

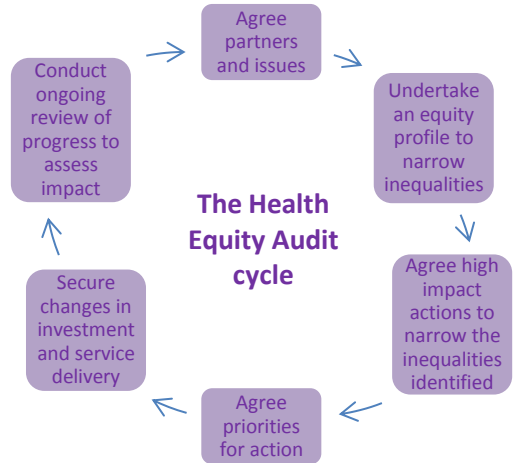
A Health Equity Audit of the Improving Access to Psychological Therapies (IAPT) service in Derbyshire: Summary of findings

Iain Little, Public Health Specialty Registrar, Derbyshire County Council

Healthy Equity Audit

Health Equity Audits assess how fairly services are distributed relative to the health needs of different population groups, rather than equally across the whole population. The aim of this HEA was to assess the equity of IAPT services in Derbyshire, with respect to age, gender, ethnicity, geography, disability, long-term condition status, sexual orientation and employment status.

Equity was assessed in relation to access to services (by comparing access rates between population groups relative to their needs) and outcome from services (by comparing the rate of positive outcomes between populations groups).

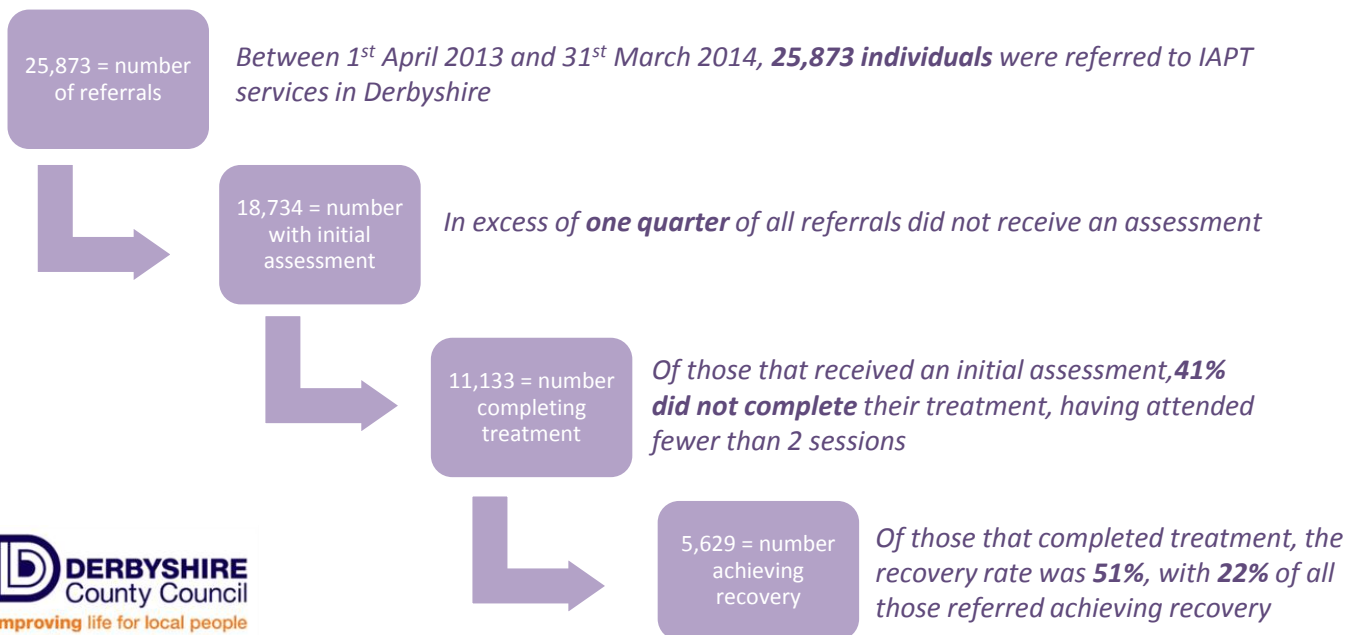


Improving Access to Psychological Therapies (IAPT) services

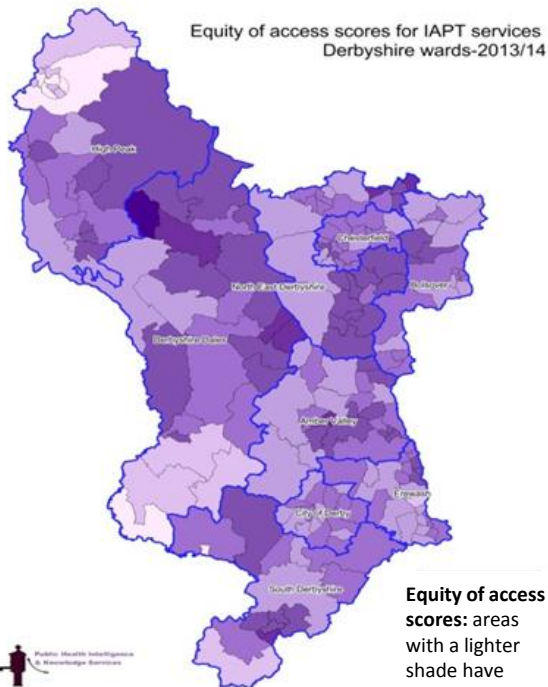
IAPT services were established in England in 2006, with the aim of raising the standards of identifying and providing non-pharmacological treatment for individuals experiencing common mental health problems. The services provide access to talking therapies, such as cognitive behavioural therapy (CBT) and guided self-help. Within Derbyshire there are five providers that operate within Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs, and an additional provider in the Glossop locality, commissioned by Tameside and Glossop CCG.

Results

There are an estimated 113,396 adults in Derbyshire with common mental health problems. 164 out of 1,000 women are estimated to have a common mental health problem, higher than the male rate of 94 per 1,000 population. The rate also varies by district, being highest in Derby City (159 per 1,000 adult population), and lowest in Derbyshire Dales (106 per 1,000 adult population).



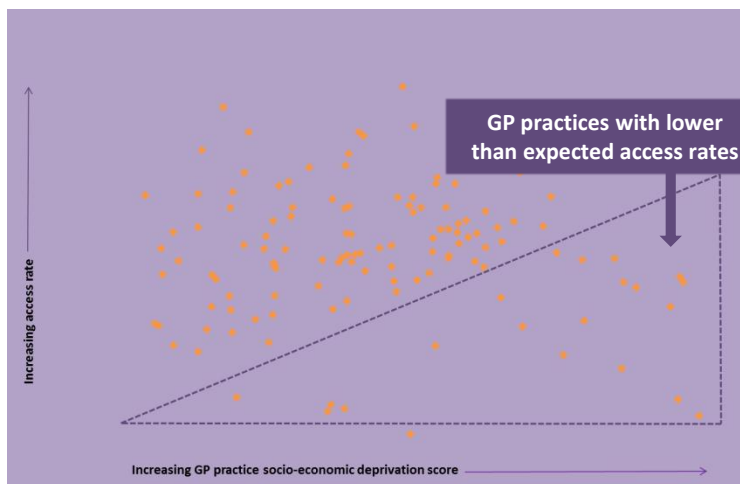
Characteristic	Summary of equity findings
Gender	There was no difference in access or outcome identified between genders.
Age	The highest access rate was amongst those aged 20-34 years, with access rates reducing as age increased. Conversely, the outcome rates increased with age, with adults aged 65 years and over having the highest outcome rates.
Geography	The more rural districts of Amber Valley, Derbyshire Dales, High Peak (excluding Glossop), North East Derbyshire and South Derbyshire had the highest rates of uptake. However, there was considerable variation in access and outcome rates at a ward-level.
CCG/GP practice	Access rates were highest for North Derbyshire CCG, and lowest for Southern Derbyshire CCG. Southern Derbyshire CCG had a higher outcome rate than the other CCGs. There was considerable variation in access to, and outcome from IAPT services by practice, and a number were identified that had lower than expected access rates relative to their level of socio-economic deprivation.
Socio-economic deprivation	Individuals from the most socio-economic deprived areas had higher access rates compared to those from less deprived areas. This pattern was reversed for outcome rates, with individuals from the least deprived areas having the highest outcome rates.
Ethnicity	Individuals from Asian and Black groups had lower access rates compared to other ethnic groups. There was no difference in outcome rates between ethnic groups, although the sample may have been too small to detect differences.
Disability	No comparison of access was undertaken due to the low recording of disability status by providers. Individuals reporting a disability had a lower outcome rate than those without a disability.
Learning disability	It was not possible to accurately assess equity of access by learning disability status due to the absence of a precise measure of the number of adults with a learning disability. Individuals with a learning disability had a lower outcome rate than those without a learning disability.
Long-term condition	Individuals with a long-term condition had lower access and outcome rates compared to those without a long-term condition.
Sexual orientation	No equity analysis was undertaken by sexual orientation due to extremely low data completeness of this variable.
Employment status	It was not possible to assess access by employment status. Individuals who were classified as unemployed had a lower outcome rate than individuals in work or retired.



Three areas of Derbyshire had very low access to services: Glossop, the area south of Ashbourne and Hatton ward.

In addition, a number of GP practices were identified that had lower than expected access rates relative to their level of socio-economic deprivation.

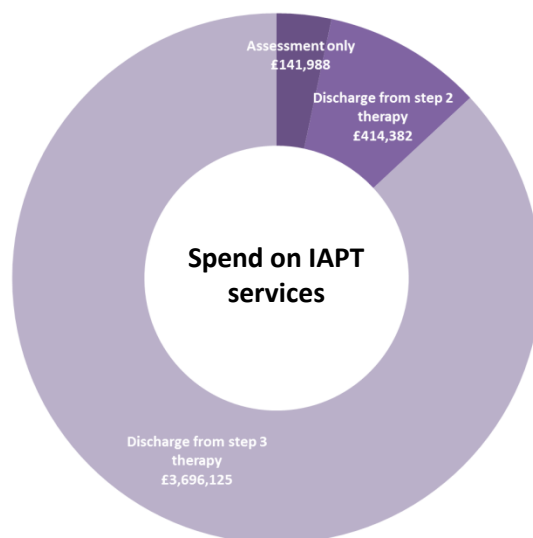
Equity of access scores: areas with a lighter shade have lower rates of access



Factors promoting recovery and Economic analysis

Individuals with a mild condition on assessment had the highest recovery rates, and the recovery rate decreased as the severity of condition at assessment increased. However, individuals with more severe disease at assessment had the greatest clinical improvement post-treatment. Only a minority of individuals received the number of contacts as recommended by NICE.

The over-whelming majority of spend was on individuals discharged from Step 3 therapy, despite there being no difference in recovery rate between those receiving Step 2, Step 3 or mixed-step therapy. The economic analysis suggests that providers are inappropriately treating a significant proportion of individuals with mild and moderate disease with Step 3 treatment, and the current tariff may encourage this.



Recommendations

The recommendations from the HEA include actions that can be quickly implemented to reduce inequities in current service provision, and those that may require more time to implement:

- providers should ensure that therapists consistently record all demographic indicators
- GP practices with low-referral rates should receive support from commissioners and providers to increase the numbers of referrals through improved case-finding and onward referral. This could include sharing of good practice from those practices that have high rates of access
- IAPT services should be promoted amongst communities that currently have inequitable rates of access. This should include promotion amongst front-line staff working in those communities, to enable case-finding and referral to services. Promotion of the self-referral pathway within these communities should increase access
- links should be made with other health improvement programmes, for example the Wellbeing Service commissioned by Public Health, to enable brief screening and cross-referrals between programmes
- the IAPT service should provide additional support to individuals in population groups that have lower outcome rates, for example by considering additional, or more intensive, support
- modelling should be undertaken to explore the impact that potential changes to the tariff structure may have on overall expenditure and outcome rates
- the characteristics of individuals who are referred to IAPT services but do not receive an assessment, and those that receive an assessment only should be profiled to better understand which population groups do not attend once referred. This could be done in conjunction with research to understand the reasons why a large proportion of those referred do not take up treatment
- research should be undertaken to better understand why there are low access rates to IAPT services amongst certain population groups, for example older people
- the IAPT providers should ensure that they provide appropriate services for all population groups, for example ensuring that all staff are aware of the needs of the local population, receive appropriate training, and that the workforce reflects the profile of the population
- providers should be encouraged to ensure NICE recommendations are implemented, especially in relation to the length of treatment
- the national direction of moving towards Payment by Results should allow incentives to be paid to providers to reduce inequities experienced at a local level (for example, incentivising providers to ensure equity of access for individuals from BME groups, and older adults).

The full report for the Health Equity Audit is available at:

http://observatory.derbyshire.gov.uk/IAS/Custom/Resources/HealthandWellbeing/Health_Equity_Audit_s/IAPT_HEA_report_feb2015.pdf