iapt

Improving Access to Psychological Therapies

NHS

IAPT for Adults Minimum Quality Standards

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

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

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3.	Joint commissioning of high and low intensity interventions within IAPT should ensure seamless transition of patients within the stepped care model. Commissioning should also aim to develop coherent care pathways linking IAPT with other mental health provision.	Providing clarity about the range of local service options aids informed choice and decision-making for referrals; and improves patient satisfaction and clinical efficiency within IAPT, between primary and secondary care provision and with other organisations providing local mental health treatment	Waiting times, and duration of treatment Proportion of patients who return positive Patient Experience Questionnaire scores
4.	Services should have a clear focus, capability and capacity to safely manage severe and complex cases.	These are the cases where the greatest clinical, and other returns, can be achieved.	Proportion of cases: • below caseness at onset • in severe range (as defined through clustering tool, or IAPT outcome measures) • with co-morbidity
B	**Access:**		
5.	Services should focus on prompt access and equity of access for the harder-to-reach local community, such as older people and the long-term unemployed.	Ensuring inclusion of marginalised groups (such as older people, long-term unemployed), under-represented clinical conditions (such as PTSD) and those	Numbers entering treatment profiled by protected characteristics (age, ethnicity, sexuality etc.) & diagnosis, compared to local prevalence profile;

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		protected under the Equalities Act will prevent and reduce health inequalities as they emerge.	Waiting times ; length of time by protected characteristics, and diagnosis.
6.	Services should seek to expand self-referral and ensure promotion and marketing to different sections of the community.	Conventional access via GPs can present barriers to access for different sectors of the community, reduce clinical reach and unintentionally maintain health inequalities.	Source of referral and profile of service users.
7.	Patients should have a choice of therapy according to preference, choice of when and where to be seen, plus how NICE recommended treatments are delivered (eg individual, group, via telephone etc.) when appropriate. Arrangements should be mutually agreed between patient and therapist as part of good care planning.	Enabling informed patient choice improves effective clinical engagement, appropriately matched therapeutic alliances and better treatment compliance, which maximizes clinical outcomes.	Proportion of patients who return positive Choice related questions (part of Patient Experience Questionnaire)
C	**Treatment:**		
8.	Service users should receive patient centered assessments (problems and goals, employment issues) plus a provisional diagnosis, and cluster assignment if	Patient-centered assessments provide the basis for effective and efficient clinical care and the delivery of an	8 & 9; Numbers of people who have a) shown reliable improvement, reliable deterioration, or no change in

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	agreed locally, at intake, with subsequent regular progress reviews.	appropriately focused course of therapy.	both PHQ9 and GAD7 (or other relevant Anxiety Disorder Specific Measure), and/or moved below caseness for depression & anxiety. b) achieved work and social adjustment goals on Work &Social Adjustment Scale measures c) good Patient Experience Questionnaire scores that indicate individual goals have been met.
9.	Treatments should be NICE recommended and evidence based, offered in the appropriate dosage by a trained and accredited workforce.	Good concordance with NICE clinical guidelines will assure optimum clinical outcomes, enable benchmarking of services and practitioner performance, and support use of practice-based evidence to inform future NICE guidelines and improved quality.	See above.
10.	Consistent arrangements for liaison with GPs at discharge and routine follow up where indicated should be in place.	Psychological treatments aim to provide sustained benefit as the evidence shows common mental health problems can be recurrent and sometimes chronic. Risk of	Number of people who are re-referred for treatment following deterioration after follow-up is complete

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		future relapse can be reduced by detection of early signs and occasional 'booster' / follow-up sessions when required. There is a higher risk of relapse for those patients taking medication at the point they stop medication. Relapse can be prevented by a planned approach to stopping medication always in liaison with the GP, prior to discharge, or via follow-up. An ongoing benefit of therapy can be sustained resilience post-treatment.	
D	**Outcomes Data Collection:**		
11.	A minimum of 90% data completeness for pre/post treatment scores should be achieved from all patient contacts.	High levels of session by session data completeness are essential to: ○ Inform and confirm each patient's journey to recovery	Data completeness: Paired observation scores. Data quality measures, including;

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		○ Help therapists identify appropriate therapy targets And to: ○ Assure safety, clinical effectiveness and patient satisfaction ○ Transfer patients between steps safely and efficiently ○ Operationally manage and use resources efficiently, through continuous evaluation of outcomes	• Proportion of cases with a provisional diagnosis • Proportion with diagnosis of mixed anxiety and depression • Appropriate use of anxiety disorder specific measures
12.	IT systems should enable therapists and service directors to have prompt access to outcomes data and to generate service reports.		Local assessment/audit by supervisors, service managers and/or data support personnel.
13.	Routine outcomes data measurement should be used to inform regular clinical supervision (see below) and to improve service quality and accountability.		Local assessment/audit by supervisors and service director.
14.	To effectively operate a stepped care service it is		Local assessment/audit. Each episode

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	essential that patients can be tracked through the full stepped care pathway through an inter-operable IT system.		of care should be traceable between steps between steps and across systems without double counting.
E	**Workforce Education and Training:**		
15.	Services should aim to develop a balanced workforce in relation to local needs, i.e. in terms of skill mix for different modalities and levels to offer best matched care according to patient preference, as well as clinical background, gender, ethnicity etc. to offer culturally acceptable options.	Consistent high quality workforce, education and training standards (as also described in NICE quality standards) correlate with: • Maintaining education and training standards proven to promote patient confidence and deliver superior recovery rates as well as achieve and maintain equitable access and culturally competent service provision • Offering consistent and continuous services by developing staff for more complex roles or maintain performance levels in existing roles	15, 16 and 17; Annual workforce census, organised locally or in conjunction with LETBs, as well as other local audits. National Audit of Psychological Therapies (therapist questionnaires)[1].
16.	Services should have a stable core of trained and accredited therapists (by an appropriate accreditation organisation for psychological therapists offering NICE-approved treatments[2]) who represent a mix of seniority across the different therapeutic modalities and can support IAPT trainees in their clinical development.		

[1] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/nationalclinicalaudits/psychologicaltherapies/psychologicaltherapies.aspx

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17.	Services should have sufficient therapists trained to deliver high intensity and low intensity treatments.	And • assure safety, clinical effectiveness and staff /trainee satisfaction and therefore efficiency of services.	
18.	Therapists (experienced and trainees) should receive regular and appropriate outcomes informed supervision; continued professional development; access to appropriate clinical facilities (e.g. clinic rooms, digital recording, telephones, IT systems) and opportunities to see a mixed caseload including some patients who present with mild or moderate symptoms. Workloads should be consistent with professional and ethical guidelines for sustainable quality of care.		18 and 19; Annual course surveys and feedback from Higher Education Institutions and training providers, as well as other local audits.
19.	Staff turnover should be monitored, e.g. via "exit interviews"		

[2] http://www.iapt.nhs.uk/workforce/accreditation/