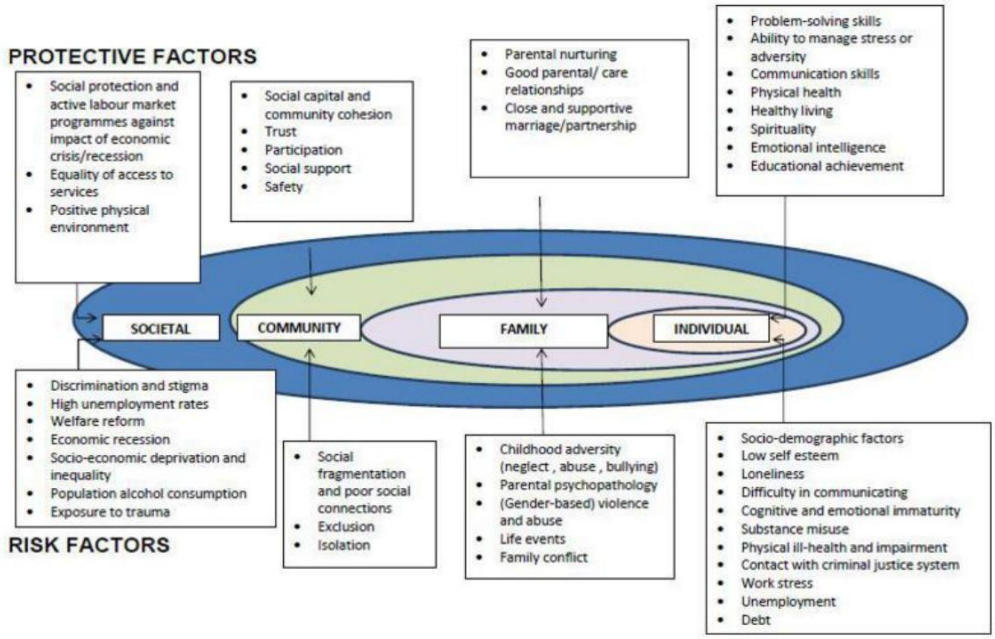
1. Population Needs

1.1 National/local context and evidence base

1.1.1 National context

Mental health is influenced by a wide range of biological and social risk factors. An illustrative model of risk and protective factors for mental health is shown in figure 1 below.

Figure 1: Risk and Protective Factors for Mental Health



Source: ***www.nhstayside.scot.nhs.uk***

Depression and anxiety disorders can have a devastating effect on individuals, their families and society. It is estimated that 16.9% of the 16+ population are experiencing a common mental health disorder at any one time.

Mental illness is a leading cause of disability in the UK and lost workdays. The cost of poor mental health to the economy is estimated to be far in excess of what the country gives the NHS to spend on mental health. So reducing the impact of common mental health disorders is not only a public health priority but an economic one.

Increasing Access to Psychological Therapies (IAPT) services provide a range of evidence-based psychological therapies to meet the needs of people experiencing a common mental health disorder in a timely manner.

Building on the Five Year Forward View for Mental Health, the NHS Long Term Plan prioritises the continued expansion of IAPT services for adults and older adults. By 2023/24, an additional 380,000 people per year will be able to access NICE-approved IAPT services, reaching 1.9 million people.

The priorities for service development are:

- **Expanding services** so that 1.9m adults access treatment each year by 2024.

- **Focusing on people with long term conditions.** Two thirds of people with a common mental health problem also have a long-term physical health problem, greatly increasing the cost of their care by an average of 45% more than those without a mental health problem. By integrating IAPT services with physical health services the NHS can provide better support to this group of people and achieve better outcomes.
- **Supporting people to find or stay in work.** Good work contributes to good mental health, and IAPT services can better contribute to improved employment outcomes.
- **Improving quality and people's experience of services.** Improving the numbers of people who recover, reducing geographic variation between services, and reducing inequalities in access and outcomes for particular population groups are all important aspects of the development of IAPT services.

1.1.2 Local context

Locally, it is estimated that the prevalence of common mental health disorders (CMD) is 16.6%, similar to the national average. Based on the GP population in Nottingham & Nottinghamshire, the below table describes CMD prevalence as a total and as a percentage of the population per Place Based Partnership (PBP).

	South Notts	City	Mid Notts	Bassetlaw	ICS
Population	389,355	388,570	340,895	122,610	1,244,740
%	31	31	27	10	
CMD Prevalence 16+	44,897	55,595	46,723	16,940	164,155
	14	21	16	18	
Anxiety	60,885	55,535	53,730	18,435	188,585
% Rate	16	14	16	15	
Depression	61,900	55,200	58,925	21,950	197,975
% Rate	16	14	17	18	
Severe Mental Illness	1,970	3,220	2,000	685	7,875
% Rate	0.51	0.83	0.59	0.56	

Source: eHealthScope (July 2022)

The Integrated Care System (ICS) all age mental health and social care strategy 2019-2024 identifies five strategic pillars to improve mental health in Nottingham & Nottinghamshire:

1. Increasing support for prevention, self-care and the wider factors that affect people's health
2. Implementing an approach that focuses on the individual (physical and mental health)
3. Improving access to services
4. Equipping a mental health-aware workforce
5. Establishing a truly integrated system

The strategy also identifies IAPT as a key enabler to delivering the strategy in enabling 25% of patients who require support to be able to access IAPT.

The Nottingham City Adult Mental Health Joint Strategic Needs Assessment (JSNA) for Nottingham City (2016) identifies a number of unmet needs and gaps:

- Citizens reported finding the system of mental health services confusing and difficult to navigate and were not always clear where to first turn for support.
- Promoting positive mental wellbeing requires active partnership work across statutory services, non-profit organisations, and voluntary and community services. In addition, communities themselves are well placed to tackle the factors that can impact on an individual's mental wellbeing.
- Broader understanding of mental health needs and the relationship with physical health needs to be improved at all levels within commissioning and provision including in physical health JSNA chapters
- The gap in life expectancy between people with mental health problems and those without needs to be reduced. This is an important priority for Nottingham City, and particularly with a focus on reducing smoking and improving identification of physical health problems early.
- Black and minority ethnic (BME) communities and high-risk groups, such as LGBT groups, offenders and asylum seekers/refugees may have challenges in terms of accessing mental health services. All commissioned services need to ensure they are able to describe the population that use their service so that gaps in access may be identified. Specific services to support community outreach need to inform wider services how to ensure services meet diverse needs.
- Mental health and employment indicators for the City show very high rates of people on out of work benefits due to mental health problems, and low employment rates for those known to secondary mental health care.

The Nottinghamshire County Adult Mental Health JSNA (2017) also highlights a number of relevant unmet needs and gaps:

- Accessing of mental health services is confusing and difficult to navigate and it is not always clear where to first turn for support. Signposting service information needs to be clearer and easily accessible.
- Broader understanding of mental health needs and the relationship with physical health needs to be improved at all levels within commissioning and provision including in physical health JSNA chapters.
- The gap in life expectancy between people with mental health problems and the general population needs to be reduced. This is an important priority for Nottinghamshire County Public Health and CCGs, and particularly with a focus on reducing smoking and improving identification of physical health problems early and improving access to LTC treatment to prevent emergency hospital admissions.
- As part of mental health recovery interventions access to employment is required to improve the employment rate for those in mental health services.
- Assessing for mental health problems is not routinely undertaken by health and social care professionals. Make Every Contact Count (MECC) needs to be utilised to raise awareness of mental health problems and sign posting to mental health services when required.

2. Outcomes

2.1 NHS Outcomes Framework Domains & Indicators

Domain 1 **Preventing people from dying prematurely**

Domain 2 **Enhancing quality of life for people with long-term conditions**

Domain 3 **Helping people to recover from episodes of ill-health or following injury**

Domain 4 **Ensuring people have a positive experience of care**

Domain 5 **Treating and caring for people in safe environment and protecting them from avoidable harm**

2.2 Locally defined outcomes

The Nottingham and Nottinghamshire ICS vision is "Our neighbourhoods, places and system will seamlessly integrate to provide joined up care. **Every citizen will enjoy their best possible health and wellbeing."**

Four key aims that IAPT will contribute to:

1. Improve outcomes in population health and healthcare
2. Tackle inequalities in outcomes, experience, and access
3. Enhance productivity and value for money
4. Help the NHS support broader social and economic development.

2.3 Nationally Defined Outcomes – Long Term Plan (2019)

a) 25% (minimum) of people entering treatment against the level of need* in the general population. **The level of need in the general adult population is known as the rate of prevalence, defined by the Psychiatric Morbidity Survey 2014.*

b) 50% (minimum) of people who complete treatment achieve recovery.

c) 75% of people referred to the Improving Access to Psychological Therapies programme enter treatment within 6 weeks

d) 95% of people referred to the Improving Access to Psychological Therapies programme enter treatment within 18 weeks

e) No more than 10% of people will wait longer than 90 days between 1st and 2nd appointment

f) Reduce the gap in recovery rate between BAME groups and their white counterparts

g) Increase access for over 65s

h) Increase access for people with long term conditions

Measuring outcomes, progress, recovery, and relapse is vital to ensure that people's treatment is reviewed, and where appropriate stopped, in line with the stepped-care model, if there are signs of deterioration or no indications of improvement (See NICE clinical guideline 123).

The collection of outcome data is a defining characteristic for IAPT and v2.1 of the minimum dataset (or subsequent versions) will be the primary source of measuring KPIs and outcomes.

The service is expected at all times to achieve the national standard , as well as the locally defined outcomes set in section 2.2. National requirements may be updated annually, and those targets will apply. Any non-achievement will result in contractual consequences.

3. Scope

3.1 Principles

3.1.1 IAPT services are characterised by three key principles:

1. Evidence-based psychological therapies at the appropriate dose: where NICE recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes.
2. Appropriately trained and supervised workforce: where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive weekly outcomes focused supervision by senior clinical practitioners with the relevant competences who can support them to continually improve.
3. Routine outcome monitoring on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person's progress. This helps guide the course of each person's treatment and provides a resource for service improvement, transparency, and public accountability.

3.1.2 Depression and anxiety disorders are extremely costly to individuals, the NHS and society. They can lead to a range of adverse psychological, social and employment outcomes. These may include:

- **Greater distress and poorer quality of life,** including higher levels of self-reported misery and disruption to a person's social, work and leisure life.
- **Poorer physical health**. For example, people with a diagnosis of depression (compared with those without) have a reduced life expectancy. They are also at increased risk of developing a physical health condition, such as heart disease, stroke, lung disease, asthma, or arthritis.
- **Unhealthy lifestyle choices**. Depression is associated with decreased physical activity and poorer adherence to dietary interventions and smoking cessation programmes.
- **Poorer educational attainment and employment outcomes.** There is a higher risk of educational underachievement and unemployment in people with depression and anxiety disorders. For those in employment, there is a higher risk of absenteeism, sub-standard performance, and reduced earnings.
- **Increased risk of relapse** if treatment is not appropriate or timely.

3.1.3 Mental health transformation sees the development of new ways of bringing together primary and secondary care with local communities, to support people with mental health conditions. As a key part of the system, IAPT plays a vital role in this transformation and is integral to true integration across mental and physical health, social care, the voluntary sector, and wider services. Throughout this transformation it is important that IAPT services remain in line with their evidence base and only provide support to those that will benefit from the uni-professional interventions offered.

(IAPT Manual: *https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf*)

3.1.4 Evidence Base

NICE-recommended psychological therapies form the basis of IAPT interventions. This is a key principle of IAPT because adherence to evidence-based interventions optimises outcomes.

IAPT provides evidence-based psychological therapies for mild, moderate, and severe depression and anxiety disorders where a uni-professional approach with or without concurrent medication management, usually by a GP, is appropriate.

A list of NICE-recommended psychological interventions can be found on pages 14-15 of the IAPT Manual.

3.2 Aims and objectives of service

The service will be a community-based service, building firmly on the Improving Access to Psychological Therapies (IAPT) programme *(https:www.england.nhs.uk/mental-health/adults/iaptl*).

It will offer a full range of evidence-based psychological interventions including NICE approved/recommended psychological therapies in line with relevant clinical guidance; associated with improved service user outcomes and recovery rates.

The service will deliver a stepped care (step 2 and step 3) model where time limited, psychological therapies is likely to have a positive outcome for the individual.

3.2.1 Aims of the service

- To ensure a local focus, as well as meeting the needs of the local population including ethnic minority communities, older adults, and students.
- Services will be easy to access with few points of escalation
- Focus on prevention and early identification, targeting interventions at risk groups.
- To integrate psychological therapies into physical health and long-term condition pathways.
- To provide a perinatal pathway for patients under the care of midwives and health visitors
- Services will be personalised, and outcome focussed recognising the service users own strengths, needs, life experiences, beliefs, aspirations, and support networks.
- Patients will be supported back to self-management and independence, wherever possible.
- The service will actively integrate with partners at system, place, and neighbourhood level, to reduce health inequalities, by delivering care in a range of settings and modes including Locality Hubs, GP Practices, health centres, community venues and the patient's own home, both face to face and via online mechanisms and telephone. Care location and mode will be based on the needs of the patient and available service offer.
- To make best use of available technology and digital options for service promotion, referral pathways and delivery of interventions.

3.2.3 Objectives

- To deliver evidence based, responsive and safe psychologically based treatment through the appropriate identification of individual need, using an identified and agreed assessment process, thereby identifying common mental health problems, and intervening early

- Ensure that any risks identified are reviewed regularly
- Pathways will be identified, co-developed and implemented at place level in response to the specific demands of local populations, driving integration across physical and mental health pathways e.g., long term conditions
- There will be co-designed local operational models which provide a seamless care pathway taking patients from primary care, mental health social prescribing, stepping up and down through the entire IAPT process (Steps 2 and 3), secondary care to discharge, regardless of entry and exit points to the pathway
- The provider will work with individual Places to develop and implement local pathways that focus on population level health outcomes, tackling inequalities and ensuring services are culturally competent and appropriate
- To ensure equity of access for all groups, including the most disadvantaged
- To deliver care and support around outcomes developed with the patient to enable them to live the lives they want to live, including good relationships, purpose, education, housing, and employment; working jointly with other services to deliver the right care and interventions at the right time
- To work with the third sector to support capacity and ability to support preventative and recovery for clients within and leaving the service
- To offer people age and developmentally appropriate information, a choice of high-quality evidence and/or good practice-based psychological therapies and modes of delivery choice (online, group, one to one, face to face, telephone, video or digital) where appropriate
- work closely with primary care, including mental health practitioners and social prescribing, to ensure that the physical health needs of patients with common mental health problems are met
- ensure that patients with needs for more intensive or specialist support are signposted/referred on appropriately
- engage and co-produce where possible with service users to ensure the views and experiences of service users inform service developments and improvements.

3.3 Service description/care pathway

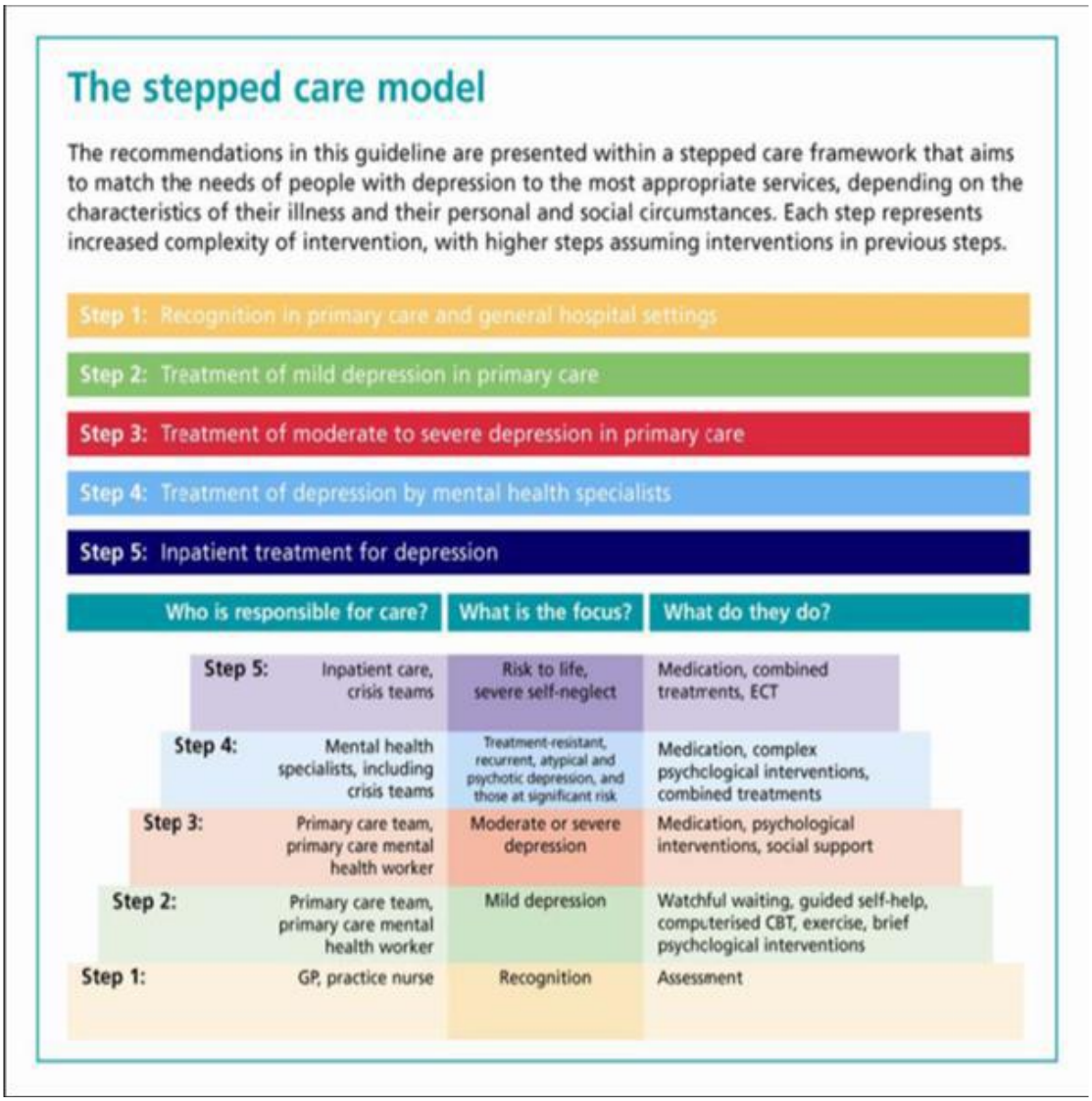
3.3.1 IAPT services are delivered using a stepped-care model (Step 2 and Step 3), which works according to the principle that people will be offered the least intrusive intervention appropriate for their needs first.

The stepped care model will ensure that local care pathways:

- provide the least intrusive, most effective intervention first
- have clear and explicit criteria for the thresholds determining access to and movement between the different levels of the pathway
- do not use single criteria (such as symptom severity) to determine movement between steps
- monitor progress and outcomes to ensure the most effective interventions are delivered and the person moves to a higher step if needed
- promote a range of evidence-based interventions at each step in the pathway
- support people in their choice of interventions
- In accordance with NICE guidance, some patients will be routed straight to high intensity interventions rather than stepped first through low intensity interventions which would not be effective in meeting their treatment needs.
- When patients are stepped up from Step 2 (low intensity) to Step 3 (high intensity), and vice versa for step down, this is classed as a single episode of care.

Many people with mild to moderate depression or anxiety disorders are likely to benefit from a course of low-intensity treatment delivered by a psychological wellbeing practitioner

(PWP). Individuals who do not fully recover at this level must be stepped up to a course of high-intensity treatment. NICE guidance recommends that people with more severe depression and those with social anxiety disorder or post-traumatic stress disorder (PTSD) receive high-intensity interventions first.



https://www.nice.org.uk/guidance/cg123/chapter/1-guidance

3.3.2 Assessment

Assessments will be person centered and cover the following:

- Providing information about the service.
- Presenting problem(s)
- A risk assessment (including self-harm or suicide, or harm to others)
- Completion of the IAPT Data Set

Type of assessment	Outcome for clinician	Outcome for patient
Screening/triage	Decision as to service eligibility and/or priority	Knows whether is accepted by service
Risk	Rating of degree of risk	If risk, knows the clinician has recognised this and agreed a plan
Diagnostic: including screening for all IAPT conditions	Accurate problem descriptor	Knows how the problem is defined and therefore understands the rationale for treatment intervention
Mental health clustering	Allocation to mental health cluster	Accesses the right package of care
Psychometric: correct outcome measures including ADSMs and MUS	Scores on measures to guide decision-making	Awareness of symptom severity and engagement with outcome measures
Problem formulation	Problem statement summary agreed with person	Able to talk about problems, feel understood and come up with a succinct summary that helps problems feel more manageable
Treatment planning: personalised goals	Agreed goals and decision as to type of treatment (based on the problem descriptor)	Has treatment goals and knows plan for treatment

The service will utilise capacity and demand modelling and implement best practice for managing waiting times, as outlined in the IAPT Manual.

3.3.3 Psychological Therapeutic Treatments/Interventions

IAPT will provide a range of evidence-based low and high intensity psychological interventions.

Key principles:

Treatment choice should be guided by the person's problem descriptor	CBT is not a single therapy but rather a broad class of therapies. For example, the indicated CBT for PTSD is very different from that for social anxiety disorder, both of which are different from that for depression. It is essential that clinicians work together with the person to clearly identify the primary clinical problem that they want help with before selecting a treatment type.
A NICE-recommended intervention	A range of NICE-recommended CBT and non-CBT interventions should be offered (see Table 2). This also includes the concurrent use of medication in moderate to severe (but not mild) depression.
Offer the least intrusive intervention first	The least intrusive NICE-recommended intervention should generally be offered first, but it is important that low-intensity interventions are only offered where there is evidence of their effectiveness. For example, a person with severe depression or other types of anxiety disorders, such as PTSD or social anxiety disorder, should normally receive a high-intensity intervention first.

Treatment should be guided by the person's choice	When NICE recommends a range of different therapies for a particular condition being treated, and where possible, people should be offered a meaningful choice about their therapy. Where treatments are on average similarly effective, giving people their preferred treatment is associated with better outcomes. Choice should include how it is provided, where it is delivered, the type of therapy and the clinician (for example, male or female).
Offer an adequate dose	All people being treated should receive an adequate dose of the treatment that is provided. NICE recommends that a person should be offered up to 14 to 20 sessions depending on the presenting problem, unless they have recovered beforehand. The number of sessions offered should never be restricted arbitrarily. People who do not respond to low-intensity treatments (and as such, still meet caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care.
A minimal wait	No person should wait longer than necessary for a course of treatment. Services should work to a high-volume specification with minimal waiting times for treatment (and within national standards), as well as facilitating movement between steps (see appropriate stepping).
Appropriate stepping	A system of scheduled reviews (supported by the routine collection of outcome measures and supervision) should be in place to promote effective stepping and avoid excessive doses of therapy. This includes stepping up when there is no improvement, stepping down when a less intensive treatment becomes more appropriate or stepping out when an alternative treatment or no treatment becomes appropriate.

The table below outlines the NICE-recommended psychological therapies:

	Condition	**Psychological therapies**	**Source**
Step 2: Low-intensity interventions (Delivered by PWPs)	Depression	Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme	NICE guidelines: NG222, CG91, CG123
	Generalised anxiety disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Panic disorder	Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT	NICE guidelines: CG113, CG123
	Depression	CBT (individual or group) or IPT	

Step 3: High-intensity interventions	For individuals with mild to moderate severity who have not responded to initial low-intensity interventions	Behavioural activation Couple therapy Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication.	NICE guidelines: NG222, CG91, CG123
	Depression Moderate to severe	CBT (individual) or IPT, each with medication	
	Depression Prevention of relapse	CBT or mindfulness-based cognitive therapy	
	Generalised anxiety disorder	CBT, applied relaxation	NICE guidelines: CG113, CG123
	Panic disorder	CBT	NICE guidelines: CG113, CG123
	Post-traumatic stress disorder (to include sexual or domestic violence survivors)	Trauma-focused CBT, eye movement desensitisation and reprocessing	NICE guidelines: CG26, CG123
	Social anxiety disorder	CBT specific for social anxiety disorder	NICE guideline: CG159
	Obsessive-compulsive disorder	CBT (including exposure and response prevention)	NICE guidelines: CG31, CG123
	Chronic fatigue syndrome	Graded exercise therapy, CBT*	NICE guideline: CG53
	Chronic pain	Combined physical and psychological interventions, including CBT* and exercise	NICE guideline: NG59 Informal consensus of the ETG

3.4. <u>Making Services Accessible</u>

3.4.1 The service will need to actively consider how to respond to the needs of the Nottingham and Nottinghamshire population at a neighbourhood, place, and system level. This will include complying with relevant equalities legislation and best practice guidance. The service is expected to make reasonable adjustments to ensure that it is open and accessible to the whole of our population.

3.4.2 Particular reference will be made to the needs of people with disabilities, people from black and other ethnic minority communities, and people from areas of high social deprivation, people who currently find it difficult to access current services and those who are under-represented within those services.

3.4.3 There is a specific expectation that people with a learning disability will not be excluded from the services offered and that reasonable adjustments will be made to ensure an inclusive service delivery model.

3.4.4 The service will be delivered in line with the requirements of the national and local autism strategy to ensure people with autism have access to mainstream public services wherever possible and in doing so will be treated fairly as individuals.

3.4.5 People who are deaf will be enabled to access services through the provision of appropriate support or referred onto SignHealth if more appropriate.

3.7.6 People who require help with language, such as interpreting, in order to access services will be provided with appropriate support.

3.4.7 The buildings must be accessible under the Disability Discrimination Act.

3.4.8 The service will meet the requirements of the Equality Act 2010, known as the 'protected characteristics'

3.4.9 The provider should consider the gender of the therapist where possible and offer a choice of therapist.

3.5 Days/hours of operation

Days and hours of operation are to be agreed. It is expected that there will be out of hours coverage (evenings/weekends) to ensure accessibility for those in work Monday to Friday.

The service will be offered in a variety of settings including General Practice/Health Centres and other clinical settings, in community venues, patient's own home and remotely.

3.6 Referral criteria and sources

The service will be responsible for promoting an increase in referral numbers in order that nationally required standards are met. This will require active marketing and promotion of the service and the development of partnerships and referral pathways with a range of other services and organisations including but not limited to long term condition services, maternity, and health visiting.

The service will accept professional referrals, guided self-referrals or self-referrals.

The service is appropriate for adults with depression and anxiety disorders who can be managed effectively in a uni-professional context. NICE-recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological

treatment, which is typically managed by the GP, though there may be some circumstances when medication is managed within secondary care.

IAPT services provide treatment for people with the following common mental health problems :

- depression
- generalised anxiety disorder
- social anxiety disorder
- panic disorder
- agoraphobia
- obsessive-compulsive disorder (OCD)
- specific phobias (such as heights or small animals)
- PTSD (trauma in response to threatening/distressing events including physical/sexual/emotional abuse/violence)
- health anxiety (hypochondriasis and medically unexplained symptoms)
- body dysmorphic disorder mixed depression and anxiety (the term for sub-syndromal depression and anxiety, rather than both depression and anxiety).

IAPT services will also provide interventions for people whose long-term condition has affected their mental health. This will include developing pathways with long term condition services, collaborating in line with national good practice guidance with long term condition services and jointly delivering programmes with long term conditions services.

Pathways will also be established with long covid services and those in the perinatal period to ensure that timely and appropriate interventions are accessible for these populations.

3.7. <u>Response time and prioritisation</u>

The provider will establish pathways for urgent referrals whose needs cannot be met within IAPT with secondary care mental health Single Point of Access and Crisis Resolution/Home Treatment Teams.
All routine/non urgent referrals for IAPT will be responded to within the national target times for assessment.

3.8 <u>Discharge Procedure (Care Transfer)</u>

The Provider will be required to have protocols in place for people who are identified as inappropriate for IAPT and onward refer as appropriate, avoiding bounce back to the GP wherever possible.

<u>3.8.1 Discharge</u>

Discharge is triggered at the last appointment (planned or unplanned) and does not include any follow-up arrangements. The discharge appointment is when the last clinical measure will count i.e., this is the measure reported on in terms of KPI / IAPT data reporting.

<u>3.8.2 Follow Up</u>

Where clinically appropriate, it is good practice to offer patients at least one follow-up appointment 3 to 6 months following discharge. Providers are asked to clearly detail their follow-up and re-referral protocols to patients, and these should be made available to

commissioners on request. Follow-up appointments may be by telephone, face to face, or digitally, and will be monitored using the IAPT MDS.

3.8.3 Re-referral

The incidences of re-referral within 12 weeks of discharge will be monitored and reviewed as per agreed follow-up protocols.

If a patient contacts the provider within 12 weeks of discharge for advice or one-off telephone contact in relation to the same problem (and this is all that is required) commissioners would anticipate that this contact **would not** constitute triggering a new episode of care. This should be recorded as Appointment Type 06 in v2.1 of the IAPT MDS (i.e., Follow-up appointment after treatment end) and would be part of the original episode of care.

Re-referrals accepted within 12 weeks of discharge will be on the basis of the patient meeting case-ness as defined in IAPT Technical Guidance. All cases re-referred within a 12-week period of discharge will be monitored. Commissioners reserve the right to review re-referral processes based on the reporting information extracted from the IAPT MDS.

3.9 Exclusions

The service will not accept for assessment and treatment any individual who are:

- A significant risk to self or others - all episodes of self-harm must be assessed in terms of severity of risk of harm, Historic or current self-harm, without suicidal intent, should also not automatically exclude someone from accessing the support of an IAPT service where clinical assessment indicates that the client's presenting problem is one suitably treated by IAPT (depression and anxiety related disorders).
- People with a learning disability who do not have a mental health need
- Those with a diagnosis of Dementia
- Are aged under 18 – unless working through transitions processes.
- Require a diagnosis for and management of ADHD / Asperger's
- Drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. The level of drug or alcohol misuse must not affect the person's ability to attend and engage in therapy sessions. If this is not the case, NICE guidelines recommend treatment for drug or alcohol misuse first.
- A person's involvement with secondary mental health care services must not lead to automatic exclusion from IAPT services. In principle, the greater the complexity of the presenting issue, the more substantial and multi-professional the package of care needs to be. Where problems are less complex, a uni-professional intervention, such as those delivered within IAPT services, may be the most appropriate, even if concurrent pharmacological treatment is provided by primary or secondary care services. However, for more complex problems, multi-professional interventions delivered by secondary mental health care services would usually be expected.

3.10 Population covered

Adults aged 18+ who are registered with a Nottingham and Nottinghamshire GP practice, in line with 'The Who Pays? Guidance'.

The 'Who Pays? Guidance' sets out the framework for establishing responsibility for commissioning an individual's care within the NHS and determining who pays for a patient's care.
https://www.england.nhs.uk/wp-content/uploads/2022/06/B1578_i_who-pays-framework-final.pdf

3.11 Interdependence with other services/providers

- People with lived experience and service user forums
- Criminal Justice services
- Crisis Resolution/Home Treatment
- Emergency services
- GPs and Primary Care including social prescribing and mental health practitioners
- Community health services including long term conditions, maternity and long covid
- Housing providers
- Secondary community mental health services including local mental health teams
- Rapid Response Liaison Psychiatry
- Social Care - Adult & Children
- Substance Misuse services
- Third Sector/ Voluntary and Community Sector
- Sexual violence services and specialist DSVA agencies; victim support and police
- Provider Collaboratives
- Health Education England

This is not an exhaustive list, and all forms of collaborative working are actively encouraged.

3.12 Workforce

Workforce standards can be found in section 4 below.

In addition to ensuring a competent and appropriately trained workforce, IAPT services will also:

- Provide in-house training opportunities
- Provide regular CPD opportunities
- Engage as required with commissioners, NHS England, and Health Education England with regards to workforce planning and recruitment of trainees
- Provide appropriate supervision for staff and trainees in line with the IAPT manual
- Implement local strategies to improve and sustain staff wellbeing
- Maintain standards of good practice for the retention of the workforce
- Record their workforce accurately and supply the Workforce Minimum Dataset to NHS Digital

4. Applicable Service Standards

4.1 Competency, Training, Education, Supervision and Research activities:

The provider will ensure that all staff are trained and competent to deliver services. Services are required to offer supervision and support to agreed professional standards;

these can be found on the IAPT website https://www.england.nhs.uk/mental-health/adults/iapt/workforce/

The service should carry out training with partner agencies in the identification of common mental health problems, will work (in conjunction with others) to educate universal and other services available to the general public on mental health and wellbeing issues relevant to the client group.

The service will conduct research where appropriate on issues relevant to the service area and client group and will contribute to Local, Regional and National networks linked to the IAPT programme.

Workforce

All IAPT clinicians should have completed an IAPT-accredited training programme, with nationally agreed curricula aligned to NICE guidance (or they should have acquired the relevant competences or skills before joining an IAPT service). All clinicians should be accredited by relevant professional bodies and supervised weekly by appropriately trained supervisors. The IAPT workforce consists of low-intensity practitioners and high-intensity therapists who together deliver the full range of NICE-recommended interventions for people with mild, moderate, and severe depression and anxiety disorders, operating within a stepped-care model. National guidance suggests that approximately 40% of the workforce in a core IAPT service should be PWPs and 60% high-intensity therapists. If IAPT-LTC is separate to core IAPT services, it is recommended that there is a slightly stronger focus on high-intensity interventions with the workforce being 30% PWPs, 60% high-intensity therapists and 10% senior therapists (such as clinical and health psychologists) who have expertise in LTCs/MUS and can manage more complex problems as well as providing supervision to others.

The service should have an appropriate skill mix within their team.

Recommended national and service level skill mix:

Training	**A Required % HIT capacity per service**	**B National % HIT capacity needed (estimate)**
Cognitive Behavioural Therapy (CBT)	70-90	80
Counselling for Depression (CfD)	0-7	3
Interpersonal Psychotherapy (IPT)	0-7	3
Dynamic Interpersonal Therapy (DIT)	0-7	3
Behavioural Couples Therapy (BCT)	0-10	4
Couples Therapy for Depression (CTfD)	0-10	4
Eye movement desensitisation and reprocessing (EMDR)	0-1	1
Mindfulness-based cognitive therapy (MBCT)	0-2	2
TOTAL		**100**

Assessment should always be provided by an appropriately trained member of staff. Treatment can be provided by accredited staff or staff working towards accreditation but supervised by a registered practitioner (i.e., appropriately trained, qualified, and experienced).

In terms of training and development:

- All staff should be appropriately trained to undertake procedures within the scope of their job role
- Staff should be culturally competent and able to respond to a range of diverse experiences and identities of clients. Through adaptation, the service should strive to meet the diversity of life experiences, lifestyles and backgrounds clients have (as outlined at http://www.iapt.nhs.uk/equalities/culturally-competent-practice/)
- All staff should be able to demonstrate Continuing Professional Development activity
- Staff should participate in peer review networks, appraisal, and Professional Development Plans

Workforce Planning

It is expected that Provider's workforce planning not only meets the demand, but ensures that it can meet access standards, and eliminates any hidden waits between assessment and treatment for example.

They will also engage with commissioners, regional and national teams in workforce planning including attending sessions, submitting returns as requested and recruiting at least the minimum nationally defined trainee expansion numbers each year.

4.2 Applicable national standards (e.g., NICE)

Providers must ensure compliance with national standards where these apply. This includes (but is not limited to) the following NICE guidance:

- NG 122 Depression in Adults
- CG113 General Anxiety Disorder & panic Disorder in Adults
- CG123 Common Mental Health Disorders
- CG91 Depression in Adults with Chronic Physical Health Problem
- CG31 Obsessive Compulsive Disorder
- CG26 Post Traumatic Stress Disorder
- CG16 Self-harm
- CG192 Antenatal and Post Natal Mental Health
- CG78 Borderline Personality Disorder
- CG159 Social Anxiety Disorder
- NG54 Learning Disabilities
- CG136 Service User Experience

Providers must also comply with IAPT requirements, including the Information Standard and Key Performance Indicator (KPI) technical guidance:

- https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual-v5.pdf
- https://digital.nhs.uk/data-and-information/data-collections-and-data-sets/data-sets/improving-access-to-psychological-therapies-data-set/improving-access-to-psychological-therapies-data-set-reports

(Or most up to date version)

IAPT-LTC Full Implementation Guide: https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/nccmh-iapt-ltc-full-implementation-guidance.pdf?sfvrsn=de824ea4_4

IAPT Positive Practice Guides support commissioners and providers to improve equity of experience, access, and outcomes for a number of specific underrepresented groups:

- Black and Ethnic Minority
- IAPT Positive Practice Guide for Working with People who use Drugs and Alcohol
- Learning Disabilities
- Long-term Conditions
- Medically Unexplained Symptoms and Functional Symptoms
- Offenders
- Older People
- Perinatal
- Veterans

All positive practice guides can be found at:
https://www.uea.ac.uk/about/norwich-medical-school/resources/improving-access-to-psychological-therapies-and-cognitive-behavioural-therapies-resources/about

5. Applicable quality requirements and CQUIN goals

To be included in the NHS Standard Contract

5.1 Applicable Quality Requirements (See Schedule 4A-D)
As per the agreed Quality Schedule.

6. Location of Provider Premises

The Provider's Premises are located at:

The service will be delivered from the providers own premises, GP practices and other community health services, and in various community venues.

7. Individual Service User Placement

Not applicable

8. Applicable Personalised Care Requirements

Not applicable