Yorkshire and the Humber IAPT Providers Network

Minutes
2 May 2018, 09:45-15:45
Novotel, Leeds

No.	AGENDA ITEMS	Action By
1.	**Welcome, Apologies and Introductions, Minutes from the Last Meeting (07.02.18) and Matters Arising, Andy Wright, IAPT Advisor, Yorkshire and the Humber Clinical Networks** Andy Wright welcomed everyone to the meeting and conducted introductions around the room focussing on what people wanted to get out of the day. Andy Wright thanked attendees for their input and gave especial thanks to the guest speakers. The minutes of the last meeting were reviewed and accepted as a correct record. The actions from the last meeting were also displayed to the attendees and attendees were advised that all actions had been completed. Andy Wright invited everyone to enjoy the day, take the time to reflect and share best practice.	
2.	**HEI Update, Steve Kellett, University of Sheffield** Steve Kellett presented to the attendees on the current training demands and future commissioning intentions for IAPT training. Steve Kellett outlined the current courses and what trainees received as part of the courses. Steve also explained the recruitment process and reiterated to the attendees that in terms of commissioning HEE would pay course fees but CCGs were expected to pay salary support. Steve Kellett encouraged all attendees to put in expressions of interest for the training. Please see the presentation slides for more information. **Questions and Answers:** *Question:* What is the LTC training for HITs? *Answer*: There is a 10 day national curriculum, which will be delivered across 2 cohorts. As the training is so new each HEI is currently able to take a lot of judgement calls in how the training is delivered, however, the focus of the training needs to be on bio-psychosocial interventions. For the previous cohort we ran the main lectures jointly with PWPs and HITs and also did some separate work. The training was spaced over a number of days. Attendee feedback indicated that people were pleased with the course and felt it gave them the necessary skills. For any further information please email s.kellett@sheffield.ac.uk. *Question:* Is the current expression of interest with the deadline of 11th May for both the October 2018 and March 2019 cohorts? *Answer*: Yes. So please put in expressions of interest for both just take your best guess on what you might need for both. *Question*: You mentioned that there is a desire to train HITs at a rate of two to	

	one to PWPs but this is not reflective of the of the turnover of staff and the increase of CBT therapists will drain the PWP pool. Is this not just going to create a huge crisis for PWP roles? *Answer*: No one in HEE or NHS England has been able to provide a rationale for the focus on HITs over PWPs. However, as a University we will be seeking trainees from a range of backgrounds, not just from the current PWP staffing. *Question*: Is there an increase in demand for the supervisors' course? *Answer*: Yes. We have just started a course and there will be another cohort before Christmas. However, I don't think it is in response to this issue it is more about services wanted to ensure they upskill their current staff. ***ACTION: Sarah Boul to send a reminder of the IAPT training places expressions of interest process and encourage attendees to submit expressions of interest.***	**Sarah Boul**
3.	**IAPT PRN Research Projects and Findings Update, Jaime Delgadillo, PRN** Jaime Delgadillo presented to the attendees on a recent piece of research focussing on improving psychological treatment outcomes using prediction and feedback methods. The research was a multisite trial and concluded that outcome feedback can help to identify and to address obstacles to improvement. Please see the presentation slides for further information. **Questions and Answers:** *Question*: When you looked at people not on track were there any emerging themes about why they were not on track? *Answer*: Yes, there is some literature on this. A previous study shows patients not on track have specific characteristics such as, socioeconomic deprivation, severe functional impairment, co-morbidity, personality traits including impulsivity, independence, suspiciousness etc. The Clinical Support Tools model that has been developed in the US has also looked at motivational deficits in therapy and has concluded that motivational interviewing may help with this. Break down of therapeutic alliance can also contribute to off track patients and this needs to be recognised and worked on. Social support deficits also contribute for example, people living alone are more likely to be off track and adverse life events including relationship breakdown, redundancy etc. also contribute. *Question*: Is the outcome tool something available on PCMIS? *Answer*: The outcome tool is now embedded in PCMIS and will be fully rolled out. We hope to advance models in other systems too. *Question*: Does the feedback need to be supported technologically? Could it be supported via a paper based system? *Answer*: No the feedback system does not need to be electronic. The idea of the system comes from a paper based idea in the first place. A little like the growth charts for a baby paper based charts for outcome feedback could be used. I currently have an MSc student redesigning the outcome feedback graphs and	

	once this work is complete we want to publish online for people to download for free and use. *Question*: How many patients were used to track the normal on track patients? *Answer*: Cases have a shared starting point from a sub-sample based on their starting point so each cluster has a minimum of 100 patients, the technology for this trial was for 1500 cases but the new trial is for 20,000 patients across 8 NHS trusts. *Questions*: Do the confidence intervals change? *Answer*: No. However, we are developing a feedback tool that will undertake machine learning and then the curves will be auto changing based on patient behaviour. The tool will learn from the patient's feedback. However, this will take a long time to fully develop. ***ACTION: All services who would like to get involved in trials going forwards please email Jaime.delgadillo@nhs.net.***	**All**
4.	**Training IAPT Staff to Deliver Mindfulness Based Cognitive Therapy, Paul Bernard, Consultant Psychiatrist, TEWV** Paul Bernard presented to the attendees on mindfulness based cognitive therapy (MBCT) giving an overview of the development of this and the evidence base for it. Paul Bernard also advised the attendees of the MBCT implementation milestones and gave an overview of the IAPT MBCT training. Please see the presentation slides for more information. **Questions and Answers:** *Question*: When we became aware of MBCT in IAPT there was a sense that it might not have felt a comfortable bed fellow. Could you say how and where you see this intervention landing in IAPT going forwards? How can we instil it? *Answer*: Some services have successfully implemented it and the main use of this intervention is for relapse prevention. It is not an initial treatment; the recommendation would be to go to CBT and medication first. However, if the patient has recurrent depression then MBCT may help with relapse prevention. MBCT is a group format intervention, which is cost effective and already used in many IAPT services. A course can have 15-20 people and it is a great alternative therapy, as it is broad ranging and targets certain psychological issues. The therapy changes relationships and people, they find it helps broader change and not just change in mood. In the secular world in which we live some people also find it gives them meaning. MBCT compliments CBT. *Question*: Is there any thought about supervision needs outside of the course if there is no senior mindfulness practitioner in service? *Answer*: For MBCT we don't have the same level of supervision as for CBT but there are national guidelines and there are supervisors and a panel of supervisors available nationally. We are keen to promote clinical guidelines on this and in the North we are developing a network to improve standards and quality.	

	Question: In Leeds we are running some MBCT for relapse prevention and outcomes are good. Do you think MBCT will feature in the next NICE guidelines as a treatment? *Answer*: MBCT is in the NICE guidelines for relapse prevention but it is hoped in the new version that it will be recommended as a treatment.	
5.	**A Strategic Vision for Workforce Wellbeing in IAPT Services: Table Top Discussion** Andy Wright introduced the table top exercise on workforce wellbeing in IAPT services. All attendees were asked to work on their tables and consider the following questions in regards to workforce wellbeing: 1. What are you doing to support wellbeing in your services? 2. How do you manage your own wellbeing as managers and senior clinicians? 3. How do you support the wellbeing of your staff? 4. What could the Network do to support you? Following the table top discussions Andy Wright asked for feedback on each of the questions. The following points were given: 1. Wellbeing champions are in post, external training provider involvement for wellbeing in IAPT and across the Trust, team time out, team lunches, have clinicians in an environment where they can be together and connect. 2. Quite strikingly we didn't come up with much we realised that we focus on looking after everyone else and not ourselves. Our leadership team have a wellbeing activity at the start of each agenda, it is possibly more symbolic than helpful but really pushes home the message about modelling behaviour. 3. Letting staff know where they can access support to look after their own wellbeing, send communications about the IAPT service in trust, conduct some specific work with individuals to change their work around and put in place some peer support such as having a team lunch, being available at any time for all staff, offering morning mindfulness classes for 8 weeks. 4. A voice back to NHS England to challenge the target culture, place more focus on PWPs and challenge the culture that HITs are the preferred staffing for IAPT services. PBR is stressful and so more help on resilience would be welcome. Create a charter or statement to say people should attend to wellbeing in services. More promotion of good practice and less focus on targets, focus on delivering services and supporting wellbeing. Also provide encouragement for services to remember the wellbeing of all staff, i.e. admin and receptionists as well as therapists. ***ACTION: Sarah Boul to collate written feedback from table top discussion and distribute to attendees after the meeting.***	**Sarah Boul**
6.	**Provider Presentation: Kirklees IAPT, John Butler, Laura Firth and Nichola Hartshorne, Kirklees IAPT** John Butler, Laura Firth and Nichola Hartshorne provided the attendees with a	

	presentation about their service. The presentation covered work the service has done to increase access, work on data cleansing and also work undertaken by the service to focus on wellbeing. Please see the presentation slides for more information. **Questions and Answers:** *Question*: When you started to look at your staff performance what did you look at and how did you respond to variation? *Answer*: We found that people were surprised by their data. IST stated that as a service we have to achieve 20 actualised contacts per week for HIT and people were surprised to realise from the data that they did not have 20. The stark reality of the data shocked people. The leadership team appointing to the Data analyst post has meant we have achieved a lot, we have to use Rio for reporting but we are moving on to PCMIS and will use more real time data to identify variation and then we can work to reduce this. Having a data analyst is one of the most significant things we have done and it has helped us to identify issues and then put in place supportive measures to help staff achieve. *Question*: You mentioned that you did a recovery workshop. How did you get people to shift to using the measures collaboratively? *Answer*: We did an experiential exercise by filling in the measures ourselves and then reflected on the experience for clients and how we could frame a conversation about the measures. The measures were introduced as a symptom review tool. *Question*: You are the first service I know that has a Step 2 manager how does this work? *Answer*: We inherited this role we didn't create it but it works really well. Having an experienced and dedicated team manager just for Step 2 works well. The staff benefit from that direct input and having a manager to communicate with the HIT lead and Clinical Lead ensures the PWPs are integrated into the wider team. *Question*: Do you work as a leadership team or do you have any overall manager to make decisions? *Answer*: We meet weekly and we make decisions collaboratively. We don't always agree and we have different ideas but we are all working towards the same goal which helps. We are open, honest and transparent and there is a cabinet collective in that decisions can be made on a majority. Nichola oversees the whole service but everyone across the service is informed and involved. *Question*: Why do you run the courses that you do and what are your numbers like? *Answer*: We had huge waiting lists and so to reduce them we trained the PWPs to sell courses in a positive way. Courses are new for us and we are monitoring recovery. We picked the courses based on staff skill sets so confidence building etc. some staff had an interest in this and wanted to lead on it. Another one had an interest in bereavement. CBT decided on their choice of courses also based	

	on staff skills and interests. Our managing emotions course is essentially an anger management course but it is predominantly for people who struggle to express anger. The feedback for this course is good. We do find that staff can be frightened of running courses but the best way to overcome them is to do them and we have to help people become good facilitators. Facilitating courses requires a skill set and we support staff to achieve this. The courses also give people a different variety of work and staff look forward to it. We have got PWPs to co-facilitate some of the HIT courses to help them learn and develop also. *Question:* Do your patients have to be assessed to attend the course? *Answer*: Yes we assess all patients before referring to the courses or other treatment. *Question*: How do you operate in terms of length of appointments etc. at Step 2? *Answer*: For a full time PWP we would expect 18 assessments and 10 treatments but if they are running a stress course this can be reduced by 2 treatments. Assessments are via telephone but people can request a face to face. The time length varies, it is roughly 45 minutes but this is because we are part of a secondary care mental health trust and so have to do the same assessment as used trust wide. However, we are trying to challenge this. *Question*: Following the work you have done to advertise the service and increase your access has this had any impact on your on your recovery rates? *Answer*: There doesn't seem to have been a significant impact on recovery, it is currently at 52%. The impact has been greatest in terms of referrals for people who are not quite right for IAPT and so we have had to conduct a lot of assessments and then signpost people on. Also clients have got more complex and LTC bring a complexity too but we have put in more supervision to help staff manage these clients. *Question*: Are you meeting your break even on your AQP contract on your groups? *Answer*: We have only just started the groups so cannot say as yet but we intend to over invite on groups to try and make up for any deficit in attendance figures.	
7.	**Senior PWP Update, Heather Stonebank, Lead PWP Advisor, Yorkshire and the Humber Clinical Networks** Heather Stonebank provided the attendees with an update on the activities of the Senior PWP Network. The presentation covered what had taken place at the last Senior PWP Network meeting, the next steps of the network including more focus on wellbeing and leadership and a reflection on how well attended the network is. Heather Stonebank then asked the attendees to complete a "Blob Tree" exercise thinking about where they would place themselves on the tree and where they would place their Senior PWPs. Heather Stonebank then challenged the attendees to conduct the exercise with their Senior PWPs in service as a means of checking on wellbeing and challenges. Please see the presentation slides for more information. ***ACTION: All to conduct the "Blob Tree" exercise with Senior PWPs in***	

	service to promote a discussion about wellbeing and challenges.	**All**
8.	**Feedback from CASPER Plus Training and Improving Access for Older Adults: Table Top Discussion, Sarah Boul, Quality Improvement Manager, Yorkshire and the Humber Clinical Networks** Sarah Boul presented to the attendees on the recent CASPER plus training undertaken with 90 PWPs across the region. Sarah Boul outlined what the training included and emphasised the focus on upskilling staff to work with older adults and people with long term conditions. Sarah Boul also asked all attendees to further consider the work they are doing with older adults and challenged attendees to take the following questions back into service for discussion: 1. What are you doing in your service to support increased access for older adults? 2. What are you doing in terms of training for your staff to work with older adults? 3. What could the Network do to support you with working with older adults? ***ACTION: All attendees to consider questions on access for older adults and feedback at the next IAPT Provider Network.***	**All**
9.	**Feedback from the National Team – BIT, Yammer, NHS Choices and Service User Involvement: Offer from the National IAPT Team, Sarah Boul, Quality Improvement Manager, Yorkshire and the Humber Clinical Networks** Sarah Boul provided the attendees with an update from the National IAPT Programme including information on work being undertaken by the Behavioural Insights Team, work on NHS Choices, how to access Yammer and the offer of support with service user involvement from the national programme. Please see the presentation slides for more information. *Question*: Is there a template that could be shared for the collation of service user feedback or further information on how a service user group could be facilitated by the national team. *Answer*: I will check with the national team and let you know. ***ACTION: Sarah Boul to enquire of the National IAPT Team if they have further information on how service user involvement facilitated by the National Team would work.***	**Sarah Boul**
10.	**Reflections on the Day and Any Other Business** Andy Wright asked the attendees to reflect on the day and asked for feedback as to whether the agenda had met people's expectations. Feedback from the attendees included: • We really liked having wellbeing on the agenda and how we can take this forward as a network. • Really helpful to share the commonalities of running IAPT services. • I have found the day revitalising. • I have taken something from every presentation and am looking forward to the next one. • Very well chaired. • Very well organised. Andy Wright thanked the attendees for their contributions and comments and	

	encouraged all to complete their evaluation forms. **AOB – HEE Training Places** Andy Wright reiterated to attendees that HEE will continue to pay for the course fees but the commitment for CCG baseline funding is the salary support. Salary support for HITs is band 6, point 21 on spine with 23% on costs: £32,675. Salary support for PWPs is band 4, point 11 on spine with 23% on costs: £23,873. Andy Wright encouraged everyone to submit an expression of interest. **AOB – IAPT 10 Year Anniversary October 2018** Andy Wright advised the attendees that in October 2018 IAPT will be celebrating its 10 year anniversary. Andy Wright asked attendees to think about how this could be celebrated and what the Network could do to support this. ***ACTION: All services to provide ideas for how to celebrate 10 years of IAPT. Please email sarah.boul@nhs.net with suggestions.***	**All / Sarah Boul**
	ITEMS FOR INFORMATION:	
	Future Meetings: The next meeting will be held in autumn 2018. A booking link and save the date will be circulated in due course.	

Summary of Actions

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1	***Sarah Boul to send a reminder of the IAPT training places expressions of interest process and encourage attendees to submit expressions of interest.***	Sarah Boul
2	***All services who would like to get involved in trials going forwards please email Jaime.delgadillo@nhs.net.***	All
3	***Sarah Boul to collate written feedback from table top discussion and distribute to attendees after the meeting.***	Sarah Boul
4	***All to conduct the "Blob Tree" exercise with Senior PWPs in service to promote a discussion about wellbeing and challenges.***	All
5	***All attendees to consider questions on access for older adults and feedback at the next IAPT Provider Network.***	All
6	***Sarah Boul to enquire of the National IAPT Team if they have further information on how service user involvement facilitated by the National Team would work.***	Sarah Boul
7	***All services to provide ideas for how to celebrate 10 years of IAPT. Please email sarah.boul@nhs.net with suggestions.***	All