [NG92].2018.

[18] Smoking: supporting people to stop. NICE Quality standard [QS43]. (QoF SMOK 003/004/005).

[19] Chronic obstructive pulmonary disease in over 16s: diagnosis and management. NICE Clinical guideline [CG101].

[20] Smoking: stopping in pregnancy and after childbirth. NICE Public health guideline [PH26].

[21] Stop smoking interventions and services. NICE guideline [NG92].2018.

[22] Smoking: supporting people to stop. NICE Quality standard [QS43]. (QoF SMOK 003/004/005).

[23] National Centre for Smoking Cessation and Training Secondhand Smoke training module.

2.6.22 People in contact with the criminal justice system

The provider will:

2.6.22.1 Ensure that it has (or can quickly draw on) specialist knowledge of the issues in relation to, and competence in working with offenders.

2.6.22.2 Ensure that service users are concurrently connected with other areas of help as necessary e.g. housing and homelessness, substance misuse services.

2.6.22.3 Demonstrate demographically appropriate levels of access to the service by this cohort of people.

2.6.23 Serving and ex-serving armed forces personnel

The provider will:

2.6.23.1 Understand the demographic profile of the local population and promote access through self-referral or charities as veterans may not be registered with GPs.

2.6.24 Primary and Secondary mental health interface

The provider will:

2.6.24.1 Be aware of the different mental health provision across the BNSSG area at both primary and secondary levels, and keep up to date with developments and changes.

2.6.24.2 Have a clear understanding of the remit of, and eligibility for secondary mental health services and refer to secondary mental health providers across BNSSG where appropriate to meet specific service user need.

2.6.24.3 Confidently communicate (to other professionals and to service users) the nature of the service, its structure, remit and eligibility.

2.6.24.4 Establish clear communications with GP practices on a patient level (in relation to attendance, completion, progress, looking ahead) in order to foster their support of the interventions that IAPT is providing their patients.

2.6.24.5 Establish clear protocols for direct referral routes into and from secondary services (particularly in relation to crisis services).

2.6.24.6 Work with Primary Care Liaison services to influence secondary care allocations.

2.6.24.7 Develop and maintain strong relationships with the CCG Locality Leads.

2.6.24.8 Record the referrals from primary and secondary care, their appropriateness and whether/the extent to which the service was able to meet their needs.

2.6.24.9 Record and follow up the referrals made to secondary mental health care, their appropriateness and whether they were allocated.

2.6.24.10 Play an active role in CCG discussions along with service users about the interface between primary and secondary care.

2.6.24.11 Ensure that service users understand the pathway, where they are currently receiving services within it and its relationship to other provision in order to support realistic expectations.

2.6.24.12 Make particular provision for tracking the progress of referrals of young people who fall between CAMHS and adult mental health services to avoid them being passed between them and not allocated to either.

2.6.25 Connections and referral pathways to and from other existing services and support

The provider will:

2.6.25.1 Put in place and implement a detailed action plan for the development of connections with relevant existing local services to create protocols and referral pathways.

2.6.25.2 Ensure the service is fully connected into the CCG's Integrated Community Localities.

2.6.26 Workforce, education and training

The provider will:

2.6.26.1 Promote an open and welcoming culture to recruit a workforce that is representative of the local population across the area through recruitment exercises, positive and welcoming advertising/publicity, skill-mixing and offering training placements and apprenticeships.

2.6.26.2 Follow and understand the changing demographics and proactively outreach to particular neighbourhoods and communities who are typically under-represented in the workforce (including BAME/cultural, LGBTQ+, Deaf people, older and disabled people, neighbourhoods with high socio-economic disadvantage).

2.6.26.3 Ensure that all staff working in the system (employed by the lead provider and any partner or subcontracted organisations) understand the service ethos and how the approach impacts on their practice.

2.6.26.4 Recruit and train the workforce to share the values of the service particularly in relation to equality and the ethos of the service.

2.6.26.5 Recruit all clinical and non-clinical service delivery staff on the basis of their knowledge of and competency in equality and the integration of the social determinants of mental health alongside their profession/specialism/role.

2.6.26.6 Use positive advertising to encourage the recruitment of bi/multi-lingual clinicians who speak the languages of local minority groups, including fluency in British Sign Language (BSL).

2.6.26.7 Ensure that the staff who undertake assessments are appropriately trained to be able to explore people's difficulties in a holistic context of their wider lives and other long-term health conditions (including learning disability/Autism Spectrum Disorder).

2.6.26.8 Provide ongoing CPD to build capability and competence in the workforce, including cultural competence.

2.6.26.9 Ensure that active steps are taken to create a (clinical and non-clinical) workforce that is representative of the local population, proactively addressing under-representation and inequitable distribution throughout the service's structure (e.g. so that BAME/disabled staff are not only in unqualified posts).

2.6.26.10 Connect regularly with clinical and other networks that have a remit for quality improvement (e.g. NHS England's IAPT Expert Reference Group (ERG).

2.6.26.11 Create a resilient, thriving and supportive workforce through promoting staff wellbeing, nurturing high aspirations and encouraging high levels of retention.

2.6.26.12 Demonstrate staff retention levels (across the whole service) that exceed national average levels in IAPT services.

2.6.26.13 Put in place a range of development opportunities in order that people can progress their careers in the service.

2.6.26.14 Seek opportunities to put in place shared (jointly funded/located) posts and other ways of ensuring integration.

2.6.27 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

The provider will:

2.6.27.1 Fully integrate the expectations and guidance of the IAPT Manual and associated Positive Practice Guides into the service delivery.

2.6.27.2 Fully integrate the RCP's 'Quality Standards for Psychological Therapies Services' as the basis for clinical quality.

2.6.27.3 Use other current good practice guidance, national policy, research and evidence to assist in driving service development and delivery where it complements the IAPT Manual and Positive Practice Guides.

2.6.27.4 Ensure connection with core national, regional and local networks where new thinking, research and good practice guidance are shared and accordingly stay up to date with developments.

2.6.27.5 Maintain an interest in developing thinking and evidence on the social determinants of poor physical and mental health and ensure that the service learns from them.

3. Scope

3.1 Aims and objectives of service

3.1.1 Service ethos

Links to key related sections:

3.1.2 Equality and equity
3.1.3 Co-production and user involvement
3.2.1 Delivery model
3.2.7 Communications
3.2.11 Perinatal mental health
3.2.12 Learning disability and neuro-atypicality (including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD))
3.2.13 Domestic and sexual abuse and violence
3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)
3.2.15 Employment and job retention support
3.2.16 Poverty, debt and benefits advice
3.5.2 Connections and referral pathways to and from other existing services and support
3.6 Workforce, education and training
3.7 Information management and technology (IM&T)

3.1.1.1 The social determinants of mental health

The Marmot Review (2010) starkly demonstrated the social determinants of mental and physical health. The connections between poverty, unemployment and social isolation with depression and anxiety are strong. Poor mental health can be caused or worsened by other issues in people's lives such as unemployment, stress at work, poverty, debt, migration, social isolation and lack of friendships/relationships, poor housing, domestic violence, modern-day slavery, bereavement, poor physical health/wellbeing, being inactive or having a long-term health condition. These factors can all impact on depression and anxiety and on the need for IAPT (either as a single service or in combination with other interventions).

> *'The social determinants of mental health—exemplified here by income inequality and poor education—are understood as being underpinned by unequal distribution of opportunity and, more deeply, by public policies (e.g., legislation that may not specifically pertain to health but ultimately has far-reaching effects on health) and social norms (e.g., cultural opinions and biases that set the stage for poorer health among disadvantaged groups).'* (Compton & Shim, 2015)[24]

This suggests that the risks of not taking a connected holistic approach to providing psychological therapies are far greater than any perceived risks inherent in giving IAPT a wider focus. It is therefore essential that people coming into this IAPT service do not have these other important issues inadvertently ignored through the service focussing on their mental health difficulties in isolation, or it not having the right external contacts to refer people for other help.

Commissioners have therefore taken an innovative and positive new approach that locates the mandated IAPT interventions (as specified in the IAPT Manual), within the wider social/cultural/health/economic/relational context in which the service and its users exist.

It is expected that, through a strong outward-focus and connections to a wide range of existing external provision (funded by the local authorities etc), the clinical IAPT interventions will be supported to meet their outcomes and maximize effectiveness and sustainability within limited resources.

In IAPT terms, recovery is only achievable through the provision of NICE approved psychological therapies/treatments. The examples below show how IAPT will operate linkages with other provision:

- For some, generally those who score below caseness, external (socio-economic and other) interventions may help divert them from IAPT treatments.
- People will be referred to external interventions alongside (rather than instead of) IAPT.
- A combined assessment and first therapy session (including GAD-7 and PHQ-9 measurements), with a course of external support under IAPT supervision and a final set of scores can count towards recovery.

By supporting people to tackle the external causes of their anxiety or depression, it is expected that, for some, therapy may not be necessary and people are diverted from it, while for others, therapy alongside associated support, such as job retention or encouragement to be more physically active, will reinforce its effectiveness.

For example:

- Somebody who is socially isolated after bereavement might receive therapy which addresses the loss, but not the isolation. A concurrent social prescribing service addresses the isolation while therapy helps work on the bereavement.
- Somebody who is at risk of losing their employment due to depression and receives an IAPT service, may lose their job while having treatment. A concurrent 'job retention' service alongside the therapy helps hold onto the employment and supports fast progress back to work.
- Somebody presenting with anxiety due to high levels of debt, may receive therapy to address the anxiety, however, without referral to appropriate debt advice/management, the cause of the anxiety is not addressed and the therapy is unlikely to be effective.

3.1.1.2 Learning

Our evidence review uncovered no other IAPT service that is holistically focussed and that

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[24] Compton, M.T. Shim, R.S. The Social Determinants of Mental Health. Focus. 2015.

overtly integrates the social determinants of health, despite the evidence of the connection of socio-economic factors with poor mental health. The lack of direct evidence for their connections to IAPT interventions reveals the absence of such services and an associated lack of research. It is therefore essential that this service measures itself well and is fully evaluated by an independent academic body with a wide contextual understanding of mental health.

3.1.1.3 Innovation Fund

The outward focussed ethos must be integral to every aspect of the service and its culture. The provider will therefore need to pilot, test and develop their practice across the area in relation to the various populations, demographics and geography. 2.5% of the total financial envelope is specifically allocated as a ring-fenced ‘innovation fund’ for development of practice that supports the ethos through testing/piloting and responsive implementation of new models of working in acknowledgement that this work will have a cost associated with it.

The need for monitoring, evaluation, whole system learning and development, as part of a culture of experimentation and continual exploration (trying things out, understanding what works, what doesn’t, where and with whom) will be essential in every aspect of the service.

3.1.2 Equality and equity

Links to key sections:

2.3 Measurement, evaluation and learning/development
3.1.1 Service ethos
3.1.3 Co-production and user involvement
3.2.1 Delivery model
3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.2.5 Assessment
3.2.6 Recovery
3.2.7 Communications
3.2.9 Younger people
3.2.10 Older people
3.2.11 Perinatal mental health
3.2.12 Learning disability and neuro-atypicality (including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD))
3.2.13 Domestic and sexual abuse and violence
3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)
3.2.15 Employment and job retention support
3.5.2 Connections and referral pathways to and from other existing services and support
3.6 Workforce, education and training
3.7 Information management and technology (IM&T)

Equality, equity, fairness and the principles of social inclusion will underpin this service. While this section lays out commissioners’ wider expectations in terms of ethos, the expectations of their practical implementation are integrated into the sections below. There will inevitably be duplications, for example many issues apply to access, communications, treatments offered and the workforce. This service will be expected to imaginatively and proactively make reasonable adjustments (Equality Act 2010) in order to enable and maximise access to, engagement with and successful outcomes from the service. Note that specific outcomes will be set in each of these areas.

3.1.2.1 Background

The IAPT Manual states that:

1. Services should be inclusive and actively promote equality, with consideration given to protected characteristics as defined by the Equality Act 2010,[25] and their duties to reduce health inequalities as set out in the Health and Social Care Act 2012.[26]

2. Service design and communications should be appropriate and accessible to meet the needs of diverse communities. Services should also publish information in a way that enables the public to judge how they aim to eliminate discrimination, advance equality of opportunity and foster good relations between different groups.

3. At the heart of the NHS Constitution is equality and fairness – everyone has an equal right to access and benefit from NHS services. No one group is exempt from depression or anxiety disorders. Therefore, demand for evidence-based therapies remains high across all communities.

4. The provider needs to understand the prevalence of depression and anxiety disorders within the local population to extend the reach of their services more effectively. Some groups have a higher prevalence of depression, or anxiety disorders. Other groups may have proportionately lower levels of identification rates, despite high need.[27]

3.1.2.2 The Public sector Equality Duty:

The main Public Sector Equality Duty (PSED) is comprised of three limbs (more commonly referred to as areas/ sections), set out in section 149(1) of the Equality Act 2010 (“the Act”):

A public authority must, in the exercise of its functions, **have due regard to the need to**:

(a) eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;

(b) advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;

(c) foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

It is anticipated that this recommissioning programme will play a part in reducing health inequalities across groups who have protected characteristics through addressing their common mental health difficulties more holistically within the wider context of an understanding of the social determinants of poor mental health.

3.1.2.3 Caring responsibility

There are particular issues for people who undertake a significant caring role/responsibility for a close family member or friend that must be recognised by the service.

- The ‘caring’ role can result in a change in the friendship/familial relationship.
- Mental health user organisations have worked to reframe the ‘carer’ role to ‘supporter’, while disabled people’s organisations have promoted independent living support services to enable the maintenance of close/partner/familial relationships through illness and disability.
- Carers’ organisations report higher than average levels of depression amongst carers (due to the caring role) as well as high levels of social isolation.

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[25] Equality Act 2010.

[26] Health and Social Care Act 2012.

[27] We still need to talk: a report on access to talking therapies. Mind. 2013.

- IAPT assessors and therapists should be sensitive to and aware of the particular needs and dynamics in relation to this role in order to provide an appropriate service.

3.1.2.4 Key issues and tensions:

3.1.2.4.1 The issue of choice (of venue, therapist, therapy, area etc) has a particular relevance for people from groups and communities that tend to be inadvertently excluded and therefore under-represented in services. Issues of stigma, safety, cultural competence, languages spoken, type of therapies offered, accessibility of venue/therapies, all have a particular and additional impact on the ability to access or sustain engagement with an intervention, achieve recovery or even trust the service.

3.1.2.4.2 There are some experiences and circumstances that, in themselves, may require the service to respond by providing a therapist who shares the person's particular characteristic – for example, women who have experienced domestic abuse or rape. Additionally, there will be occasions when someone with a protected characteristic (Equality Act 2010) requests to see a therapist who either shares their background, or does not due to concerns about confidentiality within smaller/close-knit communities. It might be that the most appropriate intervention for 16 & 17 year olds, would be to be supported by an organisation that specialises in work with children and young people. While the service should have a workforce diverse enough to be able to broadly honour such requests in a timely fashion, depending upon the specificity of the request it may not always be able to respond to it precisely, due to workforce constraints. In such circumstances there must be a clear communication with the service user to explore what might be offered.

3.1.2.4.3 While groups and courses must be promoted as key forms of intervention, mixed groups can be inaccessible for people for whom spoken English is not the first language (including Deaf BSL users). In these circumstances, the effectiveness of group interventions may only be realised through language-specific groups as therapy conducted through single or multiple interpreters can be problematic/confusing and not help engagement. However it is also undesirable to put people together merely because of the language they speak.

3.1.2.4.4 There are high levels of poor mental health amongst traveller communities along with a low take-up of services. This IAPT service will need to work to make connections with traveller communities in order to improve their access.

3.1.2.4.5 However diverse the workforce, it is unlikely that every community will be represented amongst the available trained therapists. The service will need to demonstrate high levels of competence and awareness of all equality issues across its staff team to be able to provide an appropriate service to everyone.

3.1.2.4.6 It is common for staff who have protected characteristics (Equality Act 2010) to be overtly or inadvertently channelled into equalities work or specifically with people who share their own backgrounds. While some staff may wish to specialize in work with people who share their specific experience, it should not be an expectation that they will or should. The right of staff from all groups with protected characteristics to fully develop their careers must be upheld and can conflict with the service's ability to offer the choice that some may wish for.

3.1.2.4.7 While there are IAPT Positive Practice and other guides that must inform the service's practice, it must also be understood that many people's needs are multi-layered – e.g. an older Asian woman with learning difficulties will have experiences and may face discrimination in all these areas. The provider will need to hold a wider understanding of equalities and the impact of 'intersectionality'.

3.1.2.4.8 Dealing with each equality group or protected characteristic (Equality Act 2010) in isolation can fail to notice the commonalities of need/experience, as experiences of age, race, disability, gender, sexual orientation etc overlap and interweave – e.g. people are not just ‘old’, ‘gay’, ‘asian’.

3.1.3 Co-production and user involvement

Links to key related sections:

2.2 National outcomes
2.3 Measurement, evaluation and learning/development
2.5 Local defined outcomes
3.1.1 Service ethos
3.1.2 Equality and equity
3.2.2 Improving access to, and accessibility of the service
3.7 Information management and technology (IM&T)

3.1.3.1 Background

It is essential that the experiences of anxiety and depression, and of using IAPT services are positively and thoroughly drawn on in the establishment, design, monitoring, evaluation, review and future development of this service. Therefore clear mechanisms and structures need to be put in place that enable co-production in all these aspects and stages of the service.

Commissioners expect that user involvement through a wide range of co-production processes is used as a key means of the service achieving better outcomes in all aspects of its delivery.

The National Survivor User Network (NSUN) produced the widely adopted ‘4Pi National Standards’[28] document (which is provided as Appendix M) and associated resources[29] which will provide a strong basis for this work.

3.1.3.2 Key issues and tensions:

3.1.3.2.1 IAPT is intended to be a brief and impactful intervention in people’s lives that supports and enables their social inclusion and recovery. Any means of user involvement that are developed must not encourage a longer term identification of those users as ‘IAPT user’. The establishment of a range of means of gaining feedback, consulting and involvement that are unobtrusive in people’s wider lives will mitigate this.

3.1.3.2.2 Commitment to co-production and user involvement can attract levels of mistrust as it can be an insubstantial concept without clarity and agreement.

3.1.3.2.3 Co-production requires work from all parties to establish how the partnership will operate and how users can be involved in ways that are accessible and non-tokenistic.

3.1.3.2.4 Service users often either bring high levels of skill and/or experience to co-production/involvement work, or develop them through it. Some providers offer positive opportunities for involvement to be externally acknowledged and accredited, and the skills provided to be recognised through, for example,

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[28] 4Pi National Involvement Standards. NSUN. 2015.

[29] 4Pi national involvement standards website. NSUN.

employment references, traineeships, work experience etc.

3.1.3.2.5 Co-production should blur some of the boundaries between those who have lived experience and service providers. For example, a number of IAPT services draw on the experience of former service users to run or assist with peer support groups etc.

Note on outcomes:

User involvement is not an outcome in itself, but a means to achieve better outcomes in all aspects of the service. There are therefore no specific outcomes for this section, but rather clear requirements of the provider.

3.2 Service description/care pathway

3.2.1 Delivery model

Links to key related sections:

3.1.1 Service ethos

3.1.2 Equality and equity

3.5.2 Connections and referral pathways to and from other existing services and support

Key of technical definitions and abbreviations

This specification covers the provision of a single IAPT service across the BNSSG area.

NHS Bristol, North Somerset & South Gloucestershire CCG will contract to a single lead provider organisation which will be responsible for:

3.2.1.1 Providing a single consistent approach to IAPT in BNSSG, where, regardless of their address, people have the same ways into, pathways through and range of treatments on offer from the service.

3.2.1.2 Creating and managing flexible resources within the system.

3.2.1.3 Taking a cross-area overview in order to understand patterns, demographics, successes and difficulties and implementing changes across the whole service based on the learning.

3.2.1.4 Drawing on external specialist services and resources from across the area.

3.2.1.5 Preventing duplications, overlaps or gaps in provision that can arise from multi-provider and multi-agency provision.

3.2.1.6 Using an outward-focussed holistic approach to promote social inclusion and sustainment of IAPT recovery outcomes.

3.2.1.7 The management, learning and improvement of the whole service.

3.2.1.8 Collection of all data using the provider’s IT solutions.

3.2.1.9 Whole service monitoring and evaluation.

3.2.1.10 Directly reporting on nationally required data to NHS England and KPIs to local commissioners for performance management.

3.2.1.11 The ‘front door’ of the service – communications, referral processes, the holistic assessment, allocation to therapists and pathways.

3.2.1.12 The management, accountability and monitoring of partnership and sub-contractual arrangements/relationships and performance.

3.2.1.13 Service safety, Safeguarding and Quality across the whole system.

3.2.1.14 Forging/maintaining connections with the various leads for the range of referral pathways and linked service areas that it develops.

3.2.1.15 Working with other partners in the health system to take account of the wider determinants of mental health when delivering care for any given individual.

3.2.1.16 Engaging with local mental health forums/partnerships to ensure IAPT is embedded in local strategic approaches to improving mental health.

3.2.1.17 Staff management and development.

3.2.1.18 Managing its relationship with primary and secondary care.

The ethos of this service is outward-focussed and understands service users holistically (in terms of their wider lives), and is rooted in the principles of equality.

A great deal of expertise and skill exists across the area through key local voluntary sector organisations which the IAPT service should draw upon to provide the best outcomes, in particular for under-represented groups and for specific therapeutic specialisms. Importantly, such (often locally based) expertise can be drawn upon over the entire BNSSG area to afford greater equity of service delivery. Examples include the following:

- Local neighbourhood knowledge and connections.
- Equality community connection, understanding and competency.
- Refugee issues and support.
- Health inequalities.
- Issue-based specialisms.
- Skilled therapeutic approaches.

And it is essential that the lead provider can draw upon these to support its delivery.

3.2.2 Improving access to, and accessibility of the service

Links to key related sections:

2.3 Measurement, evaluation and learning/development
3.1.2 Equality and equity
3.1.3 Co-production and user involvement
3.2.3 Timeliness of service
3.2.4 Interventions and therapies
3.2.6 Recovery
3.2.7 Communications
3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)
3.2.9 Younger people
3.2.10 Older people
3.2.11 Perinatal mental health
3.2.12 Learning disability and neuro-atypicality (including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD))
3.2.13 Domestic and sexual abuse and violence
3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)
3.2.15 Employment and job retention support

3.2.17 Housing and homelessness

3.2.19 Substance misuse

3.2.20 People in contact with the criminal justice system

3.2.21 Serving and ex-serving armed forces personnel

3.4.1 Acceptance criteria

3.4.2 Exclusions

3.7 Information management and technology (IM&T)

3.2.2.1 Background

All IAPT services must demonstrate an increase in access rates as well as in equity of access for those individuals and groups who are known to be currently under-represented in IAPT services (see 3.1.2).

IAPT services are intended to reach and be accessible to all eligible people. In practice this means placing an emphasis on those who are likely to be at ‘caseness’ (see Key of technical definitions and abbreviations), in order that they count towards meeting access targets and so that their improvements will support mandated recovery levels. However, there are many people who, although not reaching caseness, nonetheless have a level of difficulty that the service should usefully address in order to prevent future deterioration and re-presentation with greater levels of need. The service should therefore offer early online and group psycho-educational/self-help interventions to those people with levels of mental health need that are below the threshold.

While the service needs to continually increase its overall access rates, there are a number of groups with specific needs and characteristics that are typically under-represented in IAPT and whose poor mental health impacts on other aspects of their lives. The provider will need to integrate an equality approach into the delivery of the service, recognising that a significant proportion of work on access/accessibility, if thoughtfully and sensitively applied, will improve access generally. It is important that the service understands both the similar and different issues of accessibility experienced by people from neighbourhoods with high levels of deprivation and from the range of groups with protected characteristics (under the Equality Act 2010) many of whom are also generally under-represented within IAPT services. They will need to understand commonality of experience and that many people fit into more than one equality category and therefore experience multiple barriers.

The IAPT Manual and Positive Practice Guides clearly present steps that providers must take towards delivering an accessible service that attracts people from all communities and specifically addresses the issues of those groups that are typically under-represented in IAPT services.

From 1st August 2016 onwards, all organisations that provide NHS care and/or publicly-funded adult social care are legally required to follow the Accessible Information Standard. The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.[30] [31]

3.2.2.2 Key issues and tensions:

3.2.2.2.1 People’s access to services can be influenced by a range of factors that support or hinder their engagement.

3.2.2.2.2 The extent to which a service takes steps to demonstrate its intent to welcome access from all communities critically influences public trust in it.

3.2.2.2.3 Preferences for different methods of communication (see 3.2.7) and of delivering

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[30] Accessible Information Standard Specification. NHS England. 2017.

[31] Accessible Information Standard Implementation Guidance. NHS England. 2017.

therapies (see 3.2.4) vary significantly across neighbourhoods, communities, age groups.

3.2.2.2.4 Conflict exists between the desire and need for IAPT services to be locally accessible and the management of capacity across a wide geographical area.

3.2.2.2.5 In areas of high socio-economic deprivation, some people may not be used to travelling outside their neighbourhoods, which needs to be understood in relation to location and take-up of the service.

3.2.2.2.6 Location of IAPT staff within GP practices, partner agencies etc with which they already have involvement, is likely to better support access and attendance.

3.2.2.2.7 Offering choice of appointment times can place challenges upon the availability of buildings and upon therapist working hours.

3.2.2.2.8 When in a distressed state, some people can find the complexity and detail of online referral (application) processes arduous and stressful, sometimes resulting in them not completing the process. Attention must be paid to presenting an online and telephone-based referral process that is well constructed, straightforward and welcoming.

3.2.2.2.9 Most people will be able to attend IAPT services on their own, while others may wish for someone to attend their first session with them to provide support and encouragement. Some (health/social care/community) support services might assume that their service users need accompaniment in order to attend. In either case, the service will need to define its boundaries around where support and institutional service delivery practices can be helpful, and where they impinge upon effective IAPT service delivery and therapeutic boundaries/relationships.

3.2.2.2.10 Some people will require a home visit if they are unable to leave their accommodation. While home visits can support some people’s ability to access the service and lead to greater inclusion, they can also maintain others’ social isolation and represent a failure to provide them with appropriate mobility assistance (see 3.2.10 and 3.2.11).

3.2.2.2.11 All surgeries in a GP cluster may not be easily accessible to service users without their own transport, and therefore attention must be paid to the location of those used.

3.2.2.2.12 Due to a more diffuse population in rural areas, filling groups and courses can be challenging. This can cause difficulties in accessibility of location.

3.2.2.2.13 Both the availability of rooms and their market rental costs in GP practices can influence the locations of local spaces available to the service.

3.2.2.2.14 The length of the assessment and of sessions, if flexibly administered around the needs of each client, can provide a more person-centred service while supporting the service’s efficiency.

3.2.2.2.15 Deaf people, particularly those for whom British Sign Language (BSL) is their first language, face significant access barriers and exclusion from services that do not directly respond to their needs. There are high levels of poor mental health in the Deaf Community and yet Deaf people are typically under-represented in IAPT services. Additionally, there are few BSL speaking therapists for services to draw on. This service must work proactively to ensure Deaf people’s access and to promote the increase in Deaf and BSL speaking therapists in the IAPT workforce.

3.2.3 Timeliness of service

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service

3.2.5 Assessment

3.2.6 Recovery

3.2.3.1 Key issues and tensions:

3.2.3.1.1 There is a range of factors and dynamics, together with their potential mitigations, that need to be understood and worked with and that can impact waiting times, including:

- Making use of preventative 'upstream' interventions to divert from assessments.
- Use of the range of socio-economic referrals to divert from, and/or support step two and three therapies.
- Offering a high quality assessment.
- Offering courses and groups positively and confidently as key interventions.
- Offering a wide range of digital and online means of engagement with IAPT.
- Having confidence in its clinical judgement about what works best for different presentations and in what the service will offer and how it can help.
- Flexibility in the length of interventions offered.
- Operating flexibly enough to ensure that therapists' cancellation of appointments do not result in service users' treatment programmes being shortened.

3.2.3.1.2 Mental health services typically experience high rates of non-attendance, and service user groups challenge a culture that is experienced as locating responsibility for 'DNAs' with service users. A systemic understanding of attendance and promotion of it would be expected to foster a different relationship to engagement and attendance of the service.

3.2.3.1.3 Particular long-term health conditions and life-limiting illnesses can in themselves impact on people's ability to attend therapy. This needs to be understood within the service's management of attendance.

Please see the NHSE Improving Access to Psychological Therapies (IAPT) Waiting Time Guidance and FAQs for further information.[32]

3.2.4 Interventions and therapies

Links to key related sections:

3.1.2 Equality and equity

3.2.2 Improving access to, and accessibility of the service

3.2.5 Assessment

3.2.6 Recovery

3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

3.2.13 Domestic and sexual abuse and violence

3.2.15 Employment and job retention support

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[32] Improving Access to Psychological Therapies (IAPT) Waiting Time Guidance and FAQs. NHS England. 2015.

3.2.17 Housing and homelessness
3.2.19 Substance misuse
3.2.20 People in contact with the criminal justice system
3.2.21 Serving and ex-serving armed forces personnel
3.3 Population covered - conditions treated by IAPT
3.6 Workforce, education and training
3.7 Information management and technology (IM&T)

3.2.4.1 Background

A full list of current NICE-recommended psychological therapies for the conditions treated by IAPT services can be found in the IAPT Manual and in the table below.

The IAPT Manual clarifies that IAPT provides evidence-based psychological therapies for mild, moderate *and severe* depression and anxiety disorders. Treatment of people with moderate to severe depression, when appropriate, is important because such individuals are particularly likely to experience a marked reduction in disability and have their lives transformed as a result.

3.2.4.2 Digitally-enabled therapies and online resources/communication

Online and digital technologies offer an increasingly wide variety of options to providers of IAPT services including:

- Online self-help/management resources and support.
- Online text-based therapy (delivered by a therapist).
- Therapy delivered through VoIP (voice/video over the internet e.g. SKYPE, FaceTime).
- Online resources which positively promote the service and its interventions to potential users and their families/friends.

They can be variously accessed through desktop computers, tablets and smartphones (with an increasingly wide range of apps).

The IAPT Manual states:

‘Digitally-enabled therapy is psychological therapy that is provided via the internet with the support of a clinician. There is evidence to show that these therapies can achieve comparable outcomes to face-to-face therapy, when the same therapy content is delivered in an online format that allows much of the learning to be achieved through patient self-study, reinforced and supported by a suitably trained clinician.’

Average therapist time per patient can be reduced by using an empirically validated digital therapy programme, and this is likely to have a positive impact on waiting times.

While antipathy towards it remains from some (perhaps due to early judgements about particular online ‘computerised’ products resulting in a continued perception of being monolithic), there is increasing evidence that online access/communication and digitally-enabled therapies are preferred by a growing range of people. For example younger people generally like text-based online therapies and people of all ages who cannot easily/accessibly get to a service or who live in rural areas respond very positively to VoIP based therapy. While the concerns of those who are critical of digitally-enabled therapies suggest that they should be offered as a choice and positively publicised rather than imposed, their effectiveness (both to individuals and to the system) cannot be ignored.

The range/scope, evidence for and quality of the available digital and online therapies will expand over the course of this contract and the provider should maintain up to date knowledge of them.

Online resources can provide positive and straightforward means of promoting the service and all its aspects to potential service users and their family members/friends/supporters. Online resources should be provided to help family members/friends/partners to understand how they can best help support their relatives through IAPT services.

3.2.4.3 Assumptions

The following assumptions have been made:

- Early intervention (to psycho-social, psycho-educational and self-help options) and other (existing external) support (e.g. debt, unemployment, social isolation, long-term conditions, and substance misuse) can divert a number of people from needing IAPT therapies.
- Through having other associated difficulties addressed, the type/intensity and/or length of intervention for some people will reduce, and the positive outcomes will be sustained.
- A positive presentation of, and increase in group work, courses and online therapies take pressure off the perceived superiority of/need for one-to-one therapy and ensure that the intensive interventions are available more quickly to those people who require them most.
- Through establishing clarity in relation to attendance, the level of choice of therapy/therapist/re-entry offered, waiting time management etc, considerable service efficiencies can be realised.

3.2.4.4 Indicative service pathway/treatments

Below is an indicative pathway through the service listing a range of interventions at each step.

N.B. The ‘stepped-care’ approach should not necessarily indicate a fixed sequential process through treatment. Rather, good assessment should establish if someone needs to go straight from assessment to step-3. However, it is important that no matter what the level of people’s difficulties, they have access to self-management and self-help options and concurrent referral to other sources of help from elsewhere.

Early intervention/prevention – enabling diversion from IAPT:

Self-help and self-management information resources.

Signposting and referral pathways to other services providing support for issues that might be associated with anxiety/depression.

Psycho-educational courses.

Step-1

A holistic assessment/first treatment understanding the clinical need along with its social determinants.

Psycho-social interventions (individually/in groups).

Self-help/management and support groups.

Referral to other socio-economic, employment, social prescribing housing/homelessness etc services.

Referral to other health services.

Referral to secondary mental health services.

Online self-help programmes.

Referral to job retention or employment support.

Step-2

Self-help and individual guided self-help (CBT).

Computerised CBT.

Behavioural Activation.

Structured group physical activity programmes.

Psycho-educational groups.

Concurrent referral to other pathways that address other issues that are causing/worsening the depression/anxiety.

Concurrent referral to, or joint work with, other health pathways.

Employment or job retention support.

Step-3

Group and individual CBT and IPT.

Behavioural Activation.

Couple therapy.

Counselling for depression.

Brief psychodynamic therapy.

Mindfulness-based cognitive therapy.

Applied relaxation.

Trauma-focussed CBT.

Eye movement desensitisation and reprocessing.

CBT (for social anxiety disorder).

CBT (including exposure and response prevention).

Graded exercise therapy.

Combined physical and psychological interventions (for chronic pain).

Employment or job retention support.

Concurrent referral to other pathways that address other issues that are causing/worsening the depression/anxiety.

Concurrent referral to, or joint work with, other health pathways.

3.2.4.5 Key issues and tensions:

3.2.4.5.1 From the experience of the previous services across BNSSG, and from the engagement and consultation processes leading to the commissioning of this service, it is evident that there is a high expectation of individual one-to-one (face-to-face) therapy.

3.2.4.5.2 While psycho-educational courses can fulfil an essential function in IAPT in relation to self-management and recovery, they can be experienced as unconfidently delivered, pointless, impersonal and robotic in their delivery. It is important that the self-help and wellbeing messages delivered through courses are presented positively and confidently by staff who understand the subject material and give participants time for reflection, discussion and questions.

3.2.4.5.3 While one-to-one therapy is neither the only or (in many cases) the most appropriate intervention to treat the levels of depression and anxiety that are presented to the service, the take-up and experience of group based treatments has been poor. IAPT services are not able to provide one-to-one therapies to all those who want them, and so the widespread desire for one-to-one, along with the apparent mistrust of and anxiety about groups must be addressed within the service model. Positive publicity both within and outside of the service about the benefits of groups and courses could start to shift the prevalent beliefs about the second-class nature of groups as a means of treating depression and anxiety. Anxiety/uncertainty about joining a group might be addressed through facilitators making prior contact with potential members, or the provision of preparatory one-to-one sessions.

3.2.4.5.4 Demand for a service requires interpretation, and may result more from the messages that prevail about the solutions to psychological difficulties than the level of need in the area.

3.2.4.5.5 Mental health difficulties and the solutions for them are not necessarily best understood or treated as separable or requiring a serial response. Rather, a concurrent response acknowledges the multi-faceted nature of people's experience and demonstrates the recognition that the clinical IAPT service functions within a wider arena of provision that it can work in partnership with to achieve sustained recovery and cross-system improvement.

3.2.4.5.6 The IAPT Manual highlights the discrepancy between the common misconception that IAPT services are only for people with mild to moderate depression and anxiety, and the reality that they are also intended to treat (and are successfully treating) people with moderate to severe depression and anxiety. The latest IAPT annual report (2016/17) indicates that the initial average severity of IAPT scores was on the borderline between mild-moderate and moderate-severe with little variability between CCGs and therefore that people with moderate to severe depression are being treated across all IAPT services.

3.2.4.5.7 Engagement in therapy of any kind can be experienced as ('culturally' or generationally) alien, and the ease by which it is accepted and engaged with can be strongly influenced by the way that it is presented. A recognition of the power of stigma in some neighbourhoods and communities will also help the service gain wider traction and acceptance.

3.2.4.5.8 Fears about starting therapy are common, particularly so for joining a group. Individual therapy can represent a 'safer place' for some people than a group might at first appear (e.g. women who have experienced domestic abuse or rape, refugees, people who have been sexually abused). However, in such (and other) circumstances, groups of people who share a similar experience and/or culture can very positively provide a supportive environment to achieve better outcomes.

3.2.4.5.9 It is common for former IAPT service users to re-present, their issues apparently unresolved, or because their lives are complex and a single course of treatment has not provided enough benefit to sustain their recovery. Practical/positive forward ('exit') planning in the final session of therapy, follow-up groups (to provide peer support to maintain improvement) and 'recovery check-ups' are all effective tools for supporting people to take the benefits of therapy and their learning from it out into their lives. Reduction of returns to the service and sustained recovery not only demonstrate success in relation to user outcomes, but also promote service efficiency.

3.2.4.5.10 Therapy should be conducted in the first (or preferred) language of the service user and, for people for whom spoken English is not their first language, this will be most likely through an interpreter unless there are therapists available (in the service or through subcontractual arrangements) with the particular language skills required. However, therapy conducted through an interpreter can be problematic as follows:

- An interpreter can skew the therapeutic relationship by placing a distance between therapist and client
- The nuances of the process can be lost when a third party is involved in a person's (personal) therapeutic experience.

- Within relatively small and close-knit communities, members of those communities may be drawn upon as interpreters, which raises multiple issues of intrusion, embarrassment, confidentiality and their problems being known within their own community.
- Due to the scarcity of interpreters of some languages (including BSL), a service user may not be able to have the same interpreter throughout their course of therapy. This makes for disconnection and potential inconsistency of approach and quality, as well as the difficulties it creates in terms of the developing relationship with the therapist.

3.2.4.5.11 The service will encounter people who self-harm and/or who present a risk of suicide. It will need specific competence in these areas and mechanisms to ensure that potential suicide risks are assessed, immediately flagged and referred directly to appropriate mental health services (within local protocols) alongside IAPT treatment if appropriate.

3.2.4.5.12 A number of groups of people will present to the service with high levels of trauma. For example, refugees and asylum-seekers, people who have been sexually abused or experienced domestic violence in relationships. An understanding of the impact of those experiences and potential efficacious treatments in the context of overall trauma-informed practice will be needed and may require longer interventions than would normally be available.

3.2.4.5.13 The numbers of people coming to the service whose (eligible) level of depression/anxiety derives from complex bereavement have grown (including people who are bereaved through a death by suicide or where it is connected with high levels of trauma). The service will need to ensure that it is equipped to work with complex bereavement and can integrate a trauma-informed approach with bereavement counselling skills.

3.2.5 Assessment

Links to key related sections:

3.1.2 Equality and equity
3.2.3 Timeliness of service
3.2.4 Interventions and therapies
3.2.6 Recovery
3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)
3.2.11 Perinatal mental health
3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)
3.2.15 Employment and job retention support
3.2.16 Poverty, debt and benefits advice
3.4.2 Exclusions
3.7 Information management and technology (IM&T)

3.2.5.1 Background

This service ethos places central importance on the service being outward focussed and able to understand people's 'clinical need' in the context of the wide range of other socio-economic, relational, health and cultural factors that are present in their lives. The IAPT Manual also emphasises the need for a strong 'person-centred' focus to the assessment.

Person-centred care[33] supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care.

The assessment is key in ensuring that in a brief amount of time, enough of the right information is gathered about each person to be able to offer them the right treatments/interventions. Incomplete or poor assessments lead to inappropriate treatment plans and people returning for further treatment or poor recovery rates.

The outward-looking ethos of this service requires a holistic assessment that understands psychological issues in the wider context in which they exist. A wholly clinical assessment will not be sufficient to gain such an understanding of each person and could lead to failure to pick up on important factors that influence or cause the presenting issue.

Data analysis has shown that significant numbers of people return to IAPT on a regular basis, often receiving repeated treatments at steps two and three. It is expected that a strong holistic assessment, undertaken by a skilled and experienced staff member, will allow the most appropriate treatment to be identified and delivered swiftly. A critical component of this is that the range of interventions on offer are understood and confidently presented, in conjunction with an integrated understanding of the range of potential referral pathways to other services.

Everyone who reaches the assessment stage should have a holistic person-centred assessment by a skilled member of staff. This should direct each person to referral pathways covering a range of provision including employment and socio-economic support, social prescribing services and long-term physical health pathways, instead of, or concurrently with, one or more IAPT interventions.

The former South Gloucestershire CCG commissioned the University of Chester[34] to undertake a pilot study, researching the efficacy of providing a longer combined IAPT assessment and first therapy session provided by a more highly trained therapist than was typical. While the pilot was small scale, it did find that the approach reduced both the need for subsequent sessions and the number of those sessions. The research paper is provided as Appendix-I for full reference.

3.2.5.2 Pre-assessment

It will not be possible (or necessary) to offer everyone an assessment due to the sheer volume of referrals (including self-referrals), the wide range of need that they represent and because some people who present will be best supported or treated elsewhere.

It will therefore be necessary to put in place a pre-assessment triage process (with both online and telephone means of access) to get people to the right help early on and enable them to choose or be directed to other services that will better meet their immediate needs. This will potentially divert some from requiring a full assessment and IAPT service while providing encouragement to good mental health and wellbeing instead of or before the IAPT intervention. The functions of this should include:

- Provision and/or direction to online self-help/self-management resources.
- Signposting information about the range of other services and interventions available (including through the referral pathways established by the provider) to redirect those who don’t require the IAPT service (including local voluntary sector helplines).
- Offering ways in to services that may provide concurrent interventions with IAPT therapies (e.g. job retention support).

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[33] Person-centred care made simple. The Health Foundation. 2014.

[34] Findings of the University of Chester pilot study: Evaluating the impact of a therapeutic consultation session on psychotherapeutic engagement and outcomes compared with treatment-as-usual site comparators. Centre for Psychological Therapies in Primary Care. 2017.

- A mechanism for identification of anyone in a serious mental health crisis and potential referral to appropriate local crisis services.
- Connection to the young people's triage operated by the Off The Record young people's counselling service (see 2.6.11).
- Ensuring that nobody is inadvertently bypassed or missed between presentation and assessment without communication/explanation.

Preparation for the assessment can help ensure that those who go through it have a better idea of what information they will need to provide, what questions they are likely to be asked and what to expect from it. Such information can be published online and held by referring agencies, GPs etc.

3.2.5.3 Key issues and tensions:

3.2.5.3.1 The service will need to manage its capacity by undertaking the vast majority of its assessments by telephone (or through other forms of electronic communication), and the manner in which these assessments are carried out will be key in gaining user trust and meeting service purpose. However, telephone assessments are often experienced as impersonal, due to their 'call centre' presentation with its particular tone of voice/enunciation, and standard phrases, which does not lend itself to conveying genuineness, empathy or a person feeling heard or understood. The challenge for the provider will be to provide a skilled 'human' person-centred assessment to everyone no matter what medium it is conducted in.

3.2.5.3.2 The length, medium, quality, focus and language of assessments can all serve to leave people feeling unheard and the service without enough information to make a proper set of judgements about the most effective treatment(s).

3.2.5.3.3 Assessment phone calls without prior arrangement from a stranger, which in a short space of time ask intense and personal questions, can be experienced as incongruous and intrusive. These experiences would suggest the need to set times for telephone based assessments in the same way as face to face ones, and for the therapist conducting them to speak with genuine sensitivity and reassurance.

3.2.5.3.4 IAPT assessments can be experienced as too fast and impersonal. The view is expressed that assessment should be part of a longer process running through the IAPT service. While IAPT is not a long-term service, nor part of the Care Programme Approach (CPA), this view might usefully inform the need for the assessment to be of a high quality and long enough for the person to feel understood and their experience valued. This may be the case in particular where service users have experienced complex trauma and/or have multiple issues causing them to present to the service.

3.2.5.3.5 People who are in receipt of multiple services have to repeatedly 'tell their stories' (provide the same information to each agency). While IAPT's requirements are particular in relation to their use of (for example) the GAD-7 and PHQ-9 scales, much of the information sought may already have been gathered/be held elsewhere. In the context of a well-connected holistic approach, the service could improve its efficiency and service outcomes, as well as reducing service user stress and sense of intrusion, through being part of or promoting local initiatives for shared assessment processes across agencies.

3.2.5.3.6 The assessment should include an explanation of the process to follow: the next steps, expected waiting times and provision of advice about self-help opportunities that can be engaged with in the meantime.

3.2.5.3.7 Where service users have a care plan from secondary mental health services, IAPT should ensure appropriate integration with it.

3.2.5.3.8 IAPT services face criticism for applying the ‘least intervention first time’ principle to all service users. While this works well for some, others can go through repeated inappropriate interventions before getting to the one that is right for them – often deteriorating and re-presenting. An effective assessment should avoid unnecessary treatments.

3.2.5.3.9 Assessments should be conducted in the first (or preferred) language of the service user and for people for whom spoken English is not their first language, this will be most likely through an interpreter unless there are therapists available with the particular language skills. Assessments conducted through an interpreter can be problematic: an interpreter can skew the therapeutic relationship by placing a distance between therapist and client; the nuances of the process can be lost; a third party is involved in a person’s (personal) therapeutic experience and, for people from relatively small and close-knit communities, members of those communities (as an interpreter) are involved in a person’s therapy. These factors can all impact on the assessment, especially when it is combined with the first therapy session.

3.2.5.3.10 Service users voice an understandable desire to exercise agency in their treatment which tends to manifest through requests for a high level of choice of intervention, therapist, length of therapy etc. Providing such levels of choice in a high volume service can present challenges to service efficiency and its ability to meet national and local outcomes. The provider might reconcile this potential conflict through exercising positive and confident clinical judgement in relation to describing the most appropriate offer and demonstrating (through its results) that it is trust-worthy. Choice can have less emphasis placed upon it when the quality and outcomes of a service are widely known to be high.

3.2.6 Recovery

Links to key related sections:

2.3 Measurement, evaluation and learning/development
3.1.2 Equality and equity
3.2.2 Improving access to, and accessibility of the service
3.2.3 Timeliness of service
3.2.4 Interventions and therapies
3.2.5 Assessment
3.7 Information management and technology (IM&T)
Key of technical definitions and abbreviations

Recovery rates are specifically and clearly defined within IAPT reporting and are the major indicator of the service’s success. The national expectation is to achieve at least a 50% recovery rate. However the IAPT definition of recovery is specific and, whilst understanding national reporting requirements, the provider will be expected to also adopt qualitative recovery measures and follow-up information to help achieve better outcomes for service users and the continual development of the service.

3.2.7 Communications

Links to key related sections:

3.1.1 Service ethos
3.1.2 Equality and equity
3.2.2 Improving access to, and accessibility of the service
3.2.9 Younger people
3.5.2 Connections and referral pathways to and from other existing services and support
3.7 Information management and technology (IM&T)

There are broadly two types of communications that the service will need to work with:

- Outward-focussed communications about the service.
- Communications with service users about their treatments. These communications and their importance are variously covered throughout this specification.

Good communication will be an essential factor in the service's success in increasing its access rates and effectiveness. It will need to promote itself clearly, conveying confidence in it and understanding of how it can improve wellbeing in the various neighbourhoods, groups and communities across the area.

3.2.7.1 Key issues and tensions:

3.2.7.1.1 If mental health services do not clearly communicate what they can offer, who they can work with and how they can help, they run the risk of generating higher expectations of them than they are able to meet and consequently create disillusionment and disappointment for both service users and surrounding agencies/referrers. While it is impossible to entirely prevent this, clear, honest and informative communications about what it can and can't deliver should go some way to limit mismatches between expectation and reality.

3.2.7.1.2 The service needs to proactively address the widespread mistrust of groups as a valid form of therapy and intervention in depression and anxiety. This could take place through public advertising campaigns.

3.2.7.1.3 Family members often want to know and understand what help their relatives are receiving from services. It is most important that the personal work undertaken by service users going through IAPT therapy is understood and supported by their family members and friends. The service should compile and put out clear and positive publicity about supporting people through IAPT services. Such materials would include explanations of how people might change their behaviour, try out new things or express themselves differently, as well as providing advice about how to offer encouragement and acceptance of change.

3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.2.5 Assessment
3.2.10 Older people
3.5.1 Primary and secondary mental health interface
3.6 Workforce, education and training

3.2.8.1 Background

People who have mental health problems in the context of long-term physical health conditions (e.g. diabetes, chronic obstructive pulmonary disease, cardiovascular disease, cancer) and people who are troubled by symptoms inadequately explained by their medical condition (sometimes called persistent physical symptoms or medically unexplained symptoms) are poorly served by existing services. In particular, there is an urgent need to provide them with more integrated physical and psychological healthcare to improve their quality of life and reduce costs to the NHS and the wider system. Underpinned by core IAPT principles and standards, IAPT services will be required to develop and deliver a new model through integration with physical health care services.

The Five Year Forward View for Mental Health expects mental health and physical health services to work together in a more integrated way, meaning that each gains greater awareness of the issues pertinent to the other when working with patients. It asserted that there should be fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa), and that there needs to be the provision of mental health support in physical health care settings – especially in primary care.

In 2016, NHS England published Implementing the Five Year Forward View for Mental Health[35] which committed to parity of esteem for mental and physical health. There is a national expectation that 1.5 million people should access IAPT by 2020/21. Of the additional 600,000 people who should be seen, two thirds of them will have coexisting physical and mental health conditions and should be seen within IAPT services.

3.2.8.2 Integration of IAPT and LTC pathways

Integrating mental and physical healthcare can ensure a more proactive approach to mental health by reducing stigma and promoting mental health awareness. It should allow faster treatment if services are co-located by reducing barriers and enabling more effective treatment due to better understanding of coexisting physical health problems and better tailored care plans.

Mutual awareness raising and skill sharing should be associated with workforce co-location, and it is expected that the person-centred and holistically orientated approaches that result from co-location will improve the success of both IAPT and LTC/MUS pathways. This should also help to overcome common barriers that hinder the recognition and treatment of mental health problems with a co-morbid LTC or MUS, (such as diagnostic overshadowing, presenting with physical symptoms only and the time pressures that physical health teams are under).

3.2.8.3 Outreach to LTC/MUS pathways

Alongside the co-location of IAPT staff members with specific LTC pathways, the service can work to promote understanding of the commonality of experience within and between different health conditions. Despite differences in the needs of people living with disabling but not life-threatening health conditions and people who have a life-limiting illness, there will also be levels of common and shared experience, the recognition of which can provide mutual understanding and support. Similarly, the anxiety and depression that can result from long term conditions caused by, for example, the experiences of loss or reduction of function, chronic pain and/or stark changes in social/familial roles and relationships, create a potential for the service to turn shared experience into support. Therefore, the use of generic means of providing support to service users with both similar and different long term physical health conditions will be necessary. This will include the provision of self-management, issue-specific and generic psycho-educational courses, therapy and self-help/support groups, online treatments and resources that cross over conditions/pathways.

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[35] Implementing the five year forward view for mental health. NHS England.

3.2.8.4 Additional conditions treated within IAPT-LTC services

In line with the implementation of The Five Year Forward View for Mental Health, evidence-based treatment will be extended to people with comorbid LTCs or MUS. The newly developed IAPT-LTC services will focus on people who have LTCs in the context of depression and anxiety disorders and will also aim to treat the following conditions:

- Irritable bowel syndrome
- Chronic fatigue syndrome
- MUS not otherwise specified.

3.2.8.5 Key issues and tensions:

3.2.8.5.1 Integration requires a mutual commitment to joint working from both the mental health and physical health staff. Some IAPT-LTC pilot sites (elsewhere in the country) have reported resistance from physical health pathways to joint working, co-location and closer integration with IAPT services. While the provider must take responsibility for their part in establishing these relationships, commissioners will need to support them to realise this important set of national requirements.

3.2.8.5.2 The medical model of health is strong and the understanding of interplay between physical and mental health is poor.

3.2.8.5.3 Co-location without strong commitment and service development could result in the continued separation of services, but with IAPT staff bearing the responsibility for mental health rather than this being shared.

3.2.8.5.4 LTC pathways for each condition are commissioned and provided discretely from each other, often with different services across BNSSG. The IAPT provider will need to work and plan carefully to explore and put in place the most effective and efficient ways of managing co-location on the scale that is within its capacity.

3.2.8.5.5 People with life-limiting illnesses who are close to the end of their lives and/or an immediate family member, partner and/or close friend may require a specific group or joint intervention to help address particular issues in relation to the illness/terminal diagnosis (within IAPT eligibility). Individual circumstances might not allow for progression through the standard waiting list and therefore dictate that this must be provided as a matter of urgency (see 2.6.6, the ‘Timeliness of service’ section of ‘Provider Expectations’ on waiting list exceptionality).

Please see the IAPT Long-term conditions positive practice guide,[36] IAPT positive practice guidance for Medically Unexplained Symptoms/Functional Symptoms,[37] the Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms Full Implementation Guidance[38] and the position statement from the Royal College of Psychiatrists, Royal College of General Practitioners, British Psychological Society and Royal College of Physicians[39] for further information.

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[36] IAPT Long-term conditions positive practice guide. NHS. 2008.

[37] IAPT Medically Unexplained Symptoms/Functional Symptoms Positive Practice Guide. NHS. 2014.

[38] The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms. National Collaborating Centre for Mental Health - Full Implementation Guidance. 2018.

[39] Providing evidence-based psychological therapies to people with long-term conditions and/or medically unexplained symptoms. Royal College of Psychiatrists, Royal College of General Practitioners, British Psychological Society and Royal College of Physicians. 2015.

3.2.9 Younger people (16 years+)

Links to key related sections:

3.1.2 Equality and equity
3.2.2 Improving access to, and accessibility of the service
3.2.7 Communications
3.6 Workforce, education and training
3.5.2 Connections and referral pathways to and from other existing services and support

3.2.9.1 Background

This IAPT service is commissioned to provide treatment for people from the age of 16 years and must therefore have an understanding of the particular needs, and means of engagement of younger people in order to increase their access to it. It will also need to establish a positive external perception through the language it uses, the attitudes it conveys in its publicity, its methods of communication and delivery of therapies (in line with younger people's preferences) as these will all impact on its success in reaching a younger demographic (that ranges from 16 years into the mid/late 20s).

3.2.9.2 Connections with other provision

There are a number of key services and pathways across BNSSG specifically commissioned to address younger people's mental health issues which will be important for this service to forge connections with. However, the available provision differs and therefore 16 and 17 year olds will have a different landscape of external services available to them depending upon which local authority area they live in. It is therefore essential that this service treats younger people fairly and equitably across the whole service area even though they may have less equitable access to other provision.

There are currently two commissioned services that are directly relevant to IAPT:

- **Bristol and South Gloucestershire Counselling Service (for 11-18 year olds):**

  Off The Record provide the Bristol and South Gloucestershire Counselling Service for 11-18 year olds, commissioned in 2017 by Bristol and South Gloucestershire CCGs to provide 'IAPT compliant' interventions for children and young people. Note that this is 'Children and Young People's IAPT', it does not mean that they provide (adult specified) IAPT services within the terms of this contract.

  Section 3.5.3 of that service specification provides detail as to the connection with previous local IAPT services, and a mechanism whereby the service's triage process can refer or signpost young people into the IAPT service directly (bypassing waiting lists). A new arrangement will need to be negotiated and clarified with Off The Record in order to ensure a strong linkage while maintaining equity across BNSSG (see 2.6.11).

  The Bristol and South Gloucestershire Counselling Service for 11-18 year olds specification is provided as Appendix-H for full reference.

- **Kooth - Bristol and North Somerset's online service for 11-19 year olds**

  The former Bristol and North Somerset CCGs commissioned an online support and counselling service. This service forms part of the contract held by Bristol and South Gloucestershire's Community Children's Health Partnership led by Sirona Care for all young people aged 11-19. This service is online, confidential and independently accessible without any formal referral process or tracking. It offers an important additional resource for young people who present to the IAPT service.

3.2.9.3 CYP IAPT

(From NHSE 2018) The Children and Young People's Improving Access to Psychological Therapies programme (CYP-IAPT)[40] is a change programme for existing services delivering CYP mental health care. It aims to improve outcomes and experience of care for children, young people and their families by increasing access to effective services and evidence-based therapies through system-wide service improvements.

CYP-IAPT commenced in 2011 (was Government funded and centrally supported by NHS England/Health Education England up to 2018) and works with existing services that deliver mental health care for children and young people (provided by NHS, Local Authority, Voluntary Sector, Youth Justice), covering the 0-19 population. From 2019**,** the programme becomes 'business as usual'. In order to deliver the improvements in access to effective care for at least 70,000 children and young people, CCGs and provider organisations will need to continue increasing the skills of existing staff and develop a new workforce, embedding the CYP IAPT principles and ways of working across teams.

While CYP IAPT has a different remit from adult IAPT, this service should forge strong connections with those provider organisations which have embedded trained CYP Wellbeing Practitioners and work with 16 to 19 year olds, ensuring clear communications in relation to referral pathways and cross-service advice and support on young people's issues and treatments.

3.2.9.4 Students

As described in 1.1 ('Local context and evidence base') the BNSSG area is home to a large student population covering both further and higher education. Students face many issues that can make them more susceptible to common mental health problems – moving away from home for the first time, having greater potential access to drugs and alcohol, managing their lives and academic work independently with little support, having to establish new friends and social networks in a pressured environment. The increasing levels of depression and anxiety amongst students are well documented.[41,42] IAPT interventions can provide valuable and effective treatments for students with eligible need and must work to enable access amongst these groups. Connections with Students' Unions and student health services will provide important pathways to getting appropriate help. The service will also need to establish strong connections with further and higher education college student support/counselling services to ensure that students can receive the most appropriate support.

3.2.9.5 Young people who are leaving or who have left local authority care

Research has demonstrated that, despite high levels of poor mental health, care leavers are not accessing IAPT services due to a range of factors that include access criteria and waiting times.[43]

As some care leavers do not have supportive social networks (including extended family support circles), access to early intervention can be more critical to prevent later use of acute services.

Young people who are looked after by the local authority will leave care before or at the age of 18 years, and be supported by a personal adviser until the age of 25 years.

3.2.9.6 Key issues and tensions:

3.2.9.6.1 While IAPT services work with people from the age of 16 years, they can be

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[40] Children and Young People's Improving Access to Psychological Therapies Programme. NHS.

[41] Mental health of students in higher education. College report CR166. Royal College of Psychiatrists. 2011.

[42] Gunnell, D. Kidger, J. Elvidge, H. Adolescent mental health in crisis. BMJ. 2018.

[43] Braden, J. Goddard, J. Graham, D. CARING FOR BETTER HEALTH: An investigation into the health needs of care leavers. Section 9. p44. 2017.

constructed and experienced as generic adult services, with practices that feel unwelcoming/unattractive and inadvertently exclude younger people.

3.2.10 Older people (65 years +)

Links to key related sections:

3.1.2 Equality and equity

3.2.2 Improving access to, and accessibility of the service

3.5.2 Connections and referral pathways to and from other existing services and support

3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

3.2.10.1 Background

Most older people in the UK have good mental health and wellbeing, but a significant minority (an estimated 3 million) have mental health symptoms that affect the quality of their lives. Mental health problems in later life can have a massive social impact, resulting in poor quality of life, isolation and exclusion. However, evidence-based psychological therapies can be effective for older people.

It is believed that 25% of people over the age of 65 living in their own homes/neighbourhoods have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment, primarily medication.

Older people tend to engage well with IAPT interventions, completing their course of therapy and achieving good recovery scores at discharge, and yet they tend to be poorly represented in IAPT access rate figures across the country.

3.2.10.2 Key issues and tensions:

3.2.10.2.1 Depression and anxiety in older people are strongly connected with social isolation, bereavement (and the loss of friends/family/social networks), poverty and the impact of increasing disability. Treatment of the psychological difficulties without paying attention to associated factors (through referral pathways) is unlikely to enable sustained outcomes.

3.2.10.2.2 Older people can be the subjects of others' low expectations in relation to their mental/physical health/wellbeing and the services/options they are presented with. Their own ambitions and expectations of themselves are often higher than those that service providers have of them.

3.2.10.2.3 While certain issues of accessibility require a specific focus to be inclusive of older people, most means of improving access are beneficial to all under-represented groups.

See the IAPT Older People Positive Practice Guide[44] and IAPT Older People's Training and Resources[45] for more information.

3.2.11 Perinatal mental health

Links to key related sections:

3.1.1 Service ethos

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[44] IAPT Older People Positive Practice Guide. NHS. 2009.

[45] IAPT Older Peoples Training and Resources

3.1.2 Equality and equity

3.2.5 Assessment

3.5.2 Connections and referral pathways to and from other existing services and support

3.2.11.1 Background

The Antenatal and Postnatal Mental Health NICE guideline[46] recognises the serious impact of undiagnosed depression and anxiety disorders on the health and wellbeing of the mother and baby during pregnancy and the postnatal period. Therefore, the IAPT Manual recommends that women in the perinatal period are prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks.

The Perinatal Positive Practice Guide also recognises the mental health needs of fathers in the perinatal period both in relation to the prospect of fatherhood and to their partner's perinatal mental health difficulties. Men themselves can also experience perinatal mental health issues and should be referred and supported in an appropriate way. However, it must also be recognised that parenting is often not hetero-normative and these difficulties can also occur in same-sex couples/partnerships and in any partnership where there is an adult who will have a close/parental/care-giving relationship with a child. While support for partners/co-parents is important, the majority of the national evidence base for the main impact, particularly on the infant, relates to the mother's mental health and as such this needs to be prioritised.

3.2.11.2 Key issues and tensions:

3.2.11.2.1 While 'fast-tracking' of different groups to assessment in order to reduce waiting times is not recommended as the means of capacity and waiting list management, it is essential that women with depression and anxiety during pregnancy or in the first year of their child's life get assessed and treated quickly.

3.2.11.2.2 There will be a number of specific issues that impact on parents with young children being able to access and engage with therapy. The timings, location, travel required, provision of childcare/crèche or ability to have their babies in therapy with them are all key factors. Home visits can also be used an enabler of a service to women with maternal depression and anxiety in exceptional circumstances.

3.2.11.2.3 The 'perinatal' period covers women who are pregnant or have a child in its first year, and can also impact upon their partner/co-parents. They may also start to show signs of depression and anxiety later than this, which also significantly impacts on their relationships with their children and on family health and development.

3.2.11.2.4 Integration and collaboration with other services can present a significant challenge given the varying professional groups, organisational structures and funding streams. Women can present in a variety of physical and mental health settings across primary and secondary care, including maternity, adult mental health, drug and alcohol, eating disorders, learning disability, child and adolescent mental health, children's centres, health and social care services, health visiting and local voluntary sector mental health organisations.

See the IAPT Perinatal Positive Practice Guide[47] and Improving Access to Perinatal Mental Health Services in England – A Review[48] for further information.

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[46] Antenatal and postnatal mental health: clinical management and service guidance. Clinical guideline [CG192]. NICE. 2017.

[47] IAPT Perinatal Positive Practice Guide. NHS. 2013.

3.2.12 Learning disability and neuro-atypicality (including Autism Spectrum Disorder (ASD) and Attention Deficit Hyperactivity Disorder (ADHD))

Links to key related sections:

3.1.1 Service ethos

3.1.2 Equality and equity

3.2.2 Improving access to, and accessibility of the service

3.2.12.1 Background

People with the range of conditions that are grouped as learning disabilities and neuro-atypical people (including those with Autism Spectrum Disorders (ASD) and Attention Deficit Hyperactivity Disorder (ADHD)) tend to be under-represented in IAPT services and can benefit from IAPT interventions. With reasonable adjustments and promotion, equitable access to NICE-recommended therapies can be achieved.

3.2.12.2 Key issues and tensions:

3.2.12.2.1 People with learning disabilities or who are neuro-atypical can often have their mental health needs ignored or thought of in relation to the diagnosis. Rather than being assessed and offered an IAPT intervention, they are often referred to specialist services due to the common assumption that people with learning difficulties or who are neuro-atypical can only be supported by specialists. This service must not inadvertently function to perpetuate such exclusion but to promote pathways to, and the accessibility of mainstream provision.

3.2.12.2.2 Without modification or staff awareness/confidence, psychological therapies can be experienced as inaccessible to, excluding of and outside the ways of thinking or engagement of neuro-atypical people.

3.2.12.2.3 IAPT services are often ill-equipped in providing competent interventions or the necessary accessibility modifications to include people with learning disabilities, who therefore find them inaccessible. The difficulty of the content, the expectations of homework, the speed of the sessions and complexity of the language all combine to make groups and courses inaccessible and result in people being and feeling excluded and consequently giving up.

3.2.12.2.4 The GAD and PHQ scales can be experienced as conceptually inaccessible for people with learning disabilities. There are, however, adapted versions that use pictures and symbols that should be offered as accessible alternatives.

See the Learning Disabilities Positive Practice Guide[49] for further information.

3.2.13 Domestic and sexual abuse and violence

Links to key related sections:

3.1.1 Service ethos

3.1.2 Equality and equity

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[48] Improving Access to Perinatal Mental Health Services in England – A Review. NHS Improving Quality. 2015.

[49] IAPT Learning Disabilities Positive Practice Guide. NHS. 2013.

3.2.2 Improving access to, and accessibility of the service

3.2.4 Interventions and therapies

3.5.2 Connections and referral pathways to and from other existing services and support

3.2.13.1 Background

The Home Office provides a gender neutral definition of domestic violence and abuse: "controlling, coercive or threatening behaviour, violence or abuse between people aged 16 or over, who are or have been intimate partners or family members, regardless of gender or sexuality", which includes, but is not limited to, psychological, physical, sexual, financial, and emotional abuse. The Office of National Statistics article on Sexual offences in England and Wales: year ending March 2017 estimated that 20% of women and 4% of men had experienced some type of sexual assault since the age of 16, disproportionately affecting women.

Evidence is emerging, that causal relationships exist between mental disorders, particularly depression, and domestic violence/abuse. This service will therefore need to understand that domestic abuse may be a core component of some women's depression, and the potential Safeguarding implications, given that women treated by the service for depression may be more likely to be survivors of current or past domestic violence.

3.2.13.2 Sexual Assault Referral Centre (SARC)

The SARC has two distinct elements, providing:

- Immediate post-sexual assault forensic/medical examination.
- A counselling service (for those who the assault took place within the last 12 months), from the report of the assault through to the trial.

A new SARC counselling service covering the BNSSG area will be in place from 1st April 2019 with a remit outside the responsibility of IAPT.

While the SARC provides immediate post sexual-assault counselling, those who receive it may also present to IAPT for different or connected help before/after a trial and/or require onward referral. It is essential that this service is properly connected into the SARC counselling service in order to ensure seamless transitions and avoid duplications of service/intervention.

3.2.13.3 Key issues and tensions:

3.2.13.3.1 Many incidents of domestic violence or sexual assaults do not result in an arrest or go to trial, but nonetheless have a striking impact on the survivor and their life. The specific skills to work with people who have been the survivors of domestic/sexual violence and abuse within a trauma-informed approach are key.

3.2.13.3.2 While it will be important that there is a high level of generic capability across the whole service, women comprise the majority of survivors of domestic violence/abuse, sexual abuse, assault and other forms of sexual violence. Therefore it must be able to draw upon particular competence and understanding of the specific issues for women.

3.2.13.3.3 The service will also need to be able to draw upon skilled and specialist staff and interventions that recognise how gender issues impact on work with people who have experienced domestic and sexual abuse (including for men and people who are Trans or non-binary).

3.2.13.3.4 A tension lies between the short-term nature of IAPT interventions and the widely expressed position that people who have had adverse childhood experiences and extreme trauma (including childhood or adult sexual abuse) benefit from longer term treatment. The provider will need to recognise this and consider working for longer (within the boundaries of the therapies offered) with people from this cohort of service users if/where it is deemed to be more clinically effective.

3.2.13.3.5 Domestic violence/abuse and sexual assault are under-reported across different demographics and communities. Many professionals too are unaware and/or unconfident about recognising these issues or the part they play in mental health difficulties. The service will need to be very clear about its ‘professional boundaries’ and Safeguarding responsibilities in relation to reporting while creating a culture that promotes disclosure.

3.2.13.3.6 Domestic violence/abuse can often be a component of the presenting issue and yet it is common for services to not be equipped to recognize it.

3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)

Links to key related sections:

3.1.1 Service ethos

3.1.2 Equality and equity

3.2.2 Improving access to, and accessibility of the service

3.2.5 Assessment

3.5.1 Primary and secondary mental health interface

3.2.14.1 Background: people using secondary mental health services

The Five Year Forward View for Mental Health cited the IAPT-SMI pilot sites that demonstrated the positive impact of access to NICE-recommended psychological interventions on experience, outcomes and reduced healthcare utilisation by people with psychosis, bipolar disorder and personality disorders. NHS England and Health Education England were tasked with working to build on and scale up the IAPT-SMI programme so that a greater number of people have access to psychological therapy as a core component of the adult mental health services offer.

Some people with a serious mental illness and who use or have used secondary mental health services might benefit from receiving evidence-based psychological therapies for depression and anxiety, where use of such therapy would not interfere with or detract from the impact of other treatments they receive.

3.2.14.2 Background: people with complex needs (including those with personality disorder diagnoses)

People who have experienced complex trauma (particularly adverse childhood experiences) and people who are often described as having complex needs (including personality disorders) can find that IAPT treatments do not meet their needs due to the generic and short-term nature of the standard interventions. This cohort consequently tend not to reach recovery and can repeatedly re-present, further deteriorating over time. Those who have recently been discharged from secondary care who present to IAPT are often referred straight back but do not meet eligibility.

More specifically, evidence demonstrates those with a diagnosis of personality disorder or personality disorder traits can benefit from specialized CBT techniques to provide greater opportunities for effective outcomes. A number of therapies have been developed and their particular efficacy for people with these presentations is strongly supported by their evidence-base.

Bristol, North Somerset and South Gloucestershire have different mental health pathways and pictures of provision for addressing the mental health of people with complex needs (including personality disorders):

- Bristol – Complex Psychological Interventions (CPI). This is a tertiary service (which means access is dependent on being accepted by AWP secondary care). IAPT service includes a range of evidence-based interventions at steps 2&3 provided by various AQPs.
- North Somerset – Psychological Therapies Service (secondary service delivered by AWP) and the STEPPS programme delivered (by AWP) in primary care.
- South Gloucestershire – Specific funding in secondary care to support diversion from acute services. Local care pathway with a BPD Lead providing supervision and including a partnership primary/secondary care service using evidence-based interventions. Rolling out STEPPS and iMBT programmes co-facilitated between IAPT and secondary staff.

3.2.14.3 Joint working

The IAPT service cannot and should not be expected to fill the gap below secondary care for all those with such needs. However, it is expected that it does offer a range of evidence-based IAPT interventions that are known to positively work for people with eligible need who have a diagnosis of personality disorder or personality disorder traits with evidence of success where other IAPT interventions typically do not.

Work is currently underway to design a personality disorder pathway across BNSSG and it is expected that the provider will work with the pathway when it is designed and implemented.

Closer locality–based joint working between IAPT and secondary mental health services will support the development of flexible interventions and greater awareness/understanding of the eligibility for, potential and limits of each level of intervention. Closer liaison between primary and secondary care, with (for example) joint training and holding jointly facilitated groups (by IAPT and secondary mental health staff) in GP practices, should begin to improve confidence amongst GPs.

3.2.14.4 Key issues and tensions:

3.2.14.4.1 People with these diagnoses tend to be associated with secondary mental health services, but nonetheless experience common mental health difficulties, perhaps as a result of personal circumstances, life events or socio-economic factors (for example bereavement, financial or housing difficulties, social isolation). They must not be prevented from receiving specific evidence-based psychological help for such presentations outside of secondary mental health services due to either their condition or pre-existing connection with secondary services.

3.2.14.4.2 The CPI (Complex Psychological Interventions) service in Bristol may be able to offer such therapies to people with these diagnoses in conjunction with a current secondary service, or who are no longer receiving such a service.

3.2.15 Employment and job retention support

Links to key related sections:

3.1.1 Service ethos
3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.2.5 Assessment
3.5.2 Connections and referral pathways to and from other existing services and support

3.2.15.1 Background

The IAPT Manual highlights the negative personal and societal impact of depression and anxiety on educational achievement, employment, levels of absenteeism, work performance, earnings and productivity. These are accompanied by increased social welfare expenditure. These issues impact more significantly still on people with coexisting mental and physical health problems. It has been established that the longer people are absent, or out of work, the more likely they are to experience depression and anxiety. Therefore, employment advice, delivered as a core part of an IAPT service, can be integral to the success of that service.

Since its launch in 2008, there has been a recognition that many people who come into contact with IAPT services have some level of need in relation to employment (they may be unemployed, having difficulties at work, or off sick and in danger of losing their jobs).

3.2.15.2 Key issues and tensions:

3.2.15.2.1 There is a common mistrust of employment services, as they can be seen as 'forcing people off benefits and into unsuitable paid work'.

3.2.15.2.2 Generic disability employment services can tend towards relatively low expectations of people and the work that they can/should aspire to.

3.2.15.2.3 There is a tension between on the one hand, placing employment at the end of a 'journey' (a series of steps) that may lead to (or back to) it; and on the other, placing emphasis on concurrent employment (and other socio-economic) support alongside IAPT interventions to ensure that people are supported to hold on to their jobs and sense of employability.

3.2.15.2.4 If employment is continually positively referred to throughout treatment, even those who are not necessarily ready to address it during their treatment may be encouraged to seek employment support later.

3.2.15.2.5 GPs play a key role in signing people off sick from work, providing 'Fit for work' notes and supporting their phased returns. It is essential that a person's GP is kept fully involved and up to date with any employment and job retention work that IAPT (or external services) is engaged with in order to be able to support the work and their continued employment.

3.2.15.2.6 While the service's work is with individuals, there should be some recognition of and connection with wider local work being undertaken to promote 'mentally healthy workplaces'. There should be recognition of stigma and how both the experience, and fear of it can impact on individuals in their work.

3.2.16 Poverty, debt and benefits advice

Links to key related sections:

3.1.1 Service ethos

3.2.5 Assessment

3.5.2 Connections and referral pathways to and from other existing services and support

3.2.16.1 Background

The connection between poverty/debt and depression/anxiety are strong, and often directly correlate with unemployment, homelessness, substance misuse, social isolation, contact with the criminal justice system etc.

While an IAPT service in itself cannot provide welfare rights advice, it can and should have strong connections with all the debt and welfare rights advice services across the three local authority areas.

3.2.16.2 Key issues and tensions:

3.2.16.2.1 In circumstances where anxiety/depression are caused by or strongly associated with poverty and/or debt, if the service only engages with the anxiety or depression without concurrently ensuring that the financial difficulties are addressed, any improvement in mental health is likely to be fleeting and not sustained.

3.2.16.2.2 For some, a referral on to poverty/debt advice might divert them from requiring therapy, for others, the services will need to work concurrently to address both the financial and mental health difficulties.

3.2.16.2.3 For others, to have support to begin to remedy financial issues may be necessary before they are able to contemplate working on their psychological difficulties. In such circumstances, the IAPT service should have the means to hold the referral rather than require them to re-present at a later stage.

3.2.17 Housing and homelessness

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service

3.2.4 Interventions and therapies

3.5.2 Connections and referral pathways to and from other existing services and support

3.2.17.1 Background

Inadequate or insecure housing and homelessness are key factors that contribute to the deterioration of mental health. Early intervention and an assessment that recognises the role these factors play in depression and anxiety, along with offering encouragement for tenancy sustainment and having the connections in place to get people practical support from local services as quickly as possible is essential. IAPT has a key role in offering a service to people in these circumstances who exhibit the relevant mental health conditions.

Many homeless people have experienced significant early traumas and a range of other complex associated circumstances that have led or contributed to their difficulties.

The three LAs provide statutory housing services along with commissioned homelessness services/pathways that differ according to the level of need in each area. For example, Bristol has four commissioned adult homelessness pathways, specialist young people’s accommodation pathways and resettlement workers that this service should forge clear routes to and from.

There is an increasing need for the IAPT service’s practice to be trauma-informed when working with homeless and other people with complex needs, and to understand its position and work collaboratively with other agencies that may be involved with a person – e.g. homelessness, substance misuse, secondary mental health services.

3.2.17.2 Key issues and tensions:

3.2.17.2.1 Housing and homelessness provision varies across the three LA areas. This means there are significant differences in provision that can be drawn on for referral onto.

3.2.17.2.2 It is common for homeless people with mental health difficulties to find themselves repeatedly passed between homelessness, mental health and (particularly in crisis situations) emergency services.

3.2.17.2.3 There is a national requirement for an increase in housing across the UK with key fast-growing developments in BNSSG. This service will need to adapt to new housing developments and the associated shifting demography.

3.2.18 Tobacco Cessation & Harm Reduction

Links to key related sections:

3.5.2 Connections and referral pathways to and from other existing services and support

Given the known high levels of smoking prevalence among service users accessing mental health services, and the evidenced relationship between smoking and depression/anxiety, IAPT services are a key place to offer early smoking cessation interventions to support wider Public Health programmes.

3.2.19 Substance misuse

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.5.2 Connections and referral pathways to and from other existing services and support

Drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. Substance misuse clients with mental health needs should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety and there is no evidence that substance misuse per se makes the usual psychological therapies ineffective. The IAPT and substance misuse services will need to work together to develop locally agreed pathways and criteria for more specialist interventions when indicated.

Please see the IAPT positive practice guide for working with people who use drugs and alcohol[50] for further information.

3.2.20 People in contact with the criminal justice system

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.5.2 Connections and referral pathways to and from other existing services and support

National data indicate that, despite having high levels of poor mental health, people in contact with the criminal justice system tend to be under-represented in IAPT services. The service should inspect the local data and establish positive connections with local prisons, the Prison and Probation Service and the National Offender Management Service in order to ensure access from offenders who meet IAPT eligibility criteria.

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[50] IAPT positive practice guide for working with people who use drugs and alcohol. NHS. 2012.

Please see the IAPT Offenders Positive Practice Guide[51] for further information.

3.2.21 Serving and ex-serving armed forces personnel

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service

3.2.4 Interventions and therapies

3.5.2 Connections and referral pathways to and from other existing services and support

The Armed Forces Covenant[52] clearly sets out the nation's commitment to armed forces personnel, their families and veterans. There are additional risks to the mental health of people from this group, such as traumatic combat experiences, time away from family during prolonged or frequent deployment, the instability in home life this can bring and difficulty in the transition back to civilian life. It also clarifies the expectation on health services that, as veterans receive their healthcare from the NHS, they should receive priority treatment where it relates to a condition which results from their former service in the armed forces (subject to clinical need).

See the Veterans Positive Practice Guide[53] for increasing access and building capability within the workforce to understand the military culture.

3.3 Population covered - conditions treated by IAPT

Links to key related sections:

3.2.4 Interventions and therapies

This single service will cover the entire BNSSG area.

Depression and anxiety disorders are the most common mental health problems affecting individuals and society. The list below covers depression, the most common anxiety related disorders and other conditions treated within IAPT services. It is recognised that many people experience more than one of these conditions.

- Depression
- Generalised anxiety disorder
- Social anxiety disorder (social phobia)
- Panic disorder
- Agoraphobia
- Obsessive-compulsive disorder (OCD)
- Specific phobias
- Post-traumatic stress disorder (PTSD)
- Health anxiety (hypochondriasis)
- Body dysmorphic disorder
- Mixed anxiety and depressive disorder

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[51] IAPT Offenders Positive Practice Guide. NHS. 2013.
[52] The Armed Forces Covenant.
[53] IAPT Veterans Positive Practice Guide. NHS. 2013.

- Irritable bowel syndrome*
- Chronic fatigue syndrome*
- MUS not otherwise specified*

*IAPT services are only expected to treat these conditions if they have developed an IAPT-LTC pathway and have staff who have received training in the treatment of these conditions.

(From the IAPT Manual)

3.4 Any acceptance and exclusion criteria and thresholds

3.4.1 Acceptance criteria

IAPT 'Caseness':

A person is said to be at caseness when their symptom score exceeds the accepted clinical threshold for the relevant measure of symptoms. For the PHQ-9, this is a score of 10 or above. For the GAD-7, this is a score of 8 or above. Other symptom measures, such as those used to measure the severity of different anxiety disorders, have their own specific thresholds. Some outcome measures (such as the Work and Social Adjustment Scale) do not have recommended caseness thresholds but provide valuable additional information about the quality of a treatment response.

IAPT services are intended to reach and be accessible to all eligible people. In practice this means placing an emphasis on those who are likely to be at caseness, in order that they count towards meeting access targets and so that their improvements will support mandated recovery levels. However, there are many people who, although not reaching caseness, nonetheless have a level of difficulty that the service should usefully address in order to prevent future deterioration and re-presentation with greater levels of need. The service should therefore offer early online and group psycho-educational/self-help interventions to those people with levels of mental health need that are below the threshold.

3.4.2 Exclusions

Links to key related sections:

3.2.2 Improving access to, and accessibility of the service

3.2.5 Assessment

3.5.1 Primary and secondary mental health interface

Key of technical definitions and abbreviations

While the IAPT service has clear definitions of the levels of anxiety and depression that it can work with, there are very few definitive exclusion criteria for access to it. The emphasis is on inclusion and the positive and clear presentation of the service's purpose, what it is commissioned to deliver and to whom.

The following exclusions will apply:

- People who at the time of assessment, for whatever reason (e.g. acute illness, childbirth, compulsory admission), are unable to engage with IAPT therapies. They will be referred to a more appropriate care pathway, although this will not preclude their return to the IAPT service at a later time. These people will be recorded by GP cluster.
- People who, at the time of assessment have needs (defined through the service's standard measures) below IAPT's eligibility (see 'caseness', Key of technical definitions and abbreviations). They will be redirected to self-help/self-management interventions and/or other socio-economic services that can provide them with appropriate support, although this will not preclude their return to the service at a

later time.

- People who are assessed to have mental health needs that would be more appropriately supported at the secondary mental health level. They will be referred to their local secondary mental health care pathway through the positive relationships described in section 3.5.1 ‘Primary and secondary mental health interface’ below and followed up accordingly through their GP. This will not preclude their return to the service at a later time. It is not within the remit of this service to assume care co-ordination responsibility for any individual referred for treatment – the GP remains the Care Co-ordinator if the service user is not engaged with by secondary mental health services.
- People who have mental health conditions outside those that IAPT is able to treat.

3.5 Interdependence with other services/providers

3.5.1 Primary and secondary mental health interface

Links to key related sections:

2.3 Measurement, evaluation and learning/development
3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)
3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)
3.4.2 Exclusions

A set of diagrammatic representations of the current commissioned primary and secondary mental health care services across BNSSG are included as Appendices F1 to F3.2.

The IAPT Manual states that IAPT services sit within a wider system of care and spans primary and secondary mental health care. They operate a ‘hub and spoke’ model, which typically includes a central management and administration office with strong primary care and community links that enable most of the face-to-face therapy to be provided in local settings that are as easy for people to access as possible (such as GP practices, community settings and voluntary organisations).

The IAPT service forms a key part of the mental health system across BNSSG and is part of the Integrated Pathway. Strong connections and clear communications with primary care (including Primary Care Integration) and secondary mental health services are essential to the system functioning effectively.

South Gloucestershire, for example, published a leaflet describing their primary care offer which brings together the range of provision that can help people with their mental health/wellbeing at the primary care level (provided as Appendix-N). Commissioners hope that, over the course of this contract, this service will become a strong and vibrant part of the Integrated Localities programmes across BNSSG.

There is a growing demand upon mental health services which represents a level of need that lies between IAPT and secondary service eligibility. It is acknowledged that this IAPT service cannot address or be held responsible for this gap in provision, or for treating all mental health issues below secondary mental health service eligibility. However, commissioners expect the provider to work to take a key role in establishing and maintaining strong and positive relationships with GP practices, secondary mental health services and local authority provided/commissioned services, and clearly communicating its role and purpose in the wider system.

Mental health provision across BNSSG currently includes a range of different commissioned services and types of intervention – e.g. CPNs located within some practices, a primary care mental health pilot, some specific joint primary/secondary PD interventions etc.

3.5.2 Connections and referral pathways to and from other existing services and support

Links to key related sections:

3.1.1 Service ethos
3.1.2 Equality and equity
3.2.1 Delivery model
3.2.7 Communications
3.2.9 Younger people
3.2.10 Older people
3.2.11 Perinatal mental health
3.2.13 Domestic and sexual abuse and violence
3.2.15 Employment and job retention support
3.2.16 Poverty, debt and benefits advice
3.2.17 Housing and homelessness
3.2.19 Substance misuse
3.2.20 People in contact with the criminal justice system
3.2.21 Serving and ex-serving armed forces personnel
3.6 Workforce, education and training

The development of referral pathways (with associated protocols) to and from other provision is more robust than signposting. Providing a name or phone number does not necessarily result in a service user reaching the service, where a clear referral with an agreed protocol with the integral accountability can greatly improve the chance that the offer will be been taken up and its result tracked.

Similarly, the use of, and formal connection to the existing online databases that describe the wide range of statutory, voluntary and neighbourhood/community sector provision across the area (e.g. Well Aware) is more robust and extensive than staff in a service collecting/storing their own contacts in a separate database.

In practice, our approach means that the provider will put administrative resources into knowing the arena in which they operate, forge clear referral pathways and play their part in developing associated protocols to and from the wide range of (often locally based) services across the area including but not limited to:

- Debt and financial/benefits advice.
- Employment and job retention support.
- Social prescribing.[54]
- Volunteering opportunities.
- The (South Gloucestershire) Wellbeing College.
- Cultural services (including arts, sport and physical activity including Yoga, Tai Chi etc).
- Health promotion and healthy lifestyles activities.
- Substance misuse services and pathways.

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[54] Kimberlee, R. What is the Value of Social Prescribing?. Advances in Social Sciences Research Journal. 2016.

- Housing.
- Homelessness services and the Bristol Homelessness pathways.
- Sexual abuse and sexual violence support.
- Primary and secondary mental health services.

The IAPT Manual states that: ‘The provider, in partnership with primary and secondary care clinicians and commissioners should develop local care pathways in consultation with patient groups and community leaders. Collaboration is critical to enabling access to services for a range of under-represented groups. Working in partnership with patients is paramount to understand and overcome barriers that might hinder the effective shaping of local pathways. Closer working with the community and voluntary sectors will improve access to services for community groups who may find it more difficult to access services via primary care, such as people from black and minority ethnic (BAME) communities.’

Covering three local authority counties, the service will have different landscapes of external provision to draw upon. Bristol, as a large city, has a great deal more resource than either North Somerset or South Gloucestershire. While local authority funding has reduced over recent years, and funded services are more limited than previously, the service should positively connect with the local services and provision that does exist. The provider must fully understand the differences in local provision across the area, positively work with them, and clearly communicate them to service users. The discrepancies that could result in users being disadvantaged should be fed back to commissioners in order that they can be addressed at the local Health and Wellbeing Boards.

BNSSG comprises a single large city, large and smaller towns, villages and entirely rural communities, all of which must be equitably served in terms of the processes of the service and its quality. Due to the nature of the service and the geographical coverage, it is anticipated that the provider can make connections to place themselves in a strong position to work in partnership (with local authorities, the DWP, regional development programmes) across local structures, and to draw in funding resources, research and evaluation opportunities to progress this outward-focussed service model.

A table listing a wide range of key external provision for Bristol, North Somerset and South Gloucestershire is provided as a snapshot taken in May 2018 (Appendix-E).

3.6 Workforce, education and training

Links to key related sections:

3.1.1 Service ethos

3.1.2 Equality and equity

3.2.4 Interventions and therapies

3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

3.2.9 Younger people

3.5.2 Connections and referral pathways to and from other existing services and support

3.6.1 Background

Ensuring the competence and quality of the IAPT workforce: The right workforce, appropriately trained, with the right capacity and skills mix, is essential to ensuring the delivery of NICE-recommended care. Adherence to the protocols of NICE-recommended therapy is critical to good outcomes. Therefore, the success of the IAPT programme depends on the quality of the workforce.

The IAPT workforce consists of low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped-care model. National guidance suggests that approximately 40% of the workforce in a core IAPT service should be PWPs and 60% high-intensity therapists. For the new IAPT-LTC services it is recommended that there is a slightly stronger focus on high-intensity interventions with the workforce being 30% PWPs, 60% high-intensity therapists and 10% senior therapists (such as clinical and health psychologists) who have expertise in LTCs/MUS and can manage more complex problems as well as providing supervision to others.

The IAPT Manual provides essential practice guidance addressing the workforce issues in relation to a set of key areas:

- The low and high intensity workforce.
- Clinical leadership.
- Additional workforces: including managers, employment advisors, data analysts and administrative staff.
- Equality and diversity issues.
- Competences and training.
- Staff wellbeing.
- Supervision.[55]
- Career development.
- Workforce retention.

It is commissioners' expectation that the provider will follow the guidance of the Manual, build on it through their own local developments, and implement any new national requirements that are issued over the course of the contract.

3.6.2 Service ethos and the workforce

Additional to the requirements laid out in the Manual, the service ethos (see 3.1.1) requires a particular value base, competence and skill mix in its workforce in order to deliver the vision:

- The provider will need to consider staffing options and creating capacity within the service in order to integrate the ethos. This will include nurturing, building and sustaining external relationships and developing referral pathways to and from a range of existing provision across the service's footprint.
- The service will require a workforce that can integrate a high level of clinical competence with the service ethos into their practice.
- The service will need to create a culture that has the understanding of the social determinants of mental health, equality and equity at its core.
- The ethos and clinical requirements of the service must be shared throughout the entire workforce rather than located with 'specialists'.

3.6.3 Equality

This service will provide IAPT interventions to a diverse population across the service area and must recruit, train and support a workforce that is representative of the communities it serves to improve mental health and reduce inequality (see 3.1.2).

Key factors to improve equity of access and outcomes for equality communities include:

- A diverse workforce representative of the local population.
- Ensuring cultural competence through ongoing CPD and appropriate outcomes-

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[55] Competence Framework for the Supervision of Psychological Therapies.

focused supervision.

- An extensive language capacity that can cover the most widely spoken languages across the area as well as less common ones (including British Sign Language). Where therapists do not have facility in required languages, high quality interpretation services must be available.

3.6.4 Training places

IAPT services provide the context for trainees to receive supervised placements. It is expected that this service will work with the regional training providers to offer appropriate levels of training places in proportions that reflect those of the workforce.

3.6.5 Employment advisors

Employment advisers are commissioned as part of the workforce for this service, however, the size of this resource (the number of advisors over the service) will be within the provider’s own workforce planning. Employment Advisors bring particular skill and focus to the service placing importance on sustainment of, and engagement with paid employment. They will:

- Promote understanding of the importance of employment in the whole service and how it can support recovery.
- Undertake specific job retention casework.
- Undertake specific job search casework.
- Build partnerships and referral pathways with local and national organisations and services in relation to employment (specifically around health, disability and mental health).

3.6.6 Key issues and tensions:

3.6.6.1 The location of the clinical IAPT interventions within a service that presents a different focus - understanding depression and anxiety in a more holistic context - may place key challenges on leadership and training as it requires a wider ideological base than mental health staff are often used to taking. Clarity of ethos and direction will be essential, as will placing demands on the low and high intensity workforce training programmes.

3.6.6.2 It is clear that IAPT services need to be proactive in engaging people from all communities and across the age range. This will require substantial recruitment from communities that are under-represented according to access rate measurements, with associated language capabilities. There are tensions here in terms of the size, skill base and level of training of the pool of staff to draw on from different communities across the area (who may have been disadvantaged in relation to education, training and employment opportunities). Mitigations lie in innovation, a trusted reputation for anti-discriminatory employment practice, taking positive action, apprenticeship and trainee programmes etc.

3.6.6.3 The needs of service users (and therefore of the service) and those of staff in relation to both language capability and providing choice of therapist will require careful attention. While some staff may want to work in their mother tongue and/or with people from their own communities, others may not want to be restricted to who they work with.

3.6.6.4 PWPs (Psychological Wellbeing Practitioners) can report a lack of understanding from other health professionals about the remit of their role within IAPT services. Recognition of the value PWPs bring and effectively integrating them into the team is crucial.

3.6.6.5 There is a high turnover within the IAPT workforce nationally, particularly in the

PWP role. Retention and staff development must form an integral part of the service with programmes to promote them. A service culture that is vibrant, supportive and nurturing, with career development pathways will help to mitigate turnover and the associated staff loss.

3.6.6.6 The service will need to both train its own staff and contribute to training of partner agencies in relation to understanding roles and responsibilities. It will need to work with NHSE and HEE (Health Education England) to encourage wider recruitment programmes and to promote training for currently under-represented staff groups.

3.6.6.7 A predominantly homogenous workforce is likely to impact on the ability of the service to connect with and gain the trust of different communities. Importantly, social class, although not counted amongst protected characteristics in the Equality Act 2010 can influence relationships particularly in neighbourhoods of high social disadvantage.

3.7 Information management and technology (IM&T)

(Document: IMT spec v0.14 MASTER 17_07_2018)

Links to key related sections:

3.1.1 Service ethos
3.1.2 Equality and equity
3.1.3 Co-production and user involvement
3.2.2 Improving access to, and accessibility of the service
3.2.4 Interventions and therapies
3.2.5 Assessment
3.2.7 Communications
3.2.6 Recovery

3.7.1 Information management and technology (IM&T) overview

The Five Year Forward View[56] made a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that 'all patient and care records will be digital, interoperable and real-time by 2020'.[57] This requires information to flow more effectively across health and care to support the delivery of direct care.

These documents make clear that service users and carers expect that whenever and wherever they access services, those caring for them can easily access comprehensive, accurate and timely information. They anticipate professionals working with modern information systems that bring together all of the relevant information available – from diagnostic tests and clinical notes, case histories to records of personal preferences. Service user experience and the effectiveness and safety of care will be improved through working towards paper-free environments delivered at the point of care.

The focus of the IM&T systems in mental health services is on provision of seamless service user care across all services and not on organisational boundaries. It is important to ensure that the IAPT service connects appropriately to secondary mental health across BNSSG, and that information can flow freely to other services, including primary & secondary care to ensure a safe and effective care pathway for service users.

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[56] Five year forward view. NHS. 2014.

[57] Personalised Health and Care 2020: a framework for action. 2014.

The lead provider will provide appropriate and boundaryless IM&T solutions across the whole BNSSG IAPT system (including with agencies in any consortia, partnership or sub contractual arrangements), to underpin and support the entire service, backed up by appropriate policies, procedures, and service agreements. The use of technology must support easy access to the service, and the lead provider should take advantage of new and emerging technologies which will facilitate increases in both access and recovery.

The IAPT lead provider will provide a comprehensive electronic care records system operational by contract commencement that must be available across the whole service: All partner and subcontracted organisations are required to use this system. The leader provider will be responsible for system reporting including the IAPT Minimum Data Set.

If any elements of the specification are not in place at contract commencement, the lead provider will have in place

- A service impact assessment and any necessary contingency plans.
- A clear costed plan and timescale (agreed with the Commissioners during the mobilisation phase) to deliver this functionality where it is their responsibility.

3.7.2 IM&T scope

The IAPT service will be led by a single lead provider with responsibility for managing the overall digital information system. Where the lead provider is part of a consortium or engages in partnerships or sub contractual arrangements with other agencies, (in relation to clinical management and information governance) they will be responsible for ensuring information is managed and shared appropriately across the whole IAPT system. This is critical to the delivery of this model.

The general responsibilities for the lead provider are:

- Provision, support, and management of a care records system.
- Ensure that the care record is used to record accurate, complete and timely clinical information. The lead provider will ensure that the electronic care records system records all service user details and retains a record of both clinical and non-clinical contact with service users across the whole system. This will include all personal and demographic information, in accordance with the IAPT minimum dataset (MDS), all equality data (under the Equality Act 2010), all data required for performance reporting and service planning, and any communication between provider and service users.
- The provision of a reporting solution on behalf of the whole service. Partner organisations should have access to their data to enable them to manage their own services, including activity, quality and outcomes.
- Ensure the provision of appropriate infrastructure to facilitate access/connectivity to the electronic care records system and reporting solutions. This includes providing a means of connection to the information system for other partner agencies and a clear Warrantied Environment Specification for any partner equipment to be connected to the system.
- Non-clinical business applications such as secure email, finance, HR and file storage for their own service.
- Provision of access to online therapeutic services for patients, including meeting associated licensing costs, as described in the overall service specification.
- Providing patient access to one-to-one call-based therapies online, e.g. using Skype and other VOIP systems, Facebook Messenger, WhatsApp etc.

The lead provider must ensure they have a good understanding of the IM&T requirements in order to enable effective working. They will therefore:

- Have an IM&T Strategy that explicitly states how IM&T will be developed to deliver the service across the whole IAPT system whilst adhering to NHS, industry and local health community standards. This must be aligned to local IM&T strategy including the STP local digital roadmap, and local strategic solutions such as connecting care .

- Work closely with other providers to develop clear operational policies and business processes that underpin seamless care provision across the BNSSG area. This may involve health, social care and other agencies.
- Ensure that all specified information functionality in the service model is supported by the electronic care records systems. Paper records are not acceptable clinical records for any services, although service users or carers may have their own paper copies of records.
- Ensuring a robust governance framework is in place including management of data quality across the whole system.
- Work proactively and positively with other stakeholders to address Information Governance issues and deliver mutual benefits, developing the solutions using a collaborative, and problem solving approach.
- The lead provider will make the electronic care records and reporting systems available to any partner or subcontracted organisations engaged in the delivery of the service. Any partner or subcontractors will be responsible for purchasing their own local hardware infrastructure to enable full and equivalent connectivity to these systems through the connectivity mechanism the lead contractor specifies, and to the Warrantied Environment Specification provided by the lead contractor.
- Plan and manage the transfer of required IAPT service data with the outgoing provider systems. (This may include but is not limited to clinical records, emails, data on share drives and HR records) in order to support transfer of staff and patients to the new services, and ensure continuity of care. This will need to be agreed as part of the transition process. The provider will need to undertake the process agreed with the commissioner to pass on the equivalent data at the end of the contract.

3.7.3 Electronic care record system (ECR)

This document does not seek to specify the detailed requirements of the Electronic Care Record as the provider will be responsible for identifying a solution that meets the needs of the services specified. However, the ECR should meet all the key requirements defined here, including, but not limited to:

- Be patient centred i.e. enable the patient or carer to manage their care, and their interactions with the service including appropriate access to their own records Ideally Service users to should be able to read their care plan online at any given point in time.
- Be already in use in an IAPT care setting, or assured for use in this setting.
- Be intuitive to use.
- Be flexible and locally configurable, to meet current and future needs of the service.
- Enable local outcomes and KPIs to be reported, in addition to the national requirements.
- Letters and other documents produced from the system will be branded as one service, irrespective of the provider, and tailored by individual users.
- Support communications services to patients, such as SMS messages for appointment reminders.
- Allow the real time, contemporaneous collection of all notes, including appropriate clinical and non-clinical data at the point of contact with the service user.
- Allow key information to be transferred electronically when patients are referred to or discharged from services, in a clear consistent format, securely and adhering to

Data Protection standards. For example from GP clinical system (currently EMIS across BNSSG) when referred and to the GP clinical system on discharge. (This refers to messages that can be work-flowed by the receiving clinical service, ideally using NHS digital's latest transfers of care standards. Use of fax/letters/email is not the preferred solution).

- Allow for production of service user friendly communications such as Summary letter of clinical intervention.
- Integrate with national applications e.g. the Summary Care Record and Patient Demographics Service as appropriate.
- Be innovative e.g. exploit technologies that enable quick access to care data such as Single Sign-on and Context Management.
- Meet NHS Strategic requirements.
- Support safeguarding of vulnerable adults (18+ years) and safeguarding of children and young people (16+ years).
- Be accessible appropriately across the service: be available over the internet to subcontractor/partners to log in from their own working environment.
- Support caseload management.
- Minimise the number of paper forms that patients (and staff) have to fill in.
- Meet clinical safety and assurance standard for the deployment and use of health IT systems including ISB 0160.
- Meet ISO 27001.

3.7.4 Online services and information

The lead provider will be responsible for the provision and maintenance of an up-to-date patient focused website that provides and describes the ways in which the service can be accessed, who the service is for and the available treatments. It will also include:

- Consistent single branding for all IAPT services service.
- Information and education resources for service users, family members and professionals.
- Signposting to internal and external MH services.
- Self-help information including self-triage, direction to self-help and other resources, and encouragement to good mental health and wellbeing.
- Self-referral information and functionality to be able to refer online, including type of services required.
- Online contact email and chat services.
- Ability to book appointments online.
- A mechanism for patient feedback on line: to enable service users to easily provide meaningful feedback on services.
- Access to online therapies.

The website must be designed to meet accessibility standards.

Other digital services should be considered such as provision of patient access and input to their electronic records.

3.7.5 Hardware and Infrastructure

The lead provider will be responsible for hardware and infrastructure to support clinical and non-clinical applications (office & desktop applications email; print & file services; directory services; secure file transfer server http://content.digital.nhs.uk/seft; endpoint security; business applications such as finance and HR systems).

The lead provider will use industry-standard best practice frameworks and methodologies (e.g. Information Technology Infrastructure Library (ITIL) Service Management & Service Delivery). This is to ensure the information technology services and systems are aligned to the needs of the service and actively support them and add value.

The lead provider must provide, or secure the provision of, robust and resilient data and voice infrastructure, and services that will enable timely and uninterrupted delivery and management of services to include, but not limited to:

- Appropriate Health and Social Care Network (HSCN) connectivity.
- Access to support contemporaneous clinical notes.
- Regular refresh and upgrade programmes to ensure performance and capability is maintained.
- Flexibility and scalability to meet future requirements.
- Support online and real time communications to patients and staff through Chat, Skype, and Messenger etc.

Note. The lead provider will be responsible for defining the warrantied environment for connectivity to be used by partners and subcontractors.

Partner or subcontractors will be responsible for providing their own local infrastructure including devices and internet connection to enable full and equivalent connectivity to these systems. Partner or subcontractor equipment must meet the minimum specifications described in warrantied environment specification (WES) provided by the lead provider.

3.7.6 System maintenance and support

The lead provider will manage on-going IT system maintenance and support according to the NHS conditions of contract for the supply of IT systems and NHS conditions of contract for the provision of support services including but not limited to:

- Granting and revoking user access (setting up new users' accounts and profiles and dealing with password issues).
- Configuration management including keeping reference files up to date.
- Monitor and manage the system performance, including liaison with service and system suppliers.
- Manage system upgrades, including system down time. Any planned system downtime that impacts the service delivery must be agreed with the commissioner in advance.
- Ensure partners and subcontractors and service users are kept informed, and notified in advance of any significant changes or down time.
- Have disaster recovery plans (including back-up processes /systems in place) should the electronic record system fail, and ensure business continuity processes are in place and adhered to.
- Resilience ensuring no single point of failure, and that services, including service desk, continue to be available when needed, whenever and wherever services are provided e.g. out of office hours.
- Provide maintenance and support for their own hardware and software and ensure it meets the recommended specification/ WES required to effectively use the clinical system(s).
- Provide a formal service desk or contact for contractors and providers to deal with issues with the IM&T service provided; including access, connectivity and usability. This should include processes for service requests, problem reporting & relevant escalation processes both within the lead and across partners.

3.7.7 Wider Information Sharing

Wider information sharing across the mental health care pathway is at the heart of safe and effective care. As much information as possible must be made available to staff at the point of referral and the aim should be that patients and carers should only have to tell their story once. The Service will need to provide a thorough initial assessment to enable this

The lead provider will adopt appropriate technology and standards to enable interoperability, integration, and safe and secure collaboration and handoff between disparate systems and solutions from a multitude of partner agencies and suppliers across a range of organisations. These will include but are not limited to:

- The Summary Enhanced Care Record.
- Systems pertaining to the safeguarding of vulnerable adults (18+ years) and safeguarding of children and young people (16+ years).
- Working with / interfacing with other stakeholder systems outside mental health services that may hold or require data needed to provide robust and complete care.
- The local integrated clinical record system (currently Connecting Care [58]).
- Communication with the patient's GP about the patient's referral, condition, treatment and discharge.

3.7.7.1 Connecting Care:

The lead provider will sign up to the connecting care programme as the method for sharing data between stakeholder organisations contributing to care in BNSSG. They must:

- Provide resource to define the requirements in a format that allows the programme to easily develop solutions and support its roll out amongst stakeholders.
- Sign up to the Connecting Care programme and ensure that the data feed (real time or near, based on best available solution) from the core IAPT ECR is available in the Connecting Care system from the start of the contract – the commissioner will provide approximate costs and technical specs to support this.
- Contribute to, and use relevant functionality in Connecting Care' making the portal available to staff. This includes the use of new functionality such as transfer of clinical documents as it becomes available.

The lead provider should also consider information sharing strategies with stakeholders not currently part of Connecting Care, and develop where appropriate to ensure appropriate information is available along the whole care pathway.

The lead provider will need to establish clear and formal ways for the IAPT service to connect with other services e.g. employment and job retention support, social prescribing, welfare rights and debt advice, housing and homelessness, substance misuse services, NHS long-term physical health and perinatal mental health pathways etc. It is likely that IAPT therapists will not need or have time to access all such records; however the lead provider will have clear referral pathways to these services and be able to monitor uptake of these referrals and to explore outcome sharing including recovery rates.

AWP is the main provider of secondary mental health services across the BNSSG area and currently uses RiO as their client database. In order to ensure that people who are in receipt of both IAPT and secondary mental health care do not receive a poorer service through lack of connectivity of IM&T systems, the IAPT lead provider should collaborate with AWP to develop agreements and protocols for information sharing to ensure appropriate connections between their system and RiO (or any other system the mental health provider uses over the term of this contract).

Where information is already being shared with other systems and services, whether by

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[58] Connecting Care is the flagship systems integration programme in Bristol, North Somerset and South Gloucestershire and active stakeholders include; CCGs, GPs, social care, acute hospitals, community providers, the ambulance service and mental health services.

manual data entry or electronic means, this must continue until another agreed mechanism is put in place.

3.7.8 Reporting

The lead provider will be responsible for reporting on the entire service as required by the national minimum dataset requirements and as defined in this service specification. The lead provider will also have responsibility for reporting on behalf of any/all partner /subcontracted agencies where the data is in their system. The majority of reporting will derive from the electronic care records system; additional information including important qualitative data on user outcomes and experiences will also be collected for reporting.

The lead provider will work with the Commissioner to agree a mechanism so that the information collected can be provided to commissioners according to the timetable agreed locally and in an agreed format.

The lead provider will:

- Ensure there is a reporting solution that satisfies the statutory and contractual reporting requirements including:
    - Minimum Data Set(s) submissions to NHS Digital (on a monthly basis via the Exeter Portal).
    - Local KPI information.
    - All national and local indicators, including KPIs and Access and Recovery standards.[59]
- Ensure that regular service reporting and data is available to commissioners at least monthly to include details of:
    - Activity.
    - Activity, including access and recovery information for special patient groups, such as those with Long Term Conditions, Perinatal and Postnatal patients, members of the armed forces and veterans.
    - Clinical outcomes and information on the other services that the patient has been referred to, or discharged to.
    - Demographics (including the first 3 or 4 digits of the post code, protected characteristics under the Equality Act 2010).
    - ICD 10 Code reports.
    - Reports to allow commissioners to understand and reconcile any payments to be made to the lead or subcontractor providers in respect of provision of the service.
    - Reports on waiting times and caseload for the service as a whole, and for elements of it, for example for providers or treatment types.
    - Recording and reporting of attendance and reasons for non for non-attendance and notice given (there will be a protocol), including whether this is due to a therapist cancelling the appointment, a person’s illness etc.
    - Where it is possible, we need the service to be able to work with other providers that are connected through formal pathways and protocols to measure and report any associated activity that can support IAPT outcomes.
- Generate reports to support service improvement. There is a need to measure information in addition to the Minimum Data Set (MDS) in relation to understanding more about people, their issues and what has changed for them (currently it tends to

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[59] Improving Access to Psychological Therapies Data Set.

Improving Access to Psychological Therapies Data Set reports.

be the GAD/PHQ scales along with other data). There is a requirement for the provider to be flexible and develop its recording over time as part of its service improvement.

- Provide equality & diversity information over the whole system.
- Work to improve data quality and consistency and have processes and policies to ensure data quality is maintained.
- Ensure commissioners have access to the data of the whole service for contract monitoring purposes and to ensure the integrity of the data management system.
- Ensure the system is kept up to date with all current and emerging NHS data set requirements. Where required, to implement Information Standard Notice changes.
- Work with commissioners to develop any future data reporting requirements that innovative and expansive.
- Work with partner organisations to ensure appropriate information is made available to inform wider city planning such as needs assessments etc.
- Ensure the consistency with data/information from the previous service providers.
- Collect and provide information about the patient referrals and journeys through external agencies connected with protocols to referral pathways.
- Ensure service users have visibility of all freely available non-confidential service metrics (ideally on the website). Service user representation needs to be considered in the reporting function of the system.
- Be responsible for processing Subject Access Requests (SARs) regarding its service users and Freedom of Information Act (FOI) requests in respect of the service.
- Provide ad hoc reports to commissioners on request and in a timely manner to support the commissioning process and the management of performance.

3.7.9 Innovation and best use of existing technology

The lead provider must demonstrate how they:

- Propose to and are making best use of current technologies, particularly mobile, internet and telephone facilities to make the services accessible for the widest and most diverse range of people e.g. to enable young people, older people, speakers of other languages, deaf people, carers, and other key demographics to be able to contact services electronically.
- Use technology to make services more accessible to disabled people or those with specific needs. (Technology can increase access for people such as young men, older people or people with caring responsibilities or work commitments that may be a barrier to attending therapy). The provider will work with commissioners to ensure that they use technology in ways that enable the widest participation.
- Engage with neighbourhood and voluntary sector social media networks to reach high volumes of people.
- Will ensure the service and their workforce is continually responsive to innovation and new technologies: Actively participate in employing new and emerging technologies to support improved service delivery and engage with service users and representatives.

3.7.10 Staff training

The lead provider must work to ensure there is a systematic approach to IM&T training that ensures appropriate staff competency (including staff of any subcontracted/partner services) in use of IM&T including, but not limited to:

- Induction The service lead must provide training in the ECR system to all staff including subcontractors and providers so that all new starters meet a minimum competency before being allowed access to the system to ensure data quality.
- IM&T training plans (including ECR, Connecting Care & reporting solution) in place for each staff group that specifically match system processes to IAPT pathways.
- Creating ECR and other related Standard Operating Procedures (SOPs) and evidence they are adhered to.
- Processes to ensure staff are achieving and maintaining competency.
- The lead provider will ensure integration of IM&T training into their staff training programme.
- Data Quality principles and processes.
- Handling of personal data and information governance.
- Ensuring SOPs and training courses are updated, communicated and deployed as necessary in line with future system changes.

The lead provider must put in place job focussed training i.e. how the system supports staff in performing their duties supported by job focussed user guides to underpin use of the system.

The lead provider must ensure there is an up-to-date testing and training environment to facilitate continuous relevant training.

The lead provider will continually develop a network of champions from across all services and run sessions to maintain IM&T and clinical engagement across the whole service.

3.7.11 Information Governance

The lead provider must comply with all Information Governance (IG) standards, NHS standards for record-keeping[60], the Data Protection Act, General Data Protection Regulation (GDPR), Data Security and Protection Toolkit compliance, Caldicott principles (including Caldicott 2 and 3 recommendations where applicable), Department of Health standards and the common law duty of confidentiality.

The lead provider must ensure that sharing is effective and safe; however the needs of the patient must remain paramount, as detailed in Caldicott Principle 7: The duty to share information can be as important as the duty to protect patient confidentiality. Health and social care professionals should have the confidence to share information in the best interests of their patients within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

The provider and subcontracted organisations must ensure that the legal bases for sharing and processing information are clearly identified. Transparency information explaining individual's rights and how their information will be used and shared must be clearly explained and available to individuals. Where it is deemed necessary to rely on consent for information sharing it must be documented in the electronic care record.

Caldicott 2 advises that registered and regulated social workers should be considered a part of the care team, and relevant information should be shared with members of the care team when they have a legitimate relationship with the patient or service user. Care teams may also contain staff that are not registered with a regulatory authority and yet undertake direct care. The provider organisations must ensure that robust combinations of safeguards are put in for these staff with regard to the processing of personal confidential data.

The lead provider should sign up to the Core Principles agreement at http://www.protectinginfo.nhs.uk/. This can then be used to support the set-up of service level information sharing agreements with key stakeholders.

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[60] Records Management Code of Practice for Health and Social Care 2016. NHS Digital.

3.7.11.1 Core Information Governance requirements

The core requirements when acting as a service provider to the NHS are that the provider must:

- Perform an annual information governance compliance assessment via the NHS Data Security and Protection Toolkit. In doing so, shall meet all mandatory assertions for the relevant organisation type. If unable to meet this level the provider shall agree an action plan with an agreed timescale to achieve this with the commissioning organisation.
- Utilise the appropriate model of the toolkit, as agreed with the commissioner.

In relation to compliance, the following items are specifically required to assure that the self-assessment is robust. The provider must:

- Ensure they have identified senior individuals to fulfil the roles of Caldicott Guardian, Senior Information Risk Owner and where required Data Protection Officer. As a default these roles should be with separate individuals.
- Ensure all mobile devices with access to patient identifiable data (including but not limited to laptops, tablets, smartphones and removable media) are encrypted to current NHS standards https://digital.nhs.uk/cyber-security/policy-and-good-practice-in-health-care/encryption across the whole system including those owned / used by partner or subcontractors.
- Educate and train all their staff on their handling of personal data and information governance, with a minimum of an annual update and assessment of knowledge.
- Maintain all information storage within the United Kingdom, unless appropriate technical and organisational measures are in place and agreed with the commissioner.
- Have an active risk assessment and management programme to ensure the on-going security of all information assets and information flows.
- State how their systems and processes are compliant with the NHS Care Record Guarantee, including reporting on who, when and where access to a service's user information was carried out, both from the perspective of the service user and the member of staff.
- State how the use of personal data is controlled so that it is only accessible by those staff who need to know it for work related purposes. The lead provider will ensure that the purposes the data it is used for relates only to direct care provision, (including the management and development of) or non-care related uses previously agreed with the commissioner.
- Ensure that processes and methods are clearly stated and in place for all users of the system to inform service users how their information is used, how they can access their records and how they can raise any concerns about the use of their personal data.
- Provide evidence and assurance of a clear legal basis to process personal information.
- Where consent is relied upon ensure there are robust records and processes to manage consent, including how this is communicated should the service user change their mind at any time.
- Provide assurance that appropriate informing is in place as required under GDPR, so the service users are fully aware of how their information is used and shared.
- Provide evidence and assurance on the management of the creation, amendment and removal of user access to their information assets containing personal data. Staff will be set up with access to the assets they need in a swift manner and changes/removal of access are enacted at the time of need or as soon after as possible.

- Describe the controls to prevent disruption to use of information systems from threats such as viruses/malware and other continuity issues (such as power/technical failure).

Access to data must comply with NHS information governance principles e.g. role based access; legitimate relationship etc.

Transfer of information between systems should, where possible, use structured and coded electronic messaging using secure file transfer mechanisms and agreed NHS standards e.g. NHS Interoperability Toolkit (ITK) and support Health Level 7 Clinical Document Architecture (CDA) for clinical document exchange etc.

3.7.12 Permission to View (PTV)

In situations where the patient may call one organisation then be referred or signposted to others, as part of their care, any information provided to patients must explain this. The information provided on the original call must provide a clear and succinct explanation that sets the clear expectations for the patient on how their information will be accessed and used. When closing a call, a summary of what will happen next should include details of information sharing.

3.7.13 Protection and retention of information

The IAPT service can expect a proportion of people will contact it on behalf of others and it must be able to demonstrate how it ensures that the person who needs its support has consented to this where possible to do so.

All NHS organisations have a duty under the Public Records Act to make arrangements for the safe keeping and eventual disposal of all types of their records. In addition, NHS organisations are required to have robust records management procedures in place to meet the requirements set out under Data Protection legislation (including the General Data Protection Regulation and Data Protection Act 2018) and the Freedom of Information Act 2000. Detailed guidance on all aspects of record keeping and protection of information can be found in Records Management Code of Practice available at:

https://www.gov.uk/government/publications/records-management-code-of-practice-for-health-and-social-care

4. Applicable Service Standards

4.1 Applicable national standards (eg NICE)

All NICE guidance as referenced in the IAPT Manual and Positive Practice Guides (as well as in this document and its appendices).

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.2.1 The IAPT Manual

The IAPT Manual and its associated Positive Practice Guides will form the basis of, and guide the delivery of the service.

These national documents must be used to inform the core delivery of the service. This specification will not reiterate the detail of the IAPT Manual and Positive Practice Guides, but rather references them and other key documents that currently offer guidance on evidenced practice. It draws out locally pertinent issues and the key tensions. These tensions emerge from the guidance, from our own learning across the three former services in BNSSG and from our extensive consultation.

4.2.2 Service quality

The Accreditation Programme for Psychological Therapy Services published the 'Quality Standards for Psychological Therapy Services' written by the Royal College of Psychiatrists (3rd edition 2017). This document will form the basis for the service's clinical quality.

The IAPT Manual includes a helpful table of the key features of a 'better performing IAPT service' against CQC domains and this service should be delivered in accordance with this and the above RCP standards.

4.2.3 Other guidance

There is and will continue to be a wide range of published policy and guidance that directly relates to, or specifically references IAPT. This might be general, intervention-specific or user group specific.

It is also expected that the provider will follow and integrate research and evidence on the wider determinants of mental health that can support the achievement of better outcomes for service users.

4.2.4 IAPT positive practice guides

These are all publicly available at the University of East Anglia website[61].

4.3 Applicable local standards

BNSSG revised Safeguarding combined standards for IAPT (See Schedule 4 of this contract).

5. Applicable quality requirements and CQUIN goals

5.1 Applicable Quality Requirements (See Schedule 4A-C)

Quality Standards for Psychological Therapies Services[62] (provided as Appendix-G).

5.2 Applicable CQUIN goals (See Schedule 4D)

TBC.

6. Location of Provider Premises

The provider will establish a single point of entry to the service with a main administrative base and use a wide range of locations across the delivery area that enable it to provide locally based clinical/other services (see 3.2.2 Improving access to, and accessibility of the service).

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[61] IAPT Positive Practice Guides.

[62] Quality Standards for Psychological Therapies. Third edition. Accreditation Programme for Psychological Therapies Services, Royal College of Psychiatrists' Centre for Quality Improvement. 2017.

Locations will be sourced in order to provide a safe and accessible service over the entire geographical area. Premises and rooms within them will be chosen in relation to their suitability for providing courses, running groups or for individual therapy.

The CCG can offer the provider access to bookable (rentable) space in NHS Property Services owned buildings all over BNSSG, as well as a number of other spaces within the NHSPS and LIFT estate, which could be used. These are as follows:

- Large meeting spaces that are usually empty which would be ideal for running courses and groups.
- Health Education rooms (large rooms, which would be good for group work) within a number of clinical buildings.
- Rooms that are only partly used during the standard working week, and also may be available before or after normal working hours and at weekends.
- Some GP practices would offer space at minimal (or no) charge as they would see it as adding value to their service, while Other GP practices would charge for their space.

Additionally, the local authorities and many voluntary sector and community organisations are likely to have space that they make available for rental all over BNSSG.

7. Individual Service User Placement

N/A.

Key of technical definitions and abbreviations

Links to key related sections:

3.2.1 Delivery model

3.2.6 Recovery

3.4.2 Exclusions

BCC	Bristol City Council
BNSSG	Bristol, North Somerset and South Gloucestershire
BSL	British Sign Language
CCG	Clinical Commissioning Group
CBT	Cognitive Behavioural Therapy
DNA	Do not attend
FOI	Freedom of Information (Act)
FYFVMH	Five Year Forward View for Mental Health
GAD-7	Generalised Anxiety Disorder 7-item assessment/scale
GNP	Gross national product

HEE	Health Education England
IAPT	Improving Access to Psychological Therapies
IAPT 'Caseness'	A person is said to be at caseness when their symptom score exceeds the accepted clinical threshold for the relevant measure of symptoms. For the PHQ-9, this is a score of 10 or above. For the GAD-7, this is a score of 8 or above. Other symptom measures, such as those used to measure the severity of different anxiety disorders, have their own specific thresholds. Some outcome measures (such as the Work and Social Adjustment Scale) do not have recommended caseness thresholds but provide valuable additional information about the quality of a treatment response.
IAPT 'Recovery'	A national standard that at least 50% of eligible referrals should move to recovery has been set for IAPT services. A person moves to recovery if their symptoms were considered a clinical case at the start of their treatment (that is, their symptoms exceed a defined threshold as measured by scoring tools) and not a clinical case at the end of their treatment. The recovery rate is defined as: $\frac{\text{Number of referrals that moved to recovery}}{\left(\begin{array}{c}\text{Number of referrals}\\ \text{that finished a}\\ \text{course of treatment}\end{array}\right)-\left(\begin{array}{c}\text{Number of referrals}\\ \text{that finished a course}\\ \text{of treatment and started}\\ \text{treatment not at caseness}\end{array}\right)}\times 100$
IAPT 'Access'	The Access Rate is defined as the "number of people entering treatment … over the level of need, i.e. the number of people with depression and anxiety disorders in the population expressed; **a.** as a number (the number of referrals entering treatment) **b.** as a percentage of total prevalence"
IAPT-SMI	Improving Access to Psychological Therapies for Severe Mental Illness
Intersectionality	The term intersectionality attempts to describe how connected systems of power impact those who are most marginalized in society. Intersectionality considers that the various aspects of humanity, such as class, race, sexual orientation, disability and gender, do not exist separately from each other but are complexly interwoven.
LA	Local Authority
JSNA	Joint Strategic Needs Assessment
LSOA	Lower Layer Super Output Area
LTC/s	Long-term Condition/s
MDS	(IAPT) Minimum Data Set
MH	Mental Health
MUS	Medically Unexplained Symptoms
NHSE	National Health Service England

NICE	The National Institute for Health and Care Excellence
NSUN	National Survivor User Network
PH	Public Health
PHQ-9	Patient Health Questionnaire 9-item assessment/scale
Person-centred	In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care.
PWP	Psychological Wellbeing Practitioner
RCP	Royal College of Psychiatrists
SARC	Sexual Assault Referral Centre
SAR	Subject Access Request

List of appendices for reference:

Appendix-A	List of references and good practice guidance
Appendix-B	BNSSG IAPT recommissioning evidence review full search notes
Appendix-C	BNSSG Case for Change - Addressing the Health and Wellbeing Gap

JSNAs:

Appendix-D1	Bristol, 2016-17
Appendix D2.1	North Somerset Population chapter, 2015
Appendix-D2.2	North Somerset Mental Health of Adults and Older People chapter, 2013
Appendix-D2.3	North Somerset Children and Young People: Emotional Wellbeing and Mental Health chapter, 2016
Appendix D3	South Gloucestershire, 2016
Appendix-E	BNSSG IAPT reprocurement 2018/19 - Developing pathways to (and from) associated non-NHS provision

BNSSG commissioned mental health services:

Appendix-F1	Bristol Mental Health
Appendix-F2.1	North Somerset AWP Primary Care Liaison Service
Appendix-F2.2	North Somerset AWP Positive Step IAPT pathways
Appendix-F3.1	South Gloucestershire AWP triage/assessment process
Appendix-F3.2	South Gloucestershire Organisation Chart – Locality Delivery Unit
Appendix-G	Quality Standards for Psychological Therapies Services

Appendix-H	Service Specification: Bristol and South Gloucestershire Counselling Service (June 2017)
Appendix-I	Findings of the University of Chester pilot study - Evaluating the impact of a therapeutic consultation session on psychotherapeutic engagement and outcomes compared with treatment-as-usual site comparators
Appendix-J	Equality Impact Assessment
Appendix-K	Quality Impact Assessment
Appendix-L	Current IAPT service providers across BNSSG
Appendix-M	NSUN 4Pi National Involvement Standards
Appendix-N	South Gloucestershire Primary Care Offer