ISLINGTON

REPORT OF THE HEALTH AND CARE SCRUTINY COMMITTEE

EFFECTIVENESS OF IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES (IAPT) AND SIMILAR SERVICES

London Borough of Islington
July 2017

CHAIR'S FOREWORD

Islington suffers some of the highest rates of mental health issues and also suicide in the country. The reasons for this would be a subject for a separate discussion, but these statistics in themselves make an overwhelming case for improving access to psychological therapies. We also know that historically, and also in the present, Mental Health issues tend to be the poor cousin of physical health in terms of both treatment and funding. The purpose of this review is to try and establish whether the Improved Access to Psychological Therapies (IAPT) is in fact effective, and whether it is actually succeeding in doing what the name of the service suggests: ie is the service actually improving access, and if so, is it doing it in an equitable way across differing social classes and ethnicities.

The primary issue is, unsurprisingly, funding. Government targets have been to treat the top 15% of people in need of the service, which is in itself a worryingly low figure. Recently however, the government has decided to increase the target to 20% of the relevant population, but without any increase in funding. This obviously threatens to put the service under unreasonable strain, and also makes light of the work currently being undertaken by the service. We are recommending in the strongest terms that the Council lobbies the government to match the increased targets with pro-rata increased funding.

We also heard that successful access to the service varies according to ethnicity. An example is the increasing number of Turkish men needing help. This is hampered partly by the lack of Turkish-speaking therapists, and partly by cultural attitudes to therapy in the Turkish community: For example, we heard that in Turkish language, there is no word for 'mental health', and that the nearest equivalent word is 'madness'. Obviously this makes it culturally more difficult for Turks to feel comfortable accessing the service.

Waiting lists are also worrying long, with 95% of patients having to wait 18 weeks to access the service. This also suggests that existing funding is not matching the existing demand.

The committee heard that there is a lack of evening and out-of hours appointments, which obviously makes it harder for people in employment to access the service – given that a course of therapy will involve weekly sessions for a period of 12-20 weeks, it may well be problematic for working people to be taking leave on a regular basis in order to access treatment.

We also heard that, for example, bereavement services are staffed entirely with volunteers, and that there is heavy dependence on the voluntary sector for some areas of the service.

Overall, whilst the committee got the impression that staff are working hard to deliver the service, and to meet government targets, the reality would appear to be that the service is more severely under-funded than the statistics suggest, due to long waiting lists and dependence on voluntary help disguising the real impact of current low funding levels.

The committee also gained the impression that the service is currently most easily accessed by more articulate middle-class residents, and that this group of service users are most likely to

respond to it best. The committee feels that the approach and advertising of the service needs to be further developed to accommodate differing cultures and ethnicities more equitably.

COUNCILLOR MARTIN KLUTE
CHAIR HEALTH AND CARE SCRUTINY COMMITTEE

Effectiveness of IAPT Scrutiny Review

Evidence

The review ran from September 2016 until July 2017 and evidence was received from a variety of sources:

1 Presentations from witnesses – Dr. Judy Leibowitz and James Gray – Camden and Islington Foundation Trust, Maya Centre – Tahera Aanchawan (Accept Consortium) Nafsyiat – Farideh Dizadi (Accept Consortium)

2. Presentations from council officers – Jill Britten, Islington CCG, Natalie Arthur, Islington CCG

Aim of the Review
To understand local arrangements in accessing IAPT and similar services, and the effectiveness of these services in helping people recover from mental health conditions

Objectives of the Review

- **To understand current arrangements and mechanisms for accessing IAPT services**
- **To review waiting times for IAPT services**
- **To assess the effectiveness of IAPT services**
- **To feedback the findings of the scrutiny to providers**
- **Publicity and awareness of the service**

The detailed Scrutiny Initiation Document (SID) is set out at Appendix A to the report

RECOMMENDATIONS:

That the Executive be recommended –

1. **Funding** Given the target for access to treatment is set to increase to 25% from the current target of 15%, as part of the 5 year plan for Mental Health, commissioners, the Council and the CCG should look to build on any opportunities to access additional funding from National Health Service England,as it becomes available, and to press for funding to be increased pro-rata across the service to support future delivery of the service in line with the Five Year Forward View
2. **Long Term Conditions:** Work should continue to increase the focus on supporting people with long term conditions or medically unexplained systems, as well as supporting people into employment
3. **Waiting Times:** Whilst the performance of Improving Access to Psychological Therapy services in Islington has met its targets for 2015/16 in relation to access and 18 week waiting times, the performance of other Clinical Commissioning Groups in the North Central London area, particularly in Haringey, exceed that of Islington in a number of areas. The Committee suggests Haringey's performance be used as a driver for improvement with sharing of best practice pursued to achieve this target
4. **Recovery rates:** The recovery rate for ICOPE has risen each year, but is still below the target of 50%. Whilst an action plan is in place to address the poor performance against recovery levels, this is an area that needs improvement. The Committee recommends that the action plan is reviewed, and that best practice be shared with other boroughs to try to improve recovery rates
5. **Feedback:** All service users using the ICOPE service be encouraged and supported to complete Family and Friends patient experience questionnaires, and provide comments in relation to their experience of the service
6. **Hard to Reach Groups:** Given the under representation of Hard to Reach and Black, Minority, Ethnic Refugee groups in accessing mental health services, alternative methods of advertising and accessing the service be pursued
7. **Interim Support:** Given that many service users experience long waiting times, the service needs to develop some form of interim support for those on waiting lists
8. **Turkish Speaking Therapists**: It has been suggested that there is a particular shortage of Turkish speaking therapists. The service provider should attempt to improve recruitment for this community group
9. **More after-work sessions:** In order to enable equality of access to the services more after-work appointments should be made available, and that efforts should be made to locate these appointments in non-National Health Service (i.e.community) premises, as there is an element of stigma attaching to attending an National Health Service building for mental health treatment
10. **Reporting:** Action to be taken to identify and address the reporting inaccuracies identified in the locally and nationally published data for 2015/16 and ensure that this is more accurate in future. Efforts should be made to address the need for more comprehensive information in relation to ethnicity data when accessing the service

MAIN FINDINGS

1.1 Improving Access to Psychological Therapies (IAPT) is a national programme, which aims to deliver NICE compliant treatments for adults, suffering from depression and anxiety disorders, which are also described as 'common mental health problems.'

1.2 The initial programme was developed in 2006, with pilot sites in Newham and Doncaster, focussing on adults of working age. In 2007 there were further 'Pathfinder' sites developed with outcome measures, in order to explore how vulnerable groups within the local population might benefit from this service, and identify barriers to access.

1.3 In 2010 the programme was rolled out nationally to adults of all ages. Services are commissioned by local Clinical Commissioning Groups (CCG's).

1.4 IAPT services are characterised by three things: evidence based psychological therapies delivered by fully trained and accredited practitioners, with type and level of treatment matched appropriately to the mental health problem. There is routine outcome monitoring, to enable both patients and clinicians to have up to date information on progress made. Data is anonymised and published by NHS England, in order to promote transparency and to support service improvement.

1.5 Regular, outcome focussed supervision also supports clinicians to continuously improve and deliver high quality care.

1.6 Locally, IAPT services are commissioned by Islington CCG and delivered by Camden and Islington Foundation Trust and the service locally is called i COPE. This service is delivered from a range of locations to support ease of access, e.g.GP surgeries and community sites, such as Manor Gardens.

1.7 Performance is monitored quarterly by Islington CCG, as part of the larger contract monitoring framework for NHS community mental health services.

1.8 The IAPT model is a 'stepped care' model, which seeks to deliver the minimum amount of treatment required, in order to deliver a positive outcome, whilst ensuring that the intensity of treatment can be increased or decreased, in line with the people's needs and progress – i.e. 'stepped up' or 'stepped down'.

1.9 Examples of treatment available include –

- Cognitive Behavioural Therapy (CBT)
- Interpersonal Psychotherapy (IPT)
- Brief Dynamic Interpersonal Therapy (DIT)
- Couple therapy for Depression
- Counselling for Depression

1.10 IAPT services sit within primary care, and can be accessed through referral by a professional, or by self- referral, including online and Islington aims to support the majority of people suffering from step 2 or step 3.

1.11 Online self-referral consists of a simple form and requires minimal information, i.e. name of GP surgery, if registered with a GP, name, a date of birth, address and information on the type of support required. Individuals can also self-refer by telephone if they prefer.

1.12 Following referral to the service, initial assessment is carried out by a Psychological well-being practitioner, in order to determine whether the service is suitable for the individual. Where

possible, assessments will take place on the telephone, however face-to-face assessments are also possible.

1.13 Step 2 includes low intensity interventions, which include self -help, computerised cognitive behaviour therapy, advice and support in taking anti -depressants, or other psychotropic medication prescribed by General Practitioners (GP's,, psycho-educational groups, support with accessing local community resources, including employment support, and exercise on prescription and pure self-help (Books on Prescription).

1.14 Step 3 high level interventions can include, cognitive behaviour therapy, individual and group therapy, interpersonal psychotherapy, behaviour couple therapy, and for Post Traumatic Stress Disorder eye movement desensitisation and reprocessing therapy.

1.15 In addition, Islington Clinical Commissioning Group (CCG) commissions Camden and Islington Foundation Trust to deliver a step 4a service, known locally as IATP plus. This service supports patients who present with longstanding complex problems of depression or anxiety, often associated with major adverse historical and/or current life difficulties, and co-morbidities, such as personality or relationship difficulties, or long tem physical health conditions and medically unexplained conditions

1.16 The aim of the intervention is to support the management of individuals within primary care and help people manage their conditions better, and achieve personally defined goals, rather than anticipating significant clinical improvement on existing IAPT measures i.e. many will not be expected to report that they have recovered as part of the clinical definition. Patients in these groups are offered a range of interventions appropriate for Step 4a clients, to help support their management within primary care, with additional psychological support. Interventions are offered in a variety of settings, including in a patient's home.

1.17 In respect of the national picture there are national targets in place – 15% of adults with relevant disorders should have timely access to IAPT services, and in Islington this equates to 31,031 people.

1.18 50% of people accessing IAPT services will recover and 75% of people referred to the IAPT programme begin treatment within 6 weeks of referral, and 95% begin treatment within 18 weeks of referral.

1.19 The rate of referral to the service increased by 13%, year-on-year, between 2013/14 and 2014/15. The service employed a number of methods to promote the service, amongst both professionals and the general public, and the increase in referrals is likely to be as a result of this work. Similarly, projected figures for 2016/17 suggest referrals are expected to reach approximately 9,202 people.

1.20 Access to treatment is measured nationally, with a target of 15% of the prevalent population to access treatment each year. The access rate in Islington has gradually increased year-on-year, exceeding the target from 2014/15 onwards.

1.21 Performance shows that the waiting times, against the 18 week target period, were exceeded in 2015/16, and have continued this trend into 2016/17. However, the proportion of people accessing treatment within 6 weeks of referral has fallen short of the target in 2015/16, with results for Quarter 1 showing similar results.

1.22 Recovery rate targets are set nationally, with the expectation that 50% of people entering treatment will report to be 'in recovery' at the end of the treatment period. Recovery rates are defined by the number of service users moving to below case level on clinical outcome scores, as a proportion of the number of people ending contact with services, and receiving at least two sessions of treatment. On average the number of sessions of treatment required is 6/9 sessions

1.23 The recovery rate for the service continues to be below target. Although local data for 2015/16 showed a recovery rate of 48%, once ratified at national level this fell to 43%, The service provider has in place an action plan, which seeks to address this challenge, and continues to work to identify areas, which may affect final performance in this area.

1.24 IAPT services use a number of well validated patient completed questionnaires to measure change in a person's condition. Most of the questionnaires are administered at each appointment, making it possible to track improvement comparing scores over time.

1.25 A number of factors can affect whether an individual meets the criteria of having recovered including -

- Severity of need at the start of treatment
- Delayed discharge from treatment
- Clinical decisions
- Whether an individual has met the 'threshold' for recovery, prior to being discharged

1.26 The widening of the acceptance criteria for the iCOPE service, (referred to in more detail below) to include patients whose needs fall within Step 4a, means that the service is more inclusive, and supports a much broader range of patients within primary care. However, due to the way in which recovery is measured nationally, it is acknowledged by commissioners that the issue has an impact on recovery rate.

1.27 There are local reporting challenges and the IAPT service is subject to quarterly monitoring by Islington CCG, as part of the wider NHS contract for mental health services in Islington.

1.28 As mentioned earlier, in 2016/17 it was identified that there were significant discrepancies between the locally reported data and the nationally published data for 2015/16. Following investigation, it has been identified that errors within the performance monitoring programme, used by IAPT service, had led to these discrepancies. It should be recognised therefore that the published performance data for 2015/16 does not reflect the work that was delivered. The service has taken action to address the errors identified in the 2015/16 reporting process, and it is expected that the reporting for 2016/17 will be much more accurate.

1.29 The majority of the adults accessing the service are between the ages of 18 and 64 years of age. Adults over 64 are currently under-represented, and the service is working to identify ways to increase levels of engagement from this group.

1.30 Ethnicity data shows that 30% of all referrals were from adults who identified as White British, whilst 19% identified as being from non-white backgrounds. Both figures are below the Islington population, as determined by the 2011 census, which recorded 48% of the population as White British and 32% from non-white backgrounds. However, the ethnicity data must be treated with caution, due to a number of reasons, including the census population data relating to all ages not just adults and the younger population in Islington being more ethnically diverse than the older population. In addition, almost 40% of all adults referred to the service either chose not to state their ethnicity or their ethnicity was not recorded, and therefore it is possible that the ethnicity breakdown would look very different if the ethnicity of all referees was reported. Ethnicity reporting has improved in 2016/17, with 95% of ethnicity information recorded

1.31 There are additional l outcome measures and the IAPT employs a variety of methods to measure outcomes and progress of individuals accessing the service. These include work and social adjustment measures, and an enablement instrument to suit the client group involved

1.32 These measurement tools allow the service to capture outcomes relating to a number of aspects of an individual's life, and progress made in these areas before, during and at the end of treatment. Examples of this measurement include the ability to understand and cope with problems, work, social activities, and family and relationships.

1.33 In terms of long-term physical health conditions, it is widely accepted that physical and mental health are closely linked with having a long term condition, which can increase the likelihood of developing a physical health need, whilst people with long term physical health conditions can develop mental health problems. IAPT services will be expected to increase their focus on supporting people with long term physical health conditions.

The 5 year forward plan for mental health sets out the following priorities for service development by 2021-

- To expand IAPT services, with access to increase to 25%
- Focus on people with long term conditions
- Supporting people to find or remain in work
- Improving the quality and people's experience of the service

1.34 With regard to local performance in 2014/15, the access rate exceeded 15%, however recovery rates fell well short of 50%. Waiting times were also below target and identified as an area for improvement in 2015/16. In 2015/16 the 15% target for access was exceeded. The recovery rate is 48%, waiting times improved and the 18 week target was met. In 2014/15 an action plan was put in place to address the poor performance against recovery levels, which delivered a small increase by the end of the year. However, it is recognised that this needs to be a key area for improvement.

1.35 In 2016/17 access is expected to again exceed the target of 15%, possibly to 17%. This is likely to have an impact on waiting times, due to finite resources. Islington IAPT service takes referrals with higher levels of depression and anxiety, which is positive, but is likely to affect the recovery rate.

1.36 There are challenges facing the service and also in terms of delivering the 5 year forward view for mental health, however it is the intention to increase access to 25% by 2021/22. There has been to date, no further detail from NHS England as to how this will be supported and the Committee feel that this is an area that needs to be addressed.

1.37 As highlighted by the performance data, the current target for access to treatment is 15% of the prevalent population, and the service is on course to achieve 16/17% access. This was also achieved in 2015/16. As stated above, as part of the 5 year plan, this is set to increase by 25% by 2020. This will pose a significant challenge within current resources, and commissioners will be working with service providers in order to identify how to address this.

1.38 In addition to increased access rates, as part of the 5 year forward plan for Mental Health, there will be an expectation that IAPT services will increase the focus on supporting people with long term conditions, or medically unexplained symptoms, as well as supporting more people into employment. This Islington service already works well with the local Mental Health Working (Employment Support) programme, and local reporting of long-term conditions is already underway.

1.39 The performance of IAPT service in 2015/16 shows that, whilst Islington has met the targets for access and 18 week waiting times, the performance of other CCG's in the North Central London region, particularly Haringey, exceed that of Islington in a number of areas. The recovery rate for iCOPE has risen each year, but this is still below the target of 50%. In 2014/15 an action plan was put in place to address the poor performance against recovery levels, which delivered a small increase by the end of the year. However, it is recognised that this needs to be a key area for improvement in 2016/17.

1.40 The Committee received evidence from Camden and Islington NHS Foundation Trust, who delivered services on behalf of the Council, through the iCOPE service, which is referred to earlier in the report.

1.41 The iCOPE service has an established service user advisory group, which includes both current and former service users. The service consults the user group and seeks feedback, in order to identify areas of the service that can be improved, and to support developing new ideas to promote and deliver the service. In addition to the group, all service users are encouraged to complete patient experience questionnaires, friends and family feedback and there are suggestion boxes for anonymous feedback at team bases.

The service is in the process of recruiting to 'peer mental' health worker posts, to facilitate treatment workshops, and for other opportunities of supporting delivery.

The Islington iCOPE service promotes the service in a number of ways -

- Leaflets
- Posters
- Co-location in GP surgeries and other community settings to encourage ease of access
- Partnership working with local organisations and giving talks to members of those organisations

1.42 The level of mental health need in Islington is high, both in comparison with other London Boroughs, and nationally. The recent 'Healthy Lives, Healthy Minds' report by Camden and Islington Public Health team identified that local data shows that approximately 29,900 adults in Islington have diagnosed unresolved depression or anxiety (16% of residents aged 18 or over), whilst an additional 15,897 adults are estimated to have a common mental health disorder, which has not been diagnosed.

1.43 The high level of need, and the severity of those needs, presents a challenge for the IAPT service, not just in terms of capacity, but also with regards to being able to provide interventions that support people to move into a state of sustainable recovery. Where an individual's needs require more intensive support, the IAPT plus service is available to provide a variety of interventions, however, it is recognised that many people accessing the IAPT plus service will not meet the criteria for recovery.

1.44 There are a number of examples of local innovation and good practice. Examples of these include 'iCOPE talks', which in 2014/15 was delivered to parents (working in partnership with schools). This promoted the service and raised awareness of good mental health and well-being. Partnership work is also taking place with other local community organisations, in order to promote good mental health wellbeing.

1.45 The 'Leaps Project', in conjunction with Training Job Centre Plus, also enables staff to identify and refer individuals to' iCOPE'. There is also 'Mental Health Working', which regularly submit the highest number of referrals to the commissioned mental health working (employment

1.46 The Committee also received evidence from Dr. Lucy Williams-Shaw, the user involvement lead and service users of the iCOPE service.

1.47 Members were informed that there is good user satisfaction with the service and a variety of methods are used to ask users about their experience of the service with therapists asking for feedback, feedback user forms being made available in waiting areas and the ability to provide e mail feedback. This feedback is reviewed and discussed and any necessary changes made.

1.48 It was noted that 98.1% of users would recommend I COPE to family and friends as indicated by the Family and Friends test. 48% of discharged patients completed the Patient Experience Questionnaire however there are a number of reasons preventing this from being a greater return at present, although work is taking place on this.

1.49 The Committee noted that the service users who gave evidence had stated that it had been easy for them to access the service and their experiences had been positive. One of the residents had attended the group session and the other one an individual session and that they had both benefitted from these.

1.50 The Committee noted that the maximum number of sessions permitted is 20 sessions and usually ranged from 6 to 20 sessions. It was added that some evening sessions are provided, however this is constrained by availability of premises. The Committee were of the view that this is an area that should be looked at to provide more evening sessions.

1.51 A monthly poster is displayed in waiting areas regarding the feedback that has been received and how it is being acted upon.

1.52 Service users contribute by attending the iCOPE advisory group where service developments are discussed and they can join the list of advisers and contribute to focus groups, answer surveys and get involved with specific projects. In addition, they can apply to work in a paid capacity as a peer-well- being worker. Service users can also provide feedback and help recruit new staff by training to be interview Panel members.

1.53 The Committee were also informed that ‘Silvercloud’ is a 2016/17 pilot of online Cognitive Behavioural Therapy, for those people with a low level of need. This may also help to attract those people currently under-represented in IAPT services e.g. men.

1.54 In addition to the statutory IAPT service, Islington also commissions third sector organisations, to provide ‘Talking Therapies’ to meet specific needs, and the new contract commenced in September 2016.

1.55 These services are – Talking Therapies for people with Black, Minority Ethnic and Refugee (BMER) communities – Talking Therapy for people who have suffered child sexual abuse and/or domestic violence and Talking Therapy for people who have suffered bereavement. This service is commissioned through a lead provider model and includes the following organisations –

- Nafsiyat Intercultural Therapy Centre – Lead Provider
- Women’s Therapy Centre – sub contractor
- The Maya Centre – sub contractor
- Camden, City and Islington Bereavement Service – sub contractor

1.56 The support needs of those who may need longer treatment or have more complex needs, will need to be addressed e.g. refugees. Currently, additional talking therapies from the third sector support this need, however demand is high

1.57 There are also a number of challenges facing the Islington IAPT service, alongside areas where commissioners expect performance to improve.

1.58 National campaigns to remove the stigma of mental health were continuing to take place, and the IAPT service worked closely with Job Centre Plus and employment services to support people suffering from mental health problems. The benefit cap has had an effect on the mental wellbeing of some of the people who have been affected by this, and this is creating additional problems.

1.59 As stated earlier, elderly people are underrepresented in accessing mental health services, but when they did, the recovery rate is good.

1.60 Alternative ways of enabling people to access the service more conveniently and to increase access are being implemented including the use of skype or by e mail, however where people needed face to face contact, the Committee noted that this would continue to be provided.

1.61 There are a number of people with complex needs, and the IAPT plus service can assist in this. The IAPT service is well integrated with primary care and this helps increase access to the service.

1.62 The Committee noted that some BME communities had difficulty in filling in forms, and that there is a continuing need to investigate alternative methods of advertising and accessing the service. However, the most under represented group accessing services at present were in fact the white/other group. It is recognised that there are gaps in the service and the Committee noted that the Manor Gardens centre is employed to try to reach those communities currently not accessing the service.

1.63 The Committee also received evidence from service providers delivering non IATP therapies – the Mayat and Nasfiyat centres. These organisations provide a targeted response in response to local demand and had 3 elements, BMER communities, Child Sexual Abuse and Domestic violence and Bereavement service. The Mayat Centre is a women's only project and therapists were community based and looked at the client in the whole and both the Mayat and Nasfyiat Centres aimed to maximise their resources.

1.64 This is jointly funded by the Council and CCG through third sector providers, such as the Mayat and Nasyfiat centres and is a time limited service of between12 and 20 sessions. This complements existing IATP provision to support an increase in access to psychological therapies for identified under represented communities, and to provide counselling for those users would not normally access services.

1.65 The service differs from IAPT, in that it has a higher threshold, equivalent to stage 3 on the IAPT stepped care model, has a women only element, access to therapists with a range of language skills and overcomes barriers by matching therapists with the same background. As it is non NHS and helps overcome barriers associated with the fear of Mental Health services.

1.66 50% of those who complete treatment move to recovery, this is aligned with the IAPT target and 60% of those who completed treatment maintain a clinically significant improvement at 3 months post therapy. 40% of those who complete treatment maintain a clinically significant

improvement at 6 months post therapy, and 50% of those who complete treatment access ongoing support within the community, including peer support. 50% of those who complete treatment self-report an improved level of confidence in maintaining their own mental well-being.

1.67 A high number of referrals are received and the majority are accepted. The numbers on the waiting list and referrals for BMER and Bereavement services indicate that the target for accessing treatment will be met. However, there are concerns about the recovery rates for Child Sexual Abuse, Domestic Violence and Bereavement services, however it is felt that the measurement is partly affected by the data reporting tools used.

1.68 Performance against key areas of focus are - to increase people from BMER communities accessing talking therapies, and an increase in men and older people accessing talking therapies. LGTB representation is difficult to measure due to lack of self-reporting.

1.69 The challenges include demand for services compared to service capacity, there are over 100 on the waiting list, interim support for those on the waiting list, availability of Turkish speaking therapists, encouraging access from other BMER groups, encouraging access from older people and men, and performance monitoring and measuring outcomes.

1.70 It was noted that it was encouraging to see new communities accessing services.

1.71 It was also noted that future developments included investment in reporting systems, in line with the IATP service, improved performance reporting to support better understanding of gaps in provision and the low recovery rate, and to collect performance figures to contribute to local IATP data from 2018/19. In addition, to support the local Syrian refugee resettlement programme, there will be linking in with the Camden and Islington Foundation Trust's complex depression and trauma service.

1.72 The Committee considered the over representation of the Turkish community in non IATP services and whilst this is of concern, it is an indication of the success of the scheme given that the Turkish community had previously not accessed the service. It was noted that it is hoped to increase the number of Turkish therapists in the future.

1.73 The Committee were informed that in terms of BMER there was a 4/5 month waiting list but bereavement waiting lists were shorter, however work did take place with those people waiting for treatment.

1.74 The Committee were also informed that it was proving difficult getting patients to provide feedback and this is currently being looked at to introduce measures that will increase response rat

CONCLUSION

The Committee have made a number of recommendations that it is hoped will improve access to IAPT and similar services in the future. However, the Committee are of the view that the underfunding of mental health services by the Government in recent years has made it more difficult to provide adequate service provision and that, in view of the proposals in the Government's 5 year plan for mental health there needed to be much more clarity around funding for mental health provision in order to meet the targets set.

The Committee would finally like to thank all the witnesses who gave evidence to the Committee and to the service providers for the excellent work that they undertake.

MEMBERSHIP OF THE HEALTH AND CARE SCRUTINY COMMITTEE – 2016/17

MEMBERSHIP 2016/17	**MEMBERSHIP 2017/18**
Martin Klute – Chair	**Martin Klute - Chair**
Rakhia Ismail – Vice Chair	**Nurullah Turan – Vice Chair**
Nurullah Turan	**Michelline Safi-Ngogo**
Michelline Safi-Ngogo	**Jilani Chowdhury**
Una O'Halloran	**Gary Heather**
Jilani Chowdhury	**Troy Gallagher**
Gary Heather	**James Court**
Tim Nicholls	**1 Vacancy**
Co-opted Member:	**Co-opted Member:**
Bob Dowd – Islington Healthwatch	**Bob Dowd – Islington Healthwatch**
Substitutes:	**Substitutes:**
Alice Perry	**Alice Perry**
Dave Poyser	**Satnam Gill OBE**
Clare Jeapes	**Angela Picknell**
Satnam Gill	**Clare Jeapes**
Angela Picknell	
Marian Spall	

Olav Ernsten/Philip Watson – Islington Healthwatch

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Peter Moore – Democratic Services
Lead officer/s- Simon Galzynski, - Directorr Adult Social Care Jill Britten – Islington CCG

APPENDIX A

SCRUTINY REVIEW INTITATION DOCUMENT
Review: Improved Access to Psychological Therapies (IAPT)
Scrutiny Committee: Health Scrutiny Committee
Lead Officer: Simon Galczynski, Service Director Adult Social Care
Overall aim: To understand local arrangements for accessing IAPT services and similar services, and the effectiveness of these services in helping people recover from mental health conditions.
Objectives of the review:- • To understand current arrangements and mechanisms for accessing IAPT service. • To review waiting times for IAPT services. • To assess the effectiveness of IAPT services • To feedback the findings of the scrutiny to providers • Publicity and awareness of the service
Duration: Approx. 6 months
How the review will be conducted Scope: The services in scope of this time limited scrutiny review are NHS IAPT services commissioned from Camden and Islington Mental Health Trust (iCOPE). Types of evidence to be assessed: • Documentary evidence on demographics of those using the service and accessibility or reason adjustments made to ensure accessibility to the service • Documentary evidence on national standards for access, waiting times and recovery rates; including any additional outcome measures collected. • Witness evidence from a range of relevant individuals and organisations a. Patients and their representatives and consumer organisations i. Patients by experience ii. Patient representatives and groups e.g. Islington Borough User Group (IBUG) b. Commissioners i. Islington Joint Commissioning Team c. Providers i. Camden and Islington Foundation Trust
Additional information: In addition to the statutory IAPT service Islington has recently commissioned 3rd sector organisations to provide Talking Therapies to meet specific needs as below (contract commences September 2016).

- Talking Therapy for people within Black, Minority Ethnics and Refugee (BMER) communities
- Talking Therapy for people who have suffered child sexual abuse and/or domestic violence
- Talking Therapy for people who have suffered bereavement

This is commissioned under a lead provider model, the following organisations are involved.

- Nafsiyat Intercultural Therapy Centre
- Women's Therapy Centre
- The Maya Centre
- Camden, City and Islington and Westminster Bereavement Service