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Common Factors from National Support Team visits to IAPT services

North West
Leadership and Innovation Forum
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This presentation will cover

Current Performance from HSCIC 2013-14 Q4 data

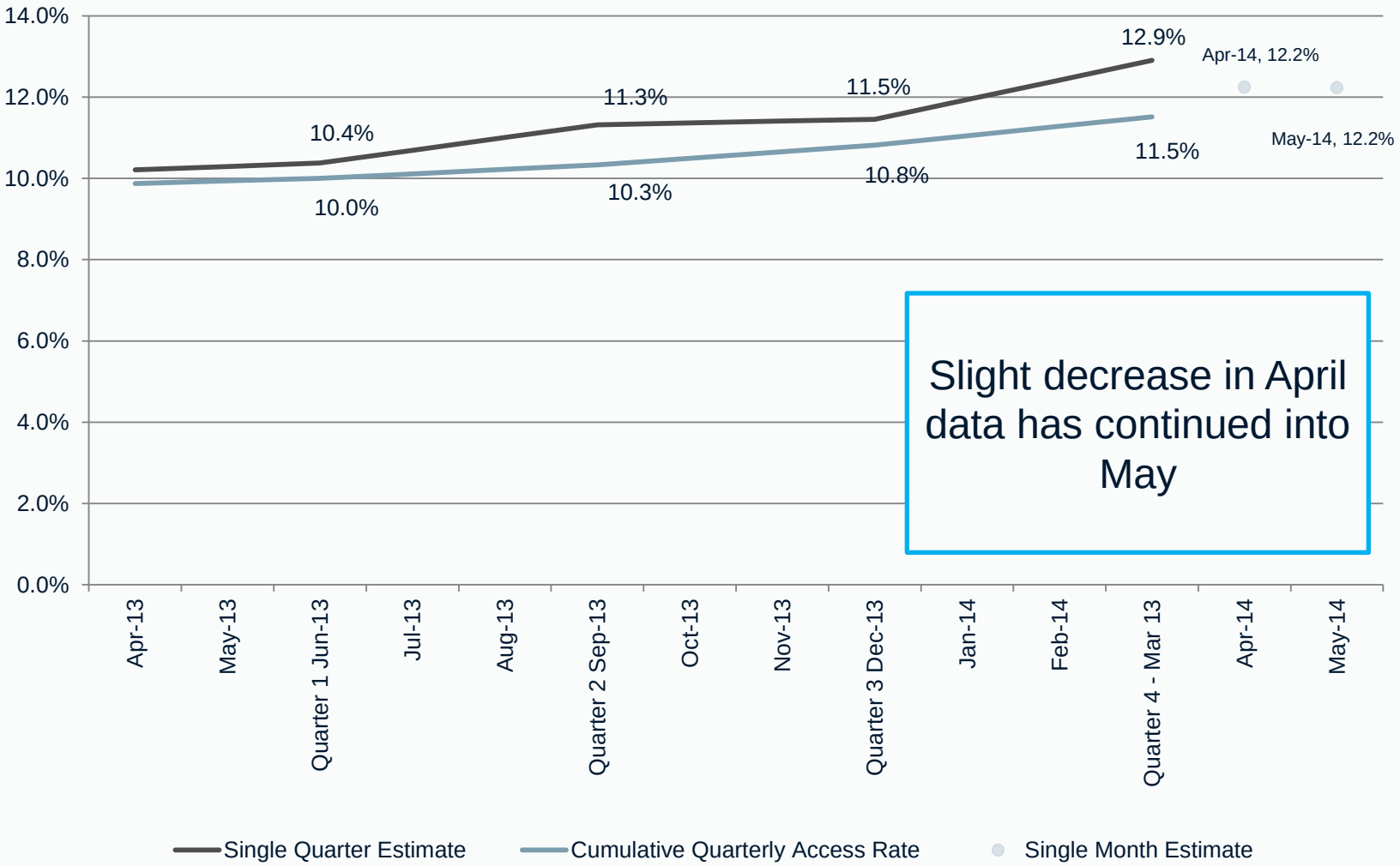
Highlight in more detail some key indicators from the Q4 data from the North Region Quarterly data pack produced by the NHS England IAPT team

Describe Common findings from in depth diagnostic visits and desktop assurance reviews

Highlight the importance Recovery and Reliable Improvement as well as Access

Refer to (and clarify) the IAPT Quality Standards throughout

Access Rates 2013/14



Data source: Improving Access to Psychological Therapies (IAPT) Dataset

Waiting Times

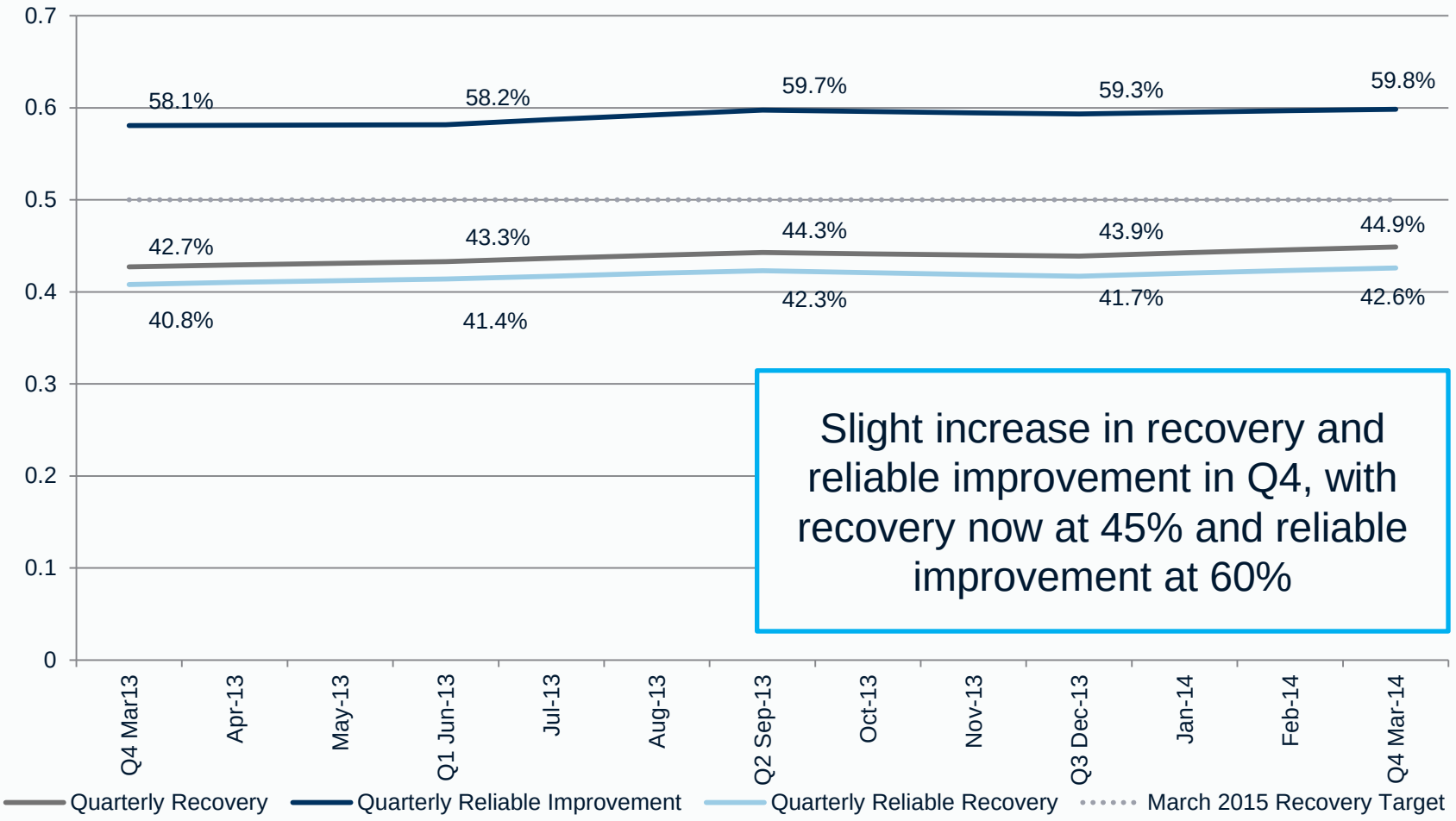
We routinely publish the length of time from referral to first treatment appointment in quarterly reports:

Quarter	Referrals with a first treatment in the quarter	Waited 28 days or less		Waited between 29 and 56 days		Waited between 57 and 90 days		Waited more than 90 days	
		Number	%	Number	%	Number	%	Number	%
Quarter 1	158,624	92,638	58.4	32,482	20.5	14,194	8.9	19,310	12.2
Quarter 2	172,984	103,542	59.9	34,197	19.8	14,283	8.3	20,962	12.1
Quarter 3	175,110	112,749	64.4	34,181	19.5	12,290	7.0	15,890	9.1
Quarter 4	197,221	122,221	62.0	38,718	19.6	15,672	7.9	20,610	10.5

In Q4 there has been a slight dip in the proportion waiting 28 days or less and a slight rise in those waiting for longer periods.

This suggests that waiting times have been longer in Q4.

Recovery Rates



Data source: Improving Access to Psychological Therapies (IAPT) Dataset

Data Quality and Provisional Diagnosis

SVODIM by Item (Valid %)

KEY					
	>=80		60-69		40-49
	70-79		50-59		<40

	Apr12	Apr13	May13	Jun13	Jul13	Aug13	Sep13	Oct13	Nov13	Dec13	Jan14	Feb14	Mar14	Apr14	May14	Jun14
NATIONAL	**61**	**71**	**71**	**72**	**73**	**74**	**75**	**76**	**76**	**77**	**77**	**78**	**77**	**78**	**77**	**78**
Appointment Type	44	58	65	68	68	64	66	77	79	82	83	83	81	84	82	85
Generalised Anxiety Disorder(GAD7)Score	63	92	92	93	93	93	93	93	93	93	93	93	93	93	93	93
GP practice Code	96	97	97	97	97	96	97	92	94	95	96	96	97	97	97	97
Patient Health Questionnaire (PHQ9) Score	63	92	92	92	93	93	94	93	93	93	93	93	93	93	93	93
Provisional Diagnosis	41	48	48	48	48	47	48	50	51	51	52	52	52	51	51	51
Therapy Types (1-4)	66	73	73	78	78	79	80	81	81	81	88	88	87	87	86	85

There continues to be little improvement with regard to completion of provisional diagnosis.

An additional area of concern is the decrease in valid appointment types being recorded in May.

Version 1.5 of the dataset is now live and appointment type is now mandatory – invalid appointment types being recorded will lead to rejection of the entire file. We will see the impact of this in the first publication from version 1.5 in November.

Regional data packs

The slides that follow are taken from the Regional data packs produced by the national IAPT team and published on the NHS England website http://www.england.nhs.uk/ourwork/sop/plan-sup-tools/iapt-packs/ to show the granularity of the data that is available and to highlight particular areas that impact on performance.

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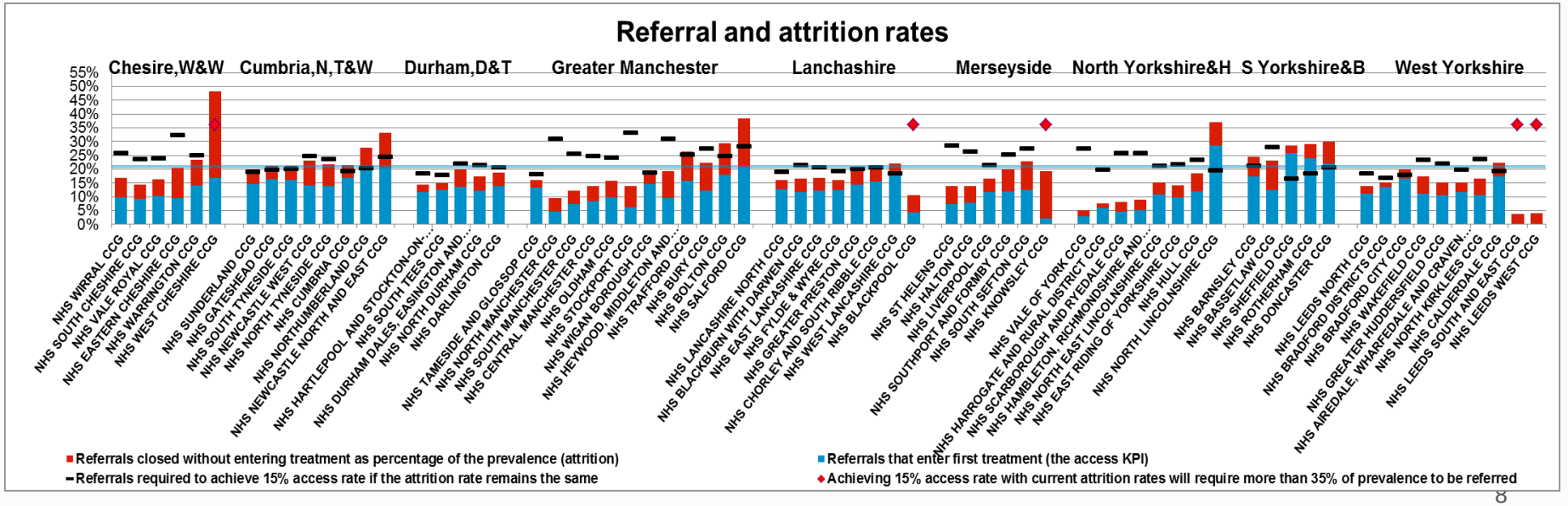
Referrals vs patients entering Treatment

(Q4 HSCIC published data)

Are the levels of referrals high enough and the attrition rates low enough to have 15% of prevalence entering treatment? Note the low opt-in levels (high attrition levels in many services

- Has the CCG got a clear plan to promote/market the service, increase self-referrals and raise psychological awareness amongst a wide range of health professions.
- Evidence: (<u>All</u> well performing LHCs have high percentages of self referrals; Changing your model or processes may reduce referrals



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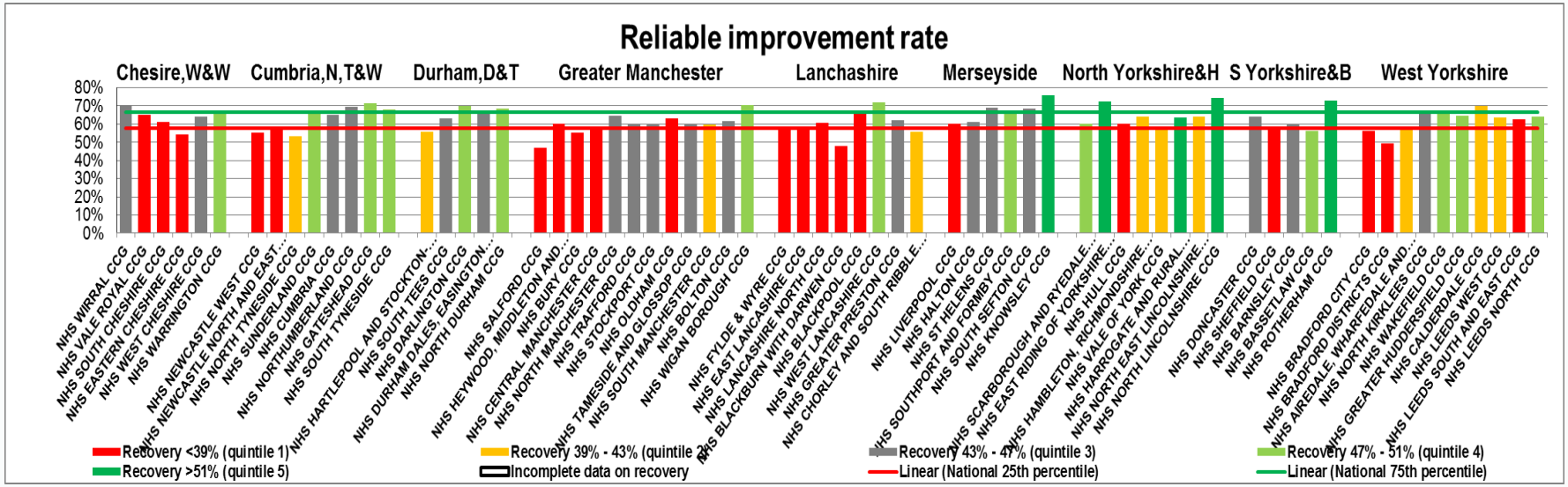
Outcomes -Recovery and Reliable Improvement (Q4HSCIC published data)

Monitoring Outcomes. There are indications that services are either 'good' on recovery and reliable improvement or 'not good' on both, suggesting there are organisational/systemic differences between good and poor performers, so not just a casemix issue.



Reliable Improvement is shown by the size of the bar and is the percentage of people that had statistically significant improvement in PHQ/GAD scores. Recovery is the percentage of patients who move from clinical caseness to below clinical caseness and is shown in five colours (red is worst 20% of CCGs, dark green is top 20% of CCGs)

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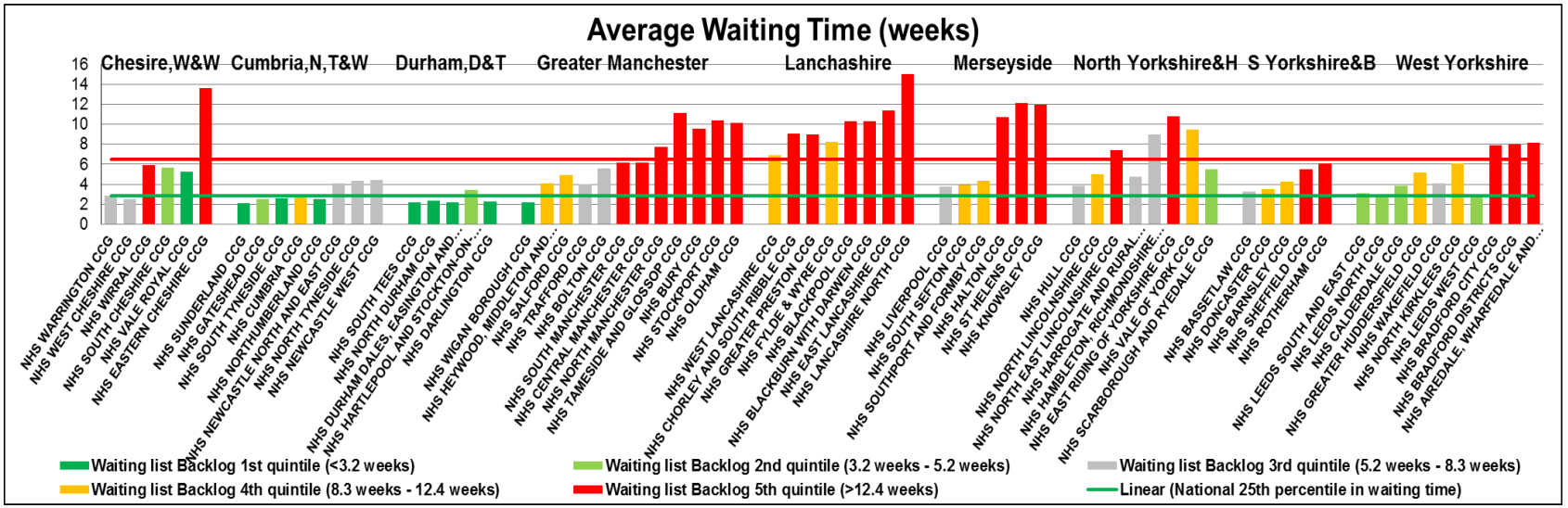
Waiting Lists (Q4 HSCIC published data)

There is strong evidence that long waiting lists suppress referrals. Additional to the 15% access volume, CCGs should have a plan to clear all waiting list that will achieve first appointments within 4 weeks for the *majority* of patients (not an average wait of 4 weeks). Are hidden waits being tackled once the patient is in the service, such as long waits for Step 3 or particular treatments /groups of staff. T



The hight of the bar is the average wait in weeks at first appointment in Q4. The colour of the bar related to the size of the waiting list (backlog) measured in weeks of activity in the backlog. There whould be a correlation between the two.

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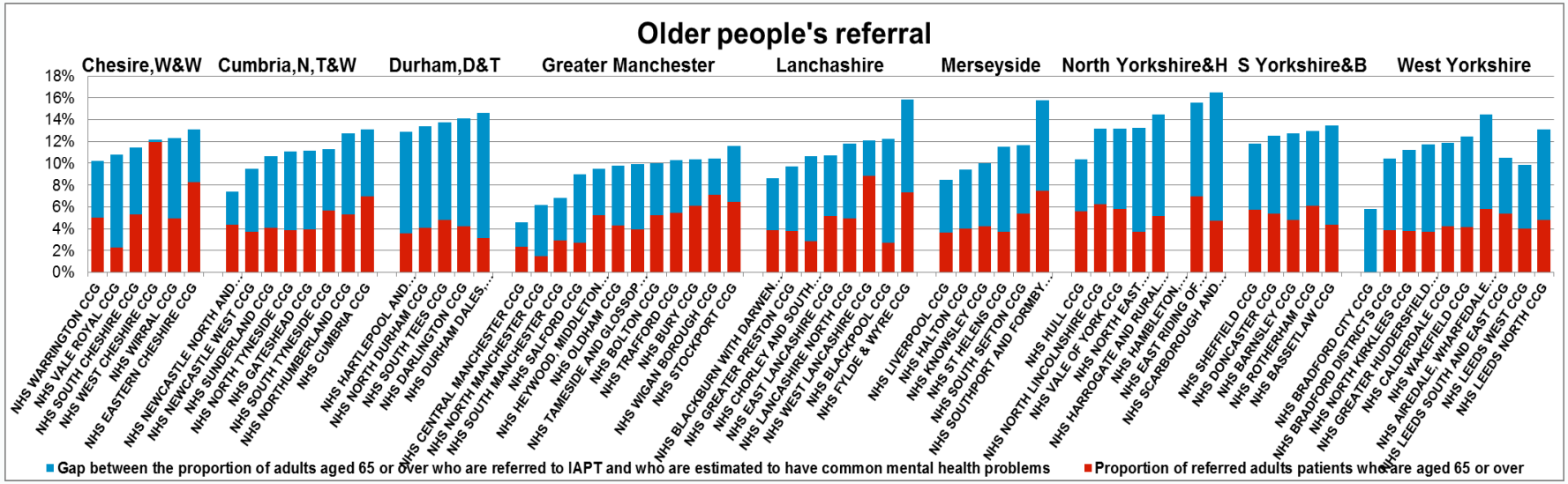
Equity of Access (Q4 HSCIC published data)

Services need to provide prompt access and equity of access ensuring inclusion of marginalised groups such as older people and the long term unemployed, under-represented clinical conditions (e.g. PTSD). There is a need for services and CCGs to monitor protected characteristics e.g. age, ethnicity, diagnosis compared with local prevalence.



Blue is the percentage of people in the CMHD prevalence that are aged >65 (CCGs with high proportion of older people in the population would have a taller bar), so the proportion of IAPT referrals that one may expect to be >65. Red is the percentage of people actually referred to IAPT that are > 65.

Recap on what the IAPT Programme set out to do

Five year program to Improve Access to Psychological Therapies

- Effective NICE approved, evidence based psychological interventions at Step 2 and 3
- A clear economic argument (keeping people in work/ready for work, keeping people well i.e. early intervention in CMHD, links with physical health).
- Previously unmet need. IRO £400M Additional funding to develop a new workforce (6000 posts by 2015).
- Adult roll out: Agreement in 2010 that 15% of prevalence would access psychological therapies, of which 50% would recover by 2015; based on the APMS 2000 prevalence of people with Mild to Moderate-Severe Anxiety and Depression - CMDH (Clusters 1-4), and is achievable.

Expectations from IAPT services in 2014

- Brief Intervention at Step 2 and 3
- CMHD (i.e. Clusters 1 to 4) but no barriers so some in clusters 5 and above
- Delivering NICE Guidance in a range of therapies
  - CBT for depression and ALL anxiety disorders
  - Counselling & Brief Dynamic Therapy for some levels of depression.
  - Interpersonal Psychotherapy
  - EMDR
  - Couples therapy
- Choice of therapy so that the most appropriate therapy is available to patients and services are developed to meet local need
- Outcomes are recorded – ROCR approved Minimum Data Set via Open Exeter
- Workforce trained and supported to deliver the above
- Potential to use the data set to include a wider range of patients SMI/PTSD/Psychosis (evidence base being developed)

iapt-for-adults-minimum-quality-standards.pdf - Adobe Reader

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IAPT for Adults Minimum Quality Standards

As IAPT services have matured and been evaluated, a number of key characteristics have emerged which appear critical in terms of assuring quality of delivery and achieving good clinical and other outcomes. These characteristics are set out below in the form of a series of standards with an accompanying rationale and suggested metric to support effective commissioning and delivery of IAPT services, and as a basis for service specifications, care pathway design and /or service audits for improving the quality of IAPT services.

	Standard	Rationale	Suggested Metric/Proxy measures
A	**Service Model:**		
1.	Services should offer a stepped care model that provides patients the appropriate level of care for their needs.	Services with a higher step-up among patients who have failed to recover from low intensity interventions will have higher overall recovery rates.	Proportion of patients who started treatment on low intensity, did not recover & then moved to high intensity.
2.	Services should include employment advisors or work closely with such advisors	There is a relationship between work and mental wellbeing. Improved non-clinical outcomes can help to release financial benefits to the local economy.	Movement off sick pay and/or benefits plus employment status

http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf

IAPT Programme v1.0 1

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IAPT Intensive Support – to date

Focus on Commissioners and Area Teams

- Five Commissioner Workshop have taken place. There has been subsequent support to commissioners and their providers in the use of the investment and sustainability tool.
- Actively communicating with eight Area Teams
- Strategic workshops in North West London and East Anglia.

Services

- High number of requests for support and feedback has been very positive.
- In depth Diagnostic Reviews completed for 6 services/locations (19 CCGs).
- Desk Top and in depth Assurance Reviews for 13 services (19 CCGs).

Tools and Guides developed

- Capacity and sustainability Checker
- Quarterly CCG data packs by Region and monthly time series for Access
- Area team / commissioner assurance check list
- National Risk list and Detailed individual CCG and provider dashboard for internal use
- In progress are: Good practice guidance; Capacity and demand and waiting list management tools for providers; a review of the IAPT Quality Standards

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The Capacity and Sustainability Checker

The next two slides show the Capacity and Sustainability Checker which is a tool available on the NHS England Website that that allow commissioners and/or providers to test various assumptions.

For example:

- The impact of changes to provider capacity/ productivity
- The impact of changing average sessions/casemix
- Impact of changes in referrals and attrition

http://www.england.nhs.uk/ourwork/sop/plan-sup-tools/

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Symmetric Partnership LLP

IAPT Capacity / Sustainability Checker v1

Introduction

This demand/capacity tool has been commissioned by the National IAPT team at NHS England. It is one of the tools developed by the IAPT Intensive Support team (IST) to assist commissioners and providers to realise the 15 % access and 50% outcomes targets.

The IST is available (at no charge) for consultation and can offer appraisal of local plans and services with continuing support where applicable.

Contact Els Drewek, Project Manager, at the National IAPT team for further information — els.drewek@nhs.net
Dean Repper, National Advisor and Implementation Support — dean.repper@nhs.net

IAPT Office — www.iapt.nhs.uk
Model developed by Symmetric — www.symmetricpartnership.co.uk

1 Getting Started

The Symmetric IAPT Capacity / Sustainability Checker is a simple spreadsheet that calculates:

- Whether a local service has enough capacity to cope with a given level of demand, based on a description of the service in terms of
  - Staffing
  - Number of sessions required per service user
  - Frequency of contact
  - DNA rates
- Whether the costs of providing that capacity can be met given a level of funding from a commissioner based on 'payment per completed treatment'

Hopefully, the spreadsheet inputs and outputs are self-explanatory. Most of the data items have additional explanations in the form of 'comments' that can be viewed by hovering over the number displayed.

Capacity checker model of iapt step23 v03 04_March201417 [Read-Only] - Microsoft Excel

File | Home | Insert | Page Layout | Formulas | Data | Review | View

Normal | Page Layout | Page Break Preview | Custom Views | Full Screen — Workbook Views
Ruler | Formula Bar | Gridlines | Headings — Show
Zoom | 100% | Zoom to Selection — Zoom
New Window | Arrange All | Freeze Panes | Split | Hide | Unhide | View Side by Side | Synchronous Scrolling | Reset Window Position — Window
Save Workspace | Switch Windows — Window
Macros — Macros

A1

Capacity / Sustainability Checker

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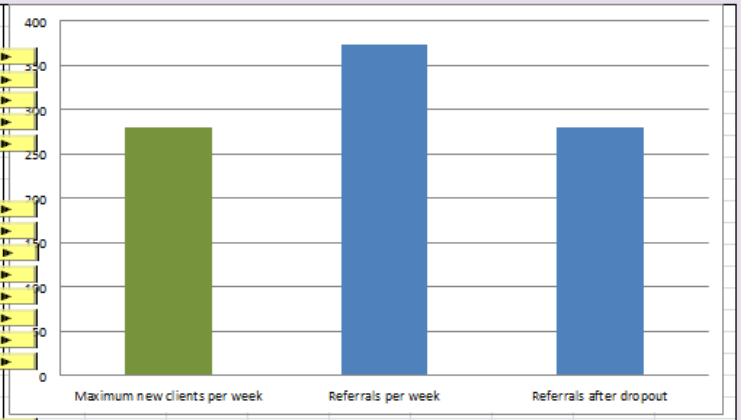
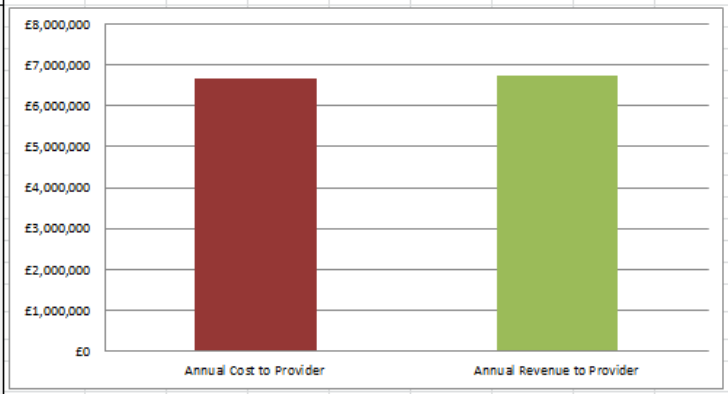
MAIN INPUTS	
People with Common MH Disorder	
Total adult population	645,180
Number with Common MH Disorder at any time	97,000
Perc of Prevalence referred to treatment pa	20
of which, % that drop out whilst waiting	25
Percent Treated who Recover	50
Service Specification	
Number of therapists (wte)	115.00
Treatment slots offered per week per therapist	24
Average duration of a treatment slot (minutes)	116
Weeks per year at work	43
Number of treatment slots needed per client	6
Weeks between treatments	2
Perc of appointments DNA	15
Costs (inc on costs) per wte	58000
Type of Contract	tariff
Annual Block Contract (if using that setting)	4200000
Payment per completed episode (if using tariff setting)	400
Supplement if good outcome (if using tariff setting)	125



MAIN OUTPUTS	
Annual Cost to Provider	£6,670,000
Annual Revenue to Provider	£6,729,375
Cost per clinical hour (actually delivered)	**£46**
Spend (by commissioner) per clinical hour	**£47**
Provider Cost per Episode	**£458**
Maximum new clients per week	281
Referrals per week	373
Referrals after dropout	280
Admissions pw	280
Total Caseload at any Time (people in treatment)	4,550
Actual clinical contact achieved (hrs pw per therapist)	20.3
Current Caseload as % of Prevalence	4.7%
Admissions as % of Prevalence	15.0%



you have spare capacity based on referrals	
you are solvent	
annual provider surplus or loss	£59,375

This simple model is based on Prevalence alone. To consider whether,

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Ready

75%

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IST Observations and Recommendations from in depth diagnostic reviews and desktop assurance visits

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Enhanced recovery high impact changes identified by well performing providers in a national workshop

…….We have observed many examples of good practice and are always keen to use those to share with other services

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Investment and Productivity

No clear evidence that one type of contract is better than another

- Good and bad block contracts, some have very effective CQUIN targets
- The need to be aware of the risk of perverse incentives e.g. in AQP contracts or CQUINs

Investment

- Investment must be linked to pathways; be clear what is being commissioned
- Underlying underinvestment is still an issue in some CCGs
- There is evidence of very low clinical contact hours per week in some services;
- The move to tariffs will make it essential that service efficiency (cost &volume, outcomes) and hence expectations from each member of staff are agreed and monitored

Capacity and Demand Modelling

- Bottom up! Based on reality. Understand the 'run rate' required, and backlogs to be cleared to achieve agreed waiting standards
- Once you are behind it is very difficult to catch up

Performance reports (many weekly!) are often not well developed

- Good individual efforts but no overview or assurance for team leaders, heads of service, COO, Board. Examples of reports required are PTL (patient tracking list); individual therapist reports
- Analyst support in large organisations can be limited and may not be delivering the reports required

Is a good clinician necessarily a good leader / manager?

- Individual efforts; skillset required; support required;

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The Model

Choice of Treatment - Some services are still largely CBT focussed

- Patients should be offered a range of treatments that are most appropriate for their needs

Lack of clarity on what could / should be reported

- Outcomes being measured and reported for some practitioners but not for others undertaking the same interventions.
- The full range of NICE/evidence based interventions; step 2 interventions as laid out in the PWP positive practice guide.

Services with high levels of complexity

- Investment may be covering unmet need at the SMI end and missing the low to moderate anxiety and depression within CMHD
- Lack of clarity in what is being commissioned

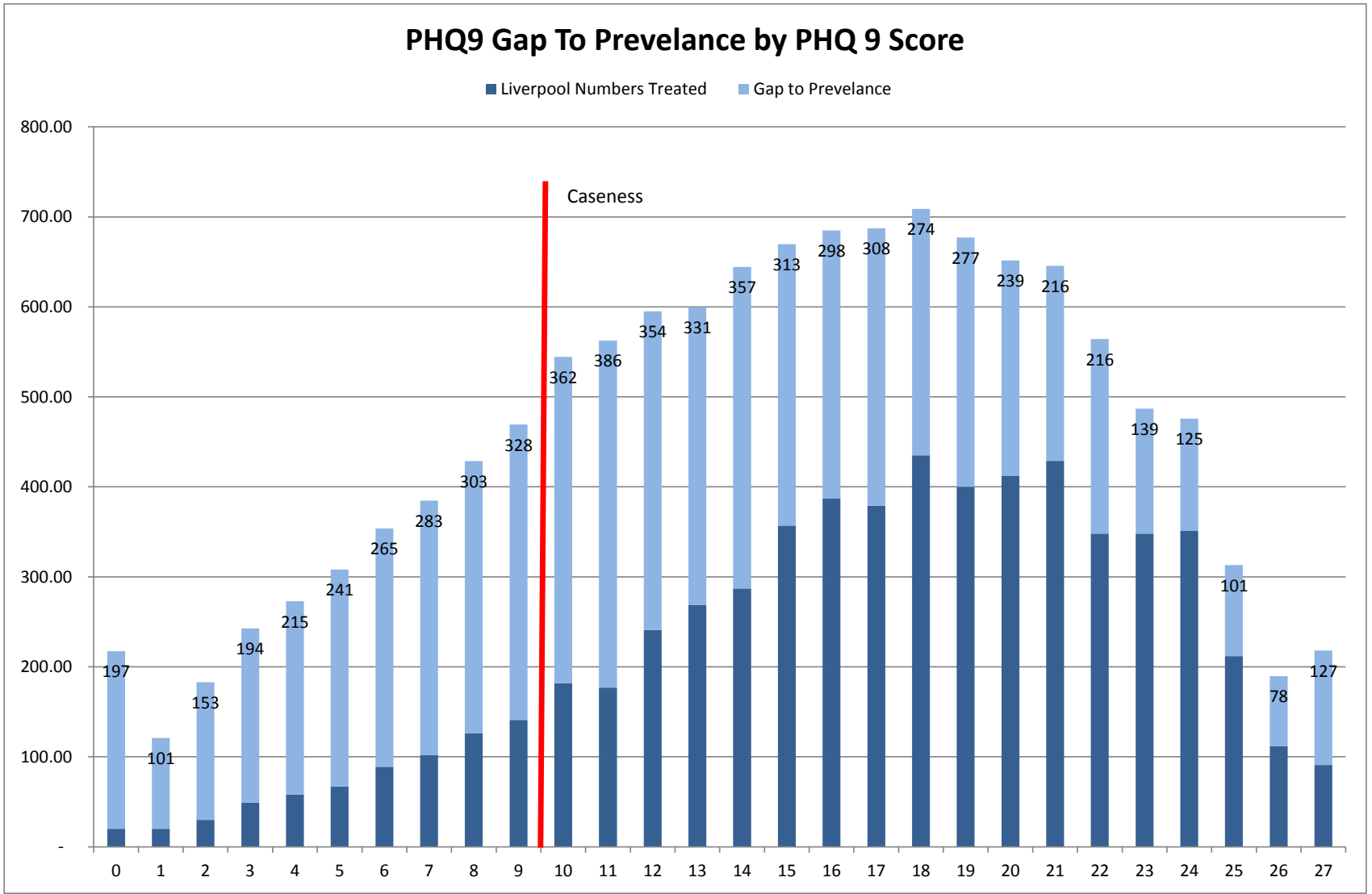
High levels of variation in percentage of Groups (>1% to 50% of contacts)

- What do good groups look like? – Competent staff; high recovery rates; % discharged from groups; patient satisfaction; step up to individual therapy;

Employment Advisors

- Availability of Employment Advisors in services and links with employment services vary and % moving off sick pay or benefits varies - Renewed focus expected

National PHQ Profile vs a service profile



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Complexity: Two ways of looking at Cluster data; Service 1 showing an exceptionally low percentage of patients in Clusters 1-3 (15%). Services 2-5 are more reflective of the case mix found in IAPT services (no national comparisons available yet)

0-3	4+	0-4	5+	Clusters
15%	85%	54%	46%	Service 1
57%	43%	90%	10%	Service 2
46%	54%	86%	14%	Service 3
47%	52%	72%	28%	Service 4
51%	49%	82%	18%	Service 5

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Access

Long waiting lists particularly at step 3

- There is strong evidence that long waits suppress referrals (from GPs and patients)
- There is also evidence from HSCIC data that short waits increase recovery rates at an organisational level.
- High levels of drop-outs may be linked to long waits

Coping strategies / behaviours noted to deal with long waits

- Adding layers to offer patients 'something' soon
- Supporting (treating) complex patients in ways other than psychological interventions to fill service gaps
- PWPs telling us they don't step up patients they know they should because of long waits at step 3
- Lack of attention to why large number of referrals are not opting in (lack of 'pull')

Equity of Access

- Older people access is well below the expected level in most local health communities
- Hard to reach groups – local issue but reliance on GP referrals will limit some groups accessing the service

Prevailing secondary care focus

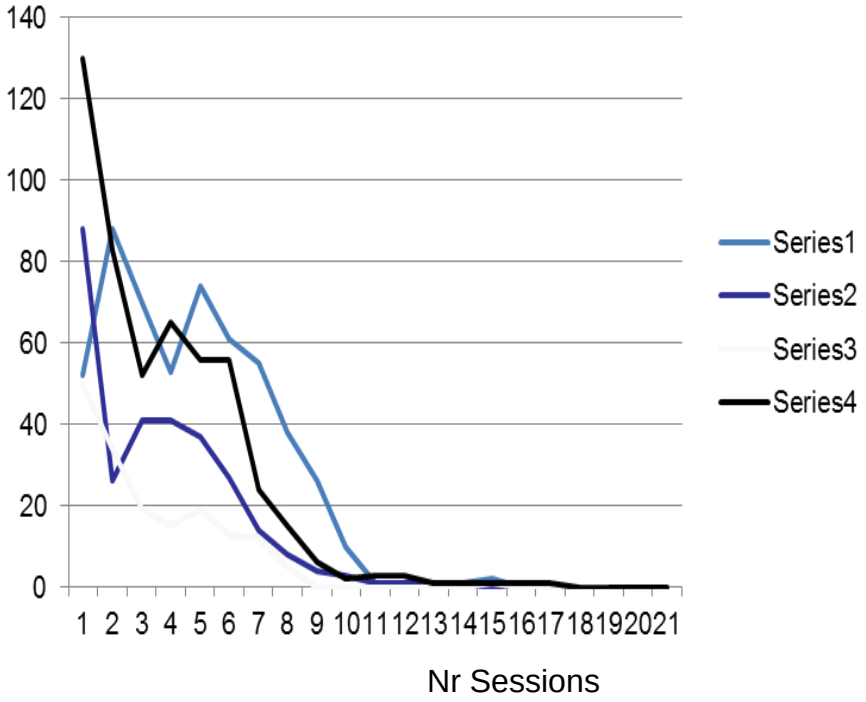
- Single points of access – risk adverse
- Low levels of self referrals and/or accepting self referrals but then insisting on full GP referrals/risk assess.

Acknowledgement that significant culture change and transformation may be required to address these issues

Distribution of average sessions - Example

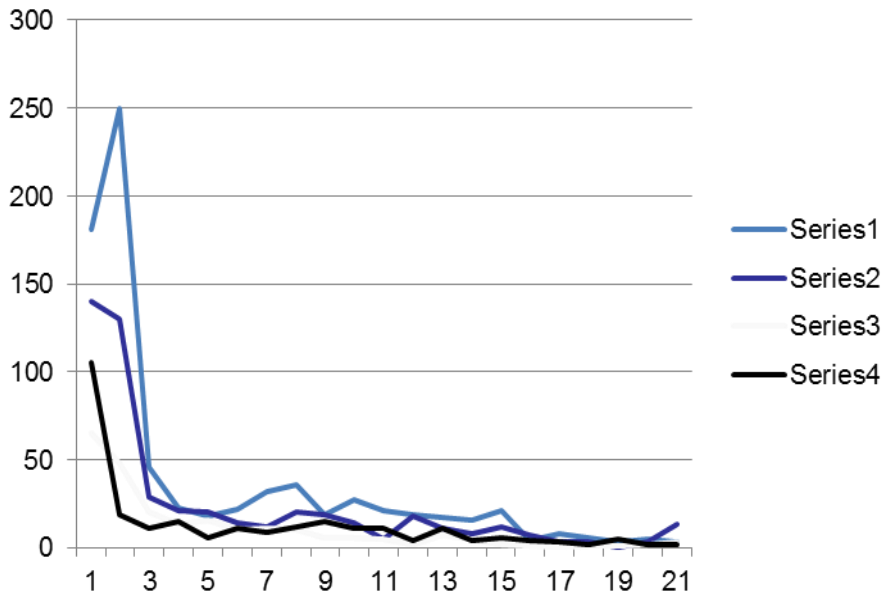
Below are the distribution of sessions in four different IAPT services in one provider. On the right the Step 3 graph shows high drop out rate (and indicates the average number of sessions at step 3 is low). On the left step 2 shows better completion rates, a peak at 4-6 sessions but quite high numbers of patients receiving 7-10 session (resulting in relatively high average sessions for step 2). The service has long waits particularly at Step 3.

Nr Patients **STEP 2**



Nr Sessions

Nr Patients **STEP 3**



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Enhancing Recovery - High Impact Changes identified by provider organisations at a national workshop (July 2014).

Triage and Choice

- Choice of treatments and access to alternative pathways
- Being able to identify the problem or diagnosis being treated (provisional diagnostics recorded).
- Providing NICE recommended therapies aligned to those conditions

Leadership and Staff Engagement

- Stable leadership with a real focus on recovery
- Attention to staff wellbeing
- Clinical Supervision – particularly to reflect on patients who are not improving.

Optimised Performance Management System

- Stepping people up if they have failed to recover
- Reliable and complete data;
- Optimised clinical productivity by data/ performance reports being available to the whole team and used in case management

Workforce

- A stable core of fully trained, experienced staff in the service

Commissioning

- The service is of sufficient size; Commissioning clear pathways; Avoiding perverse incentives

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http://www.england.nhs.uk/ourwork/sop/plan-sup-tools/iapt-packs/

http://www.iapt.nhs.uk/silo/files/iapt-for-adults-minimum-quality-standards.pdf

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