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Implementing IAPT: Lessons From The Demonstration Sites.

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Implementing IAPT: Lessons From The Demonstration Sites.

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The University of Manchester

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Executive Summary

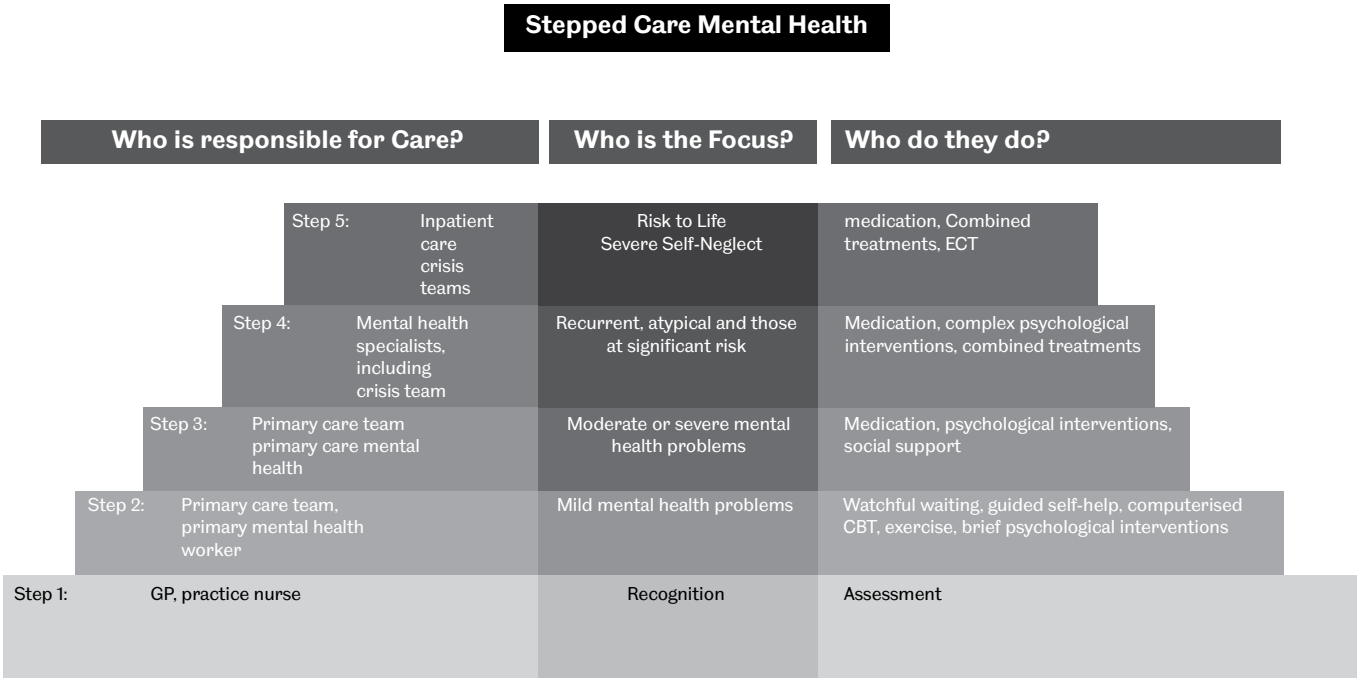
1. Introduction

1.1 Brief history of IAPT

The Increasing Access to Psychological Therapies (IAPT) programme was initiated following Professor Sir Richard Layard's report[1], which argued the case for a major increase in the availability of psychological therapies (PTs) particularly cognitive behavioural therapy, where NICE guidelines could not be implemented because of major shortfalls of service. A basic argument for IAPT was therefore the need to implement NICE guidance. The economic argument, set out in Layard et al., 2007[2], was based on therapy costs, Incapacity benefit costs, other NHS costs, gains in employment levels and reductions in sickness absence. Briefly stated, Layard et al. argued that the costs to Government of providing psychological therapy to people not now in treatment would be fully covered by the savings in incapacity benefits and the extra taxes that would result from more people being able to work. Layard et al. also suggested that this could be achieved within two years.

These arguments were made in the context of the 2006 Government strategy on health, work and wellbeing, which emphasised the important benefits of work for the individual in improving health and opportunities, for socially disadvantaged groups in reducing health inequalities, and for the wider economy[3]. The new strategy aimed to help people manage minor health problems in work, to return to work after sickness absence and to avoid work-related problems. A key part of this joint Department of Health (DH) and Department for Work and Pensions (DWP) strategy was to improve access to a choice of effective PTs for people with common mental health problems, reducing delays and waiting times in receiving appropriate therapies and extending the roles of primary care staff in delivering a wider range of interventions.

Figure 1: Model of stepped care mental health



1 Layard, R (2004). Mental Health: Britain's biggest social problem? Report presented to the Prime Minister's Strategy Unit at the Cabinet Office, 20th January 2005.

2 Layard, R, Clark, D, Knapp, M and Mayraz, G (2007) Cost Benefit Analysis of Psychological Therapy. National Institute for Economic Review No. 202 October 2007.

3 HM Government (2006) Health, work and well-being – caring for our future. A strategy for the health and well-being of working age people.

4 CSIP website, downloaded January 2007
http://www.clinicom.cpft.nhs.uk/Carepathways/Steppedcarementalhealthmodel/tabid/249/Default.aspx

The IAPT programme's main aims[4] were to:

- Improve individuals' well-being, satisfaction and choice
- Improve access and support to maintain people in work and to help them to return to work
- Develop clinical protocols to ensure clinically effective treatments are available to people in primary and community locations
- Develop service models for delivering integrated, stepped-care for people requiring access to psychological therapies across the spectrum of services
- Reduce waiting lists for accessing psychological therapies
- Develop a workforce plan for rolling-out the increases in capacity tested by the pilot sites that is sustainable, realistic and affordable

IAPT addressed the inaccessibility of psychological therapies and the long waiting lists for treatment by implementing *stepped care* (see Figure 1 page 7); key features of this approach are that treatment should be the least restrictive of effective therapies currently available and that the model is self correcting. The definition of 'least restrictive' may refer to the impact on patients in terms of cost and personal inconvenience,[5] but in the context of publicly funded healthcare systems, 'least restrictive' often refers to the amount of specialist therapist time required (i.e. treatment intensity). More intensive treatments are reserved for people who do not benefit from simpler first-line treatments, or for those who can be accurately predicted not to benefit from such treatments[6]. In this way, stepped care has the potential for deriving the greatest benefit from available therapeutic resources. However, the focus on low-intensity treatment delivery might actually be counter-productive, without the crucial self-correcting mechanism. 'Self-correcting' means that the results of treatments and decisions about treatment provision are monitored systematically, and changes are made ('stepping up') if current treatments are not achieving significant health gain[7].

Two *demonstration* sites (in Newham and Doncaster) were set up by August 2006. Initially, there were marked differences between the IAPT models in the two sites. Doncaster focused on patients for whom NICE recommends a stepped care model[8]. This emphasised high volume, rapid access to low-intensity work; guided self-help and bibliotherapy based on CBT principles, delivered principally via telephone by specially trained and supervised 'case managers'. At this stage, Doncaster had less capacity to deliver cognitive behaviour therapy by qualified practitioners and referral criteria excluded patients for whom NICE guidance did not specifically recommend stepped care (e.g. people with post-traumatic stress disorders). Newham in contrast focussed on providing unprecedented primary care access to CBT, in the format which had showed efficacy for specific presenting problems in randomised controlled trials[9], delivered by qualified and well-supervised practitioners. Newham therefore covered the full range of anxiety disorders as well as depression. These therapists worked in collaboration with employment coaches, but the original Newham system had less capacity at *step 2*. In the course of the demonstration projects the models of provision in the two sites became more similar; Newham dedicated resources to providing a *step 2* service and Doncaster developed more *step 3* capacity, consistent with the principles of stepped care. Although they became more similar in their service models, differences between the patients seen at the two sites remained, not least in their sociodemography, with a markedly diverse ethnic mix in Newham.

By November 2006, within five months of setting up the demonstration services, a business case for national roll-out had been prepared and by May 2007, a Department of Health press release announced the success of the psychological therapies pilot programme in Doncaster and Newham, and £2m new funding for a further ten pathfinder projects. Following the success of the business case within the Treasury's Central Spending Review, in October 2007 Alan Johnson announced £170m recurrent investment for IAPT to be rolled out nationally over the next three years.

The demonstration projects ended in April 2008, when direct funding ceased and responsibility transferred to the local commissioners.

1.2 Description of the SDO evaluation and study timescales

The external evaluation of the demonstration sites was commissioned by the NIHR Service Delivery and Organisation R&D programme in December 2006, following a six month bidding process and two months contracting, and work started in January 2007. The three year evaluation integrates both quantitative and qualitative methods and comprises three broad strands: (1) an evaluation of the comparative costs and outcomes of the demonstration sites compared with comparator sites; (2) an evaluation of system impacts and organisational learning and (3) patient experience within the demonstration sites. The first strand tests a central hypothesis, namely that IAPT will be cost-effective when compared with the organisation of services in non-IAPT comparator sites. As part of testing this hypothesis, in the second strand we examine in detail the system-wide impacts of the new service configurations drawing on in-depth interviews with a wide range of informants in an organisational case study, documentary evidence of IAPT implementation and information made available via local IT systems. Results from the full evaluation are due to be reported at the end of May 2010.

4 CSIP website, downloaded January 2007

5 Sobell, M. and Sobell, L. (2000) Stepped care as a heuristic approach to the treatment of alcohol problems. Journal of Consulting and Clinical Psychology, 68, 573 -579.

6 Newman, M. (2000) Recommendations for a cost-offset model of psychotherapy allocation using generalized anxiety disorder as an example. Journal of Consulting and Clinical Psychology, 68, 549 -555

7 Bower, P and Gilbody, S (2005) Stepped care in psychological therapies: access, effectiveness and efficiency: Narrative literature review. The British Journal of Psychiatry, 186, 11-17.

8/9 Depression: The treatment and management of depression in adults CG23, National Institute for Health and Clinical Excellence, Dec 2004, London (Now replaced by Depression: The treatment and management of depression in adults (update) NICE guidance CG90) http://guidance.nice.org.uk/CG90

1.3 Purpose of the organisational case study

In addition to a detailed description of formal service parameters, we are conducting extensive case study research within each site to provide information on how the delivery of the service has been operationalised. Organisational case studies comprise semi-structured interviews with strategic, operational and front line staff, interviews with stakeholders and delivery partners and documentary analysis. An important aim of the case study work at each site is to provide an understanding of how the service was implemented and any learning relevant to a future roll out. This will enhance understanding of how services are established and delivered and why desired effects are seen (or not).

1.4 Rationale for and scope of this report

The timescale of the SDO-commissioned research allows a thorough evaluation which will inform future work in this field. This report presents emergent findings, focussing specifically on the organisational case study, in terms of what can be learned and applied to the IAPT roll-out process. Presentation of interim qualitative findings at this stage also provides an opportunity for stakeholder feedback.

2. Method

2.1 Scoping exercise

The initial phase in each case study was to undertake a detailed scoping exercise to identify key stakeholders and players at different levels within each demonstration site (e.g. key strategic leads, key delivery leads, delivery personnel, administrative support personnel, service recipients) as well as to identify the range of other stakeholders, both NHS and non NHS, with whom the pilot would interface.

The purpose of this scoping work was to identify the pool of stakeholders from whom interviewees could be drawn to enable us to explore the multiple perspectives in terms of contexts and level of analysis. Within each case study we then drew up a planned programme of interviews to provide data on the areas highlighted below.

2.2 Sample

Informants were sampled from both Doncaster and Newham to include

- Strategic leads in the partner organisations; primary and secondary care Trusts,
- Strategic partners (e.g. Chamber of Commerce)
- Those responsible for implementation and operational management of the service
- IAPT service providers
- Other PT providers linking with IAPT (e.g. counsellors, psychologists)
- General Practitioners
- Employment coaches/Jobcentre staff

A total of 57 people were interviewed (see Table 1.1).

Table 1.1: Interviewees by role	n
Strategic managers (includes PCT & MH Trusts & Chief Execs, partner orgs)	17
Operational managers (IAPT & partners)	10
Other stakeholders (GPs, proj consultants)	8
Front line staff (therapists & case managers)	18
National IAPT leaders	4
Total	57

2.3 Qualitative interviews

The interviews were partially structured by a topic guide appropriate for the type of informant (Appendix B) which provided a range of issues for exploration whilst leaving the informant free to talk about their experiences and perspective without intrusive questioning. Informants were sent the topic guide in advance of the interview and informed consent for the interview was obtained. Interview duration varied between 45-90 minutes. Interviews were digitally recorded and transcribed. Digital recordings were stored securely and transcripts encrypted.

2.4 Data analytic method

The data analytic approach was derived from the Framework method, in that interview elements were first indexed, coded then analysed thematically, with recurrent themes identified from the transcripts and with reference to the research questions identified in the proposal. A team of five researchers undertook the analysis (JR, EC, RH, JC, GP) with support from two others (KD, GH).

A systematic review of the dissemination and sustainability of innovations in health service delivery and organisation[10] was identified as a possible basis for organising the themes emerging from the data analysis. Ultimately, this was not used as a formal basis for coding, but these ideas from the Greenhalgh et al model influenced the early stages of data analysis.

10 Greenhalgh T, Robert G, Bate P, Kyriakidou O, Macfarlane F, Peacock R (2004) How to Spread Good Ideas. A systematic review of the literature on diffusion, dissemination and sustainability of innovations in health service delivery and organisation. Report for the National Co-ordinating Centre for NHS Service Delivery and Organisation R & D (NCCSDO).

Each transcript was divided into coding units, each representing a separate point within a single topic. Initial indexing was undertaken on eight interview transcripts, which yielded 32 themes, derived consensually after two or more researchers independently identified themes from each interview. These 32 themes were then examined by the full team and grouped into seven higher-order themes. The individual themes within these seven groupings were used as the coding framework. Appendix C provides details of the individual themes identified. The higher order themes derived by this process were:

1. Top-down drivers (external, policy & extra-organisational comments)
2. Organisational systems (comments describing organisational factors, structures, procedures or systems relating to the delivery of IAPT)
3. Job Characteristics (comments relating to the direct work experience of those involved in delivering IAPT)
4. The innovation (comments about the design of the IAPT innovation)
5. Stakeholders (comments relating to the wide range of partners and others with an interest in the IAPT demonstration sites)
6. Implementation (comments relating to the process of introducing the IAPT service)
7. Sustainability (comments about the longer term development, sustainability and delivery of IAPT)

Using this coding frame a further 49 interviews were then each analysed by a single researcher and the coding units collated for each theme separately within an Excel spreadsheet. The key points for each theme were then extracted and written up by members of the team.

The Interim Report

This report is intended to provide early access to key findings on the development and implementation of IAPT pertinent to the pathfinders and national roll out. The organisational case studies were designed to fulfil a wider brief within the overall evaluation and as such this report is necessarily selective of the data on which it draws.

As might be expected with data of this nature, the higher order codes used in the analysis are not (nor are they intended to be) wholly discrete. As the analysis and synthesis progressed, several issues emerged across the higher order codes which are of particular relevance to the current report. For example, partnership working was consistently mentioned in relation to all higher order codes, both project management and line management and supervision were spoken about in relation to higher order codes of Organisational Systems, Job Characteristics and The Innovation. The interim report focuses on the more practical aspects of the development and early experiences of the demonstration sites. As a result, the interim report is structured as follows:

- Section 3.1 Policy context draws on data from the themes of *Top Down Drivers* and *Stakeholders*
- Section 3.2 Service design draws on data from *Organisational Systems* and *The Innovation*
- Section 3.3 Implementation process draws on data from *Implementation, Organisational Systems*, *The Innovation* and *Stakeholders...*
- Section 3.4 Partnership working draws on data from all the higher level codes
- Section 3.5 Project management draws on data from *The Innovation, Organisational Systems, Top Down Drivers* and *Stakeholders*
- Section 3.6 Line management and supervision draws on data from Job Characteristics, *The Innovation* and *Organisational Systems*
- Section 3.7 Job demands and job experience is based on *Job Characteristics*, and,
- Section 3.8 System capacity is based on *Organisational Systems, Stakeholders* and *Implementations*.

3. Findings

3.1 Policy Context

The findings presented in this report need to be understood in terms of the fast moving policy context within which decisions about the future of IAPT were being made. Confirmation of demonstration sites was given in October 2005, final project initiation documents accepted in December 2005 and the first clients were seen in July 2006. This created a number of challenges for both the demonstration sites which, in addition to setting up the new services, had to contend with the complexities of changing funding structures and success criteria as the following comments about the contracting process demonstrate:

> *"Having the funding confirmed was very much a stop-start activity which doesn't sit at all with setting things up so that was a bit messy."*

> *"There was an 8% cut, then a 20% cut, then no cut at all, so we had to go from planning a drastic cut in the service through to un-planning the cut and proceeding."*

> *"The national emerging IAPT programme kept changing its emphasis slightly in terms of... employment was always a big focus, but then they changed the goal posts and it wasn't much really."*

> *"It was very clear to us that that was where it was focused primarily, or that was where the most benefit would be made - to demonstrate effectiveness for the Treasury."*

As well as these national issues, changes within PCTs affected the demonstration sites, including the separation of commissioner and provider functions, practice-based commissioning and new procurement rules. These all had major implications for the way that partnership arrangements needed to deliver IAPT successfully were set up and sustained.

The issues discussed in the report therefore represent the challenges faced by both demonstration sites in setting up complex new services in a tight timeframe and within rapidly changing policy context and broader NHS changes.

3.2 Service Design

The aims of the IAPT programme are outlined in section 1.1. Principal amongst these is the philosophy of stepped care, which enables the maximum benefit or gain from available resources. Following assessment, the majority of people referred to the service will be offered low intensity psychological support, with higher intensity support offered to those who at assessment are identified as requiring this level of input, or who do not benefit from low intensity treatment. The remit for the demonstration sites was to develop models of service delivery to meet these aims and implement stepped care provision of PTs.

The two demonstration sites began from different places when designing their services and, over time, adapted their services to meet demands and national requirements. Here we have highlighted some of the main areas that were the focus of development and some of the unanticipated consequences and pressures:

> *"That one, the Doncaster one, was born of a much more 'across the whole locality, regeneration, employment, supporting, based approach' which looked at the development of what was subsequently being defined as the 'low-intensity workforce' and the other one was, if I can describe [Doncaster] as, sort of bottom-up, [Newham] was more top-down in that it came from the Specialist Mental Health Trust, was delivering the extension of the 'out-reach service into the community' already."*

The service model clearly has a bearing on capacity. The initial contrast in design between the Newham and Doncaster models demonstrated this with Newham's high intensity focus leading to a much lower throughput of patients than Doncaster's low intensity provision. However, both models have adapted in light of experience:

> *"Newham has, as far as I can see, recognised the need for low-intensity workers and has now employed quite a number of them and is putting more people through low-intensity particularly for depression. Doncaster, on the other hand, has recognised the need for some more high-intensity workers particularly because quite a lot of people who have been referred have quite severe depression which wasn't the original intention but that's what has happened - which all credit to them I think- for obviously GPs saying they are a valuable service. So they have both moved closer to what you might see as an IAPT service."*

One of the issues faced in service design was how to locate the low intensity service – whether to have a stand alone service or to extend existing provision. Setting up low intensity as a stand alone service was felt to ensure clear identity, resources and management, whereas extending existing services to incorporate low intensity work could have meant the service lacked identity and an appreciation of the importance of low intensity work would be lost. The more effective option was felt to be for a discrete 'service within a service' which is well-connected, with strong referral pathways and a good flow between different types of provision. Without these inter-connections, a discrete service could be seen as an import, 'just put down' without any real local ownership.

Both services had a vision of what they wanted the service to look like:

> *"We were determined that we did not want this to be seen as health or an illness service, we wanted it to be very much embedded with the business community."(Doncaster)*

> *"The things that we needed to do in this project was, be very clear about the model, very clear about what that stepped-care model was, and what were the appropriate skills and people we needed to input in to that model, and where those people were in our existing system, and if they weren't in the system, how we were then going to train these people, which was when we then got in to the training programme." (Newham)*

Important features of the demonstration sites included the need to show flexibility and patient choice in terms of how and when the service was delivered. This aspect of IAPT was very much reflected in the comments made by participants at all levels:

> *"The flexibility to move to neighbourhood level definitely is an advantage and I think just providing care in more flexible community bases so they will go to people's homes, they will go to GP practices, they will go to the Library, they will go to the community ... flexibility of the workforce to adapt to the needs of the individual."*

> *"So this is the kind of flexible work, you can say some people need to be seen every week, others need to be seen every fortnight or three weeks or whatever But it is more or less decided by the patient needs rather than what my diary says."*

However it was recognised that there were limitations within the services with regard to their ability to give choice:

> *"I don't know, maybe this is something that needs to be actually looked at further. ..., I mean when we talk about choice, so we give them the options and then they want something we can't offer them. So, in a way for example, you are stuck there and maybe somebody wants one-to-one but you are offering them just low intensity work, maybe guided self help or computerised self-help, so it becomes actually quite difficult to satisfy patients needs or maybe their expectations."*

One way of increasing the available choice for patients was to build in various add-ons, as feasible, for example: computerized CBT, bibliotherapy, books on prescription and exercise on prescription.

Another central aspect to the design of the new service was location and method of delivery. Accommodation was seen to facilitate and embody the culture of the service. It was a powerful symbol of what was new to the public, the NHS and other government services:

> *"There is something very powerful about the symbolism, I think, [where one is] based, and it reinforces the idea that it is going to be done very differently."*

> *"I think the fact you can get any mental health facility in an environment where ordinary people work, it can only do good to blow down the stigma."*

Locating IAPT services in GP practices for example was a popular option and was found to facilitate closer working between the two services. However, finding appropriate accommodation for service delivery remained challenging throughout the piloting period.

> *"there is a pressure on space and rooms ... so we are looking at more community venues outside GP surgeries where people can be seen"*

Acknowledged gaps in service provision included outreach work, and direct campaign work to combat the stigma associated with having a mental health condition.

Key Points for National Roll Out: Service design

Commissioner perspective:

- The new IAPT provision needs to operate as a 'service within a service' ie to have a discrete identity, structure and profile, rather than exist as an 'add on' to existing services. Ensuring that this model of service provision is explicitly supported through the commissioning process can have important impacts for the service in a number of ways:
  1. It helps to maintain the operational objectives and priorities of IAPT
  2. It helps to facilitate the development of clear working structures (e.g. referral pathways) between IAPT and existing provision, and
  3. It enables the value of low intensity work to be appreciated.
- Commissioners of services need to consider whether a phased implementation of the service is appropriate for local circumstances.

Strategic/Operational perspectives:

- Accommodation/location of the service was important in upholding IAPT principles of flexibility and proactive collaborative care. However finding appropriate accommodation proved difficult and requires early planning.

3.3 Implementation process

As might be expected given the timescale of the set up, there were many general criticisms of the implementation process around strategy, leadership and planning:

> *"There were lots of people involved, all very keen and enthusiastic – but totally uncoordinated. A lot of key decisions had been made, but no-one had given any thought as to how the service should actually be implemented...However, there was a real pressure to get things started, and in fact the implementation ran ahead of a proper planning process. None of the practicalities were thought through, nor the governance arrangements."*

> *"Ok, I think there's one really clear lesson - and it is a bit of a mantra of mine - I think we are very quick in the NHS and we did this with IAPT, to come up with an idea, and jump to ... start implementing, and then during implementation, we find all the issues and we take a long time to get to the point where it's actually operating in the way we want.*

3.3.1 Timescales

The demands of operating as national demonstration sites meant that a lot was achieved in a short time. However it was frequently highlighted that the pace of implementation meant that some aspects of service development suffered. There was consensus that:

> *"...taking time pays dividends, it may seem slower, but it is not time wasted...things take time to cook..."*

> *I think what we really needed to do with IAPT ... [was] to take much more of a developmental approach to getting to the answer... And not see that as wasted time...*

It was felt that engagement with key stakeholders was one of the areas to suffer, particularly with GPs:

> *"Eighteen months in we were still trying to engage some of the people who should have been engaged much sooner. GPs in general were unprepared for the advent of IAPT. The new service was kept under wraps for far too long and then sprung on GPs, so it's not surprising many of them took a long time to come round to the idea and to start using the service."*

Other areas to suffer from the speed of implementation were: supervision arrangements, clinical and operational governance, Caldicott issues and IT system infrastructure and support, especially when working from non-NHS premises.

The rapid timeframe for implementation at the demonstration sites was a contributing factor to many of the issues identified in this section. However, it is important to recognise that whilst a short timeframe might amplify these problems, they are the challenges that all new services in the roll out will face, regardless of timescale.

3.3.2 Vision and communication of vision

There was recognition of the need for a clear vision in establishing the service, however some respondents felt that this was not always achieved or maintained, particularly with the management resource to achieve the vision:

> ""I have a real concern that the people who were part and parcel of setting [the service] up and had the original vision, are not going to be on the scene [in future]..... you know, I've seen a deterioration in the vision, because the proponents of that vision have gone away from it"

> "Yet those decisions need to be informed by, and reflected in, a multi-stakeholder group that can steer the key decision points along the way."

People at different levels within the delivery organisations have very different views of what the service is about. It is difficult for 'a shared vision' at the strategic level to be uniformly passed down to all tiers and individuals at operational level.

> "But the other difficulty is that there was confusion and there were different views about what we should be targeting."

> "I mean lack of clarity about really why decisions are made and what thinking there has been about how decisions are made."

There was recognition of the need for strong management input to maintain the vision in operational settings:

> "Maybe one of the changes that probably became very apparent to me later on is if you don't have a sort of clear management structure in place to implement all these changes and to lead on this, then the whole thing will fall apart."

> "I am convinced that anything like this does need a champion. It does need a senior person to drive it, because inevitably, you will get people maybe wanting more of the action than you want them to have, because you are actually wanting to make the change... Some of this stuff is really complicated, and ...a lot of the things that I see fail, are because they haven't had that strong leadership right from the very top."

3.3.3 Engagement with other professional groups

One of the key areas in which speed of implementation caused problems was with the engagement of certain gatekeepers/referrers or other professional groups. The speed with which the services were implemented meant that preparatory discussion and agreement about referral paths was not possible, which led to opposition from other professional groups:

> "And when we were going out promoting to traditional therapists, that's where we got a lot of our oppositions from, you know, 'how can you train someone up in a few weeks to see patients that are mentally ill?."

> "Because we spent literally no time communicating with GPs about the change, before we changed it! Why do we have the issues about the relationship with CMHTs and the movement of clients between the different parts of the system – because we have never sat down and simulated what that would be like."

The IAPT services found that initially they had some problems with referrals pathways, particularly with other NHS services:

> "There were a few teething problems especially as well with some of the existing mental health services, and it was very much a question of not really understanding what we were about, what sort of treatment we provided, and getting the referral pathway sorted, was also confusing to start off with."

> "Because we would send referrals to the Community Mental Health team, they would send them back, we would send them back, then they would send them somewhere else, they would send them back, and it's the poor patient in the middle being 'ping-ponged' all over the place."

However, over time the new pathways were seen to be bedding in:

> "The GPs, the Community Mental Health teams know more about IAPT now – they are a bit more clear of the referral pathways – they are a bit more clear of what needs to go where, so I think the system is working better now."

At Doncaster, this was aided by the development of a referral matrix highlighting the appropriate referral route based on a range of factors such as severity, chronicity, complexity, impairment etc (see Appendix D)

Getting local GPs to be positive about the new service was seen a paramount, but often problematic. In both sites there were some GPs who valued and used the service and some who were more reluctant or never did:

> "And, it doesn't matter how many times we talk to them or how many times we demonstrate that's not the issue, they will continue to refer them in their own way, and as independent contractors I can't make them do anything different."

> "That was one reason, of course, why the number of referrals were lower because it's so fragmented, and difficult to get the knowledge out that this was happening – the GPs are a lot of single proprietors and not necessarily very sympathetic to the idea there is such a thing as mental illness."

> "I think there are some GPs who fundamentally won't come on board with it."

Having a GP champion for the new service was seen as vital:

> *"I think having a GP in mental health has been critical and very important and I think that the role that that has played has been very important in terms of getting GP's on board and keeping them on board."*

And using GP forums for engaging practices was useful:

> *"We have a very active GP forum which meets on the first Friday of the month, which is well attended by GPs and we, we took it there, on you know, had a, had a good session there at the first GP forum we took it to."*

3.3.4 Raising awareness and broadening access

Changing, developing and improving referral routes needed resources that were not always available to the new services. Both services decided to take referrals from services outside of the NHS, including self-referrals. The latter has been particularly successful:

> *"As it turned out we had very few referrals from community groups and occupational health and I think one of the key things there was ... to get that referral pathway working well would have required a lot of time and resource."*

> *"Self-referral has been hugely successful and has, as we know, shown that those self-referrals are more unwell than people referred by GPs."*

Both demonstration sites used a variety of methods to increase awareness and widen access to the new service. These included leafleting in a wide range of public buildings, using local communication channels such as local/community radio phone ins and face to face visits with community leaders. Some of the success of the new referral routes was attributed to advertising the service in various public buildings:

> *"We have produced leaflets and we've dropped them off in all kinds of places, libraries, community centres, local ethnic specific centres."*

> *"We had Jobcentres and we have also done a lot of leaflet drops to elicit self-referrals and our service at one stage was receiving about 40% of its referrals as self-referrals which is unusual."*

In both demonstration sites efforts were made to target sections of the community who did not traditionally use PTs. For example, Newham made particular efforts to reach minority ethnic groups:

> *"She also got in touch with an Asian radio station called Sunrise Radio, actually for a very small amount of money, £50 I think it was. We had one of our therapists on air who spoke for about half an hour about what the service did and then they took calls and that elicited quite a lot of interest."*

> *"And I've gone out to the mosques, I've gone and met religious leaders in Newham to promote this [service]."*

Developing and maintaining good working relationships with the referrers was seen as essential, although time-consuming:

> *"A lot of it has rested on [the manager], to go out and talk to the different partners and to try and ensure that referral processes are in place and then bringing partners in to talk to the case managers, or counsellors or CBT therapists, going out to different organisations."*

> *"The case managers were going out to particular practices to try and promote the service, which was a little bit difficult, I think. Also, [the manager got] a lot of the leaflets developed, got the focus group set up, did a lot of the engagement work out in the community."*

The GPs found communication and feedback from the case managers useful, and frustrating when it did not happen:

> *"We had the IAPT worker here, in the practice, working upstairs, and we could just converse each day, and if we had any problems or wanted a case discussion we could do it on a face-to-face basis, and that was brilliant."*

> *"We don't know what's happening, we don't have any feedback from them about what are we doing."*

3.3.5 Support Functions

Robust IT support systems were central to effective service delivery at both demonstration sites. The Doncaster site had access to an existing system designed to support the delivery of low intensity work. At Newham, a bespoke system was commissioned – an exercise which required a large amount of management resource and took time to get up and running, having considerable knock on effects for data management and efficient service delivery.

Likewise, the IAPT model involves a significant administrative load due to the high numbers of patients seen by each case manager, high levels of referrals from a wide range of sources and the requirement for session by session monitoring. Both the volume of administrative work and the ways of working required to support IAPT have proved challenging at both sites:

> *"The admin protocols have not been closely enough matched to the care pathway and 'paperwork has been going missing' as hard and electronic copies get passed around between sites and functions."*

Key Points for National Roll Out: Service implementation

Commissioner perspective:

- Commissioners of the new services were seen to have a key role to play in determining timeframes that support efficient and effective service development and implementation.

Commissioner/Strategic perspectives

- IT and administrative support are critical to the effective delivery of the new service. IAPT carries a considerable information and data management need. Consideration needs to be given to how administrative protocols are matched to the care pathway, what IT systems are appropriate and how IT systems can support clinicians in delivering a more proactive case management approach.

Strategic perspective:

- Sufficient time needs to be invested with stakeholders prior to the start of the service, ensuring shared vision and commitment to the development of a strong, persuasive management of the service.
- Service champions from different stakeholder groups were found to be invaluable in overcoming barriers and supporting the adoption of the new service.
- Equity of provision will not be achieved unless all GPs are using the services. Sufficient resource and a variety of methods for engaging with GPs need to be built into service development. Having a GP champion for the new service was seen as vital and using GP forums to engage practices was useful.

Operational perspective:

- Constant communication of the new service vision across all tiers and partners was flagged as critical during the implementation stage, with adequate resource to support this activity.
- Developing, monitoring and refining referral pathways from an early stage in the implementation process supported both the extent and speed with which they become embedded.
- Some of the success of the new referral routes was attributed to using a variety of advertising methods (e.g. public buildings, local radio).This was particularly the case for targeting sections of the community who did not traditionally use PTs.

3.4 Partnership working

IAPT is an innovative programme aiming to break new ground in a number of ways: Linking NHS with employment services and employers; developing the role of case managers using guided self-help (i.e. low intensity interventions); and developing new ways of working across primary and secondary care. Delivering IAPT therefore requires collaboration between different organisations, both within the NHS and between the NHS and other sectors; for example in relation to the 'returning to work' ethos, Jobcentres and local employers.

Ambiguity and uncertainty as to the constitution of the partnership, who was 'in' and who was 'out' added to the complexity of joint working. For example, the partnership was alternatively seen as an intra-NHS one (between primary and secondary care) or an extra-NHS one (between NHS, business and third sector partners) and the accompanying issues were prioritised and tackled differently in each case.

Section 3.4 considers lessons learned from partnership working and partner roles in the set up of IAPT services at the strategic, inter organisational and intra organisation levels.

3.4.1 Partnership at the strategic level

Examples were given of partnerships working well at the strategic level, with genuine commitment to involving and using partners fully:

> *"... we did it on the partnership model and all the partners were there and there was a genuine sign-up to try and do this for all and not just for mental health."*

> *"So, the ones who were used to working in a sensible kind of way and utilising partners' support and skills, they have actually cottoned on very quickly and understand the nature of what can be accessed."*

However, this needs to be contrasted with examples of *'sham'* collaboration where organisations want to show that they are involved with partnership working to '*tick the box*' or as an expedient route to winning resources. This can lead to tokenism, particularly in relation to the voluntary sector and the marginalisation of partners

> *"I still have got a nagging anxiety in that I still don't feel that, as a whole, people have gone away really understanding partnership working. I think some individuals do, and it comes naturally to them. I still get a feeling that some of it's just being paid lip service to, so they can tick the box saying they had it."*

> *"I think people weren't honest enough in the partnership. And there was really some money driving, you know they really did want to be high profile all the time... rather than it being cohesive, saying this is what we are doing as a partnership, there were a lot of personalities."*

Various challenges to maintaining partnership working were identified. These included conflicting priorities between partners, issues on data sharing and perceived changes in the programme's priorities:

> *"...until a common set of rules exists e.g. about data sharing across all partners, information cannot be shared equally...This is a governance issue which could be greatly helped through the use of very clear guidelines."*

> *"We had, just to give you an idea as an example, we had a nine-point agenda and employment was briefly mentioned on one line, on the second page, and that was my opportunity to speak and that came at point number eight, because the next was 'any other business'."*

The changing contractual climate was also a key challenge for the sustainability of partnership working, both within and beyond the NHS:

> *"This idea that the provider unit has got this Chinese wall and we are looking at options for what sort of governance structure should be around the provider unit, so is it arms-length from the PCT, so in some of the discussions it has been difficult to work out who's wearing a provider hat, or a commissioners hat, or actually do you need one of those hats"*

> *"We just had an interesting debate around the second year stuff which included how we maintained partnerships under our standing financial instructions; so, when we started we knew we had a year's money, so [institution name] is our academic partner, who was awarded the tender for a year, and then at the end of that year there was a discussion about are they still the academic partner, or do we need to tender it, and how do we do that with our SFR. So, that was learning on our part, in terms of, how can we sustain partnerships, in light of the more contractual nature that we have now."*

Service user involvement is a fundamental principle within IAPT and was seen as a key resource to aid the process of partnership working:

> *"...by constantly speaking up for reason, acting as an 'honest broker' ...this kind of patient insight... helped to keep peoples 'eye on the ball' of what of what the service was all about."*

However, the overall level of patient involvement with the design of the IAPT service was modest, with users in general not centrally involved and service design not seen as user driven, as explained by this respondent:

> *"The other concern I do have is user involvement within the service...they have had a very articulate, very involved service user, that's fine, but then it is easy to let that become your service user involvement, rather than try and do the harder work which is to build up a sense within the whole service."*

There was also recognition that the current role of service user required a certain level of skill and experience to operate effectively in the partnership and that other models of service user involvement might be appropriate:

> *"Because it's not just about the service user on the management, it's about do service users directly guide their own personal care, and drive that with the case managers and with everyone else."*

Key points for The National Roll Out: Partnership working

Commissioner perspective:

- Clear vision and strong support from the commissioners is needed to ensure real, not token, partnership working
- Clarity about the purpose of IAPT is needed through the commissioning process with an emphasis on collaboration and partnership working between NHS organisations, employers, DWP (JobCentres) and voluntary sector organisations.
- The commissioning process needs to help establish shared priorities and clear data sharing rules

Strategic perspective:

- Building on existing local strengths, either existing strategic partnerships or individuals with experience and a good track record for inter-organisational liaison were found to facilitate the partnership approach.
- Facilitated opportunities for stakeholders to meet, to bring issues out into the open, commit to transparency and talk things through were found useful as were inter-organisational focus group to tackle how to work together better on a shared task.
- The involvement of service users was found to be successful in moving the partnership forward and keeping a focus on priorities for the programme as was commitment to designing services around the needs of the patient or service user (i.e. user-centred service design). For operational managers the challenge is to ensure that there are structures in place that engage with service users and ensure their 'voice' in the development and implementation of the service.

3.4.2 Translating collaboration at the strategic level to operational practice: inter-organisational working.

Many examples were given of how, despite strategic there were barriers and difficulties in translating this into operational practice:

> *"It is easy to talk about, and say stick it on your leaflets, and get yourself in the papers, but actually doing it, is a different matter... When it first was developed and we all started talking about this, it was really exciting and it was great, and you allow yourselves to think this is a sensible way of doing things, and then the same organisational difficulties [arise], and it is so frustrating."*

In particular, barriers arose through working effectively with different partners. For example, a key feature of IAPT is the location of the service away from traditional NHS settings but this can prove challenging for the provision of basic support structure, for example:

> *"There was all this 'let's go work in XXXX' but the infrastructure, the IT, the internal post, it wasn't set up to work from there."*

Another important aspect of IAPT was the cross partner work in relation to employment and this was an area that suffered significant challenges at the operational level at both demonstration sites:

> *"...the idea was that very much employment would be on the agenda, as well as mental health care, and that was pushed forward from the very beginning. However, with limited success. [We] organized and took part in big group sessions between our advisers in that area, CMP people, and the IAPT practitioners, and explained the different roles and we had meetings and round table discussions on a practitioner level and everybody went away happy, saying 'oh yes, we will refer to you' and 'you refer to us' - and it just didn't happen."*

Key points for The National Roll Out: Operational practice

Operational partnerships require a great deal of time and resource before they begin to operate effectively. Effective solutions include:

Strategic/operational perspective

- Plan for significant amounts of strategic and operational management support during the implementation phase at a level sufficiently senior to negotiate solutions across partners

Operational perspective:

- Identify key individuals (local 'product champions') across the partner organisations to take on ambassadorial roles in relation to their own stakeholders, e.g. GPs, Chamber of Commerce and to assist in generating solutions to operational problems
- Consider the use of externally facilitated events or regular partner meetings to map out and review inter-organisation collaboration such as new pathways for referrals.

3.4.3 Intra-NHS tensions

At both the strategic and operational levels, there were tensions between the partners' agendas, sometimes conflict, and inevitably powerful barriers to working effectively together. Participants mainly reported these tensions between NHS organisations be they between primary and secondary mental health care providers; between therapists of different professional backgrounds or between existing services and IAPT.

At the structural level, examples were given of agendas that challenged the user-centred ethos of IAPT:

> *"...they were definitely after a building on that site, to do all of this out of, and that was just wholly against what we wanted to do, so there was some tension."*

Such conflict between NHS organisations at a strategic level about 'ownership' of IAPT, not only undermined the partnership approach, but impacted on a day to day operational level for staff:

> *"...it's still creating horrendous conflict because it's now this [...] kind of huge posturing between the ... [organisations] about who owns what bit and who does what bit."*

On a practical level, tensions sometimes escalate into a breakdown in respect, trust and professionalism between people who are expected to work together.

> *"It was an extremely painful and difficult process to be honest because there are so many vested interests and there were appalling clashes of personality."*

> *"I have witnessed people speaking to each other in a way that I have never witnessed people speaking before."*

> *"My colleagues and the manager will come back almost in tears – or they will go there with cases... and find that there are four people there from XXXX lined up ready to attack them. Really, it was that unpleasant."*

Interpersonal hostility, particularly when combined with failure to resolve operational issues can, over time, lead to a reversion to familiar ways of working, and sustaining the use of inter- or intra-organisational networks in these conditions is difficult to achieve.

> *"Once the service was up and running, and we got referrals coming in, the network shrunk really and effectively worked like a traditional [one], although the model of working was very different, very innovative and new and successful, in terms of how they related to the network they became very, you know, a single channel, providing a service to individuals."*

Strategic/organisational factors underpinning the intra-NHS conflict can to some extent be resolved through the types of inter-organisational approaches outlined in section 3.4.2. Some of the operational issues are rooted in professional identify and suspicion of the suitability and effectiveness of the IAPT model.

There was a general belief amongst interviewees that case management works well. However, there was recognition from several participants of early (and in some cases persistent) concerns about the case manager role, in particular the experience and level of qualification of case managers:

> *"I suppose, representing secondary care mental health services, you might expect the view that actually the Case Manager model is not the right thing to do, because they're not qualified, but actually you know... recognising that those [users] don't need secondary care mental health services and actually they don't need the level of expertise or qualification to access the development through what are often transitory and social problems, I think the Case Manager model was ideal."*

To some extent, some of the organisational/structural pressures of the project e.g. the speed with which the IAPT demonstration services had to be up and running has meant that relatively little consideration was given to how the service would work with existing provision. The impact of this has played out through operational difficulties and concerns. It has led to lack of clarity about referral pathways, feelings of discomfort amongst existing primary and secondary care workers who feel threatened and resentful:

> *"... I was like a lot of people at the beginning, a bit sceptical, but it's like when you hear things.....but once I was in ... and I could see the development, and what was happening, I am a big believer in the service and I do promote the service. "*

> *"Yeah, it has. I think there was some fear in the early days. I think they were quite frightened of us, but maybe we were quite frightened of them as well. Two different worlds, very different worlds. Although we have always worked in mental health we have never been this close with therapists before and I think there was some fear in the early days."*

There is also criticism of the reliance on CBT as a modality to the detriment of other approaches and feelings from counsellors and other professionals that counselling and other approaches are needed:

> *"I'm not a particular advocate of CBT, but I would say I remain slightly guarded and suspicious about CBT, particularly when it comes with ubiquitous PHQ-9 that everybody has to give morning, noon and night."*

> *"I know that other therapies view us with some distrust because it's viewed as a cure all, which it isn't."*

Such difficulties all have the potential to limit the effectiveness of the IAPT programme to the detriment of service users.

Key points for The National Roll Out: Intra-NHS working

Operational Perspective:

- Time and effort needs to be spent on organising how the service will interface with existing provision. This needs to be supported as an ongoing activity, rather than a one-off set up task. (an example of Doncaster's approach to this can be found at Appendix D)
- Continual monitoring and feedback on the performance of referral systems is important as is ongoing collaboration over the development and refinement of referral pathways to reinforce shared understanding of and buy in to the process.
- Organisational development events (e.g. facilitated 'time-outs') for service delivery staff and managers may be of value in developing effective operational practices:
  - Opportunities for staff from different organisations to train together
  - Overcoming preconceptions about the other organisation by arranging visits and 'shadowing' other peoples work roles.
  - Joint work with the client, such as employment coach and therapist meeting the client together
- Additionally, clear problem resolution systems help to address any system difficulties in a timely way:
  - Planned 'trouble shooting' meetings between stakeholders
  - Devolved referral and administrative problem solving sessions to enable staff to address day to day operational problems quickly.

3.5 The Project Management Role

The innovative nature of IAPT, both in delivery methods and skill mix of the workforce, means the project management role is extensive in scope. In addition to operational skills in terms of setting up new systems and processes to work within the NHS and across multiple, non-traditional settings, the role requires experience of management within and across NHS organisations, experience of inter-organisational working and extensive experience of mental health services. Views varied as to how these needs were best met – whether they could be combined into one role or required different resource at different stages of the project:

> *"The Project Manager post requires a person with high level skills and mental health experience. They need to be an experienced senior NHS manager with a good understanding of clinical governance, Caldicott issues and NHS systems and processes. They need somebody who knows mental health inside out."*

> *"Different skill sets are required at different stages…a good strategic manager may not be a good operational manager…"*

> *"More resource is required at set up than when the system is up and running…at the start you need both a project [strategic] manager and a service [operational] manager…"*

The management resource required by the demonstration projects was initially underestimated. Failure to bring in an experienced project manager at the outset, and the speed with which the services had to be set up, led to basic and/or crucial operational management tasks being neglected. Frequently mentioned issues included lack of budget control, IT system contract problems, pay problems, inadequate workspace, breakdown in links between HR, IT and Finance. Additionally lack of clarity about how to resolve day to day operating issues in turn had a detrimental effect on staff morale.

> *"I just feel that we did all that work … but there wasn't any management driver … I still know that you can make things happen faster if you've got the right managers to do it .. It felt like there were lots, and there were, lots of difficulties around basic things."*

> *"They [The Partnership Board] seem unable to implement simple things – like, finding a room with more computers in. It is enormously frustrating. So, that is a problem and I think that is partly because of the management of the place."*

Both demonstration sites were to resolve these issues by bringing in experienced project managers at a later stage in the project. At both sites the late arrival of adequately qualified/experienced project managers resulted in the role initially being one of troubleshooting:

> *"I spent more time….. I used to call it 'remedial work' rather than visioning or thinking about the service, particularly in the early days. No-one had thought about how we were going to communicate findings; no-one had thought about 'house style' for the project; there was just nothing."*

Key points for The National Roll Out: Project management

The clear and consistent message from both demonstration sites was that the complex nature of the IAPT project required considerable management resource.

Strategic/operational perspective:

- Bringing in an experienced project manager at the outset was seen as critical for the success of the service.
- This was particularly the case during the set up and implementation stages of the project where the need for additional high level, experienced strategic and operational skills were highlighted.
- Views differed as to whether this need was best addressed through a single role or separate operational and strategic leads – to some extent this may be determined by staff resources already available at roll out sites, the over-riding message was about ensuring adequate resource was in place.
- Lack of this type of resource led to considerable operational problems be it at the level of identifying solutions to day to day issues or re-visiting working arrangements between partners, creating further demands on resources down the line. Bringing in an experienced project manager was therefore seen as a sound investment in the success of the service.
- Difficulty in recruiting project managers with appropriate skills and experience was also raised, particularly given contract notice periods etc, highlighting the need to plan for managers to be in place early in the implementation process.

3.6 Line management and clinical supervision

This section of the report considers the more clinical elements of the supervisory role. The next section on job design reports on the more operational line management and clinical supervision.

The combination of establishing a new service within a short implementation timescale and the creation of a new type of post (low intensity practitioners) resulted in a heavy resource demand for both operational line management as well as clinical supervision skills. In some instances the role was combined (sometimes due to lack of line management structure), in other examples the distinction between supervisory and management roles was more clear. In some interviews participants used the term inter-changeably.

There was recognition that the line management and clinical supervision roles did not sit well together with potential tensions between dealing on the one hand with line management issues (such as workload, work flow, performance) and then on the other offering supervision on a difficult case. Different strategies have been trialled to separate these roles.

In general, participants' comments from both demonstration sites indicate that supervision is working well and is highly valued:

> *"It is lovely to have positive role models around you and see people that you respect when you see them in action ... my clinical supervisor is amazing, really experienced, she's awesome, really inspiring."*

> *"He's got the experience you know, you need that, he's a real rock and you know if you go to him you'll get the answer that you need, and that's the kind of security you need."*

At points in the pilot the desired level of, or access to supervision has not always been available. Reasons for lack of appropriate supervision vary, including increased demand for supervisory support (e.g. through 'inappropriate' referrals) resistance to the role from senior staff, under-resourcing of the supervisory role, issues with the peripatetic nature of the service and lack of clarity around who to contact, all of which can have a negative impact on staff:

> *"We had a lot of junior and very experienced staff who needed a lot of hand holding .... [who] were left exposed to not having a supportive structure around them and that I think has been very costly ... a member of the team has stepped into that role and it has made a massive difference."*

> *"It's a bit stressful not knowing who your line manager is and who you are supposed to be calling. I mean I know XXX is happy to do it but I think that we worry about the fact that a lot of us call him, put a lot of pressure on him, and if we are supposed to be calling somebody else then that's not fair on him is it? We're not really clear on who we are supposed to be calling."*

> *"It is so important that you have a supervision network ... I mean there's been times when we've been out at the surgeries and we've contacted back here just to sound something out, but there have been no Duty Managers available, which can be a bit of an issue ... I think getting that right is quite important, you need that."*

In some cases the problem appears to have been resolved through a senior colleague extending their role, rather than through formal structures to ensure that appropriate levels of supervision are accessible when needed. At both demonstration sites, participants have given instances of phoning colleagues at home out of hours. Other formal approaches have been used at both sites to meet shortfalls in supervisory support through either restructuring the team to create duty manager rotas or increasing (through appointment) the resource available to fill this role.

Key points for The National Roll Out: Line management and clinical supervision

Strategic perspective:

- Plan for separate provision of line management and clinical supervision roles.
- Clarify the responsibilities with each of these roles.

Operational perspective:

- Plan for a high level of clinical supervisory support, particularly in the start up phase.
- Specify the structure of supervision including including ratios, times etc.
- Make expectations about the level of supervisory responsibility explicit for those in senior clinical roles.
- Ensure adequate coverage of supervisory support (across locations and operating hours) through duty rotas.
- Provide clear guidance about who is providing supervision support at any time.

3.7 Job demands & job experience (Issues for operational managers)

Comments on job demands and job experience mostly relate to the overall management of the service or the day to day operating issues. With regard to the line management role, the challenges of developing a new team with non-traditional backgrounds (and sometimes no previous NHS experience) have been highlighted:

> *"Getting started with a large number of people [case managers] who are entirely new – including new to the NHS – and who have widely varying experience is a challenge. More attention needs to be paid to team-building."*

Many comments about job experience focused on the satisfaction therapists gain from working with clients:

> *"I do believe that we've made a difference to a lot of folks' lives which is a good reason to get out of bed in the morning."*

> *"It's good! I think I get a very good feedback from my clients so I see they're progressing and that gives me much pleasure in terms of personal and professional satisfaction."*

However, for employees providing the new IAPT service there were a number of demanding aspects to the job. High caseloads and the implications for time management were frequently referred to:

> *"I think sometimes there can be a bit of pressure for us to take on quite big caseloads, I think that's a bit too much to manage sometimes. I don't think people who don't work delivering low intensity realise how tough it is doing back to back to back to back phone calls and what you are expected to achieve in 20 minutes or 30 minutes. It's really demanding and to try and meet the clinical target for hours and things, is near impossible."*

The demands of the role were recognised by others in the team, particularly as the high case load could still include users with complex problems:

> *"Because we [CBT therapists] see clients for a whole hour, whereas they're seeing them 10 minutes, 15 minutes, 20 minutes, so they're carrying a lot more and they're still getting most of these more severe people."*

To some extent the pressures were exacerbated by practical or operational issues, or the service design. To meet the stipulated 20 clinical hours per week case managers found that they had to book appointments back to back. Booking clients in this way means that case managers are dependent on drop out to fulfil other core parts of their job. This was generally manageable until:

- everybody booked answers the phone/turns up for appointments, in which case there is no time to fit in other important tasks that need doing or to have a break
- there is a difficult case which requires attention, the most commonly cited problem is a client disclosing suicide risk. This has a knock on effect for all following appointments and there is often nobody available to ring round and postpone the next appointments
- a colleague is off sick, or somebody else's telephone calls need covering because of falling behind due to a crisis

> *"There are times when it gets really stressful, but that's usually down to the practical side of things, such as computer space; and the amount of time spent on letters is ridiculous."*

> *" ...[they said to me] to meet your targets you literally book your calendar back to back and allow for people not to turn up, but then if everyone does attend their phone calls or whatever, then you're stuffed and that's happened to me, and it's horrible. . . And I remember having booked in back to back, having been told to book back to back, and the person I met with was suicidal, and I had back to back phone calls afterwards, and it was horrible."*

Many different factors contribute to caseload manageability, including split-site working, case mix and patient preferences:

> *"It's not quite so bad now because I only have the one surgery, when I had two surgeries which were ... both highly deprived areas - it meant that my case load ... left me little time to do a lot of quality follow-up work. They were both high referrers, doing a lot more face-to-face work than usual, with a lot more complex cases, but not as much time to do what I would have wanted to do with them, which is to do a lot more investigative work, you know sorting out appropriate services... because of their complex needs."*

> *"So there are sort of waiting lists within waiting lists because we recognise some people ..., you know the GPs have referred, they expect their patients to be seen and if the patient has requested only to be seen only at their GP practice it does create a two tier system."*

Ensuring appropriate referrals, or reducing the number of inappropriate referrals is an important aspect of balancing the low intensity role. To some extent this is a skill acquired with experience:

> *"One of the new CBT workers went, and she had only been with us a few weeks when she went, and she came back with referrals that should not have come to us, but that wasn't her fault, but it is about being able to say – I'm able to say 'no, that is not for us and we're not taking it, and so once the decision's been made at that meeting, then that's the decision."*

Dealing with inappropriate referrals takes a substantial amount of management time: there is a continuous need to 'educate GPs' and maintain effective communication with them, in order to get suitable referrals and similarly, with other partners e.g. Jobcentre Plus, who tend to refer cases with drug, or alcohol dependency issues which IAPT cannot deal with.

There also appears to be a more fundamental challenge to planning appointments for low intensity work. There is some evidence to suggest that staff delivering high intensity work are more able to fulfil their stipulated clinical hours than those staff delivering low intensity. One of the contributing factors is thought to be the perceived importance of the appointment to the client (i.e. the additional planning and safeguarding of time to attend the appointment) with them having more commitment to a one hour face to face appointment than a 15 minute telephone appointment.

The IAPT model involves a significant amount of administrative work. Getting administrative systems sorted out has been problematic – and complicated by split site working. Administrative capacity in both sites has been a particular issue, causing knock-on difficulties for clinical staff.

> *"Yes, small things like letters to patients or GPs follow-up letters, that sort of thing. Admin was severely under-staffed, well over-worked or not enough hours in the week. I don't think they expected to have so many referrals coming in such a short space of time. So I think admin had to make a lot of changes in themselves..... But I think that was a managerial issue that needed to be constantly revisited and refined and sorted because of the different needs of the service."*

> *"The admin protocols have not been closely enough matched to the care pathway and 'paperwork has been going missing' as hard and electronic copies get passed around between sites and functions."*

> *"The result has been some horrendous errors in e.g. issuing of appointment letters to patients – double-booking and/ or wrongly addressing them."*

Key points for The National Roll Out: Job characteristics

Operational Perspective:

- Monitoring and ensuring appropriate referrals, or reducing the number of inappropriate referrals is a key operational management aspect of balancing the low intensity role.
- Managing inappropriate referrals takes a substantial amount of management time. Continual feedback and communication with referrers about the types of problems the IAPT service can deal with is central to ensuring appropriate referrals.
- The high caseload is particularly problematic when users with complex problems come through to low intensity practitioners. In addition to the points above, there is a need to ensure adequate supervisory support for dealing with inappropriate referrals effectively.
- From a line management perspective, monitoring of caseloads and workflow is important to ensure that staff do not have too many active cases at any one time.
- Monitoring and refining the administrative function was also highlighted as an important element of managing job experience. This helps to ensure the function is operating smoothly and adjusting to changes as the service develops and beds in.

3.8 System Capacity

Demand for the new services has been high, suggesting they are effectively targeting areas of previously unmet need. However, it has proved difficult to manage demand across all parts of the system and to integrate the new parts of the system with the old:

> *"So in the early months there was none of the, we didn't maximise to any extent really at all, the possibility of referring around the network, and pulling in the additional partners, that, on a day-to-day basis, certainly that... I, certainly feel that we should have done."*

The universal signal of capacity issues are waiting lists, and very long waiting times for psychological therapies were a major impetus for setting up IAPT. The aspiration to provide immediate access, at least to guided self-help and support, was easy to meet in the early stages of setting up a service but became more difficult as the system reached capacity. Different systems have been trialled to address waiting list issues, for example at one site all referrals were initially screened by a duty manager which was found to cause an unnecessary delay. The system was changed to one where all referrals were accepted and subsequently given a brief telephone assessment. This meant that the three day target for referral to assessment was being achieved, but the programme was 'running closer to the edge'.

Speed of access remains one of the defining benefits of IAPT, as described by a service user who compared IAPT with the services she received when she was ill previously:

> *"I had to wait three years for CBT. I had the services, I had a wonderful psychiatrist and a wonderful GP, and all the people that looked after me were great, but it became apparent that the thing I needed the most was the CBT, and I had to wait and wait and wait, and I just knew that there was something wrong with that and that isn't right, because when you are waiting you go further and further down into the black hole. So, the immediate access just amazes me still, it makes my face light up just thinking about it"*

Getting capacity right at each step of the stepped care model and in particular integrating capacity across the primary/ secondary care interface - is a challenge.

> *"There is this debate at the moment about who can deliver tier 3 services, as to whether they have to be qualified or again learning from IAPT can they be more Case Management. So, we have got some who are Case Managers that have developed to be doing tier 2 and tier 3 work. So, it's whether services come down from secondary to deliver in a tier 2 type of community-based whatever, or whether we need to have more of tier 3 services"*

So far both sites continue to struggle to make their care pathways work optimally for patients, and neither site has 'sized it right'. In part the problem is a 'shifting target' as waiting lists have a predictable impact on referral behaviour. This has necessitated constant monitoring of conditions and how well referral routes are operating.

The grade mix of clinical and non-clinical staff is also difficult to get right and both sites had difficulty getting the level and quantity of CBT provision right for the through-flow of clients.

> *"You can work people through a rigid step-care model where everyone runs through it unless there is a particular reason why they have to go straight up to more face-to-face therapy, but if you haven't got enough capacity and access to capacity to step people up to face-to-face therapy, then you're not going to be able to deliver the outcome that you want. "*

Managing the flow of new patients to individual case managers is especially important for new starters, to enable them to complete all their face-to-face assessments and get patients on to different stages of treatment:

"When we first started, we had an influx - so we had got all patients at the same stage of therapy..... where we are now, we've got patients at different stages of therapy process and that's easier to manage, but when we have a new case manager we have to be aware how filtering those referrals through, so they have got time to do a face-to-face assessment, and to get them on different levels."

Capacity issues are compounded by the difficulties experienced in recruiting appropriately qualified personnel at both demonstration sites. There is a national shortage of qualified and experienced CBT therapists at present:

> *"One of the other issues we've had.... is the lack of qualified CBT therapists, it has taken us an awful long time to recruit two CBT therapists....., we've had to advertise twice. The first time we interviewed we got two people but they both pulled out because of the short-term contracts associated at that time with the posts; we then got approval from the PCT to offer permanent posts but even then it wasn't easy to recruit people because there was a national shortage of them."*

The availability of suitably qualified personnel at all levels is likely to remain a significant issue for the roll out. Recruitment of senior CBT therapists has continued to be problematic. This coupled with the fact that the recruitment of low intensity workers may be restricted by the need to co-ordinate with training provision is likely to limit options for roll out sites in dealing with system capacity issues.

Key points for The National Roll Out: System capacity

Operational Perspective:

- There is a need for good criteria for waiting list management as well as constant monitoring that these criteria are being applied.
- Monitoring of cases and referral routes needs to be undertaken, particularly 'inappropriate' referrals.
- Good IT support systems are essential to enable monitoring of service users and service capacity issues at all stages
- Provision needs to be made for regular 'trouble shooting' /referral case meetings.
- Staff shortages remain an issue. Different service delivery models (e.g. alternative methods of supervision) need to be considered in order to free up clinical time.

4. Discussion: Lessons Learned

The Doncaster and Newham demonstration sites have succeeded in showing how IAPT services can be set up and delivered. Both sites have now achieved something closer to a 'steady state' and are at the stage of programme consolidation and sustainability – a fresh set of challenges with implications for the national roll out.

This section first summarises the lessons learned from the demonstration sites, then discusses issues emerging around the longer term sustainability of the IAPT service.

4.1 Lessons Learned

The opportunity to secure political and financial support for the expansion of psychological therapies (PTs) in the UK necessitated the rapid set up and operation of IAPT demonstration services. Whist undoubtedly much was achieved in a very short time, the legacy of the speedy implementation process is still evident in the demonstration sites.

This section focuses on some of the key messages from the demonstration sites that underpin or contribute to many of the difficulties faced. Getting these aspects of the development and implementation right will mitigate some of the more challenging situations that they faced.

4.2 Timescale

One of the loudest messages from the demonstration sites concerns the damaging consequences of implementing a new, complex service such as IAPT in an eight month timescale. The timeframe for the pilot had far-reaching consequences at many levels within the demonstration sites. At an operational level it militated against the adoption of best practice in the service set up, meaning implementation decisions were rushed, there was little time for consultation and the development of working relationships with partners and stakeholders, important mechanisms such as referral pathways and IT systems were not adequately tested prior to implementation

and effective communication of the new service and engagement of stakeholders was limited. These problems in turn led to confusion or lack of shared vision, mistrust between professional groups and partner organisations and suspicion of the IAPT service. At an individual level the pressure to deliver and the consequences of rushed implementation created undesirable working conditions and conflict. Ultimately limited timescale operates against the sustainability of the IAPT service, resulting in ongoing operational challenges (requiring additional resource to resolve) the loss of experienced personnel, and risking a poorer quality service to the user than could be achieved if timescales allow for good practice to be adopted at the development and implementation stage.

The types of issues experienced at the demonstration sites are not unique to the implementation of IAPT, and there is no suggestion that all such problems will be resolved simply by extending the implementation timeframe. However it needs to be recognised that the timeframe in this instance compounded the issues a new service might face and meant that in some instances they became entrenched, creating on-going problems that were more resource intensive and difficult to resolve.

For the roll out the critical lesson is for the commissioning process to operate to more realistic timeframes and recognise the benefits of an implementation process that follows good practice principles.

4.3 Managerial Resource

It is evident from the demonstration sites that the complexity of the IAPT service required a high degree of strategic and operational management resource. This was initially underestimated at both sites and measures subsequently taken to redress the balance, brining in senior managers and increasing operational management resource. The lesson learned for the roll out is that IAPT is a unique combination of:

- New service format
- New staff groups
- Highly flexible service
- Rapid access service
- Extensive partnership working with non NHS organisations
- A wide range of stakeholders & gatekeepers
- A service based on a proactive approach to care, with a remit for engaging with 'hard to reach' or non-traditional users of PTs

Managing these relationships, developing and monitoring effective referral pathways and building and sustaining relationships with existing NHS providers (in addition to the usual service set up demands) requires significant managerial resource. Ensuring that this is in place from the start avoids the escalation of problems and prevents the failure of certain parts of the partnership/partnership breakdown.

4.4 IT and Admin Support

The nature of the IAPT service means it is both data and admin 'heavy'. The peripatetic nature of the service adds complexity to the level of data and admin support systems required. Getting admin or IT wrong impacted considerably on the operational capabilities of the service. The lesson learned for the roll out concerns the need for realistic assessment of admin and data resource requirements. In particular, if new data management systems are being developed to support the roll out, then there needs to be recognition of the delays this will cause to the effective operation of the service.

4.5 Breaking down barriers, trouble shooting and conflict resolution –

Inevitably, new services will run into issues or experience teething problems during the implementation stages. In IAPT, where different organisational norms and practices are in play there is arguably a greater capacity for lack of understanding between partners. However, it is also true that within health service organisations there was suspicion and lack of understanding of the IAPT service. The lesson for the roll out is to anticipate and, where possible, prepare for such issues in the service design.

The notion of building provision into the service for resolving such issues was a frequent theme. Suggestions varied from joint site visits, joint working and shadowing to increase understanding and build working relations, to forums or cross partnership working groups with a trouble shooting remit. Whist such approaches can reduce clinical time, in the longer term they pay dividends in smoother operations and greater understanding between services. Additionally, devolved problem solving interventions have been found to result in greater engagement with the work and what are perceived as faster and more workable solutions.

4.6 Conclusion

The design and implementation of the new IAPT services undoubtedly presents a number of challenges. Arguably the innovative nature of IAPT (encompassing rapid access, high volume, proactive engagement with service users, flexible service provision, new staff groups, varied stakeholders and interfaces with a range of other services/providers) makes for a greater variety and number of challenges than other new services have encountered. The demonstration sites have succeeded in establishing these services and in the process have helped to highlight many of the issues and solutions that can inform the national roll out.

Appendix A: Full research team

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Appendix B: Topic Guides

Strand 2 (Service impacts) Operational Lead Topic Guide

This topic guide is a draft which will form the basis of discussion with the pilot sites, following which the revised guide will be piloted and amended as appropriate.

Key areas:

1. Can you start by describing your job role & how it fits into the wider Trust structure?
2. How did you get involved with the IAPT pilot?:
   i. How did you hear about it
   ii. How & why did you get involved (probe specific role)
   iii. What was the process – what did it involve? Who was involved?
3. Pilot Design:
   i. How was the service designed? (process & who was involved? what service delivery structure was adopted?)
   ii. Why was that approach chosen?
   iii. How did it link into/differ from previous PT services? (e.g. no.s of staff; training & qualifications; contractual status; supervision; no of clients seen? Time to first appointment?)
4. Describe any changes brought about by the new service to:
   i. work techniques or procedures?
   ii. the organisation of work?
   iii. Personnel?
   iv. New technology?
   v. Payment systems?
   vi. Working hours/arrangements?
5. Pilot Implementation:
   i. When did the pilot start?
   ii. How was it introduced to staff? (who affected? How? Training?)
   iii. How was it put into practice?/How did they handle the switch to the new service?
   iv. Describe any initial issues or concerns?
   v. How has it run to date?
   vi. Any major changes or surprises?
   vii. What have staff reactions to the service been?
   viii. What have patient reactions to the service been?
6. Future developments:
   i. Any changes or developments planned?
7. Any other issues/points not covered in the interview so far?

Strand 2 (Service impacts) Service Provider Topic Guide

This topic guide is a draft which will form the basis of discussion with the pilot sites, following which the revised guide will be piloted and amended as appropriate.

Key areas:

1. Can you start by describing your job role & how it fits into the wider Trust structure?

2. How did you get involved with the IAPT pilot?:
   i. How did you hear about it?/What was previous role?
   ii. How & why did you get involved?

3. Where you involved in the design of the pilot? If yes:
   i. How was the service designed? (process & who was involved? what service delivery structure was adopted?)
   ii. Why was that approach chosen?
   iii. How did it link into/differ from previous PT services? (e.g. no.s of staff; training & qualifications; contractual status; supervision; no of clients seen? Time to first appointment?)

4. How does this job compare to your previous therapeutic work?:
   i. work techniques or procedures?
   ii. the organisation of work?
   iii. Personnel?/team structures?
   iv. New technology?
   v. Payment systems?
   vi. Working hours/arrangements?

5. Pilot Implementation:
   i. When did the pilot start?
   ii. How was it introduced to you?
   iii. Was any training in the new service provided?
   iv. How was it put into practice?/How did they handle the switch to the new service?
   v. Describe any initial issues or concerns?
   vi. How has it run to date?
   vii. Any major changes or surprises?
   viii. How do you feel about the service?
   ix. What have staff reactions to the service been like in general?
   x. What have patient reactions to the service been like?

6. Future developments:
   i. How would you like to see the service continuing in the future?
   ii. Are there any changes or developments that you think could improve the service?

7. Any other issues/points not covered in the interview so far?

Strand 2 (Service impacts) Strategic Lead Topic Guide

This topic guide is a draft which will form the basis of discussion with the pilot sites, following which the revised guide will be piloted and amended as appropriate.

Key areas:

1. Interviewee job title and description of role?

2. General Trust overview:
   i. workforce size and composition,
   ii. population served,
   iii. any recent major organisational changes (ie in the last few years)
   iv. previous Trust involvement in initiatives/pilots
   v. future development plans

3. Provision of psychological therapies:
   i. Describe previous services for provision of psychological therapies
   ii. Type of provision
   iii. Strengths of the previous service
   iv. Issues with the previous service

4. Describe involvement with the IAPT pilot
   i. How did you hear about it
   ii. How & why did you get involved (probe strategic influences/implications)
   iii. What was the process – what did it involve? Who was involved?

5. The IAPT Pilot:
   i. How was the service designed? (process & who was involved? what service delivery structure was adopted?)
   ii. Why was that approach chosen?
   iii. How did it link into previous PT services?
   iv. How did it fit into strategic plans for the Trust?

6. Progress to date:
   i. When did the pilot start?
   ii. How has it run to date?
   iii. Any major changes or surprises?
   iv. Any specific difficulties from an organisational point of view?
   v. What have staff reactions to the service been?
   vi. What have patient reactions to the service been?

7. Future developments:
   i. Any changes or developments planned?

8. Any other issues/points not covered in the interview so far?

Appendix C: Coding Framework

High level theme	Sub-theme
1. 'Top-down' drivers	1.1 External pressure to deliver & lack of control
	1.2 External context: shifting goal posts/ unanticipated 'events'/ outcome measures/ success criteria/ shifting demands
	1.3 Tactical, political nature of demonstration projects (27)
	1.4 External relationships with vips (14)
	1.5 Impact of routine data collection on staff and service (21)
2. Organisational systems	2.1 System capacity (7)
	2.2 Resource issues (22)
	2.3 Workforce issues (23)
	2.4 Contractual, financial and organisational system constraints on delivery (28)
3. Job Characteristics	3.1 Job experience (3)
	3.2 Intra-IAPT collaboration or conflict and job support, organisational 'culture' and climate' (4)
	3.3 Job design (2)
	3.4 Management style & competence (1)
4. The innovation	4.1 Service design (25)
	4.2 Systems thinking (16)
	4.3 Engaging gatekeepers/ referrers/ screeners (18)
	4.4 location (13)
	4.5 New ways of working (9)
5. Stakeholders	5.1 Inter-organisational partnerships (11)
	5.2 Service user & representative organisation perspectives (20)
	5.3 Societal perspectives (32)
	5.4 Use of external expertise to guide, train and mentor (24)
	5.5 Tension between public and private sector ways of working (10)
6. Implementation	6.1 Implementation process & change management (5)
	6.2 Intended consequences and achievements/ failures (30)
	6.3 Unintended consequences & knock-on effects (26)
	6.4 Valuation of service and service model by service providers (9)
	6.5 Winning 'hearts and minds' (15)
	6.6 'Grafting' an innovation in to an existing system (19)
	6.7 Vision and leadership (8)
7. Sustainability	7.1 Sustainability of new model vs reversion to status quo (17)
	7.2 Plans for the future & lessons learned (31)
	7.3 Commissioner perspectives (29)

Appendix D: Doncaster Referral Matrix

IAPT DONCASTER

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES

		Referral guidance variables						
		Severity	Chronicity	Complexity	Impairment	Substance use	Risk	Number of previous interventions with unhelpful outcomes
Variable level	Low	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team
	Medium	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team
	High	**PCT** IAPT Primary Care Team	**PCT** IAPT Primary Care Team	**DaSH** CMHT	**DaSH** CMHT	**DaSH** Substance Misuse Services	**DaSH** CMHT/CRHTT	**DaSH** CMHT

PCT = Doncaster PCT
DaSH = Doncaster & South Humber Healthcare NHS Trust
CMHT = Community Mental Health Team
CRHTT = Crisis Resolution and Home Treatment Team

Severity (take the highest severity range of the two measures as the overall severity rating)

Low =	PHQ-9 score = 0- 9	GAD-7 score = 0- 9
Medium =	PHQ-9 score = 10-19	GAD-7 score i= 10-14
High =	PHQ-9 score = 20-27	GAD-7 score = 15-21

Chronicity

Low =	Onset of problem(s) less than one year ago (acute)
Medium =	Recent relapse of problem(s) of more than one year duration (chronic with previous remission)
High =	Ongoing problem(s) of more than one year duration (chronic without previous remission)

Impairment

Low =	No/minimal impairment in day-to-day functioning
Medium =	Moderate impairment in day-to-day functioning (e.g., significant relationship problems caused by mental health problems)
High =	Marked impairment in day-to-day functioning (e.g., unaddressed significant personal hygiene problems, such as incontinence)

Substance use

Low =	No/minimal use
Medium =	Moderate use, not affecting ability to make use of psychological therapy; where required, co-working with substance misuse services possible
High =	Substance use dependency; or substance use is primary problem; or no motivation to address substance use

Risk

Low =	No suicidal thoughts or harm to self/others; or fleeting thoughts of suicide/homicide with no intent or plan; or harm to self/others resulting only in minor injury; some protective factors present
Medium =	Regular thoughts of suicide/homicide with some intent and passive but no active plan; harm to self/others resulting in more serious but not life-threatening injury; some protective factors present
High =	Frequent thoughts of suicide/homicide with strong intent and active plans; current life-threatening self-harm/harm to others; history of serious suicide attempts or serious self-harm/harm to others; no/minimal protective factors present

Complexity

Low =	one main problem manageable by one clinician
Medium =	two or more problems manageable by one clinician; or need for more than one clinician, where individual clinicians can work independently or with minimal liaison/care coordination
High =	multiple problems requiring multi-disciplinary input and significant amount of liaison/care coordination

Number of previous interventions with unhelpful outcomes

Low =	none
Medium =	1-2
High =	3+

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