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North Essex IAPT Services

HPFT Operational Policy

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Executive Lead	Director of Service Delivery & Service User Experience
Lead Author	Service Line Lead, Clinical Lead
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Document on a Page

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Version	**Issue Date**	**Review Date**	**Lead Author**
3	14/08/2020	14/08/2023	Service Line Lead / Clinical Lead
Staff need to know about this policy because (complete in 50 words)	This is the operational policy for the three Improving Access to Psychological Therapies (IAPT) Services in North Essex. This document is intended to ensure a consistent and equitable approach to service delivery in North Essex IAPT Services and as a reference for staff and those seeking to understand how the service works.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	Patients can access the North Essex IAPT Service by referring themselves or by being referred by another professional currently involved in their care. North Essex IAPT Services aim to provide the minimum intervention necessary tailored to the needs of each individual client. Mild to moderate mental health problems will usually be treated using brief guided self-help interventions at Step 2, whereas moderately severe mental health problems will usually indicate formal psychological therapy at Step 3 An initial assessment (first assessment and treatment contact) must take place within 28 calendar days of the referral being received by the service.		
Summary of significant changes from previous version are:	The policy has been reviewed in light of COVID-19 and references that more treatment is now offered online. All reference to seeking consent from the patient to share information with the GP have been removed from this document. This reflects a change to our Information Sharing Statement which sets out how information is processed and shared and subsequent change to our practice.		

Contents Page

PART 1 – Preliminary Issues:

1. Summary

This is the operational policy for the three Improving Access to Psychological Therapies (IAPT) Services in North Essex. This document is intended to ensure a consistent and equitable approach to service delivery in North Essex IAPT Services and as a reference for staff and those seeking to understand how the service works.

2. Purpose

The North Essex Improving Access to Psychological Therapies (IAPT) Services have been established as part of the national Improving Access to Psychological Therapies programme, which was initiated in 2008 and aimed to expand the provision of evidence based psychological therapies for the treatment of anxiety and depression (DoH, 2008).

The IAPT national agenda is to increase access to NICE recommended talking therapies for anxiety disorders and depression in a range of modalities. The NICE guidelines for the management of depression, anxiety (panic disorder and generalized anxiety disorder) and obsessive-compulsive disorder (OCD) recommend using a stepped care model.

Service delivery is underpinned by principles outlined in The Five Year Forward View by increasing patient access to the North Essex IAPT Services. The Services aim to achieve the key principles through outreach work, health promotion and partnership working, with an overarching aim to reduce stigmatisation and marginalisation.

The steps and the interventions required vary across conditions, but the principle is that patients receive the least burdensome effective treatment necessary for their recovery. Within stepped care, the progression of patients from low intensity interventions through to higher intensity interventions is based on a mixture of increased need and past experience of treatment.

The Services purpose is to provide talking therapies to 15% of those in the local population experiencing common mental health difficulties, and to deliver a recovery rate of 50% measured against the IAPT approved minimum data set. The North Essex IAPT Services will also work to meet locally specified and agreed CCG targets regarding activity and performance, and support them in delivering against their commissioning priorities.

The North Essex IAPT Services works in partnership with statutory and non-statutory organisations to enhance care provision and meet agreed expectations.

The Service offers a range of treatments in accordance with NICE guidelines:

- Cognitive-Behaviour Therapy (CBT) at step 3 (High intensity) and CBT informed interventions at step 2 (Low intensity).

- Evidence based therapeutic models for depression, such as interpersonal therapy (IPT), Brief Dynamic Interpersonal Therapy (DIT), counselling for depression (CfD) and couple therapy for depression (CTfD).

- EMDR, as well as CBT, for treatment of post-traumatic stress disorder

- Step 2 interventions including guided self- help offered by psychological wellbeing practitioners, including CCBT, workshops/courses.

The staff delivering these treatments will have a recognised qualification, accreditation with a professional body, relevant training or undertaking clinical training.

3. Objectives of North Essex IAPT Services

The objectives for the North Essex IAPT Services are to:

- Provide a directly accessible primary care psychological therapy Service for patients presenting with common mental health disorders.

- Provide early access and appropriate interventions adopting a stepped care approach as per NICE guidelines

- Provide a “whole person” approach that takes account of an individual’s health comorbidities and lifestyle

- Promote self-referral and access to Services from all sectors of the community, including traditionally underserved/socially excluded groups

- Work with partners to optimise provision

- Provide all interventions and interfaces with professionals, Service users and carers in accordance with wider Trust Values.

4. Definitions

Key words / phrases in this document include:

IAPT	Improving Access to Psychological Therapies
NICE	National Institute for Health and Care Excellence
CBT	Cognitive Behaviour Therapy
IPT	Interpersonal Therapy
DIT	Dynamic Interpersonal Therapy
EMDR	Eye Movement Desensitisation and Reprocessing Therapy
CCBT	Computerised CBT programmes
PWPs	Psychological Wellbeing Practitioners
HIWs/HITs	High Intensity Workers, typically CBT Therapists, Clinical or Counselling Psychologists providing step 3 interventions

STaRs Support Time and Recovery Workers

Stepped care model: a model of delivering and monitoring care where the most effective yet least resource intensive treatment is delivered first; only “stepping up” to intensive / specialist Services as required clinically.

Step 2 interventions: self-help; guided self-help; CCBT; courses / workshops / groups designed to target mild common mental health problems; expert advice; short-term brief interventions; signposting to/mobilising resources of Step 1, watchful waiting’…with further assessment.

Step 3 interventions: brief psychological treatments / standard talking therapies for mild to moderate and severe anxiety disorders and depression including CBT, EMDR, DIT, Counselling for Depression, Couple Therapy for Depression, IPT.

PART 2 – Who does what

5. Team Locations and Opening Hours

The core operating hours for the Service are between 9:00am and 5:00pm Monday to Friday. The Service is able to provide sessions between 8:00am and 8:00pm Monday to Friday and at weekends according to patient need.

Healthy Minds (West Essex PCPT Service)

Latton Bush Centre
Southern Way
Harlow
Essex
CM18 7BL

Telephone: 0300 222 5943

Mid-Essex IAPT Service

Tekhnicon House
Springwood Drive
Braintree
Essex
CM7 2YN

Telephone: 01376 308704 or 01376 308705

Health in Mind (North East Essex IAPT)

Elm Ridge
Lexden Hospital
London Road
Colchester
Essex
CO3 4DB

Telephone: 0300 330 5455

6. Service user profile and eligibility

The North Essex IAPT Service provides:

Core IAPT for people aged 18 and over, including people with a mild learning disability, who have mild to moderate levels of common mental health problems, in particular depression and anxiety.

Services for people registered with a GP in West Essex CCG; Mid-Essex CCG and North East Essex CCG. If people are not registered with a GP, they will be given help to do so.

Psychological therapy for younger people according to the individual Service criteria agreed with each CCG. This is young people aged 14 and over in West Essex,

young people aged over 16 in North East Essex and young people aged 17 and over in Mid-Essex. North East Essex also provides for people under the age of 18 through a sub-contracting arrangement with Colchester Mind, known as “The Junction”.

Psychological therapy for people with severe mental health problems, where the primary need is anxiety and depression as described in NICE guidelines.

7. Accessibility

Access to healthcare for people with a learning disability

People with a learning disability will access appropriate services and receive the best treatment available in line with good practice and legal frameworks. Therefore all services will ensure that:

- Reasonable adjustments are made to ensure that each person has the opportunity for health, whether they have a learning disability or not. (Equality Act 2010)
- Assume that each person has capacity. If assessment shows they do not, a decision must be made in their best interest. (Mental Capacity Act 2005)
- Everyone has a right to expect and receive appropriate healthcare (Human Rights Act 1998)

Adjustments will include:

- Spending time with the individual to gain an understanding of their preferences for treatment
- Asking them where they would prefer to be treated
- Providing additional support to assist with communication, this support will be available via accessible information and/or audio equipment. Accessible information will include appointment letters and leaflets, available on the Performance page on the intranet.
- If someone has difficulty understanding their treatment it is the responsibility of the staff to refer them to a specialist learning disability service for additional support
- Valuing and welcome the contribution of the relative/carer/advocate

The North Essex IAPT Service accepts self-referrals through a web portal Patient Case Management Information System (PCMIS); hosted by University of York, Department of Health Sciences.

8. Referrals

The North Essex IAPT Service aims to provide patients access to psychological therapies. The functions and roles of the team assist in supporting the patient journey from referral to end of treatment.

Patients can access the North Essex IAPT Service by referring themselves or by being referred by another professional currently involved in their care.

North Essex IAPT Services accept referrals from GPs, allied other health professionals, from secondary care services, or from individuals in the form of a self-referral.

Referrals will be accepted in written form, by letter, secure email, directly to the teams. Self-referrals will be accepted by telephone, letter, self-referral portal (web link) or by secure email where such facilities are available. Standard forms may be used.

When a self-referral phone-call is received requesting access to the North Essex IAPT Service the person receiving the call will first establish the call is not urgent and will complete the online referral with the caller taking their demographic details (full name, date of birth, gender, ethnicity, address, phone number, GP) and, where appropriate, whether the person is agreeable to us contacting the GP. They will ask all the questions on the referral form.

If urgent the referral will be passed to a duty worker for a telephone screening assessment to be made, as a priority.

Clinical Triage Service

Where the North Essex IAPT Services are commissioned to provide a Clinical Triage Service (CTS), additional decision making will take place as to the appropriate route into mental health services and IAPT services. This results in accepting a referral for IAPT and onward referral to secondary mental health services.

Exclusion Criteria

People who present with significant risk to self or others are not usually appropriate for the North Essex IAPT Services, and should be referred to secondary care services or other appropriate/commissioned services. These include:

- Individuals who have recently attempted suicide would not normally be seen as suitable for the North Essex IAPT Services.

- Individuals identified as experiencing severe anger management problems as identified by a history of agitation or threatening manner causing fear in others. This includes physical aggression to people or animals and significant destruction of property.

- Individuals who have been charged and / or convicted of violence related issues in the last 12 months, or for whom there is a significant history of interpersonal aggression.

- Individuals identified as experiencing anger management problems or domestic violence history in the absence of a mental health problem; should be referred to other appropriate commissioned services

- Individuals with severe substance or alcohol misuse, which would interfere with the individual's ability to engage in interventions offered, should be referred to relevant drug and alcohol services.

- Where the primary difficulty is related to childhood sexual abuse, these should be referred on to local specialist services.

- Individuals open to on-going care from secondary care mental health services.

- Individuals who are regularly seriously self-harming (e.g. deep cutting, burning, scalding, or drinking bleach) or have a history of repeated self-injury requiring hospital treatment.

- Very poor functioning in more than one domain of life/extensive social care needs.

- Individuals with a primary presentation of severe and enduring mental illness, where the NICE guidance does not indicate that a brief psychological intervention in primary care is likely to be of benefit.

- Individuals with a moderate to severe learning disability whose clinical needs can best be met within specialist learning disability services.

- Individuals aged 16 and 17 who have a history of self-harming and impulsive overdosing.

- Individuals unwilling to be registered with a North Essex GP

Any such referrals should be considered on a case by case basis where the risk episode is formulated before being rejected. The relevant GP must be informed.

9. Assessment Process

North Essex IAPT Services aim to provide the minimum intervention necessary tailored to the needs of each individual client. Mild to moderate mental health problems will usually be treated using brief guided self-help interventions at Step 2, whereas moderately severe mental health problems will usually indicate formal psychological therapy at Step 3.

Step Allocation Step	**Service**	**Severity**	**Functioning**	**Risk**	**Clinical intervention**
1	**GP**	Mild	Good	None	Identification/ watchful waiting
2	IAPT Service **(Low intensity)**	Mild – moderate	Relatively unaffected	Low - no intent	Guided self-help based on CBT & signposting
3	IAPT Service **(High intensity)**	Moderate – moderately severe	Definitely impeded	No current intent	CBT or other evidence based psychological therapy
4/5	**Secondary care**	Severe	Poor	High	Multidisciplinary approach/ longer term therapy

The PHQ measures depression:	The GAD measures anxiety:
0 – 4 None 5 – 9 Mild 10 – 14 Moderate 15 – 19 Moderately Severe 20 – 27 Severe	0 – 4 None 5 - 10 Mild 11 – 15 Moderate 15 - 21 Severe

9.1 Referral screening

All referrals will be screened for one of the following outcomes:

- Initial assessment at Step 2
- Initial assessment at Step 3
- Signposting to alternative service (including return to GP)

Referrals identified for an initial assessment will be passed to the booking clerk, who will contact the individual concerned to book an initial assessment with a Step 2 (PWP Worker) or Step 3 (High Intensity Worker).

If, following a reasonable number of contact attempts, it is not possible to arrange an Initial Assessment, the case will be closed and the referrer notified.

Where the outcome is signposting to another service, a letter will be sent to the referrer indicting the outcome and a copy sent to the patient.

9.2 Initial Assessment

An initial assessment (first assessment and treatment contact) must take place within 28 calendar days of the referral being received by the service.

This will consist of the minimum assessment necessary to gather all pertinent information with a view to planning an appropriate intervention. This will include a focus on risk and the individual's needs, in order to discuss an appropriate intervention. Standardised risk questions are mandatory on the PCMIS data system at initial assessment, and the clinician must ensure that they have adequate information to answer the standardised questions.

A standard initial assessment will be carried out at Step 2 and Step 3. During the assessment an agreement will be reached confirming the appropriate step for treatment and the planned intervention. At this stage the individual may decline the service. Within a stepped care model, the majority of patients entering the service will be assessed and treated within Step 2 (Approx. 70%).

A letter will be sent to the individual indicating the outcome of the assessment and a copy sent to the patient's GP where permission has been provided.

If the outcome of the assessment identifies a Step up from Step 2 to Step 3, this should be given priority within the team, to ensure continuity of treatment for clients and management of risk issues.

9.3 Waitlist management

Having to wait for treatment can be detrimental to service users who feel unsupported. Wait lists also put considerable pressure on staff who feel their ability to offer a quality service is compromised.

When it is evident that there is a risk of new referrals not being seen within the target timeframe (internal target is 28 days; national target is 42 days) services need to create capacity to prevent waiting time breaches and keep service users safe, as best they can.

In practice this may (temporarily) involve prioritising first appointments for new referrals over ongoing treatment sessions for service users already in treatment. This might include the service running “assessment weeks” where the majority of service appointments for that week constitute first appointments.

A Standard Operating Procedure for the management of waitlists can be found in appendix 1. Case management guidance is also provided in appendix 2.

9.4 Treatments offered

9.4.1 Low intensity interventions

Contacts for low intensity assessment will usually be telephone or online, unless face to face contact is required, for example due to communication difficulties or to delivery group interventions. Interventions available are but not limited to:

- Psycho-educational workshops
- Computerised CBT
- One to one interventions either on the telephone, online or face to face

9.4.2 High Intensity intervention

High intensity treatment will take place in individual or group therapy formats.

9.4.3 Signposting/referral to another service

In specific cases one-off information or signposting will be all that is necessary. In other cases another service will be more appropriate for the client. Step 2 workers in particular have an important role in facilitating clients to access help from appropriate organisations. Following the completion of the assessment a post-assessment Patient Experience Questionnaire (PEQ) will be provided for the patient, to be completed without the therapist being present unless specifically requested by the patient.

10. Discharge

During the course of engagement the clinical worker will inform the GP in writing of progress after the initial assessment and at end of treatment when the individual is discharged from the Service.

Patients who fail to attend assessment appointments will be discharged, as it must be assumed that they have decided not to pursue treatment at this time. Once treatment has started, patients will be discharged automatically if they do not attend, or cancel two sessions during treatment. Cases may be reviewed on an individual basis dependent on circumstances.

If a person fails to contact the service or does not attend an agreed appointment, the worker will review any risk issues in line with the services DNA policy. In most instances, a letter will be sent inviting the person to make contact to arrange another time to be seen. If they fail to contact the service within 7 working days or they make contact but fail to attend the subsequent appointment, the worker will discuss the circumstances with the supervisor and a decision will be made and recorded with regard to discharging the patient, unless it is agreed with the supervisor that this course of action is clinically not in the person’s best interests. The patient and referrer will be notified accordingly.

Due to the nature of a low intensity high volume service patients will be discharged at the earliest clinically appropriate stage in their progress to recovery. Individuals who have significantly improved will often have anxieties about being discharged. It should be emphasised to such clients that they can self-refer at any point in the future for further sessions, should the need arise.

At discharge a letter must be sent to the client's GP, unless a self-referred client has specified that they do not wish us to contact their GP. Good practice would stipulate that all correspondence should be cc'd to the client unless they prefer not to have a copy. At the point of discharge all clients should be asked to complete a Patient Experience Questionnaire. This questionnaire should not be completed in the presence of the clinician unless specifically requested.

11. Staffing

The North Essex IAPT Services typically comprise Clinical, Administrative and Management roles:

- Administrative Team
- Assistant Psychologists;
- Consultant Psychiatrists
- Deputy Clinical Leads
- High Intensity Workers (HIWs) – CBT Therapists, Clinical and Counselling Psychologists
- Long term Conditions Lead Psychologist
- Psychological Wellbeing Practitioners (PWPs)
- Senior CBT Therapists
- Senior Psychological Wellbeing Practitioners (SPWPs)
- Service Managers
- Trainee High Intensity Workers
- Trainee Psychological Wellbeing Practitioners

Service Line Lead and Clinical Lead

The North Essex IAPT Service Line Lead provides operational leadership and oversight of the Services and the Clinical Lead provides senior clinical leadership and oversight for the Services. Their roles include promoting and maintaining adaptive working relationships with the CCG commissioners and other stakeholders, including but not limited to sub-contractors and partner organisations, GPs and other NHS providers.

Service Manager

Service Managers have responsibility for overseeing the operational functioning of the North Essex IAPT Teams. They are accountable for the allocation, deployment, prioritisation and delivery of Psychological Therapies, for implementing and reviewing systems, policies, standards and procedures that ensure the provision of high quality services. They are responsible for the line management of staff with the Service.

Deputy Clinical Lead

Deputy Clinical Leads provide senior clinical leadership with the teams to ensure the systematic provision of a high quality specialist Primary Care Psychological Therapy

Service. Their role is to assist the Clinical Lead and utilise delegated responsibility in ensuring the effective high quality clinical functioning of the services. They supervise and support the psychological assessment and therapy provided by psychological therapists and other clinical members of the team who provide psychologically based care and treatment.

Senior CBT Therapists

Senior CBT Therapists provide additional leadership to support the clinical operation of the teams. They will hold a clinical caseload of relatively more complex service users within the moderately severe range. They will be involved in monitoring the service provision, service development, research and evaluation.

High Intensity Workers / Therapists (HIW/HIT)

Provide evidence-based psychological therapies to service users presenting with mild, moderate to severe depression and anxiety disorders in accordance with NICE guidance.

A completed high intensity treatment will involve up to 13 clinical contacts, one of which will be for the purpose of initial assessment. If more than 13 sessions are required, this must be discussed and agreed in advance with the clinical supervisor. On occasion a maximum of 20 sessions may be required.

High Intensity Therapists will hold a caseload of up to 40 service users, providing twenty hours of completed clinical contact time each week (per WTE). Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

Trainee High Intensity Therapists

Trainee HITs provide high intensity, evidence based psychological interventions whilst undertaking a programme of training for this role. The training will equip the Trainee High Intensity Therapist to provide cognitive behavioural therapy (CBT) to service users presenting with a range of complex problems for which CBT is demonstrated to be clinically effective. They will complete a one-year post graduate certificate training programme, involving two days a week at University and three days a week providing supervised practice.

A completed high intensity treatment will involve up to 13 clinical contacts, one of which will be for the purpose of initial assessment. If more than 13 sessions are required, this must be discussed and agreed in advance with the clinical supervisor. On occasion a maximum of 20 sessions may be required.

Trainee High Intensity Therapists will hold a caseload of 24 service users, providing twelve hours of completed clinical contact time each week. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

Senior Psychological Wellbeing Practitioners

Senior PWPs have a lead role in the development and support of innovative practice within the teams, and provide clinical and caseload management supervision for the PWPs and Trainee PWPs. They are responsible for case allocations, in liaison with the Service Manager, who has overall responsibility for ensuring that Service users receive assessment and treatment within the time-frames set. In addition, they typically carry a small caseload. They have lead responsibility for the ongoing development and delivery of group programmes at Step 2.

Psychological Wellbeing Practitioners (PWPs)

PWPs work at step 2 to provide high volume, low intensity interventions to people presenting with mild to moderate depression and anxiety disorders

A completed low intensity treatment will involve up to 7 telephone, online or face-to-face clinical contacts, with the first of these contacts for assessment and the initiation of guided self-help interventions. If more than 7 clinical contacts are to be given this must be discussed and agreed in advance with a clinical supervisor. On occasion a maximum of 10 contacts may be required.

Psychological Wellbeing Practitioners will hold caseloads of up to 70 people, providing twenty hours of completed clinical contact time each week (per WTE). Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

PWPs play a key role in delivery of group programmes and workshops and may also be involved in delivery of CCBT packages.

Assessments at step 2 will take up to 50 minutes, with follow up treatment sessions (telephone, online or face to face) will usually last for 30 minutes.

Trainee Psychological Wellbeing Practitioners

Trainee PWPs provide high volume, low intensity evidence based, psychological interventions whilst undertaking a programme of training for this role. They will attend a one-year post graduate certificate training programme, involving one day a week at University, one day a week protected study leave, and three days a week providing supervised practice. Trainees also play a role in delivering group programmes and may be involved with CCBT.

Trainee Psychological Wellbeing Practitioners will hold a caseload up to 42 service users, providing twelve hours of completed clinical contact time each week. Case allocations will be completed by clinical supervisors in liaison with the Service Manager, who has overall responsibility for ensuring that service users receive assessment and treatment within the time-frames set.

Assistant Psychologists

Assistant Psychologists provide high volume, low intensity face-to-face and group facilitated cognitive behavioural therapy (CBT) based, self-management interventions to service users who present with mild to moderate depression and anxiety disorders.

These may be face to face, online or over the telephone. They will also undertake the research and auditing of identified areas, to support service development an innovation.

Administrative Staff

Administrative staff are responsible for the efficient running of administrative functions within the North Essex IAPT Services. Responsibilities include, but are not limited to, the documentation of referrals into the services, their progression and deactivation, and coordination of the electronic appointment booking system.

Duty Workers

Duty Workers may be HIW and PWPs, operating on a daily basis, screening referrals for appropriateness, responding to queries and issues of risk, and serving as a source of advice and support. Duty Workers operate on a rostered basis.

Long Term Conditions Leads

LTC lead clinicians develop and maintain the provision of psychological interventions and support for adults living with long term conditions and also young people newly diagnosed with long term conditions. They will develop and maintain long term condition-focused pathways to support service users and also supervise the development of the North Essex IAPT Service's clinical teams to promote these.

12. Working procedures

Agreed interventions will be provided in community based accommodation including GP surgeries, health centres, HPFT community sites and other community venues. Where the location requires the person to be seen without the presence of other staff (whether HPFT staff or other staff) the Lone Worker Policy will be followed.

Where possible each GP surgery will have a link worker, the worker will be responsible for promotion, providing interventions, and liaising with GPs regarding referrals in that surgery.

Audio or Video Recording clinical sessions is an important aspect of CBT, particularly during training. Patients should give informed consent to recording, and must be competent to do so. A consent to recording form should be completed by the patient.

Any recordings that are transported for the purposes of supervision or assessment must be encrypted, and all appropriate procedures relating to maintaining confidentiality followed. Any recordings submitted for assessment during training remain the property of HPFT and must be returned to the trainee for deletion once the assessment needs have been met. The Trust policy on Audio/Visual Recordings of Service Users should be adhered to.

12.1 Stepping up and stepping down

Where significant risk to self or others is identified the individual's needs become inappropriate for North Essex IAPT Services, they should be referred via e-mail to the appropriate secondary care service for an assessment. The North Essex IAPT

Services will ensure the referred person is made aware of the decision to step them up to secondary care.

The referred persons referral, notes and change of need letter will form part of the referral information shared with the receiving team, prior to the PCMIS record being deactivated.

If imminent risk is identified a direct referral to the access and assessment team may be appropriate. The GP should be kept informed with a telephone call and/or in writing.

12.2 Making treatment decisions / Interventions offered

Step 2 Low intensity Interventions

Low intensity interventions are typically delivered by PWPs and may include: pure self-help; guided self-help; behavioural activation; group work / psychoeducational courses or cCBT. They can be delivered face to face, individually or as part of a group, over the telephone, online or via computer programmes. Interventions are based on CBT principles and are brief (i.e. approximately 6 sessions). Client choice and the principle of offering the least intrusive but most appropriate intervention first will determine the treatment that is delivered. Signposting to other Services may also be a PWP intervention.

A best practice guide to low intensity interventions can be found at: http://www.iapt.nhs.uk/silo/files/psychological-wellbeingpractitioners--best-practice-guide.pdf

Computerised CBT (cCBT)

cCBT is suitable for clients with mild to moderate depression or anxiety. The support for this intervention is provided by PWPs and by STaRs, where appropriate.

Psycho-educational courses / groups

Psychoeducational courses at step 2 are suitable for patients with mild to moderate depression or anxiety. Course material is based on CBT principles and is similar to that which is delivered via guided self-help. Patients attending the groups have an allocated PWP as case manager, to contact as necessary. Patients join the course following an initial assessment to determine suitability and are also reviewed afterwards to determine any further input required.

Guided self-help (face to face, online and telephone)

Guided self-help is delivered, typically by PWPs, either face to face, online or over the telephone. Treatment usually lasts for an average of 4-6 contacts with each client. At step 2, telephone appointments are used wherever appropriate. Each client should always be enabled to make an informed choice in respect of the range of possible appropriate interventions.

Signposting / referral to another Service

In specific cases one-off information or signposting will be all that is necessary. In other cases another Service will be more appropriate for the client. PWPs in particular have an important role in facilitating clients to access help from appropriate organisations.

Links to Guided self-help materials:

http://cedar.exeter.ac.uk/iapt/lihandbook/resources/

http://iapt.nhs.uk/silo/files/reach-out-educator-manual.pdf

Please see:
NICE Guidance CG90 – Depression in adults: recognition and management

NICE Guidance CG113 - Generalised anxiety disorder and panic disorder in adults: management

NICE Guidance TA97 - Computerised cognitive behaviour therapy for depression and anxiety

NICE Guidance CG31 - Obsessive-compulsive disorder and body dysmorphic disorder: treatment

Step 3 interventions

High Intensity step 3 interventions are offered by CBT therapists, clinical and counselling psychologists and counsellors with specific training in step 3 interventions.

Cognitive behaviour therapy (CBT)

Cognitive behaviour therapy (CBT) is based on the idea that the way we feel is based on our thoughts, beliefs and behaviours. It is a “doing” therapy, focused on making changes in the present, to the way we think about situations and what we do about them. It is recommended as the first line treatment for panic, agoraphobia, social phobia, specific phobias, generalised anxiety disorder, health anxiety, obsessive compulsive disorder (OCD) and post stress disorder (PTSD) and mild to severe depression.

Treatment is usually face-to-face, and may take place either on an individual basis or within a group. A course of treatment usually averages 12 sessions (but may extend to 20), with a progress review at approximately 6 sessions. Treatment is often delivered weekly, with sessions lasting between 45 and 60 minutes, although sometimes, longer sessions may be most appropriate. To optimise learning, patients are encouraged to complete individual work between sessions, often in the form of experiments, and then bring their findings back to the next session.

Other high intensity interventions recommended by NICE

Counselling for Depression (CfD)

Counselling can help people with emotional difficulties and problems in relating to people. The main focus of treatment is on building a trusting relationship with a counsellor and on seeing the person as a "whole" rather than focusing on their symptoms, with the aim to helping them understand and express the feeling presumed to underlie their depression. There are many different types of counselling. IAPT offers a particular type of counselling, recommended by NICE, that has been developed to help people suffering from mild to moderate depression.

Treatment typically lasts 6-10 sessions, delivered over 8 - 12 weeks.

Competency framework for Counselling for depression:

http://www.ucl.ac.uk/pals/research/cehp/research-groups/core

Couples therapy for Depression

Couple therapy can help people with their relationship and the emotional difficulties that sometimes flow from problems between partners. IAPT offers a particular type that has been developed to help people suffering from depression.

Competency framework for Couple therapy for Depression:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/couples-therapy-map.html

Brief Dynamic Interpersonal therapy (DIT)

Dynamic Interpersonal Therapy or DIT is a time limited and structured psychotherapy, typically delivered over 16 weekly sessions. It aims to help patients understand connections between current symptoms and their impact on relationships, by looking at repetitive patterns in relationships that can be traced back to childhood. Once this pattern is identified, it can be used to make sense of difficulties in relationships in the here-and-now that contribute to psychological distress.

Competency framework for Brief Dynamic Interpersonal therapy:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/dit-map.html

Interpersonal Psychotherapy (IPT)

Interpersonal Psychotherapy (IPT) is a time-limited and structured psychotherapy typically delivered over 16 weekly sessions. It looks at the ways in which current difficulties in relationships contribute to psychological stress and the ways in which psychological problems affect relationships. Its central idea is that psychological symptoms, such as depressed mood, can be understood as a response to current difficulties in relationships and affect the quality of those relationships.

Typically, IPT focuses on conflict with another person, life changes that affect how you feel about yourself and others, grief and loss, difficulty in starting or keeping relationships going.

Competency framework for Interpersonal Psychotherapy:

http://www.ucl.ac.uk/clinical-psychology/competency-maps/ipt-map.html

Eye Movement Desensitisation Reprocessing (EMDR)

EMDR is a NICE guidance recommended evidence based treatment for Post-Traumatic Stress Disorder. EMDR is designed to treat traumatic memories and experiences and their psychological consequences.

Please see:

NICE Guidance CG90 – Depression in adults: recognition and management

NICE Guidance CG113 - Generalised anxiety disorder and panic disorder in adults: management

NICE Guidance CG31 - Obsessive-compulsive disorder and body dysmorphic disorder: treatment

NICE Guidance CG26 - Post-traumatic stress disorder: management

Long Term Conditions (LTC)

The NHS Five Year Forward View (2016) sets out a central ambition for the NHS to become better at helping people to manage their own health. It provides further evidence of the NHS system's shift towards further enabling patients' self-management of long term conditions. North Essex IAPT services have the potential to offer a significant role, in facilitating further integration of mental and physical healthcare services, through supporting more effective ways of working holistically. The aim of the service is to maintain and improve access and recovery rates for people with long term conditions. This is done through exploring new ways of working with long term conditions, promoting effective IAPT interventions and further developing partnership working with local health service providers.

Sub-contracting arrangements

Where an intervention above is provided by a sub-contractors, an appropriate communication will be made to that service including any relevant assessment and/or treatment information and access provided to the patient record on PCMIS (if appropriate).

It is the responsibility of the HPFT service to oversee the referral and transfer of patients to sub-contractors, including clinical review and discharge arrangements.

Safeguarding

During any assessment or intervention, all staff must ensure that any issue causing concern in relation to a person's vulnerability will be dealt with according to Essex Safeguarding Adults and Essex Safeguarding Children policies and procedures in conjunction with the HPFT safeguarding process.

13. Services for carers

Carers of people with mental health problems are able to access North Essex IAPT Services if they meet the criteria for the service.

14. Induction, supervision, training and continuous professional development

14.1 Induction

All newly appointed staff undergo a comprehensive induction programme in line with HPFT policy. They may attend the first day of the Trust's corporate induction programme. It is the responsibility of the Service Manager to ensure a local induction is provided and signed off on the Induction Check List.

During the first week of employment it is the Service Manager's responsibility to ensure the new member of staff is registered for the use of PCMIS and undertakes training in order to be competent in its use.

14.2 Supervision

Staff development and training is a high priority for HPFT and each member of staff has an annual appraisal and a Personal Development Plan identifying training needs.

14.2.1 Line Management Supervision

All staff will receive management supervision given by their Line Manager in line with the HPFT Supervision Policy. Sessions are documented, are held regularly, and offer an opportunity to focus upon professional role, workload and professional practice.

Line management responsibility rests with the identified Service Manager within the team. When required the clinical supervisor and the service manager will work together to resolve any difficulties.

14.2.2 Clinical Supervision

All clinical staff will receive clinical supervision in line with the HPFT Supervision Policy.

Supervision at step 2

Each PWP (qualified or trainee) will have a named qualified senior PWP, HIW or Senior Clinician as their supervisor. Each PWP will receive one hour of supervision weekly to discuss the worker's cases. Although discussion of cases should be prioritised according to clinical need, all the PWP's cases must be discussed within a 2-4 week period. Each PWP is clinically accountable to their individual supervisor.

In addition PWPs will meet for 2 hours of group supervision each month with a senior clinician, focussed on more detailed case discussion with a view to the further development of clinical knowledge and skills.

Supervision at Step 3

Qualified HIWs will have supervision with a senior HIW or psychologist. Supervision must occur on a regular basis, usually weekly, but may be less regularly if deemed to be appropriate by the Deputy Clinical Lead. As a minimum for more experienced

practitioners supervision must occur monthly, with the HIW's entire caseload being discussed within a 2-4 week period. Each HIW is clinically accountable to their individual supervisor.

Trainee HIWs will have one hour of supervision weekly with a qualified HIW or senior clinician. All supervisors of Trainee HIWs must be accredited by the BABCP, or eligible for accreditation. The Trainee HIW's entire caseload must be discussed within a 2-4 week period

Experienced qualified CBT therapists will have at least one hour's supervision per month with a supervisor who is eligible for BABCP accreditation.

In addition HIWs will meet for group supervision for 1 ½ hours every month, facilitated by an accredited supervisor or someone eligible for BABCP accreditation.

A focus on case-management is an important aspect of supervision for all clinicians. Supervisor alerts must be discussed and dealt with and appropriate supervision notes kept on the client's clinical record on the PCMIS data system.

At all times supervisors must ensure that their supervisees are holding the minimum caseload expected. Supervisors also have delegated responsibility for ensuring that their supervisees are meeting the minimum contact levels expected. Any performance issues that have not been resolved in supervision should be bought to the attention of the supervisee's service manager by the supervisor.

Supervision provided by university staff as part of clinical training should be regarded as advice and guidance. Clinical accountability remains with the North Essex IAPT Service supervisor.

In accordance with the policy, clinicians must ensure that there are paper copies of supervision notes, which are signed by both the supervisor and the supervisee.

14.3 Training and development

Mandatory Training contributes to the safe delivery of Services by ensuring that employees have the knowledge and skills to work safely. By understanding procedures and policies, employees are familiar and competent to proceed with the role and responsibilities expected, maintaining safety for Service users, carers and other colleagues. Employees have a responsibility to ensure that their mandatory training is a minimum of 90% compliant at any time, and refreshed when required.

Please review the HPFT NHS Trust's Learning and Development homepage for further information relating to mandatory training opportunities.

(http://trustspace/InformationCentre/learningDevelopment/default.aspx)

Course	For	Renewal period	Delivery mode	Contact information
Trust Induction	All staff	Once		L&D Team

Local Induction	All staff	Once	Local	Service Manager
Mandatory training	All staff	As indicated by Mandatory Training Compliance matrix	As indicated by Mandatory Training Compliance matrix	L&D Team
Supervision training	Clinical staff	As indicated above	As indicated above	See SBU Training Needs Analysis

14.4 Professional Development Plan/Continuous Professional Development

The Trust is committed to the principles of performance review and provision of development for every member of staff. The Performance and Development Review has been designed to support the development of a culture of performance excellence, embracing the Trust values and behaviours framework and includes a process of performance related pay progression.

Within the North Essex IAPT Services, each member of the Team will be informed of their performance, receive adaptive feedback, and assisted to identify training and developmental opportunities to enable them to perform within their current role to the standard required, and also have access to opportunities to develop their potential.

This feedback may be provided in the form of informal meetings, regular clinical and line management supervisions and during annual Performance Development Reviews.

Please refer to the HPFT NHS Trust's Professional Development Plan Policy for further information regarding identifying and accessing professional development opportunities

15. Comments, compliments and complaints

All comments, compliments and complaints should be dealt with in accordance with the Trust Compliments Concerns and Complaints Policy and Procedure.

The policy requires all formal complaints to be acknowledged within two working days with copies forwarded to the appropriate line manager and the Complaints Manager.

Comments and compliments should be sent to the Complaints Team for reporting purposes.

Leaflets outlining the procedure are available at all North Essex IAPT Service locations.

16. Communications

The treatment and information patients are given should meet the individual's communication needs especially where there are specific language and sensory

communication requirements. The HPFT guidance on Communicating with Service Users from Diverse Communities provides further information and the procedure for the interpreting service.

Where there are specific cultural/religious practices which affect compliance with treatment the service users should be given the opportunity to discuss and agree adjustments or alternatives to enable treatment to go ahead**.**
All organisations that provide NHS must identify and record information and communication needs with service users:

- At the first interaction or registration with their service
- As part of on-going routine interaction with the service by existing service users.

This includes accessible information and communication support to enable individuals to:

- Make decisions about their health and wellbeing, and about their care and treatment;
- Self-manage conditions;
- Access services appropriately and independently; and
- Make choices about treatments and procedures including the provision or withholding of consent.

17. Record management, confidentiality and access to records

All staff are responsible for all records that they create or use in the course of their duties. This responsibility is defined both in law and in other professional guidelines covering the handling of records. For example, the Public Records Act 1958, the Data Protection Act 1998 and the Freedom of Information Act 2000. The Trust's Records Management Policies give full details of those responsibilities and the standards we need to meet.

All information must be dealt with in line with HPFT's Information Asset Management policy and procedure. Clinicians should be particularly aware of the potential for confidentiality breaches as a result of email communication. Clinical contact via email should therefore be avoided. If it is necessary to communicate clinical information using email then relevant HPFT policies should be followed.

All matters relating to service users' health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person.

Patients will be provided with a copy of the Protection and Use of Service User Information (PUPI) form at booking stage. At the initial assessment all service users will be explained the terms and limits of confidentiality. This conversation will be recorded as a summary note on PCMIS. The following statement will be used on e-referral sites and in discussion with patients:

This is an NHS service provided in partnership with our local GPs and other health care providers, to ensure a joined up approach to your care. Information is therefore shared with your GP to support continuity of care. Your information will be held securely and confidentially in electronic and paper format in accordance with the principles of the Data Protection Act 2018. To find out how your information is processed and shared please refer to our 'Fair Processing Notice' and sharing information page

Patients will be asked for the following consent information

- Consent to contact via email
- Consent to contact via home/mobile/work phone
- Consent to service leaving voicemails on home/mobile/work phone
- Consent to contact via SMS

17.1 Entering clinical contacts on PCMIS

PCMIS is the primary care electronic patient record used by North Essex IAPT Services. All staff will be required to record all contacts with the individual in a timely manner on PCMIS.

PCMIS training is a mandatory requirement for all staff, and should be arranged within each team by the Service Manager.

In order to provide evidence that the best possible care and treatment is given to patients, staff must follow the record management and confidentiality polices listed below:

- Care Records Management Policy
- Clinical Information Filing Policy
- Protection & Use of Service User Information Policy
- Formal Access to Service User Records Policy
- Freedom of Information Act Policy
- Written & Electronic Communications Policy
- Corporate Records Management Policy

17.2 Clinical records / therapy notes

The IAPT minimum data set must be collected at every clinical contact (PHQ-9, GAD-7, Phobia Scales, Employment status questions, and WASAS).

A clinical contact is defined as any contact made for the purposes of assessment or intervention, even if the intervention is relatively minimal.

Accurate and up to date records must be kept on PCMIS. PCMIS forms the patient's clinical record, and as such in addition to the minimum data set PCMIS notes must be kept of contacts made, type of intervention and outcome, including progress made.

Initial sessions with a high or low intensity worker following referral screening will be recorded on PCMIS as "assessment and treatment" under contact type.

North Essex IAPT Service aims to be a paper-light service, whilst a case is open the referral letter, assessment, contact details, and key documents from PCMIS may be held in a paper file. This is to facilitate contingency plans should IT systems fail. These must be kept in line with HPFT policy on Information Asset Management.

All matters relating to service users' health and personal affairs and matters of commercial interest to the Trust are strictly confidential and such information must not be divulged to any unauthorised person.

Formal applications for access to records must to be made in writing to the Service Manager. An Access to Your Health Records" leaflet can be obtained from a member of staff. Applications for access to records held by the GP must be made in line with GP practice and procedures.

There are special rules regarding legal access to records. If any case arises where legal access is requested staff should refer to the Access to Records Policy and discuss with the Service Manager. There are also special rules relating to the sharing of information regarding children and adolescents. These are to be found in the policy on “Sharing Information and Involvement in the Legal Process of Child Protection”

During the course of therapy a brief update letter should be sent to the GP incorporating the latest PHQ-9 and GAD-7scores, unless the individual has been discharged by that time, or is due to be discharged in the immediate future.

18. Health and safety

Every employee and those persons working on behalf of the Trust have a duty to take reasonable care for the health and safety of themselves and other persons who may be affected by any acts or omissions by themselves. To cooperate with the organisation so far as it is necessary to enable management to carry out its legal duties relating to health and safety matters i.e. follow instructions and training, use equipment provided for their protection, report defects/damage/ health and safety concerns.

All staff have a duty to remedy and or report any hazards or unsafe working practices in the immediate working area to the appropriate manager or supervisor. All staff are required to participate in the Trust’s accident/incident reporting systems and to comply with the Trust’s procedures and techniques for managing risks.

19. Practice Governance

The local IAPT teams will hold a monthly team meeting. These meetings will provide an overview of the current functioning of the team, including a focus on any clinical and operational issues impacting upon the team’s effective delivery of the clinical service, in addition to any wider issues affecting the team. The meetings will include standard agenda items. The meetings will be attended by team members and will be chaired by the Service Manager or in their absence the Deputy Clinical Lead.

The North Essex IAPT Service Governance meeting will be held on a monthly basis, to be attended by senior clinical and Service Managers from each team. The purpose of this meeting will be to discuss clinical and operational issues affecting the teams across North Essex. Key decisions regarding the operation of the services will be discussed at these meetings. These meeting will also have a focus on the clinical and operational performance of the services, including a focus on clinical governance issues.

20. Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of Service users, carers and staff.

RESPECT means ensuring that the particular needs of 'protected groups' are upheld at all times and individually assessed on entry to the Service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where Service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

Access to and provision of Services must therefore take full account of needs relating to all protected groups listed above and care and support for Service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where Service users and carers experience barriers to accessing Services, the Trust is required to take appropriate remedial action.

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The following table reflects – specifically for this policy – how the design of the Service and processes involved has given consideration to all protected groups so ensuring equality and dignity for everyone.

This information reflects how staff will act in accordance with the Equality Act 2010 in meeting the needs of all protected groups.

All staff must be aware of issues relating to equality and diversity for service users and carers including:

- Understanding how to ask questions about culture, religion and ethnic background
- Arranging interpreters where necessary (refer to section 15)
- Offering adaptations for people with disabilities, e.g. Hearing Loop, Downstairs meeting rooms, etc.
- Opportunity to discuss relationships and issues relating to sexuality
- The needs of both men and women are represented equally – including the needs of trans service users.

Staff have a responsibility to challenge any discrimination they may witness and report back in accordance with risk management and complaints and incidents processes.

Staff have the right to be treated with dignity and respect. Any situations of harassment, bullying or other abuse must be dealt with in accordance with the Trust harassment & bullying policy and other associated guidelines. All staff are also entitled to access the Trust counselling Service if needed.

Staff must also be aware of issues relating to Human Rights including how they apply to staff and Service users. Information on this is available within the Trust Single Equality Scheme.

Disability access: If it is found that service users, carers or staff with disabilities are prevented from accessing any premises above ground level, a clear contingency protocol must be outlined in this operational policy.

Service user, carer and/or staff access needs (including disability)	The needs of people with disabilities and differing communication needs must be given appropriate adjustments within the Service/process/workplace to facilitate better access. Interpreters should be arranged as necessary, and the location of Services, access to physical and sensory impairment etc. taken into account when planning Service delivery. Reasonable adjustments should be made for staff members with disabilities or health needs Staff within the Service should ensure that the potential for inequality is minimised.
Involvement	Opportunities that are made available within the Service/process for Service users and carers to be involved in making contributions to the Trust and development of Services. Service user involvement should be sought in order for the potential for inequality to be minimised.
Relationships & Sexual Orientation	Staff members should take into account the needs of people in different relationships as well as those in none. This should address issues around sexual orientation (and any barriers for people around their orientation) as well as any relevant issues re: nearest relatives and family carers. For staff this may also include an awareness of the needs of LGB staff in workforce and an understanding of how an open workplace culture improves the experience for staff working in the Trust. This should also reflect how potential for inequality is minimised.
Culture & Ethnicity	Ethnic minority Service users should receive a cultural appropriate experience from the Service. This should include issues of language, diet, hygiene and personal care etc.
Spirituality	Issues of spirituality should be attended to for the Service user or carer where necessary. This should focus around the HOPE model for: **H** – Sources of Hope **O** – Needs re: organised religion **P** – Personal belief structure (including non-faith) **E** – Effects on care of practicing spiritual beliefs. (positive and negative)
Age	The Service should take into account the needs of different age groups. Access for older adults in particular, who historically are underrepresented in the Service, should be targeted for additional support.
Gender & Gender Reassignment	The Service should provide equal treatment for men and women or – where justified – one group is favoured (e.g. single sex accommodation). The needs of transgender Service users and carers should be acknowledged appropriate support offered.
Advancing equality of opportunity	The Service should seek to develop in a way that ensures incorporates equality of opportunity through continual feedback and evaluation of the Service.

Promoting and considering individual wellbeing

Under the Care Act 2014, Section 1, the Trust has a duty to promote wellbeing when carrying out any of their care and support functions in respect of a person. Wellbeing is a broad concept and is described as relating to the following areas in particular:

- Personal dignity (including treatment of the individual with respect);
- Physical and mental health and emotional wellbeing;
- Protection from abuse and neglect;
- Control by the individual over day to day life including over the care and support provided and the way in which it is provided;
- Participation in work, training, education, or recreation;
- Social and economic wellbeing;
- Domestic, family and personal;
- Suitability of living accommodation;
- The individual's contribution to society.

There is no hierarchy and all should be considered of equal importance when considering an individual's wellbeing. How an individual's wellbeing is considered will depend on their individual circumstances including their needs, goals, wishes and personal choices and how these impact on their wellbeing.

In addition to the general principle of promoting wellbeing there are a number of other key principles and standards which the Trust must have regard to when carrying out activities or functions:

- The importance of beginning with the assumption that the individual is best placed to judge their wellbeing;
- The individual's views, wishes, feelings and beliefs;
- The importance of preventing or delaying the development of needs for care and support and the importance of reducing needs that already exist;
- The need to ensure that decisions are made having regard to all the individual's circumstances;
- The importance of the individual participating as fully as possible;
- The importance of achieving a balance between the individuals wellbeing and that of any carers or relatives who are involved with the individual;
- The need to protect people from abuse or neglect;
- The need to ensure that any restriction on the individuals rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary.

21. Process for monitoring compliance with this document

Action:	Leads	Method	Frequency	Report to:
Review policy within Service quality and risk meeting	Service Line Lead / Clinical Lead	Review of operational practice / learning from incidents against policy requirements	6 months	SBU Quality & Risk meeting
Programme of audits	Clinical Lead / Practice Governance	Completion of local audits to ensure compliance with policy and best practice standards	quarterly	IAPT Quality & Risk Meeting

PART 3 – Associated Issues

22. Version Control

Version	Date of Issue	Author	Status	Comment
V1	15th August 2016	Clinical Lead, Service Line Lead	Historical	Combined operational policy created to cover 3 North Essex IAPT Services, replacing 2 policies for North East Essex and Mid-Essex Services
V2	1st October 2019	Clinical Lead, Service Line Lead	Historical	The operational policy now includes a Standard Operating Procedure in relation to waitlist management.
V3	14/08/2020	PG Facilitator	Current	

23. Archiving Arrangements

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

24. Associated Documents

STANDARD

This policy should be read in line with relevant policies which can be found on HIVE:
https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/ContentListing.aspx?subsection=5391

This policy (including its appendices) is impacted by the major incident management of Covid-19. Trust guidance is updated on an ongoing basis in line with government guidance and should be read on the HPFT Hive communication website (Link: https://hertfordshirenhs.interactgo.com/Interact/Pages/Section/Default.aspx?Section=5084)
All sites have a Business Continuity Plan detailing local arrangements for services during the COVID period. The Business Continuity Plan is kept up to date with updated requirements at team/unit level around the management of COVID-19. Staff should refer to their local Business Continuity Plan for up to date local procedures during the COVID incident management period.

The ongoing changes will have a specific impact on the following area:

- Infection prevention and control in relation to social distancing, increased cleaning regimes, COVID-secure office spaces, appropriate use of PPE and individual COVID risk assessments of staff.

All staff members are to be aware that the arrangements are in a state of change and if this policy (including its appendices) contradicts any of the covid-19 management guidance on the HPFT Hive then it is the HPFT Hive guidance that supersedes it.

25. Supporting References

STANDARD

- Children Act (1989 and 2004)
- National IAPT guidance documents
- NHS and Community Care Act
- NICE guidelines
- The Data Protection Act
- The Health and Safety at Work Act
- The Human Rights Act
- The Mental Capacity Act 2005 and Code of Practice

26. Comments and Feedback – people/groups involved in developing the policy

STANDARD

Service Line Lead	
Clinical Lead	
Deputy Clinical Leads & Senior Clinicians	
SBU Quality & Risk Group	
Service Managers	
Practice Governance Lead & Facilitator	

NHS
Hertfordshire
Partnership University
NHS Foundation Trust

HPFT

Waitlist Management in IAPT

HPFT Standard Operating Procedure

Version	1
Executive Lead	Executive Director of Service Delivery and Service User Experience
Lead Author	Peggy Postma (Herts IAPT Clinical Lead), Maggie Rosario (Essex IAPT Clinical Lead).
Approved Date	N/A
Approved By	N/A
Ratified Date	29th August 2019
Ratified By	Wellington Makala (Managing Director), Dr Indermeet Sawhney (Clinical Director), Chair's action – Essex and IAPT SBU Quality and Risk Committee.
Issue Date	11th September 2019
Expiry Date	11th September 2022
Target Audience	IAPT staff only

Document on a Page

Title of document	Waitlist Management in IAPT		
Document Type	Standard Operating Procedure (SOP)		
Ratifying Committee	Chair's action – Essex and IAPT SBU Quality and Risk Committee		
Version	**Issue Date**	**Review Date**	**Lead Author**
1	11th September 2019	11th September 2022	Peggy Postma (Herts IAPT Clinical Lead), Maggie Rosario (Essex IAPT Clinical Lead).
Staff need to know about this policy because (complete in 50 words)	Having to wait for treatment can be detrimental to service users who feel unsupported. Wait lists also put considerable pressure on staff who feel their ability to offer a quality service is compromised.		
Staff are encouraged to read the whole policy but I (the Author) have chosen three key messages from the document to share:	When it is evident that there is a risk of new referrals not being seen within the target timeframe (internal target is 28 days; national target is 42 days) services need to create capacity to prevent waiting time breaches and keep service users safe, as best they can. In practice this may (temporarily) involve prioritising first appointments for new referrals over ongoing treatment sessions for service users already in treatment. This might include the service running "assessment weeks" where the majority of service appointments for that week constitute first appointments.		
Summary of significant changes from previous version are:	None as this is the 1st version		

PART 1 – Preliminary Issues:

1. Introduction

“A key target of the IAPT programme is that 75% of the referrals that have a course of treatment should have their first treatment session with 6 weeks (42 days) and 95% within 18 weeks. This national waiting time standard refers to the period of time between the date that an initial referral was received and the start of the course of treatment.” (The Improving Access to Psychological Therapies Manual, 2018).

There is an expectation too that once taken into treatment, people are offered their second treatment session within 28 days of that first appointment. While it is not a formal KPI, services are being monitored to ensure that of those people waiting for a second treatment session, not more than 10% have to wait beyond 90 days.

HPFT IAPT services strive to provide their services according to these guidelines. Demand and capacity issues pose ongoing challenges in IAPT services nationally. For the majority of these services this means having to operate wait lists. Having to wait for treatment can be detrimental to service users who feel unsupported. Wait lists also put considerable pressure on staff who feel their ability to offer a quality service is compromised.

This document seeks to provide positive guidance on waitlist management for HPFT IAPT teams. The aim is to help teams (re)consider the challenge of managing and reducing wait lists as a fluid and creative process where at all times the service user’s safety and satisfaction is paramount.

2. The Purpose of this SOP:

(a) To outline strategies to minimise the chances of wait lists developing either for first appointments or on-going appointments

(b) To outline strategies to manage and reduce waitlists when they arise

(c) To provide guidance around the safe management of people who are accessing HPFT IAPT services and who:

(i) May be waiting longer than 42 days (6 weeks) for their initial appointment (to establish suitability of the service and agree a treatment plan),
or
(ii) May be waiting longer than 28 days for ongoing treatment following their initial appointment.

3. Outcome Measures

- Wait times to (a) initial appointment and (b) for ongoing treatment
- Patient Experience Questionnaires
- Audit of people on wait list to determine satisfaction with wait list management procedures

4. Full Standard Operating Procedure

4.1 Waits for first appointments

During the first appointment clinician and service user meet to discuss the presenting problem and treatment options available. This appointment enables both parties to determine whether the service is able to meet the service user's needs and to collaboratively agree a treatment plan.

Where it is evident that the service is unable to meet the service user's requirements, they are signposted or referred to the appropriate service to ensure they access the right service for the right problem without delay, before their symptoms deteriorate. From a risk perspective too it is important that this first appointment occurs at the earliest opportunity, to ensure the service is not 'holding' individuals in need of different or more urgent care. For that reason the HPFT internal target for first appointment is 28 days against the national target of 42 days.

4.1.1 Factors that might affect service capacity and lead to increased waits

There are several factors that might negatively affect service capacity. While services may be able to influence some of these factors, others are harder to control.

They include:

- High rates of inappropriate referrals into the service requiring clinician time to process, assess and then make referrals to more appropriate sources of help and support.
- Variable treatment availability e.g. for certain modalities of therapy / types of intervention e.g. EMDR, counselling for depression, face to face vs telephone
- Service user choice: Service users sometimes choose to wait for appointments at a more convenient time for them (for example evening appointments or following holidays) or express preferences for certain formats of intervention e.g. individual vs groups
- Staffing issues including recruitment and retention. These issues are recognised challenges for IAPT services nationally.
- Staffing issues such as sick leave but also maternity leave.
- Room space and availability of venues for delivering treatment.
- Paradoxically, resource diverted to manage wait lists divert clinical capacity away from actually delivering treatment, compounding the problem of waits.

4.1.2 Clear service criteria and commissioning of care

Service capacity may be adversely affected by high proportions of inappropriate referrals into the service requiring processing, assessment and signposting. From a service user perspective undergoing multiple first appointments and assessments is unhelpful, unnecessary and potentially distressing. Therefore it is in the best interest of service users and services to ensure that as far as possible only appropriate referrals are made, to help achieve a streamlined and efficient process and to maximise the chances of a service user engaging with and benefitting from treatment.

To achieve this it is important to ensure that all stakeholders have a good understanding of service criteria. Regular sharing of service inclusion and exclusion criteria through ongoing dialogue with referrers, other services, single point of access, commissioners etc. is essential. Information for service users on service

promotion material and websites should explain the service remit and limitations, to encourage appropriate self-referrals.

Making decisions about suitability is not always straightforward and IAPT teams need ongoing training to increase their confidence around what the service can and can't offer. IAPT staff members need access to clear and detailed information around criteria, available through Operational Policies, induction training and supervision.

IAPT staff should have a thorough understanding of the full range of additional support offered in the region and work with partner and external organisations to make use of that additional appropriate local capacity.

For a proportion of service users it may be a challenge to find a service that meets their particular needs. Services and clinicians often feel pressure to engage such service users in suboptimal interventions in order to be able to "offer something". This practice is not in the best interest of the service user and detrimentally affects service capacity. Services should audit such examples to aid Commissioners in commissioning services for people who fall outside the current offer effectively.

4.1.3 Prioritisation of first appointments at all times

Section 4.1 details why it is important to offer the first appointment as early as possible. When it is evident that there is a risk of new referrals not being seen within the target timeframe (internal target is 28 days; national target is 42 days) services need to create capacity to prevent waiting time breaches and keep service users safe, as best they can.

In practice this may (temporarily) involve prioritising first appointments for new referrals over ongoing treatment sessions for service users already in treatment. This might include the service running "assessment weeks" where the majority of service appointments for that week constitute first appointments. In doing so the proportion of people who need a different service are signposted early on, leaving the service with their "appropriate" caseload. The challenge associated with this strategy is the inevitable subsequent bottleneck for ongoing treatment.

4.1.4 Safe practice: prioritisation of certain types of user groups

In services where there is a Single Point of Access (SPA):

The SPA will review all new referrals for risk. If a referral is clearly appropriate for the IAPT Service and there are no risk concerns, the referral will be allocated straight to the appropriate IAPT Team on PC-MIS. Where risk is identified a SPA clinician will complete a triage by telephone to check risk factors, suitability and make a clinical decision with regard to the appropriate service for the person referred. Based on IAPT service criteria SPA will make a decision about step allocation with the majority of referrals being allocated for a step 2 initial appointment.

Referrals considered appropriate for step 3 or where there is a query re suitability not resolved by the abovementioned risk call, will be allocated to the appropriate team account for screening by a Senior Clinician. The Senior Clinician will decide whether the referral needs to be prioritised for an initial appointment based on the outcome of the SPA risk assessment and other relevant information (e.g. whether the referral falls into the perinatal or veteran categories).

In services where there is not a SPA:

In services without a SPA, the potential number of routes for referrals into the service is increased. Referrals are screened by an appropriately trained member of the team, with the precise designation of the staff member varying according to the route via which the referral is received, whether it be a Senior Clinician or a member of the Duty Team, for example.

At screening, a decision is made about whether the referral needs to be prioritised for an initial appointment based on any risk assessment and other relevant information (e.g. whether the referral falls into the perinatal or veteran categories), and whether the initial appointment is best conducted by a step 2 or a step 3 clinician.

4.1.5 Managing service user and referrer expectation in the event of waits for first appointments

In the event that waits to first appointment are unavoidable and exceed the targets mentioned above, the service will alert service users and their GPs of the estimated timeframe for first appointment. This communication will be in writing (email if consent for email communication has been provided) and will include information on emergency helplines and alternative sources of support.

4.2 Waits for second appointments

There is an expectation that once taken into treatment, people are offered their second treatment session within 28 days of that first appointment. While it is not a formal IAPT key performance indicator (KPI), services are currently monitored to determine that, of those people waiting for a second treatment session, not more than 10% have to wait beyond 90 days.

4.2.1 Strategies to minimise waits for second appointments

Implementing the stepped care model

In line with the stepped care model HPFT IAPT services aim to offer the most effective yet least intensive intervention necessary to achieve recovery. In following this model, services are able to maximise capacity and throughput.

1. Case management supervision

Case management supervision at steps 2 and 3 is essential to monitor adherence to the stepped care model. HPFT IAPT services provide step 2 and step 3 supervisors with detailed guidelines on effective case management (Appendix 2). The guidance includes the importance of agreeing clear goals for therapy with clients which describe a focused and time limited piece of work. It emphasises the importance of review of treatment progress and effective stepping (up and down) to help avoid excessive doses of therapy that can impact on service capacity and wait times. The guidance describes how supervisors can access and/or generate reports from the electronic patient record system (PCMIS) to inform on the above factors, both for individual supervisees or as a team overview.

2. Offer of efficient and readily available modes of therapy

At first appointment Teams are encouraged to offer efficient modes of service delivery where this is clinically appropriate. This may include group interventions or guided self-help (including computerised CBT) requiring less therapist involvement and time.

3. Enforcing the Service DNA and cancellation policy

Staff members are reminded to discuss, as part of their initial therapy contracting, the service policy around DNAs and cancellations. Staff members are advised to adhere to this and to discharge people accordingly. This ensures optimal flow through the service. To minimise DNAs, service users are sent SMS text reminders of their appointments in advance, giving the date and time of their appointment.

Where service users attempt to cancel face to face appointments, staff members are encouraged to offer alternatives e.g. telephone or online appointments, increasing the likelihood that original appointment times can be kept and maintaining continuity across treatment. This sustains rapid but effective flow through the service.

4. Only engaging service users who are ready for treatment

Not infrequently IAPT teams receive referrals from individuals who, at the time of their first appointment, indicate they are not in a position to engage with therapy but instead wish to be kept on the service caseload until they are able to commit to attending sessions. Reasons may include holidays, work commitments, other health appointments that need to be prioritised. Staff members are advised to request that service users re-refer to the service at a time when they are ready and able to engage.

An exception to the above is for perinatal referrals. If at the time of referral a service user is late into her pregnancy, the service will try to see her for her first appointment before the due date, and then book an appointment with her following the birth. Treatment is typically not started during the last few weeks before the birth as needs often change.

4.2.2 Management of people waiting for second appointments

4.2.2.1 Formal keeping in touch process

When, due to service pressures, it is evident that individuals have to wait for longer than 28 days for ongoing treatment of their choice, they will be alerted of this at their first appointment. At this stage alternative and interim sources of support will be discussed including the option of cCBT. All service users are offered the option of a “Keeping in Touch” (KIT) telephone appointment, to be scheduled approximately 28 days from their first appointment. Service users are asked to complete the PHQ9 and GAD7 from the IAPT minimum data set prior (MDS) to their KIT call – where possible the KIT may be submitted via the patient portal. This highlights any potential risk and any changes in need, which may require further action.

During the KIT the following areas are discussed:

- The scores on the MDS and current risk (using the IAPT risk measure where indicated)
- Whether the service user's circumstances and needs have changed (and amending the treatment plans accordingly which might mean accessing services more quickly)
- Whether the service user still requires an IAPT intervention
- Whether the service user would benefit from a different and/or more readily available intervention than originally agreed. Examples of the latter could be group interventions or online therapy options.
- Any changes in anticipated wait to ongoing treatment

The conditions for standard IAPT appointments apply to KIT appointments: Service users are sent text reminders of their KIT appointment and standard DNA and cancellation policies apply. KIT appointments are recorded on the service EPR (PCMIS) as "review only" appointments. In that way they do not contribute to the total number of sessions ultimately delivered for an individual service user, but a record of the contact is maintained.

In recognition of statements from some service users, that they would prefer not to receive communication from the service, whilst waiting and to ensure support tailored to need,, service users may opt out of KIT appointments. If that is the case, their decision is noted on PCMIS as an alert. Service users and their GP/referrer will be provided with written confirmation about their decision to opt out. This letter will provide information on who to contact in the event of an emergency or when circumstances change.

4.2.2.2 Contact from service users outside of the standard KIT process

On occasion, service users will make contact outside of the formal KIT process, to report a change in their circumstances / clinical status.

Depending on the nature of the call / the service users' reasons for making contact, the service user is directed to the appropriate source of support or input e.g. the admin team to change GP details for example, or the clinical team, where a discussion about clinical status or risk is appropriate.

4.2.2.3 Management of risk

Where risk is indicated (whether through the formal KIT process or informal contact) and has escalated to a level requiring more intensive support, a referral is made to appropriate services following procedures outlined in service Operational Policies. A risk management plan will be generated with the service user, to ensure their safety until additional help can be accessed

4.2.2.4 Oversight of wait list

Team managers and senior clinicians are provided with regular waiting list reports. These reports (wait list snapshots) enable effective monitoring of people who are waiting and allow senior staff to visualise where in the system waits are occurring:

- which locality
- which team
- which step
- which intervention / therapy modality
- which therapist
- how long the service user has been waiting

This information may be used to identify areas or clinicians who are struggling and prompt additional support. Such support might include reinforcing case management principles for individual clinicians or teams where it is evident that there is no effective throughput, re-allocating service users to clinicians who have more availability or offering additional interventions (e.g. groups) to alleviate areas where there might be more demand.

4.3 Monitoring service user experience of being on a wait list

As part of routine practice HPFT IAPT services seek feedback from service users on their experience of the service at the start and end of treatment using a standardized form (the “Patient Experience Questionnaire”; PEQ).

The PEQ provides an opportunity to comment on the overall experience, including time waiting for therapy. As part of ongoing service improvements services will conduct audits to establish how the measures put in place to support service users while they are waiting (such as the KIT telephone calls) are perceived and experienced.

Service users are encouraged to participate in service development by attending IAPT service user forums. These provide additional opportunity to improve the service offer.

4.4 Staff wellbeing and support

IAPT services are high volume, high pressure services where clinicians routinely manage extremely high caseloads and are expected to bring about positive change for their service users within tight timeframes. Nationally, IAPT services experience considerable challenges around staff burnout and staff retention (Steel et al., 2015). Clinical and Operational Leads in IAPT services are faced with the task of ensuring that the quality of interventions for their service users is maintained in the face of pressure to achieve high throughput while simultaneously keeping their workforce healthy, happy and in post.

Wait list management presents an additional stressor to an already pressurised workforce. The importance of case management supervision is mentioned elsewhere. Supervision is important to help identify and challenge therapist beliefs about wanting to provide what they perceive to be the “optimal” intervention – and

staff need to be supported to consider offering more efficient and shorter term modes of service delivery which meet service user's needs.

Management of wait lists should be a shared responsibility for all those working in the teams. All staff should be invited to contribute to problem solving, decision making and the generation and testing out of innovative solutions. Caseload size needs to be monitored to prevent burnout at times when the service is under increased pressure and this may involve providing temporary additional support to help increase capacity through external providers.

Part 3 – Document Control & Standards Information

- **Version Control**

Version	Date of Issue	Author	Status	Comment
1	11 Sept 2019	Peggy Postma (Herts IAPT Clinical Lead), Maggie Rosario (Essex IAPT Clinical Lead).	Current	

Appendix 2

Hertfordshire Partnership University NHS Foundation Trust

Case management – guidance

Given the ongoing service promotion that is taking place to increase access to the Essex IAPT Teams, we need to ensure we are able to safely manage the increase in referrals, support the team with this and continue to promote recovery and offer high quality interventions.

The following points are therefore intended to support staff in managing their caseloads:

During weekly regular supervision:

1. Agreeing a clear and efficient treatment plan

- It is important to draw up a problem list with patients, especially if they present with complexity and co-morbidity.

- Decide on a focussed piece of work, using SMART goals but also acknowledge with the service user that not all areas of difficulty may be addressed in this episode of therapy

- Consider promoting use of guided self-help, email-only CCBT and groups when clients present with mild presentations while still allowing for choice and explaining benefits of each.
  For example: '*You seem to struggle with depression and behavioural activation could help with this. You can do this in 3 different ways: either online, with telephone support while working through worksheets, or in a workshop. Which one would suit your lifestyle best?'*

- At Step 2, discuss all patients that are not in caseness in supervision first, before agreeing an intervention with the patient and where suitable, to direct these patients to pure self-help and discharge.

- At step 2, agree and commit to single strand interventions with clients. Only consider switching intervention if the client does not benefit from an initial technique, review this in supervision first. Switching to a different intervention needs to be done in a timely manner, to allow enough time to focus on the 2nd intervention, and as a rough guide by session 3 in a 6 session protocol.

- Ensure clients are engaged with the MDS as a meaningful reflection of their progress and use these tools clinically to help identify goals

Reviewing response to therapy:

- Manage expectations around the number of sessions offered. It is helpful to offer service users blocks of treatment (for example 6 sessions) and agree with them from the outset a review before contracting for further sessions.

For example, 'I'd like to recommend that we work together for 6 sessions focussing on x and then we will review our work together to see whether my approach has worked for you. If it has, then we can work together a while longer, but if we see that it hasn't, we can think about other options available to you, which might mean signposting you to other services and other types of interventions.

- Discharge service users if they have achieved their goals

- If your service user has been in recovery for a significant number of sessions but feel they haven't achieved their goals consider reviewing goals in light of the fact that they are in recovery, and/or provide self-help material or cCBT around these goals if they want to work on it further, using the tools they have learnt

- Advise service users that they can self-refer back to the service to work on another area of difficulty (problem B) after they have spent time consolidating and generalising skills learnt for problem A

- If service users are not committing to homework tasks, review this with them and reconsider whether CBT is appropriate for them at this point in time

- Consider alternative sources of support for service users who aren't making some improvement after 3 treatment sessions (step 2) or 6 treatment sessions (step 3) – PCMIS is very helpful here in identifying such cases by using the tabs/filter option. Bring such cases to caseload management supervision for discussion.

- Discuss in supervision by session 4 for step 2 and by session 10 for step 3 if you think a service user should be seen for more than6 sessions at step 2 or more than 12 sessions at step 3. These can be considered on a case by case basis (e.g. someone is starting to make improvements and would benefit from a few more sessions)

Review non-engagement:

- Discuss missed sessions in supervision if there is more than one DNA or cancellation

- Agree a contract with service users around DNAs and repeated cancellations at the start of treatment. There is guidance in the patient information sheet and a DNA/Cancellation policy for Wellbeing. This can be considered case by case if there is good reason (e.g. childcare or LTHC)

Ensure efficient service delivery:

- Space final sessions further apart (fortnightly or more) if the service user thinks this would be helpful – this frees up space for new service users

- Book an assessment when there is an advanced cancellation

- At step 3 consider stepping down a service user if a piece of work can be done at step 2

- Consider a telephone or online appointment if someone can't make a face to face session

- At step 3 consider using cCBT or groups as part of the intervention.

- Offer cCBT to service users who have been assessed and are waiting for treatment. Do not offer pure self-help, but use the Keeping in Touch calls as an opportunity to review how the patient has engaged with the self-help intervention and whether they require any further help from the service.

- Ensure any clients who are to be signposted (e.g. for counselling) are actioned and referred on within a week of agreeing this with your client to prevent the number of referrals building up. It can feel very overwhelming if these accumulate.

General:

- Discuss all step ups in supervision

- Only take individuals into treatment when they are able to commit to it – i.e. we will not "hold" people on caseloads who request starting therapy at a later date – in such cases please request that the service user self-refer into the service when able to start treatment.

- Please inform colleagues if you are reassigning a case to them and discuss this in supervision first (in addition to step ups)

Frequency of caseload management supervision

Supervisors need to ensure that case load management occurs on a monthly basis. Please book this in with all your supervisees at regular intervals (i.e. every 2nd week of the month), so that they are aware that during this supervision, cases will not be discussed in clinical detail but instead the focus will be on having an overview of all the cases on their caseload, and what blockages might have occurred and how to address this.

Monthly case management checklist – use relevant filters in PCMIS:

- Service users in recovery – can they be discharged?
- Service users not responding to treatment – is another service/step/intervention indicated (includes considerations re not adhering to service criteria)?
- Service users who have DNA'd/ Cancelled – should they be discharged?
- Service users post assessment – is another step indicated (includes stepping down)?
- Service users with no appointment/ last contact date exceeds 2 weeks (please remember 28 day policy)
- Service users who have been open to the service for a long time (checking for excess gaps between sessions that might suggest poor engagement and can lead to poor outcomes)
- Number of attended sessions exceeding agreed limit
- Service users not in caseness discussed in supervision
- Problem descriptors noted on PCMIS
- Use of Disorder specific measures when required.

Our Values

Welcoming Kind Positive Respectful Professional