

IAPT Service Review – Norfolk and Waveney STP

Intensive Support Team – Mental Health

20th April 2017



Context

The Mental Health Intensive Support Team (IST)

- Part of the NHS Improvement
- A free resource to NHS organisations
- Work with local health communities that are facing particular challenges in delivery of the Access, Recovery and Waiting Times KPIs, as well as delivering the IAPT Quality Standards

IST Approach – Diagnostic Review

- Agree scope and expectations with the provider and commissioner
- Obtain information from provider and commissioner to facilitate diagnostic
- Additional data collection and telephone conference calls to seek clarification as required
- Feedback and recommendations

NHS England IAPT Website www.england.nhs.uk/mental-health/adults/iapt/ including:

- IAPT Quality Standards [Link to national archives](#)
- Three year Report [Link to National Archives](#)
- 2015-16 IAPT annual report <http://digital.nhs.uk/pubs/psycther1516>

Scope

Reasons for Engagement

- Understand the reason for low outcomes
- Help to strengthen existing recovery plans
- Identify good practice from high-performing services

Limitations:

Despite several attempts, NSFT have not been able to produce reliable data relating to sessional dose, outcomes, scores and clusters. This report is provided in order to maintain momentum from the visit but this should be borne in mind when viewing some of the slides – where data is questioned this is clearly flagged.

This summary report is provided to facilitate discussion but it should be noted that a diagnostic review is inherently high level. The interpretation of IST findings should be followed up with more detailed local discussion. This summary covers:

- Value for Money
- Referrals, Access and Waits
- Severity and Complexity
- Staffing, Leadership and Management
- Recovery and reliable improvement
- Data Quality and Reporting

Good Practice

- Patient engagement, navigators and ambassadors
- Plans for moving to national tariff are well advanced and most patients are clustered
- Systems and processes for front end (first and second) appointments seem effective
- Good self-referrals and options for walk in access
- Focus on social component and peer support
- Clinical/managerial alignment at senior level
- Low overheads with over 80% of funding spent on staff and direct costs

Executive Summary

- Service user involvement in the service is strong and an area of good practice
- Many patients currently do not receive an assessment and this is contrary to NICE guidelines
- Over-reliance on groups and lack of assessment have created a complex, inefficient pathway delivering poor outcomes
- Local contractual incentives for short waits to first and second appointment have hidden waits of up to one year between second and third appointment
- Productivity amongst clinical staff is low and is not effectively managed by the provider
- A significant number of counselling staff do not have an IAPT qualification
- Investment is high, particularly considering the levels of activity and outcomes delivered
- Analytical support is under-resourced and accurate data is not available to either provider or commissioners
- Patients are limited to their 'home' GP practice at the expense of waiting times and appropriateness of treatment
- In the context of current productivity, pathway and allocative efficiency, capacity is inadequate to deliver timely treatment

The Model

Systems and Processes, Waits, Staffing and Supervision



Patient Pathway: Challenges

- The 'front end' of the patient's pathway and entry to treatment is complex and lacks consistency.
- Patients can enter the service and receive treatment in the 'workshop' element of the service without assessment. They can remain there for long periods without being evaluated – staff gave examples of up to a year. This is not consistent with NICE guidelines¹
 - The decision to treat is reported by clinical staff to be based on several non-clinical factors including
 - Pressure in the service (e.g. waiting times)
 - A perception that clinicians *should* place patients in a workshop rather than individual therapy
- Patients are experiencing long waits for treatment in some areas (up to one year was reported in Norwich CCG).
- Staff are recording treatment as having started at assessment/review appointments even when patients are being placed on waiting lists and not receiving treatment.
- Although a high number of sessions are being offered to some patients elsewhere in the service, counsellors are not offering full dosage as prescribed by NICE.
- Some counsellors are not trained or qualified in an IAPT modality.
- Clinical staff referred to a perceived gap between the offer made in primary care and what is available in secondary care. Staff reported a lack of psychological therapy resource within secondary care mental health services.

¹ Quality standard 1: "People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode"

Clinical Leadership

- The service has appointed leads in all areas of the service and this is good practice.
- Leaders have an awareness of the challenges due to frequent and often 'rushed' change and the impact this has on the workforce.
- Morale is low within the staff groups and this is a challenge to leadership in continuing to implement service improvement.
- There is an over-reliance on the patient to indicate that they require a different intervention. This is problematic given the nature of anxiety and depression.
- Whilst it is recognised that it is good practice to use a holistic model of patient care, the service is in danger of encouraging a reductionist view if it continues to see the 'social' element of the model in isolation.

Staffing and Training

High-Intensity Therapist Type	Current Ratio	NICE-Suggested Ratio ^{1,2}
CBT	61.3%	68% - 73%
Counselling for Depression	1.1%	3% - 5%
IPT	0.2%	11% - 17%
Couples Therapy	1.2%	3% - 5%
Psychodynamic	0.0%	5%
EMDR	4.9%	2%
Not IAPT Qualified	30.1%	0%

Step 2 to Step 3 Staff Ratio 41:59

Admin to Therapy Staff Ratio 1:6.9

¹ Suggested ratios derived from
 (a) NHS England Action for Choice of Therapies (ACT) working assumptions, based on NICE Guidance and relative prevalence of conditions (Prof David Clarke)
 (b) NICE National Collaborating Centre for Mental Health Estimates (Prof Steve Pilling)
² Assumes patients with a particular condition would choose equally between the NICE-recommended options for that condition.

- A significant number of counsellors are employed by the service who do not have any IAPT qualification
- IAPT funding should not be used to fund non-evidence-based interventions e.g. person-centred counselling
- The trust appears to have significant gaps, particularly relating to IPT and DIT
- Peer Support Workers appear to be providing some IAPT interventions e.g. Behavioural Activation which may be appropriate to be included in the IAPT dataset as part of an evidence-based pathway led by IAPT-qualified staff

Investment – The IAPT Model

As a guide, the investment in step 2/3 psychological therapies needs to equate to around £65-£75 per head of prevalence.

In most cases this should be sufficient to deliver 16.8% Access and 50% Recovery based on a set of modelling assumptions.

Those assumptions are:

1. 18 - 20 positive clinical contact hours are delivered per WTE therapist per week
2. An overall average of around 6 sessions per patient entering treatment. This comprises of courses of treatment (two or more sessions) averaging 9 sessions (combined Step 2&3). In addition there will be a number of patients who drop out after a single session, giving an overall average of around 6 sessions
3. 75% - 80% of investment converts to a Clinical Staff budget and approximately 20% to overheads/indirect cost.

The following slides describe where the service currently sits against these criteria.

N.B. The model described here should be a starting point for discussion. As soon as the locally agreed pathways change from the above assumptions (and there may be good reasons for doing so), the level of investment required to achieve 16.8% Access and 50% recovery will change.

Investment – Actual

Planned investment by the CCGs for 17/18 is £10,179,759 and the estimated prevalence is 112,291.

		Investment assumptions		Per Head of Prevalence		Value: staff percentage	
	2016-17 Prevalence	Investment in MH Dashboard	Trust IAPT Spend	Dashboard	Trust Spend	Staff and Direct Costs	% Staff/Direct Cost
West Norfolk	18,500	£ 1,750,000	£ 1,609,550	£ 95	£ 87	£ 1,379,267	86%
South Norfolk	25,565	£ 2,019,000	£ 1,932,154	£ 79	£ 76	£ 1,591,279	82%
Norwich	22,457	£ 2,317,000	£ 2,296,474	£ 103	£ 102	£ 1,826,149	80%
North Norfolk	18,567	£ 1,868,000	£ 1,733,058	£ 101	£ 93	£ 1,472,269	85%
Great Yarmouth and Waveney	27,202	£ 2,674,000	£ 2,608,523	£ 98	£ 96	£ 2,107,519	81%
Norfolk & Waveney STP	112,291	£ 10,628,000	£ 10,179,759	£ 95	£ 91	£ 8,376,482	82%

On this basis spending on IAPT in Norfolk is around £91 per head of prevalence.

The expected investment level to deliver 16.8% prevalence is £65-£75 per head.

Given the ambition of the CCG to deliver 16% in 17/18 this is **substantially above normal expectations** – subject to the three assumptions listed on the previous slide, which are explored in more detail on the following slides.

Assumption 1 – Productivity

Assumption: 18 - 20 positive clinical contact hours are delivered per WTE therapist per week

WTE	Step 2	Step 3	Total
Unadjusted	26,506	31,780	58,285
Vacancy/Absence	4,652	1,344	5,996
After Overtime	31,157	33,124	64,281
Net Total	26,506	31,780	58,285

Patient Hours/WTE	Step 2	Step 3	Total
Annual	539.4	405.6	461.0
42 Week Year	12.8	9.7	11.0
44 Week Year	12.3	9.2	10.5

- The trust has not been able to provide reliable information about productivity
- It is not, therefore, possible to ensure that therapists are productive and the service delivering value for money
- Based on data provided by the Trust, **productivity is extremely low**
- This may not reflect that staff are not working hard, but that the activity undertaken is not always value-adding
- This is also likely reflective of the degree of complexity in the current treatment pathways and size of waiting lists for subsequent treatments

Assumption 2 – Average Sessions

Assumption: An overall average of 6-7 sessions per patient entering treatment.

Summary Data	Including Single Sessions			Excluding Single Sessions		
	Step Two	Step Three	Total	Step Two	Step Three	Total
Mean Sessions	3.0	9.1	4.6	5.5	9.1	6.2
Median Sessions	0.3	7.9	2.0	4.1	7.3	4.8

- This is likely to be inaccurate but is based on current data as provided
- The trust are not able to provide accurate information about sessions attended
- Without accurate information there is no way for the trust to be able to monitor or demonstrate adherence to NICE-recommended dosage

Assumption 3 – Clinical Staff Spend

Assumption: 75% - 80% of investment converts to a Clinical Staff budget and approximately 20% to overheads/ indirect costs

Around 82% of the overall budget YTD has been spent on direct costs for clinical staff.

Based on this figure **the service has low overheads** compared to spending on staff, and NSFT have confirmed that there are no indirect costs allocated to the IAPT service.

Staffing levels sense check

Based on high-level guideline of 1.1 – 1.2 WTE therapy staff per 1,000 prevalence:

CCG prevalence suggests around 124-135 WTE clinical staff to deliver 16.8% access and 50% recovery rates, depending on the model commissioned.

The current therapist establishment is around 142WTE in budget.

Current staffing levels are at the higher end of expectations based on the current level of access in terms of WTE, but may be in line with the expected numbers needed to deliver the 16.8% access planned for a clinically-appropriate number of sessions.

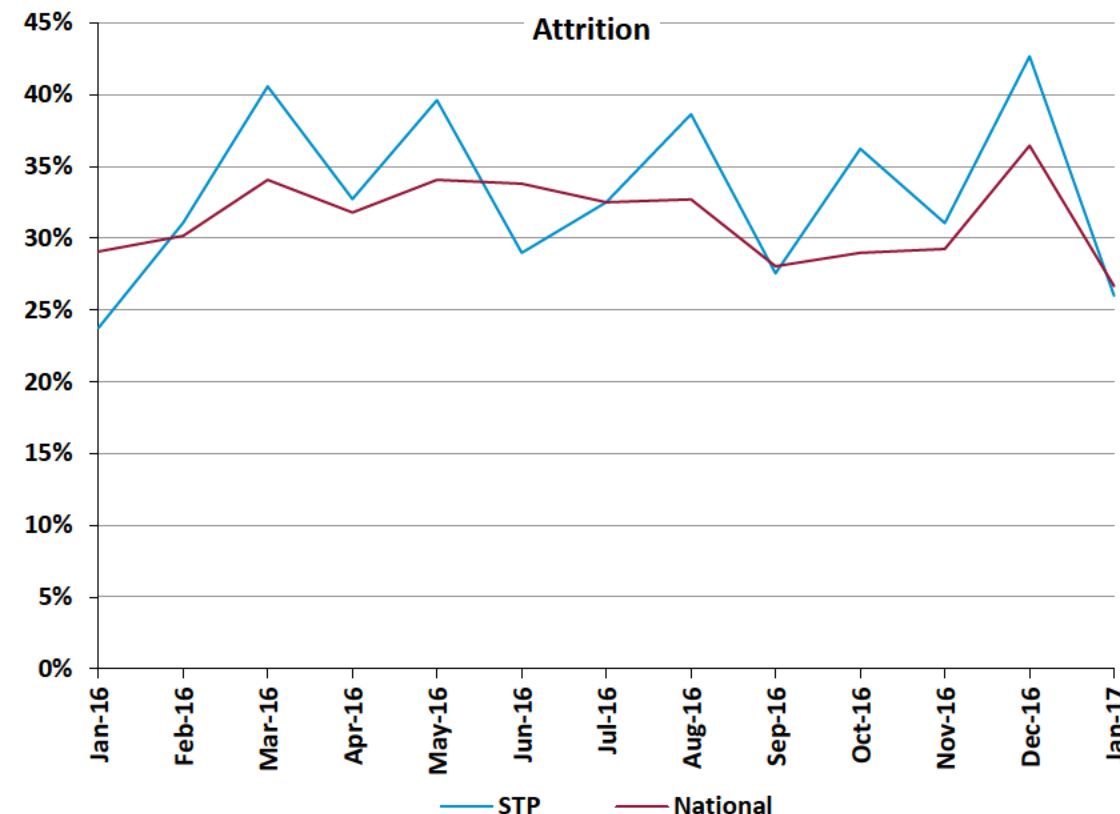
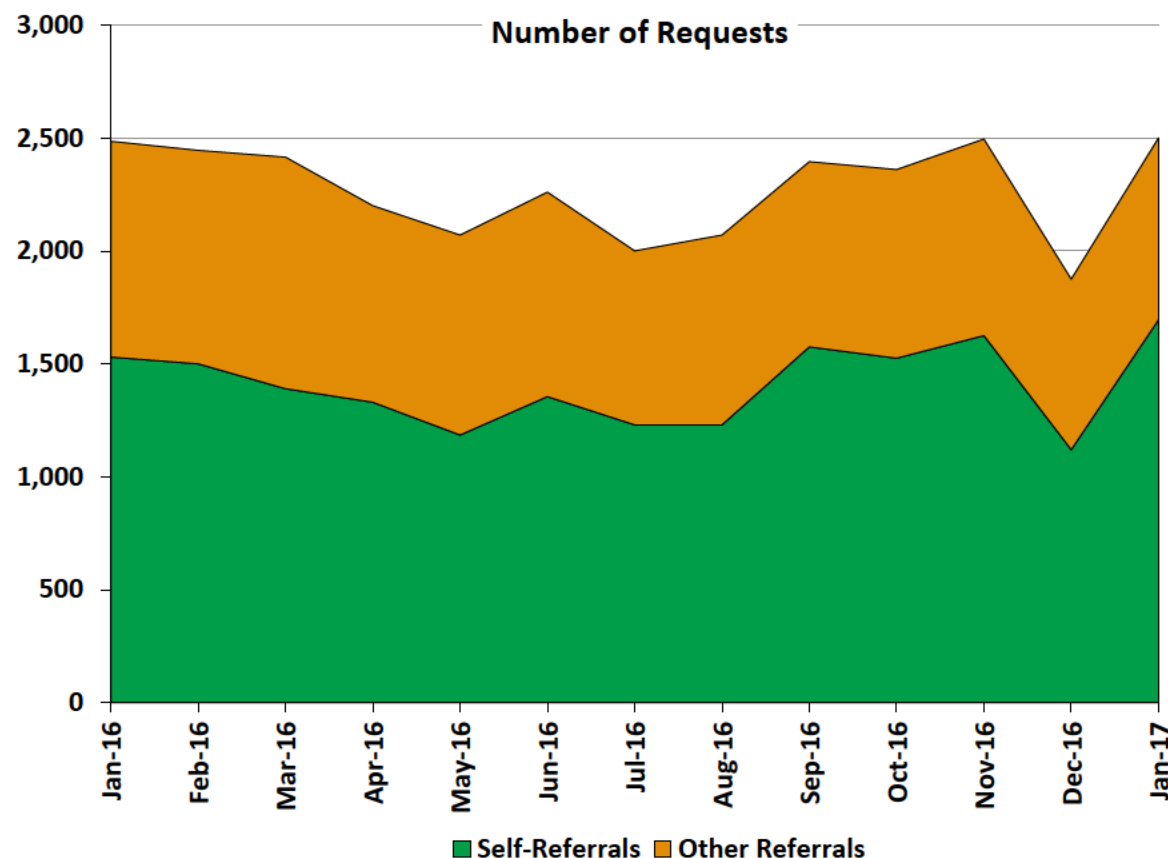
Commissioning

- CCGs have committed funding to IAPT expansion to 16.8% for 17/18
- Commissioners are well-prepared for the move to National Tariff although further work is needed at pace
- Commissioners have decided to reduce funding for IAPT to provide a non-IAPT 'Enhanced Care' Pathway
- Commissioning is clinically-led with a strong GP voice but it is important that this is heard within the context of delivering clinically-appropriate treatments, reasonable waiting times and value for money
- Contacts, KPIs and monitoring information is not aligned to national CCG performance standards
- Performance currently provided to CCG Boards does not match actual reported performance
- The IST heard that CCGs were offered the alternative of more accurate NHS Digital data but declined
- CCGs are committed to the development of LTC pathways but have not yet developed a plan or engaged with either NSFT or acute providers to discuss

Referrals and Access

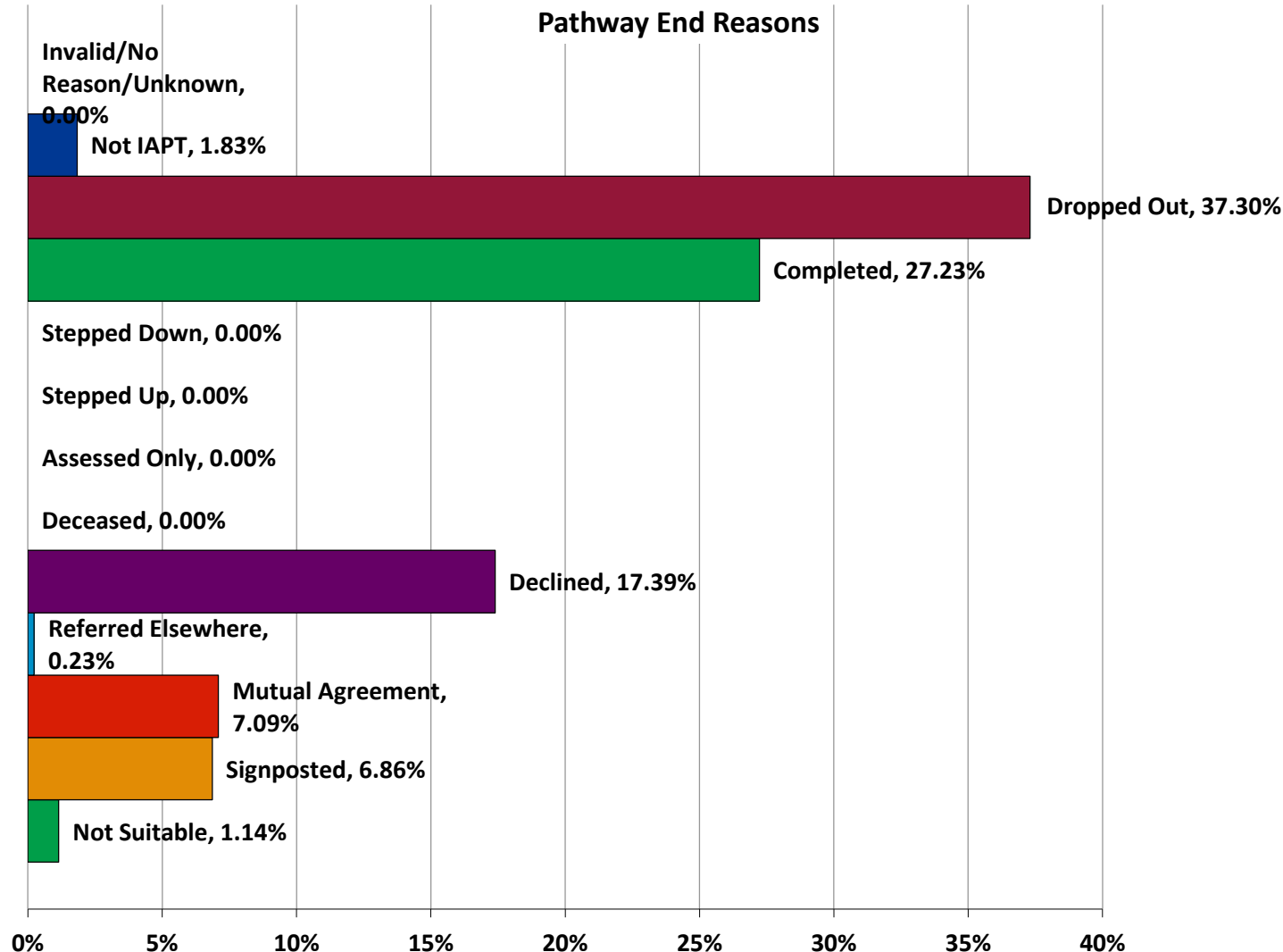


Referrals and Attrition



The number of patients referred is relatively stable across the STP overall. Attrition rates – patients dropping out between referral and first attendance – are relatively high in the context of a service with very quick first appointment access and high self-referrals.

Completion/Drop Outs



In addition to patients dropping out prior to first appointment, it appears that more patients drop out than complete treatment.

In light of the general level of data quality in NSFT IAPT data, it is recommended that the trust assess the accuracy with which this data item is completed by staff before drawing firm conclusions from this information .

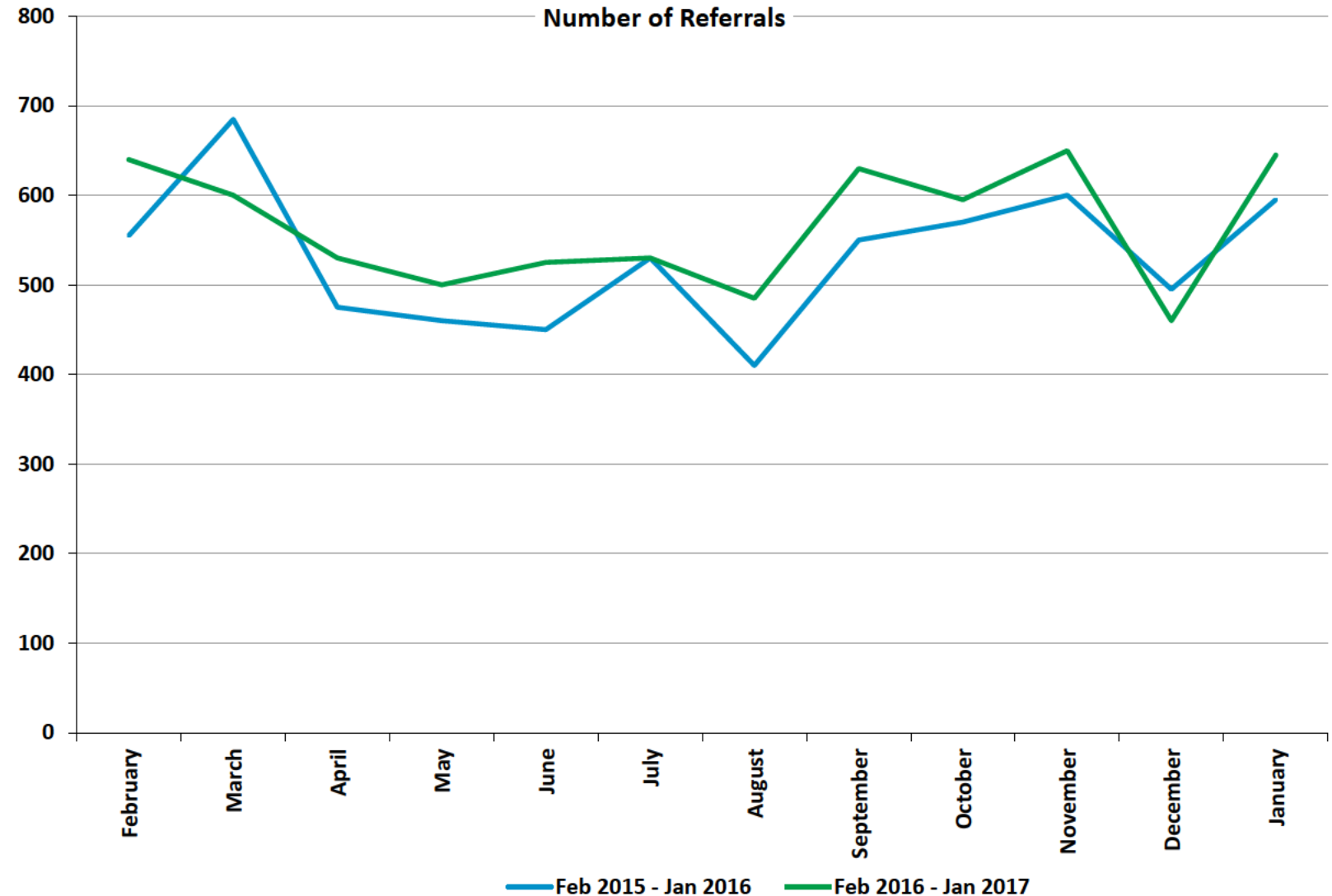
It is recommended that the trust audit attrition reasons, first using data (discharge/end reasons) then patient notes in order to understand why patients are not engaging with the service and then develop action plans accordingly.

Norwich CCG

There is a perception that there has been overperformance on the Norwich part of the contract in particular causing lengthening waiting times and pressure on staff.

Comparing data from 2016 to 2015 it appears that referrals and activity in Norwich have been consistent since before the new contract was signed in September 2015.

As such the issue appears to be related to the allocation of staff and resources around the service since the inception of the contract and not to the Norwich population or team.



Data source: January 2015 – January 2017 NHS Digital Monthly IAPT Data

Equity of Access – Older Adults

Services need to provide prompt access and equity of access ensuring inclusion of marginalised groups such as older people, the long term unemployed, BME groups and under-represented clinical conditions.

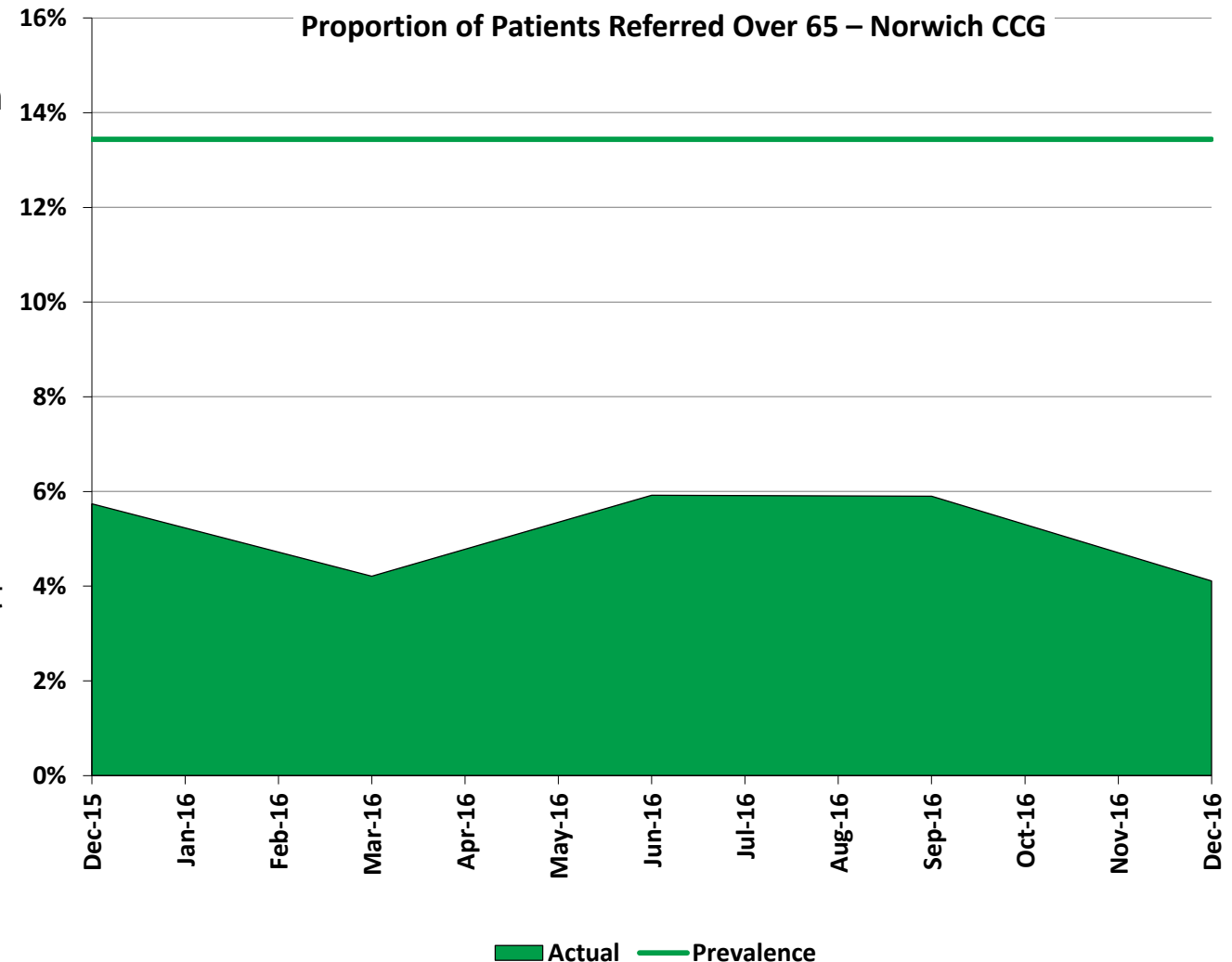
National evidence is that older people do well in IAPT services. The national recovery rate for people aged over 65 in 2014-15 was 57%.

The percentage of older people referred in Norfolk is **less than might be expected.**

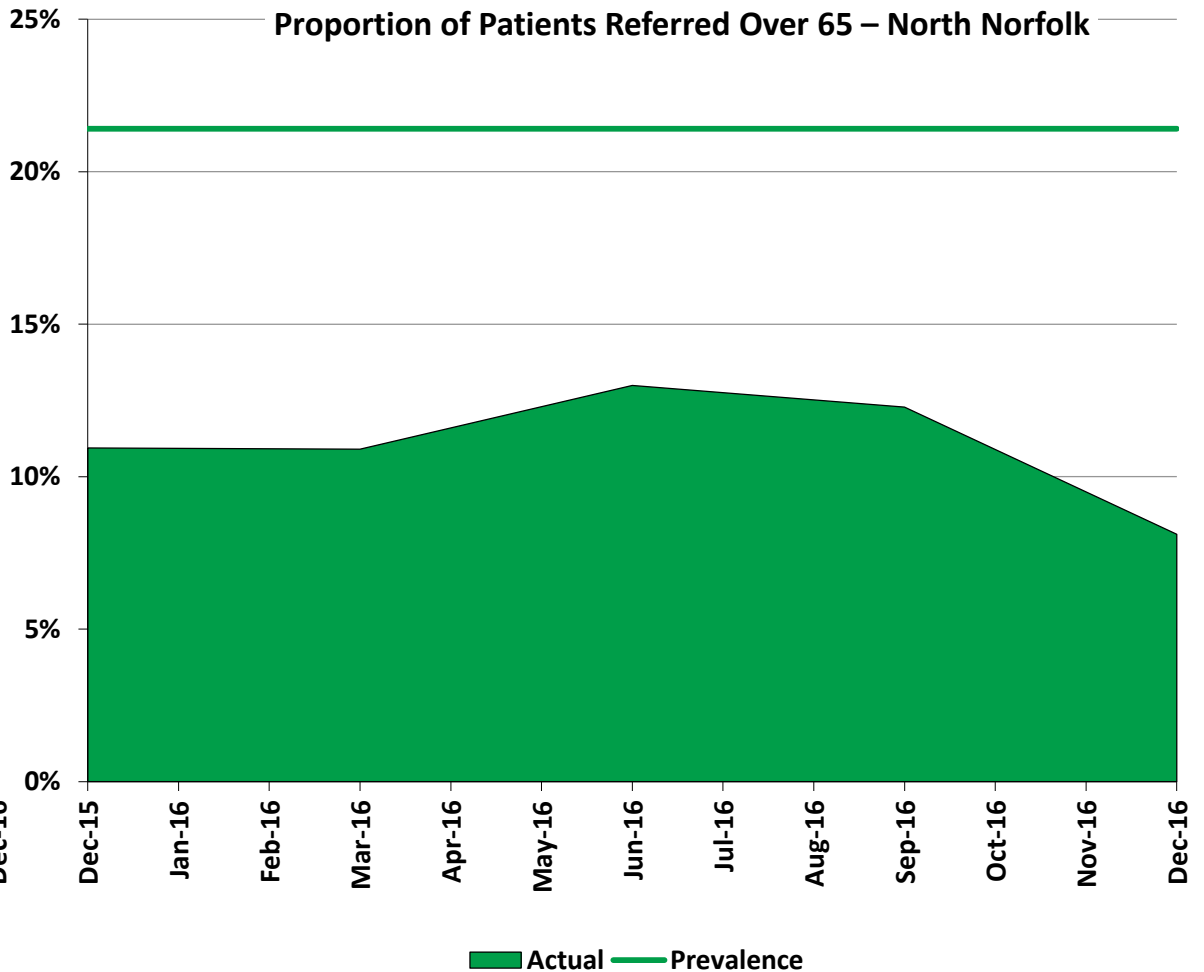
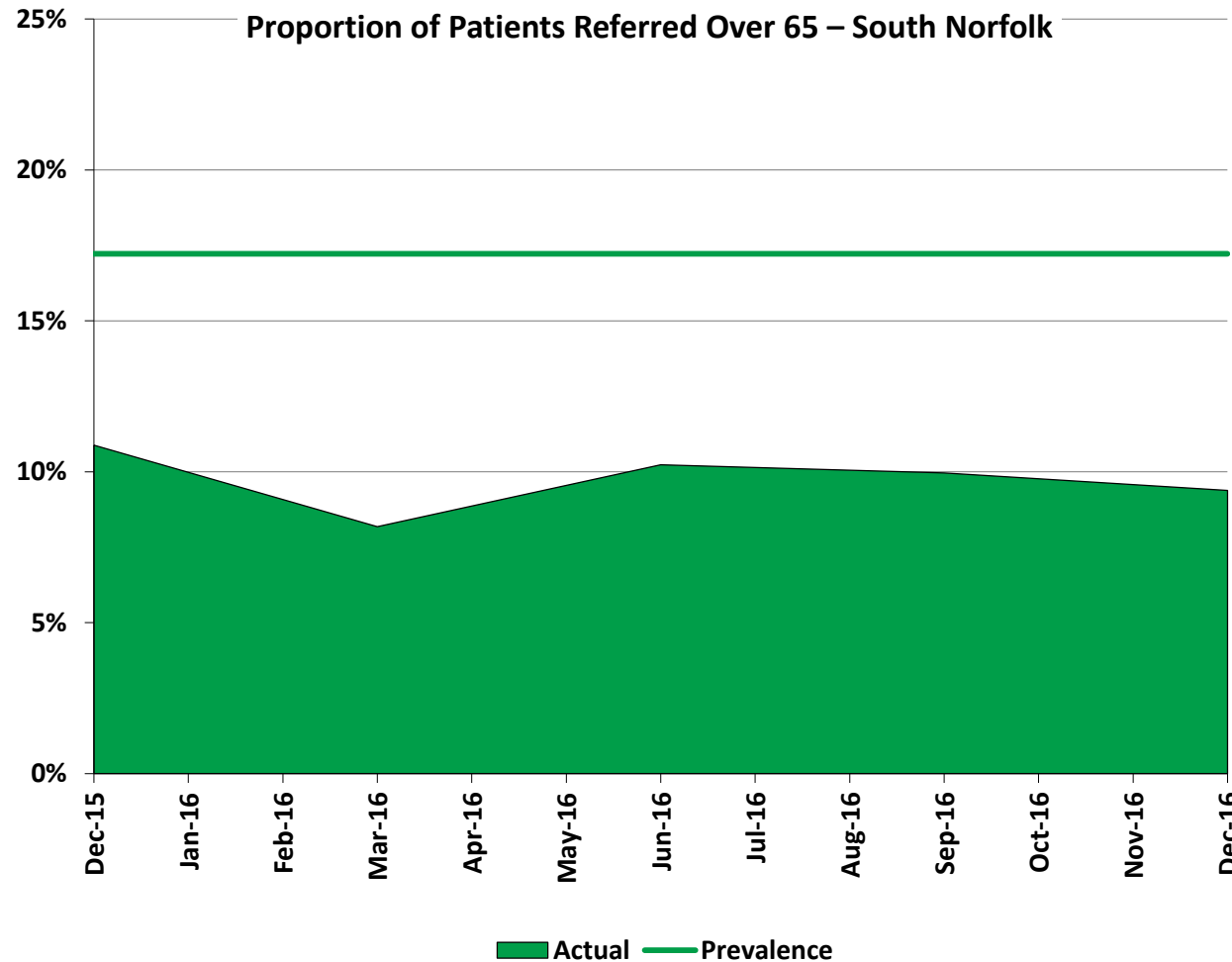
South, West and North Norfolk CCGs have chosen not to use the 17/18 Quality Premium to prioritise equity of access to IAPT (<https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-16-17>).

Reasons to be explored include:

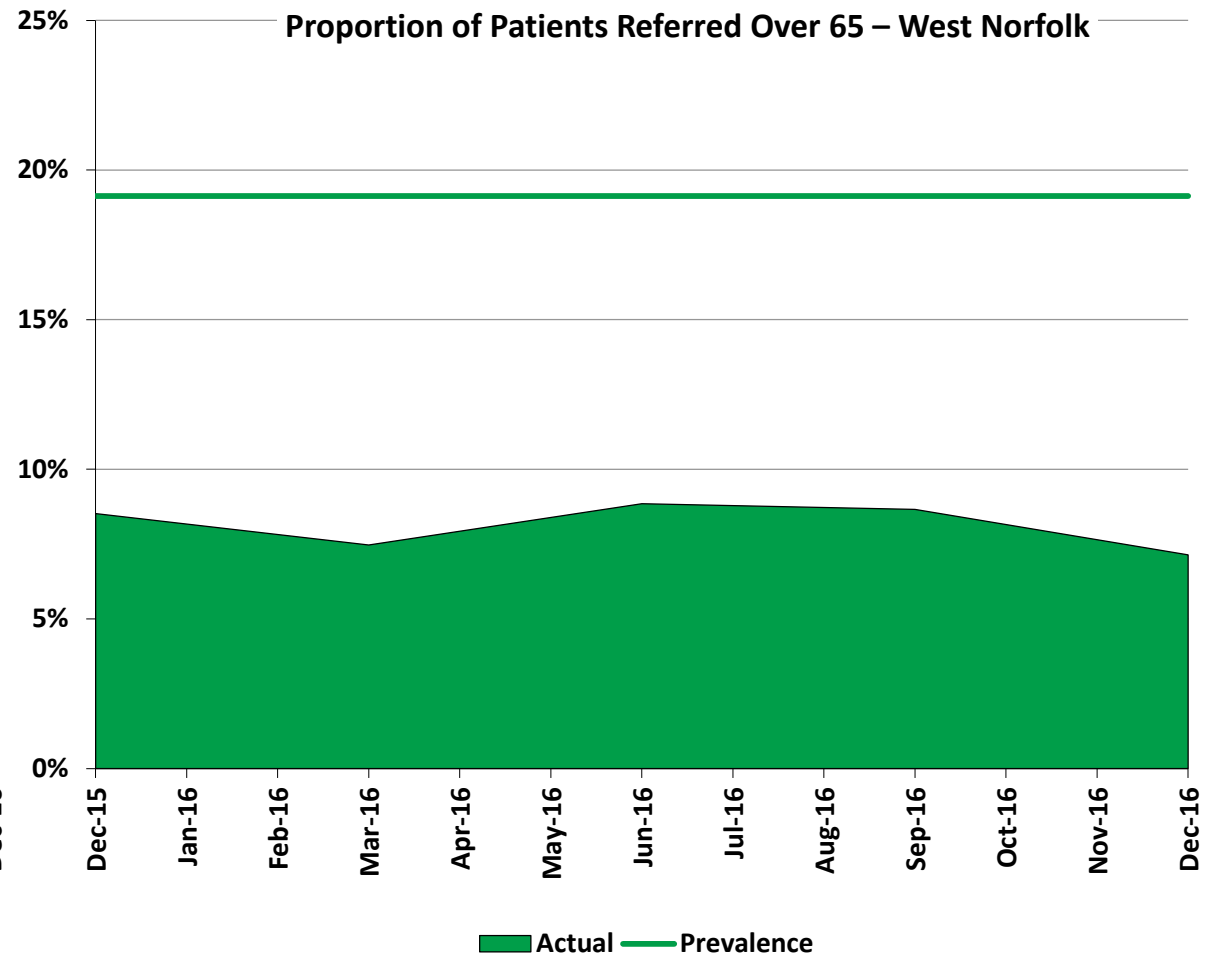
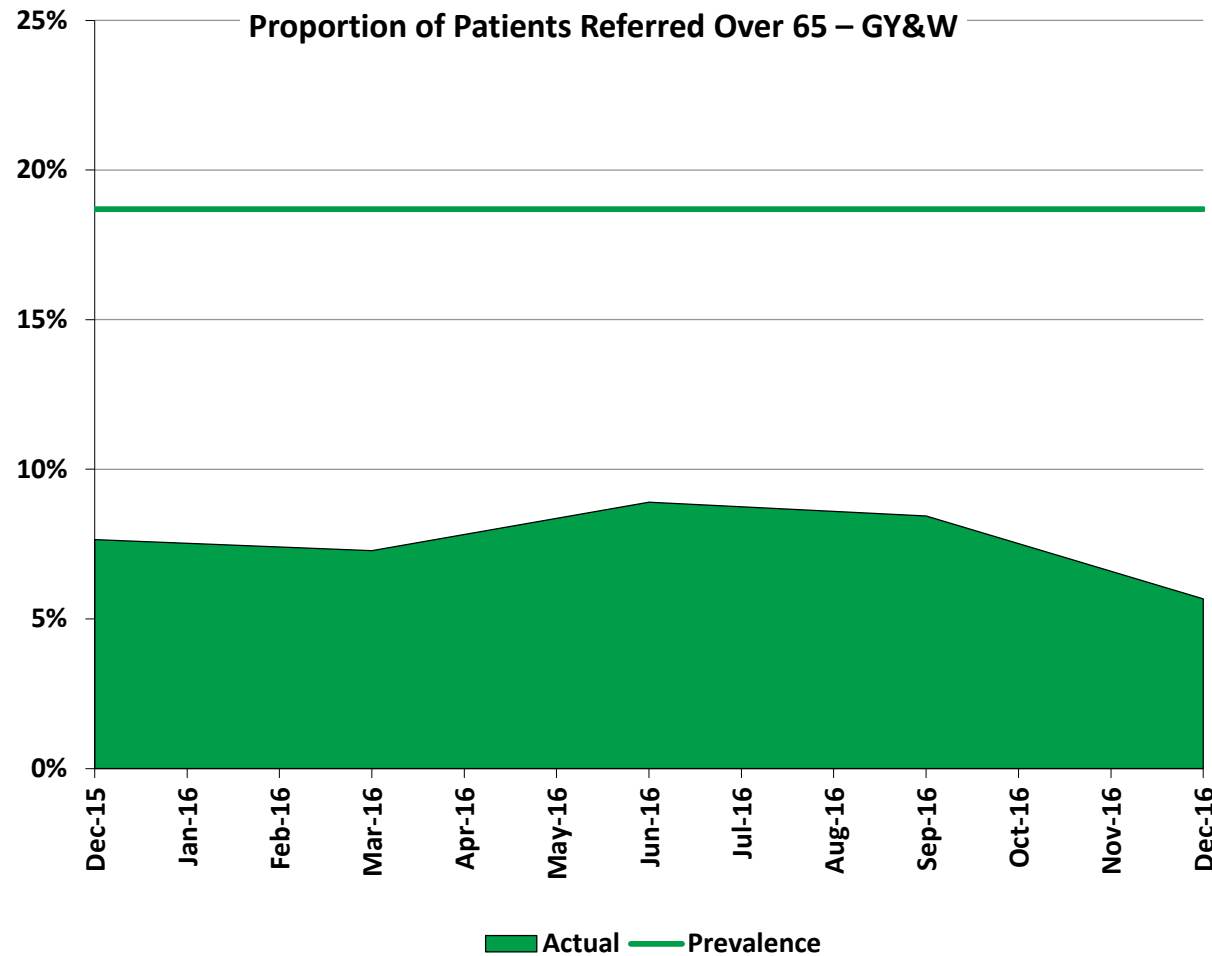
- Lack of awareness amongst health professionals, including GPs
- Marketing not targeted sufficiently to reach older people and/or the offer does not meet their need



Equity of Access – Older Adults



Equity of Access – Older Adults



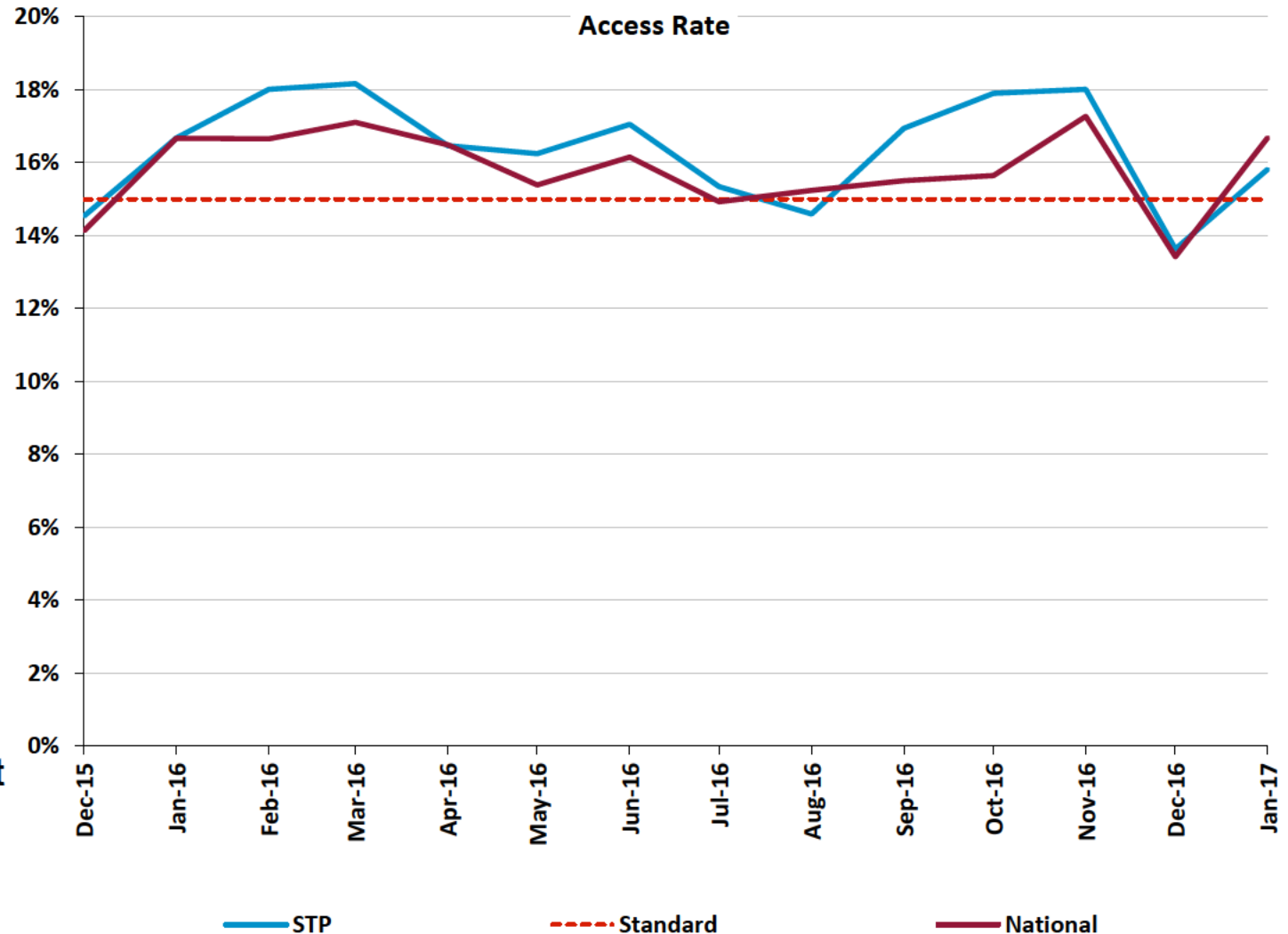
Access Rates

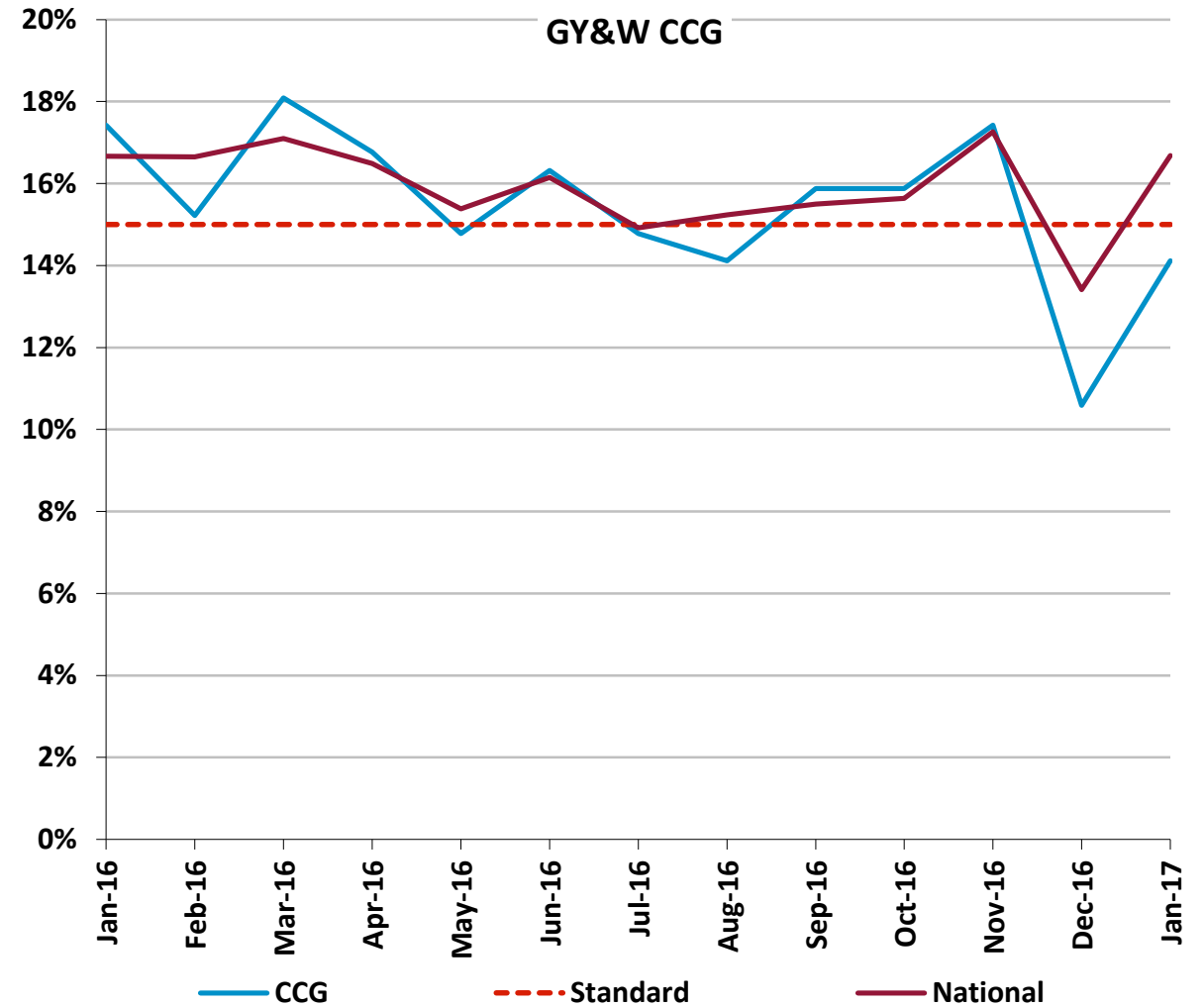
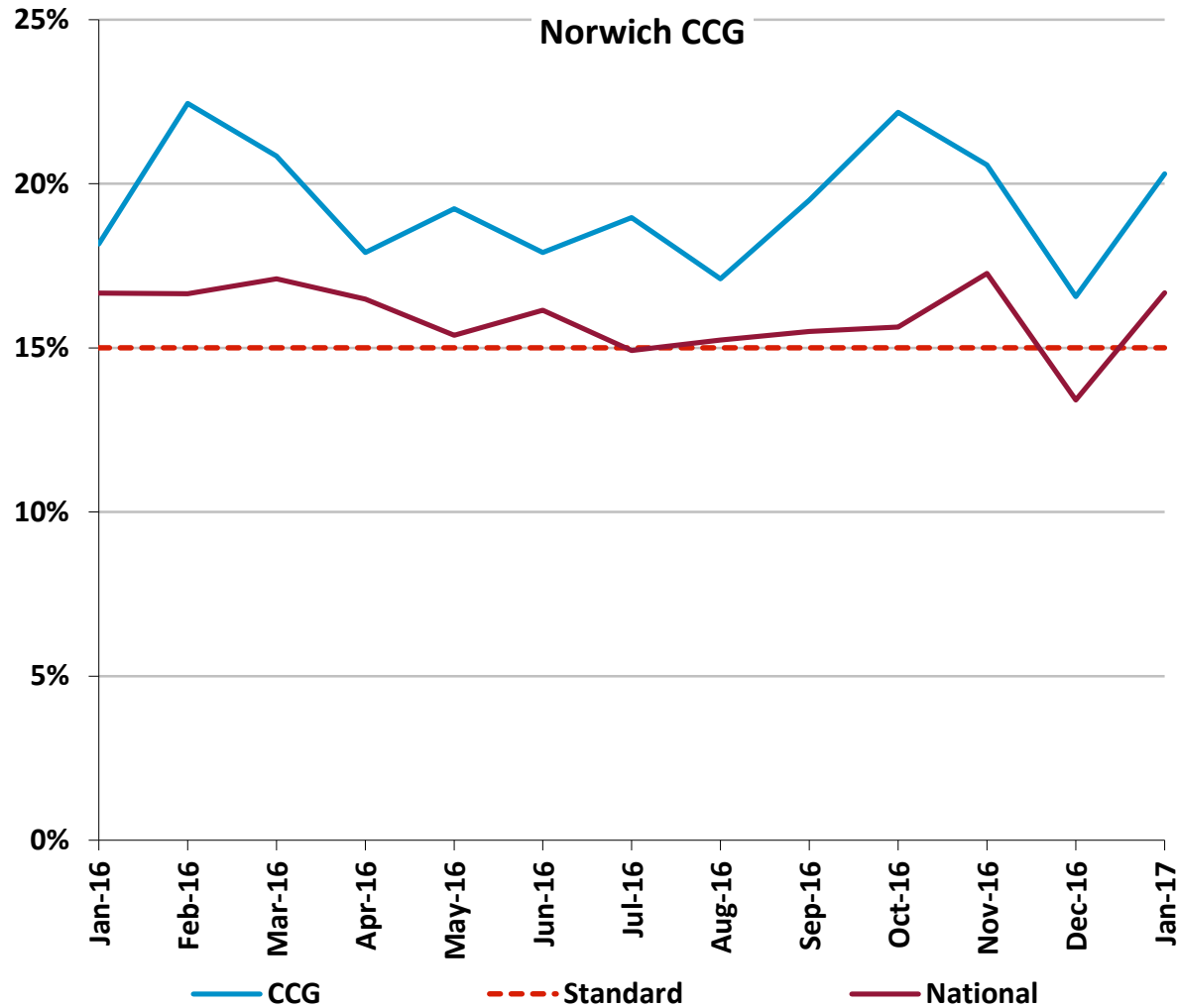
Access rates have remained over the current 15% standard and the 16% contracted level for the past year, although this is not uniform across all CCGs.

It is important to ensure that capacity is in place to deal with future growth and that adequate demand and capacity planning is in place.

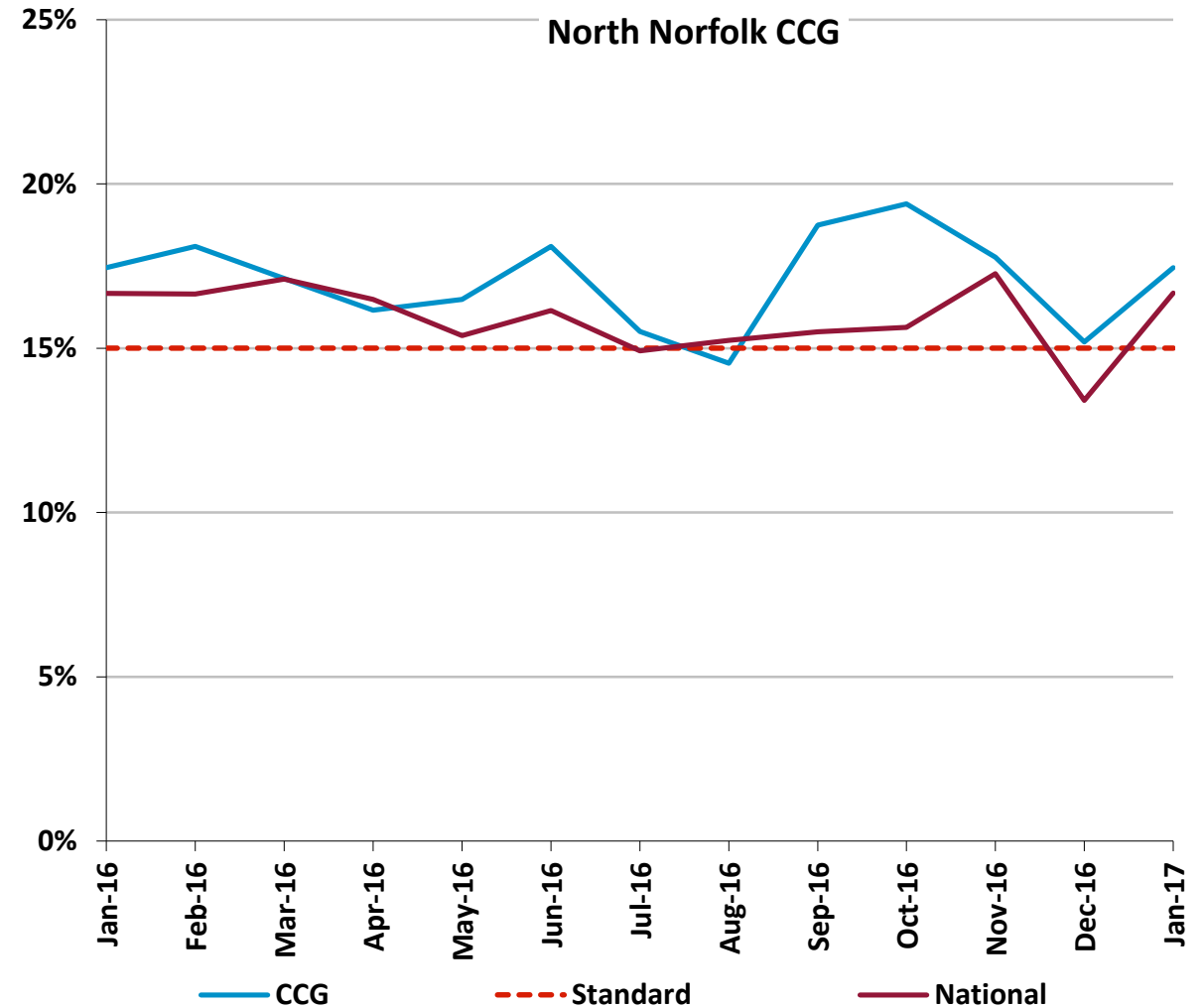
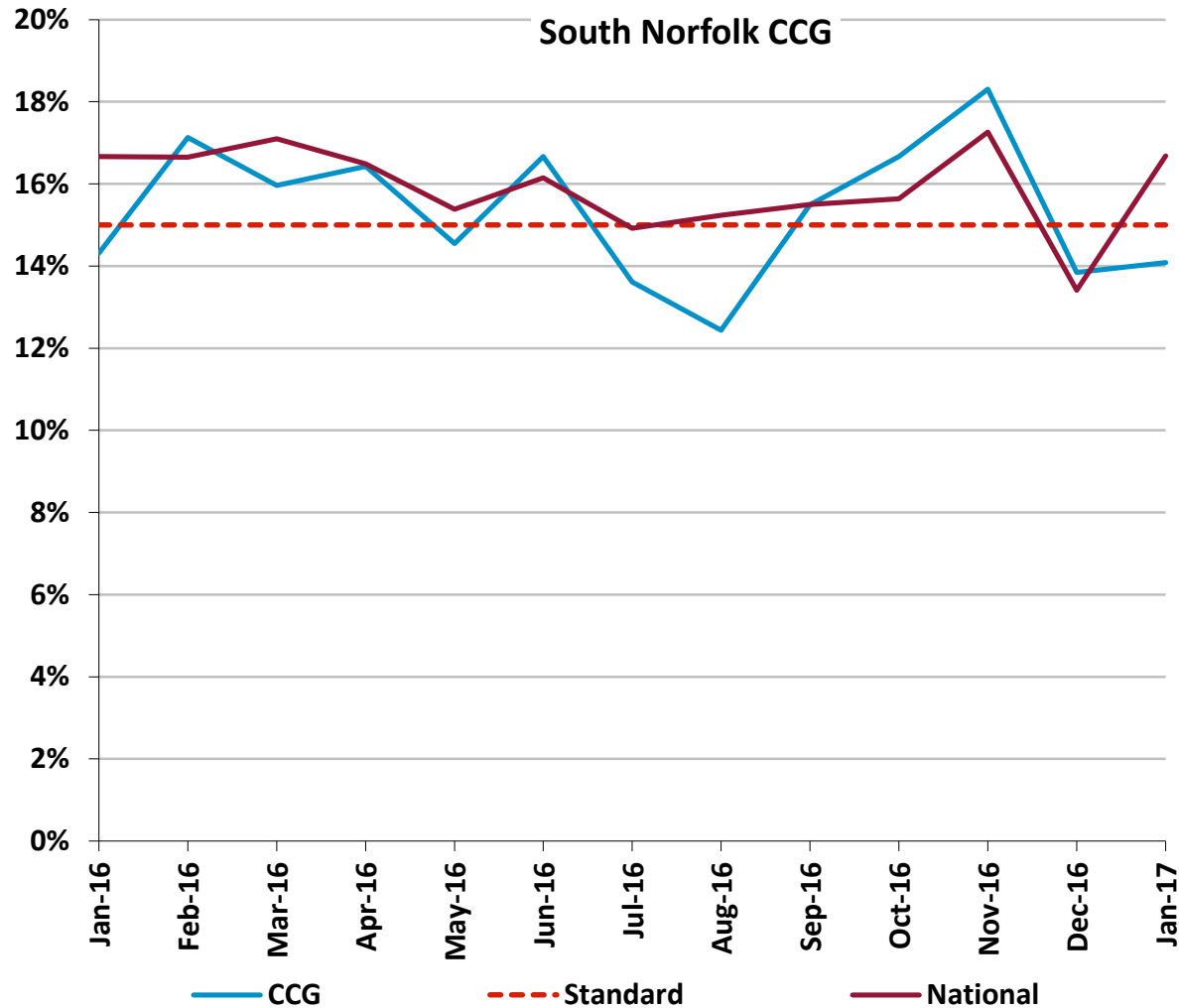
While activity has been contracted to meet 16.8% access across 2017/18, this has not been aligned to the Q4 4.2% standard specified in the planning guidance.

Although 16.8% is being delivered over the STP there is considerable variation amongst CCGs demonstrated on the following slides.

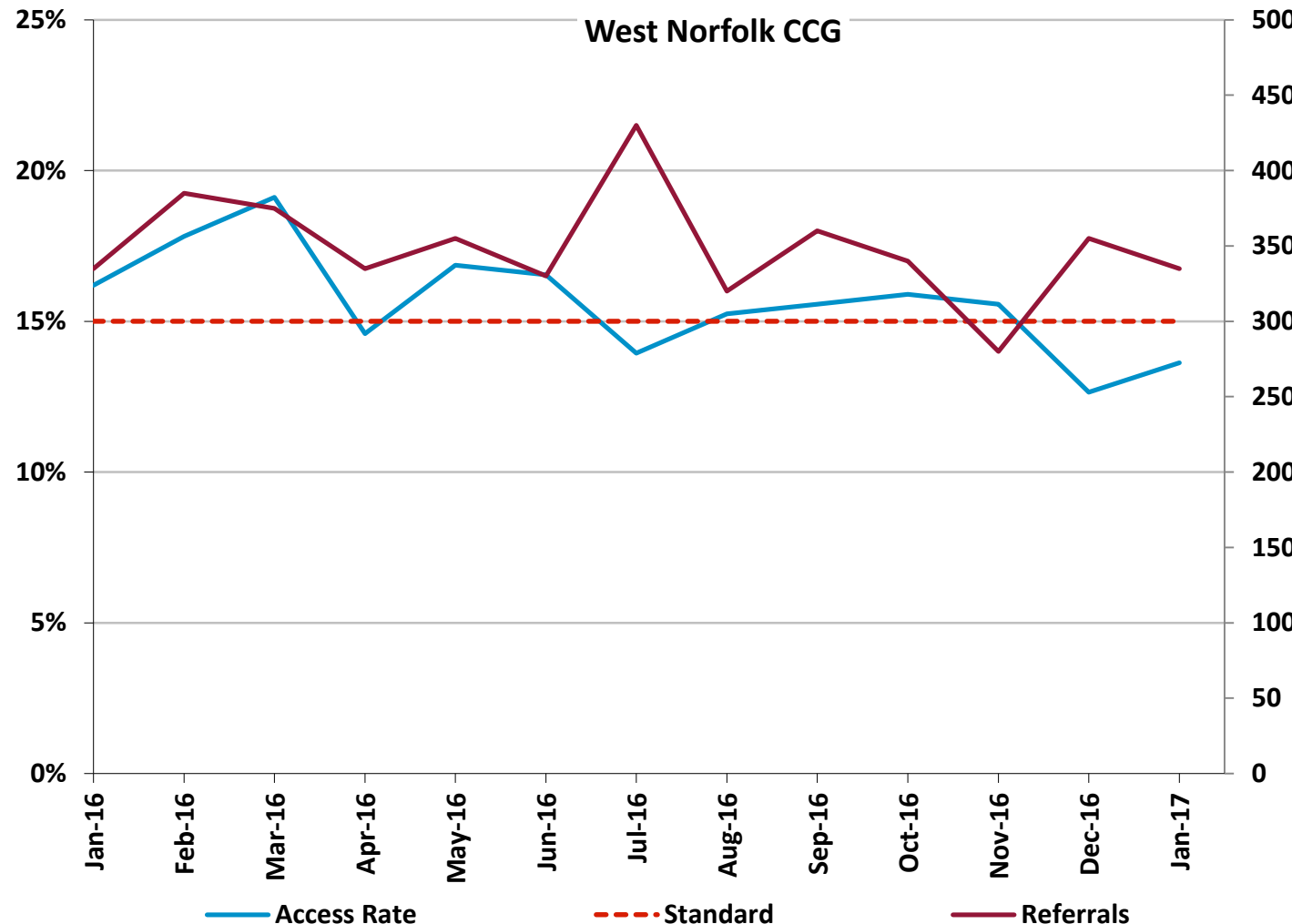




Stable Access



Declining Access and Referrals



In West Norfolk in particular it appears that both access (blue line) and referrals (puce line) are declining, in the context of a requirement to increase both.

Across all areas it is important to understand the reasons behind any decline by engaging with GPs and other referrers; it is also important to identify gaps in referrals along lines of gender, ethnicity, locality, age etc.

The extent of first treatment activity variation across different services underscores the important of ensuring that NSFT is able to manage capacity flexibly across different teams.

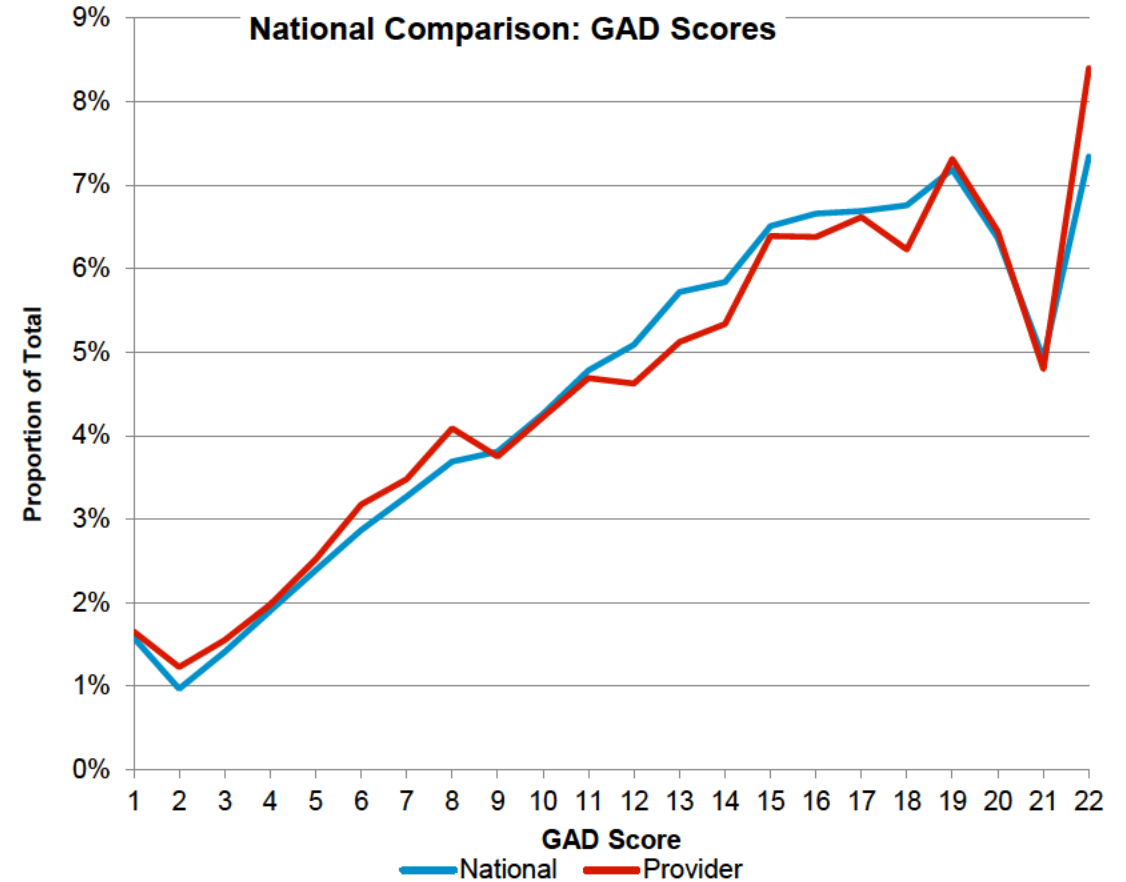
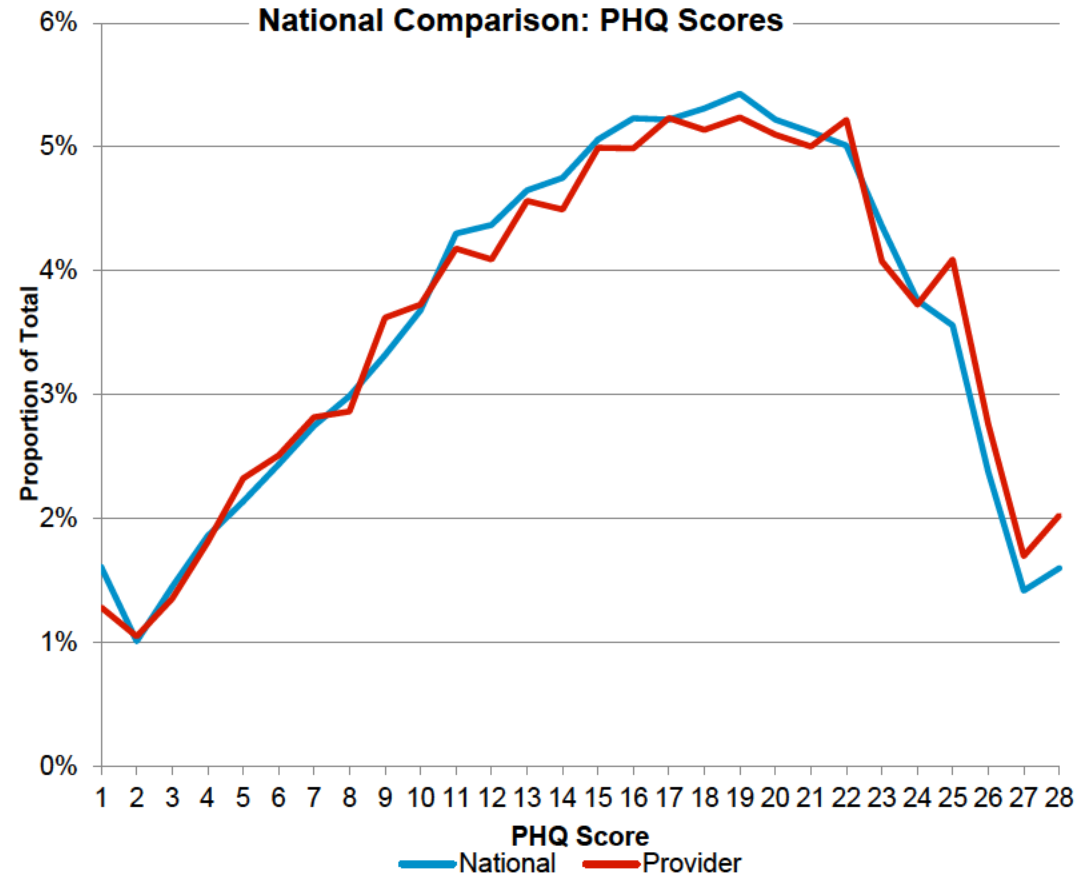
Severity and Complexity

Severity – PHQ, GAD7

Complexity – WSAS and Clustering



Severity



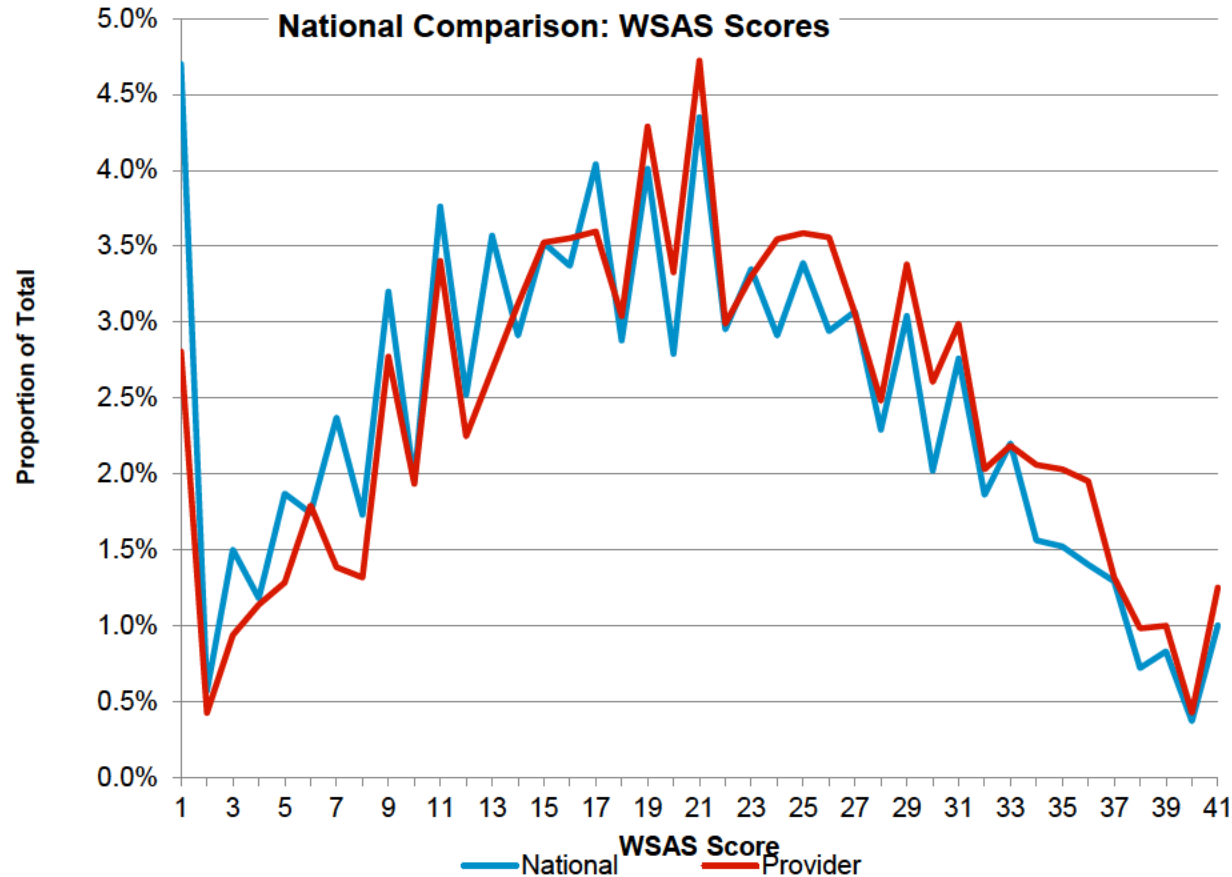
Both anxiety and depression scores indicate that the service is currently seeing a case-mix which is in line with the national average. This data covers the period of time before more severe patients were removed from the IAPT service and started on the ECP.

It is important to ensure that the IAPT service meets the needs of patients across the range of presentations, and it is recommended that this is monitored as the service criteria come into force.

Enhanced Care Pathway (ECP)

- The IST heard that the ECP is intended to provide holistic support to patients who are deemed to be 'not ready' for an IAPT intervention
- The data in regard to severity and complexity suggest that, prior to the implementation of the ECP, the complexity/severity patient profile matched the national picture
- Use of ECP could be expected to reflect in the service seeing/treating patients that are less complex/severe than the average IAPT service. If this is the case the recovery rate can be expected to be well in excess of the 50% target, and NSFT and commissioners would not have outcomes information to monitor the effectiveness of the ECP
- IST expressed concern in regard to patients on the ECP. During the visit it was suggested, and accepted, that once an 'ECP' patient is ready for psychological therapy intervention, their data will be included in the IAPT dataset
- Extra funding is to be provided for the ECP outwith the IAPT investment detailed earlier
- The primary care mental health resources to deliver the ECP could alternatively be used to support 'core IAPT', in the context of a requirement for IAPT expansion

Complexity



Echoing the picture seen with GAD/PHQ scores, patients do not appear to be more complex than the national mean.

Cluster	Proportion
Clusters 1-2	42.6%
Clusters 1-3	79.2%
Clusters 1-4	98.5%
Cluster 4 or above	20.6%
Cluster 5 or above	1.3%

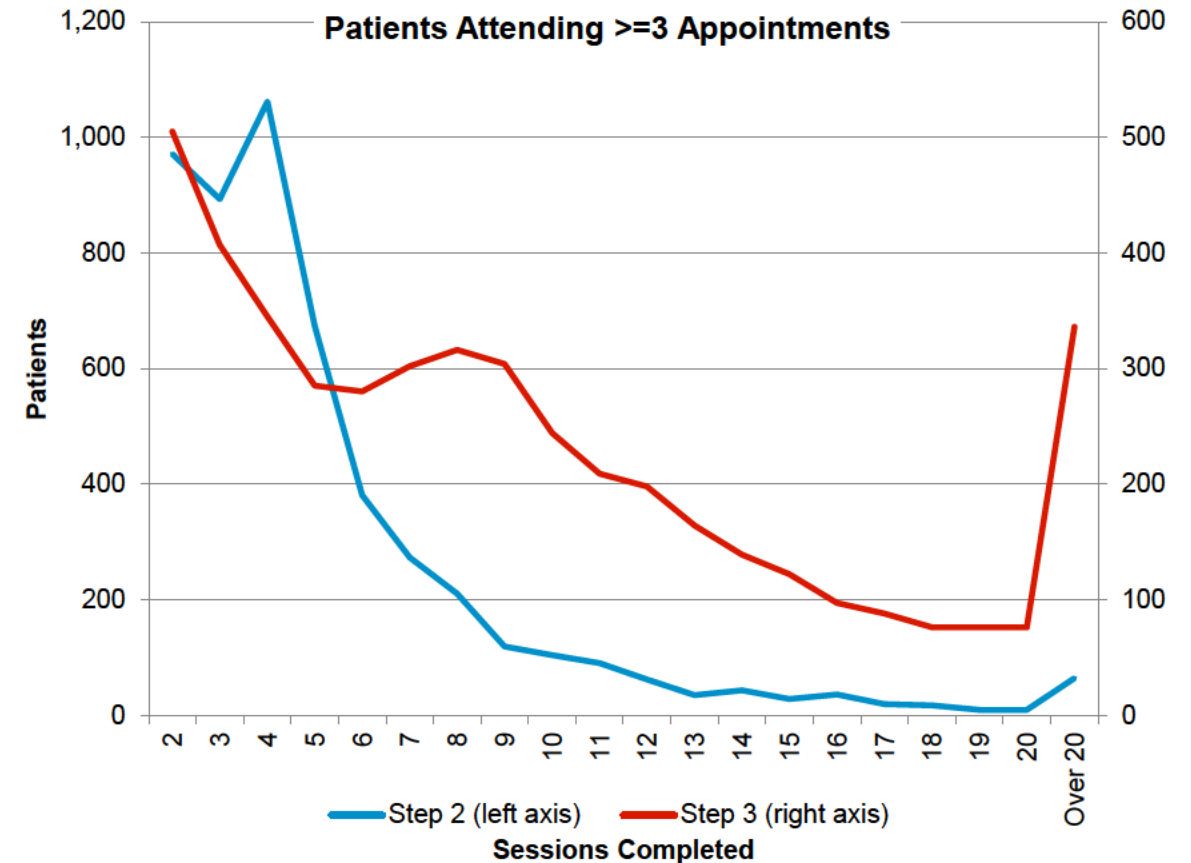
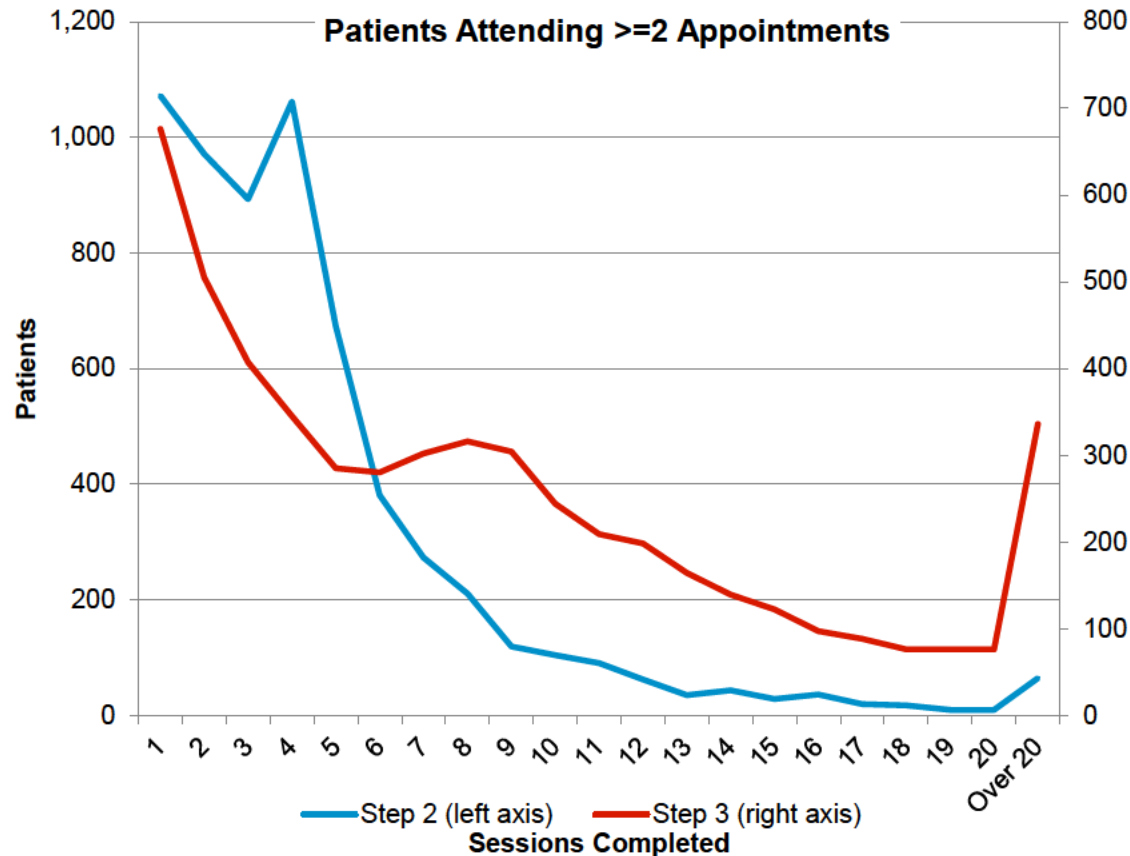
Clustering Data Completeness: ?%

NSFT were not able to provide accurate clustering information. This is of concern given the need to sue clustering as the basis for national tariff implementation.

CCG and Trust are both ready to move to national tariff, although this programme is not currently progressing.

Clustering will be used to determine payment in FY2018-19 and should be used to develop a local tariff in FY2017-18 see https://improvement.nhs.uk/documents/661/IAPT_Payment_Guidance.pdf and contact pricing@improvement.nhs.uk with specific queries

Profile of Sessions



A high number of patients at step 3 are receiving over 20 sessions; this would be regarded as an exceptional circumstance in the context of NICE guidance. This contradicts the perception amongst high intensity therapists that patients are receiving closer to 8 sessions and may be consistent with patients not receiving the most appropriate treatment.

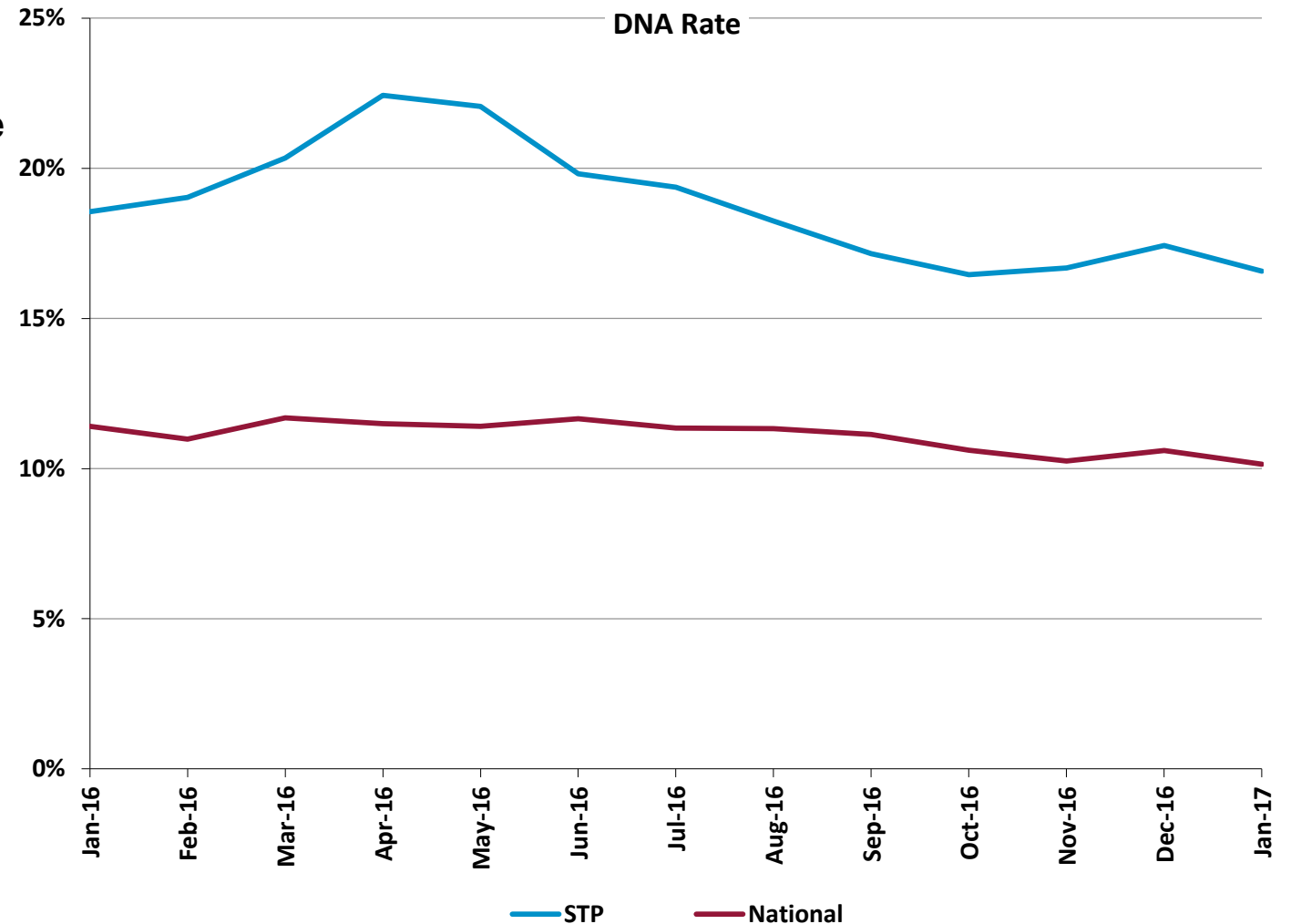
DNAs

Low DNA rates are correlated to high recovery and reliable improvement rates as they evidence high patient engagement.

DNA rates in the Trust are extremely high. It is felt that this is disproportionately due to DNAs in groups. Even excluding groups, the trust has higher DNA rates than the national average.

It is also likely the case that long waiting times are 'suppressing' DNA rates and that as waits come down there may be a rise in DNAs.

The trust does not have visibility of therapist/modality DNA rates which is likely to give rise to considerable variation.



Outcomes

Recovery and Reliable Improvement
Factors Affecting Recovery Rates



Outcomes

Recovery Rates have been consistently below the 50% minimum. Findings on reasons for low recovery rates from NHS Digital¹ and others² show that primary factors that impact on recovery rates are:

1. The choice therapy is NICE-recommended for the patient's condition

Many patients are not assessed so the correct treatment cannot be reliably delivered.

2. The appropriate number of sessions are delivered to reach recovery

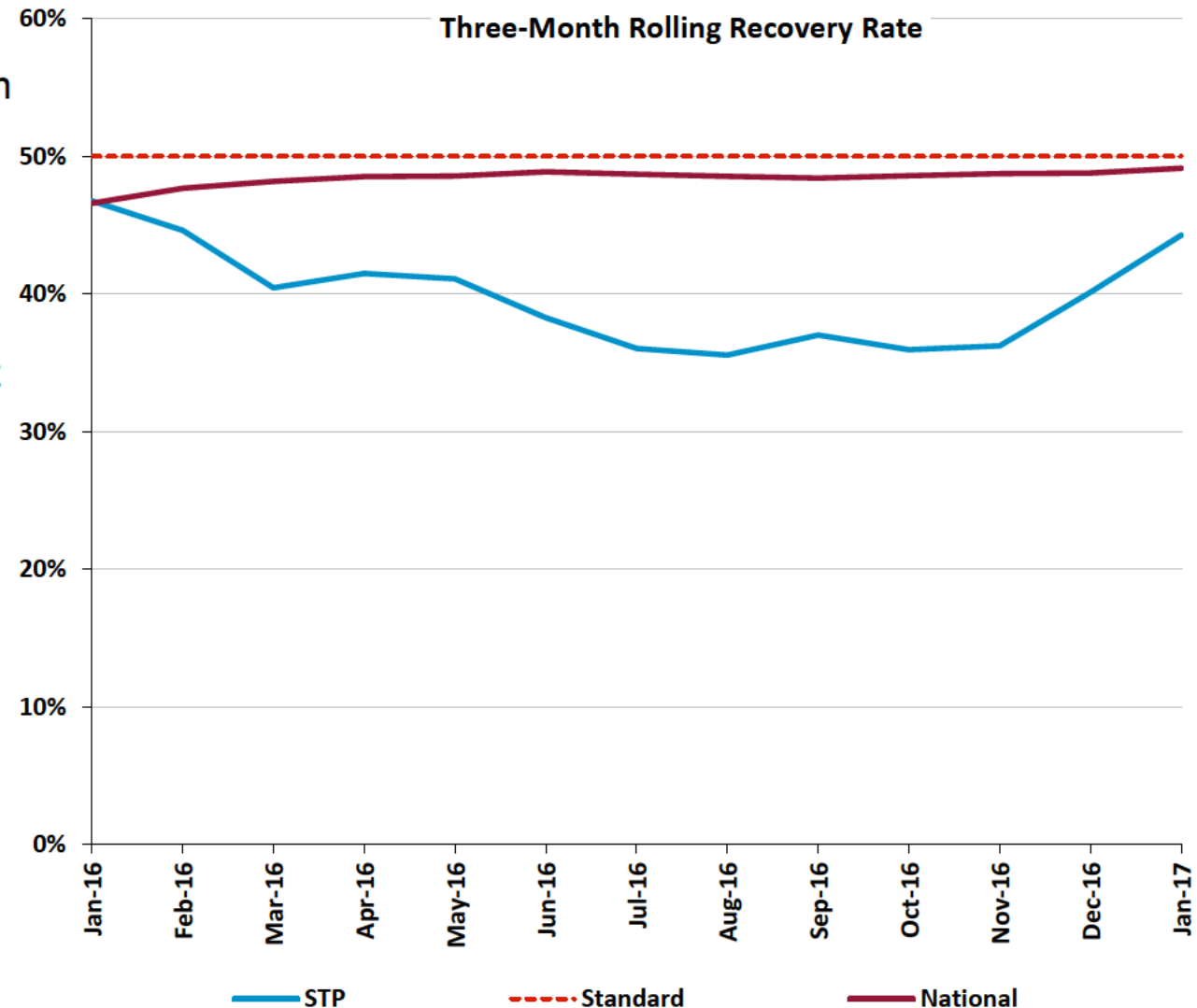
The trust was unable to produce this information.

3. IAPT MDS Data is complete and accurately recorded

Data quality in key measures is very poor.

4. Stable, trained workforce

Around one third of the step three workforce is not appropriately trained.



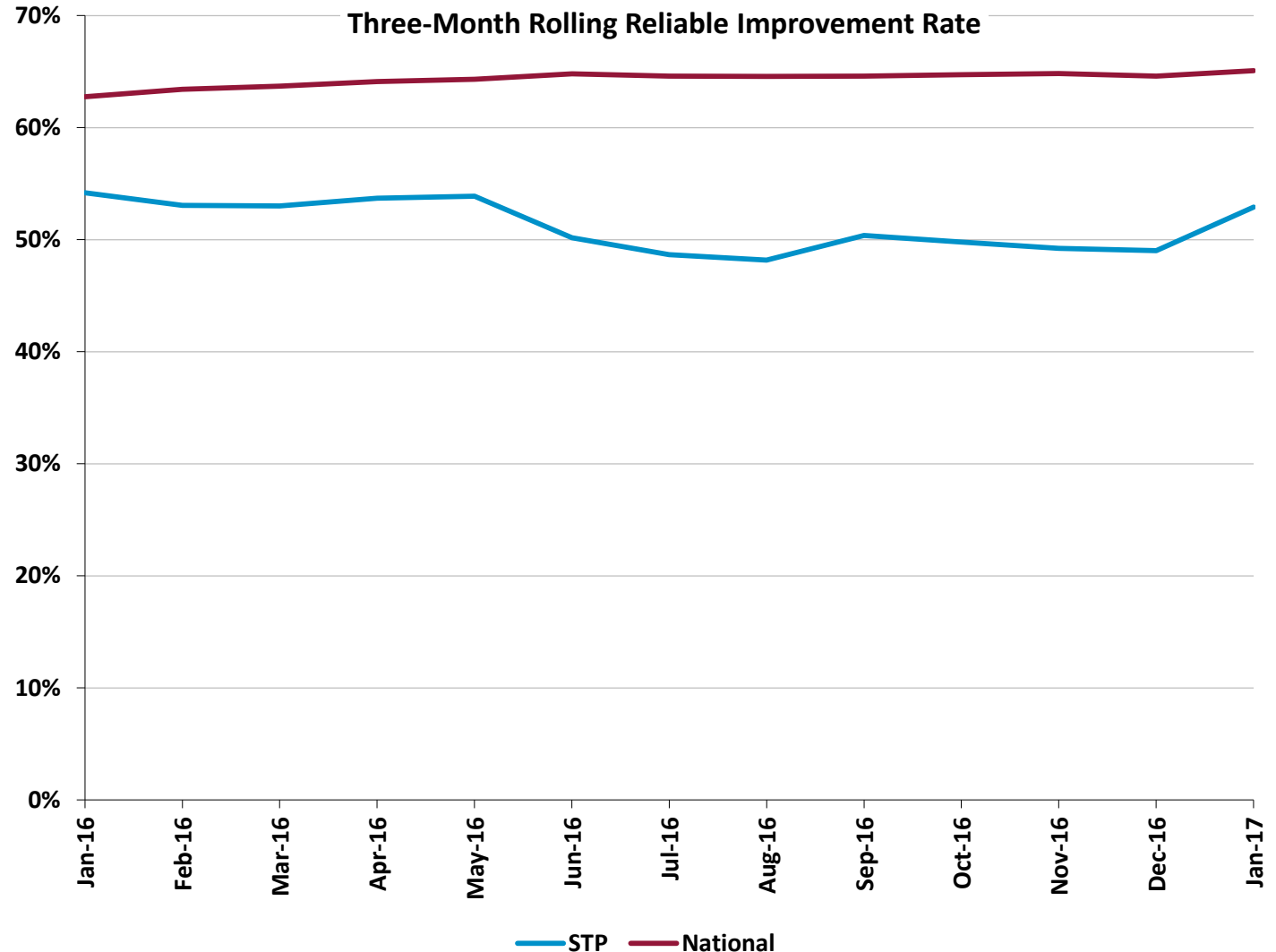
¹ <http://content.digital.nhs.uk/catalogue/PUB22110/psych-ther-ann-rep-2015-16.pdf>

² [http://www.academia.edu/4063164/Enhancing Recovery Rates Lessons from Year One of IAPT](http://www.academia.edu/4063164/Enhancing_Recovery_Rates_Lessons_from_Year_One_of_IAPT)

Outcomes

In addition the following factors contribute to those primary factors explored in other slides:

- 1) High DNA rate
- 2) High drop out rates, due to poor processes
- 3) Long waits
- 4) Poor recording of outcomes scores (all ADSMs) and presenting problem codes.
- 5) Stepped Care not used appropriately
- 6) Low self-referrals
- 7) Clinical Leadership and Supervision; Audit



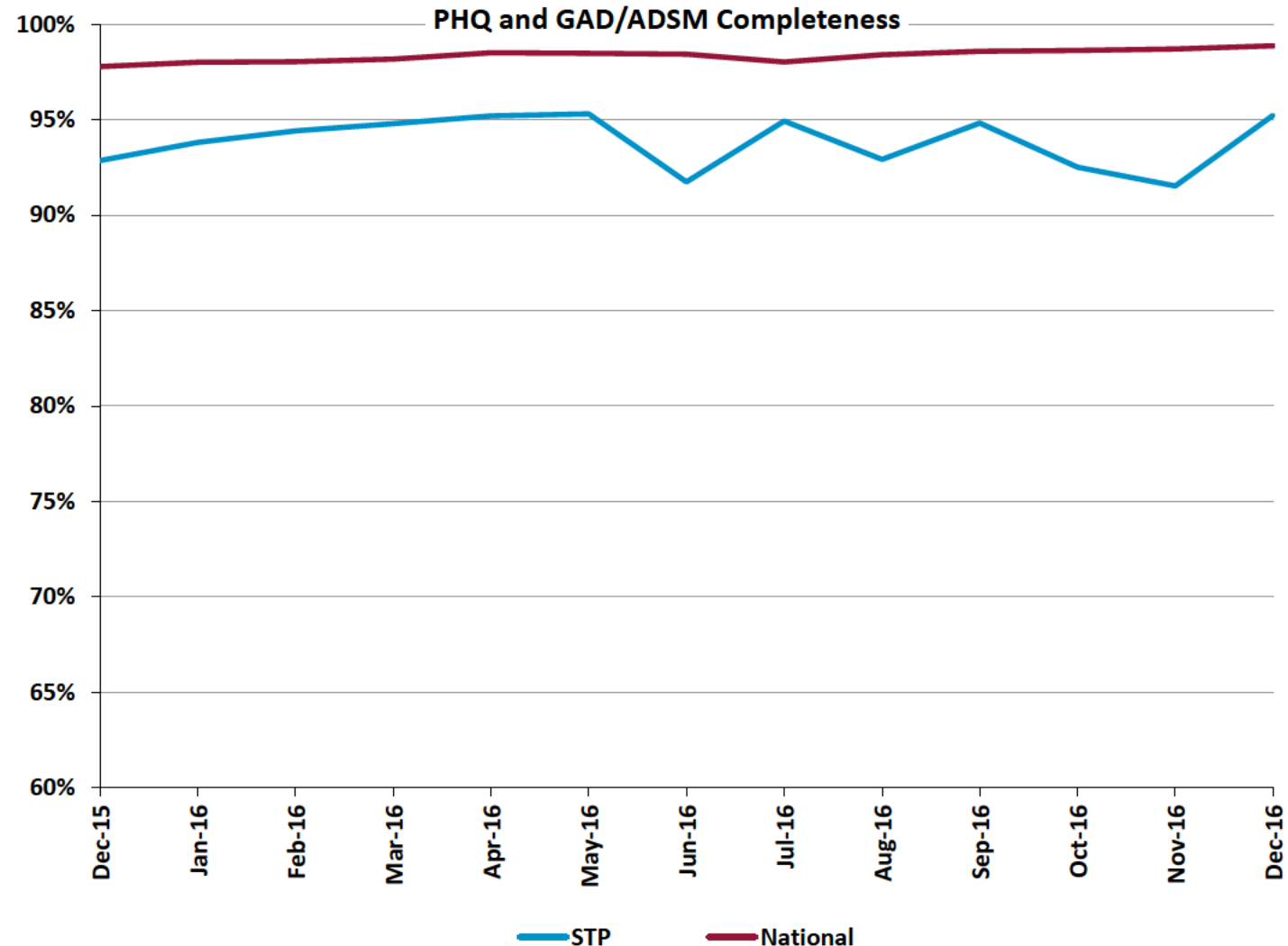
Data Completeness – Paired Scores

Paired score data completeness is important both for the recording of recovery and the demonstration of fidelity to the IAPT model.

Completion of outcome scores is below average. The national average is 98% and rising, with the majority of services recording 100%.

Therapists reported that they were unaware that ADSMs could be used in outcome calculations.

Therapists reported that they are using ADSMs in the course of their therapy but the recorded use of ADSMs is very low – around 7% across the whole of NSFT.



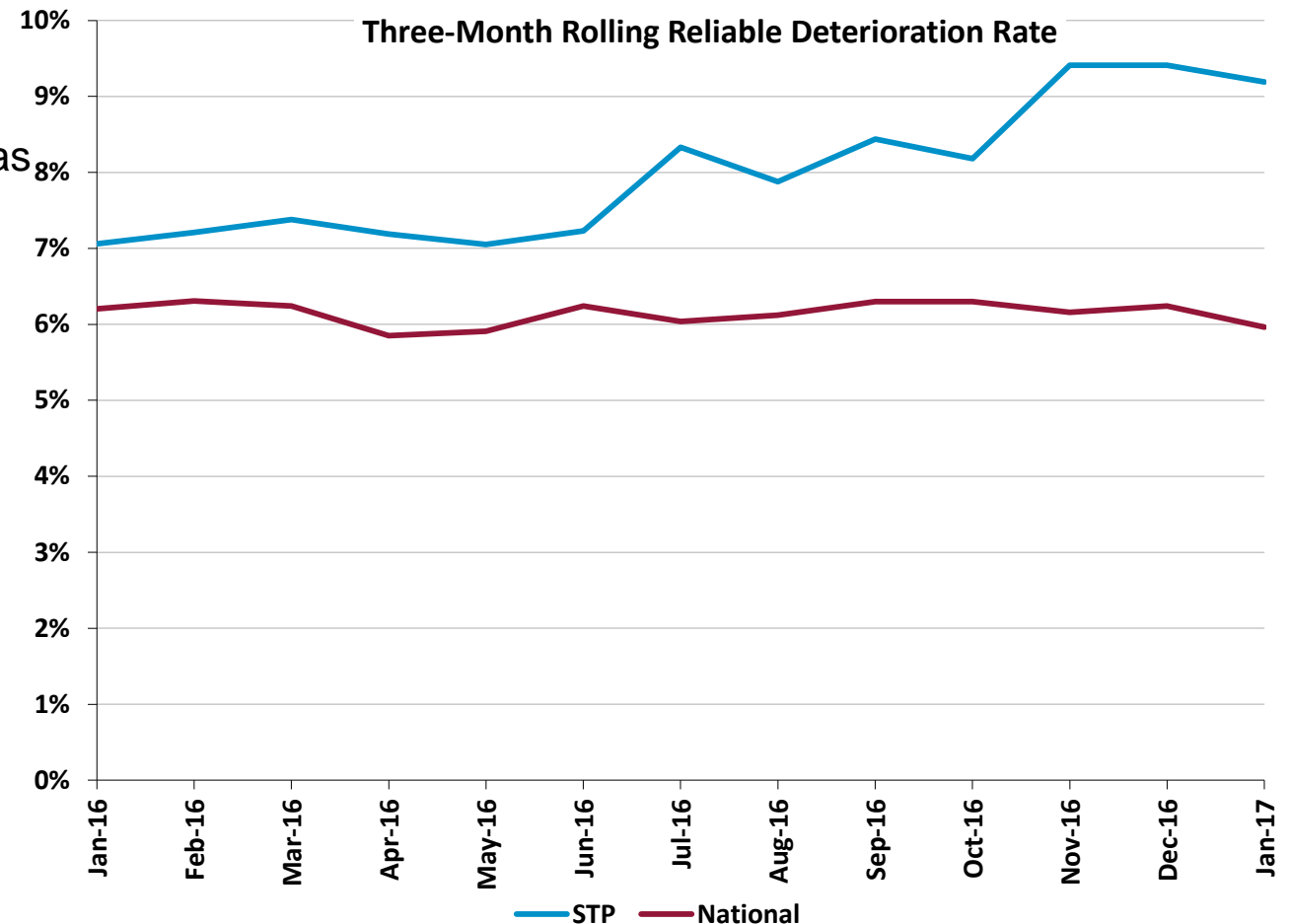
Reliable Deterioration

People who have not benefited from treatment in IAPT would be expected to show some reliable deterioration as natural fluctuations in their condition would persist.

There is, however, a growing body of evidence¹ which indicates that some psychological therapies when delivered in certain ways, can cause harm.

It is recommended that the Trust ask the following:

- Are the people who show reliable deterioration predominantly people who start below caseness or are they people who already have symptoms of clinical severity?
- Do some therapists who have seen a reasonable number of cases have particularly high reliable deterioration rates?
- Do some therapies or staff groups have particularly high reliable deterioration rates as currently implemented in the service?
- Do patients with some particular problems (ICD-10 codes) or particular backgrounds (age, gender, sexual orientation, ethnicity etc.) have particularly high reliable deterioration rates.



¹ Barlow, D.H. (2010). Negative effects from psychological treatments. American Psychologist, 65, 13-19

Data Completeness – Problem Descriptor

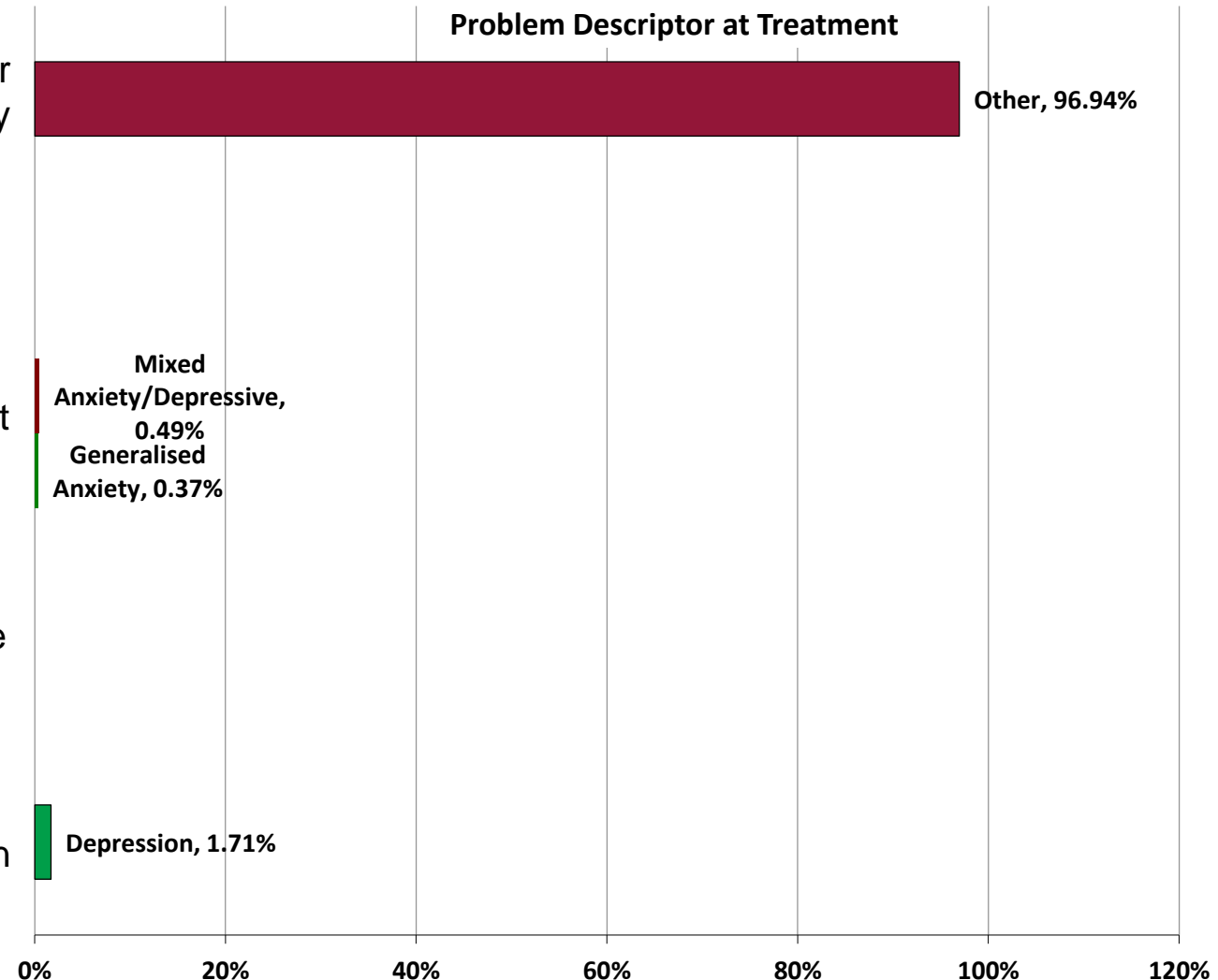
NHS Digital data for Q3 shows that around 97% of patients had a problem descriptor (ICD10) code recorded at the start or during treatment as ‘Other’ which is the default value added by admin staff on referral.

Many patients are not currently assessed, and problem descriptors are not used even where assessments do take place.

Problem definition should be used to ensure that the treatment chosen is NICE-recommended for the presenting condition during treatment (assuming appropriate treatment choices are available), to maximise recovery potential.

‘Mixed anxiety and depression’ should only be used for people with milder symptoms of depression and anxiety that are insufficiently severe or extensive to warrant any other (depression or anxiety) problem descriptor.

Services that incorrectly use the mixed anxiety and depression code for people with a depressive episode AND an anxiety disorder run the risk that they will miss the key features of the latter and hence give sub-optimal treatment.



Administrative Processes and Waits

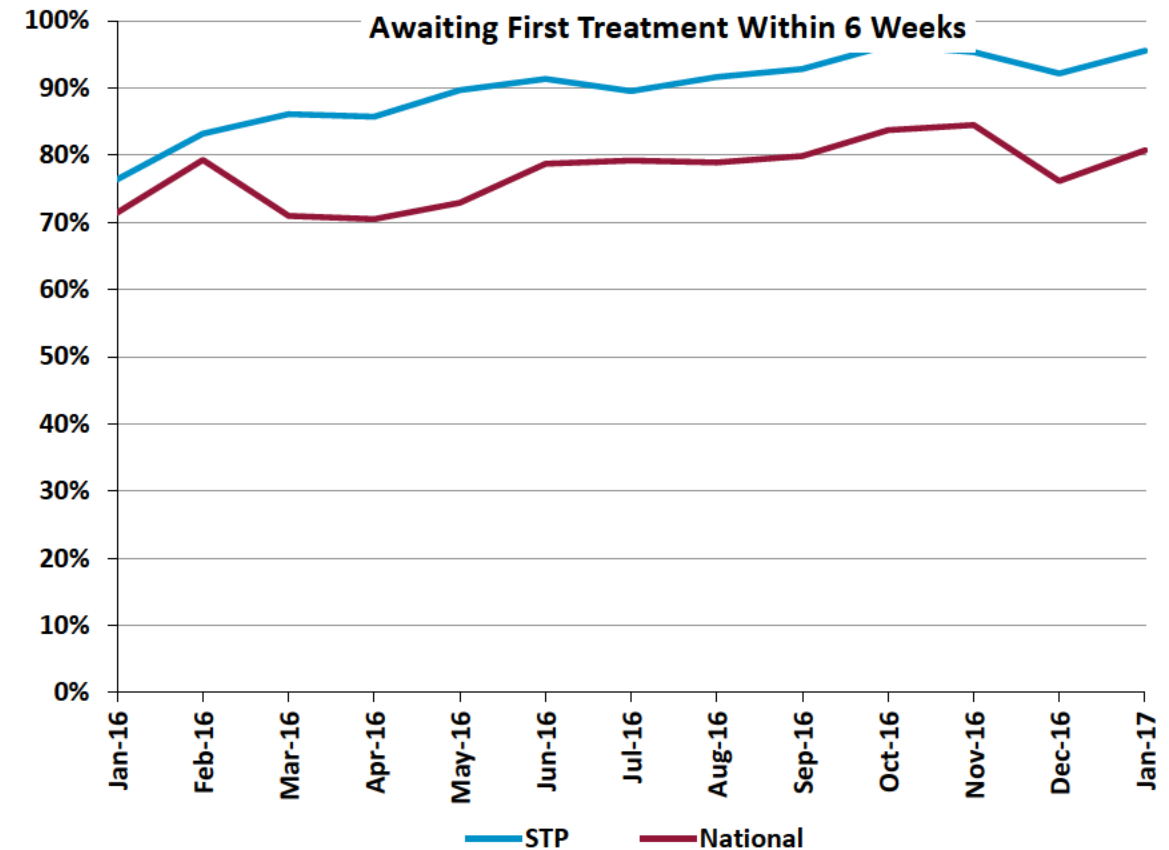
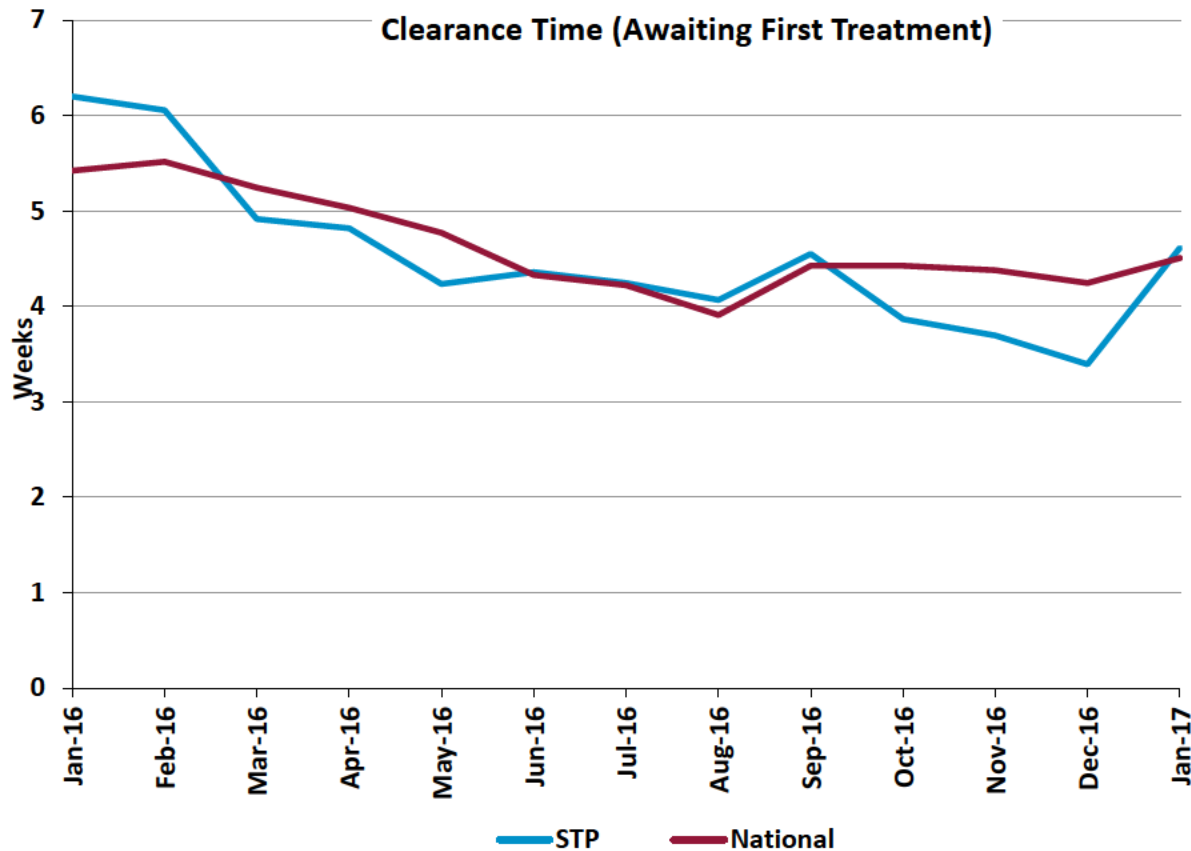
**Waiting Times and Waiting List Management
Information and Reports**



Administration and Pathway

- Patients who are referred through the SPOA (GP and health professional referrals) are triaged twice, mainly to identify if a patient is suitable for groups
- Booking processes are generally slick and patients are contacted and booked quickly for first and second appointments
- Only one attempt is made to contact patients by phone before they are sent a booking letter
- There is no guarantee that this attempt will be made 'out of hours'
- Dedicated 'new' slots are made available by all therapists. Where insufficient 'new' slots are available (Norwich), this capacity is not flexed and patients wait longer.
- Many GP surgeries will not permit other surgeries' patients to be seen, increasing waiting times and reducing access to the full range of IAPT modalities
- There is an inconsistent approach to charging for GP premises

Waiting Times – First Treatment



Waiting list size (measured as clearance time) and the proportion of patients waiting under 6 weeks are the most reliable predictor of future first treatment waiting times performance.

Against both measures, the trust is in line with national performance and delivery of the waiting times standards, and performance is improving. This is consistent with the focus on first treatment waits in contract monitoring.

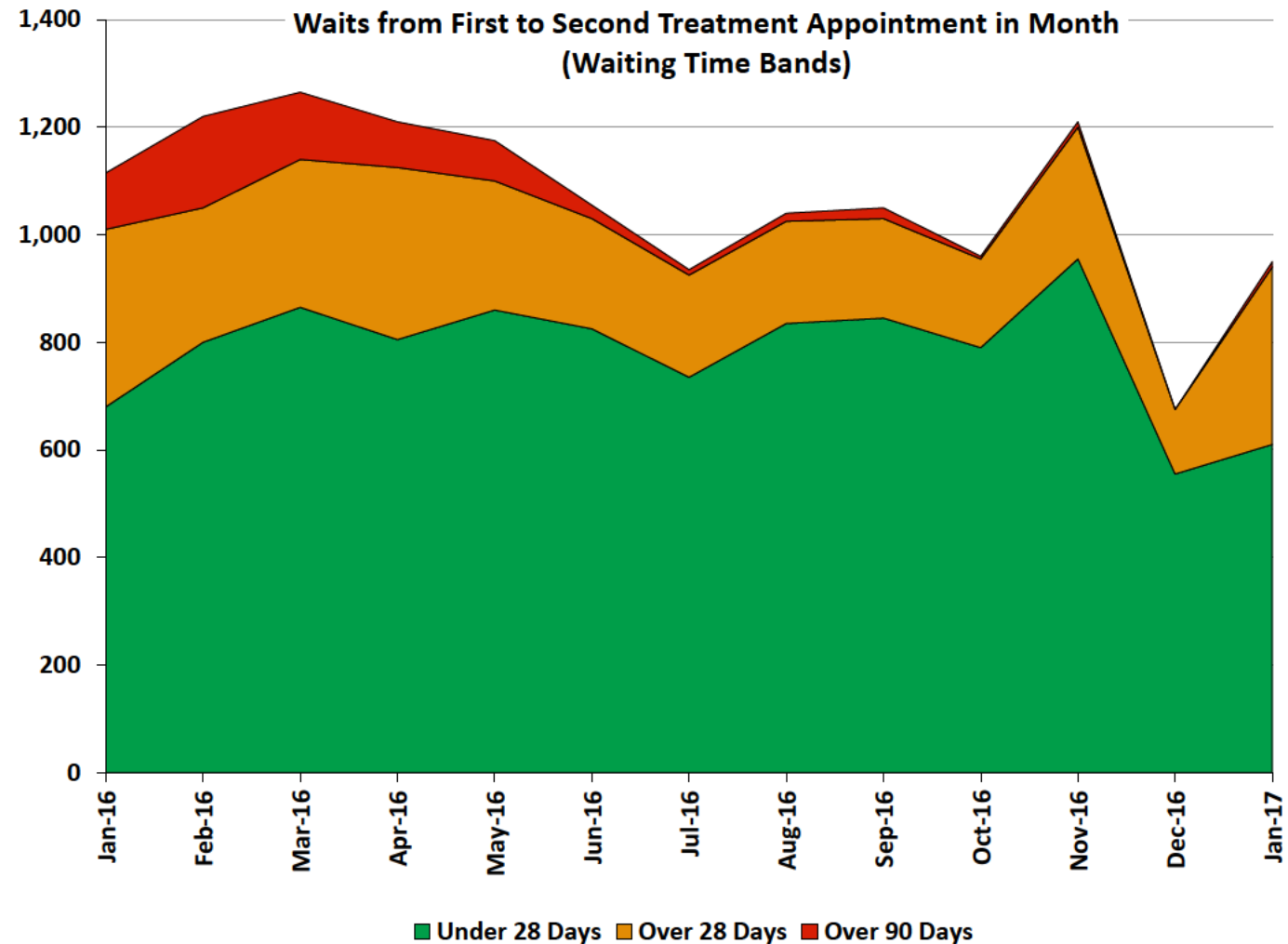
Waiting Times – Subsequent Treatment

It also appears from national data that there are no significant delays between first and second appointment.

The effects of the 15/28 day local waiting times standards mask **very long waits** between second and third treatment appointments and for step ups – in the region of six months overall, and approaching one year in Norwich CCG.

There is significant variation in waits across CCGs and across GP practices within each CCG meaning patient do not have equity of access to the service.

This is symptomatic of the imbalance of staffing resource across different CCGs and the reluctance of many GPs to allow other patient to be seen in their practices.



Information and Reports

- Data is not signed off prior to or after upload and there are no related governance processes in NSFT
- There is a redundant system to reconcile two local datasets, but no reconciliation of local to NHS Digital data
- Both provider and commissioner boards receive inaccurate local data
- There is regular data quality monitoring from a dedicated staff member, and issues are addressed with staff who make repeated errors
- Data quality checks are not currently aligned to data items which are key to supporting the service and reporting accurately e.g. paired scores, problem descriptors, ADSM use
- Data is not stored on the trust data warehouse making reporting time-consuming and inaccurate
- NHS Digital data is not checked and reconciled with local reports, and the NHS Digital PAVE and data quality reports are not used
- Regular waiting lists reports are produced to support first and second appointment processes
- No waiting list reports are produced to summarise and monitor third treatment waits
- Therapist dashboards are not currently in use and outcomes and productivity are not monitored at therapist level

Conclusions and Recommendations



Clinical and Pathway Recommendations

- Revise the patient pathway to ensure it is simplified, clear and more linear for the patient
- Ensure that all patients are assessed on entering the service
- Ensure that all patients are clustered at assessment
- Problem descriptors should be recorded at assessment and decision to treat should be based on the problem descriptor and NICE guidance.
- Patients on the enhanced care pathway who receive an IAPT psychological therapy should be included in IAPT data.
- Some of the 'social' care pathway could be considered for inclusion in IAPT data set e.g. groups/interventions that are behavioural activation and supervised by a qualified member of staff.
- Address long waits and consider an interim pathway for longest waits.
- Ensure all interventions/treatments are evidence-based and the full dosage available to patients,
- Counsellors should be required to train in an IAPT modality and a training plan put in place.

Admin and Management Recommendations

- Examine reasons behind high attrition rates and declining referrals, as well as underprovision to older adults and BME communities
- Revisit demand and capacity planning to address root cause of long waits
- Allocate increased analytical resource to IAPT within NSFT, ensure that IAPT data is easily accessible and, where possible, automated through trust data warehouse
- Use NHS Digital data in internal reports within both NSFT and CCGs, with local data only used for most recent months where NHS Digital data is not yet available
- Carry out monthly reconciliation of NHS Digital and local data using the PAVE report
- Align data quality measures to priorities such as problem descriptor, cluster and scores
- Develop more sophisticated waiting list management processes and reports for all waits
- Strengthen case management to include monitoring of delivered and forthcoming sessions, outcomes and DNA rates
- Develop therapist dashboards to support case management
- Regularly analyse outcomes by team/modality/therapist in order to focus service improvement

Contact

Follow us on Twitter [@MH_ISTNetwork](https://twitter.com/MH_ISTNetwork)

Michael Watson

Intensive Support Manager

Intensive Support Team (Mental Health)

M 07879 113 249

E M.Watson@nhs.net | W improvement.nhs.uk

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