Good Governance Institute

Connect Health

Board Assurance Prompt

Improving Access to Psychological Therapies

Good Governance Institute (GGI)

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What is this guide and who is it for?

Today, almost one in four people in the UK have a mental health condition. The Improving Access to Psychological Therapies (IAPT) programme was introduced in 2008 to improve the treatment of common mental health conditions by primary care organisations in England.

Since its inception, the IAPT programme has transformed the treatment of adult anxiety disorders and depression, and has grown year on year ensuring that more people than ever receive effective treatment. In 2018/19, 1.6 million people were referred to IAPT services and 1.09 million entered treatment. The programme is widely recognised as the most ambitious programme of talking therapies in the world.

Reflecting this success, the NHS Long Term Plan (LTP) proposed the further expansion of IAPT services, with a target of 1.9 million people to be seen by 2024. It also sets out sensible proposals for integrated IAPT services which have since begun to be acted upon.

However, in order to realise these ambitions, commissioners and providers of IAPT services will need to address a number of serious challenges; not least with significant known funding and workforce deficits, and the prospect of increased demand on mental health services as a result of COVID-19.

This briefing is therefore targeted at NHS commissioners and providers of IAPT services. It is intended to support such organisations to plan and manage IAPT services. In particular, it aims to help colleagues with no clinical background understand key healthcare issues relating to the provision of IAPT.

What are IAPT services?

The IAPT programme supports the frontline NHS to implement National Institute for Health and Clinical Excellence (NICE) guidelines for people with depression and anxiety disorders, comorbid long-term physical health conditions (LTCs), or medically unexplained symptoms (MUS).

IAPT services are commissioned by Clinical Commissioning Groups (CCGs) and typically operate through a hub and spoke model, which utilises a central administrative office but with face-to-face therapy provided much closer to where the patient lives, often in GP practices or community settings. Several key principles underpin the IAPT programme:

- **Ease of access**, including the use of self-referrals
- Offering the **most effective and least intrusive NICE-recommended psychological therapies first**, in line with a stepped-care model
- **Trained and competent clinicians**, who have regular clinical supervision that is outcome-focused and supportive
- **Meaningful choice** in treatment
- **Routine, session-by-session outcome monitoring**
- **Close links** with primary care, specialist mental health services third sector, social care and employment support

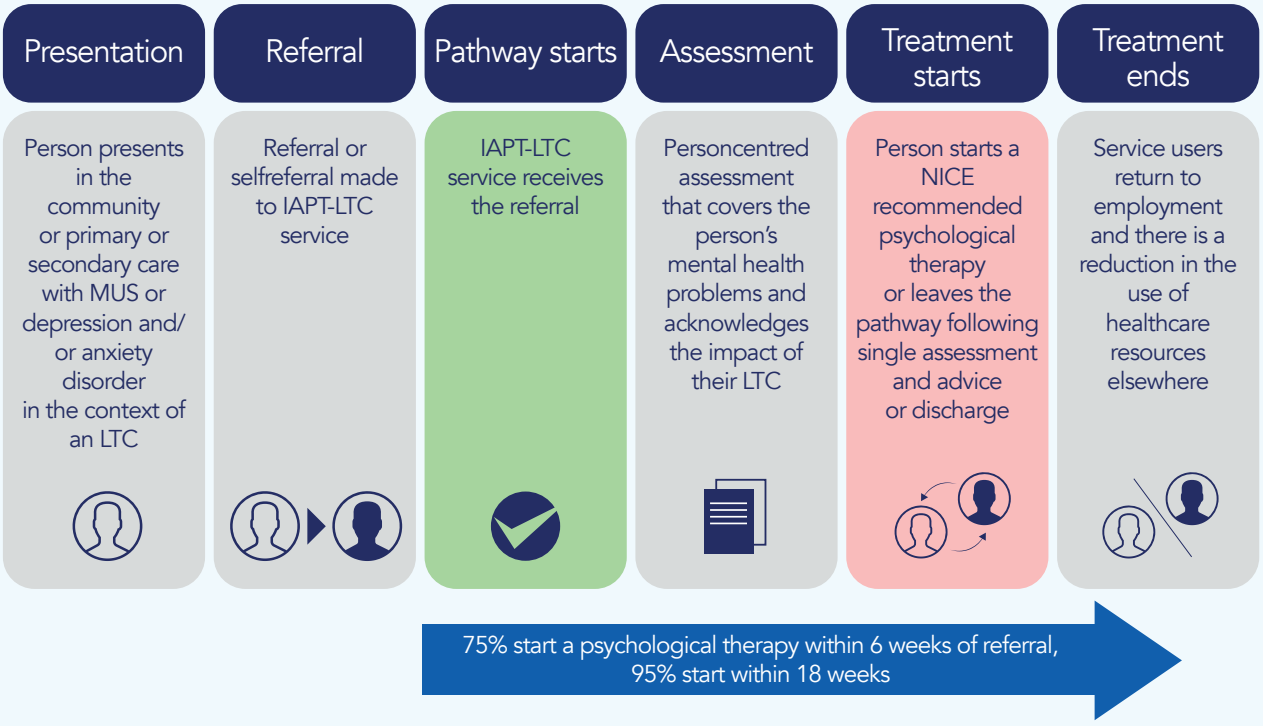
Services are delivered using a stepped-care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs first. Accordingly, 35% of patients receive low intensity treatment only, which includes guided self-help, online therapy and psychoeducation groups. A combination of low and high intensity treatment is received by 39% of patients, while 26% receive high intensity treatment only.

Thanks to the implementation of extensive routine outcome monitoring across all IAPT services, there is a significant amount of information demonstrating the effectiveness of the service:

- the average waiting time is now 19 days;
- 67% of those who experience a course of treatment show reliable and substantial reductions in their anxiety and/or depression;
- and 51% of these improve to the point at which they are classified as recovered in 2019-20 (representing a marked improvement from a recovery rate of 37% in 2009, and 52% in 2018-19)[1]

IAPT-Long Term Condition services

Adapted diagram showing IAPT Long Term Condisitons pathway.



National Collaborating Centre for Mental Health[2]

A key priority, outlined in the Five Year Forward View and reaffirmed in the NHS LTP, is for the greater implementation of 'IAPT-Long Term Condition' (LTC) services, which will expand access to psychological therapies by integrating them into physical healthcare pathways, often through co-location within GP surgeries. There is strong evidence for higher rates of depression and anxiety disorders in people with cardiovascular disease, diabetes, COPD and musculoskeletal disorders[3], as well as the fact that, for many, GP surgeries are the first port of call when a health issue arises.

Alongside the key principles of the core-IAPT programme, IAPT-LTC services can be characterised by following additional core principles:

- **Mental health case recognition methods** in general healthcare pathways
- **Co-location** with general healthcare teams and primary care
- **Revised IAPT assessment protocols and workforce**, in recognition that there are likely to be more high-intensity interventions and complex assessments conducted
- **Close links** with existing IAPT services, Core 24 liaison mental health services and clinical and health psychology services

1. https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-annual-reports-on-the-use-of-iapt-services
2. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/nncmh-iapt-ltc-short-guide.pdf?sfvrsn=12dcc7b2_2
3. For example, approximately one third of people with long-term conditions such as diabetes, also have a mental health problem.

Challenges associated with the delivery of IAPT services

Whilst it is widely accepted that the IAPT programme has been successful, this does not mean that its implementation and expansion has been without challenges, both historic and ongoing. We describe the central challenges below.

Access

We have already described how IAPT services have grown year on year since their inception. The NHS LTP reports that "more than half of patients who use IAPT services are moving to recovery, and nine out of ten people now start treatment in less than six weeks." It also envisages the further expansion of IAPT services so that by 2024, 380,000 more people are able to access them.

Although these are laudable achievements, they arguably mask certain deficiencies in service provision, particularly with regards to variation in quality of care. For example, research demonstrates that in some areas the average wait for a first appointment is four days, in others it is 55. Furthermore, across the country, the average wait between a first and second appointment varies between 13 and 112 days. Data analysed by NHS England suggests that as many as 100,000 patients who need treatment drop out between their first and second appointment each year. It is unclear how many of these do so because of waiting times but it is evidently a factor.

Reduced access and varying outcomes are particularly reported for BAME populations, although these figures are improving. In England, recovery rates vary from 33.5% (in Asian or Asian British-Pakistani males) to 50.5% (in White - Irish females). The reasons for this variation are complex, however, they demonstrate the need for more culturally appropriate services.

In 2013, a study by the mental health charity Mind revealed only one in ten people felt that their cultural needs were considered by the IAPT service they were offered. Cultural competence training, other forms of professional development, and community and stakeholder engagement are central to addressing this disparity. In practice, this may mean that the IAPT offer varies across localities, needing to be tailored closely to the cultural and demographic profile of different communities.

It is also predicted that demand for mental health services will increase as a result of COVID-19. This is the consequence of a range of factors including; heightened levels of social isolation during this period, the economic decline and the impact of increased levels of unemployment, the impact of losing loved ones (including trauma and complex grief reactions) and increased rates of sickness and trauma[4] amongst health professionals. Providers and commissioners of mental health services need to plan for this likely rise in demand, in accordance with social distancing rules and adjust appropriately. This will require increased investment (likely centrally led) as well as clear and robust steps to address the access issues outlined above.

Integration

Mental health problems are responsible for the largest burden of disease in the UK. It is therefore unsurprising that a recent survey conducted in 2018 by Mind revealed that around 40% of GP appointments involved mental health, and that this rate was increasing.

The colocation of Psychological Wellbeing Practitioners (PWPs) and therapists within GP practices is therefore both logical and central to the successful delivery of IAPT and mental health services. Despite this, IAPT-LTC services have, to date, had mixed success. Whilst it is recognised that they have increased the identification of those with common mental health problems, and introduced more trained therapists into typically 'physical' healthcare settings, there are also clear challenges around patient behaviour and the logistics of collaborative care that will need to be addressed moving forward. These include a reluctance amongst patients to associate psychological need with physical need, as well as confusion over which LTCs should be covered and where emphasis should be placed.

4. https://www.centreformentalhealth.org.uk/sites/default/files/2020-05/CentreforMentalHealth_COVID_MH_Forecasting_May20.pdf

Challenges around primary care estate are also a potential barrier to colocation. It is hoped that the establishment of primary care networks (PCNs) can support the modernisation of the primary care estate, as well as facilitate the expansion of IAPT into primary care and deliver real benefits to patients. However, these nascent collaborations are still in their formative stages and, in many areas, it is not yet clear how they will operate in practice. Beyond primary care, there is also likely benefit to be derived from collocating IAPT staff within other services. This might include a holistic approach such as within Job Centres and other such services.

Funding

The NHS LTP sets stretching expansion targets for IAPT services including investing in an extra 3,000 mental health therapists in primary care. Appropriate funding of IAPT services will be key to meeting these ambitions. The Plan commits the NHS to invest an additional £2.3bn each year by 2023/24. Mental Health Investment Standard requires CCGs to increase investment in mental health services in line with their overall increase in allocation each year, and all CCGs are currently meeting this standard. However, as has been well documented, mental health services have traditionally been underfunded - in England, mental health problems account for 28% of the burden of disease but only 13% of NHS spending.

It has been suggested that the stepped care approach within the IAPT programme can save the NHS up to £272million and the wider public sector will benefit by more than £700 million. Despite this, funding for IAPT services has not been ring-fenced and concerns have been raised about whether the achievement of national targets has been prioritised in local funding decisions. Indeed, research appears to indicate that some geographies spend half the amount of money on mental health per person in comparison to other places. Moving forward, it will be vital that commissioning bodies sufficiently fund mental health services including IAPT in order to ensure sufficient 'buy-in' for new models (such as LTC-IAPT) and for these to be effectively implemented.

Recruitment and retention

Organisations across the NHS are facing significant recruitment and retention challenges, and mental health providers are no different. The NHS Mental Health Implementation Plan 2019/20 - 2023/24 indicates that some 5,900 additional staff will be required in order to deliver the LTP ambitions for IAPT services. It will be important that these are appropriately trained and have the right skills mix especially for delivering IAPT-LTC. The importance of bodies such as Health Education England in promoting training for core and LTC IAPT as a well-defined career path will be paramount in attracting staff to the profession. However, research conducted by King's Fund, and others, indicates that we are likely to fall some way short of these targets, with some Trusts reporting particularly high vacancy rates for PWPs. It is hoped that the introduction of PWP apprenticeship schemes will widen access to training, however the impact of these is yet to be assessed. Others have indicated that IAPT-LTC training has been variable in quality, a challenge that has persisted during COVID-19 as training continued virtually.

This has ramifications for the current workforce as well as for the quality of care. For example, one study suggests that two-thirds of PWPs and half of the High-Intensity therapists, experience higher levels of emotional exhaustion, and depersonalization than seen within the broader mental health workforce. This may also be associated with the significant reporting demands placed on staff by both commissioners and national bodies.

Within the IAPT programme there are also a high proportion of staff on short-term contracts, and working across multiple employers. As a consequence, the British Medical Association have warned that the improvements to IAPT set out in the Mental Health Implementation plan are 'at risk of being unachievable'.

Digital

As a consequence of mandatory outcomes measurement, IAPT is one of the most data-rich services within the NHS. There is considerable scope to expand the use of this data to improve service design and delivery, as well as to support a wider population health management approach within systems. Patient management software, such as Iaptus and PCMIS, will prove useful in this regard.

The COVID-19 pandemic has altered the way in which the NHS thinks about digital, fast-tracking behavioural and technological changes that may previously have taken years to embed. The change within Primary Care, in particular, has been transformative with greater public acceptance and utilisation of remote consultations. This has positive implications for IAPT, with the likelihood being that there will be greater uptake of digitally enabled therapies provided online or through mobile technology, supported by a trained therapist. Utilised effectively, this will help reduce waiting lists, broaden patient choice and improve access. It also has the potential to reduce the administrative burden currently placed upon staff and as a consequence help address workforce morale and wellbeing challenges.

IAPT providers will need to be cognisant of this societal shift and plan accordingly. What is already clear is that digital technology must drive service design if it is to have the maximum impact. It will also be important for providers, Health Education England, and NHS England to ensure there are enough skilled data analysts trained and in place to maximise the use of the data available.

NICE has assessed a range of digitally enabled therapies and published details of those which it deems appropriate on its website[5]. There are concerns about the clinical effectiveness of certain digital interventions for IAPT and so this should be the first port of call when considering implementation.

The rest of this guide

Overleaf are a series of assurance questions that board members and others developing services might ask to ensure that the local service development is progressing along sustainable lines to meeting the known needs of patients in the future and is focussed on better population outcomes. These assurance questions are examples only. We also provide our view about what an appropriate answer to these questions might look like, and also what an unsatisfactory response would be.

5. https://www.nice.org.uk/about/what-we-do/our-programmes/nice-advice/improving-access-to-psychological-therapies--iapt-/submitting-a-product-to-iapt#published-IABs

Example Assurance questions

Overview

1. What assurance is available that IAPT services are supporting mental health recovery and wellbeing and of the quality of the services?

Access

2. What are common mental health issues in the local geography and demographics? In what ways can IAPT services best treat these problems in a culturally appropriate way?

Integration

3. How are we seeking to serve as an anchor institution within our local community, contributing to physical and mental wellbeing, and collaborating with multi-sector partners to achieve these aims?

4. How successfully is the IAPT programme being used as a platform to bridge mental and physical health and wellbeing?

5. What assurance is available that staff delivering IAPT services are fully competent to do so, and are adequately supported within their own roles?

Digital

6. How are we assured that we are using data to best effect in improving IAPT service design and delivery, as well as contributing to a wider population health management approach?

Finance

7. How can we assure that previously ringfenced funds are still reaching the frontline staff providing services as well as ensuring growing targets are being met?

Improving Access to Psychological Therapies Maturity Matrix

TO USE THE MATRIX: CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION IS CURRENTLY WORKING TO AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS

PROGRESS LEVELS / KEY ELEMENTS	0 NO	1 BASIC LEVEL Priciple accepted and commitment to action	2 EARLY PROGRESS Early progress in development	3 RESULTS Initial achievements evident.	4 MATURITY Results systematically achieved over time	5 EXEMPLAR Others learning from our consistent achievements
ACCESS	Among lowest performing decile in average wait times for first appointment. Among lowest performing decile in average wait between a first and second appointment.	Plans in place to improve waiting times. Clear access criteria in place.	Waiting times improving and demonstrated results recognised by partners.	Standards for timely access to treatment being met. Demonstrated evidence of equity of access. Greater efficiencies through reducing duplication and the need for multiple assessments.	Evidence of IAPT contributing to improved outcomes for service users. Evidence of consistent improvements in access performance. Recovery delivered as part of population health management approach.	Waiting list management systems in place, delivering lower levels of missed appointments and utilising patient tracking. Providing learning to others in methods to improve and maintain high levels of performance in relation to access.
SERVICE USER EXPERIENCE	Absence of information on patient experience of services.	Feedback and engagement channels on patient experience in place. Data being collected and analysed.	Cultural competence training in place as part of ongoing professional development support. Community and stakeholder engagement programmes demonstrating impact.	Patent feedback and community and stakeholder engagement informing service design and delivery. Data available to show that service users feel actively engaged in the design of their care.	Evidence of positive patient satisfaction being consistently achieved. IAPT delivered as part of holistic approach for service users. Aligned provision with physical health services and strong partnership working delivering positive outcomes for service users.	Comparatively low dropout rates. Service users engaged in therapy, and service user choice available. Nationally recognised as a leader in positive patient experience. Providing learning to others in methods to improve and maintain high levels of patient satisfaction.
PEOPLE	Recruitment and retention challenges are impacting the quality of the service and preventing adequate standards being met. Leadership is not conducting staff surveys in order to improve staff experience.	Local leadership recognises issues faced by staff and acknowledge the need to take responsibility for challenges. Recruitment and retention challenges are impacting negatively on service provision. Multidisciplinary team in place composed of senior clinicians and managers.	Staff burnout is being reduced through increased provision of clinical support. Staff survey results are improving indicating better support for staff. This is reflected in better recruitment and retention rates. Staff are trained to adequate level with assurance process being developed.	Good staffing retention levels leading to a compassionate service reflected in patient feedback. Strategy in place with evidence of maintaining retention and recruitment of staff such as a broad range of staffing engagement in place which is positively regarded by staff.	Robust assurance in place confirming high quality of staff delivering services with required qualification and training and development to enable professional development. Newly trained PWPs are receiving excellent training and support on the job to be able to deliver good therapeutic support.	Balanced caseload for staff, and comprehensive wellbeing programmes in place. Staff survey results are among the top decile in the country. Support and engagement programme within IAPT is recognised as a model for IAPT services elsewhere. Clinical leadership and clinical supervision recognised.
FINANCE	Providers unable to demonstrate they are effective and productive, and make the best use of available funding.	Lack of commissioning clarity on the local economic case delivered by IAPT services. Concerns about effective use of resources.	Service capacity required to deliver the identified level of activity is funded recurrently, with performance monitoring and contract levers in place to ensure that the agreed volumes of activity are being delivered.	Local leadership recognise the positive economic case being delivered by IAPT. Service is demonstrating robust financial management and an evidence-base for effective use of resources in delivering high quality care.	The service can demonstrate a positive financial performance benchmark, alongside positive results in service users returning to work and a reduction in the use of healthcare resource elsewhere.	Nationally recognised as a leader in demonstrating the financial impact of improved mental health and wellbeing. Evidence of consistent return on investment delivering improved outcomes for referred patients.
DIGITAL	Data collected not reliable. Outdated patient management software that means we are behind other IAPT services. Little digital provision available for patients.	Opportunities for digitally enabled therapies are recognised and being delivered as part of COVID response, however systems are limited and not as effective as they could be. Service users and those on the waiting list have awareness of digital tools available.	Digital Access is reducing burden on staff as well as waiting list. Plan in place to improve digitally enabled therapies and improving services with evidence base. Digital inclusion is part of IAPT strategy to ensure all service users can receive support during COVID.	Using Digital in Design & delivery. Digitally enabled service is being continually reviewed with impact being considered when delivering improvements. Data in IAPT in contributing to a population health management approach beyond the IAPT service. Digital inclusion strategy recognises the issues of digital exclusion are being recognised and planned for.	Digitally enabled therapy is available to patients with comparable outcomes to face to face therapies. Evidence of the impact service development through use of data, and in the accuracy of data. Strategy of how to continue digital improvements made during COVID are being considered in service discussions.	Data driven and reflective service in place, utilising capacity and demand modelling. Efficient administration supported by systems. Service is recognised as a leader in terms of digital innovation in this field and actively benchmarking with other orgs in this field. Digital inclusion is part of IAPT strategy to ensure all service users can receive support during COVID.
INTEGRATION	IAPT operates in a silo with little connection to other services. Little attempt to develop relationships with key stakeholders.	Little focus on how patients with Long Term health conditions are supported as part of wider system. Leadership recognise need to integrate service with other IAPT or primary care services, but this hasn't filtered to rest of staff.	IAPT service is working towards meeting Long Term Health condition targets, expanding specific condition support to wider patient base. Services located in GP and local health centres are supported by a multi-disciplinary team including a physiotherapist.	Service provided for a variety of patient groups that is appropriate for key local demographics, using data to inform and improve the delivery. Service is working towards integrating waiting lists with other local services.	Strong links built with other services e.g. MSK and other primary care services to deliver in a joined-up way. We are working closely with local providers to promote prevention in the community.	IAPT service has strong relationships with local services and services are delivered in parallel with integrated strategies to support changing population demographics. Service is working with other local services to ensure alignment in provision.

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GGI is grateful for the support of an educational grant from Connect Health to produce this Board Assurance Prompt.

Importantly, 25-30% of people reporting a long term musculoskeletal (MSK) problem also report depression or anxiety (England 2017). As a leading community services healthcare provider covering pain, MSK (musculoskeletal) conditions, IAPT, orthopaedics, rheumatology and occupational health physiotherapy services, serving over 350k NHS patients pa across 26 NHS partners, Connect Health has successfully partnered with the NHS for over 30 years, largely because of the extensive clinical expertise and strong focus on evidence and innovation-based service delivery and practice.

Find out more here https://www.connecthealth.co.uk/mental-health/

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