**Document Version Control**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version History** | | | |
| **Version** | **Date** | **Detail** | **Author** |
| 11.0 |  | First published draft of the Service Specification | GA |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| **Distribution** | | | |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**SCHEDULE 2**

**Service Specification**

|  |  |
| --- | --- |
| **Service Specification No.** | 1 |
| **Service** | Improving Access to Psychological Therapies |
| **Commissioner Lead** | Gemma Ashby, Derbyshire CCGs |
| **Provider Lead** |  |
| **Period** | 1st April 2020 – 31st March 2023 |
| **Date of Review** | 1st April 2021 |

|  |
| --- |
| **1. Population Needs** |
| * 1. **National context and evidence base**   **Prevalence**  Research suggests that around one in six adults (17%) meet the criteria for a common mental health disorder (CMD).  The latest Adult Psychiatric Survey found that women were more likely than men to have reported CMD symptoms. One in five women had reported CMD symptoms, compared with one in eight men. Women were also more likely than men to report severe symptoms of CMD – 10% of women surveyed reported severe symptoms compared to 6% of men[[1]](#footnote-2).  Table 1 below shows the prevalence of CMD experienced within the ‘past week’ (Adult Psychiatric Morbidity Survey - APMS 2014), Generalised anxiety disorder and CMD-NOS (mixed anxiety/depression) constituted the greater proportion of those disorders.    Table 1 Common Mental Health Disorders experienced in the ‘past week’  Depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes. These may include:  • Greater distress and poorer quality of life, including higher levels of self-reported misery and disruption to a person’s social, work and leisure life.  • Poorer physical health. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, stroke, lung disease, asthma or arthritis.  • Unhealthy lifestyle choices. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.  • Poorer educational attainment and employment outcomes. There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance and reduced earnings.  • Increased risk of relapse if treatment is not appropriate or timely.  Healthcare costs for those with coexisting mental health problems and long term conditions (LTCs) are significantly (around 50%) higher. A large proportion of this cost is accounted for by increased use of physical health services (not mental health services).  Together, depression and anxiety disorders are estimated to reduce England’s national income (GNP) by over 4% (approximately £80 million).This reduction in economic output results from increased unemployment, absenteeism (a higher number of sick days) and reduced productivity. This is accompanied by increased welfare expenditure.  The national Five Year Forward View (FYFV) for Mental Health identified a number of deliverables that included for IAPT services a 25% access rate by 2020 based on local prevalence of CMDs. The deliverables in the FYFV have been re-asserted in the National NHS Ten Year Plan and extended to 30% Access by 2023/24. National guidance also prioritises the provision of holistic care that considers both physical and mental health and for IAPT it is envisaged that services will continue to work with LTCs and Persistent Physical Symptoms (PPS).  This transformation to put mental health services on an equal footing with physical healthcare is reinforced through the General Practice Forward View which states that 3000 more mental health therapists will be primary care by 2020/21   * 1. **Local context and evidence base**   Prevalence estimates used to ascertain performance against national access targets were ultimately derived from earlier Adult Psychiatric surveys by NHS England, within Derbyshire these are uplifted each month to take account of population growth.      Figure 1 Prevalence of anxiety and depression within Derbyshire  Current prevalence estimates within Derbyshire stand at 11% of the total population, that’s over 90,000 people. There is some differentiation across the Derbyshire CCG’s:  cid:image001.png@01D4A808.2FE2E270    Figure 2 Distribution of prevalence across age groups within Derbyshire  According to the latest APMS and CMD severity scores by age group, figure 2 shows the approximate proportions from each age group expected to be accessing treatment within Derbyshire. Over a fifth of people accessing treatment are expected to be from the 45-54 age group with smaller numbers from the older adult population due to their severity scores being much lower than other age groups.  The Derbyshire Strategic Transformation Plan (STP) Joined Up Care Derbyshire has a Primary care mental health programme within the overall Mental Health STP work stream. In particular the primary care mental health programme includes a number of aims; Enhance primary care capacity; Improve the physical health of people with a Serious Mental Illness (SMI); Reduce unnecessary referrals into statutory services; Improve the psychological wellbeing of people with a LTC; and Improve employment opportunities and job retention for people with mental health problems. The latter two aims relate directly to two current IAPT projects that will be evaluated and considered as part of the IAPT re-commissioning.  The Rightcare STP ‘Where to Look’ Pack contains data from the CCG ‘Where to Look’ packs published in October 2016, collated at STP footprint level. The data in this pack includes headline opportunities, improvement opportunity tables and 'Pathways on a page' showing how CCGs in each STP differ from their peers. This is demonstrated via statistically significantly higher or lower performance compared to 10 similar CCGs (not necessarily in the same STP).  Derbyshire Rightcare identifies a number of key challenges facing Derbyshire in terms of Common Mental Health Disorders. Recorded prevalence for CMD is lower generally in Derbyshire but depression prevalence is higher in North Derbyshire and Erewash. Anti-depressant prescribing is higher across Derbyshire as a whole. There is higher level of the population in North Derbyshire, Hardwick and Southern Derbyshire diagnosed with a disability or Limiting Long Term Illness (LLTI) and higher levels of deprivation experienced in Erewash, Hardwick and North Derbyshire.  Diabetes and respiratory disease are two of the areas in Derbyshire’s Rightcare packs where the evidence supporting the opportunity for physical healthcare savings is most comprehensive, in particular for elective and non-elective admissions and primary care prescribing, with the gross cost saving per person per annum estimated to be £1000, and £1200 respectively. |
| **2. Outcomes** |
| **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 Key Service Outcomes**   * People receive a prompt initial assessment. * The treatment people received commenced promptly after their initial assessment. * People feel better as a result of the treatment they received. * Older people over 65 years were able to access a service when they needed it. * People from black and minority ethnic groups recovered as a result of the treatment they received. * People who reside in the 100 most deprived LSOAs (local super output areas) in Derbyshire recovered as a result of the treatment they receive.   **2.3 National defined outcomes**   1. 30% (minimum) of people entering treatment against the level of need in the general population by 2023/24. 2. 50% (minimum) of people who complete treatment are moving to recovery. 3. 65% (minimum) of people who complete treatment are moving to reliable improvement. 4. 75% of people referred to the Improving Access to Psychological Therapies programme enter treatment within 6 weeks 5. 95% of people referred to the Improving Access to Psychological Therapies programme enter treatment within 18 weeks   **2.4 *Local defined outcomes***   1. 14% (minimum) of people completing treatment are over the age of 65 years 2. 50% (minimum) of people from Black and Minority Ethnic (BAME) background who complete treatment are moving to recovery. 3. 50% (minimum) of people who reside in the 100 most deprived LSOAs in Derbyshire who complete treatment are moving to recovery. 4. 75% (minimum) of people will wait no more than 28 days (4 weeks) between first and second treatment appointment |
| 1. **Delivery model** |
| ***To be agreed*** |
| **4 Aims and objectives of service** |
| 4.1 The following principles will apply:   * Provide a “whole person” approach which takes account of the person’s socio-demographic characteristics, health co-morbidities, lifestyle, and network of support. * Provide a directly accessible service that promotes choice and control. * Provide early access and appropriate intervention to avoid an escalation of need. * Responsive - to respond to the needs of the local community. * Treat all people with dignity and respect in line with the Equality Act and Equality Duty. * Recovery driven with a focus on relapse prevention and self-management.   4.2 The aims of the service will be to:   * Reduce the stigma associated with a diagnosis of, or treatment for, common mental health disorders * Provide signposting, information and facilitated access to a range of community based support services * Improve service-user choice and experience of mental health services * Improve identification and awareness of common mental health disorders (e.g. through awareness training for a range of health, social care, education and welfare professionals) and promote onward referral for assessment and intervention * Improve the interface between services for people with common mental health disorders and other parts of the health system * Increase the proportion of people who are identified, assessed and receive treatment in accordance with National Institute for Health and Care Excellence (NICE) guidance/evidence based psychological care by appropriately qualified clinicians * Improve the proportion of people who make a clinically significant improvement or recover. * Improve emotional wellbeing, quality of life and functional ability in people with common mental health disorders, and long term physical health problems * Improve access and support to help people stay in work, help them return to work, help them into education or training and where appropriate help people to find meaningful activity * Improve the opportunities for pathway facilitation between services for people moving from primary to secondary care (and vice versa), and with physical healthcare * Increase partnership working and collaboration with a range of other health and social care services, residential and nursing care, employment support agencies, criminal justice agencies, wellbeing services (e.g. leisure centres, third sector, not-for-profit providers) |
| **5 Scope** |
| **5.1 Referral Route**  The pathway will be as follows:  **Self-Referral:** via telephone or on-line directly to the lead provider  **GP REFERRAL** – via NHS Electronic Referral Service or directly to the lead provider via on line, written or telephone referral  **Assessment appointment**  Assessment within 28 days of referral (NB this include Assessment appointments that include treatment)  **Step 2 and Step 3** First treatment appointment should be within 6 weeks of referral.  Maximum wait between first and second treatment appointment should be 4 weeks.  If patient assessed as being high risk/urgent refer to appropriate service on same day.  If specialist secondary mental health services are required then local protocols should be followed.  If IAPT/secondary services deemed unsuitable, alternative recommendations should be made.  **Follow-up** protocols, where appropriate, up to 12 weeks post discharge  Referral forms and on line booking forms should be available. A lo-call phone number should be provided for telephone referrals and enquiries. Promotional/information materials should be available widely across the county in all appropriate formats and languages. These should include details of the referrals process and eligibility criteria and brief details of the services available.  **5.2 Access**  Professionals and the public need clear and accessible information about how to access local IAPT services and the range of choices available. It is particularly important to promote self-referral, improve access and address the fact that anxiety disorders are commonly under-detected. As such, the provider will be expected to have a communication plan and marketing strategy.  The service should have a clear and informative website that includes relevant links to other national and local resources for mental health, physical health, social care, and wider determinants. There should be an online referral facility and details about treatments offered, groups or courses available, on line support, and eligibility criteria. It should also include performance data such as waiting times, recovery and patient feedback scores.  The CCG will work with the Lead provider to develop a Derbyshire wide brand and communication and marketing plan. This will include dedicated information for primary care and other stakeholders such as bulletins and newsletters  **Response times and prioritisation**  On receipt of referral, the Provider will contact patients within 3 working days via phone, text and/or letter. Every reasonable effort should be made to contact the patient and the following should be seen as the minimum standard:   * Two phone calls on different days/at different times * Text message with details on how to contact the service (as long as consent to text has been given) * One letter outlining information on how to contact the service and within what timeframe (before referral is closed)   For professional referrals - if the service is not able to make contact with the person, the referral should be sent back to the referrer on the 14th day after receipt explaining as such (professional referrals only). There should also be a duty system to enable professional telephone advice to be given about potential referrals.  Once contacted, the patient should be offered an assessment appointment within 28 days of referral date. A choice of telephone or face-to-face assessment appointment should be available to meet the needs of the individual concerned and to make access to services as convenient as possible.  Telephone Assessments   * Patients must be offered a choice of telephone or face to face assessment. * Telephone assessment refers to the full assessment as carried out by a suitably qualified worker, e.g. PWP, High Intensity Therapist. A telephone screening appointment or administration call, e.g. to take patient details and/or organise an appointment will not constitute as an assessment appointment session. * Should a patient opt for telephone contact and then change their mind and opt for face to face contact and vice versa, this should be accommodated. * Opting for a telephone assessment should not automatically assign the patient to telephone contacts only – patients must be made aware that they can opt for face to face contact at any point in their care pathway.   The assessment should follow good practice guidance as detailed in the IAPT Manual – see Section 6.2.1.  Following assessment the patient should be informed of the likely wait between assessment and commencing regular, structured treatment. Patients should be contacted regularly should there be any delay to the appointment and signposted to other potential services which may offer additional support during this time.  Patients identified to be at high risk (e.g. suicidal ideation, severe self- injurious behaviour, and psychotic symptomatology) should be urgently referred to the appropriate mental health service. The access standard for referral is the same day.  Where the patient has been referred to the service by the GP, the patient’s GP should be kept informed of the patient’s journey through the service which may include:  - acceptance or rejection (with reason) of referral  - approximate waiting time for treatment to commence  - progress summary  - any risk or concerns  - discharge (with completed discharge summary including any ongoing needs)  Where the patient has self-referred consent should be sought in line with the requirements of the Common Law Duty of Confidentiality before any information is shared with the GP Practice.  **5.3 Availability**  It is expected that there is a core base in each Place locality offering appointments between 8am and 8pm on 6 days per week. It is recognised that satellite bases will not be able to provide that level of cover due to various factors including, costs, staff availability, lease arrangements, and demand. In addition, where services are co-located it is expected that the provider will negotiate with the other service providers to agree the availability hours of the IAPT service.  **5.4 Assessment appointments and Assessments and Treatment appointments/Single treatment sessions**  A patient is coded as having ‘entered treatment’ if at least one session is recorded as either ‘assessment and treatment’ or ‘treatment’. It is important that these codes are only used when a significant portion of a session is devoted to delivering a NICE-recommended psychological intervention **at the appropriate Step**. If a session exclusively focuses on assessment, it should be coded as “assessment”. Services should develop written criteria for deciding whether an initial session can be coded by their staff as “assessment” or as “assessment and treatment”. Generally, very brief sessions that simply identify that IAPT is not appropriate for an individual should be coded as “assessment”. However, if any of a range of recognised appropriate interventions are a significant focus of the session, it would be appropriate to use the “assessment and treatment” code. It is recognised that some people may benefit from a single treatment session and need no further treatment or are signposted to another more appropriate service.  **5.5 Internal waits**  Both waiting list targets from referral to assessment and assessment to treatment commencement are equally important and the provider will be held to account for performance against both. This means that patients are expected to progress smoothly from assessment into appropriate meaningful treatment promptly, and that the provider should aim to ensure that the second treatment appointment should not be longer than 10 weeks from referral. This incorporates both waiting time targets of 6 weeks from referral to first treatment appoint and 4 weeks from 1st to 2nd treatment appointment. 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 minimized and certainly should not exceed the waiting time standard for the first intervention.  **5.6 Dosage**  Dosage should be offered as defined in NICE guidelines for the presenting condition. Patients should not be advised of there being a fixed number of sessions available especially where this number is not in line with NICE Guidance for the presenting diagnosis. However, there may be review points at certain intervals.  **5.7 Stepped care**  Treatment should commence on the step defined by NICE guidelines for the presenting condition(s) and follow the principle that people should be offered the least intrusive interventions appropriate to their needs first. Where a patient requires stepping up or down this will take place within the same treatment episode.  **5.8 Relapse prevention/Self-management**  Research studies have shown that high-intensity therapies that include relapse prevention procedures in their basic protocol can lead to more sustained gains and reduce relapse when compared with medications. Services should therefore not assume that patients will stay well after treatment and instead should put in place a comprehensive set of procedures that are likely to reduce relapse and improve long-term outcomes. These procedures might include:   * Focusing on ensuring that patients learn skills for overcoming emotional problems, in addition to meeting symptom recovery criteria. Some patients, particularly those with mild to moderate depression, could recover during treatment without learning any skills because they were going to recover in that period of time anyway (natural recovery). Such patients will be at increased risk of relapse unless their therapist or PWP ensures that key skills have been learned. * Developing a relapse prevention plan with patients before they are discharged. Typically relapse prevention protocols involve writing out the key learning points from therapy and looking to the future to anticipate any likely stressors or setbacks. A simple plan of how to deal with the stressors or setbacks is then developed and written down. It will involve returning to some of the strategies that worked in therapy (thought records, activity schedules, exposure therapy, social connectedness, and so on) as well as linking up with helpful resources, including contacting their clinician for a booster session, if appropriate. * Co-ordinating with GPs if a patient is considering stopping medication during follow-up. Some patients experience a re-emergence of symptoms following   discontinuation of medication. This is more likely if medication is withdrawn quickly. Liaison with GPs to agree withdrawal schedules and to monitor patients during withdrawal is therefore advised.   * Use of mobile phone apps to facilitate relapse prevention after discharge for a period. The apps could prompt patients to fill in their key outcome measures at regular intervals and give the patient easy access to their relapse prevention plan. E.g. <https://www.getflorence.co.uk/>   **5.9 Treatment episodes**  The commissioners will only pay for one treatment episode for a patient at any one time. Duplicate episodes running concurrently will not be acceptable.  When someone presents with co-morbid conditions, and it is indicated that an IAPT treatment pathway is suitable, there should only be one treatment episode for the presenting condition(s), For example, a patient presenting with depression and anxiety should be treated within one treatment episode and not have each diagnostic category treated as two separate episodes of care.  Back to back treatment episode (transfers) must not take place.  **5.10** **Re-referrals and further contact.**  If a patient or referrer contacts the service within 12 weeks of discharge and requires support/advice for the same presenting condition(s) this should be treated as part of the same treatment episode. If a follow-up appointment is required it must take place within 6 weeks of contact.  As such, new episodes of care for the same presenting conditions/treatment will not be accepted within 12 weeks of discharge.  Any re-referrals over 12 weeks of discharge for the same presenting conditions/treatment must meet caseness.  **5.11 Treatment options**  NICE-recommended psychological therapies form the basis of IAPT interventions. This is a key principle of IAPT, because adherence to evidence-based interventions optimises outcomes. Therefore, it is essential that NICE-recommended treatment is provided at the appropriate dose, in line with the identified problem descriptors, and that a choice of therapy is offered where appropriate.  **Self help**  This can take three forms – group, individual facilitated, and individual non-facilitated. This has a role in delivering low level interventions, and in some cases high intensity interventions, for treating generalised anxiety disorder, panic disorder, depression and OCD.  **Digital offer**  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. As well as maximising the geographic reach of the IAPT programme, delivering treatment via digital platforms means that treatment can be accessed anywhere and at any time. It can also help to decrease the stigma that still surrounds seeking access to mental health services.  **One to one therapy**  This should be offered where indicated by NICE guidelines.  **Groups** **- both Step 2 and Step 3**  For some clinical conditions and symptom severities, NICE recommends group work as well as one-to-one therapy. Groups need to be delivered in line with NICE guidance. Group Cognitive Behavioural Therapy (CBT) is a high-intensity therapy option which should be led by a trained high-intensity therapist, perhaps supported by a Psychological Wellbeing Practitioner (PWP). Psycho-education groups, which have a more restricted remit, may be led by appropriately trained PWPs. As with one-to-one therapy, group interventions should involve multiple sessions up to the numbers recommended by NICE for the relevant clinical condition. If patients find they are unable to attend a full course because of timing or other restrictions resulting from group administration, they should be offered alternative one-to-one therapy. NICE guidance does not support the use of single session group wellbeing interventions.  **Discharge Criteria**  A patient should be discharged when:   * they have achieved recovery as assessed by the definition of non caseness or they have achieved reliable improvement as assessed by definition of required reduction in GAD-7 and PHQ-9 scores. * it is clinically determined via a Clinical Lead that they should be ‘stepped out’ of IAPT treatment as it is no longer considered appropriate and/or they are onwardly referred into other, more appropriate services * they have do not attend 2 successive appointments for face to face, group therapy, and/or telephone based appointments * they drop out of, or decline, treatment * they cannot be contacted by the service following adequate attempts   When a patient has completed treatment, is discharged or drops out from the service:   * a copy of the treatment report is always offered to the patient * a patient experience questionnaire is given to the patient   **5.12 Population covered**  The population of Derby City and Derbyshire aged 16 and over and registered with a Derby City or Derbyshire GP Practice.  **5.13 Any acceptance and exclusion criteria and thresholds**  IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. NICE-recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment which is typically managed by the General Practitioner (GP), though there may be some circumstances when medication is managed within secondary care.  Services are available to the above population. In particular, in line with NICE Guideline CG192 Antenatal and Postnatal Mental Health, this client group should be prioritised by being assessed within 2 weeks of referral and commencing treatment within 4 weeks.  Services provide treatment for people with the following common mental health problems. It is recognised that many people suffer from more than one of these conditions.   |  |  | | --- | --- | | **Condition** | **Description** | | **Depression** | A mental health problem characterised by pervasive low mood, a loss of interest and enjoyment in ordinary things, and a range of associated emotional, physical and behavioural symptoms. Depressive episodes can vary in severity, from mild to severe. | | **Generalised anxiety disorder** | An anxiety disorder characterised by persistent and excessive worry (apprehensive expectation) about many different things, and difficulty controlling that worry. This is often accompanied by restlessness, difficulties with concentration, irritability, muscular tension and disturbed sleep. | | **Social anxiety disorder (social phobia)** | Characterised by intense fear of social or performance situations that results in considerable distress and in turn impacts on a person’s ability to function effectively in aspects of their daily life. Central to the disorder is the fear that the person will do or say something that will lead to being judged negatively by others and being embarrassed or humiliated. Feared situations are avoided or endured with intense distress. | | **Panic disorder** | Repeated and unexpected attacks of intense anxiety accompanied by physical symptoms. There is a marked fear of future attacks and this can result in avoidance of situations that may provoke a panic attack. | | **Agoraphobia** | Characterised by fear or avoidance of specific situations or activities that the person worries may trigger panic-like symptoms, or from which the person believes escape might be difficult or embarrassing, or where help may not be available. Specific feared situations can include leaving the house, being in open or crowded places, or using public transport. | | **Obsessive-compulsive disorder (OCD)** | Characterised by the recurrent presence of either an obsession (a person’s own unwanted thought, image or impulse that repeatedly enters the mind and is difficult to get rid of) or compulsions (repetitive behaviours or mental acts that the person feels driven to perform, often in an attempt to expel or ‘neutralise’ an obsessive thought). Usually a person has both obsessions and compulsions. | | **Specific phobias** | An extreme and persistent fear of a specific object or situation that is out of proportion to the actual danger or threat. This can include a fear of heights, flying, particular animals, seeing blood or receiving an injection. | | **Condition** | Description | | **Post-traumatic stress disorder (PTSD)** | The name given to one set of psychological and physical problems that can develop in response to particular threatening or distressing events, such as physical, sexual or emotional abuse, severe accidents, disasters and military action. Typical features of PTSD include repeated and intrusive distressing memories that can cause a feeling of ‘reliving or re-experiencing’ the trauma, emotional detachment and social withdrawal, avoidance of reminders and sleep disturbance. | | **Health anxiety (hypochondriasis)** | A central feature is a persistent preoccupation with the possibility that the person has, or will have, a serious physical health problem. Normal or commonplace physical symptoms are often interpreted as abnormal and distressing, or as indicators of serious illness. | | **Body dysmorphic disorder** | Characterised by a preoccupation with an imagined defect in one’s appearance or, in the case of a slight physical anomaly, the person’s concern is markedly excessive. Time consuming behaviours such as mirror-gazing, comparing features with those of others, excessive camouflaging tactics, and avoidance of social situations and intimacy are common, with a significant impact on the person’s levels of distress and/or occupational and social functioning. | | **Mixed anxiety and depressive disorder** | A mild disorder characterised by symptoms of depression and anxiety that are not intense enough to meet criteria for any of the conditions described above but are nevertheless troublesome. The diagnosis should not be used when an individual meets the criteria for a depressive disorder and one or more of the anxiety disorders above, such people should be described as being comorbid for depression and the relevant anxiety disorder(s). | | **Irritable bowel syndrome\*** | A common functional gastrointestinal disorder. It is a chronic, relapsing and often lifelong disorder, characterised by the presence of abdominal pain or discomfort associated with defaecation, a change in bowel habit together with disordered defaecation (constipation or diarrhoea or both), the sensation of abdominal distension and may include associated non-colonic symptoms. May cause associated dehydration, lack of sleep, anxiety and lethargy, which may lead to time off work, avoidance of stressful or social situations and significant reduction in quality of life. | | **Chronic fatigue syndrome\*** | Comprises a range of symptoms that include fatigue, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. A person’s symptoms may fluctuate in intensity and severity, and there is also great variability in the symptoms different people experience. It is characterised by debilitating fatigue that is unlike everyday fatigue and can be triggered by minimal activity. Diagnosis depends on functional impairment and the exclusion of other known causes for the symptoms. | | **MUS not otherwise specified\*** | Distressing physical symptoms that do not have an obvious underlying diagnosis and/or pathological process. |   Caseness is a term that refers to a person’s symptom score which 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.  People being accepted for treatment should meet caseness levels on the GAD-7/equivalent scale or PHQ-9 when these are assessed as part of the referral process. People who do not meet caseness should only be accepted into treatment by exception and only by the Clinical lead with a clear clinical rationale. In addition, they must commence on Step 2 treatment first.  Primary care psychological therapies do not encompass the whole of primary care mental health. For instance ongoing management of people with a stable psychosis/severe mental illness will be outside the scope of this service.  This Talking Therapy service is not a crisis or emergency service but may need to prioritise cases where it is deemed that a delay would significantly interfere with progress, e.g. for patients in receipt of perinatal services.  This Talking Therapy service is not targeted towards those who pose a high risk to themselves, risk to others or who are at significant risk of self-neglect. These might include; recent problem drug and/or alcohol use; recent self-harm or suicide attempt; recent episodes of violence or aggression; ongoing contact with other mental health services. In such circumstances we would recommend seeking a referral to IAPT once other issues have stabilised and/or resolved. This is because we know that people are much more likely to be successful in therapy when there are no other significant issues happening that may negatively impact on therapy. However, when an individual is stable they may benefit from access to psychological therapies. This will be an individual clinical decision made by the service Clinical Lead and the timings of this will vary between individuals.    Similarly, people who have a significant impairment of cognitive function (e.g. dementia); or significant impairment due to autistic spectrum problems or learning difficulties may be best served by specialist services. However, this by no means represents an automatic exclusion criteria. Appropriate reasonable adjustments should be made in order to allow people to access mainstream IAPT services wherever possible. Patients who need to be primarily referred for forensic or neuropsychological assessment may be best served by specialist services.  Individuals for whom drug and alcohol misuse present as primary problems are best focused towards substance misuse services. However, when their substance misuse problems have stabilised they may benefit from psychological therapies. Please refer to the drug and alcohol protocol for further guidance.    The following areas are likely to be considered outside the scope of the this service:  1) Secondary-to-primary care liaison  2) Early intervention (severe mental illness)  3) Personality disorder (severe/complex)  4) Primary care of stable psychosis  5) Medication management  All of the above, however, should not exclude a patient if it is determined that they would benefit from Step 2, Step3 or Step 3 Plus interventions. Each referral should be based on its own individual circumstances and every effort should be made, where appropriate, to support patients who would benefit from the service.  It may be necessary to coordinate treatment with other key agencies or providers such as practice nurses or community matrons (e.g. in the case of a person with a long term condition) to ensure that the patient’s needs are fully met.  If not able to work with the person for a specified reason, the provider should ensure that the referrer is advised about the decision and given information to support onward referral to other more suitable alternatives. Referral to alternative agencies may be undertaken by the provider (after informing the referrer) or the patient may be referred to their GP to discuss the suggested options and subsequent onward referral.  **5.14 Interdependence with other services/providers**  The vision for an effective Talking Therapies Service is of an integrated bio-psychosocial approach that considers a person’s wider quality of life needs, including the wider determinants of health and wellbeing such as employment, debt, welfare rights etc. This whole life approach requires the service to work closely with a range of other organisations to demonstrate improvements.  The service should have a robust relationship with a wide range of stakeholders to augment the quality of both Talking Therapies service delivery and also the wider health and social economy. Safe, integrated and effective primary care/community mental health services need clear pathways for people to move into, through and out of service provision.  Promotion of recovery and positive mental health requires collaboration and partnership with other community services and interventions as part of local service delivery. This will help to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery.  In addition, collaboration with secondary care professionals in specialist mental health and general health services (particularly physicians involved in treating long term conditions including musculoskeletal, respiratory, dermatology, diabetes, heart disease, chronic pain services, neurology and cancer) is vital to ensure that psychological treatment needs are met across the pathway in an integrated, timely and responsive manner. As such it is expected that referral protocols and pathways will be agreed with relevant partners to facilitate joint working with various options as to the degree of integration from named liaison through to co-location.  **General Practice**  Following engagement with primary care, the provider will be expected to maintain proactive and regular communication with practices including advice, information materials, training resources, and mental health awareness. Primary Care must also be kept informed of waiting times and recovery rates. Every opportunity to integrate with Primary Care should be explored including co-location where possible, practical, and affordable.  Other key service include:   * Drug and alcohol services * Health psychology * Social Care * Employment support * Student services * Public Health   The Talking Therapy service will be part of an integrated primary care/community pathway for people with common mental health disorders and will be expected to link with Public Health as part of the MH community hubs in order to ensure that Talking Therapies are part of the offer/SPOA.  **5.15 Location and venues**  The provider should have a core base in each Place locality along with various satellite bases across the county and city.  Co-location within other services should be considered where this enhances patient experience and joint working. It is expected that there will be some co-location.  The commissioners will endeavor to support the provider to negotiate reasonable service charges in particular within general practice.  Venue requirements include:   * Up to date and fit for purpose IT including telephones, internet connect and remote networking * Facilities for telephone-based Psychological Wellbeing Practitioner interventions * Consulting room space including for patients whose condition (e.g. social anxiety disorder, some cases of PTSD) requires treatment where videotaping and role play/modelling can occur * Option to access on line treatment resources * Group work * Supervision and meeting space, * Office and administrative space * Comfort facilities * Consideration of sound insulation and privacy.   Venues and facilities should be accessible both in terms of public transport links and parking facilities and compliant with all relevant local and national laws, regulations and service requirements. Particular attention should be paid to the accessibility needs of people with sensory, physical and mental impairments, as well as those who may face, for instance, cultural or language barriers. |
| **6. Applicable Service Standards** |
| **6.1 Applicable national standards (e.g. NICE)**  **6.1.1 NICE guidance**  The evidence base underpinning the use of psychological therapies in the treatment of **depression and anxiety disorders** can be found in the following NICE guidance:  • Antenatal and Postnatal Mental Health: Clinical Management and Service Guidance (NICE clinical guideline 192)  • Common Mental Health Problems: Identification and Pathways to Care (NICE clinical guideline 123)  • Computerized Cognitive Behaviour Therapy for Depression and Anxiety (NICE technology appraisal 97)  • Depression in Adults: Recognition and Management (NICE clinical guideline 90)  • Depression in Adults with a Chronic Physical Health Problem: Recognition and Management (NICE clinical guideline 91)  • Generalised Anxiety Disorder and Panic Disorder in Adults: Management (NICE clinical guideline 113)  • Obsessive-compulsive Disorder and Body Dysmorphic Disorder: Treatment (NICE clinical guideline 31)  • Post-traumatic Stress Disorder: Management (NICE clinical guideline 26)  • Social Anxiety Disorder: Recognition, Assessment and Treatment (NICE clinical guideline 159)  NICE has also issued guidelines on medically unexplained symptoms (**MUS**) and **multimorbidity**:  • Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management (NICE clinical guideline 53)  • Irritable Bowel Syndrome in Adults: Diagnosis and Management (NICE clinical guideline 61)  • Low Back Pain and Sciatica in over 16s: Assessment and Management (NICE guideline 59)  • Multimorbidity: Clinical Assessment and Management (NICE guideline 56)  **6.1.2 Patient Choice**  Wherever patient choice is clinically appropriate, providers are required to support the patient’s decision in line with the requirements in the NHS Standard Contract and NHS England’s guidance on ‘Choice in Mental Health Care’.  **6.2 Applicable standards set out in Guidance and/or issued by a competent body (e.g. Royal Colleges)**  **6.2.1 National Collaborating Centre for Mental Health**    **6.2.2 Relevant Professional bodies**  Accreditation (with relevant Professional bodies) alternatives to IAPT accredited training including British Association for Behavioural and Cognitive Psychotherapies (BABCP), British Association for Counselling and Psychotherapy (BACP), British Psychoanalytic Council (BPC).  **6.3 Staffing resources**  The provider will ensure that all staff are trained and competent to deliver services. Services are required to offer supervision and support to agreed professional standards; these can be found in the IAPT Manual above.  The service should consider the needs of the part time workforce in terms of workload and working arrangements in line with their statutory duties.  The service should implement local strategies and to improve staff wellbeing and therefore retention.  The service should have an appropriate skill mix within their team - between 30-40% of workforce PWPs, 60-70% High Intensity Therapists (HITs), 0-10% Senior Therapists such as clinical or health psychologists.  Assessment should always be provided by an appropriately trained member of staff. Treatment can be provided by accredited staff or staff working towards accreditation but supervised by a registered practitioner (i.e. appropriately trained, qualified and experienced).  Clinical hours:  It is expected that staff have a well-balanced workload of patients and that the need for time to complete administration, supervision, Continuing Professional Development (CPD) and training is taken into account.   * For high-intensity therapists it is generally considered that achieving 20 face-to-face clinical hours per week is appropriate for a full-time, fully trained individual, with pro-rata reductions for part-time workers, trainees and those with supervision or management responsibilities. * For PWPs it is more usual to set target numbers for assessments and low-intensity treatment sessions each week. These targets are usually locally agreed but should be equitable and reasonable bearing in mind the varied and stressful nature of PWP work. National guidance on PWP contacts will be issued in the near future.   Supervision  A supervision competency framework was developed for the IAPT programme and the IAPT Supervision Guidance provides support and guidance on the different types of supervision within the IAPT service.  IAPT eligibility criteria exist for all supervisors within IAPT services and all supervisors should have completed one of the IAPT supervisor-specific training programmes. A named senior therapist should be responsible for overseeing the effectiveness of supervision within the IAPT service, in conjunction with the clinical director and course directors concerned.  Principles of effective supervision to be adhered to:   * Outcomes-focused supervision where case discussion should be informed by outcome measures. * Supervision should take place weekly. * Consist of at least one hour of individual supervision with an experienced and trained supervisor located within the IAPT service. * Small group supervision that is proportionally longer in duration can also be used. * Every 2 to 4 weeks all ongoing clinical cases should be reviewed in supervision. * PWPs should receive both case management supervision (individual, one hour per week) and clinical skills supervision (at least one hour per fortnight). * Discussion of clinical cases should be prioritised according to need. * Cultural competence should be considered, as well as how supervision can support the supervisee to meet individual need.   Additional supervision for trainees:   * high-intensity trainees should receive additional supervision of training cases, lasting 1.5 hours within their two-day attendance on the course at a university * PWP trainees should receive an additional 1 hour per fortnight individual and group supervision, focused on case discussion and skill development (in addition to case management supervision).   Training/CPD/competency  Roth and Pilling have developed a competence framework for each of the therapies supported by the IAPT programme and the provider is expected to adhere to this Framework. Courses that are delivering the agreed IAPT training curricula assess trainees against this competence framework. Experienced clinicians should also consult the framework when considering their own training and development needs, and those of their supervisees.  It is expected that non-clinical staff including Managers, Administrators, Data Analysts, Finance officers etc. will be used in the delivery of the service. In addition the service may wish to use self-employed therapists to support the employed workforce and the commissioner is accepting of this with the correct employment arrangement in place.  Staff should be culturally competent and able to respond to a range of diverse experiences and identities of clients. Through adaptation, the service should strive to meet the diversity of life experiences, lifestyles and backgrounds clients have as outlined in the IAPT Manual. The service should make adequate and reasonable adjustments and provision for interpreters, carers and others from whom the patient may require assistance, providing information and signage in an appropriate range of formats, media and languages, and ensuring service and customer care is delivered in an inclusive manner which respects the diversity of users.  **6.4 Applicable local standards (not in Schedules 4 or 6)**  Co-production  The provider should plan and develop the service through collaboration with people who use the service, their families and carers, as well as seeking feedback from all relevant stakeholders in order to ensure that the service reflects the needs of local people and communities. |
| **7. Applicable quality requirements** |
| See Schedule 4 Parts A- D |
| **8. Applicable monitoring requirements** |
| See schedule 6 Parts A - B |
| **9. Local contract management and KPIs** |
| The provider will be expected to meet monthly with commissioners during the Implementation phase, reverting to quarterly from contract commencement as long as there are no outstanding delivery issues. These meetings will include, but not be limited to, the items identified in General Condition 8.  Additional items will include the Key Performance Indicators (KPIs) below:   * Implementation Plan review; * Budget expenditure; * Staffing; * Staff training matrix including mandatory training; * Training delivery to other practitioners; * Details of any waiting lists. |

1. Adult Psychiatric Morbidity Survey (APMS) 2014. [↑](#footnote-ref-2)