Realising the Benefits

IAPT at Full Roll Out

February 2010
Realising the Benefits, The IAPT Programme at Full Roll Out

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<table>
<thead>
<tr>
<th>Policy</th>
<th>Estates</th>
</tr>
</thead>
<tbody>
<tr>
<td>HR / Workforce</td>
<td>Commissioning</td>
</tr>
<tr>
<td>Management</td>
<td>IM &amp; T</td>
</tr>
<tr>
<td>Planning /</td>
<td>Finance</td>
</tr>
<tr>
<td>Clinical</td>
<td>Social Care / Partnership Working</td>
</tr>
</tbody>
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Document Purpose  Best Practice Guidance
Gateway Reference 13495
Title Realising the Benefits, The IAPT Programme at Full Roll Out
Author National Mental Health Development Unit/ IAPT Programme
Publication Date 25 Feb 2010
Target Audience PCT CEs, SHA CEs

Circulation List PCT PEC Chairs, PCT Chairs, Directors of HR, Directors of Finance

Description This updated implementation sets out the vision for completing the roll out of evidence based psychological therapy services across England in the period 2011/12 and beyond

Cross Ref From Good to Great / Realising the Benefits EqIA
Superseded Docs Improving Access to Psychological Therapies implementation plan: national guidelines for regional delivery
Action Required Completion of GAP Analysis and Delivery Plans by SHAs
Timing N/A
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Realising the Benefits

IAPT at Full Roll Out

Prepared by
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# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Forewords</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Executive Summary</td>
<td></td>
<td>6</td>
</tr>
<tr>
<td>1.0</td>
<td>Introduction</td>
<td>9</td>
</tr>
<tr>
<td>2.0</td>
<td>Policy Context</td>
<td>13</td>
</tr>
<tr>
<td>3.0</td>
<td>Key principles</td>
<td>16</td>
</tr>
<tr>
<td>4.0</td>
<td>NHS progress</td>
<td>18</td>
</tr>
<tr>
<td>5.0</td>
<td>Moving Forward</td>
<td>19</td>
</tr>
<tr>
<td>6.0</td>
<td>Beginning to Deliver IAPT in every PCT in 2010/11</td>
<td>21</td>
</tr>
<tr>
<td>7.0</td>
<td>Moving to Full Roll Out in 2011/12 and beyond</td>
<td>23</td>
</tr>
<tr>
<td>8.0</td>
<td>Next Steps – IAPT Gap Analysis and 2010/11 Delivery Plans</td>
<td>42</td>
</tr>
<tr>
<td>9.0</td>
<td>Making the case for further investment through delivering quality and productivity</td>
<td>44</td>
</tr>
<tr>
<td>10.0</td>
<td>Conclusion</td>
<td>46</td>
</tr>
</tbody>
</table>

*All appendices are presented in a separate document*
Forewords

The Improving Access to Psychological Therapies (IAPT) programme plays a critical role in relieving distress and transforming the lives of people with depression and anxiety disorders.

The way the IAPT programme has been embraced by the NHS across England is inspiring. Primary Care Trusts (PCTs) have established these new services faster than planned and, as a result, more people are getting access to the help they need. This is the NHS working at its best, with local systems responding to local needs and innovating to provide high quality services.

In the first two years of the programme, IAPT services have become an integral part of wider health and care systems. We have seen most people’s condition improve and nearly half of the 100,000 people seen by these services have moved to recovery. It’s a great start and I am confident that the NHS can develop these services to deliver the Government’s commitment to treat 900,000 people by 2011, and to roll out the programme across the population after that.

There is more to do to ensure the IAPT programme sees more people more quickly and delivers even higher quality outcomes for patients. We need to ensure the lessons of the first wave IAPT sites are learned across the country. For the IAPT programme to continue to improve, services need to reflect the updated National Institute for Health and Clinical Excellence (NICE) guidance on treating depression.

This document, an update on the original IAPT implementation guide, provides support and recommendations to assist the local NHS in meeting these challenges. After 2011, I want the NHS to be in a position to fully realise the benefits of this programme to improve the mental health and wellbeing of people across the country.

Sir David Nicholson
NHS Chief Executive
As the IAPT Programme continues to develop I am confident that it will continue to be successful in making the benefits of high quality treatment available to people across the country who suffer from the debilitating affects of depression and anxiety disorders. However, to realise this vision and continue to expand, the way IAPT services are established will need to change. The NHS must continue to take on an enhanced leadership role in completing the roll out of IAPT services in every locality and work together nationally to ensure joint leadership and appropriate oversight of the programme nationally.

To date, the roll-out has been centrally led, but as the funding for the programme becomes part of PCT baselines, the NHS becomes more accountable for the programme’s success.

In November 2009, Andy Burnham, the Secretary of State for Health, spoke at the New Savoy Partnership Conference where he confirmed that he is, ‘determined to see the programme through to its logical conclusion – with psychological therapies embedded as a core part of our response to depression and anxiety disorders’. Alongside the NHS’s public pledge, to broaden the treatments in every IAPT service and to make them available in all localities, with the other IAPT developments he outlined in his speech, this now needs to become a reality. This is the challenge that I am confident that the NHS can take on and succeed in.

There is undoubted broad commitment to full roll out and I know the NHS will develop robust local systems that ensure full implementation of the programme that consolidates IAPT services effectively.

I have seen evidence that IAPT services are already going further than the minimum service requirements by innovating to respond to local needs and making the best of local opportunities to develop excellent services. This is true both here the North West, where I hear daily about the impact services are having, and across the country.

I am therefore clear that we cannot retreat from the position we are in. To stall or to step back from where we are now is, in my mind, not an option. We have come a long way and now is the time to seize the opportunity, complete this work and secure a bright future for psychological therapy services.

The next few years will require the NHS, like all public services, to ensure that all existing funds are used as effectively as possible. This will mean the NHS must move towards full roll out by introducing quality and productivity initiatives.

This guidance provides the clarity that the NHS needs in terms of the nature of IAPT services and what they should expect to achieve. It also makes clear how the NHS can work to complete the roll out in every locality in the period after 2011 by developing robust delivery plans which will be supported by the national programme.

I am sure that service providers and commissioners alike will find this implementation guidance useful and more importantly, once implemented, those who need treatment will benefit from improved services

Mike Farrar, CBE
Chief Executive, NHS North West
Executive summary

Mental health affects everyone and everything. It governs our quality of life, our relationships and our aspirations for the future. By tackling the unmet need for treating depression and anxiety disorders, IAPT services are starting to play a central role in supporting more people than ever before to realise their true potential.

IAPT aims to relieve distress and transform lives by offering NICE-approved interventions and treatment choice to people with depression and anxiety disorders and by improving the collection, recording and measurement of patients’ health outcomes, producing the evidence to support the completion of the national roll-out of services.

The NHS has already made excellent progress in beginning the roll out of IAPT services over the past two years. As we move into 2010/11, 112 services, within three-quarters of PCTs, are being established. As a result, over 100,000 people with depression and anxiety disorders have been able to access the services in the first year – most have improved and nearly half have already moved to recovery.

However, this is still only the beginning. The aim is to offer IAPT services in every part of the country and to provide access to nearly a million people a year. To achieve this, there is still much to do.

Realising the Benefits sets out the vision for completing the roll out of evidence-based psychological therapy services across England in the period 2011/12 and beyond. It also prompts the NHS to undertake an analysis of the expected gap towards achieving this goal by 31 March 2011. ‘Full Roll Out’ is defined as people with depression or anxiety disorders being able to receive:

- **Universal Equitable Access** - IAPT services in every locality of every PCT area equally available to all regardless of ethnic group, age, socio-economic status, geographical location, depression or anxiety disorder experienced or whether they access services through their GP or by self-referral
- **Personalised Care** – By choosing from a range of NICE-recommended therapies to ensure that services are appropriate to individual needs and support empowerment and recovery
• **Efficient Services** – By not waiting longer than locally agreed waiting times standards from referral into a service to receiving a full assessment and the start of their package of care

• **Effective Services** – By monitoring outcomes for everyone to demonstrate people using services move towards recovery at the completion of their treatment programme (for at least 50-60% of people). Of those not reaching recovery, the vast majority will benefit from positive improvements in their wellbeing.

In order to achieve this vision, the NHS will need to work in partnership with people who use services and other stakeholders to develop services which are:

• Appropriate to local circumstances
• Valued by local people, particularly those people who use the services
• Able to demonstrate delivery of quality services that produce the necessary outcomes
• Able to sustain themselves through contributing to productivity savings

The document describes how this vision will be delivered by:

• Spreading the success story of the NHS in the progress that it has made so far in exceeding national expectations about the pace of national roll out
• Reconfirming the national aspirations about the progress expected to complete the first phase of the roll out to 31 March 2011, when the additional CSR07 investment (£173m) is fully allocated
• Identifying the remaining challenges in completing the roll out in every locality in the period after 2011
• SHAs working with PCTs to complete IAPT Gap Analysis Templates and 2010/11 Delivery Plans by March 2010, which confirm:
  • The expected local position by 2011
  • The gap in delivering full roll out in the period 2011/12 and beyond
  • Outline plans for bridging the gap through quality and productivity initiatives (assuming no further central investment is available)
  • The approach to developing local business cases to support a further invest-to-save investment (if there is an identified funding shortfall)
  • Plans for a sustainable workforce
To support this work, the IAPT programme will change to reflect the enhanced leadership role of the NHS in completing the national roll out of IAPT services. This will include changes to accountability and governance arrangements. To enable the NHS’s commitment to full roll out, the national team will also provide resources to co-produce practical tools, innovative solutions, benchmarking and quality improvement strategies, and further workforce development and clinical leadership support to help local systems implement and consolidate their services effectively.
1.0 Introduction

1.01 Mental health affects everyone and everything. It governs our quality of life, our relationships and our aspirations for the future. By tackling the unmet need for treating depression and anxiety disorders, IAPT services are starting to play a central role in supporting more people than ever before to realise their true potential.

1.02 IAPT aims to relieve distress and transform lives by enabling the NHS to offer NICE-approved interventions and treatment choice to people with depression and anxiety disorders. By improving the collection, recording and measuring of patients’ health outcomes, it is able to demonstrate its effectiveness and provide the evidence that supports the further expansion of new services.

1.02 In October 2007, the Government announced an historic additional investment rising to £173m by 2010/11 to begin to roll out evidence based psychological therapy services across England for people experiencing the debilitating mental health conditions of depression and anxiety disorders.

1.03 This investment was the first phase of what was expected to be a six-year implementation phase, establishing services and new IT and workforce infrastructures across the country. It provided the necessary additional resources to recruit and train 3,600 new psychological therapists, treating 900,000 more people and for providing access to services in at least half of the country by spring 2011.

1.04 During this first phase of the programme, the new investment in IAPT has been centrally distributed. The additional resources have been allocated from the Department of Health to Strategic Health Authorities (SHAs) and onto selected Primary Care Trusts (PCTs) in accordance with the criteria set out in the Improving Access to Psychological Therapies (IAPT) Implementation Plan: National guidelines for regional delivery (February 2008). In 2010/11, the majority of the additional investment (£103m) will be allocated through PCT baselines, with the last year of the current growth funds (£70m) allocated centrally.

1.05 The Implementation Plan focused on the recruitment and training of a new workforce of psychological therapists trained in Cognitive Behavioural Therapy
Realising the Benefits, The IAPT Programme at Full Roll Out

(CBT). This was because CBT has the strongest evidence base (in the NICE Guidelines) but it also had the biggest deficits in terms of the availability of a suitably trained workforce. Substantial progress has been made in addressing this deficit, but there is still further progress needed next year and in the period 2011/12 and beyond to complete the training programme and sustain the workforce.

1.06 The central aim of the programme is to implement the recommendations for the provision of psychological therapies in the NICE guidelines for depression and anxiety disorders. The Statement of Intent (November 2008) reaffirmed that IAPT services would develop from this core CBT workforce to include the full range of NICE-approved therapies. The therapies for depression have now been set out in the revised guidelines published by NICE (October 2009). Consequently, Realising the Benefits provides supplementary national guidance on how to achieve the full IAPT service model, building on the IAPT Implementation Plan.

1.07 It is clear that since the publication of the IAPT Implementation Plan the context within which the IAPT services will in future need to be implemented and nurtured has changed:

- **The programme is much further forward than expected.** Many PCTs have invested significant additional local resources to supplement the national investment as the NHS has enthusiastically embraced the programme. Consequently, in spring 2010, the coverage of IAPT services will be far further advanced than had originally been expected and 112 (75%) PCTs will be providing at least one IAPT service.

- **The mental health policy landscape has evolved.** New Horizons: A shared vision for mental health (December 2009) builds on the regional Next Stage Review (NSR) Delivery Plans to redefine the mental health policy priorities for the next phase by promoting public mental health and well-being. IAPT has been at the vanguard of this shift in focus, but it also now has a responsibility as a large programme to demonstrate that it is integral to a wider fabric of mental wellbeing initiatives. It must do this now by working in harmony with the best of existing services to promote good public mental health, high quality services, and integrated care pathways.
The financial environment is more challenging. In the light of the global economic downturn, the NHS will not continue to receive the kind of year-on-year increases in investment it has enjoyed in recent years. Consequently, the original projections for further additional central investment in the period 2011/12 and beyond to complete the roll out will need to be reconsidered. The business case for IAPT, like other NHS services, will now need to demonstrate evidence of providing high quality services which address needs and plans for delivering returns in terms of efficiency gains across the system for every pound invested in these services. IAPT is well placed to do this having pioneered routine outcomes monitoring that enables us to demonstrate meeting our projected economic benefits and savings. As more IAPT services are established, generating more outcomes data, we can extend, strengthen and reinforce the sustainability of the programme. By so doing, both the existing and the additional local services that are needed to achieve full coverage will be able to make the case for increasingly scarce investment.

In November 2009, the Secretary of State reaffirmed the Government’s commitment to IAPT – a commitment which is supported by the NHS. In response to requests for further detail on what this will entail, Realising the Benefits provides the clarity the NHS needs to be able to complete the roll out of IAPT services as we move into period 2011/12 and beyond. Specifically, it sets out the:

- Context within which full IAPT service coverage will be implemented
- Key principles for the delivery and sustainability of the new services
- Progress that has been achieved
- Function and form of IAPT services at full roll out
- Quality standards to ensure a high performing workforce and services that can deliver expected outcomes
- Proposals for securing resources for the full roll out based on demonstrating the productivity savings that will be realised through investing in new services
- Next steps for the NHS in developing IAPT Delivery Plans for 2010/11 and for the period 2011/12 and beyond, that meet the delivery criteria above and ensure sustainability
1.09 *Realising the Benefits* provides a framework for action to enable the NHS to work in partnership with key stakeholders and identify what needs to be done to move towards universal equitable service coverage in the period 2011/12 and beyond.
2.0 Policy context

2.01 *New Horizons* supersedes the Mental Health National Service Framework (1999) and aims to support everyone in England, of all ages and all backgrounds to stay mentally well. It builds on the success of the NSF, which transformed services for the 600,000 people with the most severe mental illnesses and IAPT, which provides help for the 6 million people with depression and anxiety disorders.

2.02 As IAPT services mature, *New Horizons* will challenge them to ensure that the service they provide contributes to improved mental well-being in each area. Specifically, this will mean focusing on:

- **Transitions.** Moving from youth to adulthood is a critical time for all young people yet is often marked by weaknesses in mental health services provided for them. The majority of adults who suffer from depression or anxiety disorders begin to experience their symptoms as children or young people. It is imperative that the needs of young people as they move into adulthood are appropriately addressed in IAPT services. The Government's response to the CAMHS Review, supported by *New Ways of Working for Psychological Therapists* (due March 2010) will determine how IAPT can work to support improved access to appropriate psychological therapy services for children and young people.

- **Tackling age discrimination.** Older people with mental health problems can face social exclusion and stigma, due to discrimination because of age, mental health problems and possibly associated physical health problems as well as disabilities such as dementia. IAPT services should actively tackle age discrimination by promoting and monitoring access for older people with depression and anxiety disorders. IAPT services should not be restricted to adults of working age.
2.03 In November 2009, Andy Burnham, the Secretary of State for Health, delivered a major speech on mental health at the New Savoy Partnership conference. In his speech, he reiterated the Government’s commitment to:

- Completing the full roll out of the IAPT programme by ensuring that:
  - the training programme is completed to achieve the planned numbers of new therapists and subsequent training plans to developed to maintain the workforce needs of the new services
  - services are available across the country that deliver the appropriate quality standards, including delivering universal and equitable access, personalised care and efficient and effective services
  - all services offer a choice of the full range of NICE-approved interventions
  - clinical excellence and career development is supported through a new national leadership programme
- Ensuring that new IAPT services are maintained
- Making the case for further local investment in IAPT by demonstrating quality and productivity gains

2.04 These commitments are further underlined in *NHS 2010-2015: From Good to Great, Preventative, People Centred, Productive* (DH, December 2009) five-year plan to reshape the NHS to meet the challenge of delivering high quality health care in a tough financial environment. The aim is for an NHS that is organised around patients whether at home, in a community setting or in hospital. There will be a renewed focus on prevention with the ambition of delivering productive, high quality care across the service.
2.05 *From Good to Great* specifically confirms the Government’s intention to work with the NHS to:
  
  - Establish what will be needed to achieve full geographical coverage of IAPT in every PCT
  - Move towards delivering a new waiting time standard of two weeks from referral to assessment
  - Provide a choice of the full range of NICE-approved interventions to people using IAPT services
  - Offer employment support in every service.

2.06 In December 2009 a range of policy documentation was published relating to mental health and employment. Central to this, the cross government Health, Work and Wellbeing team released “Working Our Way to Better Mental Health: A framework for action” which emphasises the importance of work for mental health and how to provide assistance to people to help people either maintain their employment or move back towards it. This includes a commitment to “support the establishment of an employment support co-ordination function in every PCT that has IAPT services, as an integral part of the IAPT service” (*No. 40, p78*).
3.0 **Key principles**

3.01 As IAPT services mature, it is essential that they address the following overarching principles:

**IAPT in context**

3.02 IAPT provides a care pathway (as described in the *IAPT Commissioning Toolkit 2008*) within a broader canvas of mental health care. IAPT cannot succeed in the longer term without local systems taking a forward-thinking view about the range of services and integrated care pathways that will need to be developed with partners to improve the mental wellbeing of the whole population. IAPT focuses on delivering a high quality services for people with depression and anxiety disorders, but it should also be commissioned as part of a range of mental well-being services, which may include:

- Psychological support for people with more severe and enduring conditions
- Counselling services for people needing emotional support but not primarily suffering from depression or anxiety disorders
- Primary care and voluntary sector support to promote good mental wellbeing across local communities

**Personalisation and choice**

3.03 IAPT services should offer effective and meaningful choices about where, who, how and what services are provided. This entails a range of NICE-recommended therapies being available locally and ensuring that people accessing services are empowered in their recovery through being fully informed about what to expect from services and the options available to them.

**Quality productivity and sustainability**

3.04 IAPT services and their workforce should continue to focus on collecting patient reported outcome measures at each clinical session as an integral part of the commitment to quality and productivity. The benefits and principles of routine data collection are described in the *IAPT Outcomes Toolkit (2008)*. This data is intended to be primarily useful to patients in providing tangible evidence of the progression they are making through their care pathway; and to their clinicians in monitoring and developing their skills, and as part of the clinical governance process. For sustainability, this data is also vital to commissioners and others in demonstrating the direct return on the investment made in services that are
benchmarking against clear outcome measures. Building on this culture of routine outcome monitoring, local systems will wish to measure the longer term financial benefits and impact of delivering IAPT services across other parts of the local health and social care system.
4.0  NHS Progress

4.01  The NHS will have succeeded in establishing 112 IAPT services by spring 2010. This leaves less than a quarter of PCTs remaining who are yet to implement their new IAPT services, which is significantly ahead of expectations.

4.02  In the first year of delivery, more than 100,000 people have benefited from accessing IAPT services, and more than 40 per cent have been helped towards recovery. The training programme is now well established with 1,500 people working in IAPT services including more than 800 existing trainees, and a further 750 new trainees recently recruited. Employment support is available in every service with staff working in services alongside clinical staff to ensure good links to vocational support. 2,400 people have been helped to move off sick pay and benefits. Outcomes from the National Data Review of first wave sites will be published in March 2010.

4.03  In March 2009, the Government recognised the contribution IAPT services were beginning to have not only in improving health and wellbeing, but also in supporting people who have been affected by the economic downturn. The Government announced an additional £13m investment in the programme. The emotional impact of debt or employment issues can often have a debilitating effect on people, which can even hinder their ability to make effective use of debt management and employment supports available. At the same time, demand on existing advice centres has outstripped capacity. The additional resource has been used, therefore, both to accelerate the availability of IAPT services across the country and to establish a national NHS Stressline service, provided by NHS Direct. The service launched in December 2009 and provides highly responsive, telephone-based support to people with mental wellbeing issues which may be related to debt or employment issues.
5.0 Moving Forward

5.01 In moving towards universal access to IAPT services, it is important to differentiate between what needs to be achieved in 2010/11, which forms part of the nationally-funded IAPT delivery commitment, and the task which will subsequently remain in the following period, after 2011, where the intention is to deliver full coverage:

- Beginning to deliver IAPT in every PCT in 2010/11

In 2010/11, each SHA is responsible for delivering its share of the Secretary of State for Health’s IAPT commitments, ensuring:

- 900,000 more people will have accessed IAPT services in the three years up to and including 2010/11 (with the annual figure rising to 500,000 per annum in year in 2010/11 or 8.3% of total prevalence\(^1\))
- Recovery rates rising to 50% for those who complete treatment
- 3,600 newly trained psychological therapists
- 25,000 people helped off sick pay and benefits over the same period
- At least 50% of the population have access to IAPT services

In addition, subject to local prioritisation, the NHS has also agreed to begin to implement IAPT in every PCT with at least one IAPT service in place in every PCT next year. Furthermore, the NHS has already started to focus on improving access to services by reducing waiting times as services mature. To support this, the national programme has committed to providing benchmarking reports, which will include waiting times data to enable local systems to monitor progress against locally agreed waiting times standards.

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\(^1\) Need for IAPT services is based on the Adult Psychiatric Morbidity Survey 2007 (NHS Information Centre, 2007) data for the number of adults experiencing depression and anxiety disorders
Moving to Full Roll Out in the period 2011/12 and beyond

The NHS will work to determine how Quality, Innovation, Productivity and Prevention (QIPP) solutions can help achieve full coverage in the period of financial challenge after April 2011. Full coverage is defined as ensuring:

- 900,000 people access IAPT services every year (a minimum of 15% of total prevalence)
- local waiting times standards
- Recovery rates for those completing treatment achieve a minimum 50% standard
- The training programme to generate the new IAPT workforce is completed and maintained
- Employment support is available in every IAPT service to support people accessing services stay in and return to work
- Services move towards 100% population coverage in every PCT
- IAPT services meet the minimum nationally agreed quality standards relating to:
  - Service delivery
  - Workforce development
  - Routine outcome monitoring
6.0 Beginning to Deliver IAPT in every PCT in 2010/11

6.01 The key challenge in 2010/11 will be to continue to develop and sustain maturing IAPT services, whilst ensuring that new services are established in PCT areas currently without a service. Despite the changes in funding flows, with the majority of the additional central resources now flowing directly into all PCT baselines, SHAs will wish to ensure that the quality standards for new and existing services continue to be met. The learning from the early adopter sites and the outcome of the IAPT National Data Review will support this.

6.02 To enable SHAs to develop effective plans with PCTs for 2010/11, IAPT Delivery Plans 2010/11 (see Section 8) will usefully address the following key areas:

- **Delivery trajectories**
  The NHS is significantly ahead of plan in delivering the Secretary of State’s IAPT commitments. Plans should update these trajectories to show whether current progress can be maintained and the commitments achieved in 2010/11.

- **Service coverage**
  Plans should also include details of how IAPT services will be established in the minority of PCTs which currently do not have a service. To support this, the IAPT Workforce & Gap Analysis Tool (see paragraph 7.09) will provide the planning parameters and assumptions to assist these PCTs in configuring their workforce and assessing their trainee requirements appropriately.

- **Waiting times**
  Local arrangements to support and monitor progress against best practice waiting times standards should be included in the Plans.

- **Supporting quality standards**
  Plans should also include a review of current progress in delivering the agreed quality standards in IAPT sites, identifying areas for improvement and specifying any additional national support that may be useful in assisting local systems delivering these standards.
6.03 To assist NHS monitoring arrangements, regular Benchmarking Reports will be published nationally demonstrating PCT and SHA progress against the IAPT Key Performance Indicators (KPIs). The KPIs are set out in the IAPT Key Performance Indicators Technical Guidance (see Annex 1). Benchmarking Reports will be disseminated via SHA Directors of Performance, who will take any necessary action.
7.0 Moving to Full Roll Out in 2011/12 and beyond

7.01 In the period after 2011, the NHS has agreed to seek to develop and extend IAPT services towards full roll out. The following section seeks to provide a definition of IAPT at full roll out and to establish the key success criteria.

7.02 The intention is to provide a common goal to assist the NHS in developing gap analyses between where each local system expects to be on the journey to full roll out by 2011 and, thereby, to begin to consider what will be required to complete the roll out in the subsequent period. The initial gap analysis should form part of the IAPT Gap Analysis Templates (see Section 8).

7.03 The learning from the first phases of IAPT service roll out has been distilled into a set of IAPT Quality Standards, which are intended to support local systems develop new services and work together to ensure they are providing an effective service for their local population. The standards are intended to be applied locally in a proactive way, rather than to support regional or national performance management.

7.04 At full roll out, IAPT services should aim to deliver the following Quality Standards:

- **Service Standards** to support the delivery of effective, NICE-approved care pathways which offer patient choice, including:
  - Universal equitable service coverage for the whole population
  - Access to services able to meet the equivalent of at least 15% of total need in each PCT every year
  - Timely access, with people waiting no longer than locally agreed waiting times standards
  - Recovery rates of at least 50% for those who complete treatment
  - Employment support to help people accessing services stay in and return to work
  - IAPT service model and care pathway
Realising the Benefits, The IAPT Programme at Full Roll Out

- **Workforce Standards** to support the development and maintenance of a competent workforce, supported by an appropriate training programme, including:
  - Operational Workforce standards
  - Workforce capacity and configuration recommendations
  - Education and training standards

- **Routine Outcome Monitoring Standards** to support the collection of evidence to demonstrate the effectiveness of services and continuous service improvement

7.05 Local systems will wish to ensure that monitoring arrangements are in place to check progress in delivering IAPT services based on these recommendations to ensure that the minimum standards are achieved.

**Service Standards**

**Universal equitable service coverage**

7.06 The delivery of universal equitable service coverage is defined as IAPT services being provided in every locality, to meet a minimum level of assessed need and being equally accessible and accessed by every section of the local community:

- Geographical coverage. SHAs have agreed to work with all PCTs to develop a gap analysis and plans for addressing the gap, to deliver IAPT services in every locality in each PCT area. These plans should also begin to address the resources needed to cover any identified gaps and to inform local, regional and national business cases for further investment in IAPT to support the move towards universal service coverage.

- Equitable access. As IAPT services move towards full geographical coverage, it is important that local systems continue to ensure that services provide equitable access to all sections of the community on the basis of clinical need. Services in every locality of every PCT area will need to be equally available to all regardless of ethnic group, age, socio-economic status, geographical location, depression or anxiety disorder experienced or whether they access services through their GP or by self-
referral. To this end, PCTs will want to ensure that the new services are subject to an Equality Impact Assessment (EqIA) as appropriate and performance data is carefully monitored to ensure progress.

7.07 To support local systems in considering their approach and to inform IAPT Delivery Plans, the following resources are provided:

- IAPT Gap Analysis Template (Annex 2)
- IAPT national Equality Impact Assessment (Annex 3)
- A full IAPT Equalities Review identifying the key challenges emerging from the IAPT National Data Review to be published in May 2010.

Increased access to meet need

7.08 As part of PCT Joint Strategic Needs Assessments, commissioners will want to plan for services to provide a minimum access to IAPT services equating to 15% of total prevalence per year. Nationally, this equates to providing access to 900,000 people annually, as envisaged in the IAPT Business Case, (with the annual figure rising to 500,000 per annum in year in 2010/11 or 8.3% of total need\(^\text{2}\)). Some localities are already planning to move beyond these national minimums and are planning to increase access to as high as 25% of total prevalence.

7.09 To support commissioners in interpreting and applying this guidance and to consider the appropriate balance of the workforce necessary to deliver services, the IAPT Workforce & Gap Analysis Tool and user guidance is available (www.iapt.nhs.uk). An overview of the use of the Tool and the key demand and capacity assumptions are provided at Annex 4.

Waiting times

7.10 During the initial phase of the programme, a best practice standard of two weeks from referral to assessment was established, although this is not mandatory. However, during the first phase of the roll out, sites have reported problems in managing demand, often through inheriting large backlogs of patients from GPs, where both the numbers and length of wait of people on IAPT waiting list needs

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\(^2\) Need for IAPT services is based on the Adult Psychiatric Morbidity Survey 2007 (NHS Information Centre, 2007) data for the number of adults experiencing depression and anxiety disorders
to be addressed. The transfer of this backlog without robust clinical review and management can lead to inappropriate referrals and untoward incidents.

7.11 To address this, many local systems have already established local waiting times monitoring processes. In order to share this best practice nationally, these arrangements will be supported by including data on progress against waiting times best practice in the IAPT Benchmarking Reports from 2010/11.

7.12 Early adopter sites have achieved waiting times standards of 14 days from referral to assessment and 28 days from referral to treatment commencing, and better in some cases. The intention is to support the NHS in spreading delivery of best practice in this area and to work with SHAs in supporting localities in more effective management of demand, capacity and patient flow as part of an overall programme of service improvement.

Recovery rates

7.13 Recovery rates are defined by patients moving to below caseness on clinical outcomes scores as a proportion of the number of people ending contact with services and receiving at least two sessions of treatment. Learning from the first year suggests IAPT services may not achieve 50% recovery in the first six months of operation. This is due to the following effects of new service implementation on recovery rate calculations:

- In the first few months of operation, many patients will not have completed their treatment
- New services reviewing inherited waiting lists which often have different needs from new referrals
- Establishing the systems and clinical practice to routinely collect sessional data can take time to establish. It should be noted that for every 10% of outcome data not collected, calculated recovery percentages will drop by 5%.

7.14 Recovery rates should be monitored closely, particularly over the first six months of implementation and steps taken to manage the effects of the above factors. This may include regularly reviewing reasons for ending treatment, identifying high proportions of did not attends (DNAs), sources/dates of referral, caseness
and data collection rates for clinical outcomes contributing to recovery e.g. PHQ9, GAD7, the IAPT Phobia Scales and Disorder Specific Measures.

7.15 Addressing these issues will support services in achieving a minimum recorded rate of 50% recovery for patients after 6 months of full service operation. To support this, Supplementary Guidance on the IAPT Outcomes Toolkit will be published in March 2010.

Employment Support

7.16 The positive link between employment and mental health is proven. Research shows that people generally enjoy better mental health when they are in work. In contrast, there is evidence that the longer individuals are absent or out of work, the more likely they are to experience depression and anxiety. Satisfying work can therefore play a vital role in improving everyone’s well-being and mental health.” (Working Our Way to Better Mental Health: Health, Work and Wellbeing 2009, p27).

7.17 Employment is a health intervention and as a result employment support is integral to IAPT services because of the positive impact work has on mental health.

7.18 Commissioners and services need to assess the local demand for appropriate employment services. Consideration and weighting should be given towards job retention - for those in work and struggling with a mental health condition – and for those seeking work with such a condition, and reflected in the local service model.

7.19 The nature of this support will be defined locally, but should be informed by the IAPT Employment Support Co-ordination and Evaluation Guide, including suggested outcomes measures (Annex 5). This underpins that the integration of employment support and therapeutic services is critical.

7.20 IAPT services should continue to monitor the employment, sick pay and benefit status of people both accessing services and completing treatment. This will enable services to identify requirements for employment support and monitor the social/economic benefits of the provision of their psychological therapy care package.
IAPT service model and care pathway

7.21 The recommended characteristics of an IAPT service were set-out in the *IAPT Implementation Plan* (February 2008). This included key planning principles defining the establishment of the service, including:

- Teams of therapists (PWPs and CBT therapists) delivering NICE-approved interventions in a system of Stepped Care, and linked employment and primary care supports
- Equity of access, including GP and self-referral procedures
- Routine outcome monitoring
- Training programme

7.22 The *IAPT Implementation Plan* (February 2008) also recommended a ratio of approximately 40 therapists (high intensity and PWPs) for a PCT serving 250,000 people with average levels of need, with numbers being scaled up or down depending on actual population to be served (locality or PCT wide) size and need. While this general recommendation still holds, the IAPT Workforce and Gap Analysis Tool allows a more detailed calculation of the workforce requirements for individual PCTs based on local need.

7.23 Building on these overarching principles, the following service quality standards have been developed through the IAPT Regional Clinical Leads’ Network (see Figure 1, page 31):

- **Referral and access criteria**
  IAPT services should have agreed referral protocols that provide clear access criteria defining the scope of the service. This should include:
    - Providing NICE-recommended psychological treatment for people with depression and all anxiety disorders
    - A clear description of the treatments available locally to clients depending on their current difficulties
    - Open to self-referral, GP referrals and referral/recommendation from all other health professionals within the locality
    - Providing fair and equitable access to all community groups
- Single point of contact for depression and anxiety disorders, including phone lines and other technologies to support effective referral management

- **Waiting list policy**
  As IAPT services mature, the collection of waiting times data will enable local systems to monitor progress against locally agreed waiting times standards.

  Active waiting list management systems should be in place to ensure that the service is responding appropriately to demand for services and is achieving an appropriate balance of people accessing the service from all parts of the local community.

- **Assessment**
  All patients should receive a person centred assessment, including a risk assessment (with associated management plan) and consideration of the IAPT outcomes measures. From this, a provisional diagnosis code, based on the IAPT minimum data set (i.e. ICD-10 codes) should be recorded. This allows the relevant NICE guideline(s) to be identified, equity of access by clinical condition to be monitored and the appropriate care pathway to be agreed.

- **Delivering the Stepped Care Pathway**
  IAPT services should deliver care pathways supported by clear clinical governance policies that include:

  - **NICE- compliance**
    NICE guidelines for depression and anxiety disorders indicate a range of evidence based treatment options suitable for specific diagnosis as well as recommendations for models of service delivery. As an outcome of the assessment process, patients and therapists should agree the NICE indicated treatment to be provided (See Figure 2, page 32).

  - **Patient choice**
    IAPT services should offer effective and meaningful choices about where, who, how and what services are provided. This entails a
range of NICE-recommended therapies being available locally and ensuring that people accessing services are empowered in their recovery through being fully informed about what to expect from services and the options available to them.

- **Stepped care protocols**
  Patients should have access to the least burdensome treatment necessary to relieve their symptoms and move to recovery. As patients move through the care pathway, they should have the facility as clinically indicated through the routine outcome measures to step up and down between low and high intensity supports, and into/out of specialist mental health services, including step four psychological therapy services. This process should be defined in an agreed clinical protocol.

- **Routine outcome monitoring**
  Delivery of IAPT care pathway treatments should be supported by the use of sessional clinical outcome measures (e.g. PHQ9, GAD7 and the other Disorder Specific Measures\(^3\)). This should include linking measures to stepping up and down protocols to ensure that the effectiveness of treatments is continuously monitored by the patient, therapist and service. Pre-post treatment clinical outcome data should be available on at least 90% of all cases that receive any treatment in the IAPT service (i.e. seen at least twice, including the assessment session).

\(^3\) IAPT Outcomes Toolkit 2008/9
Figure 1: Recommended Stepped Care Pathway for IAPT services
### Figure 2: NICE indicated Treatments for Depression and Anxiety

#### Step 1: Primary Care / IAPT service
- **Recognition of problem**: Moderate to Severe Depression with a chronic physical health problem
- **Assessment/Referral/Active Monitoring**: Includes careful monitoring of symptoms, psychoeducation about the disorder and sleep hygiene advice.
- **Collaborative care**: (consider in light of specialist assessment if depression has not responded to initial course of high intensity intervention and/or medication)

#### Step 2: Low Intensity Interventions
- **Depression**: Cognitive Behavioural Therapy (CBT) or Interpersonal Therapy (IPT), each with medication
- **Panic Disorder**: CBT or Eye Movement Desensitisation Reprocessing Therapy (EMDR)
- **Post Traumatic Stress Disorder (PTSD)**: CBT or Eye Movement Desensitisation Reprocessing Therapy (EMDR)
- **Generalised Anxiety Disorder (GAD)**: CBT
- **Obsessive Compulsive Disorder (OCD)**: CBT
- **Social Phobia**: CBT

#### Step 3: High Intensity Interventions
- **Depression**: Cognitive Behavioural Therapy (CBT) or Interpersonal Therapy (IPT), each with medication
- **Panic Disorder**: CBT or Eye Movement Desensitisation Reprocessing Therapy (EMDR)
- **Post Traumatic Stress Disorder (PTSD)**: CBT or Eye Movement Desensitisation Reprocessing Therapy (EMDR)
- **Generalised Anxiety Disorder (GAD)**: CBT
- **Obsessive Compulsive Disorder (OCD)**: CBT
- **Social Phobia**: CBT

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1. NICE Guidance on treatment of “Depression” and “Depression in people with a chronic physical health problem”. The two guidelines are very similar. However, it should be noted that the “Depression with a physical health problem” guideline does not recommend IPT, behavioural activation, counselling or brief dynamic therapy as high intensity interventions.
2. Although the recent update of the NICE Guidance for Depression recommends Behavioural Activation for the treatment of mild to moderate depression, it notes that the evidence base is not as strong as for CBT or IPT.
3. PTSD: NICE has not recommended low intensity treatments.
4. Social Phobia - NICE has not yet issued guidance on the treatment of social phobia. However, there is a substantial body of evidence supporting the effectiveness of high intensity CBT. Low intensity versions of CBT are being developed by several groups around the world and are likely to play a useful role in the future. At least one trial has also demonstrated that IPT is effective.
Delivering integrated care pathways

7.23.1 In order to deliver effective care pathways, IAPT services will also offer access to the following linked supports:

- **Employment support**
  Employment advice, debt counselling and other social assistance should be available within the IAPT service and offered as part of an integrated care plan with close liaison between clinicians and advisors from assessment, through treatment, to discharge.

- **Primary care interface**
  All services should have a local GP lead who will champion the service and provides the service’s clinical lead with feedback from general practice to help ensure that the service fulfils the needs of local GPs. There should be close collaboration with GPs over the management of medication so that it facilitates, rather than hinders, psychological treatment. Links with primary care should also be developed for all patients. This will include links to counselling services, which provide support to people experiencing psychological distress but not primarily experiencing depression or anxiety disorders covered by IAPT services.

- **Mental health service integration**
  Good links with specialist mental health services should be in place to enable patients who can benefit from IAPT services are referred to them, reducing the burden on specialist mental health services and to enable effective onward referral for IAPT patients who require more specialist support. This process should be defined in an agreed clinical protocol.

- **Discharge and onward referral policies**
  Onward referral to specialist and other NHS services and a discharge policy should all be in place in order to support patients as they move towards recovery. This may entail further liaison with primary care and review and follow-up arrangements, as appropriate.
7.23.2 To support this, the IAPT programme will publish best practice case studies to illustrate each of the quality standards based on the experience of people who use IAPT sites (www.iapt.nhs.uk).

7.23.3 The IAPT programme will also provide resources to co-produce practical tools, innovative solutions, benchmarking and quality improvement strategies, and further workforce development and clinical leadership support to help local systems implement and consolidate their services effectively.

Workforce Standards

7.24 The IAPT Workforce and Education and Training Standards aim to support IAPT services in ensuring the continued development of effective multi-disciplinary teams. The standards also support local systems in planning the appropriate numbers and configuration of training commissions required to complete the training programme as services mature.

7.25 The key Workforce and Education and Training Standards are:

- **Operational Workforce standards** to support the sustainability and development of the workforce, including the transition of trainees into a mature workforce
- **Workforce configuration recommendations** to support local systems plan the right configuration of the IAPT workforce as they move to full roll out
- **Education and training standards** to complete the training programme as it stands and sustain an ongoing programme to ensure that the IAPT workforce is competent and has the appropriate capacity to deliver the appropriate range of NICE-approved interventions
Operational Workforce standards

7.25.1 The IAPT workforce is a multi-disciplinary team, consisting of:

- Psychological therapists operating at step 3, delivering NICE-recommended interventions
- Psychological Wellbeing Practitioners (PWPs) operating at step 2, delivering NICE-recommended low intensity interventions
- Employment support working with therapists/Psychological Wellbeing Practitioners and associated staff, including GPs
- IT and administrative staff

7.25.2 It is important to consider the whole multi-disciplinary team in considering workforce standards. This workforce should have access to:

- **Regular supervision**
  Weekly supervision should be available to all clinical and other staff and provided by suitably competent and qualified individuals who themselves have a caseload in the service (leadership by example). The nature of the supervision should be tailored to the caseload of the practitioner.

- **Professional development to enhance staff retention and leadership**
  A continuing professional development programme should be in place with regular appraisals identifying the needs of each member of staff and ensuring that they continue to develop the level and breadth of their clinical and other skills, in line with the overall aims of the service. Staff progression and facilities to support the retention of skilled staff within the service should also be in place. Opportunities for career progression and leadership development should be explored for more senior staff, potentially as Advanced Practitioners (see section 7.25.7). This will be important for staff retention, service improvement, team and personal development of IAPT staff.

- **Psychological Wellbeing Practitioner (PWP) workforce development**
  In order to deliver stepped care, it is vital that the PWP workforce is developed and maintained. However, the PWP is a new role, which is not yet professionally affiliated and the learning to date suggests that it is vulnerable to high levels of attrition and turnover. Local systems should work with higher education institutions (HEIs) to develop plans for addressing
these risks. To support this, the national IAPT programme will work with the SHA Workforce Leads to disseminate learning about the PWP:

- Role and its value
- Role development in addition to high volume low intensity work
- Career progression options to a senior PWP role
- Individual accreditation options building on the course accreditation process being undertaken in 2010
- Selection criteria and training routes to build a more diverse workforce

7.25.3 In the period 2011/12 and beyond, it is crucial that the stepped increase in an IAPT workforce, which is capable of delivering NICE-approved interventions, is completed. Moreover, consideration will need to be given to how this workforce will be maintained, their career pathways established and their clinical practice accredited. To support this, the IAPT Workforce & Gap Analysis Tool also includes tools to enable the NHS in planning the numbers of new trainees needed to complete the roll out and to maintain services and training places subsequently (see Annex 4).

Workforce configuration recommendations

7.25.4 In October 2009, NICE published an updated Depression Guideline, which together with the existing guidelines for the treatment of anxiety disorders (for Anxiety, Obsessive Compulsive Disorder (OCD) and Post Traumatic Stress Disorder (PTSD)), provides the essential clinical parameters within which IAPT services must operate. The Quick Reference Guides and the full guidelines can be accessed at www.nice.org.uk

7.25.5 The IAPT care model is based on a system of Stepped Care and has been updated to reflect the updated NICE Guideline for Depression (See Figure 2). In summary, NICE recommends a range of psychological treatments for depression, but only recommends CBT (plus Eye Movement Desensitisation and Reprocessing (EMDR) for post-traumatic stress disorder (PTSD)) for any of the anxiety disorders.
7.25.6 As a result, IAPT services should offer the full range of NICE-approved therapies in a way which maximises the opportunities to offer a choice of time, venue, mode, practitioner and appropriate treatment which is personal to the individual. This will require closer integration with the existing Psychological Therapy workforce, who often have the skills required to enable IAPT to deliver the full range of treatments.

7.25.7 To support this development, the national IAPT programme will provide the following tools and resources to assist local systems:

- IAPT Competency Framework to cover the range of NICE-approved interventions to be published in Spring 2010
- Top-Up Training for non-CBT therapists who can deliver the other NICE-approved interventions
- Collaborative Care pathways for people with long term conditions who need support from primary care and IAPT
- Clinical and service leadership Positive Practice guidance based on Advanced Practitioner principles to enhance local clinical leadership of mature IAPT services

7.25.8 To assist local systems in planning the appropriate IAPT workforce configuration, the IAPT Workforce & Gap Analysis Tool, sets-out the key national recommended workforce ranges and other planning assumptions.

**Education and Training standards**

7.26 A key priority in the period 2011/12 and beyond will be to:
- Complete the IAPT training programme
- Ensure that the IAPT workforce is competent to deliver the appropriate range of NICE-approved interventions.

**Completing the training programme**

7.26.1 As part of the IAPT Gap Analysis Templates and 2010/11 Delivery Plans, SHAs will want to work with PCTs to assess the likely shortfall in the numbers of High Intensity CBT therapists and PWP s in order to complete the training programme.

7.26.2 SHA delivery trajectories for 2010/11 are likely to show that more than the 3,600 trainees planned will be in place by spring 2011. However, despite this excellent
progress, there will still be a need to recruit and train further CBT and PWP trainees to provide the core workforce to enable delivery of the final phase of service expansion.

7.26.3 The non-CBT workforce will need to be planned as an integral part of this process and their training requirements addressed through continuous professional development (CPD) opportunities.

7.26.4 The additional training requirement will be defined by each PCT, supported by the SHA Workforce Leads, informed by the IAPT Workforce & Gap Analysis Tool. This tool will also help local systems to forecast the training places they may need to commission in the period 2011/12 and beyond.

**Competency standards for all**

7.26.5 Competency Frameworks for high intensity CBT practitioners and PWPs have been published and provide the basis for nationally agreed training curricula and, in the case of PWPs, nationally available training materials for students, trainers and supervisors are available.

7.26.6 Similar competency frameworks, together with the IAPT Supervision Good Practice Guidance have been developed for IAPT Supervisor training and a refined national curricula will be published in spring 2010.

7.26.7 The Competency Frameworks, training and practice guides for the non-CBT NICE-approved interventions will be published in spring 2010.

7.26.8 Joint accreditation processes have been developed and implemented for high-intensity courses and agreed in principle between IAPT and relevant national professional bodies (e.g. BABCP, BACP and BPS) for IAPT PWP courses. Where appropriate, this also includes advice on the training and experience requirements for practitioners, in order that they can supervise within an IAPT service.

7.26.9 Similar, joint accreditation processes will be developed and agreed with relevant professional bodies for the other non-CBT NICE approved interventions.
7.26.10 Quality assurance of IAPT training will be facilitated by the IAPT Competence Framework, Training and Good Practice Guidance, together with the IAPT Accreditation process. Further details and progress are available at www.iapt.nhs.uk.

IAPT Routine Outcome Monitoring Standards

7.27 IAPT services use a standard minimum data set (MDS) which define demographic and sessional clinical and social patient reported outcome measures for at least 90% of all patients. The outcome measures are defined in the *IAPT Outcomes Toolkit* (2008) and *Supplementary Outcomes Guidance* (2010) and include:

- PHQ9 for depression
- GAD7 for anxiety in general
- Phobia scales
- Disorder Specific Measures for the particular anxiety disorders, including Post-Traumatic Stress Disorder (PTSD), Obsessive Compulsive Disorder (OCD), Social Phobia, and Panic Disorder

7.28 This data should be used in a positive way by services for:

- **Patients**
  There is value in the patient seeing the scores from their completed clinical scoring questionnaires, and seeing how the scores change over time. Scores help the patient understand more about their condition and can help support and develop the therapeutic relationship. GPs and IAPT pilot sites found this approach to be positively therapeutic. Similarly, seeing how the outcome score changes over time is also very helpful, both for those who are improving and for those not responding to treatment who may need to consider alternative interventions.

- **Clinicians**
  Session by session outcome measures help clinicians to target therapy on outstanding problems and to improve the overall quality of their interventions. The clinician needs access to similar data to the person receiving care, especially outcome scores for individuals, expressed as an average for all the people that they have treated. In this way, the
characteristics of the clinician’s workload can be understood, and compared with others, as can the effectiveness of the interventions offered.

- **Supervisors**
  Outcomes feedback to supervisors supports case reviews, and collaborative treatment planning. Supervisors need to know about the cases of the clinicians they are supervising in terms of the caseload, average length of treatment sessions, patient outcomes (including patients identified to be at risk), and levels of incomplete/missing data.

- **Commissioners and Service Managers**
  Routinely collected demographic, care pathway and outcome data enables service managers and commissioners to monitor, report on and improve overall service performance, including the equity and quality of services. The availability of accurate, comprehensive demographic, clinical condition and outcome data will also inform the development of local, regional and national evidence of the effectiveness of IAPT services. In addition, it will help to drive up standards by using benchmarking data, improving whole system care pathways and future resource planning.

7.29 The availability of effective information systems enables the consistent and effective operation of IAPT services. They enable administrative and clinical staff to provide a better service to patients in booking appointments, supporting patient choice and allowing sufficient flexibility in appointment lengths, locations and scheduling to best meet the needs of patients.

7.30 Learning from the early adopter sites suggests that the following informatics system characteristics are key. Systems should:

- Collect the IAPT Minimum Data Set (MDS) and other patient data including risk
- Comply with NHS Security Standards for the protection of patient information
- Provide aggregated data to support IAPT Key Performance Indicators
- Provide real time patient information that can be accessed during patient sessions, including remote access systems as appropriate
• Provide automated supervision alerts for all new patients, four weekly reviews, high scores of clinical outcomes, patients who have not attended scheduled appointments
• Provide standard XML reporting to support data feeds for national data standard by Autumn 2011.

7.31 Longer term monitoring of the IAPT Service Standards will be facilitated by the implementation of a national data standard for IAPT (currently under application to the Information Standards Board and due for implementation in 2011/12). In the period from 2011/12 and beyond, this will necessitate that services report a subset of data currently defined under the IAPT Minimum Data set for all patients receiving treatment under an IAPT care pathway. This will include demographic details, interventions provided and patient outcomes. Full human behavioural, technical and organisational guidance to allow services to prepare for implementation will be published in Autumn 2010. Further updates will be available from www.isb.nhs.uk/docs/improving.
8.0 Next Steps – IAPT Gap Analysis and 2010/11 Delivery Plans

8.1 SHA leads are asked to complete IAPT Gap Analysis Templates and develop regional IAPT Delivery Plans 2010/11 for consideration by the IAPT Programme Board on 30 March 2010. These will be shared in draft form for comment by the national programme team by 9 March. They will support the allocation of the final year of the current national IAPT investment (£70m) in 2010/11.

8.2 A template for the IAPT Gap Analysis Templates and 2010/11 Delivery Plans is provided at Annex 2. In summary, this includes:

- **2010/11 Delivery Plans**
  This template focuses on what will be delivered next year, including:
  - **Delivery trajectories for 2010/11** for expanding IAPT services and delivering the training programme in accordance with the agreed national delivery commitments (see section 5)
  - **Establishing the position of IAPT Roll Out at 31 March 2011** outlining progress towards full roll out in each PCT

- **Gap Analysis**
  The Gap analysis will inform any business cases to support further local investment in the expansion of IAPT services, supported by the national IAPT Quality and Productivity Evidence Base. The template includes:
  - **Mapping the gap** - comparing in each PCT the full roll out plan and the position of IAPT services at 31 March 2011 in delivering:
    - Full geographical coverage
    - Percentage of need met
    - Full range of NICE-approved therapies and relevant clinical conditions (including PTSD)
- **Delivery support requirements** – SHAs may wish to outline the ways in which they will wish to work together with other SHAs and with the co-ordinating support of the national IAPT programme to support local delivery in the following areas:
  - Quality assurance support and advice, including clinical, workforce and education and care pathway redesign and improvement
  - Benchmarking and performance reporting – access to problem solving resources and examples of best practice which may be tailored to offer specific support for challenged local systems

- **Indicative roll out plans for the period 2011/12 and beyond** outlining how SHAs will:
  - Complete the workforce training programme
  - Sustain the workforce and training commissioning requirements
  - Work with PCTs to consider how to bridge the identified gaps in delivering IAPT services to the whole population in accordance with the agreed quality standards
9.0 Making the case for further investment through delivering quality and productivity

9.1 To achieve full roll out, SHAs will want to work with PCTs to consider ways in which IAPT services can continue to develop to address the issues identified in the Gap Analyses.

9.2 The outcome of this work will provide a common resource to support local commissioners to develop business cases for further investment and inform an updated national business case.

9.3 The national programme will focus on working with the NHS to make the case for further local investment in IAPT by demonstrating the evidence of quality improvements in successfully tackling unmet need and contributing to efficiency savings across the economy and across the NHS.

9.4 Work has already commenced with a Call for Evidence to SHAs to support the collation of a national evidence base demonstrating the benefits and savings that have been realised in localities by delivering IAPT. This will compile data on:

- **Health and wellbeing gains** – in addition to recovery rates, this will demonstrate the cost efficiencies that can be realised from people recovering from a four month course of therapy and the enduring effect of this treatment (over medication)

- **Mental health care pathway** – by rationalising the disparate flow of people with depression and anxiety disorders (i.e. from CMHT, counselling referral flows), IAPT can reduce pressure on primary care, and in time secondary care, allowing resources to be used more efficiently
o **Anti-depressant prescribing rates** – as IAPT services roll out, the opportunity exists to make more appropriate use of anti-depressants in combination with psychological therapies. Annually, the NHS spends in excess of £370m on this medication. Working with GPs and PCT Prescribing Leads to constrain these costs by changing GP referral and prescribing behaviour to make better use of new IAPT services is essential.

o **Reducing referrals for medically unexplained symptoms (MUS)** – it is estimated that as many as half of all GP referrals for acute specialist opinion are for people with no clear physical health problem, where the underlying condition is likely to be psychological. By diverting these flows to IAPT services, there is a potential for significant savings to be made.

o **Improving the management of long-term conditions.** Access to IAPT can help GPs manage people with long-term conditions more effectively in primary care, reducing the burden on more specialist services.

o **Helping people to stay in and/or return to work.** People who have received psychological therapies are 14% more likely to return to work.
10.0 Conclusion

10.1 The NHS has made excellent progress in making evidence based IAPT services available across many parts of the country. It has done this through additional local investment and innovating to ensure agreed IAPT service standards are applied in ways which are appropriate to local systems.

10.2 In 2010/11, the key challenges will be to continue to expand the availability of services, applying the lessons of the early adopters to inform new sites and develop maturing services and to consider what needs to be done to complete the roll out in 2011/12 and beyond.

10.3 The financial environment will make this task more challenging, but it is clear that the evidence base demonstrating the success of the new services in delivering impressive improvements in the health and wellbeing of local communities will, together with the contribution the new services can make to system efficiencies, provide strong arguments for securing any investment that may be required.

10.4 The NHS will lead this process by developing the Gap Analysis and 2011/12 Delivery Plans, which collectively will identify the scope and scale of the challenge ahead.
Realising the Benefits

*The IAPT Programme at Full Roll Out*

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First published 25 February 2010
Published to DH website, in electronic PDF format only.
http://www.dh.gov.uk/publications