

Learning Lessons from IAPT

**Evaluation Report on the
Oxfordshire Mind Low Intensity
Psychological Services Pilot**

April - December 2008



For better
mental health

Registered Charity Number 261476

Oxfordshire 
Primary Care Trust

www.oxfordshire-mind.org.uk

‘Learning Lessons from IAPT’

Evaluation Report on the Oxfordshire Mind Step 2 Low Intensity Psychological Services Pilot April – December 2008

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Introduction from Oxfordshire Mind

For many years Oxfordshire Mind have run a programme of Cognitive Behavioural Therapy (CBT) Groups. The evaluation and feedback of this service has always been very positive and it has given us a good understanding of how effective CBT can be in equipping people with skills and techniques to take greater control over their lives.

We also hear people talk about their experience of mental distress and how they weren't able to get help until things reached crisis point. All too often people describe how they were prescribed anti-depressants but not given any other kind of help.

All of this meant that when we started to hear about the ambitious plans for the 'Improving Access to Psychological Therapies' (IAPT) Programme we were very interested to see how the plans developed locally in Oxfordshire. We were also keen to be involved and believed that our experience and the skills of Mind workers would have a lot to contribute. We were keen to see that the CBT Groups were included within the programme and that the potential role of the voluntary sector was fully recognised.

We were pleased to be given the opportunity to set up the first 'Step 2' IAPT service in Oxfordshire. This evaluation report of that Pilot Project certainly indicates that the work has been successful and made a significant difference to a great many patients referred by all the participating GP practices. The credit for this achievement should go to the small team of workers who have been out there doing the work. But tremendous thanks should also go to the Primary Care Trust and the 22 GP practices who have worked with us.

The IAPT Programme has now moved on. The Step 2 Pilot has come to an end and plans are advanced for training up new workers and developing an IAPT service that will work across the whole county. The lessons of this Pilot will certainly be useful in this next stage.

We hope you find this Evaluation Report interesting and please do get in touch if you would like any more information.

Patrick Taylor
Director
Oxfordshire Mind

Introduction from Oxfordshire Primary Care Trust

2007 was a good year for Primary Care Psychological Services. Following the Comprehensive Spending Review the Government announced a three year investment plan to Improve Access to Psychological Therapies (IAPT). In Oxfordshire this should equate to additional investment in future years of £1.5 million.

At the end of 2007 the momentum of the national programme was gaining pace and it was recognised that Oxfordshire had no Step 2 type service in place. The Primary Care Trust (PCT) agreed to invest in a pilot to introduce this type of service in Primary Care in order to provide the fertile ground necessary to roll out a new service.

The PCT was pleased to appoint Oxfordshire Mind, a well known and respected third sector organisation to deliver the pilot; Oxfordshire Mind had already expressed an interest in getting involved in running a primary care service and they demonstrated their confidence by hitting the ground running and providing a service that was well received by GPs and primary care teams.

Juliet Long
Service Development Manager
Joint Commissioning Team (Mental Health)
Oxfordshire Primary Care Trust

SECTION 1

Overview of the Pilot

The pilot ran from April to December 2008.

It was funded by Oxfordshire Primary Care Trust (PCT) as part of the Dept of Health 'Improving Access to Psychological Therapies' (IAPT) programme.

The service was to help people referred by GP practices who are suffering from depression, anxiety and other common mental health problems.

The pilot operated in 22 out of the 84 GP practices in Oxfordshire. Six GP practices were in Oxford City. Six were in North Oxfordshire. Ten were in the Vale of White Horse. There were more practices in the Vale because the Vale GP Practice Based Commissioning Consortium (PBC) opted to use 'freed up resources' to provide additional funding.

A team of four 'Primary Care Mental Health Workers' were employed working under the supervision of a clinical psychologist who managed the service. The team were employed by Oxfordshire Mind. Oxfordshire Mind already worked in partnership with Oxfordshire Buckinghamshire Mental Health NHS Trust (OBMH) to deliver a programme of CBT based therapeutic groups. OBMH also provided support to the Pilot.

Each worker worked with a number of identified GP practices with a front-line role of helping patients referred by their GP. The workers usually spend half a day a week seeing patients within each of the partner GP practices.

Each worker carried out work that is described in the IAPT model as 'low intensity'. They did short term work seeing patients for a limited number of face-to-face sessions (between 1 and 3 times) and telephone follow up. They provided Step 2 psychological therapy interventions including assessment, guided self help, signposting, CCBT, referral and follow up.

Record keeping and data collection was an important part of the work. Each worker was equipped with a laptop and mobile internet access. Data from assessment and each patient contact was entered on the PC-MIS Management information System developed by the University of York for IAPT. The data collected followed the IAPT requirements and national Minimum Data Set.

The workers were recruited and trained in the first part of the Pilot. The work in GP practices started in June 2008. The data in this report comes from the period up to 31 October 2008.

The Pilot was overseen by a Steering Group which met monthly and included representation from Oxfordshire Mind, Oxfordshire PCT, CSIP and a local GP champion. The Steering Group produced a detailed Performance Plan which

identified the objectives, risks, milestones and governance arrangements for the work.

What was the Pilot aiming to achieve?

The *overarching objective* for the pilot was to create the fertile conditions for the development and embedding of stepped care in Oxfordshire.

To achieve this objective the following goals were established for the pilot:

- To promote new and effective access take-up of Step 2 high volume/low intensity psychological therapies for people aged 18 or above suffering from depression, anxiety and other common mental health problems
- To work collaboratively with targeted GP practices in Oxford City, North Oxfordshire and the Vale to promote the 'stepped care' approach and generate appropriate referrals
- To train and develop a new workforce with the competencies to provide Step 2 interventions
- To test out referral routes, IAPT data collection and a wide range of Step 2 interventions
- To develop a model of good practice which improves patient outcomes and evaluate the organisational, operational policies, service standards and clinical governance processes which need to be in place to support the future delivery of an IAPT service in Oxfordshire.

The pilot was also required to deliver against the following four Key Performance Indicators:

- Numbers of beneficiaries receiving Step 2 treatment

The project will deliver Step 2 treatments and assessments benefiting 225 people experiencing mild depression, anxiety and other common mental health problems, aged 18 and over in the key target areas.

- Response times

From initial receipt of referral from the GP, the project will contact the patient within 3 working days to arrange an assessment appointment. The project will aim to undertake assessments within 10 working days of the initial referral.

- Activity

The Project will offer up to 3-7 contact interventions per patient (including the initial assessment) drawing on a range of required Step 2 treatment options.

- Treatment times

80% of patients undertaking treatment will complete Step 2 interventions within 2.5 hours or less. 20% of project patients undertaking treatment will complete Step 2 interventions within a maximum of 4 hours.

SECTION 2

Analysing the Data

Record keeping and data collection was an important part of the work. Data from assessment and each patient contact was entered on the PC-MIS Management information System developed by the University of York. The data collected followed the IAPT requirements and national Minimum Data Set.

It was a requirement of the pilot to encourage all patients to complete the full set of questionnaires (the Minimum Data Set) at the beginning and completion of treatment, with key clinical measures recorded at every point of contact.

The following standard questionnaires were completed at assessment and the final session:

- PHQ9 and GAD7 (Health and Wellbeing)
- W&SAS and IEQ (Inclusion and Employment)
- PEQ1 or 2 (Patient Satisfaction)

Data from PHQ9 and GAD7 was also collected at each and every Session.

This meant that the data could be gathered to monitor changes in the patient's mental health, as well as information on patient demographics, satisfaction and experience.

The data entered onto PC-MIS by the team covering all case-work up 31 October 2008 was analysed by a data specialist, Daniel Zahl, who produced the information for the reports that follow in this section.

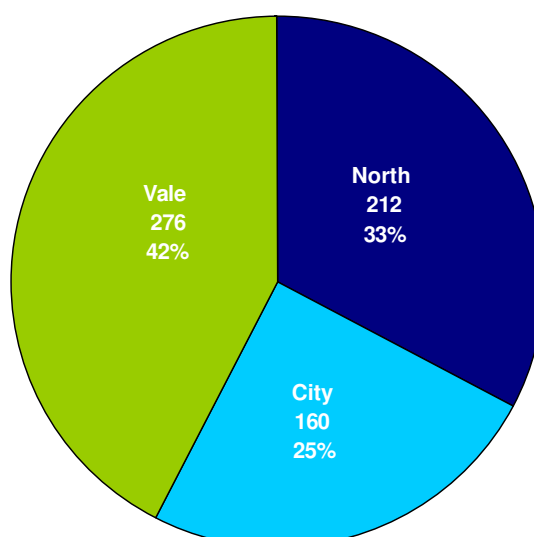
Referrals

Total Referrals

PBC area	Total referrals	Referrals per 1000 population
NORTH	212	3.6
CITY	160	3.5
VALE	276	2.9
TOTAL REFERRALS	648	3.3

The vast majority of all referrals during the pilot came from GPs who made 630 out of the total 648 referrals (97.2%). 3 Referrals were made by the Practice/community nurse (0.5%), and Counsellors/clinical psychologist referred 15 (2.3%).

Total Referrals by PBC area



Referrals by GP Practice: North

Surgery	Total referrals	Referrals per 1000 population
Hightown*	60	5.7
Windrush	38	4.6
West Bar	67	3.6
Deddington	35	3.9
Bloxham	3	0.4
Wychwood	9	1.7
TOTAL	212	3.6

* Referrals closed for Hightown Surgery 19/08/2008 – 15/09/2008 due to growing waiting time for assessment.

Referrals by GP Practice : Oxford City

Surgery	Total referrals	Referrals per 1000 population
Jericho (Dr K)	60	9.6
Jericho (Dr C)	4	1.9
Jericho (Dr B)	7	1.2
19 Beaumont St	28	2.2
Blackbird Leys	38	3.8
Temple Cowley	23	2.7
TOTAL	160	3.5

Referrals by GP Practice: Vale

Surgery	Total referrals	Referrals per 1000 population
Didcot HC	38	2.4
Oak Tree	13	1.7
Woodlands	30	3.0
Long Furlong	34	4.1
Marcham Road	18	1.4
Grove	13	2.9
Church Street	44	3.6
Newbury Street	27	2.6
Fern Hill	27	6.6
White Horse	32	3.4
TOTAL	276	2.9

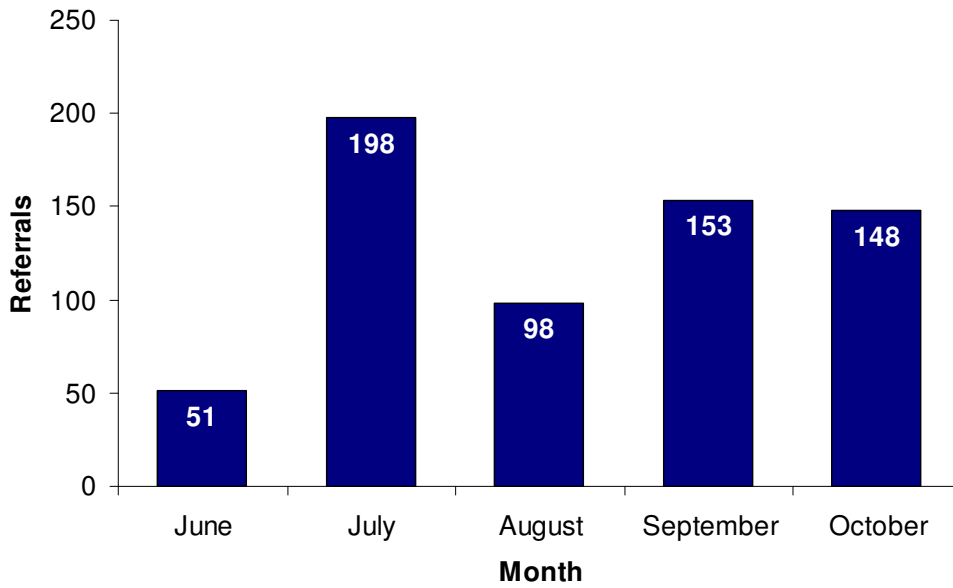
Three highest-referring practices overall were:

- West Bar Surgery, Banbury
- Hightown Surgery, Banbury
- Jericho, Dr Kearley Surgery, City

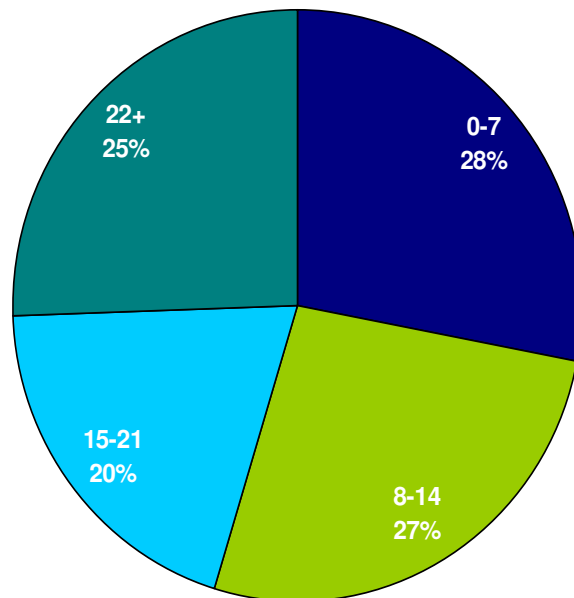
Three highest referring practices based on population:

- - Jericho, Dr Kearley Surgery, Oxford
- - Fern Hill Surgery, Farringdon
- - Hightown Surgery, Banbury

Total monthly referrals

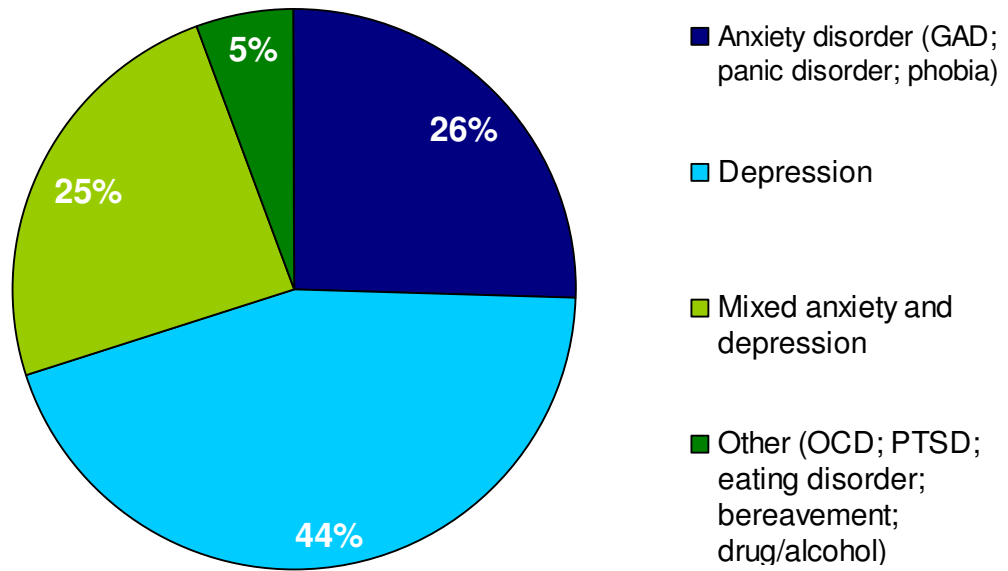


Time from Referral to Assessment (days)



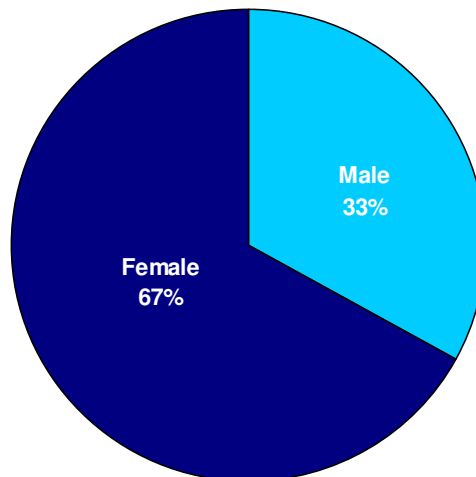
222 patients (55%) were seen at or within 14 days (10 working days) from referral. The range was between 0 days (5 patients) and 92 days (1 patient). The mean was 17.9 days.

Primary Referred Problem

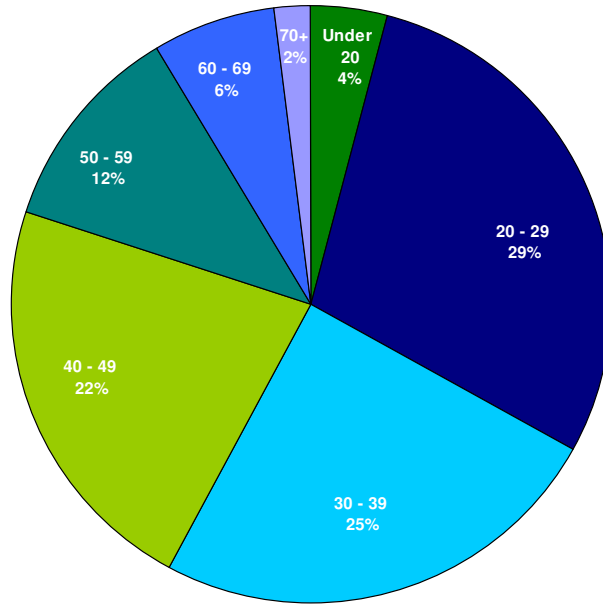


Demographic Information

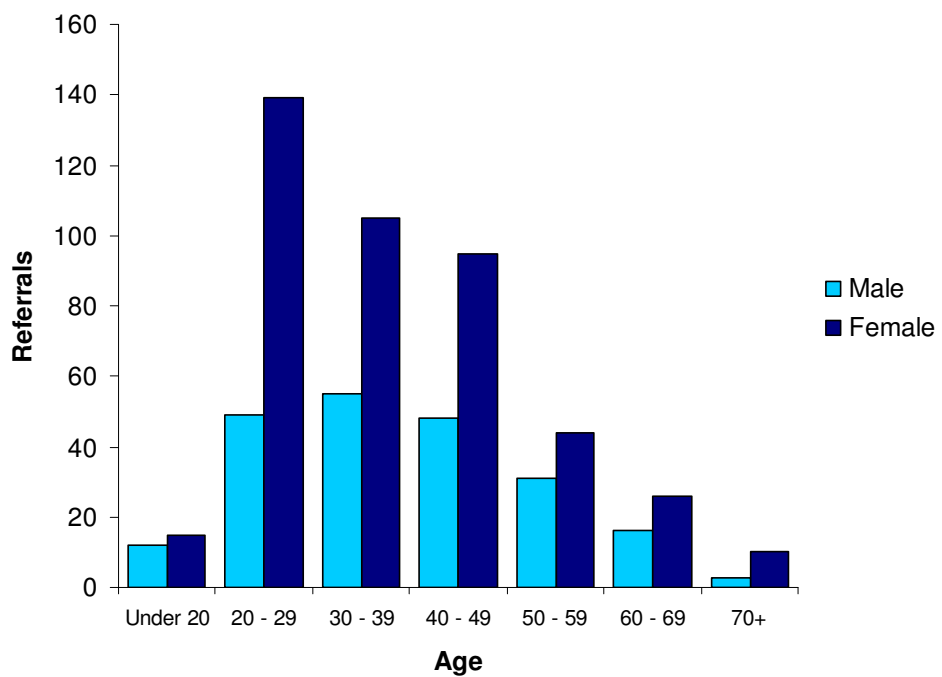
Gender (N=648)



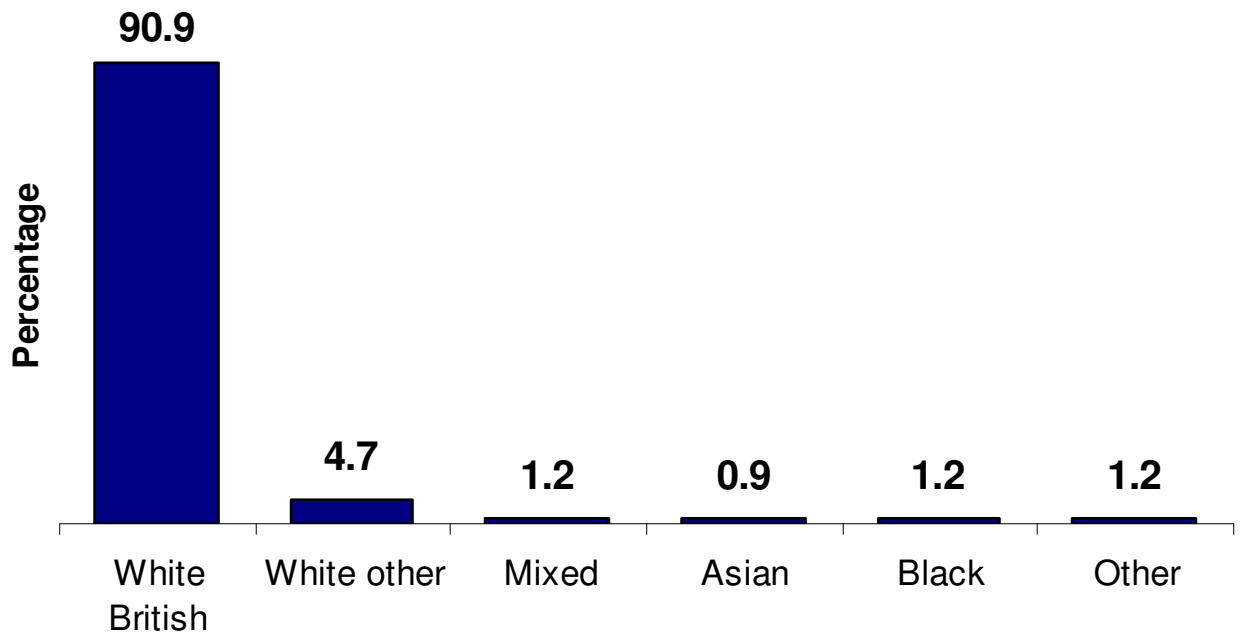
Age Bands (N=648)



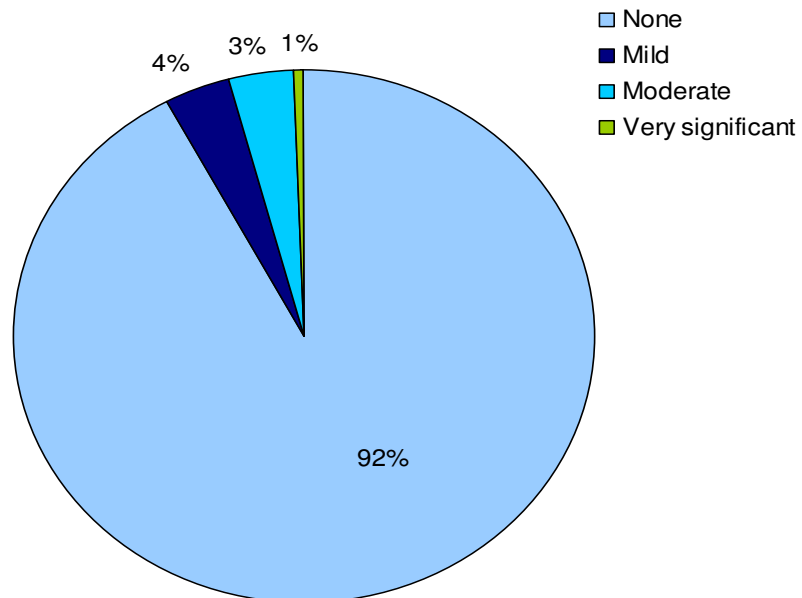
Age Bands by Gender (N=648)



Ethnicity (N=429)



Physical Disability (N= 432)



Sexuality

92.8% of patients that completed this section described themselves as heterosexual.

7.2% of patients that completed this section described themselves as homosexual or bisexual.

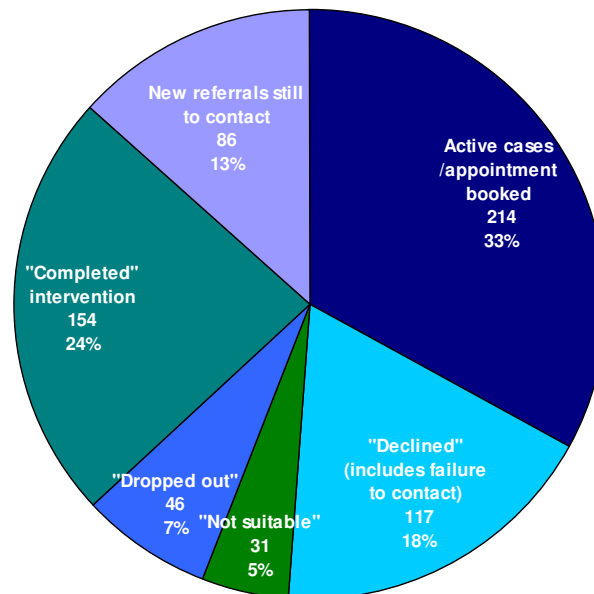
Of those who completed an assessment 77 patients (18.8%) did not give a response for this section.

Employment

At assessment, 11.6 % of patients were receiving Statutory Sick Pay and 6.8% were on Incapacity Benefit.

PC-MIS status of patients on 31st October 2008

(N= 648)



PHQ9 & GAD7 Data

PHQ9 is a questionnaire widely used in Primary Care to indicate the level and severity of depression.

GAD7 is used similarly to indicate the level and severity of anxiety.

Both these questionnaires were used (following IAPT guidance) at each and every point of contact with a patient and the information entered into PC-MIS.

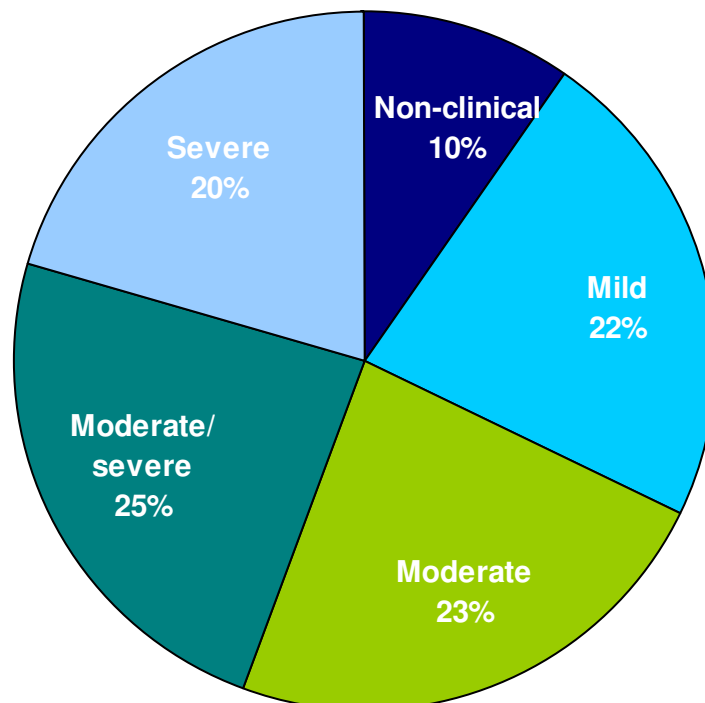
The data from these questionnaires is especially interesting as it is an indicator of whether someones mental health improves and whether the level of their depression and anxiety reduces.

A high PHQ9 score indicates a high (severe) level of depression and a low PHQ9 score indicates a low (mild) level of depression ,

A high GAD7 score indicates a high (severe) level of anxiety and a low GAD7 score indicates a low (mild) level of anxiety,

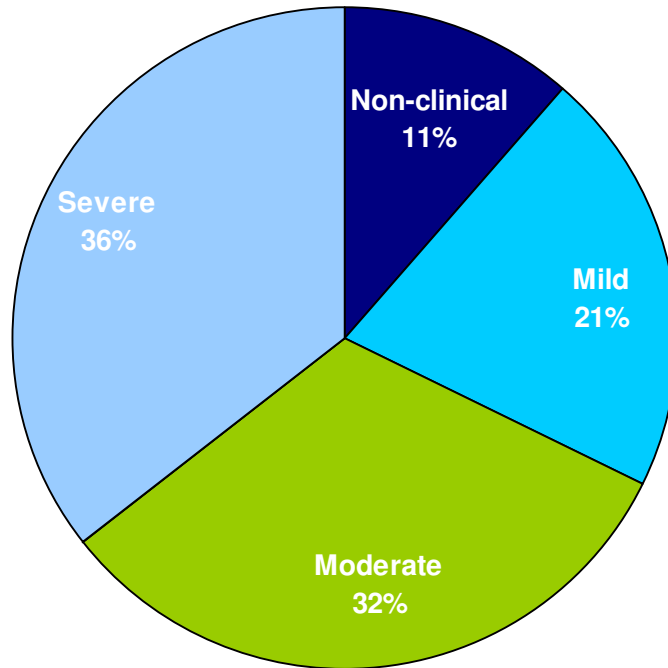
Severity of depression at assessment (PHQ9) (N= 406)

48.5% of patients scored in the moderate/severe or severe range for depression.



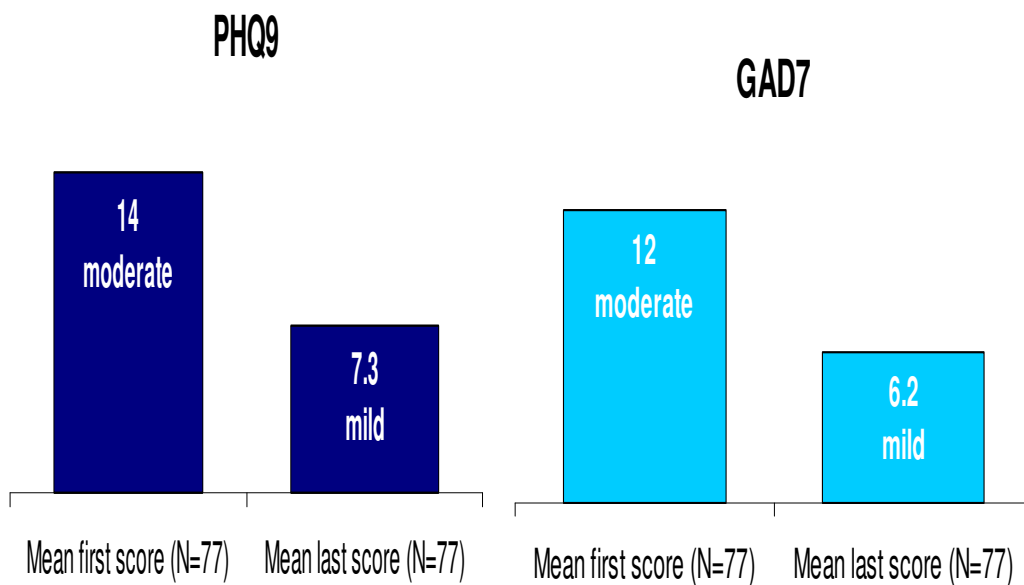
Severity of anxiety at assessment (GAD7) (N= 405)

35.6% of patients were scoring in the severe range for anxiety.



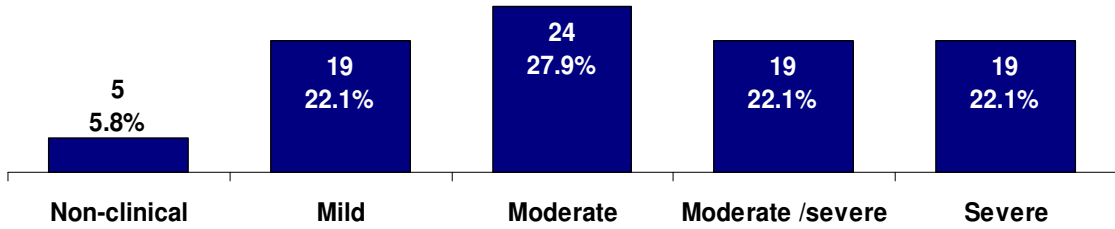
Health and Wellbeing Outcomes

Of those who had completed the intervention and had more than one appointment, we noted success in reducing the patients' mean index of depression or anxiety between the first and last scores for both PHQ9 and GAD7.

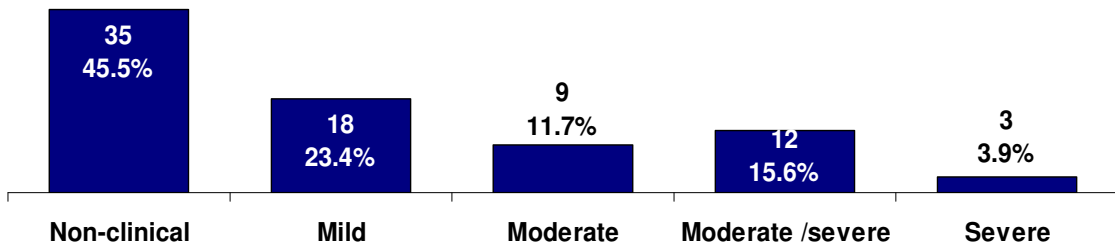


Patients by PHQ9 category for completers:

First Score (n:77)

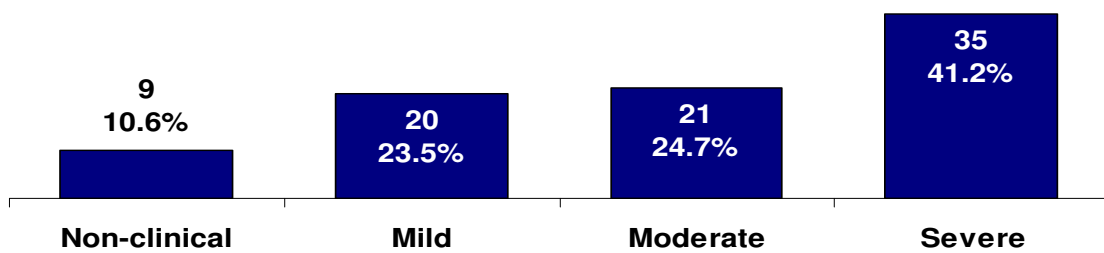


Last score (n: 77)

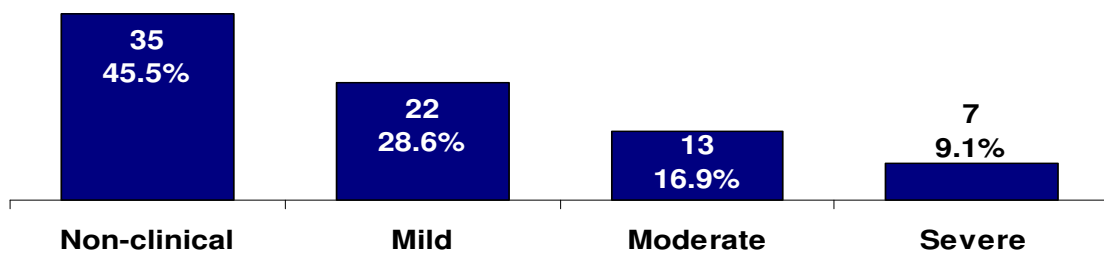


Patients by GAD7 category for completers:

First Score (n: 77)



Last score (n: 77)



Inclusion and Employment Outcomes

Work & Social Adjustment Scale for Completers (more than one appointment) N= 36

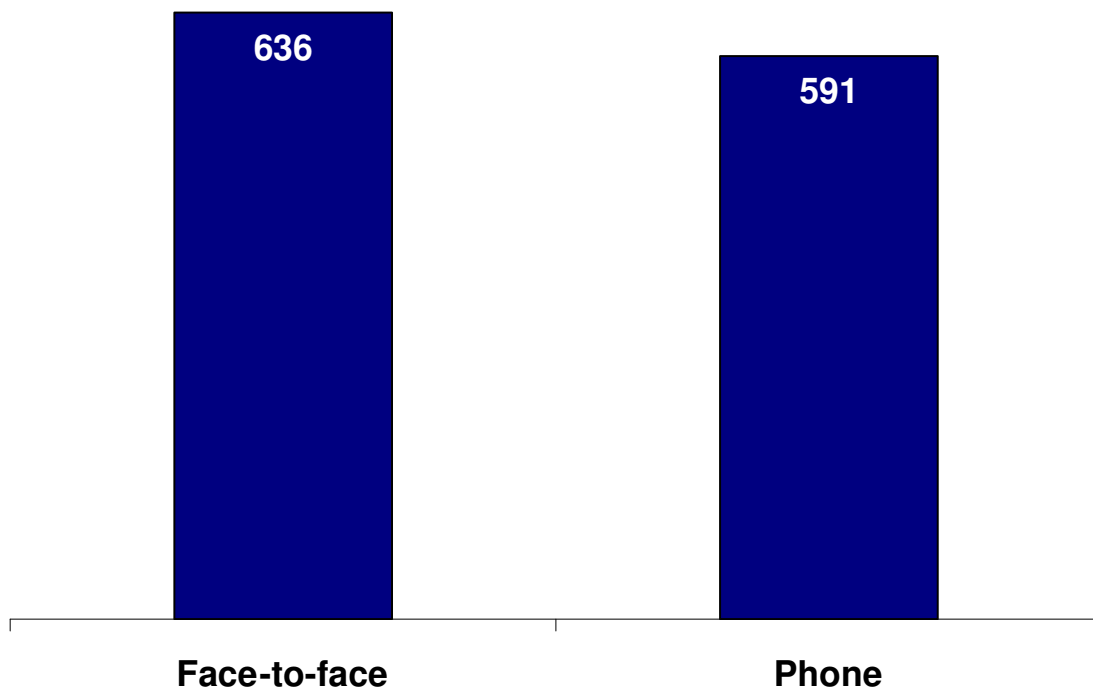
- Mean first score: 18.9 (range = 3 - 36)
- Mean last score: 11.5 (range = 0 - 30)

Inclusion & Employment Questionnaire for completers (more than one appointment) N=39

- 17.6% were on statutory sick pay at assessment
- 10.3% were on statutory sick pay at last appointment

Appointment Data

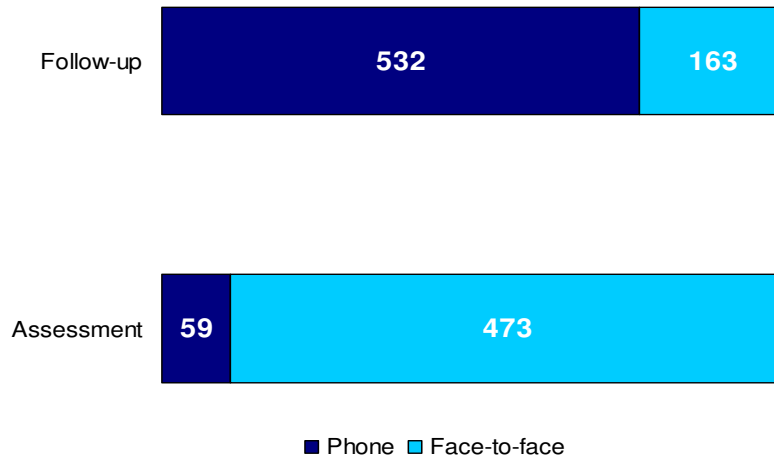
Type of contact (total appointments offered: 1227)



Appointment type by contact type

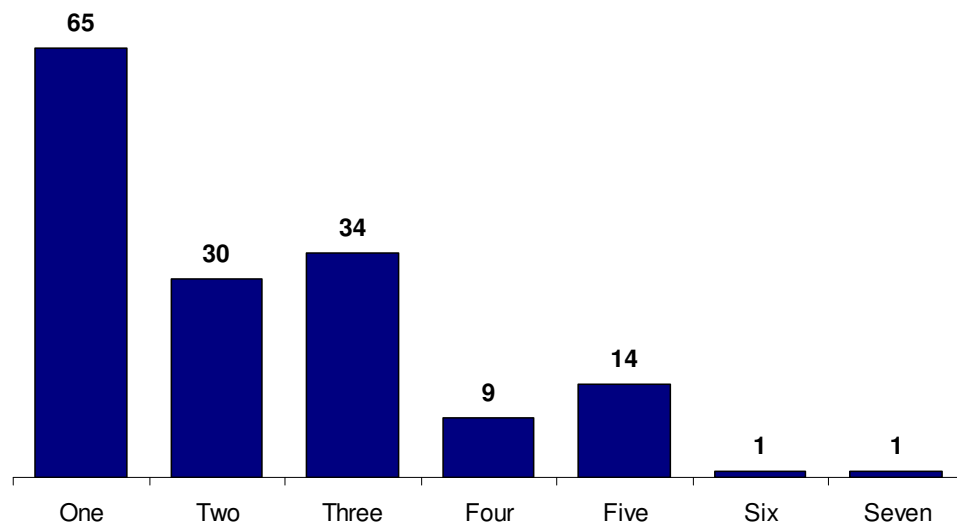
Total assessments: 532 Total follow-ups: 695

The mean length of assessment appointments was 42.5 minutes, and follow-up appointments were mean length 20.7 minutes long.



The number of appointments attended for 'Completers' (N=154)

65 completers only had one appointment and 89 completers had more than one appointment.

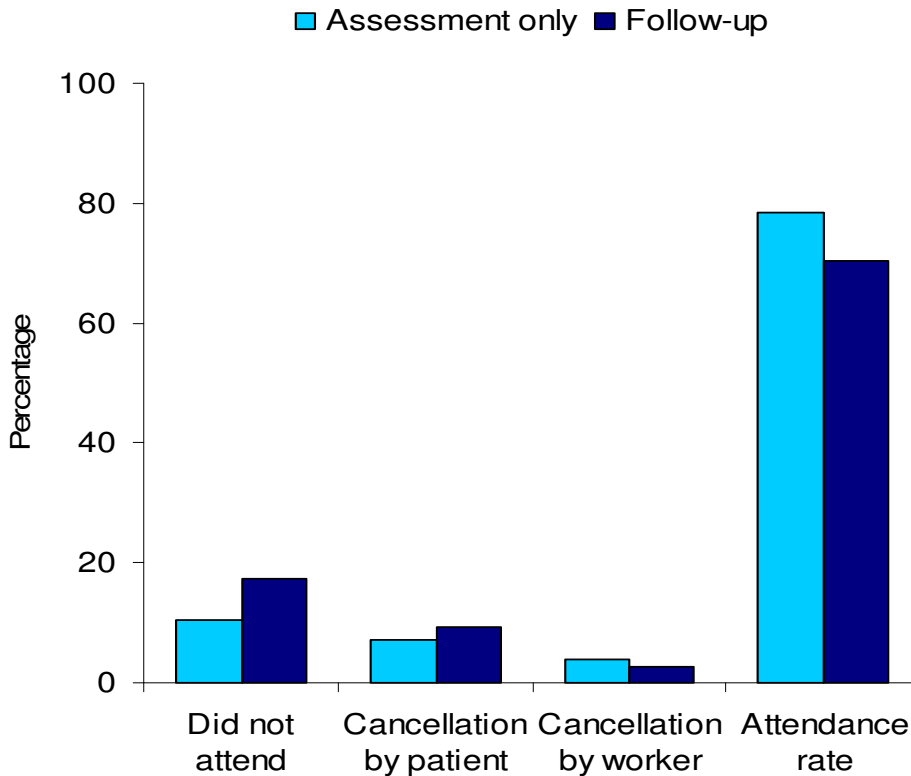


The number of patients completing intervention within 2.5hrs (150 minutes) was 148 (96%). Only six patients (4%) completed in more than 2.5hrs and the maximum hours of contact for those who completed was 4.25hrs (255 mins) and was just one person.

Appointment attendance

Overall attendance rate: 73.8%
 Cancellations by patients: 8.5%
 Cancellations by workers: 3.2%
 Did Not Attend (DNA) rate: 14.5%

Graphically this can be represented as:



Interventions Used

(Total of 905 appointments) The following table shows the number of appointments when each separate type of intervention was used. It also shows the percentage of appointments when each intervention was used.

	Number of times intervention used	% of all appointments undertaken
cCBT	118	13.0
Information Giving	284	31.4
Signposting	190	2.1
Self Help Resources	303	33.5
Bibliotherapy	96	10.6
CBT Intervention	188	20.8
TOTAL	1179	111.4

Computerised CBT

The two cCBT programmes used were 'Beating the Blues' (BtB) and 'Fear Fighter' (FF), with data up to 31st October. Of the 28 patients set up on BtB (9 male, 19 female), six presented with depression only and 22 had mixed anxiety/depression. 26 patients had only had medication treatment previously, one had had no previous treatment and one had had private counselling/therapy. A total of 108 sessions were undertaken on BtB. By the end of data collection four patients had quit and a further 12 had not logged on for a month and so 57% were labelled 'inactive'. Overall three patients completed and positive verbal reports received from each of those.

Three patients in total set up on Fear Fighter, again with data up to 31st October. All stopped using after two sessions (two patients) or one session (one patient) and remained inactive.

For Signposting the most common categories were recorded:

- Other counselling (voluntary, Relate, Cruse etc)
- Mind CBT groups
- Community Resource Projects
- LEaP employment support
- livinglifetothefull.com website
- Benefits for Better Mental Health.

12.7% of patients were stepped up to Step 3 interventions.

SECTION 3

Feedback from Stakeholders

A key part of the Evaluation of the Pilot was collecting feedback from patients, GP's, and the team of Step 2 workers. This feedback was collected through a mixture of questionnaires and meetings at each of the participating practices.

Feedback from Patients

70% of patients completed the Patient Experience Questionnaire PEQ1 at assessment, and of those 96.8% were very or mostly satisfied with time they had had to wait for their assessment.

54% of patients completed the Patient Experience Questionnaire PEQ2 at discharge

- 95.2% were very or mostly satisfied with overall experience of using the service
- 92.9% were very or mostly satisfied with the type of treatment received.
- 97.6% were very or mostly satisfied with the therapist that treated them
- 96.3% said important decisions about their treatment were made with their full involvement.

General feedback by patients was extremely positive:

- 'It has been really good and helpful, fantastic idea.'
- 'It has been excellent.'
- 'Thank you for your time, listening and offering support. Although I have not required any further help etc. during a period of my life which has been very difficult, it has been very reassuring to know you were there.'
- 'Thanks for your help in getting my life back on track.'
- 'I have suffered from anxiety for a number of years – I have tried different treatments during this time. I am really pleased with my progress over the past few months, and having the help and support [from the Mind worker] has been invaluable. He has taught me some useful techniques to help me cope with the everyday situations I was scared of. I am really grateful for his help and professional advice.'

Feedback from Participating GP's

GP's were asked to give feedback on what they liked and disliked about the service and for their views on the service response times and communication between the service and themselves as referring GP's.

What GP's Liked:

The most frequent comments were:

- Local, easy and rapid access (19)

- Speed of response (13)
- Additional treatment options (7)
- Delivering service from surgeries (6)
- Signposting, assessing social *and* clinical needs (6)
- Straightforward referral processes (5)
- Helpful for mild to moderate depression (5)
- Taking pressure off GPs, psychologists, counsellors (4)
- Filling a gap in provision for patients who fall below threshold for CMHT (4)

Some individual quotes were

- “It's one of the services that has made a difference. It's truly local... patients feel like they are being taken seriously - it is very good to have the service within the practice... This is different to the practice-based counselling... we didn't have any CBT input before so it gave us a new service, not just more service”
- ‘Valued hugely’
- ‘Accessible to both GP and patients’
- ‘We made 23 referrals – that’s 23 people who wouldn’t have had anything else’
- ‘Ideal for those with early or low grade depression and who need pointing to a particular service’.

What GP’s Disliked:

The most frequent comments were:

- No dislikes about the service (8)
- That it ended (6)
- Not running long enough to get the full benefit (4)
- Uncertainty about outcomes (3)
- Focus on phone follow up instead of face to face (3)
- Lack of cover generating waiting list build up (3)
- Insufficient time to evaluate strengths/weaknesses (2)
- Uncertainty about range of services it was offering (2)
- Referring back patients needing to be ‘stepped up’ to GP instead of making a direct referral (2)
- Service only available one session a week (1)

GP views on the service Response Times

33 made positive comments (OK, good, very good, excellent):

‘2 weeks between referral and assessment is impressive... I have confidence that if I made a referral something would happen and it would be followed up’.

5 made qualified positive comments: *‘Seemed fairly good but backlogs when worker on annual leave’; ‘Good but concern as waiting lists lengthening’.*

5 made critical comments: *'Was nothing like as initially proposed'; 'It's getting slower'; 'Slow at times of sick leave, holiday and study leave. We seemed to reach capacity quite quickly.'*

GP views on communication between the service and themselves as referring GP's

35 positive comments (OK, good, very good, excellent): *'Good simple referral methods'; 'Assessment forms come back with PHQ9/GAD scores'; 'Email referrals worked well. Good to receive feedback/updates'; 'Notes directly entered on EMIS'; 'Better than many services'.*

5 qualified comments: *'Good communication about figures, waiting times, poor communication regarding individual patients'; 'OK but variable – some letters to GP, mostly notes on the computer'; 'Maybe more direct discussions'.*

4 negative comments: *'There seems to be little. The once a month summary is not much help'; 'I don't think I had feedback on all patients'; 'Limited'.*

Feedback from the Step 2 Workers

What Step 2 Worker Liked

- The service model
- Focussed short term work and how it can make a difference
- Being involved in a new much needed service and being able to give patients the time they need to find the service/resources they need
- Gaining experience of working in a range of GP practices and feeling a part of the Primary Care team

What Step 2 Worker Disliked

- Chasing patients, limited administrative support and frustration not knowing why people drop out
- Carrying cases that were unsuitable for Step 2 with nowhere to refer them
- Managing the demand - seeing 'huge volumes' of patients,
- Spending a lot of time travelling between practices
- Supervision dictated by the PC-MIS IT system - limited opportunity for reflective practice

SECTION 4

Process Evaluation

This element of the evaluation focuses on project processes, systems and procedures and assesses their efficacy. The report identifies the key processes, makes some evaluative comments and highlights any key learning points.

Initial induction training

Intensive 2 week training organised by Oxfordshire Mind was consistent with the University of York's 'Reach Out' Low Intensity model. The training enabled the new LI team to be familiarised with the IAPT model; working in primary care; and the development of competencies around assessment, Step 2 interventions and data collection using the PC-MIS system. Feedback about the training was positive, although more input on the delivery of LI interventions (especially self-help materials) was identified. This initial training was supplemented by additional training inputs during the pilot, with all LI workers accessing places on the regional IAPT training in November.

Learning Points: Consensus that a minimum of 2 months is required to bring a new worker up to speed and the recognition that participation in regional IAPT training can absorb at least 2 days a week (2 week block followed by one day a week, plus study time during term time), with implications for workload and activity levels.

Engagement with GPs and collaboration

The team undertook concerted awareness raising with participating GP practices to promote the service model and engage GPs in the pilot. Initial reactions to the pilot were mixed but the team developed good working relationships with GPs. By the end of the pilot every GP practice had referred patients, in spite of huge variations in referral rates. Team members reported that the appropriateness of GP referrals improved as the pilot developed. Evaluation meetings with practices and a large number of returned questionnaires indicate that GPs valued the service and the way it was linked to their practices and were positive about the communication and working relationships which were established with the pilot. Both GPs and the team members have indicated that more time for face to face discussions about patients would be useful.

Learning Points: The importance of investing substantial time developing collaborative working with GPs and counsellors from the inception of the service and the need to maintain ongoing communication channels. A recognition that GPs have a major role facilitating patients' access to psychological services and the importance of engaging with PBC consortia. From the delivery side, the need for LI workers to have a high level of communication skills.

Access arrangements for Patients

Each worker was allocated to around 5-6 GP practices and was able to offer (on average) a regular half-day session once a week. Patients identified the “local”, “easy” and “rapid access” features as a major benefit of the service model, with some patients identifying location as the reason for attending appointments. Feedback from GPs indicated that they valued the practice-based approach, as did counsellors who were attached to GP surgeries. Disadvantages of the service model included a large proportion of staff time being absorbed by travelling between surgeries and the limited number of sessions per week available to patients. The pilot was unable to offer an out-of-hours service.

4.5% of patients referred were of non-white origin. Health Community Development Workers (CDW's) felt that the pilot should offer open access and self-referral, with sessions in both GP surgeries and community settings to give patients more choice.

Learning Points: Given the number of participating surgeries (22) and the staffing resources available, the maximum number of half-day sessions a LI worker can deliver across GP surgeries under this service model is 5. In addition, workload analysis indicated that it is only realistic to offer 3 assessments per session. If GP practices in specific localities are prepared to co-operate (enabling us to offer LI services from one GP practice or a neutral community setting), the number of half-day sessions in an area could be substantially increased. Self-referral may need to be encouraged in BME communities in any future service model, requiring a proactive outreach in collaboration with CDWs.

Information and Publicity

Information about the service was produced for patients and referring professionals and set out the key stages of the patient pathway and timescales for assessments and Step 2 treatment. Feedback from GPs and patients indicated that the information was clear and self-explanatory.

Learning Point: Face to face communication with referring professionals needs to complement the production of good quality information.

Eligibility Criteria

The service was open to all patients in targeted areas experiencing mild to moderate depression and anxiety, who could benefit from Step 2 interventions. The eligibility criteria were set out in promotional material and reinforced as LI workers engaged with GPs. During the course of the project staff have reported that GPs have increasingly made appropriate referrals. The service has not supported people receiving Step 4 CMHT services, patients with severe and enduring mental health problems, patients in crisis or people at risk of suicide and self harm. However it has been able to offer a service to patients whose primary treatment may need to be at Step 3, but who needs help with a specific issue (e.g. signposting). However, in the absence of Step 3 provision, the pilot has been careful not to maintain patients needing Step 3 services as this blocks system throughput. Some issues also arose around people whose primary problems were long-term conditions (chronic

fatigue/pain) rather than mental health, and the role of the Step 2 service in the light of waiting lists for some specialist services. There is a view that Step 2/3 may have a role to play.

Learning Points: Engaging with GPs in the early phase of service has enabled GPs to make appropriate referrals. Service gaps at Step 3 or specialist services should not be absorbed by Step 2 as it skews the service.

Referral processes

Feedback from GPs indicated that the referral processes were clear, simple and straightforward, with GPs making informed decisions and referring appropriately. Referrals by email were deemed the most efficient by LI workers, with all GPs having access to secure NHS emails. Workers became more confident about referring patients back to GPs when they were inappropriate and not holding on to patients requiring Step 3. Referral figures were set on a monthly basis per practice by consortia, breaking down referrals per 1000 patients.

In terms of onward referrals from Step 2-3 the pilot worked on the basis that any 'stepping up' would be routed via the patient's GP. Feedback suggests that most GPs are happy to encourage the LI workers to make direct referrals from Step 2-3, as long as GPs are consulted. A number of GPs funnelled all their patients through Step 2 (the pure stepped model), with implications for counselling, with others arguing that patients should be referred immediately to the appropriate Step (the allocation model).

Learning Points: As above, experience highlights the need for good communication by LI workers with GPs and Practice Managers to reinforce referral procedures. A sustained period of activity over 6 months has now enabled us to identify referral trends, patterns and workload implications. There is real scope to encourage Step 2 referrals from other Primary Care staff and the development of self-referral. The service may be improved if all new patients are subject to a quick telephone screening process, which will ensure that patients are seen as soon as possible at the right step.

Contacting the Patient

After GP referral, the system was for the LI worker to contact the patient within 3 working days to make an appointment at their local GP surgery and for them to be seen within 10 working days. Patients were encouraged to pick up a 'Patient Pack' from their surgery, consisting of explanatory information and the MDS (Minimum Data Set) Questionnaire to complete prior to assessment. Sometimes the GP would pass on this pack. In some cases it was sent by the LI workers. The team have reported that a high proportion of patients were difficult to contact by phone to arrange appointments, requiring letters to be sent out and a number of follow up letters.

Learning Points: The team achieved the service standard of contacting patients within 3 days, which seems realistic, but the mean time from referral to assessment averaged 17.9 working days (IAPT target 14 days/10 working days). There needs to be recognition that there are factors outside our control. Patients do not always

answer phone calls and have to be followed up a number of times, which generates service inefficiencies.

Assessment process.

The pilot has attached great importance to the standardised assessment process to identify primary problems, their impact and areas of change and to explore if Step 2 treatment options would be useful and appropriate. The assessment process has been informed by the MDS (Minimum Data Set) Questionnaire as a key assessment tool. Staff have developed their confidence and skills around assessment, delivered in the main face to face but with some telephone assessments undertaken. If patients are appropriate for Step 2 a choice of treatment has been offered with arrangements made to take it forward. After assessment, a summary sheet has been sent to the referring GPs, identifying treatment plans or recommending a higher intervention at Step 3/4 or other specialist treatment. The team have had to work very productively to undertake all the core components of the assessment process (including succinct recording) within a very tight timeframe.

Learning Points: The maximum time for a thorough assessment is deemed to be 45 minutes. Patients tended to opt for face to face assessments, with patients appearing to value the sense of personal connection and engagement with the LI worker. The investment in thorough assessments seems to pay dividends, with some patients being discharged post assessment or only needing one follow up intervention. There is a view that that the assessment is a therapeutic tool in itself for some patients and the time given to it should not be compromised. Completion of MDS prior to assessments aids efficiency but we need to recognise the needs of patients with language or basic skills needs.

Treatment interventions

The team supported patients with a range of NICE compliant LI interventions with all treatments delivered under clinical supervision, including information, problem solving and goal setting, CBT guided self help, behavioural activation, Bibliotherapy, cCBT, 'Exercise on Prescription', signposting to other services (benefits, training, employment housing, leisure) and access to Mind CBT groups. After identifying the treatment option(s) at the assessment phase face-to-face, follow-up has predominantly been undertaken by phone. Although the team report that they have gained confidence delivering the interventions they feel they could have benefited from more guidance and training on CBT guided self-help.

The pilot has actively supported and promoted the 'Books on Prescription' service in local libraries and raised awareness about eligibility criteria for the 'Exercise on Prescription' scheme with a number of GPs. Over 25 patients were set up on cCBT and were offered a programme of short-term telephone support. The preferred system was 'Beating the Blues', although in September a small number of patients were set up on 'Fear Fighter'. The benefit of Fear Fighter is not evident with all 4 patients who were set up, dropping out after a few sessions. A number of GPs have been very positive that the pilot has enabled patients to access and benefit from cCBT for the first time, with the clinical help available to support this new service. An issue relating to CMHT patients' access to cCBT emerged during the course of the pilot. There were a small number of referrals specifically for cCBT of CMHT patients

who were being seen simultaneously at Step 4. Technically these patients were ineligible to access a service from the pilot given our exclusion criteria, but it was agreed to make an exception, given the very small number of patients involved.

A number of GPs have valued the benefits of signposting as a valued additional service, complementing the LI psychological therapeutic inputs. The team has worked closely with the 'Benefits for Better Mental Health' project, Restore and a range of other providers, with staff comprehensively mapping local services to support the improved social inclusion of patients. Where appropriate patients have been linked into Oxfordshire Mind Community Resource Projects and much scope exists to facilitate this kind of access.

Learning Points: There needs to be more training inputs for LI staff on CBT guided self help. It has been established that one-to-one groundwork and follow-up work (3-4 contacts) is vital to support the effectiveness of cCBT and maximise patient engagement. Securing 'administrator status' for 'Beating the Blues' is essential to ensure that patients are properly monitored and that risk alerts are not missed. There is a need to strengthen the partnership between the OPCT and the Library service to extend the 'Books on Prescription' scheme countywide and publicise and extend user-friendly titles. All books, booklets and websites used in the pilot need to be reviewed to evaluate their efficacy. The signposting component of the service is valued as an adjunct to low intensity treatments and a number of GPs have indicated that it provides much needed information about local resources available to patients.

A flexible stepped care model

Within the IAPT stepped care model there are two operating models. The first is the 'stratified model' where all patients are seen at Step 2 and are then stepped up as necessary to higher intensity services. This is in contrast to the 'allocation model' where a patient bypasses Step 2 and is referred directly to higher intensity support. In practice, the pilot operated both these models and worked flexibly with GP preferences.

Learning Points: The pilot has underlined the need for flexibility in relation to the application of the stepped care model.

Maintaining patient contact and preventing DNAs

The service experienced an overall 14% DNA appointments rate. We understand that rates are not dissimilar to counselling, with some GPs telling us that there are always DNAs in Primary Care services. Non-engagement, cancellations and missed appointments impact on service productivity and we need to undertake a follow up analysis of why people DNA. One LI worker said it was demoralising when patients just dropped out, not knowing why and how the service could be improved.

Learning Points: The reasons why people are failing to engage is currently unknown and some follow up work is required to identify the issues/ barriers for non-participating patients. The LI workers have identified a number of possible explanations (e.g. the service is not right for the patient; disappointment with the options available – e.g. wanting more groups or 1:1 CBT; not finding it helpful; anxiety about seeking help; personal chemistry with the worker; not being ready to

make changes; the worker not understanding the patient's difficulties; the patient starting to feel better; the assessment giving them a way forward). At a practical level in the future phase of the service we may need to consider alerting patients by text about their upcoming appointments.

Liaison with GPs through treatment

A high proportion of GPs were positive about the quality of liaison and communication offered by the service. Post-assessment GPs were sent summary sheets and patient information was entered on to the EMIS system (where possible), enabling GPs to track their patients' progress. Any concerns about potential risks to patients were immediately passed on to GPs. The pilot communicated regularly with GPs, sending monthly summaries to each surgery about the number of referrals, caseloads, number of patients completing treatments and updates on waiting times. Some GPs felt that more ongoing information was required about individual patients. Workers informed GPs when patients were discharged or referred them back to GPs if they felt a patient needed 'stepping up'. As the project progressed some GPs indicated that they would be happy for LI workers to make referrals directly to Step 3 if they were consulted.

Learning Points: The need to keep channels of communication open with GPs has been established. Some GPs want reports on patient progress during treatment, and weekly summaries have been suggested. Recognising that some GPs want to make the decisions about 'stepping up their patients', while others are prepared to offer LI workers some limited autonomy to undertake this.

IAPT Data collection

It was a requirement of the pilot to encourage all patients to complete the full set of questionnaires (the Minimum Data Set) at the beginning/completion of treatment, with key clinical measures recorded at every sessional contact (GAD-7 and PHQ-9). This data and the assessment and treatment notes were inputted into the PC-MIS, which is a secure web based system. Patients offered their co-operation and took on board that fact that the data set could support clinical decision making, monitor patient progress and evidence efficacy. Initially there was real concern that the MDS requirements would be a barrier to patient involvement but most patients have seemed happy to complete forms. Although the team got up to speed very quickly with PC-MIS system, data inputting was deemed to be very time consuming (the terms 'tedious' and 'horrendous' were mentioned). PC-MIS also delivered less than it originally promised and displayed a number of weaknesses. Contrary to expectations the first version of PC-MIS was not able to generate standardised template letters, and the team had to supplement PC-MIS with their own database (in order to collect data at the end of the month). It is hoped that the new version of PC-MIS (V2) will iron these problems out. We did not meet targets on the completion of questionnaires and 'missing data' is a problem. Staff reported that it was difficult to get feedback forms and exit questionnaires. PC-MIS has real value as tool to collect (and analyse) data, as well as supporting casework and supervision, but we need to ensure that any upgraded system is fit for purpose.

Learning Points: There is a need to ensure that the questionnaires are revised, as

they are currently repetitive, with some of the questions difficult to understand. We propose that non-essential information is removed. There is consensus that data collection does inform the clinical assessment and helps monitor progress. The data system needs to deliver against expectations or additional administrative burdens are placed on staff. Data inputting is labour intensive and this needs to be factored into workload planning. There is a need to ensure that MDS questionnaires are completed in advance of assessment to improve efficiency.

IT systems

Laptops, secure NHS emails and internet access (via dongles where internet access was unavailable at surgeries) have meant that LI workers have been able to work peripatetically and input/ access data as they have undertaken half-day sessions across the target area. This has greatly enhanced workers' productivity and supported efficient data management. The NHS email has provided secure means of transferring patient information to GPs, although some GPs do not yet have secure systems themselves. Where communication systems were secure, patient notes were entered on to 'EMIS' and 'Vision' at assessment stage wherever possible. However GPs would have to await a discharge summary at the end of treatment to track how their patients had progressed.

Learning points: ICT has greatly enhanced the delivery of the service indicating that laptops, remote internet access and secure NHS email accounts are a prerequisite of any future IAPT service.

Supervision processes and case management

All team members worked under the clinical supervision of the Project Manager who is a trained psychologist. The demand for the service has meant that workers had very high caseloads (up to 80; IAPT suggest 45) and this put pressure on supervision capacity. Supervision is dictated by the PC-MIS system, which necessitates reviewing large numbers of patients on the caseload on a weekly basis. LI workers have sometimes felt that discussion of individual client needs is not sufficiently in-depth given the volume of patients. One-to-one supervision has been complemented by group supervision with Dr Denise Barulis, which provided some opportunity for group support and some reflection on practice. During the course of the pilot the Project Manager has undertaken 2 days of IAPT supervision training from the 5-day training package. She believes that a dedicated LI clinical supervisor is required to manage a LI service. She feels that it requires a different 'mind set' and supervisory competencies from those needed at Step 3. The Project Manager was supervised by Linda McDiarmid. To deliver the pilot substantial management inputs were required from Linda, given the complexities and challenges of delivering the service.

Learning points: Recognising that the way the PC-MIS system is configured means that intensive supervisory inputs on a weekly basis are required to discuss high volumes of cases. There is also a need to build in time for more 'in depth' reflective practice and learning based on realistic caseloads.

Capacity and demand management

The pilot quickly generated high levels of demand on account of high levels of unmet need. Capacity was tested within a few months of the service being operational on account of the time required for data entry, administration and GP liaison. In response, the number of surgeries some workers covered was reduced (from 6 to 5), with attempts made to reduce the number of assessments booked in each session from 3 to 2. The latter aim was not consistently achieved. Although there was some slippage in timescales from first contact to assessment a mean of 17 days was achieved. Individual surgeries were alerted where backlogs and delays were anticipated and at one point referrals were suspended pro-tem at Hightown, Banbury (where appointments were being booked 7 weeks ahead). At some surgeries there were up to 4-week waiting lists. Delivering a service with a small team of 4 workers was a real challenge when staff were on leave or on sick leave, leading to a build-up of workload and longer waiting times for assessment and treatment interventions. The Project Manager describes the pilot service as “high octane, high activity throughput”, with little capacity to respond to contingencies. When staff were off sick, the Project Manager needed to have access to team members’ diaries to alert patients about the cancellation of their appointments but was not in a position to reschedule them. A centralised booking system would overcome these problems and this is envisaged in the next phase of the service. As the PC-MIS system is structured around weekly supervision, staff absence has meant that the number of cases discussed in supervision increases dramatically with implications for quality standards.

At the mid-point of the project there was some discussion in the Steering Group about improving worker productivity, including reducing time for assessment (and recording), tightening eligibility criteria, more telephone assessments and limiting feedback to GPs. It was felt that implementing these proposals would compromise the quality of the service.

Learning Points: Experience in the pilot highlights the need to build in staff cover for leave /sickness and the need to be realistic with GPs about the number of referrals that can be made in the light of resources available. It is proposed that in the future GPs are given indicative allocations of patients they can refer on a monthly basis, based on their patient practice populations. There would be flexibility to accommodate additional patients needing treatment, especially if take-up was lower elsewhere. If not, it is proposed that patients would go on a waiting list. This approach would provide transparent targets for staff, clarify service capacity for GPs and provide a benchmark to manage the service. This will ensure that the service is not overloaded and that GPs and patients do not lose confidence in the system. Managing staff sickness and leave has underlined the need for a centralised booking system so appointments can be re-scheduled.

‘Stepping up’ and the interface with Step 3

The stepped care model is predicated on throughput to Step 3 if the patient needs this type of intervention. In the absence of a parallel Step 3 service the pilot operated to a greater extent as a stand-alone. However, the pilot established good working relationships with colleagues at Step 3 (counsellors and psychologists) and where

there was capacity 'stepping up' worked well with a significant number of referrals made. However in a number of surgeries there was no access to psychology services, and in many cases where counselling was available there were substantial waiting lists. This created bottlenecks for the LI pilot and hindered patient throughput. In a number of cases the pilot received appropriate referrals from Step 3 and on occasions it offered LI support while patients waited to access Step 3 support. There was a view that in doing so the pilot was hiding deficiencies in the system and that this should not have been offered.

Learning Point: The pilot has established real gaps in Step 3 services. For the stepped care model to work this needs to be resolved in the next phase of the service.

Clinical Governance processes, risk management, data management processes and client confidentiality

The pilot was delivered in accordance with the 'Caldicott Guidelines' with the Director of Oxfordshire Mind and the Project Manager designated 'accountable officers' on all matters relating to confidentiality and safe handling of data. Ensuring that our Information-sharing systems were in compliance with PCT guidelines was a major undertaking and very labour intensive. Given the resources available to the pilot investment in this area was not sufficient and needs to be prioritised in any future service. A risk register was formulated and agreed by the Steering Group and a lone worker policy was developed. Governance for the pilot was provided by a multi-agency Steering Group (OPCT, Oxfordshire Mind, CSIP and local GP representation), that received monthly reports about clinical governance processes and took corrective action as necessary. Clinical governance and good practice was informed by Helen Turner from CSIP.

Learning Points: The above processes need to be robust and our systems were greatly enhanced by support received from support staff at the OPCT. However, governance systems, especially around issues like data management will need to be watertight.

Joint working with Primary Care

The delivery of the pilot was a productive collaboration with the PCT at strategic and local level. The Commissioners of the pilot played a key role in the Steering Group, overseeing its delivery. They were also very proactive in liaising with GP practices to embed the LI service and made a number of practical interventions to secure access to the NHS email system and unblocking problems. At a local level GPs, Primary Care colleagues and PBC consortia had a critical role in the successful delivery of the pilot, 'making things work on the ground' (e.g. providing premises, engaging with the pilot and proposing improvements).

Learning Points: The pilot has demonstrated the benefits of this IAPT partnership with the OPCT. For the future IAPT service to be successful will require the collaboration of the PCT Commissioners and their colleagues, GPs and the PBC consortia.

SECTION 5

Final Comments and Key Points of Learning

Oxfordshire Mind were pleased to be given the opportunity to set up the first 'Step 2' IAPT service in Oxfordshire. This evaluation report of that Pilot Project certainly indicates that the work has been successful and made a significant difference to a great many patients referred by all the participating GP practices. The credit for this achievement should go to the small team of workers who have been out there doing the work. But tremendous thanks should also go to the Primary Care Trust and the 22 GP practices who have worked with us.

The Pilot experienced high rates of referrals by GPs and other health professionals. There were 648 referrals in 5 months and feedback indicates that the quick and easy referral routes were appreciated and helped extend access. The Pilot has revealed that there is much scope to extend the reach of the service to a more heterogeneous population in terms of ethnicity and age.

Significant numbers of those referred had severe difficulties with depression being the most common reason for referral. The data reveals a positive impact on mental health including reduced levels of depression and anxiety. The results also indicate that the targets set for the time from first referral to assessment and the duration of the intervention have been achieved. Both of these appear to contribute to the largely positive patient and stakeholder feedback and a strong desire to see work continue.

The *overarching objective* for the pilot was to create the fertile conditions for the development and embedding of stepped care in Oxfordshire. The Step 2 Pilot has come to an end and plans are advanced for training up new workers and developing an IAPT service that will cover the whole county. The Pilot has certainly helped create establish 'fertile conditions' for Step 2 to be a vital and integral part of the development of IAPT in Oxfordshire.

A final comment from a participating GP:

"The service has proved extremely useful. I think it stands a chance of making a real difference to mental health management. I am very disappointed that the pilot time has already come to an end and I would be very keen to have such a service offered to my patients in the long term. It is one of the most positive innovations in primary care in along time. Please can we have it sustained".

SECTION 6

Acknowledgment and Thanks

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Mind Step 2 Low Intensity Manager:

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Windrush Surgery
West Bar Surgery
Deddington Health Centre
Bloxham Surgery
Wychwood Surgery

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Blackbird Leys Health Centre
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