ENCLOSURE 5

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES RE-PROCUREMENT

SUMMARY:
To increase access to psychological therapies for those people suffering from mild to moderate depression and or anxiety. With the aim of having 25% of the mental health cohort population able to access Improving Access to Psychological Therapies (IAPT) each year by 2020. The current target is 15%. Of those people who access the service the aim is for 50% to leave the service in recovery.

The rationale for improving access to psychological therapies is to ensure that as many people as possible receive the treatment and support they need not only to address the immediate problems of anxiety and or depression but to also offset and prevent more complex and or chronic mental illness at a later date.

KEY ISSUES:

Background
Improving Access to Psychological Therapies (IAPT) is a key focus for the Five Year Forward Plan (2016 – 2021) for mental health and in particular, the Parity of Esteem Programme driven by NHS England 2013/14.

No Health without Mental Health, the Government Mental Health Strategy (DH February 2011), reinforces the need for continued improvements to wellbeing and the prevention of mental health problems in the population whilst re-emphasising the need to acknowledge the link between mental health and good physical health in achieving these goals.

Current Service
The current service contract comes to an end in March 2017 we therefore are working to a timeline that will ensure we have a service fully mobilized for the beginning of April 2017.

Access / Recovery
Getting the right numbers of people to access the service with the right level of need to respond effectively to NICE recommended effective talking therapies.

Through an effective marketing and engagement Programme and a single point of access that gets the right people to the right level of service first time of asking, the new service will ensure we meet the targets for achieving the percentage of population to access and 50%
recovery for all those accessing.

**Achieving target**
It is essential that we have a newly designed IAPT service capable of flexing and flowing to meet patient demand or we will not achieve the targets for 2020-21, of 25% of the population with common mental health problems (estimated to be 32,000 people in Bromley which equates to 8,000 people) accessing an IAPT service.

The aim is the new service will achieve this by getting patients who are IAPT compliant into treatment in the right numbers at the right stepped level of care via a single point of access at the right time every time.

**Proposed Model**
There are a number of models that can be used by commissioners to commission the IAPT service such as;

1. Prime Provider (with multiple providers delivering different steps via one contract with the prime provider)
2. Single provider (delivering all steps through one contract),
3. Alliance (delivering different steps via separate contracts),
4. AQP model which relies upon Any Qualified Provider tendering for all or parts of the delivery

The preferred model is the Prime Provider Model (option1)

Option 2 the single provider model does not allow for the range and diversity of options and choices to be available to patients

Option 3 is at risk of being uncoordinated and having built in hand offs within the overall system

Option 4 is at risk of inducing hyper completion as providers compete for patients to engage with their part of the system

Option 1 is the preferred option as it mitigates to reduce hyper completion with 1 contract, ensures there is diversity and choice by sub-contracting additional providers and provides overall coordination and governance of all aspects of service delivery.

**Proposed investment**

<table>
<thead>
<tr>
<th></th>
<th>Value 2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steeped Care</td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td>1,009,659</td>
</tr>
<tr>
<td>Step 3</td>
<td>1,596,752</td>
</tr>
<tr>
<td>Primary Care Interface</td>
<td>225,000</td>
</tr>
<tr>
<td>Total:</td>
<td>2,831,411</td>
</tr>
</tbody>
</table>
This has been agreed with finance and the clinical executive group and benchmarked to other IAPT services as being value for money (coming in at a mid-point).

The proposed performance (see attached spreadsheet) outlines the level of resource required in terms of staff, sessions to be delivered, for how many and for how long to ensure the service is able to meet both access and recovery targets.

As part of procurement regulations we are required to test the market to acquire competitive tenders of a newly designed service.

Throughout the procurement process we will be liaising with NHS CSU HR colleagues to ensure the right advice is received regarding staff equality and TUPE issues

Appendices
- Service Specification
- Spreadsheet Demand and Capacity modelling

**OVERALL RISK ASSESSMENT**

The overall risk to the procurement of the service is low as there is a robust time line and project management team in place which will oversee the procurement process through to completion in April 2017

**COMMITTEE INVOLVEMENT:**
- Clinical Executive Group 19th May 2016
- Clinical Executive Group 14th July 2016

**PUBLIC AND USER INVOLVEMENT:**
- Service User feedback on future service redesign received as part of the Healthwatch Consultation August 2015 and in November 2015.
- Market Engagement May 2016

At the service user feedback there was a clear message that awareness of and access to the service needed greatly improving. Once people were in the service they had a very positive experience; the biggest barrier was getting an appointment in the first instance.

At the Market Engagement providers were enthusiastic and supportive of the model being promoted namely the Prime Provider model and sub-contracting aspect which would allow for a more flexible work force to flex as required when there were peaks and or troughs in demand.
IMPACT ASSESSMENT:
Many people suffering from Long Term Conditions are at risk of depression and or anxiety. The service will have a positive impact in supporting people. The primary aim of the service is to support recovery from episodes of mental ill health.

The service will be provided to all residents of Bromley making appropriate modifications and changes to accommodate specific needs of individuals from Bromley's diverse population; be this in respect of disability, language, culture gender etc.

The impact of the service will be positive upon the health of those people with common mental health problems

RECOMMENDATIONS:
The Governing Body is asked to:-
• Approve to proceed to procurement of option 1.

ACRONYMS
Improving Access to Psychological Therapies (IAPT)
Quality, Innovation, Productivity and Prevention (QIPP)
Did Not Attend (DNA)
Single Point of Access (SPOA)
Commissioning Support Unit (CSU)
Transfer of Undertakings Protection of Employment (TUPE)

DIRECTORS CONTACT:
Name: Mark Cheung
Post: Chief Finance Officer
E-Mail: mark.cheung@nhs.net
Telephone: 01689 66104

AUTHOR CONTACT:
Name: Stuart Thompson
Post Interim MH Commissioner
Email: stuart.thompson3@nhs.net
Phone: 01689 866514

GP CLINICAL LEAD:
Name: Stuart Robertson
E-Mail: stuart.robertson2@nhs.net
Telephone:
### 1. Purpose

**1.1 Aims**

IAPT is a key focus for the Five Year Forward Plan (2016 – 2021) for mental health and in particular, Parity of Esteem Programme driven by NHS England 2013/14. No Health without Mental Health, the Government Mental Health Strategy (DH February 2011), reinforces the need for continued improvements to wellbeing and the prevention of mental health problems in the population whilst re-emphasising the need to acknowledge the link between mental health and good physical health in achieving these goals.

There are a number of approaches that can be used by commissioners when commissioning the IAPT service namely;

1. **Prime Provider** (with multiple providers delivering different steps via one contract with the prime provider)
2. **Single provider** (delivering all steps through one contract),
3. **Alliance** (delivering different steps via (separate contracts),
4. **AQP model** which relies upon Any Qualified Provider tendering for all or parts of the delivery

The chosen model is the Prime Provider Model (option1)

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Option 1 is the preferred option as it mitigates to reduce hyper completion with 1 contract, ensures there is diversity and choice by sub-contracting additional providers and provides overall coordination and governance of all aspects of service delivery.

The Key Service aims for the Bromley IAPT service are as follows:

- Reduce the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Increased proportion of people with common mental health disorders who are identified, assessed and receive treatment in accordance with appropriate NICE guidance.
- Improve access and support in order to maintain people in work, help them to return to work, help them into education or training and where appropriate help people to find meaningful activity.
- Improve emotional wellbeing, quality of life and functional ability in people with common mental health disorders.
- Improve individual’s well-being and functionality, this will include people with physical health problems.
- Increase social participation and community integration of service users.
- Improving service-user experience of mental health services.
- Improved access to screening for depression and anxiety of patients with a long-term condition, Older people and people from BME communities.

1.2 Evidence Base

NICE guidance recommends low intensity psychological therapy (step 2) as first line response before medication is offered for people with persistent sub-threshold depressive symptoms or mild to moderate depression; Generalised Anxiety Disorder (GAD); mild to moderate panic disorder and mild to moderate Obsessive Compulsive Disorder (OCD). Local primary care practitioners, across a range of disciplines (health trainers, health visitors, practice nurses etc.), encounter such needs in at least a third of their consultations and practitioners in community based services such as community centres (locally known as UCAN centres), housing or employment support report many more.

The most common method of treatment for common mental health problems in primary care is psychotropic medication. This is due to the limited availability of psychological interventions, despite the fact that these treatments are generally preferred by patients and recommended by NICE.

According to the Bromley Joint Strategic Needs Assessment, the prevalence of people self-reporting anxiety (nervous trouble) and depression within the previous 12 months has increased. The prevalence of people scoring above the GHQ12 threshold and therefore experiencing the symptoms of mental health problems has also increased in Bromley.

There is emerging robust evidence that the impact of rolling out IAPT compliant services can be significant and achieved relatively rapidly. For example, a general practice in England recently followed up a large cohort of its patients who had been referred to IAPT. It looked at how patterns of healthcare utilisation and therefore costs had changed between the period before referral and two years later. Some of the patients had not received IAPT treatment, some had received partial treatment and some had received full IAPT treatment. By comparing matched samples of treated and untreated patients it was possible to estimate how the treatment had affected their usage of physical healthcare. This short study found that annual expenditure overall had fallen substantially for the groups receiving IAPT treatment.
We have also learned from undertaking service user consultation and review of existing IAPT services that the following is also essential to delivering a successful service.

| **Excellent clinical leadership, with a real focus on recovery** | The overarching requirement for good leadership is not only at senior level but at team level, and includes: feedback of individual therapist performance, individually tailored Continuing Professional Development (CPD) for staff; benchmarking and active decision making by the whole team; individual accountability; and a culture of enquiry. |
| **Optimised performance management systems** | Including clinical supervision with a focus on data and recovery performance; accessible, reliable and complete data; tracking outcomes at an individual therapist level, and including this as part of performance management activity at a project level. |
| **Workforce stability and experience** | The best performing providers have good retention rates and highly skilled and experienced workforces. |
| **Assessment and access:** | Providers put an emphasis on correct assessment and getting the patients to the right therapists within waiting time targets this includes an accurate judgement of their presenting problems (including provisional diagnosis using ICD10 codes). |
| **Choice of NICE compliant treatments and access to alternative pathways** | discussing treatment choices with patients and identifying step-up or step-down options when appropriate to ensure patients are at the right place at the right time with the right therapist every time. |
| **Flexible number of sessions fitting clients’ needs** | Well performing providers generally had an open-ended approach to the overall number of sessions that could be offered. However, therapists and clients discussed sessions in terms of relatively short ‘blocks’ in order to help focus therapist and client on making progress (i.e six sessions followed by a review and further such blocks as appropriate). |
| **Data informed, service level reflective practice:** | Evidence indicates sustained increases in recovery rates have been achieved by systematically reviewing all non-recovered cases and taking specific actions on the themes identified as reasons for non-recovery. |
| **Work collaboratively with the local Third sector** | To support access for hard to reach groups and ensure there is a diversity of provision that reflects the needs of the local population. |
1.3 Local Strategic Context and need

The IAPT service will work with local health and social care commissioners to develop a step 2 & 3 IAPT service which meets the needs identified in Bromley's Joint Strategic Needs Assessment (JSNA):

Areas of need and most risk

- Age Peaks Middel Age
- Older People
- Gender
- Deprivation
- Ethnicity

- Alcohol Use
- Drug Use
- Contact with criminal justice system

Demography

- Working Patterns
- Caring Responsibilities
- Social Support Networks
- Ex Military Personnel

Behaviour

- Atenatal & Postnatal period
- Learning Disability
- Cognitive impairment
- Chronic Physical Health

Lifestyle

- National, mental health/psychological symptoms are common in the adult population affecting up to 1 in 3 people. Applied to Bromley, this prevalence would mean that 64,000 people are suffering from one of these symptoms at any one time. About half of those with symptoms, 1 in 6, will suffer from a recognised mental health problem including depression, phobias, obsessive compulsive disorder, panic disorder, generalised anxiety disorder and mixed anxiety and depressive disorder. In Bromley this would equate to about 32,000 people, of whom about 4,000 people will be known to secondary care services such as Oxleas Foundation Mental Health Trust.

The current estimated number of people with common mental health problems in Bromley such as depression and anxiety disorders, including posttraumatic stress disorder and obsessive-compulsive disorder, is circa 32,000. This would require 4,800 people to be accessing IAPT services each year to achieve the 15% annual access target. The five year forward plan for Mental Health requires IAPT to achieve 25% of population by 2020 this would require 8000 people to access the service each year.

1.4 Objectives

The service will provide

- Evidence-based psychological therapies, as approved by the National Institute for Health and Clinical Excellence (NICE), for people with depression and anxiety disorders
- Access to services and treatments by people experiencing depression and anxiety disorders from all communities within the local population
- Increased health and well-being, with at least 50% of those completing treatment moving to recovery and most experiencing a meaningful improvement in their condition
- Patient choice and high levels of satisfaction from people using services and their carers
• Timely access, with people waiting no longer than locally agreed waiting times standards
• Improved employment, benefit, and social inclusion status including help for people to retain employment, return to work, improve their vocational situation, and participate in the activities of daily living.

In the new prime provider model the lead provider will be responsible for ensuring IAPT is delivered;

• Equitably across Bromley (via multiple access points)
• At the earliest opportunity
• Targets hard to reach groups
• Increases self-referrals
• Improve accuracy of referrals from GP’s
• Through single standardised system of (access, assessment & referral)

1.5 Expected Outcomes

The service will be expected to measure and demonstrate positive impact in the following areas according to the targets set out throughout this specification:

• Recovery from common mental health problems
• Clinically significant change in common mental health problems
• Achievement of outcome goals jointly determined by the patient and clinician.
• Sustained recovery from common mental health problems, post intervention (within 3 month check up
• Mental wellbeing amongst those with common mental health problems
• Patient satisfaction with the service offered (quality, choice, timeliness, accessibility, appropriateness, transition from other services, transition to other services)
• Sustained patient satisfaction with the service offered, post intervention

1.6 Public Health Outcomes

The service will also be expected to demonstrate, as part of regular service evaluation, positive performance amongst individuals in contact with the service according to the following outcomes associated to the Public Health Outcomes Framework:

• Employment
• Diet
• Smoking prevalence
• 16-18 year olds not in education, employment or training
• Sickness absence
• Utilisation of green space for exercise/health reasons
• Hospital admissions as a result of self-harm
• Proportion of physically active and inactive adults
• Self-reported wellbeing
• Improve access to psychological intervention for people with the first signs and symptoms of common mental health problems
• Deliver a service for people with common mental health problems, according to a public health approach, according to known needs intelligence and as part of community engagement to reduce barriers and inequalities
• Develop the health and wellbeing agenda to support self-care/management through preventative/early identified initiatives and clearly defined care pathways
• Develop local Improving Access to Psychological Therapies (IAPT) services
• Target services more equitably and focus on mental and physical health needs, particularly amongst those people within the 9 protected characteristic groups (as referenced in the 2010 Equality Act).
2. Scope

2.1 Service Description

Referral and Assessment;
Will adopt a stratified approach to engaging people in the service, through a single point of access (SPOC) team via multiple access points. So that regardless of what step a referrer thinks the patient is at they will go to the assessment team to ensure they are then assessed accurately and get to the right service at the right time every time.

Step 2:
Will provide low-intensity service and will include the components below. It will be provided through individual and group sessions (as recommended in NICE Guidance) and will include both brief face-to-face contact and telephone support. Key elements will include:
Use of interventions detailed below (1-6 sessions, average 4 sessions):

- Education
- Bibliotherapy
- Behavioural activation
- Signposting o Guided cognitive-behavioural self-help
- Problem-Solving o Guided self-directed exposure therapy
- Referring to various services including social services and exercise referral
- Introduction to services - this will require the worker to accompany the client to the required service if support is needed.
- Computerised CBT (8 sessions)
- Concomitant medication advice and support for patients receiving antidepressant medication
  Telephone ‘collaborative care’ support for patients on antidepressant medication
- Individual CBT sessions with a therapist (6-8 face-to-face sessions, average 7 sessions)

Steps 3;
Will provide a high-intensity service and includes the following components:
Individual CBT (8-20 sessions, average of 12 sessions over 6 months)
Group CBT (6-10 people, up to 12 x 2hr sessions)
Therapy sessions should be supplemented by guided self-help when appropriate materials are available.

Concomitant medication advice and support for patients receiving antidepressant medication
Telephone ‘collaborative care’ support for patients on antidepressant medication

The provider will be responsible for case management and communicating with the service users GP when required, including referral to higher steps (specialist services outside the IAPT service, CMHTs, in-patient care). Step 3+ - 4 patients will be directly referred to those services that work with patients over a longer period of time and will include Oxleas Acute services.
2.2 Service Pathway

**All Referrals Direct to Single Point of Access (SPOA)**
Contact to be made within 2 working days

**Multi-Site Single Point of Access**
Assessment completed within 5 working days

**None Caseness**
Sign Posting Provided

**Outcome Measures Completed**

**STEP 2 / STEP 3**
Right Treatment, Right Place, Right Therapist, Every Time

**TREATMENT REVIEW**
Patient Discharged
Recovery Achieved
Significant Improvement

**Outcomes Reported To Commissioners**

**STEP 4 NHS**

**Long Term Complex**

**Step 4 required**
Patients are supported to access the most suitable service
2.3 Accessibility

The service will accept adult (16+) referrals. The service will work with people who are registered with a Bromley GP. The service is open to people with ‘sub-threshold’ conditions and, as such, formal diagnosis is not a requirement for access.

The service will be available during core office hours of 8am – 8pm, with at least two evening and weekend sessions as required.

The Service will not provide support to people under the age of 16 or with active severe conditions, i.e. psychosis, or for those at a high level of risk of suicide, self-harm or harm to others.

Where there are co-morbid difficulties including (but not exclusively) Substance Misuse, Eating Disorders, Learning difficulties and Personality Disorder the service will make reasonable adjustments to ensure the delivery of services. Clients will only be excluded on the basis of: other factors indicate risk levels are above those considered appropriate for management at step 2 or step 3; mental health needs are caused solely by their use of substances; use of substances is chaotic or unmanageable, or where the risks associated with use of substances are too high to be safely managed.

The service will directly accept self-referrals or referrals by a GP or other health and social care professionals and staff, including the third sector. Referral routes will not be reduced or restricted by service re-design or pathway re-designs in any aspect of the local system.

The service will engage with mental health services across all steps of intervention including those provided by public, private and voluntary sector organisations. Patients will be stepped up or down dependant on need. The service will also engage with community services focussed on health and lifestyle and support patients to access these, either upon discharge or parallel to intervention by the service, as appropriate. (this will include the newly commissioned Recovery Works Service)

The service will be responsible for providing detailed information, awareness and training on appropriate decision making regarding access to wellbeing and mental health support to those that refer or signpost to the service.

Domiciliary visits and telephone support will be provided where people are unable to attend health and community venues.

2.4 Interdependencies

In order to provide a stepped approach to care, the Provider will provide high quality low intensity interventions at Step 2 and ensure processes are in place to ‘step up’ patients where necessary to the local IAPT step 3 provider(s). The Provider will also have the necessary systems in place to receive patients who are ‘stepped down’ or referred appropriately from other providers and or parts of the system as part of a seamless care pathway for IAPT services.

It is expected that to develop adequate choice of services for people with common mental health problems, the service will develop robust collaborative working arrangements with current service providers, across sectors that contribute towards the social, psychological, health and welfare needs of people accessing the service. The provider will keep up to speed with local service developments and will ensure that appropriate partnership opportunities are identified and established.

The service will provide dedicated support to those people looking to retain and or gain employment and will have strong links to the newly commissioned Recovery Works service, for both receiving referrals and supporting people within employment. The 2.8 posts dedicated to this work in the current provision will be retained in the new IAPT service.

The Provider will be expected to demonstrate on-going engagement from key stakeholders specifically patients and their Carers in understanding and prioritising the needs of people with common mental health problems.

The aim of partnership arrangements will be to achieve the best outcomes for patients; the principles of partnership arrangements will be will be set out formally in partnership arrangement policies and
agreements. These principles will include detail such as referral systems, joint working arrangements and feedback and communication systems where appropriate.

Specifically, the Provider will work closely with the following partners:

- General practice
- Mental health services
- Substance misuse services
- Employment services and employers
- Offender services
- Public health lifestyle/wellness services
- Community and voluntary sector organisations

The provider will demonstrate robust and meaningful involvement of service users and those who care for them in the development and delivery of services, reaching each of the 9 protected characteristic groups (as referenced in the 2010 Equality Act). In addition the service will engage with people/groups who may inequitably access the service or who are at risk of poor mental health or who face barriers to accessing support.

These population groups include:

- Military veterans
- People living in deprived circumstances
- People with long term conditions (LTC)
- Older people living in isolation
- New parents
- people included within the 9 protected characteristics, especially those who have higher mental health needs.

Service delivery will be tailored to meet the needs of these population groups. Therapists will be trained and competent in understanding the complexities of each group and will have access to specific supervision in the provision of a service responsive to the diverse needs of local communities. Service delivery settings and information provided by the service will be responsive to the needs of these population groups and outcomes will be monitored routinely to establish the most effective model of working with specific communities.

3. Service Delivery

3.1 Service model

The service will provide multiple points of access via a SPOA, to increase ease of access recognising that people will not necessarily start at the same place however we know that ostensibly, most people with a mild to moderate mental health difficulty will access the Bromley Primary Care Psychological Therapy Services at Step 2 and receive a Low Intensity interventions.

Over time we envisage the system will increase in intelligence and be able to ensure for example returning patients get to the part of the system they require first time of asking without un-necessary stepping up and or down. This will be managed by the SPOA component of the service

The lead provider will be required to put in place a single information system which greatly enhance and support the management and flow of patients through a stepped care programme of delivery.

The Step 3 High Intensity Service will provide suitable assessment and psychological intervention appropriate to step 3 of the local stepped care system. After a decision to treat is made via SPOA assessment, the first contact with the individual shall be deemed as the start of treatment.

Regular outcome monitoring will take place. For Step 3 high intensity care this will be the IAPT
outcomes monitoring requirements at each session.

### 3.2 Single information system

The primary purpose of outcomes measurement is to improve people’s experience and benefits from the service. It also helps service providers improve their services. Additionally, collection of routine outcomes within IAPT services contributes to and helps monitor the delivery of national commitments, including the NHS Vital Signs. The service must follow the guidelines set out in the IAPT Outcomes Toolkit 2008/9, published in July 2008.

On average, the IAPT service will be delivered between 4-6 sessions:
- Pure self-help (such as books on prescription where there is no direct support in the use of the materials based on CBT principles)
- Guided self-help (which is facilitated and based on CBT principles and can be supported through face to face and/or telephone contact)
- Brief CBT
- Signposting
- Behavioural activation
- Psycho educational groups
- Problem solving
- CBT

Some people will access Step 3 at the outset, and these will be predominantly people with Post Traumatic Stress Disorder (PTSD), severe OCD, or severe Depression with significant risk. Although using a stratified approach some people will access step three initially based on the severity and impact of their presenting problems. Other people will access step three when interventions at step two have been deemed unsuccessful.

Indications from national IAPT data analysis suggest there could be 30% of people accessing step 2 care, later stepped up to step 3 interventions.

People will receive a high intensity intervention from the following list. This more structured approach will necessitate a contact of between 6-20 session (Average 12)
- CBT (including Group CBT)
- Interpersonal therapy (IPT)
- Counselling
- Couples therapy
- Behavioural Activation
- Applied Relaxation
- Any other IAPT recommended evidence-based therapies

Some people with complex needs will access step 4 care through being unresponsive to step three intervention.

### 3.3 Governance

There will be a requirement for the lead provider to put in place governance arrangements to manage the Bromley IAPT contract. This should be based upon positive contractual relationships that ensure:

- The governance arrangements are fair to all partners
- The roles and responsibilities are clear and understood by all parties
- Escalation routes are set out clearly with problems being solved as early as possible
- Communicating and sharing information with all partners at the appropriate level in each organisation

### 3.4 Managing Demand and Capacity

The service will clearly set out its plans to manage predicted periods of demand so that it has sufficient capacity at these key times. The service will also clearly set out and implement its plans to manage periods of down time typically Summer and Winter Holiday times. This should include the ability to flex staffing and resourcing at these times so that peaks and troughs in demand do not negatively impact on the service to both meet targets and also respond to patient and client need.
Below is an overview of the type of service modelling that will be required:

<table>
<thead>
<tr>
<th>Service Specification</th>
<th>Description</th>
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<tbody>
<tr>
<td>This table describes the amount of service to be provided. Note that one significant constraint is that the service consists of ‘treatment slots with a therapist’. It is possible to vary the number of sessions each user will need, and the frequency (number of weeks between sessions).</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Number of therapists (wte)</th>
<th>The number of whole time equivalent therapists employed. Increases (or reduces) total service capacity. Increasing this variable costs but may also increase income as more users are admitted. But increasing capacity above a certain level will lead to ‘insufficient income’ if not all capacity is used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment slots offered per week per therapist</td>
<td>The number of treatment slots offered per week per therapist. In most cases, a treatment ‘slot’ lasts for an hour, but the term ‘slot’ is used to accommodate local differences. The following variable (weeks per year at work) will adjust the capacity available for weeks not worked. Increases (or reduces) total service capacity without changing total costs. By increasing this variable, it is possible to generate more income for the same cost, but there is obviously a limit to how many clinical hours one therapist can deliver.</td>
</tr>
<tr>
<td>Average duration of a treatment slot (mins)</td>
<td>Average duration of a treatment slot / appointment Affects the cost and spend per clinical hour outputs.</td>
</tr>
<tr>
<td>Weeks per year at work</td>
<td>The average number of weeks in a year that one therapist will work, taking into account time off because of annual leave, sickness absence, training, or any other absence (typical values between 42 and 44 weeks). This factors in annual leave, sick leave etc. to the capacity calculation. Increasing this number will increase capacity without increasing cost, but for most providers the number of weeks worked per therapist will be fixed and hard to change.</td>
</tr>
<tr>
<td>Number of treatment slots needed per client</td>
<td>The average (or prescribed) number of sessions that one client will need (not counting DNA). This has a major bearing on capacity. Reducing sessions per client increases capacity for no extra cost, so financial indicators will improve but the service may become less effective.</td>
</tr>
<tr>
<td>Weeks between treatments</td>
<td>The frequency of contact expressed as a number of weeks between sessions. The most frequent would be ‘weekly’ (enter 1), the typical value entered is ‘fortnightly’ (enter 3). Note that this input has negligible impact on the maximum new clients per week, though it does increase the total caseload. Note that if a service user is seen twice per week, you could enter 0.5. Increasing this setting reduces overall capacity, thereby reducing the ‘max capacity’ and ‘insufficient income’ in the Annual Commissioner Contract. If payment per episode increases so will income, and all indicators based on income, such as ‘annual surplus or loss’ increases so will income!</td>
</tr>
<tr>
<td>Percent of appointments DNA</td>
<td>The input variable chosen is ‘the percentage of all appointments that are not kept’. So, if a typical service offers 100 appointments per week, and normally sees 80 clients, enter 20. The model assumes that if someone does not attend they will be offered a further appointment. Actually makes very little difference to capacity (in terms of max capacity and ‘insufficient income’ in the Annual Commissioner Contract). Increasing this number in the middle of a time period would result in a temporary increase in admissions per week, but they would soon revert back to the previous level.</td>
</tr>
<tr>
<td>Costs (inc on costs) per wte</td>
<td>The costs of the service are calculated simply as a cost per wte therapist plus on costs, so enter here the total annual service cost divided by the number of therapists. It would be possible to work up a more detailed costing calculation but we are keeping things simple here. This, along with the number of wte staff, determines the total cost of the service, so influences any output based on cost, such as cost per hour delivered, or overall solvency.</td>
</tr>
<tr>
<td>Type of Contract</td>
<td>Use the drop down control to select either ‘block’ or ‘tariff’. This determines how the ‘annual revenue to provider’ will be calculated, whether it will be based on a block contract or a tariff based on completed treatments.</td>
</tr>
<tr>
<td>Annual Block Contract</td>
<td>If using the Block Contract option, enter here the total amount of that contract. This determines how the ‘annual revenue to provider’ will be calculated when ‘type of contract’ is set to ‘block’</td>
</tr>
<tr>
<td>Payment per completed episode</td>
<td>If this service were to be commissioned based on activity rather than by a block contract, enter here the payment to be made per completed episode. This shows in the Annual Commissioner Contract. If payment per episode increases so will income, and all indicators based on income, such as ‘annual surplus or loss’.</td>
</tr>
<tr>
<td>Supplement per episode if good outcome</td>
<td>If there were to be an element of ‘payment by results’, enter here an ADDITIONAL amount payable per completed episode where the person has improved to the point of being ‘no longer unwell’. This operates in the same way as the variable above, by increasing the total amount payable for successful episodes (set as the ‘percent treated who recover’).</td>
</tr>
</tbody>
</table>
3.5 Performance Management / Finance

Treatment Waiting Times

In line with nationally mandated mental health waiting time targets:
In 2015/16 the following nationally mandated IAPT waiting times will be introduced:

- 75% of people referred to the Improving Access to Psychological Therapies programme will be treated within 6 weeks of referral, and 95% will be treated within 18 weeks of referral.

KPI Specifics.

- The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

- The proportion of people that wait 18 weeks or less from referral to entering a course of IAPT treatment against the number of people who finish a course of treatment in the reporting period.

Supporting KPI's

- The proportion of people that wait 18 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period

- The proportion of people that wait 6 weeks or less from referral to their first IAPT treatment appointment against the number of people who enter treatment in the reporting period

Proposed Investment

<table>
<thead>
<tr>
<th>Steeped Care</th>
<th>Value 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 2</td>
<td>£1,009,659</td>
</tr>
<tr>
<td>Step 3</td>
<td>£1,596,752</td>
</tr>
<tr>
<td>Primary Care Interface</td>
<td>£225,000</td>
</tr>
<tr>
<td>Total:-</td>
<td>£2,831,411</td>
</tr>
</tbody>
</table>
4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries
The Service will cater for any person registered to an NHS Bromley General Practitioner. The majority are likely to live within Bromley boundaries but not all. Those resident in other areas but registered with a Bromley GP will have the same access rights to Bromley services. There may also be some travelling or homeless people who are resident for short periods of time, that are not registered to any GP, who may be referred to the service.

4.2 Location(s) of Service Delivery
The service will be based within the community with care delivered from appropriate clinics/GP surgeries/other community locations (minimum 3 across the borough)

4.3 Referral Route & Sources
The service will ensure that referrals are maximised from every available source with particular attention being given to improving self-referral and the accuracy of GP referrals. All clients and referrers must be able to access the services they need easily, without unreasonable delay and by the most direct route possible. Clear policies of referral criteria and the provider’s complaints procedure must be available to all clients and referrers together with timely redress.

The service will be expected to be able to have a central publicised point for the receipt and logging of all referrals.

The service will be expected to be able to receive referrals from both professionals and patients through:
- Online portals
- Telephone
- Post
- Fax

In all instances, the service will ensure that the relevant GP practice has been informed about the patient referral.

4.4 Service Eligibility Criteria
The service will be expected to primarily with mental health care clusters 1-3:
- Care Cluster 1: Common Mental Health Problems (Low Severity) - This group has definite but minor problems of depressed mood, anxiety or other disorder, but they do not present with any psychotic symptoms.
- Care Cluster 2: Common Mental Health Problems (Low Severity with Greater Need) - This group definite but minor problems of depressed mood, anxiety or other disorder, but not with any psychotic symptoms. They may have already received care associated with Care Cluster 1 and require more specific intervention, or previously been successfully treated at a higher level but are re-presenting with low level symptoms.
- Care Cluster 3: Non-Psychotic (Moderate Severity) - This group has moderate problems involving depressed mood, anxiety or other disorder (not including psychosis).

Eligibility criteria include people presenting with at least one of the following conditions, either as a sole or co-morbid diagnosis, where a psychological therapy intervention would be appropriate.

4.5 Assessment/Screening
The service will be expected to make contact with the patient with 2 days of referral being received in order to arrange an assessment in order support patient engagement and minimise waiting times. An assessment can be undertaken either face to face, telephone or video conferencing facilities. The assessment/screening will focus on the presenting problem, a basic risk assessment and referral on to other agencies, if appropriate. This will include the following elements:
Prior to the start of treatment all patients should receive a comprehensive ‘patient centred’ assessment that clearly identifies the full range and impact of their mental health problems and any linked employment, social and physical health issues.

Risk (suicide, harm to others, etc.) should be assessed at initial contact and at each contact thereafter.

All patients must have their clinical, work and social outcomes assessed using standardised measures that are appropriate to the conditions being treated. Key measures should be given at each treatment session so that a clinical end point is available even if patients finish treatment early.

People identified to be at high risk (e.g. suicidal ideation, severe self- injurious behaviour, psychotic symptomatology) should be urgently referred to the appropriate mental health service crisis support services. The access standard for referral is the same day. Where an assessment is undertaken the assessor will discuss the range of options/therapies available (that are appropriate for the clinical presentation) taking into consideration gender, ethnicity and other diversity issues and offer choice wherever possible.

4.6 Exclusion criteria

- Anyone not registered with a Bromley GP
- Young Persons under the age of 16 years are excluded from this service.
- People who have complex problems, presentations other than anxiety and depression, who’s psychological needs will be met by Step 4 services
- People suffering ‘severe mental illness’ to the extent that primary mental health services are deemed inappropriate.
- People requiring an ‘urgent’ service (ie: those presenting in crisis)
- People requiring out of hours support to the extent that primary mental health services are deemed inappropriate
- People requiring long term support
- Those with a severe learning disability to an extent that primary mental health services are deemed inappropriate.

If the above exclusion criteria apply then the team will offer advice on how to access alternative services.

5. Discharge Criteria & Planning

Discharge will be agreed with the individual based on treatment completion, measures of recovery and/or improved management of the presenting problem(s) The referring agent will be informed of discharge and progress of the treatment within 14 days of discharge. Relapse plans should be agreed and the process for re-referral, if needed in the future, should be communicated to the individual.

A client can be discharged at any point throughout the dedicated number of sessions and this decision would be made in collaboration with the client based on their progress. If it becomes apparent at any point that the available number of sessions is not going to be adequate a decision will be made with the client about whether stepping up to another service/therapy would be appropriate.

The referrer and GP are informed of the outcome of therapy upon discharge and the relevant information is recorded as per IAPT Minimum Data Set,

If a client is signposted or referred to another agency this will be clearly documented and recorded in the initial contact summary that is forward to the clients GP.

Clear discharge processes must be developed to ensure that all relevant partners are included in the process and excellent communications are in place. This will incorporate principles of the Stepped Care process and ensure that risk is managed and appropriate relapse prevention plans are developed and articulated. Discharge plans must be developed with service users and carers (where
appropriate) and other professionals involved (where appropriate but likely to include GP’s) all are fully aware of this plan.
People with Common MH Disorder

- Total adult population: 300,000
- Number with Common MH Disorder at any time: 32,000
- Percent of Prevalence referred to treatment: 27%
- Of which, % that drop out whilst waiting: 5%
- Percent Treated who Recover: 50%

Service Specification

- Number of therapists (wte): 58.50
- Treatment slots offered per week per therapist: 25
- Average duration of a treatment slot (minutes): 60
- Weeks per year at work: 46
- Number of treatment slots needed per client: 6
- Weeks between treatments: 2
- Perc of appointments DNA: 11%
- Costs (inc on costs) per wte: £48,000
- Type of Contract: block
- Annual Block Contract (if using that setting): £2,831,411
- Payment per completed episode (if using tariff setting): £475
- Supplement if good outcome (if using tariff setting): £150

MAIN OUTPUTS

- Annual Cost to Provider: £2,808,000
- Annual Revenue to Provider: £2,831,411
- Cost per clinical hour (actually delivered): £64
- Spend (by commissioner) per clinical hour: £65
- Provider Cost per Episode: £342
- Maximum new clients per week: 173
- Referrals per week: 166
- Referrals after dropout: 158
- Admissions pw: 158
- Total Caseload at any Time (people in treatment): 2,367
- Actual clinical contact achieved (hrs pw per therapist): 20.4
- Current Caseload as % of Prevalence: 7.4%
- Admissions as % of Prevalence: 25.7%

you have spare capacity based on referrals
you are solvent
annual provider surplus or loss: £23,411