Yorkshire and the Humber IAPT Providers Network

Minutes
4 October 2017, 10:00-15:30
Oxford Place, Leeds

Present:			
Surname	**First Name**	**Job Title**	**Employer**
Baker	Emma	Information Analyst	Tees, Esk and Wear Valleys NHS Trust
Barnes	Dawn	Operational Manager	City Health Care Partnership CIC
Bell	James	Team Manager	Rotherham, Doncaster and Scunthorpe NHS Foundation Trust Rotherham IAPT
Beresford	Sunita	Clinical Lead	Rotherham, Doncaster and Scunthorpe NHS Foundation Trust Rotherham IAPT
Boul	Sarah	Quality Improvement Lead, Mental Health	Yorkshire and the Humber CN
Bray - Menezes	Debi	Service Manager	Tees, Esk and Wear Valley NHS Foundation Trust (York IAPT)
Bridges	Emily	Admin Supervisor	Bradford District Care Trust
Brownbridge	Linda	IAPT Clinical Lead	Navigo (Grimsby)
Butler	John	IAPT Team Manager	South West Yorkshire Partnership NHS Foundation Trust
Callaghan	Steve	IAPT Service Manager	Leeds Community Healthcare NHS Trust
Campbell	Rebecca	Quality Improvement Manager, Mental Health	Yorkshire and the Humber CN
Collins	Mick	Clinical Lead	Insight Healthcare (Bassetlaw)
Dalton	Navneet	Analyst	Work and Health Unit (DWP)
Delgadillo	Jaime	Lecturer in Clinical Psychology/Cognitive Behavioural Therapist	University of Sheffield/Leeds IAPT
Edwards	Sharon	Senior Psychological Therapist & Step 2 Clinical	Bradford District Care Trust

		Lead	
French	Linda	Senior Graduate Mental Health Worker	NAViGO Health and Social Care CIC
Hagan	Sarah	Team Manager	Tees, Esk and Wear Valley NHS Foundation Trust - North Yorkshire IAPT
Hartshorne	Nichola	Kirklees & Calderdale IAPT HI Team Manager	South West Yorkshire Partnership NHS Foundation Trust
Harvey	Melissa	Deputy General Manager	South West Yorkshire Partnership NHS Foundation Trust
Hobbs	Alison	North Yorkshire IAPT Clinical Lead	Tees, Esk and Wear Valley NHS Foundation Trust - North Yorkshire IAPT
Holdsworth	Liz	MHAT Manager	South West Yorkshire Partnership NHS Foundation Trust
Jarman	Kevin	Employment Advisers in IAPT Initiative Lead	Work and Health Unit (DWP)
Kellett	Steve	IAPT Programme Director and Consultant Clinical Psychologist	Sheffield University and Sheffield Health and Social Care NHS Foundation Trust
Knowles	Mark	IAPT Manager	Sheffield Health and Social Care Trust
Laverie	Pauline	Team Manager	City (IAPT) Services, Bradford District Care Trust
Lee	Julie	Team Manager	Tees, Esk and Wear Valley NHS Foundation Trust - North Yorkshire IAPT
Lowe	Brigid	EA in IAPT Project Manager	North Region (DWP)
Matharoo	Rachel	IAPT Teacher	University of Sheffield
Moody	Ed	High Intensity Team leader & IPT Therapist	Turning Point Rightsteps® Wakefield
Sainty	Andrew	Team Manager	East Riding Emotional Wellbeing Service (IAPT)
Smithsimmons	Andrew	Clinical Lead	Ieso Digital Health Ltd

Speck	Ros	Performance Manager	Rotherham, Doncaster and Scunthorpe NHS Foundation Trust North Lincs.
Squires	Joanne	Clinical Lead Step 3 and 4	Bradford District Care Trust
Stonebank	Heather	Senior PWP	Sheffield Health and Social Care Trust
Wallace-Davies	Nii	Account Manager	Ieso Digital Health Ltd
Whale	Charlotte	Quality Improvement Manager, U&EC	Yorkshire and the Humber CN
Wood	Craig	Business Development Manager	Ieso Digital Health Ltd
Wright	Andy	IAPT Clinical Advisor	Yorkshire and the Humber CN
Apologies:			
Surname	**First Name**	**Job Title**	**Employer**
Barkham	Liz	Lead Psychologist; Offender Health	Nottinghamshire Healthcare NHS Foundation Trust
Carr	Jason	Senior Operations Manager	Turning Point Talking Therapies (Wakefield)
Farrington	Sam	Clinical Lead, Chartered Psychologist	Insight Healthcare
Morton	Suzanne	Turning Point, Implementation and Development Manager	Turning Point Rightsteps® Wakefield
Oxtoby	Liz	Head of Service-Clinical Lead (Adult)	Northpoint Wellbeing
Rae	Carrie	Assurance and Delivery Manager – Mental Health	NHS England – North (Yorkshire & The Humber) & Greater Manchester Health & Social Care Partnership

No.	AGENDA ITEMS	Action By
1.	**Welcome, Apologies and Introductions, Andy Wright, IAPT Advisor, Yorkshire and the Humber Clinical Networks** Andy Wright welcomed everyone to the meeting and conducted introductions.	
2.	**Minutes from the Last Meeting (24.05.17) and Matters Arising, IAPT Advisor, Yorkshire and the Humber Clinical Networks** The minutes of the last meeting were reviewed and accepted as a correct record. The actions were displayed to the attendees and attendees were advised that all actions had been completed. It was agreed that Sarah Boul would recirculate the Yammer guidance and link to the IAPT maps. ***Action: Sarah Boul to circulate Yammer guidance and link to IAPT maps to all attendees.***	**Sarah Boul**
3.	**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 the key topics discussed in the Network, learning from the network and key topics going forward. Please see the presentation slides for more information. Andy Wright advised the attendees that at the Senior PWP Network there was keenness for Senior PWPs to understand more about data and Andy Wright encouraged services to involve Senior PWPs in data discussions. Andy Wright respectfully reminded services that Senior PWPs needed support to implement the learning gained in the Senior PWP Network. Andy Wright encouraged service managers and clinical leads to debrief with their Senior PWPs following the network meetings to embed the learning back into services.	
4.	**Update from the Northern IAPT Practice Research Network, Jaime Delgadillo, PhD, Lecturer in Clinical Psychology, University of Sheffield** Jaime Delgadillo provided an overview of the publications of research from the Northern PRN for the last three years and provided an overview of two studies yet to be released. Jaime Delgadillo also provided an overview of recent research into wellbeing. Please see the presentation slides for more information. **Questions and Answers:** *Question:* Outcomes are improved with staff that are not burned out. Is there any understanding about the absence of work stress that means patients will have improved recovery? *Answer:* We don't know about the mechanism that links occupational burnout with outcomes. One possibility is that if you are highly stressed with your own individual problems your attention may be divided, you may not pay wholehearted attention to the patient. There is some research that indicates practising mindfulness may increase ability to pay attention and thus improve patient outcomes even if the therapist is experiencing work or personal stress.	

	Comment: Heart rate monitoring is an important element of measuring anxiety in therapists and this is an area that it would be interesting to undertake more research. *Response:* In some services there is a programme in place where the service has bought all staff Fitbit's to monitor heartrate against effectiveness. This kind of research may become more mainstream in the future. *Question:* Your research indicates that a burned out therapist is less effective. Have you considered that a therapist may be aware that they are burned out and this is affecting their performance? *Answer:* It could be that the therapist has noticed lower recovery rates and this subsequently makes them perform less well. However, the control in our study seems to suggest this is less likely. *Question:* We don't have a common definition of burnout and often burnout is caused by work stress and home life stress? *Answer:* Regarding a definition of burnout we can recognise it and we use a validated questionnaire that measures disengagement and burnout. However, we understand the mechanisms of burnout less - is the issue work or work and home or caseloads or complexity? The research indicates that the cause of burnout is multifactorial; we would like to follow this up further with services so please get in touch if you would like to be part of this research. *Question:* Regarding relapse prevention at Step 2 what are the implications and what are the next steps to improve this area? *Answer:* The study showed that we can identify cases at greater risk of relapse than others. To improve I would recommend checking your patients PHQ scores and review to see if they will benefit from booster sessions. Then put in place a relapse prevention blueprint and undertake activities such as reactivation of cognition, such as asking a patient to relive the worst point of their depression. If they show visible signs of distress do not discharge the patient, they require more intervention before discharge.	
5.	**Provider Presentation and Q&A: IESO Digital Health, Andrew Smithsimmons, Clinical Lead, IESO** Andrew Smithsimmons provided an overview of the IESO service and an overview of how to improve patient outcomes via the use of big data, supporting therapists and supporting therapist wellbeing and being accountable and transparent. Please see the presentation slides for more information. **Questions and Answers:** *Question:* Who are the workforce in IESO? *Answer:* Our workforce are BABCP accredited CBT therapists. People come from very different backgrounds. The largest group of therapists are NHS IAPT practitioners who also work part time with a small IESO caseload. There are also a small number of therapists who are full time IESO workers. People from different countries can be IESO therapists but this is limited to those countries that adhere to British data protection laws.	

	Question: The ability to embrace new technologies across the region is variable. How have you helped your staff to learn to work with technology or do you attract people who more naturally like technology? *Answer:* We have a dedicated team of people that provide training and we provide peer support as individual therapists. The support team is very accessible and efficient. *Question:* Regarding your completion and DNA rates how do these compare to national rates and how do you collect patient feedback? *Answer:* Both our dropout rate and DNA rate are lower, by about 2%, compared to national data. However, regarding the dropout rates it is important to note that patients are able to consider in advance if they want to start this treatment and so the people who do start treatment are already more likely to be engaged, which is a factor in our lower dropout rates. Regarding patient feedback we use the PEQ and ask for written feedback, this is reviewed all the time and is made into dashboards for all therapists to review and reflect on. *Question:* Do you triangulate recovery rates against scores and do you collect data on deprivation? *Answer:* Our data scientists would be able to give a full, comprehensive answer but nationally our cohort of patients' tend to have higher severity of depression than the national IAPT rates when we triangulate the rates against the scores. We do collect data on deprivation, we have to compare deprivation to all the treatments we deliver to ensure we are meeting patient needs.	
6.	**Progress Update on Employment Advisors in IAPT, Kevin Jarman, Employment Advisers in IAPT Initiative Lead, Work and Health Unit (DWP)** Kevin Jarman presented to the attendees on the Employment Advisors programme covering the background to the programme, models of employment support in IAPT, what the programme is hoping to achieve, the training being offered, the expectations of services and practitioners involved and what support is available. Please see the presentation slides for more information. **Questions and Answers:** *Question:* There is a clear economic rationale and a clinical rationale for employment advisors. However, there is a conflict of interest between treating a patient and trying to get people into meaningful employment. What kind of language is the best to use to get these two things to happen together in a mutually beneficial way? *Answer:* We do not have a robust data collection mechanism around this. Compelling people to take it up therapy and sanctioning them if they do not do it is absolutely not the purpose of this programme and will not happen. Accessing therapy is a personal choice. The system has created barriers for people and the language around this should to be improved as we want to do what is best to help people be well and enter gainful employment if appropriate. *Question:* When will the training for the employment advisors start? *Answer:* For the Wave 1 sites it will begin in February 2018. Unfortunately HEE	

	are unable to provide the training and so we are having to procure with a different provider, hence the delay in starting the training programme. *Question:* How will data be collected for the employment advisor trials? Will it be like the long term conditions pilot or via National data? *Answer:* Currently the KPIs for the programme are in discussion and so we are developing ideas around what the right/good outcome measures will be. We do not want to produce perverse incentives and want to collect robust but correct data. We will be undertaking a process evaluation in Spring 2018 and will conduct this via qualitative interviews. *Question:* Our service is part of Wave 1 and we have just recruited 5 employment advisors so have a 1:15 ratio. Is there funding available to take the service to the desired 1:8 ratio. *Answer:* Please contact Brigid Lowe to discuss further. *Question*: I also manage an employment support service and am flowing data to NHS benchmarking. Is there likely to be an overlap of data from the support service and employment advisor pilot? *Answer:* Please email Navneet Dalton and she will explore this with NHS Digital. *Question:* Is the 15 days national training related to the IPS training? *Answer:* Yes, it is based on IPS principals. Please review the curriculum documents, which have been circulated to Wave 1 and Wave 2 sites, for further information.	
7.	**Low Intensity Competency Project, Steve Kellett and Rachael Matharoo, University of Sheffield** Rachel Matharoo presented to the attendees on the Low Intensity Competency Project covering the aims and aspirations of the project, the competency scales developed and the outputs of the project study. Please see the presentation slides for more information. **Questions and Answers:** *Question:* How is the feedback received by people who are assessed? *Answer:* It is difficult to say but from personal experience this method of feedback is better than the previous ReachOut model, it has greater depth. *Question:* Have you used this model with qualified PWPs who were trained used ReachOut? *Answer:* We are just introducing it into live supervision now and, from a personal perspective, I have found it useful in developing my skills. It will be useful to realign people to the PWP model. I will be providing training on it with qualified PWPs too. *Question:* Do you use the model on non-qualified PWPs?	

	Answer: For qualified staff we use it to try and increase recovery rates and for non-qualified staff it is used to assess their competency. *Question:* Would you be willing to provide this presentation again but at the next Yorkshire and the Humber Senior PWP Network? *Answer:* Yes! *Question:* Would you consider developing more competency measures for other elements of the Step 2 role such as Silver Cloud? *Answer:* There is some scope for further development. *Question:* If we are assessing worker competencies this is great for development but also has implications for continued employment in terms of the measures being used as a performance management tool – do you see this happening? *Answer:* That is not why we developed it but could see that it may get used in that way. Competency is not a stable state. Competency data from trials shows people are not competent across the board and it is a variable state. However, if you undertake sampling you can identify highs or lows that could be used in performance management. Generally this is for supervision and improving treatment delivery not for performance management. *Comment*: Our Senior PWPs have been using the new framework to keep track of trainees and qualified PWPs. This framework has been really useful and I would recommend it.	
8.	**Sense Check:** Andy Wright advised the attendees that, as a Network, we have covered a wide range of topics and do not want to lose the learning from the topics that have covered. Andy Wright also advised that the Clinical Network is connected to many other parts of the system including Health Education England, the National IAPT Team, NHS Improvement, NHS England etc. and want to ensure that information is shared. With the former in mind Andy Wright provided a brief update/check in on the following: • **Health Education England (HEE)** Andy Wright advised the attendees that HEE is undergoing significant change, there are impending issues with salary support and course demand is very high. Andy Wright acknowledged that following the last distribution of training places most services received about half of what was requested. Currently there are no specific updates from HEE but the Clinical Network have provided repeated feedback regarding issues with training places, salary support etc. Steve Kellett provided a brief update on the training cohorts at the University of Sheffield, advising that the HIT and PWP October 2016 cohorts are due to finish soon, the October 2017 cohort will start in the next week and there will be another cohort in March 2018. Steve Kellett advised that Cheryl Day will be in contact with services regarding the allocation of places for March 2018. Steve Kellett advised, informally, that it is likely that the March 2018 cohort may be the last cohort to receive salary support. Steve Kellett also advised that it is unlikely	

	the long term conditions training will run once the current courses have been completed. Andy Wright advised the attendees that the HEE widening participation research survey will have implications for providers and commissioners and the full report will be shared in due course. Steve Kellett advised that he is supportive of widening access but acknowledges that it is a difficult change to make. • **PBR (multiple episodes)** Andy Wright advised the attendees that the Clinical Network hosted a PBR event earlier in the year. Andy Wright acknowledged that the event left people with more questions than answers and advised that the presenters at the PBR event had been invited to the Network meeting today but were unable to attend. Andy Wright also advised that the PBR tool discussed at the event earlier in the year was currently still in production and not yet available to those services that had signed up as trailblazers. Progress is slow and it is possible that the implementation of an outcomes based payment system will not begin in April 2018. • **Increased Access Targets and Access for BAME and Older Adults** Andy Wright advised the attendees that there is a good clinical rationale within IAPT for working with patients who may be in the perinatal period, an older adult or from a BAME community. Andy Wright advised attendees that the Network wants to keep these topics on the agenda and if anyone has any best practice to share in working with these patient groups to please email sarah.boul@nhs.net. ***ACTION: Any services with best practice case studies in working with patients in the perinatal period, older adults or people from BAME communities please email sarah.boul@nhs.net***	**All** • **Best Practice Pairing Volunteers** Andy Wright advised the attendees that the National IAPT Team have asked us to reach out to our services around areas in which they have of expertise that they would be willing to share with other services. For example, services may have expertise in outcomes based payment systems, perinatal mental health, BAME, older adults etc. Andy Wright advised services that if they would be happy to be a contact point for other services to please contact Sarah Boul with preferred contact details and area/s of expertise. ***ACTION: Any services that are happy to be an area of expertise contact point for other services please email sarah.boul@nhs.net with your preferred contact details and area/s of expertise.***	**All**
9.	**Any Other Business** • **IAPT Data Discussion (Group Work by System Provider)** Andy Wright advised the attendees that the Clinical Network have an aspiration to produce a Yorkshire and the Humber IAPT data report that shows NHS Digital data in an accessible format. Andy Wright advised that the NHS England North Region Analytical Team have designed a report that makes NHS Digital data more accessible. This report will be showcased at the next meeting along with information on how to access it. ***ACTION: Sarah Boul to ensure NHS England North Region IAPT Report***	**Sarah Boul**

	will be showcased at next IAPT Providers' meeting. • **CASPER Training** Andy Wright provided the attendees with an overview of the CASPER trial and advised attendees that the Clinical Network has been in discussion with the University of York and, having obtained a small amount of funding, are looking to provide some training to services in Yorkshire and the Humber in behavioural activation techniques with **older adults** who are in caseness. Andy Wright advised services who would be interested in taking part in the training to contact Sarah Boul. ***ACTION: Any services that would like to take part in the CASPER Plus training for working with older adults please email sarah.boul@nhs.net with your expression of interest.***	**All**
	ITEMS FOR INFORMATION:	
	Future Meetings: The next meeting will be held in late January 2018. A save the date will be circulated in due course.	

Summary of Actions

No.	Action	Owner
1	***Sarah Boul to circulate Yammer guidance and link to IAPT maps to all attendees.***	Sarah Boul
2	***Any services with best practice case studies in working with patients in the perinatal period, older adults or people from BAME communities please email sarah.boul@nhs.net***	All / Sarah Boul
3	***Any services that are happy to be an area of expertise contact point for other services please email sarah.boul@nhs.net with your preferred contact details and area/s of expertise.***	All / Sarah Boul
4	***Sarah Boul to ensure NHS England North Region IAPT Report will be showcased at next IAPT Providers' meeting.***	Sarah Boul
5	***Any services that would like to take part in the CASPER Plus training for working with older adults please email sarah.boul@nhs.net with your expression of interest.***	All / Sarah Boul