iapt
Improving Access to Psychological Therapies

NHS

Commissioning Talking Therapies for 2011/12

Issue 3 **March 2011**

1. Introduction

1.1 This note supports Primary Care Trusts (PCTs) in commissioning services to meet the needs of local people who are experiencing the common mental health problems of depression and anxiety disorders.

1.2 Specifically, it supports commissioners in developing local business cases for 2011/12 that generate efficiency and cash **savings of around £340 on average for each patient who is treated with IAPT services.** Savings may have already been taken into account locally in some areas.

1.3 There is strong evidence that appropriate and inclusive services and care pathways for people with common mental health conditions reduce an individual's usage of NHS services leading to efficiencies and cost savings, as well as contributing to overall mental wellbeing. This approach promotes inclusive, equitable services that meet the needs of the whole community.

1.4 Increasingly, there will be room for innovative approaches in the services commissioned, along with flexibility tailored to local need and to the personal needs of individuals seeking treatment. The key focus is on the outcomes achieved, and we will be evolving a currency and tariff to enable the introduction over the next year or so of Payment by Results for talking therapies.

2. Building the local business case

2.1 Funding

2.1.1 All of the £173m funding awarded to the IAPT programme in the 2007 Comprehensive Spending Review (CSR07) is in PCT baselines from April 2011, distributed on the basis of weighted capitation. None of this funding will be centrally allocated, via Strategic Health Authorities (SHAs), as has been the case in previous years.

2.1.2 All commissioners of talking therapies will want to work with finance leads to identify this funding at the earliest opportunity to ensure services are maintained.

2.1.3 The Government's October 2010 Spending Review included around £400 million to complete the roll out of psychological therapy services by 2014/15. Details of how this investment will flow were announced in the NHS Operating Framework (Dec 2010)[1] and the Mental Health Strategy 'No Health Without Mental Health' (Feb 2011)[2], providing further clarity and guidance about the savings the programme can generate for the NHS and the wider public sector[5].

[1] The Operating Framework for the NHS in England 2011/12 (Dec 2010) gateway reference 15216
[2] No Health Without Mental Health: *A Cross-Government Mental Health Strategy for people of all ages* (Feb 2011) gateway reference 14679

2.2 Cost Savings

2.2.1 Commissioning IAPT services is likely to result in achieving savings to offset the upfront cost in the budgetary year in which services are delivered, as well as possible net cost savings to the local NHS in the long term[3].

2.2.2 Untreated depression and anxiety disorders are associated with increased health care usage – not only ongoing consultations and treatment in relation to the specific mental health condition, but also increased health care usage more generally.[4] Treating individuals with IAPT services will help to reduce this usage, delivering important cost savings to the PCT.

2.2.3 As a worked example, IAPT treatment will deliver efficiency and cash savings to the local NHS of an estimated £1,060 on average for each additional person who recovers from depression or anxiety disorder.

2.2.4 The expected saving for all patients who receive IAPT treatment can be determined from the overall recovery rate for patients who undergo IAPT therapy (National Standard of 50% recovery), minus the proportion that would make a natural sustained recovery without any treatment. Evidence indicates that the natural recovery rate is around 18%.

2.2.5 Based on the expected IAPT recovery rate of 50% and a natural recovery rate of 18%, **the expected efficiency and cash saving to the PCT per patient treated is £340 on average**. This compares favourably with the upfront cost of a course of treatment.

2.2.6 For each patient recovering from depression or anxiety disorder as a result of IAPT treatment, **average savings over the following two years include**[5] :

- **3.2 fewer GP consultations on average, constituting efficiency savings** by freeing up GP time to be used in other productive ways. These cannot generally be direct cash-releasing savings because the weighted capitation formula reimburses GPs on a per patient basis rather than per consultation. However, this indirectly delivers benefits to other patients who can be treated in the freed-up time, and ultimately potential cash-releasing savings to the local NHS (e.g. through successfully preventing acute secondary care admissions from the GP consultations booked into the freed-up time).

- **1.5 fewer inpatient bed nights on average, resulting in direct cash-releasing savings** to the PCT for those admissions with an activity-based tariff. It is expected that the savings will be predominantly in general health care admissions, rather than mental health admissions, which may be quite limited for this patient group in the first place.

[3] DH estimates that the main health care savings are realisable within three years of referral to an IAPT service.
[4] Layard, R., Clark, D., Knapp, M., Mayraz, G.(2007). 'Cost-Benefit Analysis of Psychological Therapy'. Centre for Economic Performance. CEP Discussion Paper No 829, October 2007.
[5] Estimates of possible savings are taken from analysis of the British Household Panel Survey undertaken by DH, published in 'Talking therapies: a four year plan of action – impact assessment', http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123994.

For admissions where there is a block contract, there will be only efficiency savings. Direct cash savings can be achieved for admissions avoided where the reimbursement mechanism is activity or volume-based.[6] As services move increasingly to tariff, cash savings will correspondingly increase. For the limited reductions in mental health admissions, a national currency for mental health is being developed, with patients grouped into care clusters rather than Healthcare Resource Groups (HRGs).

- **0.7 less outpatient procedures on average, generating direct cash-releasing savings** in the same way as for inpatient bed nights.

Service type	Reduction in service usage	2010/2011 unit costs	Efficiency and cash savings	Key
GP consultations	3.2	£38	£120	A
Inpatient bed nights	1.5	£533	£800	B
Outpatient procedures	0.7	£200	£140	C
Total expected saving per person who recovers (rounded)			**£1,060**	**D=A+B+C**
IAPT recovery rate (national estimate)			50%	E
Natural recovery rate (guide)			18%	F
Recovery rate due to IAPT			32%	G=E-F
Total expected saving per IAPT patient (rounded)			**£340**	H=DxG

TABLE 1: Worked example of savings[5]

2.2.7 Table 1 above provides a current best estimate of the average savings per patient that can be expected in the two years following completion of IAPT treatment. This draws upon extensive modelling and analysis supporting the economic case for the national IAPT programme, published in Annex B of *'Talking therapies: a four year plan of action – impact assessment*[5]. In particular, the expected reductions in health care usage following successful IAPT treatment are taken from analysis of the British Household Panel Survey. This is an annual longitudinal dataset of over 10,000 households, containing survey information on a variety of fields including health care usage, as well as a marker for common mental health problems[7].

Regression analysis has been used to determine the increased usage by those with common mental health problems.[8] This finds that, per annum, people with common mental health problems have on average: 2.65 more GP consultations; 1.21 more inpatient bed nights, 0.60 more outpatient procedures, and 0.05 more

[6] For local-level contracts which are not activity or volume-based, e.g. block contracts, there may still exist the possibility for cash-releasing savings in the longer term, through subsequent re-negotiation.
[7] The marker for common mental health problems is labelled: *'Anxiety, depression or bad nerves; psychiatric problems'.*
[8] A simple percentage comparison may overestimate the size of the effect of common mental health problems on health care usage, due to the presence of other factors that may be driving the difference which are not caused by mental health itself. Regression analysis allows a range of these factors to be controlled for, including age, gender, and importantly the presence of physical comorbidity.

A&E consultations than those with no self-defined mental health problem[9]. IAPT services are expected to reduce this gap in the two years following successful treatment, generating reductions in healthcare usage as reported in Table 1 above.[10]

2.2.8 There are important caveats to these estimates, discussed in more detail in Annex B of *'Talking therapies: a four year plan of action – impact assessment'*[8]. First, the estimated reductions in healthcare usage are calculated using data from a national survey, the British Household Panel Survey, rather than IAPT-specific data. Secondly, it has not been possible to distinguish between reductions in physical and mental health care; the estimates are composite and cover all presentations. Thirdly, the estimated reductions are on an average basis across all patients, and there will inevitably be a distribution of individual reductions around these averages, with some patients exhibiting very large reductions being balanced by other patients not exhibiting any reductions at all. Therefore, depending on the make-up of a particular PCT population, or simply due to random variation, there may be variations from the quoted average reductions at a local level.

2.2.9 A study of healthcare usage using data from IAPT sites is currently in pre-publication, undertaken by St George's Medical School, and should be available later in 2011. This uses IAPT-specific health care usage data and therefore should be of close relevance. The findings of this paper, while not available yet, are expected to corroborate and extend on the level of savings set out above.

2.2.10 Across the country, investment in IAPT services will deliver savings to cover a majority of the upfront cost by conservative estimates, and may indeed be net saving to the overall NHS according to other estimates. Alongside the savings to the NHS, the other benefits of successful IAPT treatment are considerable:

- Improvement in mental health and wellbeing to the individual and consequently to their family, friends and community;
- Additional productivity and gain to the economy through people regaining or retaining work; and
- Tax and benefit savings to the exchequer through moving people from Employment Support Allowance into work or supporting them to retain work without relapse onto out-of-work benefits.

Once these other areas are considered, the overall benefits of IAPT therapy far outweigh the initial investment.

2.2.11 Considering just the clinical benefit to patients alone, CBT is as effective as medication in bringing people to recovery and more effective at preventing relapse[11]. IAPT provides an evidenced-based and patient sought-after alternative to medication, and represents excellent value-for-money in terms of the patient benefit it achieves.

[9] A&E consultations have not been included as an area for possible savings, as the difference was not statistically significant.

[10] To be conservative and to reflect the fact that not all of the identified additional usage may be eradicated, ranges have been constructed for each of GP consultations and inpatient bed nights, using 60% and 100% of the identified difference. For example, there are 2.65 additional GP consultations per year or 5.3 over two years. A best estimate of the expected reduction is therefore taken to be 3 – 5, rounded to the nearest consultation.

[11] Mental Health: Britain's biggest social problem. (Layard R., December 2004)

Benefits for patients

- **Patient choice and satisfaction**
- **Measurable improvement towards recovery**
- **Less chance of relapse**
- **More appropriate use of healthcare resources**
- **More purposeful activity (work, education, training, volunteering)**
- **Shorter waiting times**
- **Inclusive, anti-discriminatory services**
- **Universal access**

2.3 NHS policy context

2.3.1 ***The Coalition – Our Programme for Government*** (May 2010) included the government's commitment to talking therapies to reduce long-term NHS costs.

2.3.2 **The White Paper *Equity and Excellence: Liberating the NHS*** (July 2010) aims to

- Enable long term savings to the NHS
- Meet local and individual needs while enabling equitable access for all
- Collect good quality data to inform future service delivery

2.3.3 ***The Spending Review*** (October 2010) specifically stated that the health settlement will enable Department of Health to 'expand access to psychological therapies'[12].

2.3.4 ***Equality Act 2010*** requires all services to promote equality across their communities and to publish information in a way that the public can judge how it has been used to eliminate discrimination, advance equality of opportunity and foster good relations between different groups. A socio-economic duty for public bodies and a public sector equality duty will be determined over the winter and come into force in April 2011.

2.3.5 **The *NHS Operating Framework*** (December 2010) will include more details on the performance mechanisms linked to the Spending Review announcement.

2.3.6 **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-of-action.pdf)

2.3.7 **Quality, Innovation Productivity and Prevention (QIPP)** approaches can deliver further benefits from IAPT services by

- **Health and wellbeing gains** – IAPT services, delivered alongside or without medication, are more successful in preventing relapse than medication alone

[12] Spending Review 2010,Chapter 2 Departmental Settlements, p43

- **Mental health and wellbeing care pathway** – by channelling all flows of patients with depression and anxiety disorders (i.e. from CMHT, counselling referral flows) through IAPT pressure on primary care and, in time, secondary care can be reduced

- **Reducing referrals for medically unexplained symptoms (MUS)** – up to half of all GP referrals for acute specialist opinion are estimated to be for people with no clear physical health problem, where the underlying condition is likely to be psychological. By appropriately diverting these flows to IAPT services, there is a potential for making significant savings[13], as well as providing a more appropriate service that meets the needs of patients.

- **Improving the management of long-term conditions.** Access to IAPT can help GPs manage people with long-term conditions more effectively in primary care, reducing the burden on more specialist services. There is a wealth of evidence that providing psychological support in addition to the standard medical approach for the management of a physical long-term condition, improves outcomes from the perspective of the patient, as well as a reduction in the use of health care resources.[14]
- **Helping people to stay in and/or return to work.** People who have received psychological therapies and recovered from depression are 14 percentage points more likely to return to work than those who have not.[15]

- **Commissioning employment advisers (EA)** as a core part of an IAPT service benefits the individual; the local economy and the exchequer. **Importantly for commissioners, an EA intervention delivered alongside IAPT can yield significant cost savings for the PCT over and above that which an IAPT intervention alone can provide.** Download evidence and cost benefit illustration from; http://iapt.nmhdu.org.uk/silo/files/building-a-business-case-for-employment-advice-and-support-in-iapt.pdf

2.4 Meeting local need

2.4.1 The local NHS and local authorities assess the needs of their local population in the Joint Strategic Needs Assessment and it is essential to link the business case process to the findings of that assessment.

2.4.2 In line with the IAPT Business Case and Talking therapies: a four year plan of action, commissioners will want to plan to provide a minimum access to IAPT services equating to 15% of total common mental health prevalence per year, which is 900,000 people annually. A small number of localities are already planning to move beyond this and increase access up to 25% of total prevalence.

[13] David McDaid, Michael Parsonage, A-La Park (due to be published December 2010) 'Tackling medically unexplained symptoms', in Martin Knapp, David McDaid and Michael Parsonage (editors) Mental Health Promotion and Prevention:The Economic Case. PSSRU, London School of Economics and Political Science.
[14] Derek King, Iris Molosankwe, David McDaid (due to be published December 2010) 'Incremental costs associated with collaborative care in treating depression in individuals with type II diabetes', in Martin Knapp, David McDaid and Michael Parsonage (editors) Mental Health Promotion and Prevention: The Economic Case. PSSRU, London School of Economics and Political Science.
[15] Layard, R., Clark, D., Knapp, M., Mayraz, G.(2007). 'Cost-Benefit Analysis of Psychological Therapy'. Centre for Economic Performance. CEP Discussion Paper No 829, October 2007.

3. Service delivery

3.1 Service model

3.1.1 Patients should expect to receive culturally appropriate NICE-compliant IAPT interventions from a skilled and qualified workforce and should also receive support to remain in or return to work alongside their clinical treatment. As services mature, they should be able to offer patients an informed choice from the range of NICE-approved interventions.

3.1.2 Increasingly, there will be room for innovation in services that still achieve the required outcomes, meet the local needs and those of the individuals taking part in treatment. Earlier guidance on service principles, quality standards, protocols, care pathways and essential data for service monitoring and improvements is outlined in Realising the Benefits (pages 28-32) and can be downloaded from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_112982

3.1.3 Experience of the first few years of the IAPT programme has shown that the following service features are most likely to lead to the best outcomes. These include:

- Conducting a person centred assessment that includes characterising clients' presenting problems in terms of the relevant ICD-10 codes which offers a provisional diagnosis
- Providing NICE recommended treatment for the presenting problem(s)
- Using session by session measures to obtain pre and post treatment outcome data on over 90% of all patients who start treatment (irrespective of whether they complete or drop-out).
- Use of anxiety disorder specific measures, as well as the PHQ and GAD, to help guide, and monitor the outcome of a course of psychological treatment for specific disorders such as PTSD, OCD, panic disorder, agoraphobia, and social phobia
- Using stepped care when recommended by NICE, with regular review (at least every four weeks) to decide whether to continue low intensity treatment or step up to high intensity treatment. The IAPT Clinical Record, patient preference and discussion with supervisors should inform these decisions.
- Ensuring patients receive an adequate dose of the specific treatment(s) being provided and never arbitrarily restricting the number of sessions for individual patients. Treatment should not end until the patient has received at least one adequate dose of treatment: patients who do not respond to low intensity treatment should be given at least one dose of high intensity treatment as well.
- Including medication management in patient treatment plans
- Having an agreed protocol for assessing and managing patient risks to self and others
- Offering personalised care which responds to diverse backgrounds and lifestyles
- Close co-ordination of employment assistance and psychological therapy, with the two running alongside each other.
- Providing all therapists with weekly, outcome-informed, clinical supervision.
- Working to a high volume specification with minimal wait times for treatment at any step and between steps

For low intensity therapy delivered by PWPs:

- Making large-scale use of telephone treatment sessions at low intensity where appropriate (up to 75 per cent of treatment sessions)
- Using automated systems of clinical case management supervision weekly for Psychological Wellbeing Practitioners (PWPs). (This is not the same as clinical supervision – see p10 of the IAPT Reach Out Supervisors Guide, for more information. This can be downloaded from: http://www.iapt.nhs.uk/search/?keywords=supervisors+manual
- Providing guided self-help
- Ensuring any worker operating as a PWP has either been trained by an accredited training provider on the full four module IAPT low intensity course or, if they already have a professional qualification, two modules of top-up training

3.2 Workforce Training and Accreditation

3.2.1 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. Services are required to offer supervision and support to agreed standards; these can be found on the IAPT website http://www.iapt.nhs.uk/workforce/

3.2.2 The IAPT workforce is quality assured by explicit competency frameworks; national curricula and learning materials, delivered through accredited training courses. Commissioners can ensure these 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/

3.2.3 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

3.2.4 Training that should be commissioned in 2011/12 includes

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

3.2.5 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/search/?keywords=curriculum+and+commissioning+outline

3.2.6 From 1 April 2011, funding for IAPT training will be via the funds provided through the Multi Professional Education and Training (MPET) SLA 2011/12. The Service Level Agreement (SLA) refers to the Improving Access to Psychological Therapy (IAPT) Guidance for Commissioning IAPT Training 2011/12 - 2014/15 and contains information to support the roll out of the IAPT programme. The document can be downloaded from http://www.iapt.nhs.uk/silo/files/guidance-for-commissioning-iapt-training-201112-201415.pdf

3.3 Employment advice and support

3.3.1 It is widely accepted that work is generally good for mental health – including for people with mental health conditions[16]. It is established that the longer people are absent or out of work, the more likely they are to experience depression and anxiety. Therefore, employment advice delivered as a core part of an IAPT service can be integral to the success of that service. There are many examples of successful IAPT employment advice services and it is crucial that this good practice is maintained and extended to all IAPT sites.

3.3.2 **Employment Advisers (EA)** in IAPT work directly with individuals who are in employment as well as people who are out of work and on health-related benefits. They provide practical advice and relevant intervention helping these individuals retain employment or enter the workplace (either for the first time or after a period on health-related out-of-work benefits).The specifics of service delivery can be decided at a local level.

3.3.3 **Employment Support Co-ordination (ESC)** is a key role/function with an aim to ensure that IAPT services are sufficiently integrated with relevant employment bodies at a local level – this can mean building relationships with Jobcentre Plus, Work Programme and other relevant employment support providers, local chambers of commerce and local employers. The ESC generally operates at a strategic level and does not have a caseload but can complement and support the work of a hands-on Employment Advice service.

3.3.4 Key service design principles relevant to Employment Advisers and Employment Support Co-ordination may aid commissioners in setting up these services. Guidance, along with some service delivery examples, can be downloaded from: http://iapt.nmhdu.org.uk/silo/files/employment-advice-and-employment-support-coordination-in-iapt-service-design-principles.pdf

3.4 Data that supports commissioners, patients and providers

3.4.1 The collection of outcome data is a defining characteristic for stepped care and the National Institute for Health and Clinical Excellence (NICE) recommended model of delivery of psychological therapies.

3.4.2 IAPT has established a central principle of sessional collection of outcome measures. This has a therapeutic value as well as ensuring that patients, commissioners and providers can see the progress made towards recovery by individuals and the success of the service delivery overall.

[16] Waddell, Gordon and Burton, A. Kim (2006) *Is work good for your health and well-being?* The Stationery Office, London, UK. ISBN 9780117036949

3.4.3 An NHS data standard for IAPT has been approved (Information Standards Board reference 1520). Implementation of the data standard will enable patients, commissioners and providers to access transparent information that facilitates benchmarking for patient choice, service monitoring and service improvement. The ISB has issued an Information Standards Notice to confirm the commencement of the IAPT Data Standard. Further information is available in theIAPT Data Handbook, version 2, available from http://www.iapt.nhs.uk/services/measuring-outcomes/

[NOTE: Commissioners may wish to use the Standards Enforcement in Procurement (STEP) tool available on the ISB website at http://www.isb.nhs.uk/use/step to ensure supplier compliance with ISB standards. Both existing and prospective information system suppliers should be encouraged to visit the ISB site for updates and may be invited to register to use the STEP tool as part of the procurement process Further advice about the adoption of ISB standards and procurement, including an example contract clause, is available at http://www.isb.nhs.uk/use/procurement]

3.4.4 The recommended IAPT data set includes information on:

- Patient demographics; geographical, gender, age, ethnicity, religion, sexual orientation and disability
- Care pathways; provisional diagnosis information, psychological intervention types, referral and sessional details
- Appointments; clinical, economic and social outcomes (including employment status) relating to the interventions provided

3.4.5 Data collection rates should be monitored on a regular basis to help ensure that sites are achieving at least 90% complete outcomes for the number of people who have had two or more therapeutic sessions, including as a minimum PHQ-9 and GAD7. This percentage can be calculated, using relevant data fields embedded in systems, and should be incorporated in the automated validation procedures of capable systems.

3.4.6 Key Performance Indicators have measured the success of the IAPT programme across the country. Local commissioning arrangements should lead further development of IAPT data and information systems. Certain key KPIs will support future expansion of services as outlined in the Spending Review 2010. Detailed information of current KPIs is available from the IAPT website, http://www.iapt.nhs.uk/services/measuring-outcomes/

3.4.7 As services mature, commissioners and clinical leads will want to address deficiencies in service provision and, in particular, inequalities affecting protected groups defined in equalities legislation. Data reports generated in services should inform this analysis, and commissioned data systems should have the capability to produce such reports on demand. Guidance on the use of data in addressing inequalities is in the IAPT Equality Guidance for Commissioners, *Being Fair. Including All* – available from http://www.iapt.nhs.uk/equalities/

3.4.8 Where specific shortcomings in system or supplier performance are identified, improvements in data collection systems and practices may be negotiated through contract monitoring or re-tendering procedures.

3.4.9 A rich supply of data has been produced for analysis locally e.g. by NHS Bournemouth & Poole, and through structured regional evaluations, such as the South West IAPT Evaluation Project (interim report expected March 2011).
Link to NHS Bournemouth file; http://www.iapt.nhs.uk/services/commissioning/
Link to SW Evaluation project; http://www.swdc.org.uk/silo/files/evaluation-project-summary.doc

[*NOTE: Where it is proposed to use existing data in a research study patient consent should not be assumed and Caldicott Guardians must be consulted*.]

3.5 Equality Focused Services

3.5.1 Demand for evidence-based psychological therapies services remains high across all communities. Some groups may have higher prevalence of anxiety disorders and depression than others (e.g. the homeless, military veterans). Other groups may have proportionately lower levels of identification despite high levels of need (e.g. people who are gay, lesbian or bisexual). The needs of all these groups should be taken into account alongside those with the legally protected characteristics of age, disability, ethnicity, faith, gender, sexual orientation, pregnancy and maternity.

3.5.2 The local NHS is responsible in law for publishing data that demonstrates reasonable steps are being taken to deliver equalities focused services. Commissioners have a clear role in ensuring this is done.

3.5.3 Knowledge about the groups and individuals who are accessing services is essential to achieving this. The IAPT Equality Guidance for Commissioners, *Being Fair. Including All* (http://www.iapt.nhs.uk/equalities/) outlines the approach, so that commissioners can ensure transparent arrangements for this are in place locally. This document provides practical guidance on:

- Legal context
- 'How to' guide
- Advancing equalities in evidence-based therapies
- Standard requirements for equality data

3.5.4 In order to meet assessed local needs, services are obliged to undertake service promotion within the local community to make sure all groups are aware of psychological services, how to access them and of opportunities for them to help shape services that personalise care where appropriate. Critically, services are to focus on ensuring people who receive treatment achieve equitable outcomes.

3.6 Patient Choice

3.6.1 Patients should expect to play a central role in decisions about their treatment and should benefit from high quality and accessible information to inform their decisions. IAPT services should be flexible enough to offer effective and meaningful choices about where, who, how and what services are provided.

3.6.2 This entails a range of NICE-recommended therapies being available locally and ensuring that people accessing services are empowered in their recovery through

being fully informed about what to expect from services and the options available to them.

3.6.3 Patients should play a part in determining the approach to their clinical care, including being given a choice of therapy and, when appropriate (e.g. for disabled or older people) a little more time. The feedback they give on the information they receive, their involvement in their care and the overall service will be a key measure of success for services.

3.7 Service Promotion and Information

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

3.7.2 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.

3.7.3 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

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

4. Future planning for Talking Therapies

4.1 Payment by Results

4.1.1 The NHS White Paper *Equity and excellence: Liberating the NHS* (July 2010) gave a specific commitment to develop a currency and tariff for talking therapies. This will link payment to delivery of key outcomes related to access, recovery/improvement, social participation (including employment/ purposeful activity outcomes), choice and patient satisfaction.

4.1.2 The currency will be aligned to the mental health Payment by Results (PbR) care clusters using already-collected IAPT data items.

A feasibility study starting in early 2011 will test the collection of relevant data items, allocation to care clusters and application of a potential tariff. In the meantime, commissioners will want to ensure IAPT providers universally apply the IAPT clinical metrics so that they can see the agreed quality outcomes are achieved across communities.

4.2 Forward look

4.2.1 The 2011/12 year will be critical for the continued expansion and consolidation of psychological therapy services. It is also a transitional year where commissioning

arrangements will begin to move to GP Commissioning Consortia, SHAs will come to an end and the NHS Commissioning Board will emerge.

4.2.2 The role of PCT commissioners in ensuring effective planning and delivery of services at this stage is vital as they can influence conditions for the future success of services as the new arrangements come into effect.

References

[1] The Operating Framework for the NHS in England 2011/12 (Dec 2010) gateway reference 15216

[2] No Health Without Mental Health: *A Cross-Government Mental Health Strategy for people of all ages* (Feb 2011) gateway reference 14679

[4] Layard, R., Clark, D., Knapp, M., Mayraz, G.(2007). 'Cost-Benefit Analysis of Psychological Therapy'. Centre for Economic Performance. CEP Discussion Paper No 829, October 2007.

[5] 'Talking therapies: a four year plan of action – impact assessment', http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsLegislation/DH_123994

[11] Layard R. (Dec 2004) Mental Health: Britain's biggest social problem.

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