Yorkshire and the Humber Mental Health Network

IAPT Providers Network
7 February 2018

- Andy Wright, IAPT Clinical Advisor and Sarah Boul, Quality Improvement Manager
  - andywright1@nhs.net and sarah.boul@nhs.net
  - Twitter: @YHSCN_MHDN #yhmentalhealth
  - February 2018
Housekeeping:

- Fire
- Toilet facilities
- No phone
- Parking

Other elements:

- Twitter handle: @YHSCN_MHDN
- Hashtag: #yhmentalhealth
- Website: www.england.nhs.uk
Yorkshire and the Humber IAPT Providers Network

Welcome

Andy Wright, IAPT Advisor, Yorkshire and the Humber Clinical Networks
Yorkshire and the Humber
IAPT Providers Network

Minutes from Last Meeting (04.10.17)

and

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

Senior PWP Network Update

Heather Stonebank, Lead PWP, Sheffield Health and Social Care NHS Foundation Trust and Lead PWP Advisor, Yorkshire and the Humber Clinical Network
THANK YOU
SPWP Network Meeting agenda

- Wellbeing Activity – North Yorkshire
- Group skills supervision – Leeds
- Service presentation – Kirkless & Calderdale
- Low Intensity Competency Project – Sheffield University
- Reflection – Leadership, data and the future - All
Leadership, data and the future

• Keen interest in leadership – SPWP play a key role
  How can we support leadership within the profession?

• Data – lots of interest, how to communicate, interpret
  and use data to our advantage – how can we support?

• Future – lots of key themes – national updates,
  recovery, recognition of the role, service
  presentations, sharing good practice and wellbeing.
Nurturing leadership within the role

- Role models
- Understand the bigger picture - National – Regional – Local
- Translate ideas into actions
- Connect the team and understand the workforce—what motivates them
- Share values and vision and translate into a meaningful narrative
- Help PWPs work towards a vision and goals – make the experience enjoyable - wellbeing
Key messages

• Sharing messages - ‘what would you like from us?’

• How can we keep SPWP’s up to date with priorities?

• They can really help you!
Feedback

• ‘Thank you it's been very thought provoking’

• ‘Found the day really helpful and think it definitely needs to continue’

• ‘Really great day, extremely helpful and valuable, offered lots of opportunity to reflect/learn and take ideas forward into our service. Thank you.’
Word Cloud
Next steps

• Wellbeing

• Service presentation and best practice examples

• Step 2 topic discussions – supporting step 2 interventions - cCBT

• Leadership

• Data
Reflections

• Presentations all led by members of the network from a range of services

• Great participation and involvement

• Enthusiasm to learn from each other – ‘Absolutely amazing and a great learning opportunity.’

• Members valuing the network – ‘Please can it continue.’
I began to realize how important it was to be an enthusiast in life. If you are interested in something, no matter what it is, go at it full speed. Embrace it with both arms, hug it, love it and above all become passionate about it. Lukewarm is no good.

Roald Dahl
Discussion points:

- Are you getting the most out of your SPWP’s for example they are really interested in the data
- How are you encouraging the integration of learning from the SPWP network in your service
- How can we develop their leadership potential
- What key messages does the provider forum want to send to the SPWP network
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Senior PWP Network

Thank you for listening!
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IAPT Providers Network

IST Data Top Tips and Q&A

Sarah Butt, IST Manager, NHS Improvement
Mental Health Intensive Support Team
IAPT Update
Yorkshire and Humber Clinical Network
Provider Meeting
7th February 2018

Sarah Butt
Improvement Manager – Mental Health
Mental Health IST Offer

- IAPT
  - Data Quality
  - Access
  - Waiting Times
  - Recovery
- Early Intervention Psychosis
  - Switch from Unity to MHSDS
  - Increase in uptake of SNOMED
  - 50% target
- Child and Adolescent Mental Health including Eating Disorder
  - Data completeness and coverage
  - Accessing Standard
  - Productivity
Mental Health IST Approach

England Wide Offer:
Tools; Guidance, best practice to be published on NHS I Improvement Hub

Regional:
Workshops, Conferences, Masterclasses
Guide Regions / DCO MH delivery teams

Individual System Support:
Diagnostic Reviews; Demand and Capacity Modelling; Short Interventions; Guidance and support on best practice for Leadership
IST and Yorkshire and Humber

- Diagnostics Reviews x 6 CCG’s completed
- Desktops x 6 CCG’s completed
- Regular contact and ongoing support with further 5 CCG’s
Focus on getting data right first time as close to real time as possible.

Does your Local and NHS Digital data match?
Are you making use of:

**PAVE:** provided for Refresh 7-10 days after window closes. Allows Providers to measure Access; waits; numbers recovered and RI.
NB: cannot exactly calculate recovery

**Pre and Post Extracts:** both mimic the original upload table format. Check uploads vs pre-deadline vs. post deadline to ensure consistency. Further technical information regards submissions can be found in the NHS digital “understanding and replicating published reports”.

**Data Quality Notices:** provided for both Primary and Refresh submissions. Providers can also access the monthly Data Quality (VODIM) Reports which provides the ability to check the validity of the data.
NHS Digital Reports

- NHS Digital Reports are Monthly and Quarterly Data
- Example Monthly report is the Data activity: `://digital.nhs.uk/search?q=iapt+monthly&s=s`

- NHS Digital reports Supress (Shown as an *asterix) for any value less than 5 and round all values to the nearest 5.

- Recovery and waiting times are now reported with an exact % to avoid any rounding issues.

- Providers receive NHS Digital calculated data (entering treatment, waits etc) around three weeks in advance of publication in their PAVE Report.

- Providers and CCG’s can access pseudonymised patient level data through OpenExeter
Useful links and documents

Providers/CCGs asking technical questions

- **Guidance on system/provider changes** – tells a provider/CCG how to avoid data issues when transferring to a new system/provider
- **Waiting Times FAQ**
- **Planning Guidance** (NHS England and NHS Improvement KPIs)
- **PAVE Specification** for providers to check/preview NHS Digital data
- **IAPT Reporting FAQs** (‘How to replicate our reports’) if providers ask for help understanding the published data
- **Metadata** (technical definitions for all IAPT reports)
- **Technical Output Specification** (reference for questions about uploading data or using OpenExeter)
- **Who pays?** information on how to allocate patients to the appropriate CCG

Webpages containing all reports

- [http://content.digital.nhs.uk/iaptmonthly](http://content.digital.nhs.uk/iaptmonthly)
  
  and
  
  [http://content.digital.nhs.uk/iaptreports](http://content.digital.nhs.uk/iaptreports)
**Data - Clustering**

**Why is this important?**
Completeness and Accuracy

**What is your clustering profile?**
Does this reflect your profile of patients being seen in the service?
How confident are you in the inter-rata reliability of all clinical staff clustering?
Are you using national data to check Clustering completeness (NHSD Data quality Report - Monthly)

![Patients By Cluster](chart)

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Proportion</th>
</tr>
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<tbody>
<tr>
<td>Clusters 1-2</td>
<td>10.4%</td>
</tr>
<tr>
<td>Clusters 1-3</td>
<td>46.4%</td>
</tr>
<tr>
<td>Clusters 1-4</td>
<td>85.1%</td>
</tr>
<tr>
<td>Cluster 4 or above</td>
<td>53.4%</td>
</tr>
<tr>
<td>Cluster 5 or above</td>
<td>14.7%</td>
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</table>
Data - Open Pathways

- Are the open pathways true open pathways with inactive cases or are these discharged cases that have not been closed?

- Are you as a service clear about reasons?

- Are data analysts reviewing open pathway data on a routine and regular basis?

- Do you undertake routine data checks on Open Pathways - how long the patient has been waiting?

- Do you use the data in case management on a routine and regular basis?

- Important for the patient; throughput; outcome base payment
"Inactive Open Referrals" graph. Someone has an ‘open referral’ when they have attended at least one treatment appointment and not been discharged. The waiting time is the number of days since their last attended treatment appointment.
Contact

Sarah Butt | Improvement Manager – Mental Health

M 07714 777070
E sarah.butt1@nhs.net  W Improvement@nhs.uk
T @MH ISTNetwork
Yorkshire and the Humber
IAPT Providers Network

Time for a break?

15 minutes only please!
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IAPT Providers Network

IAPT Data on Unify

Sarah Boul, Quality Improvement Manager,
Yorkshire and the Humber Clinical Networks
Accessing Unify 2

- First step is to go to the following website:
Accessing Unify 2

- Next step is to request an account by clicking here
Accessing Unify 2

• Then fill in the new user account details and submit!
Accessing Unify 2

- You will receive your log in details in a few days and once received log in by clicking here
Accessing Unify 2

- Log in!
Accessing Unify 2

• Go to the report library and have a browse!
Accessing Unify 2

- Press the little “plus” signs to drill down to the IAPT reports and then click away to load an exciting IAPT overview!
Accessing Unify 2

- There are two useful reports published each month – the general NHS Digital report and the user friendly recovery dashboard:
Accessing Unify 2

- The Recovery Report Dashboard includes numerous indicators and options to compare (I’ve hidden the services!):
Accessing Unify 2

- For data on your own service click on the CCG summary tab.
Accessing Unify 2

- The CCG summary tab shows lots of useful service information
Accessing Unify 2

- And there’s more!
Accessing Unify 2

- The IAPT monthly report contains a download of the NHS Digital data but is presented in a more user friendly format:
Accessing Unify 2

- And there’s more!

<table>
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<tr>
<th>B1</th>
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<tbody>
<tr>
<td>19</td>
<td>JAPT - Supporting Measure (Entered Treatment (Started))</td>
</tr>
<tr>
<td>20</td>
<td>JAPT - Supporting Measure (Entered Treatment) by Region</td>
</tr>
<tr>
<td>21</td>
<td>JAPT - Supporting Measure (Entered Treatment) by Region Geog</td>
</tr>
<tr>
<td>22</td>
<td>JAPT - Number of Treatments</td>
</tr>
<tr>
<td>23</td>
<td>JAPT - Number of Treatments by Region</td>
</tr>
<tr>
<td>24</td>
<td>JAPT - Referral Rate</td>
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<tr>
<td>25</td>
<td>JAPT - Referral Rate by Region</td>
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<tr>
<td>26</td>
<td>JAPT - Referral Rate by Region Geog</td>
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<tr>
<td>27</td>
<td>JAPT - First to Second Treatment</td>
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<tr>
<td>28</td>
<td>JAPT - First to Second Treatment by Region</td>
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<tr>
<td>29</td>
<td>JAPT - First to Second Treatment by Region Geog</td>
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<tr>
<td>30</td>
<td>Additional</td>
</tr>
</tbody>
</table>

Summary of performance against the IAPT Supporting Measure (Entered Treatment 6 weeks and 18 weeks) for the most recent month.

NHS England region overview of IAPT Supporting Measure (Entered Treatment 6 weeks and 18 weeks) highlighting best and worst performing CCGs for the most recent month.

Comparison of the IAPT Supporting Measure (Entered Treatment 6 weeks and 18 weeks (Started)) performance across LO teams for the most recent month.

Summary of performance against the Mean and Median Number of Treatments for the most recent month. It also includes the Completed Appointments versus Single Treatment Appointments.

NHS England region overview of Mean Number of Treatments, Median Number of Treatments and Completed Appointments versus Single Treatment Appointments highlighting best and worst performing CCGs for the most recent month.

Summary of performance against the IAPT Referral Rate for the most recent month. Also includes the Number of Referrals Received.

NHS England region overview of IAPT Referral Rate performance and Number of Referrals Received highlighting best and worst performing CCGs for the most recent month.

Comparison of the overall Referral Rate performance and Number of Referrals Received across LO teams for the most recent month.

Summary of performance against the IAPT First to Second Treatment over 28 days and over 90 days for the most recent month.

NHS England region overview of IAPT First to Second Treatment over 28 days and over 90 days highlighting best and worst performing CCGs for the most recent month.

Comparison of the IAPT First to Second Treatment over 28 days and over 90 days performance across LO teams for the most recent month.

Comparison of Access Rate and Recovery Rate performance measures for England, across LO teams and old Area Team organisations over time.
Accessing Unify 2

Example service information includes:
Accessing Unify 2

- Example regional information includes:
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IAPT Data – Table Top Discussions
Questions for table top discussion

On your tables please consider the following questions and capture your key points on the sheet provided for feedback to the room:

1. Which are your top 3 most useful reports and why?
2. How do you ensure the data reaches all the way through your service?
3. How detailed is your monitoring of data in month, how do you achieve this and how do you apply your learning?
4. How do we take a medium to long term strategic view of data and how do we reflect on our medium to long term goals for utilising data?
5. Is there anything we could do in the provider network that could help services to realise the benefits of the data?
Time for some lunch?
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IAPT Providers Network

National IAPT Programme Update, Key Themes for 2018/19 and Q&A

Ursula James, National IAPT Programme Manager, NHS England
National IAPT Programme Update, Key Themes for 2018/19 and Q&A

Ursula James – National IAPT Programme Manager
What were the national IAPT team’s priorities?

- Designing and developing with local areas new integrated IAPT service models and business cases to support their spread – in both primary and secondary care
  - Supporting and working with Early Implementers Wave 1 and 2
- Improving the equality of access and outcomes for all adults (older people and people from minority ethnic groups are underrepresented in services. The proportion of older people in services has risen following focused local and national work to improve it, but still needs work)
  - Working with Clinical Networks across the country to improve equity of access
- Improving the quality of services – improving and sustaining the recovery rate, addressing variability, improving the outcomes for people using services in the perinatal period, improving choice of treatments in services
  - Working with HEE to deliver training in modalities, regional “deep dives” in IAPT performance, producing the IAPT manual
- Improving the productivity of services – starting with encouraging appropriate use of digital services
  - Development of the Digital ERG and collaboration with NICE on endorsing digital products for use in IAPT services
- Supporting the implementation of activity and outcomes based payment in IAPT
  - Through data, payments and levers team in collaboration with NHS Improvement
- Improving the sustainability of the IAPT workforce
  - Development of workforce and wellbeing project manager role, benchmarking, gathering data and cascading “what works”
Key responsibilities of the IAPT programme in 2018/19

- FYFV commitments
- Regional Deep Dives
- Enhanced annex to delivery pack for regions
- Work with stakeholders
- Collaborating with other ALB’s (Arms Length Bodies) where delivery commitments are shared ie: HEE
- Engage providers, commissioners, and clinical networks in assuring and supporting quality
What is the definition of IAPT?
IAPT services provide evidence-based treatments for people with depression and anxiety disorders, IAPT services are characterised by three key principles:

**Evidence-based psychological therapies at the appropriate dose:** where NICE-recommended therapies are matched to the mental health problem, and the intensity and duration of delivery is designed to optimise outcomes.

**Appropriately trained and supervised workforce:** where high-quality care is provided by clinicians who are trained to an agreed level of competence and accredited in the specific therapies they deliver, and who receive weekly outcomes-focused supervision by senior clinical practitioners with the relevant competences who can support them to continuously improve.

**Routine outcome monitoring** on a session-by-session basis, so that the person having therapy and the clinician offering it have up-to-date information on the person’s progress. This helps guide the course of each person’s treatment and provides a resource for service improvement, transparency and public accountability. Services are delivered using a stepped-care model, which works according to the principle that people should be offered the least intrusive intervention appropriate for their needs first.

Key questions for local systems addressing IAPT

- Has a local IAPT network been established? Is it chaired by a local provider?
- Has the IAPT network been supported with admin and SCN/Assurance and Delivery input and interpretation of target standards?
- Where there are longstanding issues, have recommendations been made for support to CCGs from Region and nationally including the national programme lead/manager, Intensive Support team and Analytics?
- Has there been strategic clinical advice into CCG/providers to facilitate achievement of IAPT service delivery developments?
- Are the CCG and provider using the IAPT manual to inform service design and delivery?
- Where the national standards have not been achieved, have CCGs developed improvement plans, and is delivery being monitored against an agreed improvement trajectory?
- Are CCG plans with providers being monitored around the requirement for full implementation in 18/19 through IAPT Network meetings?
- Have CCGs been provided with support to commission service models to deliver 5YFV targets?
- Has clinical input been provided for service developments for delivery of national targets?
- Has an offer been developed for peer to peer review or Network review of service models?
- Has assurance been provided that funding is in place for the service to meet the 25% access by 2020/21? The increase of 10% in access will require a minimum of 50% increase in staffing levels.
- Is the CCG monitoring the provider on the access of people from under-represented groups (i.e. Older adults/BME)?
- Is the IAPT Dashboard shared on a monthly basis with CCGs so as to influence commissioning discussions with their providers?
- Does the CCG have sufficient training places to reflect need to increase staffing levels?
- Is there a trajectory plan in place to deliver the number of trainees required up to 20/21 to achieve national access standard of 25%?
- Has there been input to support sub-regional wide initiatives to deliver workforce solutions?
- Are there discussions happening locally to assure therapists are being placed in primary care accommodation?
**Positive practice examples**

There are many examples of positive practice in IAPT services. The small selection of examples included here are not templates for whole service provision. Instead, they are selected to illustrate how services have tackled one or more specific problems.

The **Positive Practice in Mental Health Collaborative (PPiMH)** is a user-led, multi-agency collaborative of 75 organisations, including NHS Trusts, CCGs, third sector providers and service user groups. The aim of the organisation is to facilitate shared learning of positive practice in mental health services across organisations and sectors.

The Positive Practice in Mental Health Collaborative provides a [directory](#) of positive practice in mental health services. The NCCMH is working together with the Positive Practice in Mental Health Collaborative to identify and share examples of positive practice in mental health across England.

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### The key principles of effective treatment and stepped care

<table>
<thead>
<tr>
<th>Treatment choice should be guided by the person’s problem descriptor</th>
<th>CBT is not a single therapy but rather a broad class of therapies. For example, the indicated CBT for PTSD is very different from that for social anxiety disorder, both of which are different from that for depression. It is essential that clinicians work together with the person to clearly identify the primary clinical problem that they want help with before selecting a treatment type.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A NICE-recommended intervention</td>
<td>A range of NICE-recommended CBT and non-CBT interventions should be offered. This also includes the concurrent use of medication in moderate to severe (but not mild) depression.</td>
</tr>
<tr>
<td>Offer the least intrusive intervention first</td>
<td>The least-intrusive NICE-recommended intervention should generally be offered first. But it is important that low-intensity interventions are only offered where there is evidence of their effectiveness. For example, a person with severe depression or other types of anxiety disorders, such as PTSD or social anxiety disorder, should normally receive a high-intensity intervention first.</td>
</tr>
<tr>
<td>Treatment should be guided by the person’s choice</td>
<td>When NICE recommends a range of different therapies for a particular condition being treated, and where possible, people should be offered a meaningful choice about their therapy. Where treatments are on average similarly effective, giving people their preferred treatment is associated with better outcomes. Choice should include how it is provided, where it is delivered, the type of therapy and the clinician (for example, male or female).</td>
</tr>
<tr>
<td>Offer an adequate dose</td>
<td>All people being treated should receive an adequate dose of the treatment that is provided. NICE recommends that a person should be offered up to 14 to 20 sessions depending on the presenting problem, unless they have recovered beforehand. The number of sessions offered should never be restricted arbitrarily. People who do not respond to low-intensity treatments (and as such, still meet Caseness) should be given at least one full dose of high-intensity treatment as well within the same episode of care.</td>
</tr>
<tr>
<td>A minimal wait</td>
<td>No person should wait longer than necessary for a course of treatment. Services should work to a high-volume specification with minimal waiting times for treatment (and within national standards), as well as facilitating movement between steps (see appropriate stepping)</td>
</tr>
<tr>
<td>Appropriate stepping</td>
<td>A system of scheduled reviews (supported by the routine collection of outcome measures and supervision) should be in place to promote effective stepping and avoid excessive doses of therapy. This includes stepping up when there is no improvement, stepping down when a less intensive treatment becomes more appropriate or stepping out when an alternative treatment or no treatment becomes appropriate.</td>
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Enhanced Detail: Adult Mental Health – (IAPT-LTC)

Guidance and Support
The following are available:
- FAQ’s, Slides and Documents from IAPT-LTC Commissioning Events
- IAPT-LTC Data Handbook
- Yammer Site
- Positive Practice in Mental Health Collaborative

IAPT-LTC services provide evidence-based (NICE-recommended) psychological therapies for people with LTCs who also have depression and anxiety disorders, or who have MUS. The interventions are provided by therapists who have trained in the IAPT-LTC Top up training.

While some services will be hospital-based, it is expected that most will be embedded in primary care and community settings. IAPT-LTC services are built on the same key principles that underpin the IAPT programme (see the IAPT manual).

In addition to core IAPT principles, IAPT-LTC will provide:

- Case recognition methods in physical health pathways
- Integrated care pathways: all therapists should be co-located with general health care teams and primary care. This requires participation in multidisciplinary team meetings, care planning and, where required, joint working.
- Revised IAPT assessment protocols for the integrated pathways: protocols should reflect the increased complexity associated with the assessment of depression and anxiety disorders in people with LTCs and MUS
- Revised IAPT workforce: including expansion and upskilling
- Sharing best practice with existing IAPT services: IAPT-LTC and existing IAPT services would normally have shared personnel and shared management, training and supervision arrangements. This may also contribute to reduced costs. In the long-term areas should be working towards a single IAPT provision for everyone.
- Close links with the wider system: Effective links should be built with:
  - Core 24 liaison mental health services/integrated psychological medicine: these services provide care in general hospital emergency departments, inpatient units and outpatient clinics and work with people with mental health problems in the context of an LTC and MUS (see the urgent and emergency liaison mental health care pathway for adults and older adults)
  - Clinical and health psychology services: these services focus on the inter-relationships between behavioural, emotional, cognitive, social and biological components of physical health problems. In doing so they are involved in the promotion and maintenance of health, and the prevention, treatment and rehabilitation of illness and disability. Clinical and health psychologists help people who have an LTC and are having difficulties adjusting to the condition. They also support other clinicians in managing the person’s condition and are likely to be an integral part of the IAPT-LTC workforce
Enhanced Detail: Adult Mental Health – (IAPT-LTC)

Key questions for local systems addressing IAPT-LTC

- Has there been strategic clinical advice into CCG/providers to facilitate achievement of IAPT service delivery developments?
- Have CCGs been provided with support to commission service models to deliver 5YFV targets?
- Is IAPT-LTC commissioning on track to deliver in 2018?
- Has support been provided for full implementation including assurance of plans?
- Has work been undertaken with whole system to model potential delivery of integrated anxiety and depression screening into LTC pathways with clear signposting to appropriate delivery of IAPT Services?
- Has clinical input been provided for service developments for delivery of national targets?
- Has an offer been developed for peer to peer review or Network review of service models?
- Has assurance been provided that funding is in place for the service to meet the 25% access by 2020/21? The increase of 10% in access will require a minimum of 50% increase in staffing levels.
- Is the IAPT Dashboard shared on a monthly basis with CCGs so as to influence commissioning discussions with their providers?
- Does the CCG have sufficient training places to reflect need to increase staffing levels?
- Is there a trajectory plan in place to deliver the number of trainees required up to 20/21 to achieve national access standard of 25%?
- Has there been input to support sub-regional wide initiatives to deliver workforce solutions?
- Is there capacity in local HEEs to deliver training – are you linked in with local HEE leads?
- Are there discussions happening locally to assure therapists are being placed in primary care accommodation?
Enhanced Detail: Adult Mental Health (IAPT-LTC)

- NICE has issued guidelines on medically unexplained symptoms (MUS) and multimorbidity:
  - Chronic Fatigue Syndrome/Myalgic Encephalomyelitis (or Encephalopathy): Diagnosis and Management (NICE clinical guideline 53)
  - Irritable Bowel Syndrome in Adults: Diagnosis and Management (NICE clinical guideline 61)
  - Multimorbidity: Clinical Assessment and Management (NICE guideline 56)
  - Information on the physical treatments for long-term physical health conditions (LTCs) and treatment of individual mental health problems can be found on the NICE website

Commissioners should ensure that IAPT-LTC services:

- are co-produced and implemented in collaboration with people using the services and their families and carers
- are co-located in physical health care pathways with IAPT clinicians working effectively with the wider system, including existing IAPT services, other mental health services and physical health care teams
- place a strong emphasis on the recognition of mental health problems, with case recognition and assessment systems in place across physical and mental health services
- have clear access criteria for IAPT-LTC services that are agreed with all relevant services
- ensure equity of access for all adults – local commissioners should make explicit in service and commissioning documents how they have taken into account their duties placed on them under the Equality Act 2010 and with regard to reducing health inequalities as set out in the Health and Social Care Act 2012 and the 2014 Guidance for NHS Commissioners on Equality and Health Inequalities Legal Duty
- ensure routine, session-by-session monitoring of mental health and related outcomes, with services obtaining pre- and post-treatment scores on at least 90% of service users (IAPT manual)

Recommended workforce for IAPT and IAPT-LTC services

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<thead>
<tr>
<th></th>
<th>IAPT services</th>
<th>IAPT-LTC services</th>
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<tbody>
<tr>
<td>PWPs</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>High-intensity therapists</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Senior therapists (including clinical and health psychologists)</td>
<td>60%</td>
<td>10%</td>
</tr>
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</table>

www.england.nhs.uk
Enhanced Detail: Adult Mental Health (IAPT-LTC)

Key commissioning considerations

1. Plan
   - Set clear objectives that identify where IAPT-LTC services fit within the context of your local plans for integration
   - Assess local need and demand of your current and future local population; this should include an Equality Impact Assessment

2. Lead and engage
   - Establish effective leadership: there must be visible commitment from senior colleagues across both commissioner and provider organisations
   - Engage key stakeholders and consider how to make a compelling argument for each; this includes GPs, physical health care providers, liaison mental health professionals and clinical and health psychologists, voluntary sector organisations, IAPT providers and other mental health providers
   - Promote co-production, this involves planning and developing services with people using the services, their families and carers at all stages

3. Establish a business case
   - Determine shared objectives; consider how IAPT-LTC services can help to achieve other national and local strategic priorities
   - Outline a service model of optimal pathways and systems
   - Develop a workforce model, including training and recruitment plans

4. Strong governance arrangements
   - Agree data quality and performance monitoring plans up to 2020/21
   - Ensure local providers make the necessary updates to their electronic systems

5. Benefits realisation plan
   - Identify key benefits and how these will be delivered, measured and reported
   - Recognise upfront that the benefits of integrated pathways rarely accrue in the same place as the costs

6. Levers and incentives
   - Hold both IAPT and physical healthcare providers to account for outcomes
   - Have contractual levers and incentives that streamline the delivery of care across the gaps between providers
   - Shift the flow of money between providers and review existing payment structures
Improving the equality of access and outcomes for all adults – work to continue into 2018/19

- Quality Premium 2017-2019 – Older People access and BAME outcomes
- Older Adults and BAME Action Plan – with actions for providers, clinical networks and commissioners
- Awareness campaign
- Work through Age UK
- Conferences on Older Adults - Further collaborations between the networks are currently being planned to focus on areas of inequalities
- Innovation in service delivery events suggested to networks due to the impact on access for under-represented groups
- Blogs on Older Adults in IAPT on NHS England website – strategic comms plan across IAPT
- Engagement event planned (21/3/18). To include third sector, patient groups, service reps, and long term conditions patient groups
- Working with Universities UK to ensure equitable access to evidence based treatments
- Collaboration between BIT, EHRC and NHS England to commence in January looking at barriers to access for hard to reach groups in IAPT. This will have a particular focus on Older Adults and black men. The initial phase will take place in January – July 2018 will involve an evidence base and behavioural science review. At the end of this phase a report will outline recommendations for a possible RCT
Improving the quality of services

• Nationally the access standard is being met overall and progress towards 25% by 2020/21 is on track, however there are a growing number of CCGs that did not meet the rolling quarterly access in September 2017 and October 2017
• The monthly recovery rate has been met at a national level since January 2017. The rolling quarter recovery rate has been met nationally from March 2017, but the London and North regions still remain below target - plans for support are in place from national and regional teams

• October 2017 88.3% entered treatment within 6 weeks and 98.5% entered treatment within 18 weeks
• IAPT manual is complete and going through clearance processes for publication
• Innovation in service delivery events suggested to networks – could include expansion and access increases, impact on service delivery, waiting times and hidden waits in services
• Supporting regional colleagues and clinical networks in identifying and mitigating against:-

❖ Potential for reduction in quality due to increase in access and funding challenges
❖ Potential impact on recovery rates, as number of trainees increase in services in line with increase in access
❖ Nationally and regionally the waiting time standards have consistently been exceeded, however there are concerns around the average waiting time between 1st to 2nd appointments and this has been highlighted at Regional Quarterly Deep Dives and intensive support is in place for outliers.
## Improving the quality of services – current core metrics reporting

<table>
<thead>
<tr>
<th>Name</th>
<th>IAPT access rate</th>
<th>IAPT recovery rate</th>
<th>IAPT waiting times - 6 weeks</th>
<th>IAPT waiting times - 18 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
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<td>NORTH</td>
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<td>88.2%</td>
<td>98.7%</td>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>IAPT access rate</th>
<th>IAPT recovery rate</th>
<th>IAPT waiting times - 6 weeks</th>
<th>IAPT waiting times - 18 weeks</th>
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<td>YORKSHIRE and the HUMBER DCO</td>
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<td>97.8%</td>
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<tr>
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<td>NHS LEEDS SOUTH AND EAST CCG</td>
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<td>NHS WAKEFIELD CCG</td>
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</table>
Improving the productivity of services

NHS England in collaboration with NICE - Digital therapies in IAPT assessment and endorsement project

- Publish Assessment Briefings on digital therapy products
- Introduce provisionally approved products into services for testing
- Provide grant based funding for the development of promising products
- Two further products to be assessed by NICE before the end of FY 17/18
- Publish full reports on each fully evaluated product

- The first four out of a possible six products have been reviewed by NICE this financial year
- Three assessment briefings will be published on NICE’s website, expected 23 January 2018
- The first of the competed grants processes has been set up and is ready to go live once it is confirmed whether any of the products are identified as being eligible for development funding
- 8 services have been provisionally selected to test the products once they are ready
- IT systems should be set up to collect data for the evaluation by 18/19 January 2018
Supporting the implementation of activity and outcomes based payment in IAPT

• 2017/19 National Tariff
  • Revised guidance setting out whether localities:
    • Must implement the payment approach set out in guidance i.e. are alternatives acceptable
    • Must attach prices to clusters only
    • Must wait to progress implementation until the tool is available
    • Must link all 10 quality and outcome measures to payment
    • Must only link 5% of contract value to measures
  • Case studies which bring the implementation of outcomes-based payment approaches to life
    • 95% activity (assessment and treatment) with 5% outcomes
    • 90% block with 10% outcomes based on step intensity
    • 100% AQP cluster-step intensity hybrid

• Pricing teams are also exploring the development of non-mandatory prices for cluster-based episodes of treatment
Improving the sustainability of the IAPT workforce

- Best practice examples of IAPT staff wellbeing and PWP career development to be shared via various routes eg NHSE website, yammer, clinical networks, IAPT manual
- Self-care and resilience – discussions being held in national Expert Reference Group about whether this could be included in IAPT curriculums
- Collation of support and development opportunities and resources for staff
- Case studies to promote and value the PWP role
- This project is falling under a number of different work streams—workforce, education & training
- 3 best practice examples of IAPT staff wellbeing and career development published
- Lots of interest from services and networks, invites to speak and share best practice
- Wellbeing webinar hosted by Rebecca Minton on 21st February 2018 from 1.30-2.30pm, for IAPT Clinical and Service leads
Designing and developing with local areas new integrated IAPT service models

Increase access to evidence-based psychological therapies to reach 25% of need, helping 600,000 more people per year

NHS Operational Planning and Contracting Guidance
2017-2019

NEXT STEPS ON THE NHS FIVE YEAR FORWARD VIEW

www.england.nhs.uk
What will this mean for CCGs and Providers in 2018?

- CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21.

- To meet the increase in access (66%), providers will need an additional increase in staff of at least 50%.

- Overall planning of workforce should include increasing the number of trainees to meet 4,500 commitment by 2020/21, this has been disseminated via regional teams with numbers at CCG level.

- Overall planning of workforce should include increasing the numbers of therapists co-located in general practice by 3,000 by 2020/21.

- From **2018/19**, commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems – IAPT-LTC
To implement integrated psychological therapies at scale – improving care and outcomes for people with mental health problems and long term physical health problems, and distressing and persistent medically unexplained symptoms.

To build capacity in the IAPT workforce, starting the expansion of the workforce needed to meet 600,000 extra people entering treatment by 2020/21.

68 CCGs part of Wave 1 and 2 Early Implementers

62% of all STP’s have at least 1 CCG within commissioning IAPT-LTC
IAPT-LTC Definition

What defines an Integrated IAPT service?

An integrated service will expand access to psychological therapies for people with long term health conditions or MUS by providing care genuinely integrated into physical health pathways working as part of a multidisciplinary team, with therapists, who have trained in IAPT LTC/MUS top up training, providing evidence based treatments co-located with physical health colleagues.

It is important to keep this definition in mind when setting up your integrated service. It may be that in the beginning all these requirements are not met however you should be aiming for a service model which satisfies all 3 of the criteria above.
How?

- Co-located physical and mental healthcare

- NICE-recommended therapies, adapted for people with LTCs and delivered by properly trained therapists. **Hence the need for CPD courses for IAPT Hi & PWPs**

- IT systems support outcome monitoring for all (mental health symptoms, disability, perception of physical health problems).

- All IAPT’s existing quality standards.

- Closely linked to, and managed with core IAPT (don’t try to reinvent the wheel)
Which LTC’s? Summary of Wave 1 and 2 sites

The most common LTCs that are likely to be seen in new integrated IAPT services:-

- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Cardiovascular disease (CHD)
- Musculoskeletal problems, Chronic pain.
- MUS

Colocation for the Early Implementers:-

- GP Practices/Primary Care
- Acute Hospitals and Secondary Care
- Community Teams
Commissioners

- There is enthusiasm in providers and CCGs to develop integrated services, and there are examples of services that are already providing psychological therapies in this way.
- Start early! Engagement, relationships and development of pathways does take time.
- Develop a good implementation plan which is co-produced, has both physical and mental health input along with service user collaboration.
- When developing pathways, carefully consider local nuance – where lends itself to integrated working? What do the Right Care packs show?
- Mapping exercise to prevent duplicate commissioning - what is commissioned from the physical care envelope.
- Can you make this work across the STP/ vanguard.
Learning from process so far

Providers

• Start early- Engagement, relationships and development of pathways does take time
• Ensure there is clarity re the distinctions between IAPT LTC, Liaison Psychiatry and health psychology, and that the pathways between all three are clear
• Make links top down and bottom up
• Don’t underestimate the important of publicity and marketing- start this early too
• How should you brand your service to appeal to the target audience – think about language, stigma, visual design..
• Training and engagement of Physical Health Care staff
• Can you dual train practitioners?
• Undergoing significant service developments at pace can have an impact on staff wellbeing - ensure steps are taken to support the team
Allocation to Core IAPT vs Integrated IAPT

- IAPT clients with a co-morbid LTC that is not a significant problem – treated in Core IAPT

- IAPT clients with a co-morbid LTC that significantly impacts on wellbeing, for which IAPT treatment will need to be adapted – Integrated IAPT

- **Referrals** through –
  - Usual route (Self/GP Referral)
  - Directly from specialist physical health teams/workers (e.g. Diabetes Service)
  - Generic community physical health workers (e.g. District Nurses/Matrons, Practice Nurses)
Pathway Example

Professional Groups working with diabetes; potential referrers to IAPT

- GP’s, Practice Nurses, District Nurses
- Diabetes Specialist Nurses
- Desmond Course
- RAID / Psychiatric Liaison
- Vanguard Community Integrated Teams
- Hospital based Medics, Nurses, AHP’s (Diabetes Team)
- Diabetes UK & User Voice via Support Groups
- Carers Centre

Why refer to IAPT?

- Depression is twice as common in people with diabetes as in the general population.
- At least 4 in 10 people with diabetes experience emotional problems such as anxiety, depression and diabetes-related emotional distress.
- Emotional distress reduces an individual’s ability and motivation to self-manage their illness leading to poorer health outcomes and reduced quality of life.
- The independent Mental Health Task Force estimates that physical healthcare costs are 50% higher for people with Type 2 Diabetes with poor mental health – costing an extra £1.8 billion every year.

(Diabetes UK, 2016)

When to Refer to IAPT

- Newly diagnosed or early in diagnosis – adjustment to diagnosis and associated anxieties, coping with role changes, health promotion and preventative work, promoting effective self-management of physical and emotional wellbeing.
- Progressing or worsening of illness presentation – managing anxiety/low mood associated with worsening physical health, role transitions and adjustments, loss/grief reactions, feeling a burden to others.
- Unstable diabetes – health promotion, is low mood or anxiety impacting on self-management of diabetes, lifestyle choices and changes.
- Stable diabetes – anxiety and obsessional traits developing in trying to keep self well and diabetes stable.

IAPT Treatment Options
Leaflet Example

Whittington Health NHS

ARE YOU LIVING WITH DIABETES OR COPD?

I WAS FEELING STRESSED AND WORRIED ABOUT MY DIABETES SO I REFERRED MYSELF TO IAPT FOR SOME SUPPORT, WHICH REALLY HELPED.

LET'S TALK

A FREE AND CONFIDENTIAL TALKING THERAPY SERVICE IN HARINGEY

FOR MORE INFORMATION PLEASE CALL 020 3074 2280, OR TO REFER YOURSELF ONLINE PLEASE VISIT OUR WEBSITE

iapt

lets-talk-iapt.nhs.uk

NHS England

NAVIGO

Long Term Conditions Service:
Respiratory Conditions and Mood

Having a long term condition such as Chronic Obstructive Pulmonary Disease (COPD) or asthma, can affect all areas of our life, not just our physical health. Open Minds is now providing a new service to help people with respiratory conditions maintain the best possible health and wellbeing.
Impact of integration on referral source

• Initial information from Early Implementer sites indicates a significant amount of referrals have come from physical health care colleagues who are new referrers into IAPT services

• Early indication of a significantly higher proportion of older adults (compared to the core IAPT services)

• Early indication of a more balanced gender split (currently 2/3 female to 1/3 male in core IAPT)
Early Implementer Initial Outcomes

- Early Implementer sites report recovery rates of >50% for patients in IAPT-LTC pathways

- Results of local evaluations from wave 1 early implementer sites demonstrate reductions in healthcare utilisation for patients seen in IAPT-LTC

- Table below is taken from initial site evaluation following 446 patients in IAPT-LTC with pre and post CSRI (Client Services Receipt Inventory)

<table>
<thead>
<tr>
<th>Financial Savings</th>
<th>GP (NHS Channel Shift Method)</th>
<th>Physiotherapy</th>
<th>Specialist Nurse (Cardiac etc)</th>
<th>A&amp;E (Accident &amp; Emergency)?</th>
<th>Hospital Inpatient Admissions</th>
<th>Total</th>
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<tr>
<td>Cardiovascular</td>
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<td>£1,581.00</td>
<td>£20,475.00</td>
<td>£2,688.00</td>
<td>£58,194.00</td>
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<td>Diabetes</td>
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<td>£16,730.00</td>
<td>£1,120.00</td>
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<td>£32,880.00</td>
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<td>All Pathways</td>
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<td>£5,376.00</td>
<td>£122,434.00</td>
<td>£192,918.00</td>
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</table>
Initial CSRI Data

- Sites who have shared their initial local evaluation data report:
  
  I. Reduction in GP appointments post treatment
  
  II. Reduction in doctor/consultant appointments post treatment
  
  III. Reductions in medical investigations post treatment
  
  IV. Reductions in hospital admissions and A & E attendances

- Some sites reported increases in specialist nurse use – indicating better use of healthcare and condition management
Impact of IAPT-LTC CPD training

“the specialist training helped to highlight the varied ways that ill health can have a negative impact on a person’s experience of life”

“…encouraged me to incorporate other relevant approaches…”

“…feel more confident …”

“…felt helpless, but now. I don’t feel quite as lost!”

“…easily be able to liaise with the nurses and physiotherapists to ask questions relating to my clients”

“….get these questions answered by the professional involved.…”

“….now I am more at ease with making contact with physical health professionals about a client because it does feel like our business. “
Feedback from patients

“I am joining in with life again, I am noticing things around me. I am able to make more effort and can do so much now without experiencing any stress at all’.

‘People have been telling me I look so much happier in myself, my daughter is amazed as I am offering to look after the babies. It made me realise how much I had been ignoring the family around, my health is in control and I have my life back’.

“My diabetes has also changed- my mood has changed because I have control of my sugar better than I ever had done. I’ve got the depressed attitude out of the way and I can manage the diabetes better.”

“Anxiety was more disabling to me than my heart attack or the surgery”

“After my heart attack I was feeling chest pain and I kept going to A & E and hospital but they said I was fine. Then I saw the Heart2Heart therapist and realised I was depressed. I’ve got a long way to go but I can get out of the house now and I am thinking of returning to work”
Feedback from professionals

• “Just wanted to let you know that I saw LJ last week and it was like having a completely different person sat in front of me.”

• “X is absolutely thrilled with the work you have been doing with him and reports you have finally helped him to understand why he has struggled for years with his health management behaviours.”

• “Patients report your help has impacted their whole life - work, relationships & diabetes.”

• Thanks - your input is certainly making my job with patients much easier!”
Q1: We are keen to access the additional training and salary support that is on offer, but have not heard anything about it despite reaching out to our local HEE offices, how can we get in touch?

A: Please get in touch with Elaine at Elaine.Bowden@hee.nhs.uk and she can investigate.

Q2: Will there be an uplift in CCG baseline to pay for the IAPT expansion in the coming year?

A: Money for mental health is flowing into CCG baseline. However, as money is not ring-fenced, it will require some strong commissioning. Commissioners need to recognise the impact of IAPT-LTC on use of primary care and acute services. We understand that it is challenging but it is important to remember mental health is one of our national priorities. The 2017-19 Operational and Planning Guidance demonstrates the requirement that from April 2018 all CCGs should be commissioning IAPT-LTC in addition to their core IAPT service. As 2/3 of the overall expansion in access should be through IAPT-LTC services – this is a key FYFV commitment.

Q3: Are there any rules which require additional IAPT training for GP employed accredited counsellors, which would prevent them being part of a system/pathway at step 3?

The commitment in GPFV is to increase the number of additional mental health service working in primary care. The majority of the 4,500 trainees and newly qualified practitioners will enter core IAPT releasing more experienced practitioners into primary care. So the 3,000 will already be qualified practitioners with a significant amount of experience. In most circumstances we would expect individuals working in these complex pathways to have the additional top-up training in LTC but beyond that, there are no additional formal qualifications required.

The IAPT manual is clear that any counsellors (e.g. GP Practice counsellors) are required to have completed the IAPT counselling for depression training, the Interpersonal Therapy step 3 IAPT training, or the Couples Counselling for Depression in order to provide step 3 (or any) IAPT evidence based treatment. Counsellors who have not completed an IAPT accredited training cannot provide treatment or attend the top up training to work in IAPT-LTC.
**Recent Q & A’s from Claire Murdoch’s webinars**

**Q4: Is it possible to clarify if there is any information coming out to demonstrate the models from the early implementers e.g. staffing put in and costs etc.?**

A: FAQ is available which incorporates the relevant empirical evidence we have used. We have also shared with you some early findings from our IAPT-LTC early implementer.

**Q5: What services from physical health should be cut to pay for IAPT-LTC?**

A: It is the commissioners’ responsibility to determine local needs and priorities. Early findings from the IAPT-LTC programme have found a reduction in physical healthcare usage. This would seem to indicate a strong case for investment and strengthens the argument for at least some disinvestment from services where reduced activity is anticipated. However the role of the central team in NHSE is not to determine local priorities but to indicate best commissioning practice aligned with potential impact including both clinical and economic benefits. This material can be used to determine these priorities and NHSE with other ALB colleagues particularly NHSI can then provide service development and quality improvement support in order to secure better outcomes for local populations.

**Q6: It is very hard to interest core IAPT people in moving across to integrated IAPT-LTC – what are your thoughts?**

A: We agree that there is more work that can be done especially in communicating to core IAPT practitioners the clinical and other opportunities available in stepping into roles in IAPT-LTC services. We are hoping the recent series of national workshops where a range of early implementer sites presented on progress to date will have stimulated more qualified practitioners to consider a move into more integrated services alongside primary care and general acute service colleagues.

On the other hand, some services offer a part-time model. This enables therapists to undertake interesting training and diversify their skills while remaining part of core IAPT service. Service leads have confirmed that a 0.6/0.4 split of WTE works well for them.

If you do find it hard to achieve an improved balance of clinical input in line with requirements to increase IAPT input into LTC pathways locally please email the IAPT national team england.mentalheath@nhs.net

www.england.nhs.uk
Q7: How much is CBT tailored to LTCs in IAPT? For instance, evidence from health psychology that you need to give people self-management skills in LTCs as well as treating the depression/anxiety, or you will not improve their health.

A: The training curricula for top up training have been developed to deliver enhanced competencies in working with people with LTC or MUS. This has been developed by a multi-disciplinary group of clinicians and commissioned from a number of providers. The details of the competency framework and curricula can be found on the HEE website.

Q8: Do you think that there will be a role in terms of social prescribing with this and more joint working with the voluntary sector?

A: Yes. Some of the more successful IAPT services are nested within more broadly focused wellbeing services with very good links with primary care services, a clear focus on resilience through addressing a range of individual needs and linked to community networks where these exist. We see the IAPT offer, particularly supporting people with a LTC or MUS as a good fit with more holistic services but it is imperative that the therapeutic interventions offered remain aligned with the evidence base, delivered by qualified and accredited practitioners, using routine outcome monitoring to track progress collaboratively with their clients. Only data from the IAPT offer can be included in the submissions to NHS Digital and count towards the national standards.
Thank you for listening

Contact me on ujames@nhs.net
Yorkshire and the Humber IAPT Providers Network

Time for a break?

15 minutes only please!
Yorkshire and the Humber IAPT Providers Network

Older People in IAPT Toolkit

Georgie Thrippeleton, Quality Improvement Lead, Yorkshire and the Humber Clinical Networks
Older People’s Mental Health
A Toolkit for Increasing Access to IAPT Services

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National Drivers

Foreword
CCG MH Quality Premium

Purpose
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Foreword

Tom Wright, CBE, Age UK said….

It is now widely accepted that the mental health needs of older people have historically been under-recognised and under-treated. Although the proportion of those affected is broadly in line with other age groups, older people have not been able to access the same level of support.

Research has also found that older people with common mental health conditions are more likely to be on drug therapies and less likely to be in receipt of talking therapies compared to other age groups. Older people themselves may be reluctant to seek help – with fewer than one in six older people with depression ever discussing it with their GP.

Later life is a time when getting the right support is extremely important for wellbeing due to the complex challenges older people often face. As our population ages, it is crucial to ensure that older people’s mental health not only attains parity with physical health diagnostics and care, but parity with other age groups too. (Older People’s Mental Health Primer, 2017)

**Call to Action:** The estimated prevalence of common mental health disorders for adults over the age of 64 in England is 18% (Adult psychiatric morbidity survey, 2007). Access rates to IAPT nationally for this group is an average of 6.4%. (DOH 2011).

Older Adults also have lower drop out rates and higher completion rates for treatment (IAPT Yearly Report). The national recovery rate for Older Adults is on average 13% higher than the average for the general population.
Purpose of the Toolkit

This toolkit aims to support Commissioners and Providers to increase the number of over 65’s accessing IAPT services.

The Toolkit brings together all relevant national documents and drivers that support this agenda, with a particular focus on the CCG Quality Indicator for older people, which 11 CCG’s have signed up in Yorkshire and the Humber.

Why increase the number of over 65’s in IAPT?

At the heart of the NHS constitution is equality and fairness – everyone has an equal right to access and benefit from NHS services. No one group is exempt from depression or anxiety disorders. Yet many barriers are preventing older people from accessing psychological interventions including, older people’s views, behaviours and attitudes to mental health issues, have physical health conditions that distract them from recognising their co-morbid mental health condition, use of language and the belief that ‘feeling low’ is a common part of ageing to name but a few.

Ten million people in the UK are aged over 65 and yet older adults are under-represented in IAPT, with only 6.5% accessing IAPT nationally. It is believed that 25% of people over the age of 65 living in the community have symptoms of depression serious enough to warrant intervention, but only a third of them discuss it with their GPs, and only half of those get treatment, primarily medication.

Older people are more likely to be living with a long term condition, or be affected by loneliness or isolation, or be in a caring role which can all be factors contributing to mental health issues.
National Drivers

A number of key publications support this agenda, including the following:

**Older People’s Mental Health Primer** (2017) — this document describes distinctive features of common mental health problems in older adults, aims to increase professionals confidence in diagnosing and treating older adults, be aware of the interaction of physical and mental health in older adults, with much more useful information in this area.

**Mental Health Five Year Forward View** — Setting the agenda for 2020/21 the document sets out a strategy to improve mental health care. It states that one in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.

**2018/19 NHS Delivery Plan** (include link once published) - the plan includes continuing to maintain 50% IAPT recover rates and supports the participation in the Quality Premium to increase access for under represented groups such as older people and BME.
CCG MH Quality Premium *(updated guidance expected imminently)*

Equity of Access and outcomes in IAPT services 2017-2019

11 CCG’s in Yorkshire & the Humber have signed up to this Quality Premium:

1. Recovery rate of people accessing IAPT services identified as BAME; improvement of at least 5 percentage points or to same level as white British, whichever is smaller.

And

2. Proportion of people accessing IAPT services aged 65+; to increase to at least 50% of the proportion of adults aged 65+ in the local population or by at least 33%, whichever is greater in 2017/18; to increase to at least 70% of the proportion of adults aged 65+ in the local population, or by an additional 33% in 2018/19, whichever is greater.

Link to data to be included.
Case Studies & Top Tips
The following case studies show examples of work in practice

**North Yorkshire**—A specific older people’s improvement group led to clinicians embracing the champion role, engagement of stakeholders, promotional material to develop an older person’s specific approach, investment in training and enhancing the core IAPT offer to be more inclusive of older people.

**Sheffield**—The service integrated with primary care and developed a group named Older Adults Overcoming Worry Group to specifically support older people with GAD as well as reducing social isolation.

Camden
Hull
Huddersfield
Thames valley

**Top Tips & Key Themes include:** Collaborative Working, Partnership Approach, Language Used, Champions for older people, making local links with Third Sector and Charitable Organisations

**CASPER research**—The aim of the CASPER research programme was to examine how best to treat older people (aged 65+) who suffer from low mood and depression. Full findings report can be found via the link.

**START Programme**—START is an eight session manualised intervention aimed at promoting the development of coping strategies for carers of people with dementia.
Yorkshire and the Humber
IAPT Providers Network

Update on IAPT PBR Toolkit

Kit Hadley-Day, NHS Digital
IAPT Tariff Tool

- Who am I?
- The IAPT Tariff Model
- Model Implementations
- Web Tool Update
- Exeter Development Update
- Data Quality
- Questions
What is the National Casemix Office

- Responsible for creating the Hospital Resource Groups used for costing and pricing the activities performed in hospitals
- Produce the freely available grouping software used throughout the physical acute service
- Provide ‘Patients to Pound notes’ costing and tariff modelling and analysis
- For more information visit the website http://content.digital.nhs.uk/casemix
The IAPT Tariff Model

• Developed in collaboration between NHS England and the National Casemix Office
• It is driven from the current IAPT data set (version 1.5)
• Consistent with guidance on an outcomes-based payment approach for IAPT services covering:
  – Activity component (assessment and episode of treatment)
  – Outcomes component (10 national quality and outcomes measures)
Model Implementations

• Web Tool
  • This tool contains provider level data and had the facility to allow local customisation of model variables to assist in Provider / Commissioner negotiations and impact analysis
  • This is only available to Providers

• Exeter Implementation
  • This allows the tool to be automatically applied to the post processing national flows of data based on reference data submitted by providers
  • Extracts from this system are available to both Providers and Commissioners
Web Tool Update

• User assurance cloud service.
  • This has been a significant success with nearly one hundred registered users, we still have available user accounts available

• Full cloud service
  • The full cloud service is in the last stages of testing and should be available via the Exeter Portal by the start if the next financial year. This will contain post processed IAPT data
Exeter Development Update

• Payment Extracts linked to payment periods
• Submission periods has two formal processing opportunities (Primary and Refresh)
• Payment will produce Flex and Frozen positions
• Frozen will still be produced even where a primary submission was the only one on the received (no refresh submitted by the site)
Exeter Development Update cont.

• Phase 1
  • IAPT calculation outcomes and pathways
  • Providers can receive outcome calculations based on reference data provided to NHS Digital
  • Trailblazer provider sites already participating (we can add more on request)
Exeter Development Update cont.

• Phase 2
  – **IAPT end to end calculations**
    – Providers can receive end to end calculations (contained in their post deadline extracts) based on reference data provided to NHS Digital (Assessment, Activity and Outcomes)
    – Will be available for processing April 2018 submissions
Exeter Development Update – Reference Data

• Reference data required to drive outputs
• Examples can be created and tested on IAPT cloud planning web grouper
• Template available for sites to populate
Data Quality

• Data quality is vital to ensure accurate reimbursement calculations

• Feedback from current users suggests that proper analysis of the available data quality is vital to understanding how parts of the model can be applied

• Failure to understand current data quality and how improving the data quality may affect the model could lead to uncomfortable results
Any Questions
Yorkshire and the Humber
IAPT Providers Network

Any Other Business
Key themes and achievements in 2017/18
Access to IAPT for IAPT Staff
Yorkshire and the Humber
IAPT Providers Network

Thank you for Attending!

Please remember to fill out your evaluation forms!