

Improving Access to Psychological Therapies

Workforce Planning and Capacity Tool

DRAFT

Frequently Asked Questions

What is the purpose of the tool?

The tool has been designed to enable the IAPT Pathfinder sites to assess the workforce development and service redesign necessary to translate current service provision into a service configuration, which meets the principles of the IAPT programme. As such, it should be read in conjunction with the other guidance (e.g. Service specification, Practical approach to workforce etc.) available from the IAPT website.

We also intend to demonstrate the tool during our schedule of visits by the IAPT Workforce Team to each of the Pathfinder sites.

Using known epidemiology for common mental health problems, it estimates the numbers of patients presenting for treatment and calculates the numbers and types of therapists required in order to meet demand. This is based upon the assumptions built into the IAPT Business Case, together with expert advice derived from the relevant NICE Guidance. The result is an estimate of the workforce profile required which can then be compared with the existing workforce.

Does the tool provide me with a definitive answer as to the workforce profile that I would expect providers to employ?

No, but it does allow you to model several different scenarios based around your local demographics which could be used as a starting point for discussions around future workforce profiles and service redesign. Although it is based upon several fixed assumptions derived from best practice, it also allows you to model the characteristics of your local health community, and to explore different assumptions about the kinds of psychological interventions you wish to commission, the type and skills mix of staff to be employed, and assumptions about case loads and patient's contacts. Essentially, we see the merits of this tool as providing a focus on workforce and enabling commissioners to think through different models of service provision.

We hope to update and refine the tool, as and when, future outcome data is gathered and analysed concerning the performance of the national demonstration sites and other relevant trials and studies.

What do I need to do in order to utilise the tool?

Please follow the instructions on the spreadsheet. You will need to select the relevant geographical location of your PCT and cut and paste the specific ONS statistics relating the population and prevalence of disorder; this produces a listing of weekly prevalences for each common mental health problem listed.

All red boxes in the spreadsheet are predetermined values that have been set based either on expert opinion or NICE guidance, and cannot be modified. Many of these assumptions have been adopted within the IAPT Outline Business Case.

Blue boxes, on the other hand, can be modified so as to reflect local demand or to model different assumptions about service delivery models. More guidance on how these might be varied are provided below. The default options reflect best practice derived from NICE guidance.

What exactly does the tool calculate for each category of mental disorder and how can I influence it to reflect local circumstances?

The model is based upon common care pathways for each common mental disorder that presents and might be treated within primary care. Local variations which need to be considered are:

- Age range of the services commissioned. You can limit the page of patients served by your service by altering the blue cells related to age range (default: 16 – 75 years). Currently the model starts at age 16 years but we are developing a model which could be applied specifically to CAMHS services, and to older people.
- Overall prevalence may be determined by socioeconomic factors such as social deprivation. An index, which adjusts prevalence for deprivation etc, is available for the old PCT configuration; efforts are being made to recalculate this index for the new configuration. Prevalence could be changed by as much as 40% in either direction by using the index (NPMSdep).
- The actual numbers of patients seen, based on the prevalence figures, will depend upon presentation (ie % of those that seek help) and detection (% of those identified as a case by their GP). We have preset these at 50% and 50% and suggest that you use these parameters unless you know that local practice differs significantly.
- Of particular importance, is the mix of common mental health problems and referral patterns within the service. The demand for treatments and ultimately the workforce profile is driven by the prevalence of different disorders and the resultant referrals to the service. It is possible that local variations in the mix of prevalence may be known by the service – if so these percentages can be locally determined.

However, it is more likely that different services will differ between which conditions/disorders are treated within primary care and which are referred on to secondary care.

You can reflect this by weighting the percentage of patients referred to the service for each of these disorders. To illustrate this, we have provided worksheets for the two demonstration sites (spreadsheet tabs – Newham and Doncaster) which have distinctive features with respect to referrals and mix of disorders. Doncaster reflects a predominance of referrals indicating depression whereas the Newham service takes a wider range of disorders including Post Traumatic Stress Disorder, Obsessive-Compulsive Disorder etc. As you can see from the exemplars, these differences in mix of disorders referred and treated impact ultimately on the skill mix required for the workforce, particularly in terms of the numbers of low and high intensity practitioners.

- Different services will have different referral patterns and provision across the primary and secondary care interface and these will be a major determinant of demand for treatment and the resulting workforce profile. However, it is important to emphasise that the current model only predicts prevalence and demand for common mental health problems (ie depression and anxiety disorders) and accordingly cannot be used as an accurate and comprehensive estimate of the secondary care workforce. Other disorders and their relevant care pathways (ie psychosis, eating disorders and bipolar disorders), together with specialist services for personality disorder, brain injury, learning disability, etc would also need to be factored in. Similarly, we have not estimated the impact of long-term conditions, unexplained medical symptoms, older people, or CAMHS on either demand for primary or secondary care services. We emphasize, therefore, that this is NOT a generic workforce tool for mental health services but one derived specifically to support the IAPT programme.
- Another factor to be considered is the period of time (ie duration of presenting condition) required before a GP refers a patient to the service. NICE guidance suggest a period of watchful waiting prior to active intervention, and the referral criteria for Newham and the current IAPT Pathfinders suggest that treatment is accessed after a six month duration. Doncaster, has offered low intensity services to patients immediately on detection and the duration of the presenting problem could be as low as a few weeks. This raises the issue of what has sometimes been referred to as Step 0 which constitutes more generally available mental health promotion strategies which could be available to patients whilst watchful waiting takes its course.
- Finally, commissioners should also consider what assumptions they wish to make around the application of the Stepped Care model that they adopt for their service. There are two important factors to consider which can be modelled within the spreadsheet. The first

considers whether all patients are introduced to treatments at the lower steps (step 2), before being “stepped up” as required. If this is the case, you will enter %100 in the blue cell. However, following triage assessment, some services will refer patients to higher steps or even directly to secondary care. In these circumstances, a lower percentage (eg 80%) might be appropriate. Similarly, different assumptions can be made about the percentages of patients “stepped up”: the current model assumes 10% but some data sources suggest that this could be higher (around 30%) and may depend also on the severity of the disorder (mild vs moderate/severe) and the nature of the intervention (low vs high intensity). Differential recovery rates might also need to be considered.

How is the workforce profile calculated and can I influence the type of therapists and skill mix of the service that I wish to commission?

Based on the demand calculated for each care pathway, and following the application of the various local factors described above, the total numbers of patients requiring treatment are identified. These are categorised into the relevant percentages that might require low intensity interventions, high intensity interventions¹ or those patients that chose to be treated by antidepressant medication alone. The model then makes various assumptions about the numbers of patient contacts a day for each type of therapist/intervention, the overall percentage time the therapist engages in direct patient contact (ie case load), and the duration each episode of care in contacts or sessions. Table 1 below sets out the default options in the model and how they are based upon on the Outline Business Case. Based on more recent practice, we have modified the total contact time for low intensity workers from X to Y hours. You should allow time for your service to reach a steady state, which means that the balance between number of assessment and treatment sessions will be dynamic, and change over the set up of the service. You will also need to allow for some spare capacity to account for variations in referral patterns, and also DNAs and unscheduled discontinuations of treatment.

Again, we have provided default options for these parameters but....

How are costs determined and what grade or type of therapist should be employed?

The costs are derived from the average salary costs of low and high intensity practitioners as estimated for the business case, together with estimates of the medication costs (see boxes X and Y). Please note that employer's on costs are factored in later in box W. The specific make up of both your existing and future workforce will depend obviously on the types of therapists employed and their related AfC bandings, together with the levels of

¹ Text from OBC describing low and high intensity interventions

experience and training of the staff. Please remember, that high intensity practitioners will be required to contribute to the service in critical areas of provision outside of direct therapy, and functions around supervision, training, audit and governance, service improvement, R&D should all be considered when deciding gradings and skill mix. Another factor to be considered is the number of trainees working under supervision within the service.

Finally, we have identified some further specialist roles which were included in the OBC (i.e. employment coaches and GP with SI) which also require consideration.

Drug Costs

As part of the care pathways section of the template, estimates are made of the likely number of people choosing a medication, rather than talking therapies. Current costs for three commonly prescribed SSRI antidepressants are averaged, and the costs calculated for a course of treatment. The assumptions associated with the length of treatment can be adjusted (they are in a blue box), and are based on current best practice. Of interest is the difference in cost between a single 60mg capsule course of fluoxetine, and 3 x 20mg capsules over the same period. A conversation with the Pharmaceutical advisor may well generate some extra savings. The costs of SSRI prescribing included in this template for each PCT are based on 2006/07 costs from the PPA.

What does the model finally tell me?

The final sets of calculations identifies the gap between your current workforce profile and that estimated using IAPT principles and local circumstances. This means that you will need to survey the current staff in your service and categorise them by wte, AfC bandings and the types of interventions (and time spent delivering each) that each provides. The latter will essentially refer to high and low intensity interventions. It is likely that there will be a substantial gap between the workforce profile estimated by the model and the present capacity of the service. It is unlikely, that the additional resources associated with initiatives underpinning the IAPT Pathfinders will accommodate this gap in resources. Moreover, if you adopt different priorities and alter the assumptions about patient contacts etc, you can model a range of different workforce profiles. We suggest, therefore, that you aim to use this workforce tool to model different scenarios and inform your decision making around workforce development and service redesign.

