Primary Care Psychological Therapies (Adults)

Preface

Introduction

This implementation pack has been designed to support commissioners to deliver Any Qualified Provider in Primary Care Psychological Therapies (Adults) locally. It has been developed by NHS commissioners, clinical experts and Department of Health officials, working in partnership. The use of this pack is not mandatory. Commissioners can refine it to meet local needs and, over time, help to improve it. The pack is simply a place to start, avoiding duplicating effort.

This pack should be used for services that are commissioned using the Any Qualified Provider model – where commissioners are aiming to secure innovation or deliver more choice for patients for example. Other forms of procurement are also available, which might suit other circumstances, more details of these can be found in DH procurement guidance.

This pack has been prepared by working with a range of professionals, from both clinical and commissioning backgrounds and we recommend that commissioners using these packs continue to engage with clinicians, professional and a wide range of providers wherever possible.

Generally we expect there to be consistency across service specifications to sustain quality and help to spread best practice, but where necessary specifications should be amended to reflect local variations in need .

More information and further resources for commissioners can be found here, http://nww.supply2health.nhs.uk/AQPRESOURCECENTRE/Pages/AQPHome.aspx including a pricing principles document that should be read alongside this implementation pack.

If commissioners do come up with innovative new ways to drive up the quality of care by offering choice of provider - please use the AQP resource forum to share your hard work.

Workforce, education and training implications

When commissioning service under patient choice of AQP, there are some important workforce, education and training considerations, which commissioners must take into consideration. **Annex 2** provides some additional details on these issues.

Glossary

A glossary of terms used within this implementation pack is included in **Annex 4.**

Next Steps

These packs will be used by commissioners undertaking AQP in Primary Care Psychological Therapies (Adults) through 2012/13. An evaluation of the pack and the AQP process will be undertaken during this period. In the meantime, if you have any questions or comments on this pack, please contact AQP.Queries@dh.gsi.gov.uk.

Contents of this pack

Section 1

Service Specification

B.1 - SCOPE

Part 1 - Service Specifications

Mandatory headings 1 – 3. Mandatory but detail for local determination and agreement.
Optional headings 4 – 6. Optional to use, detail for local determination and agreement.

All subheadings for local determination and agreement.

Service Specification No.	
Service	**Primary Care Psychological Therapies (Adults)**
Commissioner Lead	
Provider Lead	
Period	
Date of Review	

Purpose

The purpose of this implementation guidance pack, including the outline service specification, is to assist commissioners in developing their plans for provision of Primary Care Psychological Therapies for Adults across a range of mental health conditions using an Any Qualified Provider process. It will also be of assistance to potential provider organisations, service users and members of the public with an interest in this area. Patients will be able to choose from Any Qualified Provider to deliver their care, based on which one best meets their needs. Providers from all sectors, including NHS trusts, voluntary organisations, social enterprises and the independent sector will continue to have a role in providing NHS services.

The policy background is outlined in the "Further Guidance" Annex.

1. Population Needs

1.1 National/ local context and evidence base

It is estimated that around 17.7% of adults aged 18 and older meet the diagnostic criteria for at least one common mental health disorder[i].

Reducing the prevalence of common mental health disorders is a major public health concern. In 2007 the annual cost to treat depression and anxiety disorders in England was nearly £3 billion, with an additional economic impact of around £13 billion in lost earnings among people of working age.

The Primary Care Psychological Therapies Services (Adults) should be developed based on a local Joint Strategic Needs Analysis,[ii] informed by national epidemiological research and should consider the needs of the whole community for primary care psychological therapies.

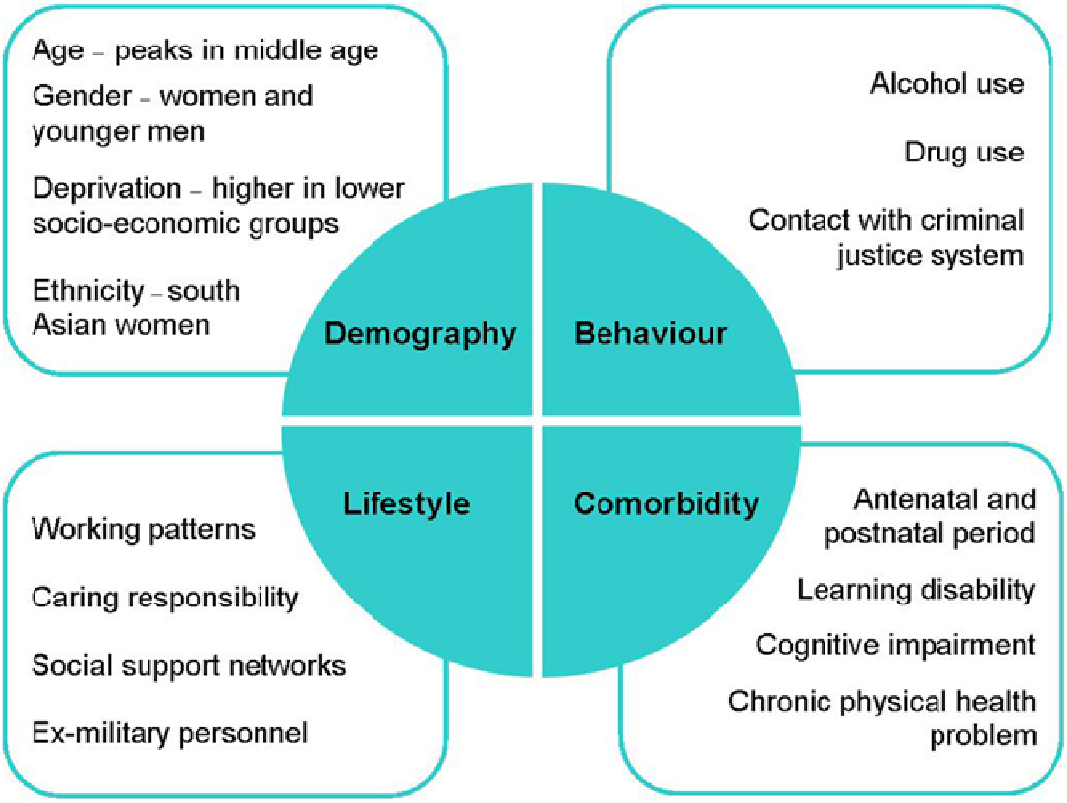
Local needs analyses should consider:

- prevalence and incidence of common mental health disorders
- additional factors that influence local service need
- existing local practice and determination of optimum capacity

Background and guidance in relation to assessing service levels for people with common mental health

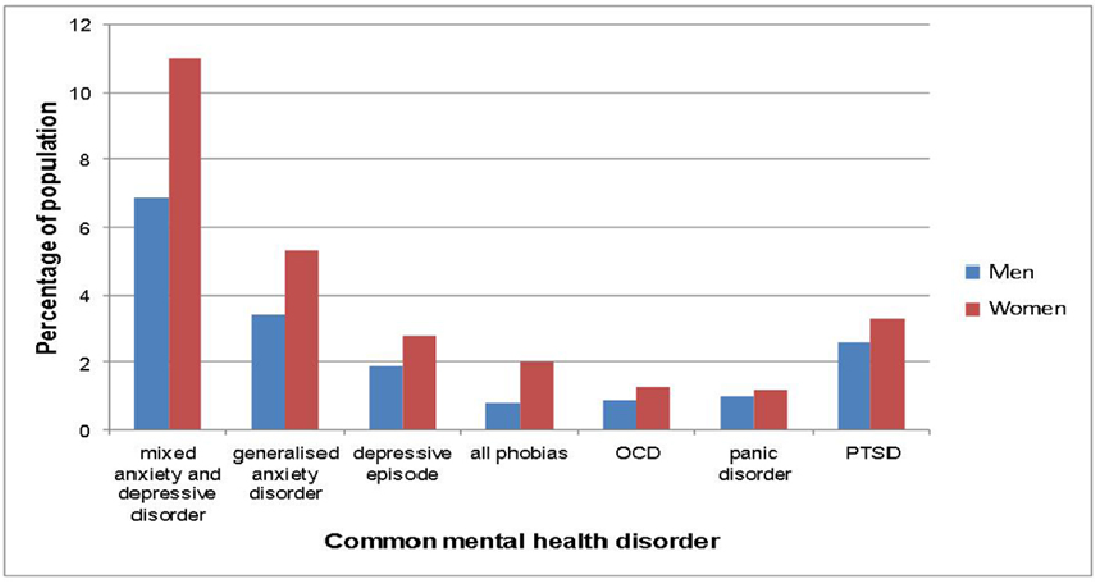
disorders is available from the NICE commissioning guidance[iii]

Figure 1 Risk factors for common mental health disorders[iv]



A number of recent national surveys, including those conducted by the Office of National Statistics have provided baseline information regarding the prevalence of mental health problems

Figure 2 Prevalence of common mental health disorders



National estimates suggest that at any one time 15.1% adults (over 15 years old) have symptoms of common mental disorder (CMD), such as: anxiety; depression; obsessive-compulsive disorder; or post traumatic stress. About half of these (7.5%) are severe enough to warrant treatment (such as talking

therapy or medication

Table 1: 1 week prevalence rates of common mental health disorders

Condition	1-week prevalence rates
Generalised anxiety disorder	4.4%
Depressive episode (mild, moderate and severe)	2.3%
Phobias	1.4%
Obsessive compulsive disorder	1.1%
Panic disorder	1.1%
Mixed anxiety and depressive disorder	9%
Post-traumatic stress disorder	3%

Local needs assessments will need to profile the socio-demographic breakdown of the local population in terms of factors which influence the prevalence of mental disorder.

Socio-demographic variables to be considered in terms of the local population include:

- Age and gender breakdown
- Ethnicity
- Language
- Religion
- Disability
- Sexual orientation
- Socio-economic profile (e.g. MOSAIC groups; Index of Multiple Deprivation)

The Needs Analysis should include a review of current psychological therapies service provision and a "gap analysis" regarding any shortfalls, barriers to access or inadequacies in current provision.

A baseline analysis of inequalities in service access and outcome will highlight priority areas for service development. This may include a map of existing services for people with common mental health disorders and their interface with other local social care, residential and nursing care, community mental health services, welfare and debt advice, employment services and hospital services, as well as the:

- Number of people currently being treated in community-based psychological therapy services or specialist community mental health teams, and other relevant services.
- Number of people who see their GP and have a recorded incidence of one or more common mental health disorders.
- Estimated prevalence of co-morbidities (for example long term conditions, other mental health disorders, drug and alcohol misuse, pregnancy, learning disabilities, cognitive impairment).

The National Mental Health Strategy (February 2011) has broadened the benefits of talking therapies to contribute to improved outcomes, well-being and recovery for children and adolescents, older people, those with severe and enduring mental illness (SEMI) and those with long-term physical health conditions (LTCs) or medically unexplained symptoms (MUS). Further details are provided in the supporting document 'Talking therapies: A four year plan of action'. (http://www.iapt.nhs.uk/silo/files/talking-therapies-a-four-year-plan-ofaction.pdf)

'Talking Therapies: a Four-Year Plan for Action' states: The aim is to develop talking therapies services

that offer treatments for depression and anxiety disorders approved by the National Institute for Health and Clinical Excellence (NICE) across England by March 2015, the end of the Spending Review period. This involves:

- completing the nationwide roll-out of IAPT services for adults of all ages who have depression or anxiety disorders, paying particular attention to ensuring appropriate access for people over 65;
- initiating a stand-alone programme to extend access to psychological therapies to children and young people
- building on learning from the IAPT programme and using NICE-approved and 'best evidence'-based therapies where NICE guidelines are pending;
- broadening the benefits of talking therapies by extending them to people with physical long-term conditions or medically unexplained symptoms, which are physical symptoms caused by psychological distress; and
- Expanding access to talking therapies services for people with severe mental illness.

There is strong evidence that appropriate and inclusive services and pathways for people with common mental health problems, specifically depression and anxiety, reduce an individual's usage of NHS services whilst contributing to over all mental well being and economic productivity.

The NICE commissioning and benchmarking tool can assist commissioners and providers in developing comprehensive services to meet local needs[v]

2. Scope

2.1 Aims and objectives of service

The Provider shall deliver and facilitate access to a range of services within the Contract Area that are developed to:

- Reduce the stigma and discrimination associated with a diagnosis of, or treatment for, common mental health disorders.
- Provide signposting, information and support to facilitate access to a range of community based support services
- Improving service-user choice and experience of mental health services.
- Improve identification and awareness of common mental health disorders (e.g. through awareness training for a range of health, social care, education and welfare professionals) and promote onward referral for assessment and intervention
- Improving the interface between services for people with common mental health disorders
- Increase the proportion of people who are identified, assessed and receive treatment in accordance with NICE guidance/evidence based psychological care by appropriately qualified clinicians
- Improve the proportion of people who make a clinically significant improvement or recover.
- 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
- Improve access and support 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

The Primary Care Psychological Therapies (PCPT) service will be a community based service, building firmly on the Improving Access to Psychological Therapies (IAPT) programme (see http://www.iapt.nhs.uk/) offering a 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[vi].

A traditional IAPT model should cover:

- depression[vii],

- generalised anxiety disorder
- mixed depression and anxiety[1]
- panic disorder
- obsessive-compulsive disorder[viii],
- phobias (including social anxiety disorder (social phobia))
- post-traumatic stress disorder[ix])
- health anxiety (Hypochondriasis)

The proposed "IAPT Plus" model for PCPT services is largely comprised of IAPT services for common mental health conditions such as anxiety and depression[2] but will also encompass other conditions including:

- Adjustment disorders[x]
- eating disorders (mild-to-moderate)[xi]
- anger management[xii];
- depression or anxiety in adults with a chronic physical health problem[xiii] or medically unexplained symptoms[xiv]
- substance misuse (alcohol misuse[xv]
- mild learning disability or cognitive impairment(endnote xxvii)
- personality disorder (not severe)[xvi], [xvii]
- other comorbid mental health conditions (e.g. non-acute or stable psychosis) where anxiety or depression-related symptomatology is present[3]

A broader focus incorporates some delivery of "Step 4" *(see section 2.2 of this document)* high intensity therapies (often delivered by psychologists as part of Community Mental Health Teams (CMHTs)) for more complex conditions with co-morbidities (e.g. personality disorder, substance misuse). If the Step 4 psychological therapist is the lead clinician and the service user does not require multi-disciplinary case/care management and/or other co-morbidities (e.g. borderline personality disorder) are not the primary focus of treatment, then these more complex and severe cases could also be treated within the Primary Care Psychological Therapies Service.

The AQP Primary Care Psychological Therapies will thus primarily address mental health Payment by Results (PbR) Care Clusters 1-4 as follows:

- Care Cluster 1: Common Mental Health Problems (Low Severity) - This group of service users 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 of service users has 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 of service users have moderate problems involving depressed mood, anxiety or other disorder (not including psychosis)
- Care Cluster 4: Non-Psychotic (Severe) - This group of service users is characterised by severe depression and/or anxiety and/or other disorders, and increasing complexity of needs. They may experience disruption to function in everyday life and there is an increasing likelihood of significant risks.

However, many IAPT services are seeing substantial numbers of patients in:

[1] A large number of people present with mild or "sub-syndromal" symptoms of mixed anxiety and depression which are insufficiently severe to meet diagnostic criteria for anxiety disorder or major depressive disorder and do not require psychological treatment

[2] IAPT high intensity services can successfully treat the vast majority of severe cases of anxiety and depression with or without concurrent medication management and employment assistance

[3] Need to ensure that staff have competencies in this area as it may not have been covered in core IAPT training

- Care Cluster 5: Non-psychotic Disorders (Very Severe) – This group will be severely depressed and/or anxious. They will not present with distressing hallucinations or delusions but may have some unreasonable beliefs. They may often be at high risk for suicide and they may present safeguarding issues and have severe disruption to everyday living.

Smaller numbers of people in Clusters 6-8 may also be seen although these groups more typically present to specialist mental health services.

- Care Cluster 6: Non-psychotic Disorder of Over-valued Ideas - Moderate to very severe disorders that are difficult to treat. This may include treatment resistant eating disorder, OCD etc, where extreme beliefs are strongly held, some personality disorders and enduring depression.

- Care Cluster 7: Enduring Non-psychotic Disorders (High Disability) - This group suffers from moderate to severe disorders that are very disabling. They will have received treatment for a number of years and although they may have improvement in positive symptoms considerable disability remains that is likely to affect role functioning in many ways.
- Care Cluster 8: Non-Psychotic Chaotic and Challenging Disorders - This group will have a wide range of symptoms and chaotic and challenging lifestyles. They are characterised by moderate to very severe repeat deliberate self-harm and/or other impulsive behaviour and chaotic, over dependent engagement and often hostile with services.

Underlying principles

- To provide a "whole person" approach to the delivery of Primary Care Psychological Therapy Services which takes account of the person's sociodemographic characteristics, health co-morbidities and lifestyle
- To provide a **directly accessible primary care driven** service
- To provide **early access** and appropriate interventions to people with common mental health problems in the Contract Area adopting a stepped approach according to NICE guidelines
- To promote access to services from all sectors of the community including traditionally underserved/socially excluded groups (see guidance[xviii]) which may include
    - black and minority ethnic groups, including people who do not have English as their first language
    - certain age and gender groups e.g.
        - older people, including people living in nursing homes or with dementia
        - younger people, especially young men
        - South Asian women
    - black and minority ethnic groups persons in prison or in contact with the criminal justice system
    - service and ex-service personnel
    - refugees and asylum seekers
    - long term conditions
    - lesbian, gay, bisexual and transgender people
    - people from deprived communities, including people who are on low incomes, unemployed or homeless, single-parents and carers.
- To provide **high quality and flexible support** to service users that maximises individual potential. This may include:
    - Language and communication support
    - Use of multi-media technology
    - Creche facilities
    - Subsidised transport
    - Home-based interventions
    - Non-traditional community settings
- To **promote recovery** and **minimise the disabling effects** of mental ill health
- To promote choice of provider
- to provide a **person-centred service**, and recognise the need for all organisations to work in **partnership** with Service Users in a holistic and inclusive manner
- Support to families and cares in terms of assessment of their own caring, physical, social, occupational and/or mental health needs and information on how they can support the person or access relevant support groups and networks
- To **evaluate the effectiveness** of the Primary Care Psychological Therapies Services through

systematic and comprehensive collection of **pre- and post-treatment outcome** data on at least 90% of patients treated

2.2 Service description/ care pathway

The Primary Care Psychological Therapies Service is based on a stepped care model. The least intensive intervention appropriate to a person's needs is provided first and people can readily "step up or down" the care pathway in accordance with their changing needs and response to treatment. The PCPTS should be part of an **integrated care pathway** for people with common mental health disorders and should build on existing multi-agency partnerships with a variety of statutory, voluntary and private providers working collaboratively.

The stepped care mode should 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 (e.g. those with severe depression or anxiety disorders or PTSD) will be routed straight to high intensity (Step 3 interventions) rather than stepped first through low intensity interventions which would not be effective in meeting their treatment needs.

The Stepped Care Service Model for Primary Care Psychological Therapies acknowledges the crucial role of the **promotion of well-being and positive mental health** for the population and the role of self-help for lower intensity psychological problems. Promotion of good mental health and psychological well-being (Step 0) and mental health plays an important role in the primary prevention of mental health problems (e.g. promotion of mental health in the workplace[xix].

Services should be **easily accessible** within the community and incorporate various styles of engagement and delivery ranging from self-help materials, telephone advice and counselling and group approaches. Multiple points of access to the PCPTS service will facilitate links with the wider community and promote access to services from people from a range of socially excluded groups. This may include use of accessible, non-stigmatised community venues (including the person'

There should be clear and explicit criteria for entry into the service and multiple means to access the service, including self-referral.

The Service should **encourage self-referral** as a recent evaluation of psychological intervention services demonstrated that self-referred service users present with symptoms as severe as those of GP-referred service users but recover with fewer sessions of treatment. Promotion of self-referral pathways may thus improve cost-effectiveness of service and promote better access for hitherto under-served sections of the community.

Promotion of recovery and positive mental health provides an opportunity for **collaboration and partnership** with other community services and interventions as part of local service delivery (e.g. social care, housing, environmental services, education, criminal justice agencies, substance misuse services, physical activity and leisure services, black and minority ethnic focused services etc). This will help to build community resilience and opportunities for primary prevention of mental ill health and promotion of recovery.

In addition, **collaboration with secondary care** professionals in specialist mental health and general health services (particularly physicians involved in treating long term musculoskeletal, respiratory, dermatology, diabetes, heart disease, chronic pain services, neurology and cancer) is vital to ensure that psychological treatment needs are met across the pathway in an integrated, timely and responsive manner.

The Care Pathway

Service Promotion and Information

A clear strategy designed to promote appropriate use of the primary /community psychological therapies service will actively help to secure the savings in other parts of the local NHS expenditure.

Experience has shown that encouraging self-referral by service users does not result in services being inundated by demand. On the contrary, it uncovers and addresses otherwise unmet need in the local population.

Service promotion has two distinct target audiences:-

- Health, employment and social care professionals who may refer their patients or clients to the psychological therapies service and be keen to see the treatment reduce demand on other aspects of NHS and other services
- Local residents and workers, who need accessible information about how the service may be able to help them recover their sense of wellbeing

Useful materials for promoting the service can be downloaded and adapted for local use from http://www.iapt.nhs.uk/services/providers/

Access to services

- Services will be available across local areas in a variety of primary care and community settings
- Each general practice shall have direct access to the service with a worker forming an integral aspect of the primary care team through allocated time with each practice.
- Appointments will be directly accessible from the practice, with GP practices providing some infrastructure support (e.g. booking of appointments)
- A "clinical hub" capacity is needed which can accommodate the following functions, facilitated by up-to-dated Information and Communications Technology (ICT):
    - Facilities for telephone-based Psychological Well-being Practitioner interventions
    - Consulting room space for patients whose condition (e.g. social anxiety disorder, some cases of PTSD) requires treatment where videotaping and role play/modelling can occur
    - Group work
    - Alternative venue for patients who prefer to be seen away from GP premises
    - PWP access to supervision from High Intensity Worker

Self Referral Options

The service will develop direct access for people to self refer into the service. Early identification of psychological problems and early intervention is associated with better outcomes from IAPT services

Referral Criteria and sources

The service will be available to people experiencing mental distress in relation to common mental health problems such as anxiety and depression (which may also be linked to a physical health condition).

The IAPT Data Handbook (http://www.iapt.nhs.uk/silo/files/iapt-data-handbook-v2.pdf - page 22-27) describes the suggested thresholds for entry to therapeutic services, based on the use of a range of clinical assessment tools. Commissioners should use these as benchmarks when agreeing appropriate local referral criteria for the services that they wish to commission via AQP.

Referral processes

The expectation is that individuals will be offered the least intensive or burdensome intervention that is likely to result in clinical improvement. It should be easy for a person to "step in and step out" of services.

Where an assessment / triage 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.

Once an individual is assessed their pathway will be based on interventions to address individual need – this would take into account the stepped care model (including recommended treatments according to NICE guidelines for anxiety and depression) but in addition services to support functionality and social well being.

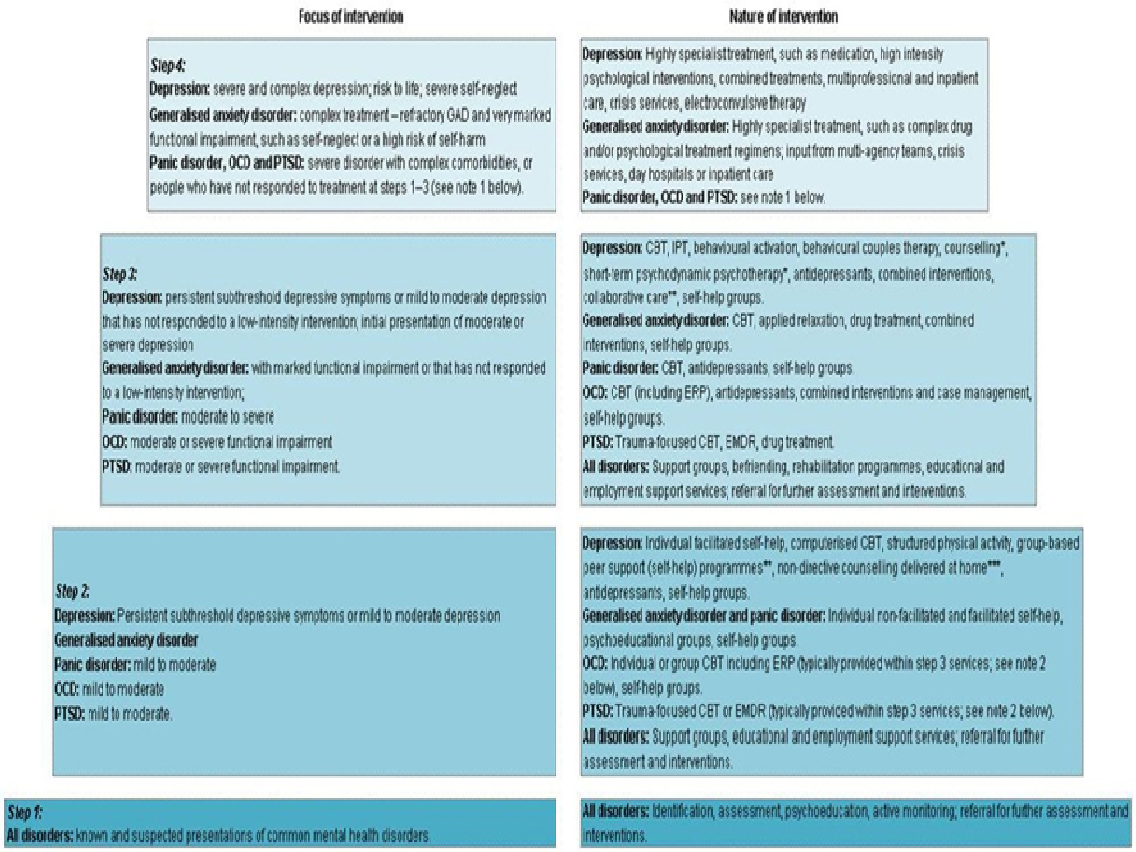
Response times and prioritisation

Response times from referral to decision to treat or refer on need to be determined by local commissioners.

However, IAPT Services are required to meet an access standard of 1 to 3 working days from Referral to Decision to Treat. At Step 3, services are required to meet a standard of no more than 28 days from Referral to Step 3 treatment commencing.

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. The access standard for referral is the same day.

Figure 3 Stepped Care Model: Focus and Nature of Interventions



'Talking therapies: a four year plan of action' estimates that two-thirds of people with common mental health disorders have mild mental health disorders and so need low-intensity treatment at step 2. One-third have moderate or severe mental health disorders and so need higher intensity treatment at step 3 and allocation of provider resources should reflect this.

Figure 4 Estimated proportion of the prevalent population with common mental health disorders who will enter each step of care

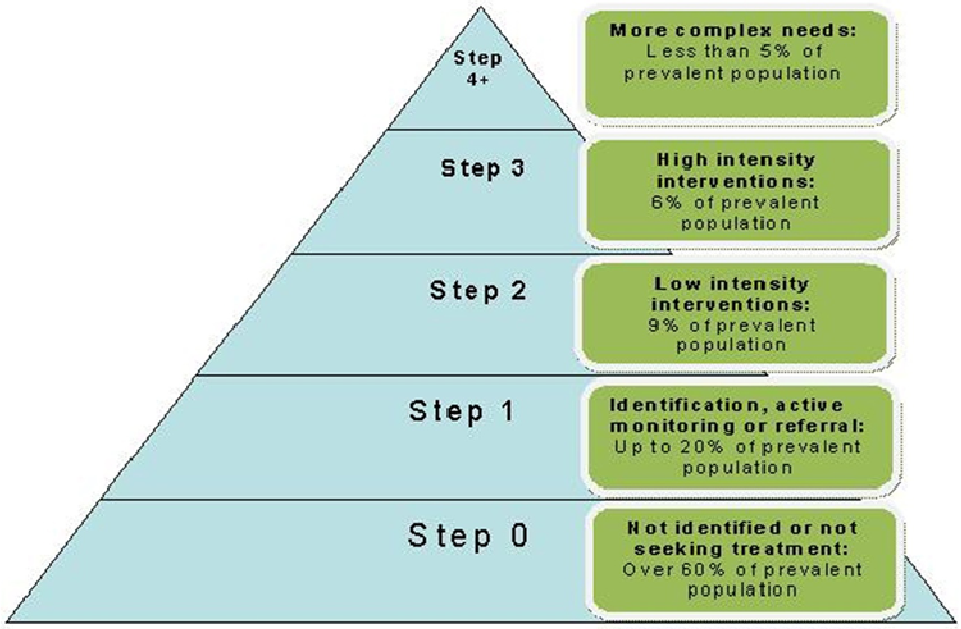


Table 2: Estimated proportion of the prevalent population who will enter each step

Step of care	Percentage of prevalent population
Step 0 (Not identified or not seeking treatment)	More than 60%
Step 1 (Identification, advice or referral, watchful waiting)	Up to 20%[a]
Step 2 (Low-intensity psychological interventions)	9%[b]
Step 3 (High-intensity psychological interventions)	6%[b]
Step 4 and above (More complex needs)	Less than 5%[a]

[a] Estimate based on the expert opinion of the Topic Advisory Group.

[b] It is assumed that 15% the prevalent population will be able to receive psychological treatment at steps 2 and 3 each year, in accordance with Department of Health (2011) 'Realising the benefits. IAPT at full roll-out', and that of these 60% will receive treatment at step 2 and 40% at step 3.

Focus of interventions in stepped care

The focus of interventions at various levels of stepped care is highlighted below

Table 3: Step 1 services focus and nature of intervention

Focus of the intervention	Nature of the intervention
Presentation with known or suspected common mental health disorders	Identification Assessment Psychoeducation Active monitoring Referral for further assessment and interventions.

Improved identification and awareness of common mental health problems and pathways to care by general practitioners and other health, education, welfare and criminal justice professionals is a crucial aspect of Step 1 services.

Use of shared, validated assessment tools can reduce unnecessary additional assessments and better targeting and responsiveness of services to meet assessed need. This should include risk assessment of individuals who may be vulnerable and/or present a risk of harm to self or others.

Table 4: Low-intensity psychological interventions recommended at Step 2

Psychological intervention	Disorder
Cognitive behavioural therapy (computerised)	• Depression
Cognitive behavioural therapy (individual) including exposure and response prevention[a]	• Obsessive-compulsive disorder
Cognitive behavioural therapy (group) including exposure and response prevention[a]	• Obsessive-compulsive disorder
Cognitive behavioural therapy (trauma-focused)[a]	• Post-traumatic stress disorder
Eye movement desensitising and reprocessing[a]	• Post-traumatic stress disorder
Group-based peer support (self-help) programmes	• Depression (with a chronic physical health condition)
Non-directive counselling delivered at home	• Depression (antenatal and postnatal)[b]
Psychoeducational groups	• Generalised anxiety disorder • Panic disorder
Self-help groups	• Depression • Generalised anxiety disorder • Obsessive-compulsive disorder • Panic disorder
Self help (individual facilitated)	• Depression • Generalised anxiety disorder • Panic disorder
Self help (individual non-facilitated)	• Generalised anxiety disorder • Panic disorder

a. These interventions may typically be commissioned from, and provided by, trained, specialist staff in step 3 services
b Commissioners may also wish to refer to the NICE commissioning guide 'Antenatal and postnatal mental health services' when developing services for this group
NB The NICE implementation of stepped care commissioning guidance Tables for Step2 (above)and Step 3 (overleaf) psychological interventions do not explicitly mention treatments for phobias

There is a need to ensure that Step 2 and Step 3 providers are commissioned in sufficient numbers to meet locally identified needs for service and that they are competent to deliver interventions in accordance with NICE guidelines; using validated evidence-based assessment, monitoring and outcome tools

Table 5: High intensity psychological interventions at Step 3

Psychological intervention	Disorder
Applied relaxation	• Generalised anxiety disorder
Behavioural activation	• Depression
Behavioural couples therapy	• Depression
Bibliotherapy based on cognitive behavioural therapy principles	• Panic disorder
Cognitive behavioural therapy (CBT)	• Depression • Generalised anxiety disorder • Panic disorder
Cognitive behavioural therapy including exposure and response prevention	• Obsessive-compulsive disorder
Cognitive behavioural therapy (trauma-focused)	• Post-traumatic stress disorder
Counselling	• Depression (for people who decline an antidepressant, cognitive behavioural therapy, interpersonal psychotherapy, behavioural activation or behavioural couples therapy)
Eye movement desensitising and reprocessing	• Post-traumatic stress disorder
Interpersonal psychotherapy	• Depression
Self-help groups	• Depression • Generalised anxiety disorder • Panic disorder

A variety of evidence-based clinical interventions; (Including self help options) will be available to include, but not exclusively:-

- Cognitive Behavioural Therapy
- Interpersonal Therapy
- Counselling
- Brief Psychodynamic Therapy
- Solution Focused Therapies
- Family Therapy
- Psycho Sexual Therapy
- Personal support;
- Personal development opportunities

Step 4 services

Only a small minority of people are likely to need treatment in step 4 services and these treatments will be outside the scope of the primary care psychological therapies service if they involve complex multi-

disciplinary case or care programme approach management and medication management supervised by secondary or specialist mental health services.

Table 6: Step 4 services

Focus of the intervention	Nature of the intervention
Depression: severe and complex depression; risk to life; severe self-neglect	Highly specialist treatment, such as medication, high intensity psychological interventions, combined treatments, multiprofessional and inpatient care, crisis services, electroconvulsive therapy
Generalised anxiety disorder: complex treatment-refractory generalised anxiety disorder and very marked functional impairment, such as self-neglect or a high risk of self-harm	Highly specialist treatment, such as complex drug and/or psychological treatment regimens; input from multi-agency teams, crisis services, day hospitals or inpatient care
Panic disorder, obsessive compulsive disorder and post-traumatic stress disorder: People that have not responded to treatment at steps 1–3, or who have severe disorders and complex comorbidities that prevent effective management at steps 1–3	Specialist services at step 4 will vary according to individual need and clinical judgement. The principle interventions at step 4 are similar to those listed for depression and generalised anxiety disorder above, with the exception that electroconvulsive disorder is not indicated.

NICE recommends a range of additional support services for people with common mental health disorders. These include:

- education and employment support services – steps 2 and 3; these may be provided by local job centres or occupational health/therapy departments
- support groups – steps 2 and 3; these are typically provided by not-for-profit organisations
- befriending – step 3; these are typically provided by not-for-profit organisations
- Rehabilitation programmes – step 3.

The NICE commissioning and benchmarking tool is a useful aid to planning services for people at various steps of care[xx].

Competency, Training, Education, Supervision and Research activities:

The IAPT workforce model is a collaborative one between employers and universities, where trainees are recruited jointly to new posts, provided with training in their first year and given substantive posts on successful completion of their training[xxi]. Services are required to offer supervision and support to agreed professional standards; these can be found on the IAPT website http://www.iapt.nhs.uk/workforce/

The IAPT workforce is quality assured by explicit competency frameworks; national curricula and learning materials, delivered through accredited training courses. Commissioners can ensure these professional standards are maintained through robust workforce planning and by giving priority to protecting local courses, in consultation with their SHA colleagues (and education commissioning agents in 2012 onwards). The range of IAPT competency frameworks, training materials and curricula give education and training commissioners the tools needed to ensure a competent and skilled workforce is in place to deliver culturally competent services. Download from: http://www.iapt.nhs.uk/workforce/

The IAPT workforce consists primarily of High Intensity therapists delivering step 3 interventions and Psychological Wellbeing Practitioners (PWP) delivering step 2 interventions. The PWP is a new role and can be sustained in the long term, by offering wider access to candidates from local communities and ensuring there are career development opportunities within the role. Download PWP Best Practice Guide from: http://www.iapt.nhs.uk/silo/files/psychological-wellbeing-practitioners-best-practice-guide.pdf

Guidance on best practice and anticipated workload for Psychological Wellbeing Practitioners and High Intensity workers is available on the IAPT website, http://iapt.nhs.uk/.

Relevant training for IAPT staff that should be commissioned through Strategic Health Authorities in 2011/12 includes

- Cognitive Behaviour Therapy (CBT) for both High Intensity and PWP
- Other NICE-approved therapies for depression only: (Interpersonal Psychotherapy/IPT; Couple Therapy for Depression; Counselling for Depression; and Brief Dynamic Interpersonal Therapy/DIT
- Supervision

Further details on this as well as individual and course accreditation are in the IAPT Curriculum and Commissioning Outline which can be downloaded from http://www.iapt.nhs.uk/workforce/workforce/

The service will 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.

Supervision from experienced accredited practitioners (e.g. clinical psychologists and other suitable qualified high intensity workers is essential and guidance is available on professional standards and requirements[xxii]).

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.

The report on New Ways of Working (NWW) for Psychological Therapists[xxiii] considers the place of the counselling and psychotherapy workforce in mental health services and in the wider healthcare setting. Five key areas have been addressed:

- The evidence base for psychological therapies: implications for policy and practice
- Identifying the numbers and trainings of counsellors and psychotherapists in England
- Describing a proposed career framework for practitioners delivering psychological therapies
- Clarifying how care pathways and team approaches could inform the integration of IAPT into primary care focussed psychological therapy services
- The workforce interface in providing services to children and young people

Figure 5 Recommended Stepped Care Pathway for IAPT services

The figure below gives an example of a mapped care pathway.

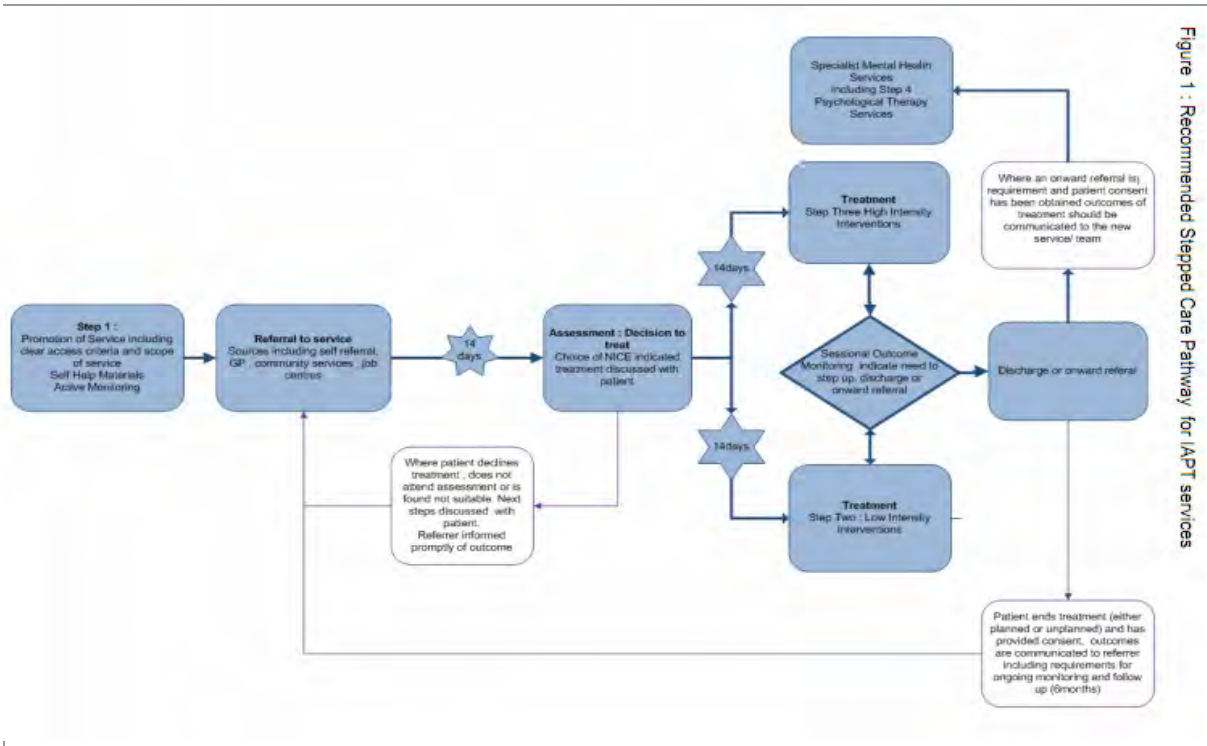


Figure 1 : Recommended Stepped Care Pathway for IAPT services

2.2 Population covered

The population to be covered will be defined by commissioners and may relate to geographic and/or primary care commissioning boundaries. Areas of high deprivation or populations which have traditionally under-accessed services may be priorities.

2.3 Any acceptance and exclusion criteria

This service specification has been designed for adult service users. This is normally defined as those over 18 years of age.

AQP for primary care psychological therapies does not encompass the whole of primary care mental health. For instance, management of people with a stable psychosis/severe mental illness will be outside the scope of this.

The primary care psychological therapies service is not targeted towards those who pose a high risk to themselves, risk to others or who are at significant risk of self-neglect. This may include “hard-to-engage” people who have consistently rejected various treatment options offered.

This group may include people suffering from acute psychosis or who are actively suicidal and those who have a pre-existing diagnosis of severe and enduring, unstable mental illness. Such individuals’ needs are best met via specialist or secondary community mental health teams and associated services. However, when an individual with psychosis is being stably managed, they may benefit from access to psychological therapies.

Similarly, people who have a significant impairment of cognitive function (e.g. dementia); or significant impairment due to autistic spectrum problems or learning difficulties are best served by specialist services. This may also include patients who need to be primarily referred for forensic or neuropsychological assessment.

Individuals for whom drug and alcohol misuse present as primary problems are best focused towards substance misuse services. However, when their substance misuse problems have stabilised they may benefit from psychological therapies.

In discussion the following areas were mentioned as within the scope of a primary care mental health model, but are likely to be considered outside the scope of the “IAPT Plus” or AQP Primary Care Psychological Therapies service:

1) Secondary-to-primary care liaison
2) Early intervention (severe mental illness)
3) Personality disorder (severe/complex)
4) Primary care of stable psychosis
5) Medication management

2.4 Interdependencies with other services

The vision for an effective Primary Care Psychological Therapies Service is of an integrated bio-psychosocial approach that considers a person's wider quality of life needs. This whole life approach would require the Primary Care Psychological Therapies service to work closely with a range of other organisations to demonstrate improvements.

Where necessary the service will develop shared care arrangements with other relevant services to ensure patients' needs are fully met, and all aspects of their care and treatment co-ordinated. The service will not be expected to take on any care coordination functions.

If the service is not able to work with the person for any reason they should ensure that they are referred by their GP to suitable alternative provision to manage their mental health needs

Integral to the vision for an integrated Primary Care Psychological Therapies are services being community based and working in unison with other public service arrangements. Primary Care Psychological Therapies providers would have a robust relationship with a wide range of stakeholders to augment the quality of both Primary Care Psychological Therapies service delivery and also the wider health economy.

Safe, integrated and effective primary care psychological services need clear pathways for people to move into, through and out of service provision. Mechanisms for resolution of disputes at various states of the care pathway are essential.

Primary Care Psychological Therapies services may adopt a consortium approach of delivery, which includes a range of appropriately qualified large and smaller service providers.

"Micro-providers" who have specific expertise (e.g. in working with smaller ethnic minority groups) may be able to partner with other providers to provide services tailored to community needs and their contribution should be encouraged under AQP provisions.

Because of their often unique features, third sector providers have a track record of being able to provide many important elements of the overall service delivery.

The PCPT service will form part of a spectrum of services commissioned to address the Mental Health Needs of its population. It is specifically responsible for responding to people with mild or moderate common mental health problems. Partnership working and collaboration with a range of other health and social care services, residential and nursing care, employment support agencies, criminal justice agencies, well-being services (e.g. leisure services; health promotion) will be required. These partner agencies are likely to include a variety of statutory, third sector and independent sector providers.

The service will also need to work in partnership with specialist / secondary mental health services to ensure that people with more complex needs have these met in timely ways which are clinically appropriate.

3. Applicable Service Standards

3.1 Applicable national standards eg NICE, Royal College

Providers should be meeting the quality measures specified in the contract and NICE quality guidance[xxiv] and other reliable sources of evidence[xxv].

1) Use of standardised and validated assessment tools to reduce duplication of assessments
2) Use of validated outcome measures
3) Promote accessibility of services e.g.
    a. Hours of operation
    b. Accessible, non-stigmatised community venues (including home)
    c. Use or appropriate technology
4) Workforce competencies to deliver psychological therapies

    a. Appropriate training
    b. Regular supervision
    c. Ongoing personal development plan and training

http://www.nice.org.uk/usingguidance/commissioningguides/commonmentalhealthdisorderservices/commonmentalhealthdisorderservices.jsp

3.2 Applicable local standards

A strategy to improve the identification and management of common mental health disorders in terms of local Quality Innovation, Productive and Prevention (QIPP[xxvi]) initiatives could include the following aspects:

Table 7: Delivering QIPP through stepped care for common mental health disorder [iii]

QIPP model	Example output
Partnership	• Development of common mental health disorder partnership, with shared governance procedures
Improving recognition of common mental health disorders	• Development of programme of local awareness raising for targeted healthcare, education, social care and welfare professionals.
Improving assessment and diagnosis of common mental health disorders	• Increasing assessment and diagnosis of common mental health disorders in primary care, using tools validated for primary care
Reducing inappropriate prescribing of antidepressants	• Reducing inappropriate prescribing of antidepressants by following NICE guidance recommendations for the treatment of sub-threshold, mild and moderate conditions
Reducing inappropriate or unnecessary referrals to community mental health teams and/or secondary care psychiatry services	• People with common mental health disorders are first assessed and receive interventions at the lowest step suitable for their needs

4. Key Service Outcomes

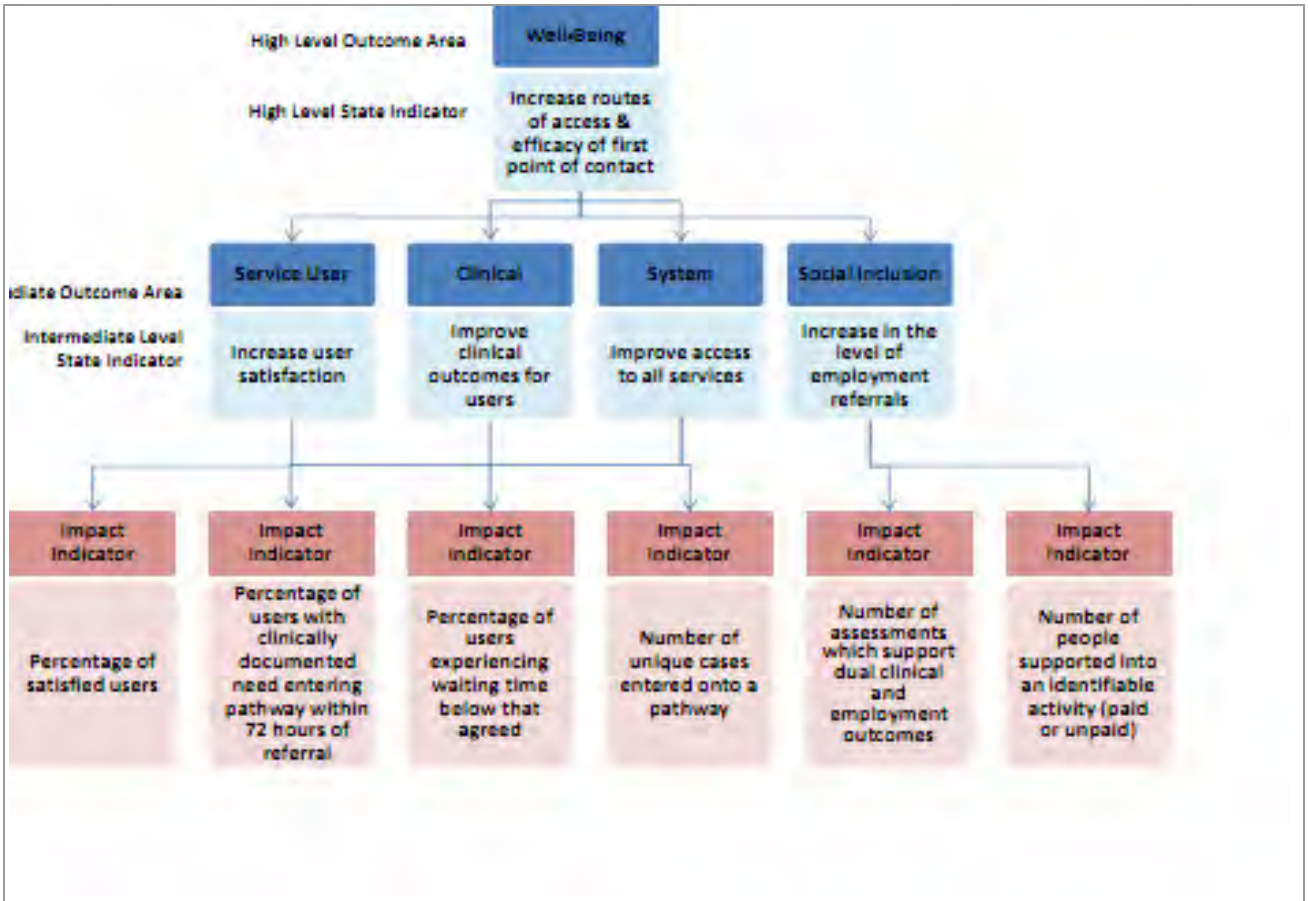
Measuring outcomes, progress, recovery and relapse is vital to ensure that people's treatment is reviewed, and where appropriate stopped, in line with the stepped-care model, if there are signs of deterioration or no indications of improvement (See NICE clinical guideline 123)[xxvii]

The collection of outcome data is a defining characteristic for IAPT and the pre-existing data set can be amended and incorporated to measure KPIs and outcomes for the AQP primary care psychological therapies service. The NHS Outcomes Framework 2011/12[xxviii] also includes quality of life and outcome measures for mental health services, and there are similar proposals for outcome in social care[xxix]

The Key Service Outcomes for Primary Care Psychological Therapies should be as follows:

1. Increased proportion of people with common mental health disorders who are identified, assessed and receive treatment in accordance with appropriate NICE guidance
2. Improved speed of access and response at various nodes in the care service pathway
3. Increased proportion of people with common mental health disorders who make a clinically significant improvement or recover
4. Increased social participation and community integration of service users
5. Improved service user choice and experience of services
6. Increased number of individuals successfully treated (recovered) per £100,000 expenditure

Figure 6 Hierarchy of Service Outcomes and Indicators



5. Location of Provider Premises

The Provider's Premises are located at:

[Name and address of Provider's Premises **OR** state "Not Applicable"]

The PCPTS will be delivered from a range of community venues

The face to face primary psychological care for mental health must be delivered in an environment which is conducive to the needs of the individual, offering anonymity if required (e.g. in some cases of self referral).

- Delivered close to patient's homes wherever possible (and in patient's own homes where they are housebound or have prohibitive mobility issues).
- Provided in a range of community settings (GP practices, libraries, resource centres and employment settings).
- Closely aligned with GP practices to ensure good integration with primary care.
- Includes a "clinical hub" to accommodate core functions(e.g. PWP telephone advice; small group work; video feedback role play; consulting space for patients who wish/need to be seen away from GP practice)
- Integrated within local healthcare systems.
- In a location well-served by public transport
- Services would need to be provided in easily accessible locations which reflect local health needs.
- service provision must be integrated with existing local service providers and GP practices
- Space for individual and where appropriate group interventions would need to be identified and built into the cost of the service.
- Office space for administration, supervision and other non-clinical activity would need to be identified and the cost built in.

6. Individual Service User Placement

[Insert details including price where appropriate of Individual Service User Placement]
Not applicable

Part 2 - Essential Services

[For local agreement]

Not applicable

Part 3 - Activity Planning, Prices and Payment

3.1 Indicative Activity Plan

Indicative Activity Plan

Under AQP provisions, it is possible to set Indicative Activity Levels to zero but commissioners will model the likely expected demand for services and priorities within available budgets (see endnote xx for NICE implementation of stepped care modelling spreadsheet)

3.2 Commissioning Ambitions based on Activity Plan

[State “Not Applicable” where appropriate OR where inserted, the Commissioning Ambitions must not conflict with information in Service Specifications. The standard template published alongside this contract is recommended]

Not applicable

3.3 Capacity Review

[Where relevant to the Service, relevant parts of the Activity Plan and Capacity Review should be inserted here.]

Not applicable

3.4 Prices and Payment

Costing psychological therapies AQP

There are two costing models currently in development which would be applicable to costing the psychological therapies AQP. The first is the mental health PbR costing framework, which will be implemented across all mental health services in England from 1st April 2012.

The second is the IAPT costing framework, which is currently being piloted.

PbR Mental Health Care clusters

The breakthrough in creating a currency for mental health was the development of a set of 'care clusters' by clinicians working in Yorkshire. They recognised that to gain a broad understanding of the needs of people who used mental health services they needed to build on from simple clinical diagnoses.

They proposed that the needs of most people in mental health services could be captured within one of 21 Care Clusters. So for example in cluster one would be people who had a definite but minor problems of depressed mood or anxiety, in cluster 10 people who presenting to services for a first time with psychotic problems, and in cluster 17 people with moderate to severe psychosis, with unstable and chaotic lives and were hard to engage with services.

Assessment is made using the Mental Health Clustering tool, which is largely based on the Health of the Nation Outcome Scales (HoNOS) which has been the standard psychiatric assessment for over a decade, with some additional questions to create a Mental Health Clustering Tool. The clustering encompasses people seen in primary care, primarily in cluster 1 to 4.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_130196

The care clusters will be the contract currency from 1st April 2012 and most mental health providers have developed costs for each cluster which can be used (in tandem with the NICE commissioning stepped care guidelines and spreadsheet (op.cit. iii)) to enable commissioners to model costs and produce a cost framework from 1st April 2012.

IAPT costing

The IAPT costing framework is currently being piloted and is based on payment for four elements:

1. Access to the service

2. Clinical improvement and Recovery

3. Well being, meaningful occupation and employment outcome

4. Patient satisfaction and Choice

The measures of recovery will be those currently built into the IAPT framework, so create no new burden or data collection requirements.

There will be different weighting to each of these elements, and this is currently being tested and reports from the IAPT PbR pilot work are anticipated in Summer 2012 and it is anticipated that the future cost framework will align with this once the success of the pilots is confirmed.

http://www.iapt.nhs.uk/iapt/

Principles for AQP costing

1. Start with cluster costs

2. Collect IAPT outcome measures

3. Therefore enable shift for PbR analysis (i.e. input costs) to greater emphasis on outcome measures as the pilots prove themselves

Recommended Currency for Primary Care Psychological Therapies AQP for 2012/13

The recommended currency for Primary Care AQP will be based on PbR Care clusters that have been mandated for introduction in Mental Health services from April 2012. The proposal is to have a proportion of the currency paid for undertaking the required activity on behalf of the patient. The other portion of the payment will be for the successful recovery of the patient following treatment. Our suggestion for the introduction of AQP for Primary Care Psychological Therapies would be to split the payment as:

- Undertaking treatment on behalf of the patient – X% of cluster tariff
- Recovery[4] of the patient – Y% of cluster tariff

Our initial thoughts are that this could be based on a 75% / 25% split. However, the circumstances of the commissioner may mean that different proportions are appropriate. For instance where there is a developed market already with several providers likely to qualify, a greater percentage of the payment may be apportioned to the recovery of the patient. Where there is an immature market, then the commissioner may set the proportion for recovery lower to attract new players in (at lower risk) and then raise the proportion as the market becomes more established. The recommended recovery payment element should be based on full recovery, and not simply movement to a lower cluster. There may also be a case for including a proportion of the payment for the assessment.

In order to set the price for the service, some allowance must be made for the expected proportion of patients that will recover as well as the costs of providing the service. The price should be set at a sufficient level to attract a reasonable number of players in to the market and make the risk of some patients not recovering acceptable enough to providers not to put them off.

The DH PbR Team are currently working with current providers to determine the shadow local tariffs for Mental Health Care Clusters. It is advised that commissioners use the results of that work to inform their prices.

It has not been possible to construct a price for Primary Care Psychological Therapies as this will depend to a great extent on the specific remit of the services that the commissioner wants to have supplied under AQP. This should therefore be determined locally. However, there is a considerable amount of work underway across the country led by the DH PbR Team. As a result of this work, by the 1st April 2011 local cluster based tariffs will have been agreed between providers and commissioners. If you have any queries about this, please contact the DH PbR Team. In the mean time the NICE guidance recently published includes a useful financial modelling tool to allow local price calculation. This can be accessed via: http://www.nice.org.uk/usingguidance/commissioningguides/commonmentalhealthdisorderservices/commonmentalhealthdisorderservices.jsp

For further information on what the constituent elements of the service might be for costing purposes, please see section 6 and 8 of the CSIP IAPT Outline Service Specification[xxx]

[4] It may be appropriate to consider percentage gain towards recover as some patients may not completely recover but still make significant gains – particularly those whose symptoms are more severe at pre-treatment.

Recommended Currency for Primary Care Psychological Therapies AQP in the longer term

We recommend, subject to the outcome of the IAPT pilots, that the use of IAPT outcome measures is introduced to appropriate services. It is envisaged that there may be some changes to the IAPT currency model as a result of the pilots, so it is not possible to set here exactly how that will work. Commissioners are advised to await the result of the IAPT pilots and incorporate the results into future currencies as appropriate

3.5 Expected Annual Contract Values

[To be inserted for each Commissioner where relevant to the Services **OR** state "Not Applicable"]

Under AQP provisions an overall budget is agreed which is associated with expected demand for service and activity levels but the market will largely dictate which provider is chosen by patients to meet their service needs.

The estimated demand for PCPTS can be anticipated and modelled using the NICE commissioning stepped care tool[v] to include:

a. Review of current commissioned activity for common mental disorder in the target population
b. Future change in capacity required
c. Model of future commissioning intentions and associated costs
    a. Likely cost of new or additional services
    b. Anticipated set-up costs.
    c. Cost of facilities, for example venue hire
    d. Cost of staff travel to services and service-users' homes
    e. Unit costs per service user for each step of the care pathway
    f. Potential savings

B.2 - QUALITY

Part 1 - Quality Requirements

Under standard NHS contractual requirements, service providers are required to produce regular reports regarding service performance.

Of the Key Performance Indicators (KPIs) set out below to assess the outcomes of the AQP primary care psychological therapies services, we have highlighted the ones that we regard as most important in terms of impact and ease of measurement:

1) Access to service measures
    a. Population coverage (proportion of people receiving services in relation to estimates of community morbidity for common psychological problems)
    b. Increasing the proportion of people with common mental health disorders who are identified, assessed and receive treatment in accordance with NICE guidance, analysed by various sociodemographic groups (e.g. age, gender, ethnicity, socio-economic status etc)
    c. Increased choice and access to evidence based psychological therapies, particularly for groups who may be reluctant to engage with statutory services.
2) Service delivery and infrastructure measures
    a. Improved speed of access and response at various nodes in the care service pathway
    b. Improved interface between services for people with common mental health disorders and flow of people into and out of the service
    c. Improved identification of risks of harm to self and others and prevention of avoidable harm
3) Recovery outcomes and indicators
    a. Improving the proportion of people with common mental health disorders who make a clinically significant improvement or recover as evidenced by symptom change using standardised outcome measures (e.g. GAD7; PHQ9; appropriate anxiety disorder specific measures)on greater than 90% of patients treated
    b. Increased number of Service Users accessing psychological therapies that are 'moving towards recovery'.
    c. Reducing the proportion of people with common mental health disorders who relapse
4) Social participation and community integration
    a. Helping people stay in education, employment or meaningful activities and reducing long-term unemployment
    b. Increased number of Service Users accessing psychological therapies that are moving off sick-pay and benefits.
    c. Improved social adjustment and participation (e.g. as evidenced by Work and Social Adjustment Scale)
    d. Improved emotional wellbeing, functional ability an overall quality of life (e.g. as evidenced by Quality of Life measure)
5) Patient choice and satisfaction with services
    a. Improved service user choice and experience of services (e.g. as evidenced by Patient Experience Questionnaire)
6) Cost-effective service delivery system representing better potential value for money
    a. Increased number of Service Users and Carers with psychological disorder who can be managed successfully within primary care thus reducing the need to refer complex cases to secondary mental health or hospital care
    b. Reduction in referrals to secondary/specialist services
    c. Decreased repeat GP consultation rates for psychological disorder
    d. Decreased repeat consumption of psychotropic medication
    e. fewer inappropriate referrals to secondary mental health care services, including community mental health teams
    f. reduced use of hospital-based services as a result of increasing access to services in the local community and in primary care

g. costs avoided from successful use of psychological interventions reducing the inappropriate use of medications such as antidepressants
h. fewer GP visits to monitor progress and response to medication
i. fewer GP visits, because of earlier identification
j. wider economic savings from improved employability of people recovering from a common mental health disorder; this would deliver savings in the form of additional tax receipts and reduced welfare benefits payments.
k. Number of individuals successfully treated (recovered) per £100,000 expenditure
l. Unit cost per service user and outcome (see benchmarking tool endnote v).

HOWEVER, It is recognised that depending on local demographics, maturity of service and local preference commissioners may choose to prioritise different KPIs. Commissioners may also wish to use local outcome/KPI indicators relevant to their communities.

Suggested Specific Primary Care Psychological Therapies Quality Requirements

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	Access - Access by target groups (These can be defined as age, gender, ethnicity). The Protected characteristics and Target groups will be locally determined and specified in advance in the service level agreement.	100%	Activity data. User Feedback (where patients indicate that they have been prevented from accessing a service by a provider unless a specific exclusion has been agreed as part of contract with commissioner).	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target
	Service Delivery - Patients are seen within 28 days of referral.	90%	Activity data. User Feedback.	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target
	Service Delivery - Use of a locally agreed assessment tool that can determine the nature, duration and severity of the presenting disorder, and associated functional impairment.	100%	Assessment Data. Activity Data	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target
	Service Delivery – Staff Competency. % of staff trained and competent to deliver services as set out in contract	100%	Skills Audit Activity data	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target
	Recovery Outcome - Improved Psychological Status of Patients	90%	Activity Data. Assessment score.	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target
	Social Participation - Work & Social Adjustment Scale (W&SAS) – more than	75%	Activity Data. Work & Social Adjustment Scale (W&SAS)	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective

Technical Guidance Reference	Quality Requirement	Threshold	Method of Measurement	Consequence of breach
	75% of patients showing improvement against Work & Social Adjustment Scale (W&SAS) after treatment. *(alternative: patient moves from being unemployed to employed during the course of their treatment **or** moves from receiving Statutory Sick pay (SSP) to not receiving it **or** moves from receiving Job seekers allowance, incapacity benefit/ income support to not receiving it)*		assessment. *(alternative: employment / unemployment data)*	Action Plan and/or consistently fail to meet / exceed the target
	Patient Experience – From a minimum sample of 30% of patients, more than 75% report a 'good' or 'very good' patient experience.	75%	Patient Experience Questionnaire (to be agreed by Commissioner)	1. Review 2. Corrective Action Plan 3. Disqualification if failure to implement Corrective Action Plan and/or consistently fail to meet / exceed the target

NB: Thresholds may need to be adjusted by the commissioner depending on the baseline for the population served, and are likely to change over time as services become established and more data becomes available.

Other specific service quality requirements for delivery of PCPT services could include:

- Sharing of assessment information is should be shared between providers, to prevent unnecessary additional assessments.
- Assessment and treatment from an appropriately trained, qualified and competent professional.
- Standardised, validated tools to measure treatment outcomes and service delivery

See also Section 1.7 of 'Further Guidance for Primary Care Psychological Therapies (adults)'

Part 2 - **Nationally Specified Events [DN: To be finalised]**

Technical Guidance Reference	Nationally Specified Event	Threshold	Method of Measurement	Consequence per breach

Nationally specified events are recorded in the standard contract.

Part 3 - Never Events

national definition (part of standard contract)

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)

B.3 – INCENTIVE SCHEMES

Part 1 - Nationally Mandated Incentive Schemes

[For national determination]

Part 2 - Commissioning for Quality and Innovation (CQUIN)

Local Commissioning for Quality and Innovation (CQUIN[xxxi]) goals and incentives will form part of the overall contract for service providers. Local quality improvement goals may include

The CQUIN framework will be important for implementing NICE quality standards, improving service-user experience and driving improvement of outcomes (including patient reported outcomes measures)[xxxii] through setting clear goals in key target areas with attached financial incentives.

- improving assessment for people with common mental health disorders, resulting in more timely and responsive services and improved service-user experience
- improving availability of carer and family assessments for the families and carers of people using psychological intervention services, resulting in improved mental health for families and carers, and improved carer and family experience
- improving access and outcomes among people from locally targeted socially excluded groups, and people with defined chronic physical health conditions, learning disabilities or cognitive impairment
- improved wellbeing for people receiving psychological interventions, measured using locally agreed indicators such as the IAPT data standard
- ensuring assessment includes indicators of employment status, or other targeted indicators, to improve recovery and outcomes for people with common mental health disorders.

Table 1: CQUIN Scheme

[The Parties are recommended to use the on-line standard template for CQUIN schemes 2011/12 available on the website of the NHS Institute for Innovation and Improvement (at http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html) to facilitate the completion and recording of their CQUIN scheme.

Where the Parties use the on-line standard template, a copy of the completed scheme must still be printed and appended to this Schedule 18 Part 2 in place of the tables below.]

Quality Incentive Payments can be agreed to be paid monthly or by single annual payments.

PLEASE DELETE AS APPROPRIATE "The Parties agree that Quality Incentive Payments shall be paid monthly and therefore the provisions set out in paragraphs 5 to 13 below shall apply." **OR "**The Parties agree that Quality Incentive Payments shall be paid annually and therefore the provisions set out in paragraphs 14 to 19 below shall apply.

Summary of goals[5]

Goal Number	**Goal Name**	**Description of Goal**	**Goal weighting** (% of CQUIN scheme available)	**Expected financial value of Goal (£)**	**Quality Domain** (Safety, Effectiveness, Patient Experience or Innovation)
1		[insert locally agreed goals]			
2		[insert locally agreed goals]			
etc					
		Totals:			

5 The on-line standard template on the website of the NHS Institute for Innovation and Improvement contains some additional fields to assist its automated functions. Parties may include these additional fields in the completed version of the scheme included in the contract

Summary of indicators

Goal Number	Indicator Number[6]	Indicator Name	Indicator Weighting (% of CQUIN scheme available)	Expected financial value of Indicator (£)
1		[insert the indicator or indicators that are agreed in respect of each goal]		
2				
3				
Etc				
		Totals:		

Detail of indicator (to be completed for each indicator)

Indicator number	
Indicator name	
Indicator weighting (% of CQUIN scheme available)	
Description of indicator	
Numerator	
Denominator	
Rationale for inclusion	
Data source	
Frequency of data collection	
Organisation responsible for data collection	
Frequency of reporting to commissioner	
Baseline period/date	
Baseline value	
Final indicator period/date (on which payment is based)	
Final indicator value (payment threshold)	
Rules for calculation of payment due at final indicator period/date (including evidence to be supplied to commissioner)	
Final indicator reporting date	
Are there rules for any agreed in-year milestones that result in payment?	
Are there any rules for partial achievement of the indicator at the final indicator period/date?	

Milestones (only to be completed for indicators that contain in-year milestones)

6 There may be several indicators for each goal

Date/period milestone relates to	Rules for achievement of milestones (including evidence to be supplied to commissioner)	Date milestone to be reported	Milestone weighting (% of CQUIN scheme available)
		Total:	

Rules for partial achievement at final indicator period/date (only complete if the indicator has rules for partial achievement at final indicator period/date)

Final indicator value for the part achievement threshold	% of CQUIN scheme available for meeting final indicator value

1. Subject to paragraph 2, if the Provider satisfies a Quality Incentive Scheme Indicator set out in Schedule 18 Part 2 Table 1, a Quality Incentive Payment shall be payable by the Commissioners to the Provider in accordance with this Schedule 18 Part 2.

2. The Commissioners shall not be liable to make Quality Incentive Payments under this Schedule 18 Part 2 to the Provider in respect of any Contract Year which in aggregate exceed the applicable Actual Outturn Value percentage for the relevant Contract Year set out below:

Contract Year	Maximum aggregate Quality Incentive Payment
1st Contract Year	[For national determination and local insertion]

and for the avoidance of doubt this paragraph shall limit only those Quality Incentive Payments made under this Schedule 18 Part 2, and shall not limit any Quality Incentive Payments made under any Quality Incentive Scheme set out in Schedule 18 Part 1 or Schedule 18 Part 3.

3. The Provider shall in accordance with clause [33] of this Agreement submit to the Co-ordinating Commissioner a Service Quality Performance Report which shall include details of the Provider's performance against and progress towards the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in the month to which the Service Quality Performance Report relates.

4. The provisions set out in paragraphs 5 to 13 below apply in respect of Quality Incentive Payments made by monthly instalments. The provisions set out in paragraphs 14 to 19 apply in respect of Quality Incentive Payments made by a single annual payment.

Monthly Quality Incentive Payments

5. Where the Co-ordinating Commissioner and the Provider have agreed that Quality Incentive Payments should be made on a monthly basis by any Commissioners, then in each month after the Service Commencement Date during the term of this Agreement each relevant Commissioner shall make the default Quality Incentive Payment set out below to the Provider:

Commissioners	Monthly Quality Incentive Payment – 1st Contract Year
[insert name of each Commissioner making monthly CQUIN payments]	

and the Provider and the Co-ordinating Commissioner may from time to time, whether as a result of a review performed under paragraph 6 below or otherwise, agree to vary the default monthly Quality Incentive Payment for any Commissioner set out above.

6. The Co-ordinating Commissioner shall review the Quality Incentive Payments made by the Commissioners under paragraph 5 on the basis of the information submitted by the Provider under this Agreement on the Provider's performance against the Quality Incentive Scheme Indicators. Such reviews shall be carried out as part of each Review under clause [8].

7. In performing the review under paragraph 6 the Co-ordinating Commissioner shall reconcile the Quality Incentive Payments made by the relevant Commissioners under paragraph 5 against the Quality Incentive Payments that those Commissioners are liable to pay under paragraph 1 on the basis of the Provider's performance against

the Quality Incentive Scheme Indicators, as evidenced by the information submitted by the Provider under this Agreement.

8. Following such reconciliation, where applicable, the Provider shall invoice the relevant Commissioners separately for any reconciliation Quality Incentive Payments.

9. Within [10] Operational Days of completion of the review under paragraph 6, the Co-ordinating Commissioner shall submit a Quality Incentive Payment reconciliation account to the Provider.

10. In each reconciliation account prepared under paragraph 9 the Co-ordinating Commissioner:

10.1 shall identify the Quality Incentive Payments to which the Provider is entitled, on the basis of the Provider's performance against the Quality Incentive Scheme Indicators set out in Schedule 18 Part 2 Table 1 in those months of the relevant Contract Year that have elapsed at the time of the review;

10.2 shall ensure that the Quality Incentive Payments made to the Provider in respect of completed Contract Years comply with the requirements of paragraph 2;

10.3 may correct the conclusions of any previous reconciliation account, whether relating to the Contract Year under review or to any previous Contract Year; and

10.4 shall identify any reconciliation payments due from the Provider to any Commissioner, or from any Commissioner to the Provider.

11. Within [5] Operational Days of receipt of the Quality Incentive Payment reconciliation account from the Co-ordinating Commissioner, the Provider shall either agree, or, acting in good faith, contest such reconciliation account.

12. The Provider's agreement of the Quality Incentive Payment reconciliation account (such agreement not to be unreasonably withheld) shall trigger a reconciliation payment by the relevant Commissioner(s) to the Provider, or by the Provider to the relevant Commissioner(s), as appropriate, and such payment shall be made within [10] Operational Days of the Provider's agreement of the reconciliation account and the Provider's invoice.

13. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment reconciliation account:

13.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting such account, and in particular identifying which elements are contested and which are not contested;

13.2 any uncontested payment identified in the Quality Incentive Payment reconciliation account shall be paid in accordance with paragraph 12 by the Party from whom it is due; and

13.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 13.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 13 the relevant Party shall pay any amount agreed or determined to be payable.

Single annual payment of Quality Incentive Payments

14. Where the Provider and Co-ordinating Commissioner have agreed that one single Quality Incentive Payment should be made to the Provider by any Commissioner at the end of each Contract Year, then at the end of each Contract Year during the term of this Agreement each Commissioner set out in the table in this paragraph 14 shall, subject to the Provider's performance against the Quality Incentive Scheme Indicators, make a single Quality Incentive Payment to the Provider in accordance with the procedure set out in paragraphs 15 to 19 below.

Commissioners making single annual Quality Incentive Payment at the end of the Contract Year
[insert name of any Commissioner making a single annual CQUIN payments] [Insert amount of the single annual CQUIN payment for each relevant Commissioner]

15. The Co-ordinating Commissioner shall, within [10] Operational Days of the end of the Contract Year to which the Quality Incentive Payments relate or its receipt of final information from the Provider on its performance against the Quality Incentive Scheme Indicators during that Contract Year (whichever is the later), submit to the Provider a statement of the Quality Incentive Payments to which the Provider is entitled on the basis of the Provider's performance against the Quality Incentive Scheme Indicators during the relevant Contract Year, as evidenced by the information submitted by the Provider under this Agreement.

16. Within [5] Operational Days of receipt of the Quality Incentive Payment statement from the Co-ordinating Commissioner under paragraph 15, the Provider shall either agree, or, acting in good faith, contest such statement.

17. The Provider's agreement of the Quality Incentive Payment statement (such agreement not to be unreasonably withheld) shall trigger a payment by the relevant Commissioner(s) to the Provider, and such payment shall be made within [10] Operational Days of the Provider's agreement of the statement and the Provider's invoice.

18. In the event that the Quality Incentive Payment under paragraph 17 is paid before the final reconciliation account for the relevant Contract Year is agreed under clause [7] (*Prices and Payment*) of this Agreement, then if the Actual Outturn Value for the relevant Contract Year is not the same as the expected Annual Contract Value against which the Quality Incentive Payment was calculated, the Co-ordinating Commissioner shall within [10] Operational Days of the agreement of the final reconciliation account under clause [7] send the Provider a reconciliation statement reconciling the Quality Incentive Payment against what it would have been had it been calculated against the Actual Outturn Value, and a reconciliation payment in accordance with that reconciliation statement shall be made by the relevant Commissioner to the Provider or by the Provider to the relevant Commissioner, as appropriate, within [10] Operational Days of the submission to the Provider of the reconciliation statement under this paragraph 18.

19. If the Provider, acting in good faith, contests the Co-ordinating Commissioner's Quality Incentive Payment statement under paragraph 15 or reconciliation statement under paragraph 18:

    19.1 the Provider shall within [5] Operational Days notify the Co-ordinating Commissioner, setting out reasonable detail of the reasons for contesting the relevant statement, and in particular identifying which elements are contested and which are not contested;

19.2 any uncontested payment identified in the relevant statement shall be paid in accordance with paragraph 17 by the relevant Commissioner or the Provider, as the case may be; and

19.3 if the matter has not been resolved within 20 Operational Days of the date of notification under paragraph 19.1, either Party may refer the matter to dispute resolution under clause [28] (*Dispute Resolution*),

and within [20] Operational Days of the resolution of any Dispute referred to dispute resolution in accordance with this paragraph 19 the relevant Party shall pay any amount agreed or determined to be payable.

Part 3 - Locally Agreed Incentive Schemes

[For local agreement]

B.4 - PLANS

Part 1 - Eliminating Mixed Sex Accommodation Plan

[Insert/append EMSA Plan]

Not applicable

Part 2 - Service Development and Improvement Plan

Service development and improvement plans are a matter for local determination but may include

- Long-term impact of increased access to low and high intensity psychological interventions on referrals to other services and prescribing.
- Long-term impact of improved diagnosis of common mental health disorders on referrals to low and high intensity psychological interventions and on prescribing.
- Planned service development setting out any productivity improvements

Local good practice implementation databases (e.g. NICE shared learning[xxxiii]) may suggest fertile areas for service improvement.

Service Development and Improvement Plan

Description of Scheme	**Milestones**	**Timescales**	**Expected Benefit**	**Consequence of Achievement/ Breach**
[insert as defined locally]	**[insert as defined locally]**	**[insert as defined locally]**	**[insert as defined locally]**	**Subject to clause [32] (Contract Management)**

B.4 – SERVICE USER, CARER AND STAFF SURVEYS

Part 1 – Service User, Carer and Staff Surveys

[Mandatory but for local agreement – set out survey type, frequency, how it is to be reported and publication method where relevant]

Processes to understand service-user experience of common mental health disorder services, in order to develop and monitor services are needed.

This should include quality assurance and clinical governance processes incorporating expectations of how service-user opinion, preference and experience will be used to inform service delivery for example, focus groups, representation on working groups, and user satisfaction surveys; in accordance with good practice regarding patient and public involvement[xxxiv], [xxxv] and staff consultation.

Monitoring of complaints and compliments will also inform service development.
Parallel process for gaining staff views on services should also be employed (e.g. NHS Staff Survey[xxxvi]

B.5 - PROGRAMMES

Part 1 - Clinical Networks and Screening Programmes

[For local agreement and not to conflict with any information in Service Specifications]

Clinical networks for psychological therapies etc

B.6 - INFORMATION MANAGEMENT

All information gathered for the purposes of reporting is subject to the requirements set out in clause [27], (*Data Protection, Freedom of Information and Transparency*) and clause [56] (*Compliance with the Law*).

Part 1 - National Requirements Reported Centrally

1. The Provider and Commissioner shall comply with the reporting requirements of SUS and UNIFY2**.** This includes compliance with the required format, schedules for delivery of data and definitions as set out in the Information Centre guidance and all Information Standards Notices (ISNs), where applicable to the service being provided.

2. The Provider shall ensure that each dataset that it provides under this Agreement contains the Organisation Data Service (ODS) code for the relevant Commissioner, and where the Commissioner to which a dataset relates is a Specialised Commissioning Group, or for the purposes of this Agreement hosts, represents or acts on behalf of a Specialised Commissioning Group, the Provider shall ensure that the dataset contains the ODS code for such Specialised Commissioning Group.

3. The Provider shall collect and report to the Commissioner on the patient-reported outcomes measures (PROMS) in accordance with applicable Guidance.

4. The Provider shall comply with the national reporting requirements in relation to Sleeping Accommodation Breaches as set out in the Professional Letter.

Part 2 - National Requirements Reported Locally

Serious Untoward Incidents (SUIs)

All Serious Untoward Incidents must be reported via appropriate national and local mechanisms, and a root cause analysis appropriately undertaken. Providers that fail to do so should be considered in breach of contract.

Part 3 - Local Requirements Reported Locally

[Insert information that is local required and agreed - to include format, method of delivery and Frequency.]

Local commissioners will determine reporting requirements but should build on the IAPT data standard which forms the basis of national data collection for IAPT services and is a clinical management tool that is used to record service-user outcomes measures. The measures include:

- Service-user details – demographic details that can be used to demonstrate compliance with the Equality Act 2010
- Disability details – comorbid physical or mental health disorders, learning disability, sensory impairment
- Referral data – provisional diagnosis to inform the clinical approach, and key dates including waiting times
- Appointment data – clinical, work and social functioning outcome scores, including disorder-specific measures, and key dates to measure recovery rates

The clinical, work and social functioning outcome measures are:

- Patient health questionnaire (PHQ-9) for depression
- Generalised anxiety disorder assessment (GAD-7)
- IAPT phobia scales
- A range of anxiety disorder specific measures (ADSMs)
- Work and social adjustment scale (WSAS)
- IAPT employment status questions
- IAPT patient choice and experience questionnaire

Appropriate measures should be taken at every service-user contact.

Further information can be found in the IAPT data handbook[xxxvii]:

Regular audit and performance reports regarding assessment, intervention and treatment outcomes will be required[xxxviii].

Other performance monitoring requirements relating to local need and demand for treatment (e.g. impact of PCPTS on admissions to community mental health or inpatient services may be important local indicators.

Similarly, equality impact assessment of the PCPTS can determine which sociodemographic groups may be under-represented in access to the service.

Part 4 - Data Quality Improvement Plan

Data Quality Indicator	Data Quality Threshold	Method of Measurement	Milestone Date	Consequence
[for local definition]	[for local definition]	[for local definition]	[for local definition]	[for local definition]

Section 2

Information Requirements for Patients

Section 2 – Information Requirement for Patients

The following information should be shared with patients to support them to choose between different providers of Primary Care Psychological Therapy Services, as well as understand how they will be able to interact with the service.

Information should be made available in all appropriately accessible formats and also in languages other than English appropriate to the population covered by the service. All necessary information should be given to individuals at the time of referral to assist in making informed choices.

The outcome of the consultation with people who have experienced primary care psychological services suggest that overall, all of the ten identified criteria below are important in making decisions between services. The following bullet points are in order of priority as identified by service users:

1) Details about how quickly patients will be able to get a service;
2) Information on what happens to patients when they leave the service (follow-up care etc);
3) The range of specific services offered by the provider;
4) Opening / access times, including availability during evenings and weekends;
5) Information relating to the effectiveness of the service;
6) Staff qualifications;
7) Location of service;
8) Information about how patients will be welcomed into the service;
9) Testimonials from previous users of the service;
10) The provider's length of experience of delivering the service.

However, the overall feedback from the consultation is that all the above ten factors add value to at least some patients in making decisions relating to choice. No other factors were identified by participants as being of particular important at time of making the choice.

Section 3

Recommendations on qualification requirements for the service

Section 3 – Recommendations on qualification requirements for the service

1 The current proposed AQP qualification process would include criteria such as evidence that the provider has a Monitor license (where required) and CQC registration (where a regulated activity is being provided). Where a provider does not need a CQC registration, this will not preclude them from becoming a qualified provider, as long as they can meet proportionate, equivalent criteria regarding clinical quality and safety.

2 For professionals and occupational groups which are currently not subject to statutory professional regulation, the Government is proposing a system of assured voluntary registration as a more proportional alternative to compulsory statutory regulation for unregulated groups of health and social care workers. Under the proposed new system, the CHRE will be renamed as the Professional Standards Authority for Health and Social Care (PSA) and will be the national accrediting body for voluntary registers. It is anticipated that the accreditation scheme will be open to applications from 2012, with the first tranche of applicant registers receiving accreditation by the end of 2012.

3 Whilst for many healthcare professionals, registration would be voluntary, when procuring services, commissioners could give weight to registration of staff or make it a qualification requirement. Individual members of the public seeking care from self-employed practitioners will be able to choose to go to practitioners on an assured voluntary register.

4 To deliver effective Psychological Therapies in Primary Care for Adults requires a skill mix of staff available to deliver both "High Intensity and Low Intensity" interventions, as similarly described in the IAPT model. The Low Intensity service being staffed by Psychological Wellbeing Practitioners who can provide a high volume of "low intensity" therapeutic interventions and High Intensity Psychological Therapeutic Practitioners who can provide appropriate therapies for people requiring more complex interventions. All staff should be required to demonstrate the relevant qualifications, competencies, supervision arrangements and access to appropriate, work-based education and training necessary to enable them to deliver the service[xxxix]. The main accrediting bodies are the British Association of Counsellors and Psychotherapists (BACP), the United Kingdom Council of Psychotherapists (UKCP), the British Psychoanalytic Council (BPC) and the British Association of Behavioural and Cognitive Psychotherapists (BABCP) and the British Psychological Society (BPS).

5 Staff development, accreditation and competency:

5.1 The service will be responsible for ensuring that adequate training and appropriate case management and clinical supervision in the required therapeutic competencies are provided to staff,[xl].

5.2 The Provider must ensure that all staff involved in providing any aspect of care under this Service Specification adhere to the following professional service standards in order to provide quality provision and fulfil clinical governance requirements.

- Mentoring – for students or newly qualified practitioners
- Induction - for newly appointed practitioners
- Appropriate management of the service and the practitioners
- Clinical Supervision – an ethical requirement of all professional talking therapy bodies. For BABCP accreditation of high intensity training, attendance at regional IAPT specific supervision training is mandatory.

- Quality Assurance - evidence of audits, evaluation and research based practice

5.3 The provider will ensure management and case supervision at all levels[xli]; [xlii]. Treatments should be provided by health professionals with appropriate training in the relevant intervention. Staff must have regular supervision from a suitably qualified health professional.

Section 4

Additional Notes by the implementation pack team

Section 4 – Additional Notes by the implementation pack team

Comments on Consultation on Any Qualified Provider (AQP) Primary Care Psychological Therapies (adults) Service to date

To date, a number of comments have from primary care stakeholders and associated experts have been received regarding the draft AQP Primary Care Psychological Therapies Service (adults) Specification. Key themes emerging include:

Estimating need

Commissioners need to be clear about what measures (e.g. incidence/prevalence) are being used to establish baseline of need.

Health and social needs should be considered to avoid an "over-medicalised" diagnostic framework for assessing needs.

Service Integration

The key to success involves enabling and strengthening working together, local partnership, and avoiding fragmentation.

Development of effective shared care models is important for more severe/complex co-morbid conditions.

Third sector organisations often have a track record of coordinating care across health and social agencies.

Forging long term relationships

GPs want to work with people who have acknowledged expertise and who are committed to build and sustain long term relationships with the GPs

Understanding primary care

Service providers need to understand the primary care environment and to be flexible and responsive in their working methods

Role of the third sector

Third sector services and social enterprises are highly regarded by many GPs and are perceived to match the professional standards and outcomes of statutory services in many instances.

Dissemination of good practice and clinical networks

Case studies of successful practical case work and successful implementation are of great assistance to GPs in commissioning primary care psychological services. This might include networks for quality assurance and consistency between localities.

Scope of Primary Care Psychological Therapies (adults) service

There has been a diversity of views about what the scope of such a service should be. Some have advocated that implementation pack should focus purely on IAPT services as they contend that this is where the strongest evidence lies. Others believe that a much more radical and wider service specification is required to encourage innovation and increase patient choice. We have taken an approach that seeks to steer a middle course, building on the core of IAPT, but adding in other conditions and services (the 'IAPT Plus' model). It will clearly be up to commissioners to determine for themselves how they wish to approach this on the basis of their local clinical issues and the breadth of evidence available to them.

A number of people have raised questions regarding other groups (e.g. people with Asperger's Syndrome) and where these needs may be met.

NHS Bristol have been developing a bottom up approach to AQP and are willing to discuss this with commissioners who are interested in this approach. Please contact Mark Hayman or James Woods if you would like to discuss this.

Risk Management

Clinical risk management must be integral to service delivery and commissioning, involving consistent risk assessment tools in relation to risk of harm to self and others.

Use of common screening, assessment and treatment outcome measures will help to achieve a consistent approach.

Competition and Commissioning

We have received a number of concerns regarding the use of AQP for this service. Whilst the core implementation pack team are open to the view that competition may well improve choice and help to drive up service quality, we acknowledge that there are risks and strong commissioning and provider relationships will be required to ensure that patients do not fall into gaps between services. Even where AQP is in use, there remains a need for services to work in an integrated way to ensure a seamless service to patients.

Commissioners need to consider how to develop the market for provision of psychological therapies and avoid the twin dangers of large monopoly providers (who can readily absorb variance in access rates to their services) and fragmentation with multiple small providers, leading to large commissioning (and provision) management overheads to manage a plethora of small contracts across the pathway of care.

Appropriate ICT (information and communication technology) may assist the process.

Service delivery system risks include significant over- or under-capacity of services. Small providers may be particularly vulnerable to exiting the market and not being able to sustain activity.

Framework agreements with indicative/expected levels of activity and indicative budgets may help to anticipate or manage these risks.

Existing tools such as CQUIN and QIPP can be used to increase capacity and choice of services.

Provider accreditation in terms of prior experience in delivering service and skills base is important.

There may be an "optimal number" (6-10?) of providers in any one locality to provide primary care psychological therapy services which promotes innovation and choice but does not incur burdensome overheads in terms of service management and commissioning.

Some reviewers have raised a general concern that under AQP some providers may see an incentive to over-diagnose patients and possibly lead people towards additional services that they may not need. Commissioners will need to ensure that they are able to audit services to ensure that such issues do not occur.

Workforce

Implementation of AQP could de-stabilise existing IAPT services and their associated university training programmes leading to imbalances in supply of appropriately trained workers. Commissioning plans thus need to include clear workforce assumptions and development plans.

There is a need to ensure that practitioners have the skills to deal with more complex/severe/comorbid conditions which may not have been covered in their core IAPT or associated trainings.

Self-referral

Although IAPT encourages self referral mechanisms, commissioners will need to consider the implications under AQP to ensure that services are not overwhelmed by inappropriate demand. The use of appropriate pre-screening tools can help to manage this process.

Cost-Effectiveness

Commissioners need to ensure that they are not "paying twice" for psychological therapy services (especially within the "IAPT plus" model) which specialist mental health services are already being paid to provide.

In addition, there is a need to develop clear tender/contractual documentation to ensure that "gaming" between providers is reduced and that patients flow to appropriate levels of stepped care. In addition there is a need to ensure that providers are not merely providing new services to meet new demands rather than enhancing cost-effectiveness of previous provision.

The AQP process in the future may need to link with the development of personal health budgets but caution is needed based on the chequered experience of implementation of social care budgets.

There is a need to examine cost-effectiveness across the whole health/social care delivery system. For instance many local authorities have stopped providing certain social care services for lower assessed need groups and option for "signposting" to such services are no longer realistic. Shared objectives in the context of Joint Strategic Needs Assessment and mental health strategies can help to set local priorities and scope of services. For instance, supporting carers can be highly cost-effective in straitened times.

Caution is needed in relation to some outcome measures (e.g. reduced consultation rates in primary care for depression as an outcome measure may lead to poorer clinical outcomes as consultation rates may already be too low for some sociodemographic groups). Finer grain targets (e.g. in relation to repeat consultations/medication; frequent surgery attenders with medically unexplained symptoms) may be more appropriate in achieving clinically appropriate cost-efficiencies.

Annex 1

Details of the core delivery team/ Acknowledgements

Annex 1: The core implementation pack team consisted of the following:

Duncan Henderson	**Implementation Pack lead, NHS West Midlands**
James Woods	**Implementation Pack Lead, NHS Bristol**
Lawrence Moulin	**Mental Health Lead, NHS West Midlands**
Amanda Gatherer	**Director of Psychological Services and Head of Psychology, Birmingham and Solihull Mental Health Foundation Trust**
Alison Longwill	**Consultant Clinical Psychologist (West Midlands)**
Sally Whitley	**Commissioning Manager for Mental Health and Learning Disabilities, NHS Bristol**
Andy Gill	**Strategic Planning Specialist, NHS West Midlands**

Our thanks and acknowledgements go also to the following members of the wider reference and stakeholder review groups for their help and support in contributing to and reviewing the documentation, including:

Name	**Organisation**
David Clark	National Clinical Advisor to IAPT
Kevin Mullins	National IAPT Programme Lead, Department of Health
Rufaro Kausi	IAPT Programme, Department of Health
Kirsten Raw	Royal College of Nursing
Anne Garland	Royal College of Nursing
Mark Hayman	Bristol PCT
Kate Schneider	NHS South of England (West)
Alex Stirzaker	NHS South of England (West)
Kathy Roberts	Mental Health Provider Forum
Prof. Helen Lester	Birmingham University/GP
Liz Howels OBE	Avon and Wiltshire Mental Health
Andy Ibbs	NHS South of England (West)
Benjamin Fry	Get Stable
Richard Evans	The Artemis Foundation
Dr Dave Porteous	General Practitioner – The Fishponds Family Practice
Graeme Barnell	Bournemouth and Poole PCT
Julie Kell	NHS North Somerset PCT
Jeanette George	NHS North Somerset PCT
Joanne Dobson	NHS Tees
Shelagh Meldrum	Circle Bath
Stephen Illingworth	South Gloucestershire PCT
Dr Phil McCarthy	Westbury Surgery

Roger Tweedale	GP Care UK Limited
Robert Waugh	Inclusion Matters
James de Pury	South West Development Centre
John Mellor-Clark	Core IMS
Adeyanju Bakare	Bristol PCT
Alex Stirzaker	SWDC Expert Reference Group - IAPT
Claire Sperring	SWDC Expert Reference Group – IAPT
Silvia Cataudo	SWDC Expert Reference Group – IAPT
Jean Alger-Green	SWDC Expert Reference Group – IAPT
Jean Grant	South Gloucestershire PCT
Dan Burningham	Mental Health Strategies
Bentley Kaye	NHS South West
Dr Anand Chitnis	GP
Mick Wallace	Rethink
Mark Kenwright	North Staffordshire PCT
Nicola Bromage	Staffordshire County Council
Alex Nuthall	South Staffordshire & Shropshire Foundation Trust
Margaret Newton	South Staffordshire & Shropshire Foundation Trust
Lesley Burton	Dudley and Walsall Mental Health Trust
Heidi Davies	Dudley and Walsall Mental Health Trust
Jeanette McLoughlin	Black Country Partnership NHS Foundation Trust
Sue Vincent	Sandwell MIND
Brian Simpson	Wolverhampton PCT
Rachel Parham-Connolly	Herefordshire PCT
Robert Peel	Coventry & Warwickshire Partnership Trust
Carol Peckham	Solihull Care Trust
Joanne Gill	Birmingham & Solihull Mental Health Foundation Trust
Terry Downes	Birmingham & Solihull Mental Health Foundation Trust
Michael Stout	Worcestershire Mental Health Partnership Trust
Dr Mark Rousseau	GP
Dr Julian Povey	GP
Fran Beck	NHS Telford & Wrekin & Shropshire County PCT
Liz Welsh	Shropshire County PCT
Samantha Ruthven-Hill	Shropshire County PCT
Michael Bennett	NHS Telford & Wrekin
Anna Charalambous-Green	NHS Telford & Wrekin
Vanessa Devlin	Birmingham & Solihull PCT Cluster
Dr Caron Morton	GP
Fiona Sutcliffe	Contracts Team, Department of Health
Alison Treadgold	Nottingham City PCT
Sue Nowak	Payment by Results team DH
Jeff Love	Stoke City Council
Amanda Edwards	Hereford PCT
Anet Baker	Walsall PCT
Anima Thawait	Coventry PCT
Chris Lewington	Warwickshire County Council
D Hitchen	Worcestershire County Council
Dawn Williams	Staffordshire County Council
Elaine Woodward	Dudley PCT
Gurdip Chima	Wolverhampton City Council
Jane Sims	Birmingham East & North PCT

Joanne Carney	Birmingham East & North PCT
Joanne Hankinson	Birmingham East & North PCT
John Brady	Coventry PCT
Julia Phillips	Solihull PCT
Lesley Brougham	Sandwell PCT
Lisa Hill	Sandwell PCT
Lisa Jacob	Telford & Wrekin PCT
Lorna Ferguson	Warwickshire County Council
Mary-Ann Doyle	West Midlands Specialised Services Agency
Michael Bennett	Telford & Wrekin PCT
Michael Kay	Birmingham East & North PCT
Paul Woodin	Sandwell PCT
Phil Bryan	West Midlands Specialised Services Agency
Ron Daley	Staffordshire County Council
S Harris	Worcestershire County Council
Sally Eason	Warwickshire PCT
Samantha Hill	Shropshire PCT
Stephanie Wain	Telford & Wrekin PCT
Teresa Hewitt Moran	West Midlands SHA

In addition Bristol City has undertaken a large-scale public consultation process for the whole of mental health and we would like to thank all those involved.

We would also like to thank all the patients who have shared their views with us anonymously via questionnaires.

Annex 2

Annex 2 (to be completed)

Please note Annex 2 is being updated - the following link will take you to the latest version of this document.
http://nww.supply2health.nhs.uk/AQPResourceCentre/Pages/Annex2.aspx

Annex 3

Public Sector Equality Duty

Annex 3

Public Sector Equality Duty

The Equality Act 2010 replaces the previous anti-discrimination laws with a single Act making it easier for people to understand. It also strengthens the law in important ways, to help tackle discrimination and inequality. The Public Sector Equality Duty, which came into effect on 5 April 2011, sets out the responsibilities a public authority must undertake in order to ensure an environment that fosters good relations between persons of differing protected characteristics. Protected characteristics under the Equalities Act 2010 are age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation. The Equality Duty has three aims. it requires public bodies to have due regard to the need to:

- eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and people who do not share it; and
- Foster good relations between people who share a protected characteristic and people who do not share it.

Commissioners should have regard to the Public Sector Equality Duty when commissioning services for patients. For more information, please visit the Department of Health website and search for 'Equality and Diversity'.

Annex 4

Glossary

AQP: Any Qualified Provider - a way of commissioning NHS services that enables patients to choose any provider that meets the necessary quality standards and is prepared to deliver a service for the price set and according to the terms and conditions set out in the NHS Contract.

BABCP: the British Association of Behavioural and Cognitive Psychotherapists

BACP: British Association of Counsellors and Psychotherapists

BPC: the British Psychoanalytic Council

BPS: and the British Psychological Society ().

CCBT: Computerised Cognitive Behavioural Therapy

CBT: Cognitive Behavioural Therapy

CQUIN: Commissioning for Quality & Innovation. A mechanism for incentivising quality improvement within NHS contracts.

HIW: High Intensity Worker - High Intensity Psychological Therapists provide a course of cognitive behavioural therapy (CBT) at Step 3. These roles are likely to be delivered by a mix of professions including CBT therapists, clinical psychologists, counsellors, nurses, occupational therapists, and psychotherapists. However they are required to be an accredited/accreditable BABCP practitioner or able to demonstrate equivalence.

IAPT: National NHS Programme for Improving Access to Psychological Therapies

MOSAIC- Mosaic UK is Experian's system for classification of UK households. It is one of a number of commercially available geodemographic segmentation systems, applying the principles of geodemography to consumer household and individual data collated from a number of governmental and commercial sources

NICE: National Institute of Clinical Excellence - n independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

PSA: Professional Standards Authority for Health and Social Care, which will be the national accrediting body for voluntary registers.

Psychoeducation: A method of helping persons with a mental illness or anyone with an interest in mental illness, to access the facts about a broad range of mental illnesses in a clear and concise manner. It is also a way of accessing and learning strategies to deal with mental illness and its effects.

PWP: Psychological Well-being Practitioner: PWPs work within the Improving Access to Psychological Therapies (IAPT) service. They provide high volume, low intensity interventions for clients with mild to moderate depression, based on a cognitive behavioural model.

UKCP: United Kingdom Council of Psychotherapists

Annex 5

References

Annexe 5 – References

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[vii] http://www.nice.org.uk/guidance/cg90

[viii] http://www.nice.org.uk/guidance/cg31

[ix] http://www.nice.org.uk/guidance/CG26

[x] http://www.mdguidelines.com/adjustment-disorder-with-anxious-mood

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