

# Improving Access to Psychological Therapies

*Implementation Plan: National  
guidelines for regional delivery*

Care Services Improvement Partnership 

National Institute for  
**Mental Health in England**

## DH INFORMATION READER BOX

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HR/Workforce Management Planning/ Clinical	Estates Commissioning IM & T Finance Social Care/Partnership Working

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<b>Description</b>	This document provides SHAs, PCTs, training providers and service providers with an overview of what is needed to deliver the implementation of IAPT. The additional funding from the Comprehensive Spending Review 2007 will pay for the major training programme that provides the necessary number of suitably trained therapists and enables progressive expansion of NICE-compliant local Psychological Therapies services.
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<b>Action Required</b>	SHAs will need to engage with potential local training providers and develop plans for tender completion April 2008, to begin training in September 2008. SHAs will need to select PCTs to become IAPT sites by April 2008, to introduce IAPT services in tandem with the commencement of training places in September 2008.
<b>Timing</b>	
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<b>For Recipient's Use</b>	

# Improving Access to Psychological Therapies

*Implementation Plan: National  
guidelines for regional delivery*



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# 1 Foreword



The Improving Access to Psychological Therapies programme has already captured the imagination of primary care trusts up and down the country.

It is transforming the lives of thousands of people with depression and anxiety disorders in the areas that have been involved so far. This document describes how that transformation can begin to be delivered in every strategic health authority area over the next few years.

Clearly, these new psychological therapies services will need the best aspects of world-class commissioning if they are to meet people's needs in a well-rounded way.

The two early demonstration sites, in Doncaster and Newham, have evidence of excellent outcomes for many of those they have treated, in line with the expectations of the National Institute for Health and Clinical Excellence (NICE), and can show how they have added life to years.

These pilots concentrated on working-age adults as a first step, but the programme has now moved forward with 11 pathfinder sites and begun to address health inequalities by focusing effort on the specific needs of a range of vulnerable groups and developing pathways to meet the needs of the whole population.

This programme has huge potential for individuals accessing these services, for their families and friends, for the NHS as a whole, for communities and for the wider economy, as people regain their independence and energy and return to full participation.

Substantial investment has been secured, and this Implementation Plan provides clarity about the form and nature of the services to be established. The plan describes how this additional resource will be used to deliver a major **training programme** and an expansion of **NICE-compliant psychological therapies services**.

Delivering these new, state-of-the-art psychological therapies services will not only demonstrate a paradigm shift in meeting the health needs of a large group of people, but also show that the NHS can deliver innovative new services valued by the wider population.

A handwritten signature in black ink, appearing to read 'David Nicholson'. The signature is fluid and cursive, with a long horizontal stroke at the end.

David Nicholson  
NHS Chief Executive

## 2 Summary of key actions for 2008/09

- 2.1 This document provides strategic health authorities (SHAs), primary care trusts (PCTs), training providers and service providers with an overview of what is needed to deliver Improving Access to Psychological Therapies (IAPT). Key actions for SHAs are summarised below.
- 2.2 The additional funding from the Comprehensive Spending Review 2007 will pay for a **major training programme** to provide the necessary number of suitably trained therapists and enables progressive expansion of **National Institute for Health and Clinical Excellence (NICE)-compliant local psychological therapies services**.

### IAPT training programme

- 2.3 SHAs will need to commission their share of training places for high- and low-intensity trainees, on the basis of the criteria for training provider selection at **Annex A**. Key points to consider are that:
- training providers will need to demonstrate a commitment to using the national curricula (supporting documents) and learning and assessment materials, or demonstrate clear equivalence between their courses and those curricula and materials
  - to meet these high standards of training in year one, it is likely that training places will need to be centred in one or two providers per SHA (to ensure that there are enough suitably qualified tutors to cover all aspects of the course, for example).

### IAPT services

- 2.4 Each SHA has agreed to identify at least two PCTs to become IAPT sites, on the basis of the site selection criteria at **Annex B**. Key points to consider are that:
- services will need to have enough therapists (low- and high-intensity) to meet the needs of the whole PCT population
  - at least one-third of therapists will need to be fully trained, and these will need to include a director, supervisors, and a balance of low- and high-intensity therapists
  - services will need to provide the region's trainees with appropriate on-the-job training.

## Performance indicators

2.5 IAPT is the subject of a Public Service Agreement (PSA) between the Department of Health and the Treasury, and an Operating Framework 2008/09 Vital Sign. The Secretary of State has set a range of outcomes that need to be delivered in return for the additional resources provided. These will form the basis of regional performance indicators, to be developed in agreement with SHAs. They are:

- **PCT coverage** – at least 20 PCTs to implement IAPT services in 2008/09, and this coverage should increase over 2009/10 and 2010/11
- **building a skilled workforce** – training programmes to deliver 3,600 therapists by 2010/11 with an appropriate skill mix and supervision arrangements
- **extending access to NICE-compliant services** – 900,000 more people accessing treatment, with half of those who complete the programme moving to recovery and 25,000 fewer on sick pay and benefits, by 2010/11.

## Timescales

2.6 SHAs will need to engage with potential local training providers and develop plans for tender completion in Spring 2008, to begin training in **September 2008**.

2.7 SHAs will need to identify PCTs to become IAPT sites in Spring 2008, to introduce IAPT services in tandem with the commencement of training places in **September 2008**.

## Governance and funding

2.8 In 2008/09, resources will be pooled and spent centrally, for and on behalf of SHAs. The IAPT Programme Board will provide national oversight. Performance management will be via the usual NHS mechanisms. Regional governance processes will need to be established as appropriate.

2.9 Support in delivering IAPT will be available, both regionally and nationally, from the Care Services Improvement Partnership (CSIP).

# 3 Introduction

3.1 The Government has recently announced additional targeted funding in the Comprehensive Spending Review (CSR07) to begin national roll-out of **new local psychological therapies services**. This will enable PCTs to implement the NICE guidelines for people suffering from depression and/or anxiety disorders. The ultimate aim is a service for each PCT.

3.2 This document describes how those services will look when the system is fully in place and outlines how SHAs and PCTs can make it happen through:

- a major **training programme** to produce an expanded, specialised workforce of psychological therapists, skilled in NICE-recommended therapies (Section 4)
- progressive expansion of **NICE-compliant psychological therapies services**, in phase with the expansion in the number of trained therapists, until the whole country is covered by adequately staffed NICE-recommended services (Section 4)
- **every PCT improving its services**, in preparation for national roll-out, as set out in the NHS Operating Framework, and according to plans agreed with their SHAs (Section 7).

3.3 In CSR07, the following funds have been allocated to IAPT:

- £33 million in 2008/09
- a further £70 million to a total of £103 million in 2009/10
- a further £70 million to a total of £173 million in 2010/11.

3.4 This money will be used to pay for the major training programme required to provide the required number of suitably trained therapists and to enable the progressive expansion of NICE-compliant local psychological therapies services. Each SHA will want to plan how best to achieve these changes in collaboration with the Department of Health.

## Background

3.5 Depression and anxiety disorders are serious conditions and have a major impact on how well an individual is able to function. A recent World Health Organization (WHO) study compared depression with angina, asthma, diabetes and arthritis and concluded that the

impact of depression on a person's functioning was 50% more serious than the impact of any of the four physical conditions.<sup>1</sup> At present 40% of disability worldwide is due to depression and anxiety.<sup>2</sup>

- 3.6 Nevertheless, only a third of people with diagnosable depression and less than a quarter of those with anxiety disorders are in treatment. The NICE guidelines say that people with these conditions, unless they are very recent or very mild, should be offered an evidence-based psychological therapy, such as cognitive behavioural therapy (CBT), as an alternative to anti-depressants. These therapies have been shown to be as effective as anti-depressants in the short term and more effective at preventing relapse. However, in many places around the country, NHS psychological therapies are either unavailable or subject to significant delays. Since many people are unwilling to take anti-depressants, the result is massive under-treatment of these very serious conditions.
- 3.7 The Psychiatric Morbidity Survey indicates that there are some **6 million people** in the UK with these conditions, roughly half with depression as their primary problem and half with an anxiety disorder.<sup>3</sup> People from diverse communities are represented within these figures. Many have had their condition for some years.<sup>4</sup> The cost is large: in human terms, to the individual, their family and friends; to the wider economy, in terms of lost employment and output; and to the NHS, in terms of repeated visits to GP surgeries and avoidable referrals to acute and specialist mental health services.
- 3.8 People with depression or anxiety disorders deserve to receive NICE-recommended treatments. SHAs will play a key role in enabling the major training programmes involved, so that PCTs can commission NICE-compliant services in this field. (NICE will shortly be issuing commissioning guidelines.)
- 3.9 Once appropriate services are in place, substantial savings to the NHS will be possible from the reduction in unnecessary visits to GP surgeries and unnecessary referrals from GPs either to specialists for unexplained physical symptoms or to mental health facilities.
- 3.10 It is clear that incremental changes would not be able to address the situation: a new approach to delivering local psychological therapies services is needed. The challenge is simple – to implement the NICE guidelines for this large group of people.

<sup>1</sup> Mousavi et al. (2007) Depression, chronic diseases, and decrements in health: results from the World Health Surveys, *The Lancet*, 370:851–858.

<sup>2</sup> WHO (2002), *The Global Burden of Disease*.

<sup>3</sup> Psychiatric Morbidity Survey (2000).

<sup>4</sup> Psychiatric Morbidity Survey (2000).

## 4 Characteristics of an IAPT service

- 4.1 The development of IAPT services should be integral to community-wide efforts to develop person- and family-centred services, which promote people's emotional and psychological well-being.
- 4.2 People suffering from depression and/or anxiety disorders often have concerns relating to employment, debt or relationship difficulties. IAPT services will need to respond to these issues in a holistic way, and have good links to other support services.
- 4.3 PCTs will be responsible for commissioning IAPT services, ensuring that appropriate standards are met and expected outcomes delivered. They will also need to maximise the positive impact the new service can have on the mental well-being of the wider community by working with other members of their Local Strategic Partnerships (LSP).

### Teams of therapists

- 4.4 The basic service model envisages a team of therapists within a PCT taking referrals from GPs, as well as self-referrals, and delivering NICE-compliant therapies at the level required in convenient settings in primary care or elsewhere in the community. The team may be supported by employment advisors (with access to other relevant social supports, such as housing services), a GP advisor (to provide medical advice and liaise with other GPs) and administrative staff.
- 4.5 The size of each service will depend on the population of the PCT and on its level of need (which ranges across England between 80% and 140% of the average need). Some larger PCTs may wish to have more than one team.
- 4.6 It is estimated that **for a population of 250,000 with average levels of need, some 40 properly trained therapists** should be sufficient for the purpose. Indicative staffing figures for setting up a full service can be found in the IAPT Workforce Capacity Tool ([www.mhchoice.csip.org.uk/psychological-therapies/workforce-capacity-tool.html](http://www.mhchoice.csip.org.uk/psychological-therapies/workforce-capacity-tool.html)).
- 4.7 Evidence also shows that these therapists will be far more effective if they work as part of a **single team**, led by senior therapists. This will ensure continuity of care to people moving to recovery, as well as offering supervision, support, in-service training and career progression to the members of the team.

- 4.8 Most therapy will be delivered close to people's homes – in GP surgeries, Jobcentres, or premises of voluntary organisations. Support and some low-intensity therapy (guided self-help) can also be delivered over the telephone. The team will need a central base where members can undertake supervision sessions, some therapy sessions and the necessary record-keeping and administration. The team will need to include enough administrative staff and have access to expertise in employment, housing and benefits so that it can offer an integrated service which will help people to return to normal functioning.
- 4.9 Members of the team will need to be **qualified in the therapy they are delivering** – anything less involves risks, since inappropriate therapy can do harm.

### Equality of access

- 4.10 The normal process of referral will be through primary care. However, some people do not want to tell their GP or practice staff about their mental health problems. Self-referral is acceptable, as the evidence shows that those who come forward are at least as ill as those referred by GPs. It is also important that Jobcentres and employers encourage those who need help to get referred. The service needs close links to all parts of the community, to make access for all as easy as possible.

### Delivering NICE-compliant treatment

- 4.11 The psychological treatments on offer should be suitable for people with depression and anxiety disorders (including panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, social phobia, generalised anxiety disorder, specific phobias and health anxiety).
- 4.12 Every person who is referred (or self-refers) should first receive a patient-centred **assessment** by a member of the psychological therapies team. They should then be treated as the NICE guidelines recommend ([www.nice.org.uk/guidance](http://www.nice.org.uk/guidance)). The relevant evidence-based treatments should be given at the minimum level necessary to achieve full and sustained recovery.
- 4.13 For depression, a system of stepped care is recommended. Most people with mild to moderate depression should begin at Step Two with a relatively brief intervention. This is described as **low-intensity** treatment. This may take the form of watchful waiting, guided self-help (which can be delivered over the telephone) or brief face-to-face psychological interventions (up to seven sessions). It can also include guided use of computerised CBT (cCBT).
- 4.14 A person who is severely depressed or does not respond to low-intensity treatment needs Step Three **high-intensity** treatment involving up to 20 therapy sessions, normally on a face-to-face basis.

- 4.15 For some anxiety conditions, such as post-traumatic stress disorder, social phobia or obsessive-compulsive disorder, patients normally go straight to high-intensity treatment (usually 7 to 14 sessions) unless the problem is very mild or recent. High-intensity treatment is also recommended for other persistent anxiety disorders (generalised anxiety disorder, panic disorder), but guided self-help (including computerised CBT) has been shown to be effective for some individuals and can be deployed in a stepped care system.
- 4.16 NICE guidance also recommends considering the concurrent use of medication in moderate to severe (but not mild) depression.
- 4.17 The types of psychological therapy are spelt out in the NICE guidelines. These are now being revised, but currently recommend CBT for all conditions and certain other therapies for specifically listed conditions.
- 4.18 As services mature, it is expected that they will continue to ensure that the treatments they provide are regularly reviewed to ensure that they reflect updated NICE guidelines.

### **Routine outcome monitoring**

- 4.19 The service as a whole, and individual therapists, will need to be able to demonstrate the outcomes that they have delivered.
- 4.20 At a service level, routine health and well-being outcomes monitoring provides a vital tool through which supervisors and commissioners can monitor what the service is achieving, and supports the delivery of IAPT service performance indicators (see Section 7).
- 4.21 Therapists will need to record the progress of the people they are treating throughout the client care pathway. This will assist with case monitoring, decision making at admission, clinical review and discharge, and maintaining continuity of care, and will help IAPT commissioners and service teams to understand better the needs of the people using the service.

### **The right workforce**

- 4.22 Workforce capacity and capability need to be geared to the likely pattern of demand from patients. Depending on local need, this is likely to require a ratio of around six high- to four low-intensity therapists. High-intensity, fully qualified therapists will provide supervision.
- 4.23 Some therapists will of course already be in post or available on the open market, working in either the private sector or the NHS (many as clinical psychologists). The programme will draw on these therapists in order to start delivering the services and provide initial leadership. It is envisaged that when the new service is complete in, say, six years' time, the majority of the staff will be 'new', that is, people who have been trained for the purpose since 2008.

- 4.24 At present, the greatest shortage of therapists is in CBT, which will be the most widely used therapy in the new service. Initially, therefore, IAPT training will focus on CBT. The focus will broaden as the deficit is addressed and the NICE guidelines are reviewed.
- 4.25 Trainees in high-intensity therapy are likely to be drawn from the professions of clinical psychology and psychotherapy, as well as people with experience of mental health in other capacities, such as nurses, counsellors and other professional groups. They will need a one-year course involving up to two days a week (equivalent) off-the-job training in a training institution, with the rest of the week working in an IAPT service providing therapy under supervision. All trainees will be employees of the services.
- 4.26 The trainee low-intensity therapists will need a one-year course involving one day a week (equivalent) off-site, together with supervised work handling cases in IAPT services. These trainees are likely to be drawn from wider sources. It is recommended that people with relevant life and work experience, as well as psychology graduates, be encouraged to apply for these roles.
- 4.27 There will be national curricula (supporting documents) and qualifications for both these types of courses. In order to attract the best possible workforce, it is envisaged that all training places will be widely advertised. Selection of trainees will be carried out in collaboration by the service and the training providers.
- 4.28 The creation of this **new workforce of psychological therapists** is the greatest challenge of the programme, and its success depends critically on good commissioning of training by SHAs and on the commissioning of NICE-compliant services by PCTs.

## 5 Moving the system forward

5.1 The additional investment in IAPT will support the NHS in implementing the relevant NICE guidelines by funding the following over the CSR07 period:

- an expanded number of **training places**
- accredited **training providers**
- a proportion of **trained staff** to lead and supervise the new service
- **supervision** training for trained staff
- an expanded number of **IAPT services** providing access and training locations.

### Establishing IAPT training programmes

5.2 Over the implementation period, training places will be provided across England as shown in Table 1:

**Table 1: Training places 2008/09 to 2010/11**

	Low-intensity	High-intensity	Total
2008/09	250	350	600
2009/10	615	820	1,435
2010/11	525	785	1,310

5.3 During this period, each SHA will commission a given number of places on the basis of its share of the figures shown in Table 1. It will identify at least one training provider for the high-intensity trainees and one for the low-intensity trainees, which could be in the same institution where appropriate.

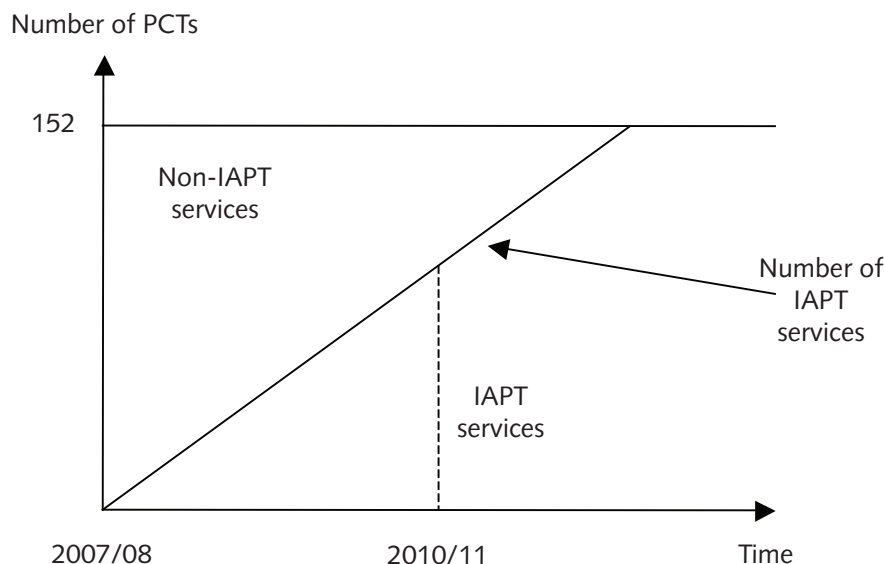
5.4 To deliver high standards of training in year one, it is likely that training places will need to be centred in one or two providers per SHA. This will have a number of advantages, the most important being to ensure that there are enough suitably qualified tutors to cover all aspects of the course. Long-term contracts should be encouraged to enable training providers to employ good staff and design courses to IAPT requirements. From 2009/10, each SHA may want to involve one or more additional training providers, or else simply to expand the throughput of the original provider(s).

- 5.5 The Department of Health and CSIP will work with SHAs in the selection process. High-intensity training courses are intended to be accredited by the British Association of Behavioural and Cognitive Psychotherapies (BABCP). An accreditation process for low-intensity courses is being developed. SHAs will need to use the criteria at **Annex A** when selecting training providers.
- 5.6 All training costs will be paid for out of IAPT funds. This will include the fees to the training provider, including supervision costs. The full-time salaries of trainees will also be funded by IAPT. Course fees are expected to be in the region of £4,000 to £4,300 for low-intensity training, and £8,200 to £9,000 for high-intensity training. Low-intensity trainees are expected to be paid at Band 4, while high-intensity trainees are usually expected to be paid at Band 6 or 7.
- 5.7 SHAs will report each year on the numbers in training and completing training. Courses will include comprehensive and rigorous assessment of trainees' clinical skills and knowledge.

### Establishing IAPT services

- 5.8 The challenge of service development in this area is different from anything normally encountered. Typically, health services are developed evenly across all localities at a similar speed. But in this field, such a large training programme is necessary that we can only provide suitable training environments for the trainees if we ensure **some localities run ahead of others**.
- 5.9 When the Secretary of State for Health announced the additional funding for psychological therapies, he said that psychological therapies would be rolled out to **20 new areas** in 2008/09. Over the implementation period while the service develops, the number of services that satisfy IAPT standards will increase and the number that do not will diminish (see Figure 1).
- 5.10 SHAs will want to oversee the roll-out of IAPT services throughout the planning period 2008/09–2010/11, and be clear about PCTs' plans to commission IAPT services in the future. SHAs may find it helpful to engage the regionally based CSIP to support them in this.

**Figure 1: Projected expansion of IAPT services**



5.11 SHAs have therefore agreed to identify at least two PCTs each to receive funding in 2008/09. Depending on local circumstances, it may be possible to establish services in more than two PCTs. It is unlikely that year one funding will be able to stretch far beyond four services per SHA due to the need to provide:

- a full service that meets the needs of the whole PCT population
- a service with an appropriate proportion of fully trained staff
- appropriate on-the-job training for the region's trainees.

5.12 It is therefore important that in 2008/09 the PCTs selected should have a core service of fully trained staff already in place to provide supervision for the new trainees and to lead the new service. To support this, a proportion of the fully trained staff salaries will be funded by IAPT. This resource will increase throughout the CSR07 period in proportion to the increasing numbers of trainees.

5.13 The exact configuration of the new services will be agreed locally. PCTs may wish to commission service providers from both statutory and non-statutory sectors as will be locally appropriate. Commissioners will need to ensure that service providers establish integrated teams covering all aspects of the IAPT service model. PCTs have a legal duty to assimilate equalities into commissioning guidelines and to reflect continually upon the

effectiveness of the service for the local population. Further support materials will be published shortly in the *Psychological Therapies Commissioning Toolkit*.

5.14 While the size of teams is likely to vary between areas, the table below shows indicative staffing levels for a service in an 'average' PCT in 2008/09, based on a team of 40 therapists.

**Table 2: Indicative staffing levels for a service in an average PCT in 2008/09**

	Trainees (IAPT-funded)	Trained staff (IAPT-funded)	Trained staff (PCT-funded)	All staff
Low-intensity	11	2	3	16
High-intensity	15	4	5	24
Total	26	6	8	40

5.15 SHAs have agreed to identify PCTs who wish to become IAPT sites on the basis of the criteria at **Annex B**. Any PCT selected as an IAPT site can expect to be offered ongoing funding for staff and trainees. Any variable element in support could depend on performance.

## 6 Funding

- 6.1 In 2008/09, an additional £33 million is available to support the first phase of the IAPT implementation process. At least 20 new IAPT services (with at least two in every SHA area) will be established, supported by appropriate training provider commissions.
- 6.2 In this first year, the funding will be pooled and spent for and on behalf of SHAs by the Department of Health. Oversight will be provided by the IAPT National Programme Board, co-chaired by Ivan Lewis, Parliamentary Under-Secretary of State for Care Services. The board will provide the focus for close joint working between key national stakeholders (including the Department of Health, SHAs and the CSIP).
- 6.3 It is proposed that the £33 million will be notionally allocated to SHAs (according to the part of the weighted capitation formula that determines demand for mental health services). There are two discrete components to the funding:
- therapist training costs – this is the amount available to each SHA to establish regional training providers
  - therapist salaries and on-costs (service provision costs) – this is the amount available to each SHA to enable the selected IAPT PCTs to establish and maintain the new services.

# 7 Performance indicators, service standards and outcomes monitoring

- 7.1 A standard set of performance indicators will be developed with SHAs to support regional performance monitoring of each IAPT service. These will be collated nationally, and averages will be published to enable benchmarking (subject to Review of Central Returns (ROCR) approval).
- 7.2 Regional performance indicators will be based on the range of outcomes that the Secretary of State committed the NHS to delivering in return for the additional resources provided. They are:
- **PCT coverage** – at least 20 PCTs to implement IAPT services in 2008/09, and this coverage should increase over 2009/10 and 2010/11
  - **Building a skilled workforce** – training programmes to deliver 3,600 therapists by 2010/11 with an appropriate skill mix and supervision arrangements
  - **extending access to NICE-compliant services** – 900,000 more people accessing treatment, with half of those who complete the programme moving to recovery and 25,000 fewer on sick pay and benefits, by 2010/11.
- 7.3 Service-level performance indicators will be based on an outcomes framework. Effectiveness can be demonstrated by the collection and analysis of service throughput and outcomes data for everyone who uses the services.
- 7.4 More details and further guidance will be provided in the *IAPT Outcomes Framework 2008/09*, expected to be published in March 2008. This will include details of collection and monitoring in the following performance areas, subject to discussions with the SHAs and ROCR approval:

## Access standards

- accessibility:
  - ensuring waiting times and the range of interventions provided across the stepped care model are appropriate

- equity of access:
  - ensuring the service is available to all sections of the community, by means of a local equality impact assessment
- population coverage (PSA indicator):
  - demonstrating improvements in the proportion of people with depression and/or anxiety disorders who receive psychological therapies

### Health and well-being outcomes

- effectiveness:
  - obtaining pre- and post-treatment outcome data for at least 90% of the people treated in the service
  - demonstrating reductions in symptoms
  - demonstrating social inclusion and employment status

### Service standards

- acceptability and quality:
  - monitoring satisfaction and choice among people who use IAPT services
  - monitoring supervision of trainees and experienced staff.

## 8 Guidance for non-IAPT services

- 8.1 The Department of Health's PSA with the Treasury aims to improve the well-being and inclusion of people with depression and/or anxiety disorders through improved access to psychological therapies. The full PSA can be found at [www.hm-treasury.gov.uk./media/5/A/pbr\\_csr07\\_psa18.pdf](http://www.hm-treasury.gov.uk./media/5/A/pbr_csr07_psa18.pdf)
- 8.2 The NHS Operating Framework 2008/09 states that to prepare for the new IAPT services being available more widely in future, PCTs will need to begin planning how they will implement a stepped-care psychological therapies service. The first step will be to carry out a needs assessment of their local population.
- 8.3 Psychological therapies services for depression and anxiety disorders will also improve universally across PCTs, as a result of PSA 18 and the NHS Operating Framework. SHAs will need to commit to supporting and monitoring all PCTs in improving their services through routine commissioning. SHAs will agree with the Department of Health how best to monitor and report this improvement regionally and nationally.
- 8.4 As indicated in the NHS Operating Framework, PCTs may now want to plan to improve their psychological therapies services and initiate a local needs assessment. They may also want to begin scoping their state of readiness to deliver IAPT services in preparation for becoming an IAPT site in the future.
- 8.5 A commissioning toolkit to support PCTs in establishing and monitoring psychological therapies services will be available shortly.

## 9 Next steps

- 9.1 Discussions continue at a national level about how IAPT will be incorporated into the governance and monitoring processes of the NHS and the Department of Health.
- 9.2 During February and March 2008, SHAs will be able to work with regional and national CSIP teams to develop plans to deliver IAPT in their local areas.
- 9.3 For further discussion, please contact the IAPT National Team ([iapt@dh.gsi.gov.uk](mailto:iapt@dh.gsi.gov.uk)) or your CSIP Regional Development Centre IAPT lead.

### Supporting documents

- 9.4 There are a number of supporting documents to the IAPT Implementation Plan currently available via the Department of Health website, at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh\\_083150](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/dh_083150). These include:

- *Curriculum for low-intensity therapies workers*
- *Curriculum for high-intensity therapies workers*
- *Equality impact assessment*
- *Impact assessment.*

- 9.5 Further supporting documents will be available by 1 April 2008, including:

- *Psychological Therapies Services Commissioning Toolkit*
- *IAPT Outcomes Framework 2008/09.*

- 9.6 These can be accessed from 1 April 2008 via the following websites:

[www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html](http://www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html)

[www.newwaysofworking.org.uk/psychotherapy.aspx](http://www.newwaysofworking.org.uk/psychotherapy.aspx)

# Annex A: Criteria for training provider selection

- Training providers will need to be able to deliver the specification (low-intensity, high-intensity and supervision elements) described in the national curricula (supporting documents).
- Training providers will need to commit to using the national curricula and learning and assessment materials, or demonstrate clear equivalence between their courses and those curricula and materials.
- Training providers will need to give evidence that they have successfully delivered similar projects in the past.
- Training providers will need to demonstrate capability and expertise in the area, including continuing links to clinical practice.
- Training providers will need to have capacity to provide supervision, in collaboration with service providers.
- If recruitment of key personnel is required a person specification for each post will need to be provided.
- Training providers will need to commit to working to BABCP revised standards for accreditation.
- Training providers will need to commit to working collaboratively with services.

# Annex B: Criteria for PCT selection

- PCTs will need to demonstrate commitment to the IAPT service characteristics set out in Section 4 of the Implementation Plan and to have established relationships with current and potential service providers.
- Services will need to have enough suitably qualified therapists to meet the needs of the whole PCT population (in large PCTs this may require more than one service).
- PCTs will need to have carried out (or be in the process of carrying out) a Joint Strategic Needs Assessment (JSNA) – an accurate assessment of health need, in relation to prevalence of depression and anxiety, and of the gaps between existing provision and unmet need.
- In PCTs selected for 2008/09, at least one-third of therapists will need to be fully trained, and these will need to include a director, supervisors, and a balance of low- and high-intensity therapists to ensure an appropriate balance between providing on-the-job training and a quality service. These therapists should be already in post, or else available via agreements with other organisations such as secondary care trusts.
- PCTs will need to demonstrate that there is no reduction in current funding of psychological therapies services and that they have considered the impact of new services on existing psychological therapies and other mental health services, ensuring that appropriate integrated care pathways are provided.
- IAPT services will need to provide trainees with appropriate on-the-job training. SHAs will select their training provider(s), on the basis of the criteria in Annex A. The PCTs selected will need to demonstrate that arrangements are in place to allow close working between the service and training providers. This is to ensure that trainees receive an integrated training comprising on-the-job training in an IAPT service and off-the-job training with the selected training provider(s).

- Systems and processes will need to be in place to demonstrate capability to collect and monitor IAPT routine outcomes with
  - data for evidence-based practice, benchmarking and service development
  - a clear protocol for when measures are collected
  - IT to collect the full range of outcome measures.
- A local equality impact assessment will need to be carried out, to include details of self-referral and other access routes and demonstrating that services will eliminate discrimination, promote equality of opportunity and good relations between people from different groups, and improve equality of access by promoting self-referral.
- PCTs will need to have a track record of delivering significant service change effectively, including applying service improvement methodology in primary care and/or mental health settings and initiating services from a virtual standing start.
- PCTs will need to demonstrate engagement from key stakeholders in prioritising the needs of people with common mental health problems in the context of Local Area Agreements/Local Strategic Partnerships and building on the JSNA. Key stakeholders will need to include people who use the services and those who support them, GPs, employment and housing services, and voluntary and community organisations.











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