BNSSG (Bristol, North Somerset and South Gloucestershire)
IAPT (Improving Access to Psychological Therapies) service
Draft Specification
brief summary & overview

i. Introduction to this specification

This is a summary of the specification for the Bristol, North Somerset and South Gloucestershire (BNSSG) IAPT service.

i.i Approach

The connections between poverty, unemployment and social isolation and depression and anxiety are well evidenced. Commissioners have therefore taken an innovative and positive approach that makes connections between IAPT and other services that offer support for these and other issues.

It is expected that, through a strong outward-focus and setting up connections to and from a wide range of **existing external** (often local authority funded) services and support across the area, within limited resources, the clinical IAPT interventions will be better supported to be more effective and sustainable and improve service user outcomes.

The outward-looking approach will require a holistic assessment that understands psychological issues in the wider context in which they exist. A wholly clinical assessment will not be sufficient to gain such an understanding of each person and could lead to failure to pick up on important things that cause or influence the presenting issue.

i.ii Structure

The expectations of IAPT's impact are extensive and cover a wide range of both core and specific areas. This specification is therefore structured in sections that highlight these.

This document only provides a brief summary and gives an overview of the specification's structure without the detail. However, a service specification is all about detail and clarity, To find these, you'll need to read the full document.

i.iii Delivery of the service's national and local outcomes

This specification is based on a set of strictly defined national requirements and outcomes as well as locally defined expectations and outcomes. While it does not strictly stipulate either the model by which the service ethos should be delivered, or exactly how the provider will measure the delivery. However, commissioners expectations are ambitious for the service and will be subject to careful monitoring and accountability throughout the contract. It crucially sets out an ethos and approach (above) that offers the opportunity to an innovative outward-looking and ambitious lead provider to draw on their experience, skills and connections to develop a delivery model to meet these requirements.

i.iv The IAPT Manual

The national expectations of IAPT service delivery are described in the IAPT Manual and further developed in a set of 'Positive Practice Guides'. The reporting requirements of the MDS (Minimum Data Set) are provided on the NHS digital website.

These national documents must be used to inform the core delivery of the service.

The Manual describes the complexities involved in delivering an effective IAPT service, and Commissioners have built on it and the Positive Practice Guides by integrating the learning from the three current (BNSSG) services and the public engagement/consultation process to construct this specification.

1. Population Needs

This section describes the geography and population profile of the Bristol, North Somerset and South Gloucestershire area (BNSSG) including the equalities profiles. It lists the prevalence of common mental health problems and describes the social determinants of poor mental health and how they differ across BNSSG.

1.2 Evidence review summary

Public Health (Bristol City Council) 2017 conducted a review of the evidence for IAPT services. The specification includes a summary of the review.

1.3 National IAPT priorities

The provider will use the IAPT Manual which will form the basis, and guide their delivery of the service.

The manual encompasses the following national priorities for IAPT service development and delivery:

- Expanding services so that at least 1.5 million adults can access care each year by 2020/21
- Focusing on people with depression and/or any of the anxiety disorders. As IAPT services expand they are expected to increase access to treatment for people who also have long-term physical health conditions, by recruiting and deploying appropriately trained staff in IAPT services where psychological and physical treatment are co-located (these are called 'IAPT-LTC services' in the manual). Such services should also have a focus on people distressed by medically unexplained symptoms, to help this group of people achieve better outcomes
- Improving quality and people's experience of services. This includes improving the numbers of people who recover, reducing geographic variation between services and reducing inequalities in access and outcomes for particular population groups
- Supporting people to find or stay in work, so that IAPT services can better meet a person's individual employment needs and contribute to improved employment outcomes.

2. Outcomes

This section covers both the national and locally defined outcomes.

2.3 Measurement, evaluation and learning/development

The national requirements for IAPT to report on the Minimum Data Set (MDS) are clear and the IAPT Manual (and Positive Practice Guides) provide thorough guidance.

Over the course of the contract, this service will need to develop and adapt, shaping itself to meet changing need, demographics and national requirements. In order to be able to achieve this, a culture will need to be nurtured across the entire service that is flexible and enthusiastic about learning and improvement.

2.4 Relationship with commissioners

This contract affords the provider the responsibility and agency to operate within the available financial resources across the whole service using its data to help it make decisions and inform continual developments.

This contract places expectations on the provider to make connections and to develop pathways/protocols across the wider system. It is acknowledged that these will not all be easily accomplished without the reciprocal agreement and co-operation of the partner agencies or the support of CCG and local authority commissioners.

The provider's relationship with commissioners must therefore be dynamic, working together to ensure the best outcomes for service users and to meet national requirements.

2.5 Local defined outcomes

This section has a set of local outcomes under the various headings covered in the specification.

2.6 Provider expectations

This section contains commissioner expectations of the provider in each section.

3. Scope

3.1 Aims and objectives of service

3.1.1 Service ethos

3.1.1.1 The social determinants of mental health

The Marmot Review (2010) starkly demonstrated the social determinants of mental and physical health. The connections between poverty, unemployment and social isolation with depression and anxiety are high. Poor mental health can be caused or worsened by other issues in people's lives such as unemployment, poverty, debt, social isolation and lack of friendships/relationships, poor housing, domestic violence, bereavement, poor physical health/wellbeing, being inactive or having a long-term health condition. These factors can all impact on depression and anxiety and on the need for IAPT (either as a single service or in combination with other interventions).

This suggests that the risks of not taking a connected holistic approach to providing psychological therapies are far greater than any perceived risks inherent in giving IAPT a wider focus. It is therefore essential that people coming into this IAPT service do not have these other important issues inadvertently ignored through the service focussing on their mental health difficulties in isolation, or it not having the right external contacts to refer people for other help.

Commissioners have therefore taken an innovative and positive new approach that locates the mandated IAPT interventions (as specified in the IAPT Manual), within the wider social/cultural/health/economic/relational context in which the service and its users exist.

It is expected that, through a strong outward-focus and connections to a wide range of existing external provision (funded by the local authorities etc), the clinical IAPT interventions will be supported to meet their outcomes and maximize effectiveness and

sustainability within limited resources.

By supporting people to tackle the external causes of their anxiety or depression, it is expected that, for some, therapy may not be necessary and people are diverted from it, while for others, therapy alongside associated support, such as job retention or encouragement to be more physically active, will reinforce its effectiveness.

For example:

- Somebody who is socially isolated after a bereavement might receive therapy which addresses the loss, but not the isolation. A concurrent social prescribing service addresses the isolation while therapy helps work on the bereavement.
- Somebody who is at risk of losing their employment due to depression and receives an IAPT service, may lose their job while having treatment. A concurrent 'job retention' service alongside the therapy helps hold onto the employment and supports a fast progress back to work.
- Somebody presenting with anxiety due to high levels of debt, may receive therapy to address the anxiety, however, without referral to appropriate debt advice/management, the cause of the anxiety is not addressed and the therapy is unlikely to be effective.

3.1.2 Equality and equity

Equality, equity, fairness and the principles of social inclusion will underpin this service. While this section lays out commissioners' wider expectations in terms of ethos, the expectations of their practical implementation are integrated into the sections below. There will inevitably be duplications, for example many issues apply to access, communications, treatments offered and the workforce. Note that specific outcomes will be set in each of these areas.

The IAPT Manual states that:

1. Services should be inclusive and actively promote equality, with consideration given to protected characteristics as defined by the Equality Act 2010, and their duties to reduce health inequalities as set out in the Health and Social Care Act 2012.

2. Service design and communications should be appropriate and accessible to meet the needs of diverse communities. Services should also publish information in a way that enables the public to judge how they aim to eliminate discrimination, advance equality of opportunity and foster good relations between different groups.

3. At the heart of the NHS Constitution is equality and fairness – everyone has an equal right to access and benefit from NHS services. No one group is exempt from depression or anxiety disorders. Therefore, demand for evidence-based therapies remains high across all communities.

4. The provider needs to understand the prevalence of depression and anxiety disorders within the local population to extend the reach of their services more effectively. Some groups have a higher prevalence of depression, or anxiety disorders. Other groups may have proportionately lower levels of identification rates, despite high need.

3.1.3 Co-production and user involvement

It is essential that the experiences of anxiety and depression, and of using IAPT services are positively and thoroughly drawn on in the establishment, design, monitoring, evaluation, review and future development of this service. Therefore clear mechanisms and structures need to be put in place that enable co-production in all these aspects and stages of the service.

Commissioners expect that user involvement through a wide range of co-production processes is used as a key means of the service achieving better outcomes in all aspects of its delivery.

3.2 Service description/care pathway

3.2.1 Delivery model

This specification covers provision of a single IAPT service across the BNSSG area.

NHS Bristol, North Somerset & South Gloucestershire CCG will contract to a single lead provider organisation which will:

- Provide a single consistent approach to IAPT in BNSSG, where, regardless of their address, people have the same ways in to, pathways through and range of treatments on offer from the service.
- Be able to use and create flexible resources within the system.
- Take a cross-area overview in order to understand patterns, demographics, successes and difficulties and be able to implement changes across the whole service based on the learning.
- Draw on external specialist services and resources from across the area when they are needed.
- Use an outward-focussed holistic approach to promote social inclusion and sustainment of IAPT recovery outcomes.

The ethos of this service is outward-focused and understands service users holistically (in terms of their wider lives), and is rooted in the principles of equality.

A great deal of expertise and skill exists across the area through key local voluntary sector organisations which the IAPT service should draw upon to provide the best outcomes, in particular for under-represented groups and for specific therapeutic specialisms. Including the following:

- Local neighbourhood knowledge and connections.
- Equality community connection, understanding and competency.
- Refugee issues and support.
- Health inequalities.
- Issue-based specialisms.
- Skilled therapeutic approaches.

And it is essential that the lead provider can draw upon these to support its delivery.

3.2.2 Improving access to, and accessibility of the service

All IAPT services must demonstrate an increase in access rates as well as in equity of access for those individuals and groups who are known to be currently under-represented in IAPT services (see 3.1.2).

The IAPT Manual and Positive Practice Guides provide a strong basis from which the provider must draw.

While the service needs to continually increase its overall access rates, there are a number of groups with specific needs and characteristics that are typically under-represented in IAPT and whose poor mental health impacts on other aspects of their lives.

The provider will need to integrate an equality approach into the delivery of the service, recognising that a significant proportion of work on access/accessibility, if thoughtfully and sensitively applied, will improve access generally. It is important that the service understands both the similar and different issues of accessibility experienced by people from neighbourhoods with high levels of deprivation and from the range of groups with Protected Characteristics (under the Equality Act 2010) many of whom are also generally under-represented within IAPT services. They will need to understand commonality of experience and that many people fit into more than one equalities category and therefore experience

multiple barriers.

The IAPT Manual and Positive Practice Guides clearly present steps that providers must take towards delivering an accessible service that attracts people from all communities and specifically addresses the issues of those groups that are typically under-represented in services.

3.2.3 Timeliness of service

- There is a range of factors and dynamics that need to be understood and worked with and that can impact waiting times together with their potential mitigations, including:
  - Making use of preventative 'upstream' interventions to divert from assessments.
  - Use of the range of socio-economic referrals to divert from, and/or support step two and three therapies.
  - Offering a high quality assessment.
  - Offering courses and groups positively and confidently as key interventions.
  - Offering a wide range of digital and online means of engagement with IAPT.
  - Having confidence in its clinical judgement about what works best for different presentations and in what the service will offer and how it can help.
  - Flexibility in the length of interventions offered.
  - Operating flexibly enough to ensure that therapists' cancellation of appointments do not result in the service user's treatment programme being shortened.

3.2.4 Interventions and therapies

This section covers the types of therapies and interventions that the service will provide. It discusses the tensions in individual and group therapies, digital and online-based treatments.

3.2.4.4 Assumptions

The following assumptions have been made:

- Early intervention (to psycho-social, psycho-educational and self-help options) and other (existing external) support (e.g. debt, unemployment, social isolation, long-term conditions, and substance misuse) can divert a number of people from needing IAPT therapies.
- Through having other associated difficulties addressed, the type/intensity and/or length of intervention for some people will reduce, and the positive outcomes will be sustained.
- A positive presentation of, and increase in group work, courses and online therapies take pressure off the perceived superiority of/need for one-to-one therapy and ensure that the intensive interventions are available more quickly to those people who require them most.
- Through establishing clarity in relation to attendance, the level of choice of therapy/therapist/re-entry offered, waiting time management etc, considerable service efficiencies can be realised.

3.2.5 Assessment

This service ethos places central importance on the service being outward focussed and able to understand people's 'clinical need' in the context of the wide range of other socio-economic, relational, health and cultural factors that are present in their lives. The IAPT Manual also emphasises the need for a strong 'person-centred' focus to the assessment.

Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care.

The assessment is key in ensuring that in a brief amount of time, enough of the right information is gathered about each person to be able to offer them the right treatments/interventions. Incomplete or poor assessments lead to inappropriate treatment plans and people returning for further treatments or poor recovery rates.

The outward-looking ethos of this service requires a holistic assessment that understands psychological issues in the wider context in which they exist. A wholly clinical assessment will not be sufficient to gain such an understanding of each person and could lead to failure to pick up on important factors that influence or cause the presenting issue.

3.2.6 Recovery

Recovery rates are specifically and clearly defined within IAPT reporting and are the major indicator of the service's success. The national expectation is to achieve at least a 50% recovery rate. However the IAPT definition of recovery is specific and, whilst understanding national reporting requirements, the provider will be expected to also adopt qualitative recovery measures and follow-up information to help achieve better outcomes for service users and the continual development of the service.

3.2.7 Communications

Good communications will be an essential factor in the service's success in increasing its access rates and effectiveness. It will need to promote itself clearly, conveying confidence in it and understanding of how it can improve wellbeing in the various neighbourhoods, groups and communities across the area.

3.2.8 Long-term health conditions (LTCs) and medically unexplained symptoms (MUS)

People who have mental health problems in the context of long-term physical health conditions (e.g. diabetes, chronic obstructive pulmonary disease, cardiovascular disease, cancer) and people who are troubled by symptoms inadequately explained by their medical condition (sometimes called persistent physical symptoms or medically unexplained symptoms) are poorly served by existing services. In particular, there is an urgent need to provide them with more integrated physical and psychological healthcare to improve their quality of life and reduce costs to the NHS and the wider system. Underpinned by core IAPT principles and standards, IAPT services will be required to develop and deliver a new model through integration with physical health care services.

The Five Year Forward View for Mental Health expects mental health and physical health services to work together in a more integrated way, meaning that each gains greater awareness of the issues pertinent to the other when working with patients. It asserted that there should be fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa), and that there needs to be the provision of mental health support in physical health care settings – especially in primary care.

In 2016, NHS England published Implementing the Five Year Forward View for Mental Health which committed to parity of esteem for mental and physical health. There is a national expectation that 1.5 million people should access IAPT by 2020/21. Of the additional 600,000 people who should be seen, two thirds of them will have coexisting physical and mental health conditions and should be seen within IAPT services.

3.2.9 Younger people (16 years+)

This IAPT service is commissioned to provide treatment for people from the age of 16 years

and must therefore have an understanding of the particular needs, and means of engagement of younger people in order to increase their access to it. It will also need to establish a positive external perception through the language it uses, the attitudes it conveys in its publicity, its methods of communication and delivery of therapies (in line with younger people's preferences) as these will all impact on its success in reaching a younger demographic (that ranges from 16 years into the mid/late 20s).

The service will need to establish strong connections with further and higher education college student support/counselling services to ensure that students can receive the most appropriate support.

3.2.9.3 Young people who are leaving or who have left local authority care

Research has demonstrated that, despite high levels of poor mental health, care leavers are not accessing IAPT services due to a range of factors that include access criteria and waiting times.

As some care leavers do not have supportive social networks (including extended family support circles), access to early intervention can be more critical to prevent later use of acute services.

Young people who are looked after by the local authority will leave care before or at the age of 18 years, and be supported by a personal adviser until the age of 21 years.

3.2.10 Older people

Most older people in the UK have good mental health and wellbeing, but a significant minority (an estimated 3 million) have mental health symptoms that affect the quality of their lives. Mental health problems in later life can have a massive social impact, resulting in poor quality of life, isolation and exclusion. However, evidence-based psychological therapies can be effective for older people.

It is believed that 25% of people over the age of 65 living in the community have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment, primarily medication.

Older people tend to engage well with IAPT interventions, completing their course of therapy and achieving good recovery scores at discharge, and yet they tend to be poorly represented in IAPT access rate figures across the country.

3.2.11 Perinatal mental health

The Antenatal and Postnatal Mental Health NICE guideline recognises the serious impact of undiagnosed depression and anxiety disorders on the health and wellbeing of the mother and baby during pregnancy and the postnatal period. Therefore, the IAPT Manual recommends that women in the perinatal period are prioritised for assessment within 2 weeks of referral and commence treatment within 4 weeks.

The Positive Practice Guide fully recognises the mental health needs of fathers in the perinatal period both in relation to the prospect of fatherhood and to their partner's perinatal mental health difficulties. Men themselves can also experience perinatal mental health issues and should be referred and supported in an appropriate way. However, it must also be recognised that parenting is often not hetero-normative and these difficulties can also occur in same-sex couples/partnerships and in any partnership where there is an adult who will have a close/parental/care-giving relationship with a child.

3.2.12 Learning disability (including Autism Spectrum Disorder - ASD)

People with the range of conditions that are grouped as learning disabilities are under-

represented in IAPT services and can benefit from IAPT interventions. With reasonable adjustments and promotion, equitable access to NICE-recommended therapies can be achieved.

3.2.13 Sexual abuse and sexual violence

People who have experienced sexual abuse either as children or as adults, may have presentations and requirements of the IAPT service that are specific to these experiences.

3.2.14 Psychosis, bipolar disorder and complex needs (including those with personality disorder diagnoses)

3.2.14.1 Background: people using secondary mental health services

The Five Year Forward View for Mental Health cited the IAPT-SMI (serious mental illness) pilot sites that demonstrated the positive impact of access to NICE-recommended psychological interventions on experience, outcomes and reduced healthcare utilisation by people with psychosis, bipolar disorder and personality disorders. NHS England and Health Education England were tasked with working to build on and scale up the IAPT-SMI programme so that a greater number of people have access to psychological therapy as a core component of the adult mental health services offer.

Some people with a serious mental illness and who use or have used secondary mental health services might benefit from receiving evidence-based psychological therapies for depression and anxiety, where use of such therapy would not interfere with or detract from the impact of other treatments they receive.

People who have experienced complex trauma in the past and who are often described as having complex needs (including personality disorders) tend to find that IAPT treatments do not meet their needs as they are not specifically orientated and shorter term than tends to be most appropriate. They consequently do not reach recovery and repeatedly re-present, deteriorating over time. Even if already discharged from secondary care, they are often referred straight back to secondary services but do not meet their eligibility criteria.

More specifically, evidence demonstrates those with a diagnosis of personality disorder or personality disorder traits can benefit from specialized CBT techniques to provide greater opportunities for effective outcomes. A number of therapies have been developed and their particular efficacy for people with these presentations is strongly supported by their evidence-base.

3.2.15 Employment and job retention support

The IAPT Manual highlights the negative personal and societal impact of depression and anxiety on educational achievement, employment, levels of absenteeism, work performance, earnings and productivity. These are accompanied by increased social welfare expenditure. These issues impact more significantly still on people with coexisting mental and physical health problems. It has been 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.

Since its launch in 2008, there has been a recognition that many people who come into contact with IAPT services have some level of need in relation to employment (they may be unemployed, having difficulties at work, or off sick and in danger of losing their jobs).

3.2.16 Poverty, debt and benefits advice

The connection between poverty/debt and depression/anxiety are strong, and often directly correlate with unemployment, homelessness, substance misuse, social isolation, contact

with the criminal justice system etc.

While an IAPT service in itself cannot provide welfare rights advice, it can and should have strong connections with all the debt and welfare rights advice services across the three local authority areas.

3.2.17 Housing and homelessness

Inadequate or insecure housing and homelessness are key factors that contribute to the deterioration of mental health. Early intervention and an assessment that recognises the role these factors play in depression and anxiety, along with offering encouragement for tenancy sustainment and having the connections in place to get people practical support from local services as quickly as possible is essential. IAPT has a key role in offering a service to people in these circumstances who exhibit the relevant mental health conditions.

Many homeless people have experienced significant early traumas and a range of other complex associated circumstances that have led or contributed to their difficulties.

The three LAs provide statutory housing services along with commissioned homelessness services/pathways that differ according to the level of need in each area. For example, Bristol has four commissioned adult homelessness pathways, specialist young people's accommodation pathways and resettlement workers that this service should forge clear routes to and from.

There is an increasing need for the IAPT service's practice to be trauma-informed when working with homeless and other people with complex needs, and to understand its position and work collaboratively with other agencies that may be involved with a person – e.g. homelessness, substance misuse, secondary mental health services.

3.2.18 Tobacco Cessation & Harm Reduction

Given the known high levels of smoking prevalence among service users accessing mental health services, and the proven relationship of smoking with depression and anxiety, IAPT services are a key place to offer early smoking cessation interventions to support wider Public Health programmes.

3.2.19 Substance misuse

Drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. Substance misuse clients with mental health needs should have access to NICE-recommended psychological interventions, including CBT for depression and anxiety and there is no evidence that substance misuse per se makes the usual psychological therapies ineffective. The IAPT and substance misuse services will need to work together to develop locally agreed pathways and criteria for more specialist interventions when indicated.

Please see the IAPT positive practice guide for working with people who use drugs and alcohol for further information.

3.2.20 People in contact with the criminal justice system

National data indicate that, despite having high levels of poor mental health, people in contact with the criminal justice system tend to be under-represented in IAPT services. The service should inspect the local data and establish positive connections with local prisons, the Prison and Probation Service and the National Offender Management Service in order to ensure access from offenders who meet IAPT eligibility criteria.

Please see the IAPT Offenders Positive Practice Guide for further information.

3.2.21 Serving and ex-serving armed forces personnel

The Armed Forces Covenant clearly sets out the nation's commitment to armed forces personnel, their families and veterans. There are additional risks to the mental health of people from this group, such as traumatic combat experiences, time away from family during prolonged or frequent deployment, the instability in home life this can bring and difficulty in the transition back to civilian life.

See the Veterans Positive Practice Guide for increasing access and building capability within the workforce to understand the military culture.

3.5.1 Primary and Secondary mental health interface

The IAPT Manual states that IAPT services sit within a wider system of care and spans primary and secondary mental health care. They operate a 'hub and spoke' model, which typically includes a central management and administration office with strong primary care and community links that enable most of the face-to-face therapy to be provided in local settings that are as easy for people to access as possible (such as GP practices, community settings and voluntary organisations).

The IAPT service forms a key part of the mental health system across BNSSG and is part of the Integrated Pathway. Strong connections and clear communications with primary care (including Primary Care Integration) and secondary mental health services are essential to the system functioning effectively.

South Gloucestershire, for example, published a leaflet publicising their primary care offer which brings together the range of provision that can help people with their mental health/wellbeing at the primary care level. Commissioners hope that, over the course of this contract, this service will become a strong and vibrant part of the Integrated Localities programmes across BNSSG.

There is a growing demand upon mental health services which represents a level of need that lies between IAPT and secondary service eligibility. It is acknowledged that this IAPT service cannot address or be held responsible for this gap in provision, or for treating all mental health issues below secondary mental health service eligibility. However, commissioners expect the provider to work with them to take a key role in establishing and maintaining strong and positive relationships with GP practices, secondary mental health services and local authority provided/commissioned services, and clearly communicating its role and purpose in the wider system.

Mental health provision across BNSSG currently includes a range of different commissioned services and types of intervention – e.g. CPNs located within some practices, a primary care mental health pilot, some specific joint primary/secondary PD interventions etc.

3.5.2 Connections and referral pathways to and from other existing services and support

The development of referral pathways (with associated protocols) to and from other provision is more robust than signposting. Providing a name or phone number does not necessarily result in a service user reaching the service, where a clear referral with an agreed protocol with the integral accountability can ensure that the offer has been taken up and its result tracked.

Similarly, the use of, and formal connection to the existing online databases that describe the wide range of statutory, voluntary and neighbourhood/community sector provision across the area is more robust and extensive than staff in a service collecting/storing their own contacts in a separate database.

In practice, our approach means that the provider will put administrative resources into knowing the arena in which they operate, forge clear referral pathways and play their part in

developing associated protocols to and from the wide range of (often locally based) services across the area including but not limited to:

- Debt and financial/benefits advice
- Employment and job retention support
- Social prescribing
- The (South Gloucestershire) Wellbeing College
- Cultural services (including sport and physical activity)
- Health promotion and healthy lifestyles activities
- Substance misuse services and pathways
- Housing
- (Bristol) Homelessness services and pathways
- Sexual abuse and sexual violence support

Covering three local authority counties, the service will have different landscapes of external provision to draw upon. Bristol, as a large city, has a great deal more resource than either North Somerset or South Gloucestershire. While local authority funding has reduced over recent years, and funded services are more limited, than previously, the service should positively connect with the local services and provision that does exist. The provider must fully understand the differences in local provision across the area, can positively work with them, and clearly communicate them to service users. The discrepancies that could result in users being disadvantaged should be fed back to commissioners in order that they can be addressed at the local Health and Wellbeing Boards.

3.6 Workforce, education and training

Ensuring the competence and quality of the IAPT workforce: The right workforce, appropriately trained, with the right capacity and skills mix, is essential to ensuring the delivery of NICE-recommended care. Adherence to the protocols of NICE-recommended therapy is critical to good outcomes. Therefore, the success of the IAPT programme depends on the quality of the workforce.

The IAPT Manual provides essential practice guidance addressing the workforce issues in relation to a set of key areas:

- The low and high intensity workforce.
- Clinical leadership.
- Additional workforces: including managers, employment advisors, data analysts and administrative staff.
- Equality and diversity issues.
- Competences and training.
- Staff wellbeing.
- Supervision.
- Career development.
- Workforce retention.

It is commissioners' expectation that the provider will follow the guidance of the Manual, build on it through their own local developments, and implement any new national requirements that are issued over the course of the contract.

Additional to the requirements laid out in the Manual, the service ethos (see 3.1.1) requires a particular value base, competence and skill mix in its workforce in order to deliver the vision:

- The provider will need to consider staffing options and creating capacity within the service in order to integrate the ethos. This will include nurturing, building and sustaining external relationships and developing referral pathways to and from a range of existing provision across the service's footprint.
- The service will require a workforce that can integrate a high level of clinical competence with the service ethos into their practice.
- The service will need to create a culture that has the understanding of the social determinants of mental health, equality and equity at its core.
- The ethos and clinical requirements of the service must be shared throughout the entire workforce rather than located with 'specialists'.

3.7 Information management and technology (IM&T)

The Five Year Forward View made a commitment that, by 2020, there would be "fully interoperable electronic health records so that patient's records are paperless". This was supported by a Government commitment in Personalised Health and Care 2020 that 'all patient and care records will be digital, interoperable and real-time by 2020'. This requires information to flow more effectively across health and care to support the delivery of direct care.

Service users and carers expect that whenever and wherever they access services, those caring for them can easily access comprehensive, accurate and timely information. They anticipate professionals working with modern information systems that bring together all of the relevant information available – from diagnostic tests and clinical notes, case histories to records of personal preferences. Service user experience and the effectiveness and safety of care will be improved through working towards paper-free environments delivered at the point of care.

The focus of the IM&T systems in mental health services is on provision of seamless service user care across all services and not on organisational boundaries. It is important to ensure that the IAPT service connects appropriately to secondary mental health across BNSSG, and that information is able to flow freely between it, primary and secondary care and other services to ensure a safe and effective care pathway for service users.

The lead provider will provide appropriate and boundaryless IM&T solutions across the whole BNSSG IAPT system (including with agencies in any consortia, partnership or sub-contractual arrangements), to underpin and support the entire service, backed up by appropriate policies and procedures. The use of technology must support easy access to the service, and the lead provider agency should take advantage of new and emerging technologies which will facilitate increases in both access and recovery.

4. Applicable Service Standards

4.2 Applicable standards set out in Guidance and/or issued by a competent body (eg Royal Colleges)

4.2.2 Service quality

The Accreditation Programme for Psychological Therapy Services published the 'Quality Standards for Psychological Therapy Services' written by the Royal College of Psychiatrists (3rd edition 2017). This document will form the basis for the service's clinical quality.

The IAPT Manual includes a helpful table of the key features of a 'better performing IAPT service' against CQC domains.

5.1	**Applicable Quality Requirements (See Schedule 4A-C)** Quality Standards for Psychological Therapies Services.
6.	**Location of Provider Premises**
The provider will establish a single main service administrative base and use a wide range of locations across the service delivery area that enable it to deliver locally based services.	

Key of technical definitions and abbreviations

Links to key related sections:

3.2.1 Delivery model

3.2.6 Recovery

Error! Reference source not found.

BCC	Bristol City Council
BNSSG	Bristol, North Somerset and South Gloucestershire
BSL	British Sign Language
CCG	Clinical Commissioning Group
CBT	Cognitive Behavioural Therapy
DNA	Do not attend
FYFVMH	Five Year Forward View for Mental Health
GAD-7	Generalised Anxiety Disorder-7
GNP	Gross national product
HEE	Health Education England
IAPT	Improving Access to Psychological Therapies
IAPT 'Caseness'	A person is said to be at caseness when their symptom score exceeds the accepted clinical threshold for the relevant measure of symptoms. For the PHQ-9, this is a score of 10 or above. For the GAD-7, this is a score of 8 or above. Other symptom measures, such as those used to measure the severity of different anxiety disorders, have their own specific thresholds. Some outcome measures (such as the Work and Social Adjustment Scale) do not have recommended caseness thresholds but provide valuable additional information about the quality of a treatment response.
IAPT 'Recovery'	A national standard that at least 50% of eligible referrals should move to recovery has been set for IAPT services. A person moves to recovery if their symptoms were considered a clinical case at the start of their treatment (that is, their symptoms exceed a defined threshold as measured by scoring tools) and not a clinical case at the end of their treatment. The recovery rate is defined as:

$$\frac{\text{Number of referrals that moved to recovery}}{\left(\begin{array}{c}\text{Number of referrals}\\ \text{that finished a}\\ \text{course of treatment}\end{array}\right) - \left(\begin{array}{c}\text{Number of referrals}\\ \text{that finished a course}\\ \text{of treatment and started}\\ \text{treatment not at caseness}\end{array}\right)} \times 100$$

IAPT 'Access'	The Access Rate is defined as the "number of people entering treatment … over the level of need, i.e. the number of people with depression and anxiety disorders in the population expressed; **a.** as a number (the number of referrals entering treatment) **b.** as a percentage of total prevalence"
IAPT-SMI	Improving Access to Psychological Therapies for Severe Mental Illness
Intersectionality	The term intersectionality attempts to describe how connected systems of power impact those who are most marginalized in society. Intersectionality considers that the various aspects of humanity, such as class, race, sexual orientation, disability and gender, do not exist separately from each other but are complexly interwoven.
LA	Local Authority
LSOA	Lower Layer Super Output Area
LTC/s	Long-term Condition/s
MDS	(IAPT) Minimum Data Set
MH	Mental Health
MUS	Medically Unexplained Symptoms
NHSE	National Health Service England
NICE	The National Institute for Health and Care Excellence
PH	Public Health
PHQ-9	Patient Health Questionnaire-9
Person-centred	In person-centred care, health and social care professionals work collaboratively with people who use services. Person-centred care supports people to develop the knowledge, skills and confidence they need to more effectively manage and make informed decisions about their own health and health care.
PWP	Psychological Wellbeing Practitioner
RCP	Royal College of Psychiatrists
SARC	Sexual Assault Referral Centre