Health and Social Care Scrutiny and Performance Panel **Agenda Item No. 7**

29 January 2013

Primary Care Talking Therapies

Ward(s) All

Portfolios: Cllr B. McCracken – Social Care and Health

Executive Summary:

- This report is to inform members of the aims of Primary Care Talking Therapy Service.
- It shows current team performance in relation to local targets and both regional and national indicators.
- Additionally, concerns around capacity and referral rates are raised.
- It also highlights the imminent introduction of a new internet based therapy service to reduce demand on the local NHS provider.

No decisions are required of members but, to be informed of the current and future service delivery. A report will be presented in the future updating scrutiny panel of the impact of service changes to users as well as key performance indicator information.

Reason for scrutiny:

The reason this report has come to health and social cares scrutiny is to update and inform panel members on the progress made and effectiveness of the service in delivering primary care talking therapies in Walsall in a climate of economic crisis

In delivering this report the JCU mental health team would welcome the opportunity to present this pathway to members should it be so desired so as to fully inform and share this area of primary mental health care

Recommendations:

That:

Health and Scrutiny Panel accept the performance and development noted in this report

Background papers:

1. Primary Care talking therapies service specification
2. Primary care talking therapies scorecard
3. BWW evidence paper

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1. Report

Introduction

Primary Mental Health Care is a relatively recent concept in health care. It is defined as:

- First line interventions that are provided as an integral part of general health care
- Mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services

Common mental health problems can be costly if not treated early as users may require treatment later in secondary care or inpatient services

Some 17.6% of the adult population (21.0% of women and 11.9% of men) have a common mental health problems (anxiety and/or depression)

Additional information and the service specification are attached (appendix 2).

Service delivery

In Walsall we had existing primary care talking therapy services which were co located within GP surgeries prior to the advent of the Improving Access to Talking Therapies initiative introduced by the DoH. Walsall was funded by this initiative in wave 3 in 2010 with a small allocation of £380,000

The provision of primary mental health services has a number of objectives

- Should be provided mainly in primary care (GP surgeries) by the primary care team working collaboratively with other services, with access to specialist expertise and to a range of secondary care services as required
- Effective treatment of common mental health disorders using a stepped care approach
- Have a clear focus on prevention and early detection
- Promote self-management by patients including the use of personalised care plans
- Should be holistic – mental health has physical, psychological, social and spiritual elements
- Outcomes systematically measured and reported

Outcome measures

The outcomes we measure and capture in Walsall include:

- Cost efficiency
    - PbR (payment by results)
    - % of people with LTC(long term conditions) who have been screened for anxiety and depression
    - % of people with MUS (medically unexplained symptoms)
- Outcomes effectiveness
    - Personalised care plans and patient goals
    - CORE (for effectiveness of talking treatments0
    - Compliance with IAPT date standards
- For patients safety
    - <75 mortality rate
    - QOF incentives
    - Completed suicide rates
- For recovery
    - Employment rates of people with mental illness

- Patient self-defined goals
- Mental health recovery star

The Primary Care Talking Therapy service in Walsall has been developed to support the delivery of the mental health strategy

1. More people will have good mental health
2. More people with mental health problems will recover
3. More people with mental health problems will have good physical health
4. More people will have a positive experience of care and support
5. Fewer people will suffer avoidable harm
6. Fewer people will experience stigma and discrimination

Performance of the service 2011/12

Details below for a number of performance figures to inform on the progress of this service

	Q1 2011-12	Q2 2011-12	Q3 2011-12	Q4 2011-12	Total 2011-12
Number of referrals	2659	1903	3458	2014	10034
Not suitable	61	72	58	101	292
Number of service users offered initial assessments	1836	1603	2400	1963	7802
Number of service users who attended initial assessment	1127	1250	1539	1202	5118
Number of DNA's for initial assessment	411	438	475	478	1802
DNA rate	36%	35%	31%	40%	Avg. 36%
Number of service users who received treatment after assessment	1003	1178	1480	1121	4782

As can be identified there are a number of DNAs (did not attends) which the commissioners and the providers are working towards identifying solutions

Performance measures in 11/12	Annual Target	Achieved
The number of people who have been referred for psychological therapies	6147	10034
The number of people who have entered psychological therapies. This includes those that may only require one intervention	4818	5118

- Walsall received 3877 more referrals than planned
- Walsall saw 300 more people enter psychological therapies than planned.

This increase could be due to the economic climate in people accessing services for anxiety and/or depression

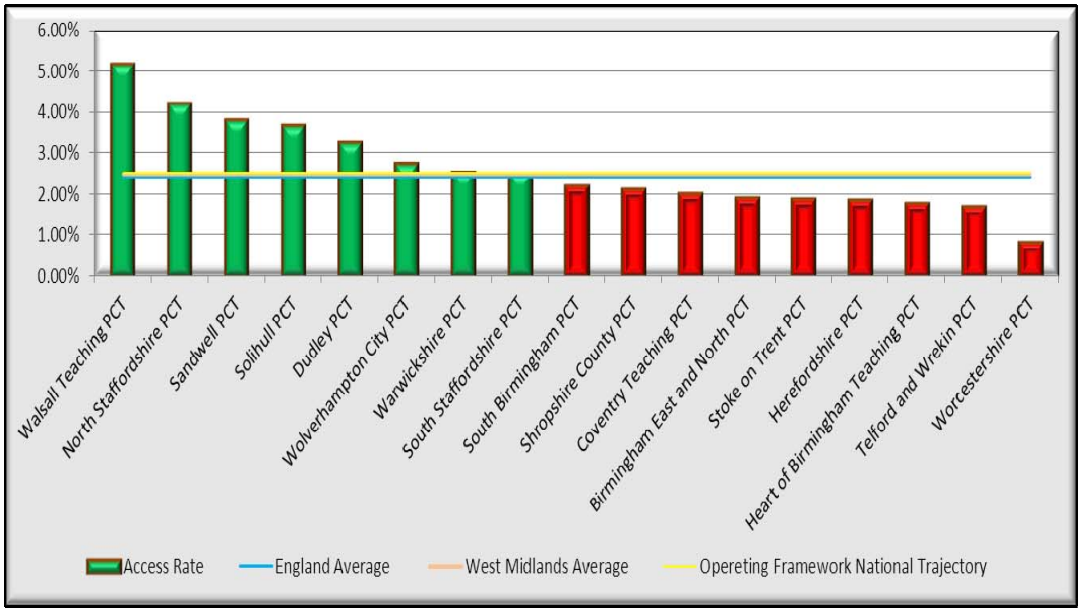
Performance of the service 2012/13

The table below shows activity and performance in primary care talking therapies in the first 6 months of 12/13. Key conclusions are:

- The volume of referrals remains high and is increasing quarter on quarter.
- The number of people entering and completing treatment is increasing quarter on quarter.
- Long waits (>28 days) are decreasing.
- The number of people moving off sick pay and benefits has improved in Dudley, but has decreased slightly in Walsall

	Location	Apr	May	Jun	Q1 2012-13	Jul	Aug	Sep	Q2 2012-13	DOT
No. Referrals In	**Trust**	1192	1406	1225	**3823**	1464	1210	1444	**4118**	⇧
	Dudley	507	682	578	**1767**	624	502	663	**1789**	⇧
	Walsall	685	874	660	**2219**	840	708	781	**2329**	⇧
No. ≥28 Day Wait	**Trust**	276	328	326	**535**	300	313	294	**480**	⇩
	Dudley	129	143	141	**241**	148	152	112	**228**	⇩
	Walsall	147	185	185	**294**	152	161	182	**252**	⇩
No. People entered Psych. Services	**Trust**	739	936	762	**2437**	990	772	943	**2705**	⇧
	Dudley	300	422	345	**1067**	411	317	417	**1145**	⇧
	Walsall	439	514	417	**1370**	579	455	526	**1560**	⇧
No. Completed Treatment	**Trust**	240	253	201	**694**	257	231	250	**738**	⇧
	Dudley	122	129	97	**348**	131	117	140	**388**	⇧
	Walsall	118	124	104	**346**	126	114	110	**350**	⇧
No. Moving to Recovery	**Trust**	111	112	84	**307**	124	102	119	**345**	⇧
	Dudley	56	58	35	**149**	67	50	71	**188**	⇧
	Walsall	55	54	49	**158**	57	52	48	**157**	⇧
No. Moving off sick pay and benefits	**Trust**	20	21	18	**59**	20	17	18	**55**	⇩
	Dudley	5	10	6	**21**	10	8	11	**29**	⇧
	Walsall	15	11	12	**38**	10	9	7	**26**	⇩

	Q3 2011-12		Q4 2011-12		Q1 2012-13		Q2 2012-13		DOT
	AVG (days)	MAX (days)	AVG (days)	MAX (days)	AVG (days)	MAX (days)	AVG (days)	MAX (days)	Av
Waiting time for initial assessment	10	189	6	119	5	177	3	88	↓
Waiting time for treatment	14	225	6	119	6	135	4	80	↓
Waiting time step 2	24	225	7	70	3	80	4	56	↓
Waiting time step 3	10	189	6	119	6	135	4	80	↓
Waiting time step 4	13	26	58	58	0	0	0	0	↓



Walsall has become one of the highest performers in delivering talking therapies across the west midalnds in 2011/12

2012/13 comparison performance data (as seen on appendix 1)

Walsall Primary Care team have been able to achieve twice the regional and national average percentage score for clients entering the service, indicator PHQ13_05 ***(Walsall over 5%, regional 2.5% and national 2.5% for the period)***. This implies that the team have successfully ensured an easy access route to services, and GP's are well informed of the service and are able to make referrals into it.

The team have also achieved above their target for people moving to recovery, KPI 6. With a target of 202 and achieved 315 for the two quarters thus far which is a ***55% over achievement against the plan***.

KPI PHQ13_06 identifies clients no longer requiring a service after their last planned treatment session. Walsall Primary Care Service achieved greater than the national average on this target ***(50% compared to 46%***). The team failed to meet the SHA regional average of 51% however.

Given that Walsall Primary care has been so successful in attracting referrals in to the service it now faces greater challenges of being to meet this high demand and deliver the expected outcomes across a larger number of clients compared to other Primary care teams. Additionally,

targets are being stretched further based on existing performance and this will need to be explored further with those setting targets as Walsall proves to be an exceptional case due to its success at achieving high referral rates.

Commissioning of a new lower level service (Big White Wall)

It can be clearly seen that the demand for primary care talking therapies is increaseing beyond capacity to deliver. To solve these capacity issues commissioners have sourced funding from the Council's reablement budget to secure an online psycological therapies service that has a track record of delivering this service to a number of areas

The online provider is called Big White Wall (BWW) and is evidenced to be effective in the most vulnerable groups who don't seek support when depression is evidenced in the 17 – 25 male age group who prefer anonymity and the personal apprach this method of delviery offers.

The purpose of this service is to provide access to web based online support for mental health by:

- Offering a range of clinically based therapeutic interventions aimed at supporting self management, giving choice and accessibility in a safe environment with no stigma attached
- Combining social networking principles with a choice of clinically informed interventions to improve mental wellbeing
- Improve the outcomes of people with mental ill health in Walsall
- Providing an online service open 24/7
- Providing options of online; group, community or one to one counselling services
- Incorporating use of Cognitive Behaviour Therapy tools, and interactive assessment tools
- Access to Self Help features to support self-management of mental health
- Having Staff 24/7 to monitor activity and who act as moderators and give continuous feedback when the service is accessed and ensure safeguarding of vulnerable adults
- Providing the option of one to one online live therapy counselling service by offering a range of real time therapies by instant text or audio visual supported by qualified therapists with relevant accreditation and experience who are also subject to clinical supervision.
- Having access to appropriate clinicians who advise staff and influence service development and who are available to support staff as necessary as part of the 24/7 service.
- Offering opportunities to access Peer support through an online community
- Providing a range of information and advice about mental health and wellbeing.
- Providing a service which can be accessed instantly with no waiting lists
- Providing anonymity when online

With contracts in place we will be commissioning this service during January 2013 and will be monitoring the success and progress of this new initiative

Table
KPI1
KPI 3a
KPI 3b
PHQ13_05
KPI 4
KPI 5
KPI 6a
KPI 6b
PHQ13_06
KPI 7
IAPT Compliant
Experimental Analysis SQU_04

Description
The number of people who have depression and/or anxiety disorders (taken from the Psychiatric Morbidity
The number of people who have been referred for psychological therapies during the reporting period
The number of active referrals who have waited more than 28 days from referral to first treatment/first therapeutic session (at the end of the reporting period)
People who have entered (i.e.received) treatment as a proportion of people with anxiety or depression (%)
The number of people who have entered (i.e. received) psychological therapies during the reporting period
The number of people who have completed treatment (minimum 2 treatment contacts) during the reporting period broken down by gender
The number of people who are “moving to recovery” (of those who have completed treatment, those who at initial assessment achieved "caseness" and at final session did not) during the reporting period
The number of people who have completed treatment not at clinical caseness at initial assessment
Number of people not at caseness at their last session, as a proportion of people who were at caseness at their first session (%)
The number of people moving off sick pay or benefits during the reporting period
Response to the question "Are you an IAPT-compliant service?"
People who have entered (i.e.received) treatment as a proportion of people with anxiety or depression (%), experimental figures to provide a year to date measure

SCHEDULE 2

THE SERVICES

Part 1: Service Specifications

Mandatory headings Sections 1-3.
Optional headings Sections 4-6. Subheadings for local determination and agreement]

Service	**Primary Care Talking Therapies – Mental Health Services**
Commissioner Lead	**Anet Baker**
Provider Lead	
Period	**April 2010 – March 2013**
Date of Review	**Oct 2010**

1. Purpose

1.1 Strategic context

Joint Strategy for Mental Health Services for Adults of Working Age and Older Adults (ref) Primary Mental Health Needs Assessment.

1.2 Aims

The Intermediate Primary Care Mental Health Services (IPCMHS) will be a community based service offering a range of evidence based psychological interventions to those with a wide spectrum of common mental health problems. It will employ a biopsychosocial model of care, as opposed to a purely health model and provide a service in the heart of the community for every member of the community.

There are many specialisms within the scope of this service and therefore these specialisms will be expected to take an integrated approach to service delivery; developing relationships with local specialist organisations to maximise the impact of this service on the local community.

The main aims are to:

- Offer a wide range of evidence based intermediate primary psychological care for mental health by appropriately qualified clinicians.
- Improve individual's well-being, satisfaction and choice.
- Improve access and support to maintain people in work, help them to return to work, help them into education or training and where appropriate help people to find meaningful activity.
- To improve people's functionality.
- Develop clinical protocols to ensure clinically effective treatments are available to people in primary and community locations.
- Develop service models for delivering integrated, stepped-care for people requiring access to intermediate primary psychological care for mental health across the spectrum of services.
- Reduce waiting times for accessing specialist intermediate primary psychological care for mental health.
- Develop a workforce plan for rolling-out the increases in capacity that is sustainable, realistic and affordable.

1.3 Evidence Base

All psychological interventions offered by the IPCMHS will be evidence based and provided by appropriately qualified accredited/registered practitioners. This will include the National Institute for Health and Clinical Excellence (NICE) recommendations regarding a range of intermediate primary care for mental health to treat people with depression and anxiety disorders and bring them to recovery.

The NICE guidelines for the management of depression, anxiety (panic disorder and generalised anxiety disorder), PTSD and Obsessive-Compulsive Disorder (OCD) recommend a Stepped Care model. The IPCMHS will be expected to achieve this by providing:

- Effective service models to support the delivery of NICE guidelines based on a system of stepped care.
- Access and both clinical and service outcome metrics to demonstrate the benefits of the new services across the pathway.

1.4 General

The IPCMHS has been developed using existing boundaries within the borough and will form a whole system approach to intermediate primary psychological care for mental health encompassing primary care, IAPT and specialist primary care Mental Health and Clinical Health Psychology service provision across the care pathway. The teams will work seamlessly with each other and with other mental health services outside the remit of this service.

Mental Health: New ways of working for everyone. Department of Health (DOH) 2005 New Horizons (DOH 2009)

1.5 Policy Context

Department of Health policy on Improving Access to Intermediate Primary Psychological Care for Mental Health Services.

2.1 Service user groups covered including exclusion criteria

The IPCMHS is not a secondary care mental health service. This service will provide evidence based/approved interventions for appropriately diagnosed people as stated in national guidelines. It will be important to maintain the distinct boundary between IPCMHS and secondary care mental services but also actively engage with them to facilitate the clinically appropriate stepping up and down of patients.

The following are exclusions from the current service:

- Acute psychosis
- Actively suicidal, risk to themselves or significant self-neglect
- Patients who pose a high risk to staff or others
- Patients who need to be primarily referred for forensic or neuropsychological assessment
- Significant impairment of cognitive function (e.g. dementia); significant impairment due to autistic spectrum problems or learning difficulties.
- People with a diagnosis of a severe and enduring mental illness who are currently active to secondary mental health services.
- People who have consistently not engaged with previous therapy treatment options offered.

- Patients with significant eating disorders.
- Patients who require CPA.
- Drug/alcohol problems are not a reason for excluding an individual. However, if their use is to such a degree that they are incapable of engaging in therapy they will not benefit from IPCMHS and should be sign-posted/referred to the appropriate Alcohol/Drug service

Cross reference with service spec for Adult primary care psychology (attached).

2.2 Geographical population

Patients registered with Walsall responsible GPs.

2.3 Service Description- overview ie what is provided

Assessment, interventions and care planning as described in relevant NICE guidance (CG 22, 90 or 91 as appropriate).

2.4 Accessibility/acceptability

The IPCMHS will provide equality of access across the borough with a specific emphasis on improving accessibility and service usage for vulnerable communities. There will be a proactive targeting of vulnerable communities based on a robust Needs Assessment and Equalities Impact Assessment. It is vital that IPCMHS not only makes its services entirely accessible but also actively promotes services to hard to reach groups and facilitates the reduction in waiting times across the whole stepped care pathway.

3. Service Delivery

3.1 Location of service

The face to face Intermediate primary psychological care for mental health will be delivered in an environment which is conducive to the needs of the individual, offering anonymity if required (e.g. in some cases of self referral).

The Provider will need to ensure that services are provided in easily accessible locations which reflect local mental health needs. Ideally service provision should be integrated with existing local service providers (the PWP's could be based within the 3rd sector via a contracted-out provision with appropriate supervision).

Space for psycho-educational groups will be identified and paid for by the service Provider in suitable premises that are compliant with the Disability Discrimination Act. The Commissioners reserve the right to visit premises and to gain assurance that the quality of the environment is suitable for patients.

Office space for administration, supervision and other non-clinical activity will be identified and paid for by the service Provider.

3.2 Days/ hours of operation

- IPCMH services will provide out of hours opportunities for patients. The objective will be to provide an 8am-8pm service over 6 days per week. (To be confirmed)
- There will be a single point of contact for referrals received into the IPCMHS.
- The service should accept referrals for a 17+ age range.

3.3 Referral Care pathways and discharge processes

3.3.1 Individuals with common mental health problems (including depression and/or anxiety) will access the service via a GP referral, referral by other or self referral. When an individual is not referred by their GP the referral may need to be discussed with their GP, with the individual's consent.

3.3.2 The service provider/s will work with GP practices to enable practices to refer individuals who are: a) presenting with mild to moderate mental health problems; b) unlikely to recover quickly without intervention and c) will benefit from the service offered.

3.3.3 Once an individual is assessed and accepted for treatment, their patient pathway will be based on the stepped care model (including recommended treatments according to NICE guidelines for anxiety and depression). The expectation is that individuals will be offered the least intensive intervention that is likely to result in clinical improvement. Any decision to bypass step 2 should be made by the assessing team rather than the referrer.

3.3.4 At assessment the provider will discuss the choice of different therapies available (that are appropriate for the clinical presentation and based on NICE guidance or evidence based practice) taking into consideration gender, ethnicity and other diversity issues and offer choice wherever possible.

Step 3 High Intensity Service	Depression Mild, Moderate and Severe	CBT , IPT behavioural activation
	Depression Mild-Moderate	Counselling , couples therapy
	Panic Disorder	CBT
	Generalised anxiety disorder (GAD) mild- moderate	CBT
	Social Phobia	CBT ,
	Post Traumatic Stress Disorder (PTSD)	CBT , eye movement desensitisation and reprocessing (EMDR)
	Obsessive Compulsive Disorder (OCD	CBT
Step 2 : Low Intensity Service	Depression Mild-Moderate	cCBT , guided self-help , behavioural activation , exercise
	Panic Disorder Mild -Moderate	cCBT , guided self-help , pure self help ,
	Generalised anxiety disorder (GAD) mild- moderate	cCBT , guided self-help , pure self help , psychoeducation groups
	OCD mild - moderate	Guided Self-Help
Step 1 : Primary Care/ IAPT Service	Recognition of Problem	Asessment / Watchful Waiting

3.4 Response times

Section Indicator	Indicator	Requirement	Timescales	Evidence
Access & Choice	Telephone or in person/letter contact within 48 hours of referral.	100%	Quarterly	Data Collection
	Each individual received an information pack and relevant assessment tool within 3 working days from initial telephone contact. (PWPS)	100%	Quarterly	Data Collection
	Treatment at step 2 commence within 10 working days.	98%	Quarterly	Data Collection
	Decision to set-up from 2 to 3 within 10 working days.	98%	Quarterly	Data Collection
	Treatment at step 3 commence within 14 working days.	80%	Quarterly	Data Collection
	Treatment at step 3 commence within 21 working days.	20%	Quarterly	Data Collection
	Decision to step up from 3 to 4 within 5 working days.	98%	Quarterly	Data Collection
	Number of referrals broken down into: • GP • Self referral • Other professional • Voluntary organisation • Other ie housing, education etc	100%	Quarterly	Data Collection
	Number and reasons for waiting time breaches.	100%	Quarterly	Data Collection
	Demonstrate that service user has been empowered to make informed choice about options of care and treatment available including: Choice of date, time and venue.	100%	Quarterly	Data Collection

	Demonstrate the nature of intervention(s) offered.	100%	Quarterly	Data Collection
	Average number of length of sessions in each step.	100%	Quarterly	Data Collection
	Type of therapist offering the intervention.	100%	Quarterly	Data Collection
	Epidemiology data e.g. gender, sexuality, age, disability, ethnicity and race.	100%	Quarterly	Data Collection
	Skill mix of staff delivering interventions, level of competence and skill.	100%	Quarterly	Data Collection
	Ensure all referrals from teams of children who are in the transitional phase are assesses within the time scales and appropriate services offered as dictated for adult users.	100%	Quarterly	Data Collection
	Demonstrate that choice and professional judgement are the main determinants of the service received by 17-19 year olds.	100%	Quarterly	Data Collection
	Ensure all referrals into signposting services are undertaking applying the agreed criteria.	100%	Quarterly	PCT survey of all referrals into signposted services
	Levels of referrals into signposted services.	100%	Quarterly	Data Collection

3.5
Partnerships

Integral to the Walsall vision for IPCMHS are services being community based and working in unison with other public service arrangements. IPCMHS will build relationships with a wide range of stakeholders to augment the quality of both IPCMHS service delivery and also the wider health economy.

More specifically NHS Walsall expects, where appropriate, IPCMHS services to adopt a consortia approach of delivery. The vision for IPCMHS is of an integrated biopsychosocial approach that considers a person's wider life needs. This whole life approach will require IPCMHS to work closely with a range of other organisations to demonstrate improvements.

Transitions and interfaces between services and agencies

The transition period for a fully compliant, fully functioning service to be providing the appropriate levels of service there will be a six month transition period during which time funding for recruitment to the PWP and HI workers will be forthcoming upon commencement of employment. Funding for the existing primary care and specialist psychology will continue in shadow cost and volume model.

Following a full six months of the new service model being fully operational a complete review of the service pathway will be undertaken to ensure resources are targeted at the most appropriate level within the stepped care model. This review will also take Secondary Care Service provision into account.

Response times and service targets will be applicable for all new referrals with a separate monitoring of waiting times for existing referrals being undertaken simultaneously.

Subcontractors

Providers can sub-contract, where clinically appropriate, parts of the IPCMHS with a preference for PWPs to be subcontracted out to the thirds sector. Any sub-contract arrangement will require excellent relationship management and performance management by the lead contractor and the employment of appropriately trained and qualified personnel

The provider will maintain records and have responsibility to report to the commissioner the outcomes of all aspects of this service specification

3.6 Staffing

Skill mix, education, training and clinical competencies to meet IAPT requirements(as set out in DOH 2007 document) are required and provision of a service to meet needs of population .Staffing levels should be in line with the provision of 6.6 HI and 7.4 PWPs as agreed with the SHA/RDC.

3.7 Training/ Education/ Research activities

In accordance with the Walsall IAPT implementation model the provider will have the training costs met centrally for 6.6 HIW and 7.4 PWP, the remaining training costs will need to be considered within the contract cost. All staff will need to be 'IAPT competent' and this training must be accessed through the regionally commissioned accredited programmes and supported by appropriate clinical supervision structures

The Provider must liaise with the relevant training establishment at the short-listing stage of their employment process for HIW and PWP, to ensure that candidates will meet the criteria set in accordance with IAPT for admission to the SHA commissioned training scheme.

Any persons employed by the provider in trainee roles without prior liaison with the relevant training establishment, who are subsequently deemed not suitable for the IAPT training programmes, will be employed at the Provider's risk and not be eligible to count against workforce targets.

PWP workers must receive adequate clinical supervision from High Intensity Workers who are trained to BABCP requirements or BPS equivalent. H I workers will also be clinically supervised practitioners

The Provider will meet and continue to meet any registration (eg HPC) standards that apply and must be able to demonstrate this to the commissioner.

Enhanced Criminal Records Bureau

As set out by the Commission for Quality Care an Enhanced Criminal Records Bureau

Certificate will be held on record by the Provider for all staff and will be available for inspection.

3.8 Data collection activity and outcome reporting

Inputs and out comes

Inputs to access at levels 1 -4 are approximations based on forecasted needs analysis and are subject to change within economic or demographic change which will be negotiated between the provider and the commissioner

	2009 figures	2019 figures
Step 1 – 2 **Anxiety** **depression**	 **9,659** **,5754**	 **9,859** **5,874**
Step 3-4 **Anxiety related depression**	 **18,906**	 **19,306**
Totals	**34,321**	**35,039**

Outcome measures

These outcome measures are for year 1 (2010/11) targets will be stretched to demonstrate the inclusion of primary care and specialist psychology into the Intermediate Primary Care, Mental Health Services pathway

Outcome measure	Q1	Q2	Q3	Q4
No people who have entered psychological therapies	**0**	**274**	**821**	**1506**
No of people w ho have completed treatment	**0**	**37**	**112**	**206**
No of people who are moving to recovery	**0**	**9**	**27**	**49**
No of people moving off sick pay and benefits	**0**	**8**	**23**	**43**
No high intensity trainees by end of year				**6.6**
No of Psychology wellbeing practitioners by end of year				**7.4**

Dataset as specified in IAPT outcomes toolkit 2008/09 (July 2008)

4. Quality Indicators including relevant CQUIN indicators	*Quality Indicator(s)*	*Method of Measurement/ information requirement*	*Incentive or sanction*

5. Activity Plan
Activity Plan
6. Prices & Costs

6.1 Price

Basis of Contract	Unit of Measurement	Price	Thresholds	Expected Annual Contract Value
Block Arrangement/Cost and Volume Arrangement/National Tariff/Non-Tariff Price_____*		**£**		**£**
Total		**£**		**£**

**delete as appropriate*