Yorkshire and the Humber Mental Health Network

IAPT-LTC
31 October 2017

- Andy Wright, IAPT Advisor and Sarah Boul, Quality Improvement Manager
- andywright1@nhs.net and sarah.boul@nhs.net
- Twitter: @YHSCN_MHDN #yhmentalhealth
- October 2017
Housekeeping:

- Fire
- Toilet access
- No mobile phone
- Parking

Other icons:

- Refreshment area
- Lunch sign
- Twitter handle @YHSCN_MHDN
- #yhmentalhealth

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Welcome and Introduction

Andy Wright, IAPT Advisor, Yorkshire and the Humber Clinical Networks
Introduction to the IAPT-LTC Programme

Professor David Clark
National Clinical & Informatics Advisor for IAPT and Chair of Experimental Psychology, University of Oxford
Introduction to IAPT LTC: Why and How?.

David M Clark
National Clinical and Informatics Advisor
(davidmclark@nhs.net)
Background to IAPT

• “the greatest revolution in British mental health in fifty years” Sir Simon Wessely

• “a world beating programme” Nature editorial

• “the world’s most ambitious effort to treat depression, anxiety and other common mental illness” New York Times feature (July 2017)
Enormous progress has already been made in psychological treatment research

- NICE recognizes the advance and recommends evidence-based psychological therapies as first line treatments for:
  - Depression
  - Anxiety related disorders (Generalized anxiety, panic disorder, obsessive compulsive disorder, social anxiety, agoraphobia, PTSD, health anxiety, specific phobias)
  - Eating Disorders

- BUT most members of the public weren’t benefiting
The IAPT Solution

Increase the availability of effective (NICE recommended) psychological treatments for depression and all anxiety disorders by:

• training a large number of psychological therapists

• deploying them in specialized, local services for depression and anxiety disorders

• measuring and reporting clinical outcomes for ALL patients who receive a course of treatment (public transparency)
How did it come about?

Omagh Bomb,
Lobbying & Public Campaign

Political Support

Brown
Cameron & Clegg
May

NICE guideline

THE DEPRESSION REPORT
A Poor Deal for Depression and Anxiety Disorders

WE NEED TO TALK
The limits of psychological therapy in the NWH

Thrive
THE POWER OF PSYCHOLOGICAL THERAPY
RICHARD LAYARD • DAVID M. CLARK

‘Comprehensive, humane and generous’
MELVIN BRAGG
Mental health problems:

- Account for 38% of all illness
- Most common cause of disability in working age population (*depress GDP by 4%, which is £80 billion per annum*)
- Public prefers therapy to medication 3:1
- Psychological therapy pays for itself
WHY IAPT HAS ZERO NET COST

• Gross cost per person treated £650

• Savings on physical healthcare > £650

• Savings on benefits/taxes > £650

• Actual cost per course of treatment £684
IAPT So Far (2017)

• Stepped care psychological therapy services established in every area of England. Self-referral.

• Approx 16% of local prevalence (950,000 per year) seen in services

• Around 60% have course of treatment (approx 575,000 per year)

• Outcomes recorded in 98% of cases (pre-IAPT 38%)
IAPT So Far (2017)

- Nationally 51% recover and further 16% improve (Jan- July 2017).

- Substantial Pre-Post Effect sizes
  - Depression (PHQ-9) \( \text{ES} = 1.4 \)
  - Anxiety (GAD-7) \( \text{ES} = 1.5 \)

- Overall results as good as research studies and in line with economic model
IAPT national recovery rates

Recovery Rate (%) vs Quarter

- 2008/09 to 2016/17

Quarter:
Q3, Q4, Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4, Q1, Q2, Q3, Q4

Recovery Rate:
0.0%, 10.0%, 20.0%, 30.0%, 40.0%, 50.0%, 60.0%

National Target (50%)
Predictors of CCG level variation in Reliable Improvement & Recovery

<table>
<thead>
<tr>
<th>Predictor</th>
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<tbody>
<tr>
<td>Problem descriptor completeness (%)</td>
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<tr>
<td>Average number of sessions</td>
</tr>
<tr>
<td>Average wait time</td>
</tr>
<tr>
<td>DNA rate (% of sessions)</td>
</tr>
<tr>
<td>Percent of patients who get a course of treatment</td>
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</tbody>
</table>
Predictors of reliable improvement

**Average waiting time**

Reliable Improvement – Mean number of days people waited to enter treatment

**Number of sessions**

Reliable Improvement – Mean number of treatment appointments
Recovery Rates are higher when therapists stick to NICE recommended treatments

**Self-help treatment for Depression:**
Guided 50% vs Pure 36% (p < .0001)

**Generalized anxiety disorder treatment**
CBT 55% or Guided Self-help 59%
vs
Counselling 46% (p < .0001)
Expanding IAPT by 2021

- Increase numbers seen & treated by 66% (from 900,000 seen in 2015 to 1.5 million in 2021)
- Focus 2/3 of expansion on people with LTCs and/or MUS
- Increase use of digitally assisted therapies
- Expand workforce by 50-60%
Why focus on people with LTCs?

**Fairness**

- Currently under-represented. 21% of people treated in IAPT services but 40% of cases in the community.

**Great prospects for patients and their families**

- NHS Digital data shows outcomes as similar to people without LTCs (43% vs 46% recovery in 2015/16 LTC vs Non-LTC)

**A moment in history**
Why focus on people with LTCs?

**Economic Sense for the NHS** (Layard & Clark 2014, Ch 11)

- LTC healthcare costs 50% higher in people with depression and/or anxiety disorders
- Psychological therapy reduces physical healthcare costs by average of 20% (meta-analysis of 91 studies)
- When data is available on cost of psychological treatment and physical healthcare savings exceeds costs
- IAPT LTC wave 1 and Wave 2 sites are collecting further “on the ground” economic data
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 & PWP**s

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

• Suitable accommodation.

• All IAPT’s existing quality standards.

• Closely linked to, and managed with core IAPT (don’t try to reinvent the wheel)
Which Long-Term Conditions?

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.
Medically Unexplained Symptoms

• Medically unexplained symptoms are common. Individuals with persistent and distressing MUS can be severely disabled and are frequent users of the NHS.

• RCTs have shown that psychological therapies are effective. The therapies are mainly based on CBT principles and build on the core competencies of the IAPT workforce but include additional procedures. Hence the need for CPD training.
Types of MUS

- Irritable bowel syndrome  *(High intensity CBT)*
- Chronic Fatigue Syndrome  *(Hi CBT & GET)*
- Chronic Pain  *(CBT in integrated pain management)*
- MUS not otherwise specified  *(Broad based CBT)*

**Engagement** in treatment can be a challenge, but many of the key principles have already been touched upon in HI training of health anxiety and panic disorder

- Positive evidence for psychological modulation
- Right terms (symptom management) Reduced reassurance
Forthcoming Helpful Documents

• The IAPT Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms
  – Specific guidance on how to develop IAPT-LTC services

• The Improving Access to Psychological Therapies Manual
  – Single source for all information on the IAPT programme (workforce, measures, therapies, outcomes, supervision, service improvement etc)
The IAPT Manual Chapters (1)

Main Guide

1. Introduction
2. Conditions treated by IAPT
3. Importance of delivering evidence-based care
4. The Workforce
5. Delivering effective assessment and treatment
6. Importance of data: monitoring outcomes & activity
7. Getting better results: Improving access
8. Getting better results: Reducing waiting times
9. Getting better results: Improving recovery
Main Guide

10. Getting better results: improving equity of access and outcomes for all
11. Working with the wider system
12. Key features of a well-commissioned IAPT service
The IAPT Manual Chapters (3)

Appendices & Helpful Resources

• Competence frameworks for IAPT therapies
• IAPT screening prompts for assessment interview
• Clinical cut-offs and reliable change
• Examples of Patient Tracking Lists (PTLs)
• Positive Practice Examples
• Case identification tools (screening questionnaires)
• Outcome Questionnaires
• Patient Experience Questionnaire
• Helpful web-based resources
Thank You
Learning from the IAPT-LTC Programme

Ursula James
IAPT Programme Manager, NHS England
IAPT Programme

Learning from Wave 1 and Wave 2 Early Implementers

Integrating IAPT with physical health pathways
IAPT-LTC

Ursula James – National IAPT Programme Manager
FYFV Commitments: Increase access to 1.5m people a year
FYFV Commitments: Integrated IAPT services

• Two thirds of expansion, by 2020/21, to be ‘Integrated IAPT’ services – integrated with physical health pathways for people with long term conditions or distressing and persistent medically unexplained symptoms.

• In 2016/17 and 2017/18: Early Implementers supported centrally

• From 2018/19, CCGs to commission IAPT-LTC services locally
NHS Operational Planning and Commissioning Guidance 2017-2019

• CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21.
• Ensure local workforce planning includes the number of therapists needed and mechanisms are in place to fund trainees.
• From **2018/19**, commission IAPT services integrated with physical healthcare and supporting people with physical and mental health problems.
FYFV Commitments: build capacity in the workforce

Projected trainee numbers

<table>
<thead>
<tr>
<th>Year</th>
<th>PWP Trainees</th>
<th>HIT Trainees</th>
<th>Culmative Total</th>
<th>Co-located Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016/17</td>
<td>210</td>
<td>390</td>
<td>600</td>
<td>50</td>
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<tr>
<td>2017/18</td>
<td>400</td>
<td>200</td>
<td>600</td>
<td>150</td>
</tr>
<tr>
<td>2018/19</td>
<td>413</td>
<td>755</td>
<td>1168</td>
<td>300</td>
</tr>
<tr>
<td>2019/20</td>
<td>413</td>
<td>755</td>
<td>1523</td>
<td>450</td>
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<tr>
<td>2020/21</td>
<td>338</td>
<td>630</td>
<td>1963</td>
<td>600</td>
</tr>
</tbody>
</table>

Culmative totals of trained staff

PWP trainees
HIT trainees
Culmative total
Co-located staff in primary care

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

- We are calculating each CCG’s share of the additional 4,500 therapists and the 3,000 MH therapists in primary care
- This is based on simplistic assumptions using prevalence
- We will share these with regions and use them as starting points for refinement based on local intelligence
- This will be an iterative process

In wave 1 352 additional practitioners started working in primary care as a result of the expansion
Lessons from IAPT programme, including LTC/MUS: data is critical

• Getting outcome data on everyone is critical. It helped core IAPT go from 38% recovery (2009) to 51% now.

• LTC/MUS pilots fell below this standard – important to integrate data into business as usual (session by session, data view in every supervision, IT system support, digital input).

• Integrated services need to collect some additional data on the perceived impact of the LTC and healthcare utilization (e.g. CSRI)

• Important to be clear from the beginning about what to collect, when, why, and how data completeness is monitored.
<table>
<thead>
<tr>
<th>Financial Incentives</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
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<tr>
<td>Outcomes based tariff</td>
<td>Preparation</td>
<td>Shadow implementation</td>
<td>Full implementation</td>
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<tr>
<td>Quality Premium</td>
<td>Quality Premium Active</td>
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<tr>
<th>Supporting productivity</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
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<tbody>
<tr>
<td>Digital information for commissioners scoping</td>
<td>Development of a digital therapy endorsement programme</td>
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</table>

<table>
<thead>
<tr>
<th>Guidance and building evidence</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
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<tbody>
<tr>
<td>Interim implementation guidance for integrated IAPT</td>
<td>Updated guidance for integrated IAPT. Updated Core IAPT guidance published</td>
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<tr>
<td>New evidence</td>
<td>Commission analysis of early implementers</td>
<td>Gather evidence for analysis</td>
<td>Final evidence from analysis</td>
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<tr>
<td>Comms</td>
<td>Regular communications on the case for expansion – including evidence, best practice and fit with system priorities</td>
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IAPT Early Implementer Programme

Aim:

• 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 learn how best to implement integrated psychological therapies at scale in an NHS context – moving from trials and pilots to business as usual.
• To build the return on investment case for integrated psychological therapies – demonstrating savings in physical health care.
• 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.

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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 collocated with physical health colleagues.

It is important to keep this definition in mind when setting up your integrated service. It may be that while 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.
IAPT EI Programme

Working with 22 areas covering 30 CCG’s in Wave 1 (started from January 2017), with further 15 areas covering 38 CCG’s in Wave 2 (started from April 2017)

Components of expansion programme:

- Developing curricula & training offer
- Allocating funds for Early Implementers
- Guidance to support service design / implementation
- Data collection & analysis
- Support for early implementers

HEE have commissioned LTC training with courses already started

Funding approved for Wave 1 and Wave 2 sites

Integrated IAPT Evidence Based Treatment Pathway Draft available

Work Packages agreed, support available to EI sites and workshops arranged

National workshops continuing. Yammer site is working well. Site visits and implementation calls with new Wave 2 sites completed. Delivery calls with Wave 1 sites completed

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What is available to support implementation?

- CPD for therapists in psychological therapy for people with long term conditions / medically unexplained symptoms: starting late 2016 & in 2017
- Sharing ideas and emerging practice from early implementers
- Extra core trainees in 2016/17 and 2017/18 for IAPT EI and Universal offer places
- Service design: implementation guidance available
<table>
<thead>
<tr>
<th>Area</th>
<th>Co-location proposal</th>
<th>Diabetes</th>
<th>COPD / Resp.</th>
<th>CVD / Cardiac</th>
<th>MUS</th>
<th>Other</th>
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<tbody>
<tr>
<td>Blackburn With Darwen &amp; South Lancs</td>
<td>Community respiratory teams &amp; integrated care teams (aligned with GP clusters)</td>
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<tr>
<td>Calderdale</td>
<td>General practice</td>
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<td>Chiltern &amp; Aylesbury Vale</td>
<td>General practice, community teams &amp; outpatients teams</td>
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<td>Chronic pain</td>
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<tr>
<td>Herts Valleys &amp; West Essex</td>
<td>In development</td>
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<td>Chronic pain</td>
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<tr>
<td>Horsham and Mid Sussex, Coastal West Sussex &amp; Crawley</td>
<td>LTC teams: specialist heart failure teams, diabetes nurse specialists, community respiratory nursing teams, proactive care teams</td>
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<td>Chronic pain</td>
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<tr>
<td>North Staffordshire</td>
<td>General practice, long term conditions teams</td>
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<td>Chronic pain</td>
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<tr>
<td>North Tyneside</td>
<td>Primarily in general practice and primary care community teams</td>
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<td>Chronic pain, Cancer</td>
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<tr>
<td>Nottingham West</td>
<td>Integrated local care team</td>
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<td>Pre-diabetes, dermatology, people in top 2% most at risk of admission to hospital</td>
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<td>Portsmouth</td>
<td>Specialist long term conditions teams</td>
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<td>Chronic pain, CFS</td>
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<tr>
<td>Sunderland</td>
<td>Integrated community teams based in primary care</td>
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<td>chronic pain, cancer, obesity</td>
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<tr>
<td>Windsor, Ascot and Maidenhead, Bracknell and Ascot</td>
<td>Community hubs (LTC teams) and GP practice clusters</td>
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<tr>
<td>Wokingham, Slough &amp; Windsor, Ascot &amp; Maidenhead, Bracknell and Ascot</td>
<td>Community hubs (LTC teams) and GP practice clusters</td>
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<td>Oxfordshire</td>
<td>Integrated locality teams within the 6 GP localities</td>
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<td>MUS, CFS</td>
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<td>Greater Huddersfield</td>
<td>LTC multidisciplinary teams</td>
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<td>Pain management, Dementia</td>
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<tr>
<td>Harrogate And Rural District</td>
<td>LTC teams</td>
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<tr>
<td>Warrington</td>
<td>General practice</td>
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<tr>
<td>Richmond</td>
<td>General practice, community teams and acute trust teams</td>
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<tr>
<td>Swindon</td>
<td>In development - general practice linking to specialist teams</td>
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<td>Hillingdon</td>
<td>Secondary care teams</td>
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<td>NEW Devon</td>
<td>General practice, district hospitals, community hospitals</td>
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<td>Obesity</td>
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<td>Cambridgeshire and Peterborough</td>
<td>LTC teams and primary care mental health service from 2017/18 (to be located in general practice)</td>
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<td>NE Hampshire and Farnham</td>
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# Summary of Wave 2 Sites

<table>
<thead>
<tr>
<th>Area</th>
<th>Co-located in</th>
<th>Long term conditions</th>
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<tbody>
<tr>
<td></td>
<td>GP practice / primary care</td>
<td>Community services</td>
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<tr>
<td>BANES &amp; Wiltshire CCGs</td>
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<td>✓</td>
</tr>
<tr>
<td>Coventry and Warwickshire STP</td>
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<tr>
<td>Derbyshire STP</td>
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<td>South Derbyshire CCG</td>
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<tr>
<td>Dorset CCG</td>
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<tr>
<td>East Kent CCGs</td>
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<tr>
<td>North Central London STP</td>
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<td>✓</td>
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<tr>
<td>North East Lincolnshire CCG</td>
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<tr>
<td>North West London STP</td>
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<td>Nottingham City CCG</td>
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<td>Sheffield CCG</td>
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<tr>
<td>Solihull CCG</td>
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<td>Staffordshire &amp; Stoke-on-Trent STP</td>
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<tr>
<td>Telford &amp; Wrekin CCG</td>
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<tr>
<td>Thurrock CCG</td>
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Learning from process so far

• 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

• Joint working across NHS England national and regional teams, HEE, and the MH IST has strengthened the process and results from early implementers

• The financial context means some EI areas have had concerns about financial risk – for instance taking on staff – despite a strong savings case on integrated psychological therapies

• National direction is to support areas to make the case for the programme – the publication of the implementation plan helped in making clear direction of travel.
Learning from EI’s- Commissioners

- 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

- Think about future proofing the investment whilst developing the implementation plan, how local evaluation evidences savings

- 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
Learning from EI’s- Commissioners (2)

- Ensure there is clarity re the distinctions between IAPT LTC, Liaison Psychiatry and health psychology, and that the pathways between all three are clear

- Link in with existing work streams in physical health

- Can you make this work across the STP/ vanguard

- Use a patient focus group

- Use GP champions

- Consider what the GP priorities are in terms of conditions
Learning from EI’s- Providers

• Start early- Engagement, relationships and development of pathways does take time

• Make links top down and bottom up

• Cast your net widely

• 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
Learning from EI’s- Providers (2)

- Do you need to use alternative language
- Do you need to train PHC staff
- Can you dual train practitioners
- Be clear on the design - NOT signposting- need integration and co-location
- Need to think about how to “sell” this to physical health colleagues to demonstrate the benefits
- Designing the pathway so that the service can catch people when they are first diagnosed rather than further down the pathway
Headline figures for 16/17

- 133 PWP trainees were recruited as part of the expansion
- 121 PWP’s started the LTC CPD training
- 23 Integrated IAPT services started delivery in January 2017
- 172 HI trainees were recruited as part of the expansion
- 143 HI’s started the LTC CPD training
- 3202 patients were seen in an Integrated service in 16/17

IAPT- LTC
Achievements in 16/17:

- Expansion when other areas are shrinking
- Integrated IAPT Manual completed
- Commitment to additional training for IAPT therapists
- Funding moved from NHS England to local areas
- Huge levels of recruitment and collaboration between sites
- Networking between sites - Yammer & workshops
- Data linkage problems have been solved in some areas - we can tell you where
- Patient stories being collected
Plan for 17/18

- **45,000 patients**
- **207 HI CPD**
- **195 HI trainees**
- **176 PWP trainees**
- **260 PWP CPD**

IAPT-LTC
Feedback so far

• Herts Valleys Clinical Commissioning Group
Service user: “This service provided me with the space to talk about worries about my diabetes no one else has asked me about before. I really value that ... as well as the subsequent support,” Service user feedback.

• Nottingham West CCG
“Patient post thoracic surgery left with significant pain and neuralgia. Became increasingly suicidal on higher doses of opiates. Since working with IAPT mood has improved and analgesia reduced. Lot of evidence that using a biopsychosocial model of pain can reduce the use of opiates and their depressive and endocrinological side effects.”
GP Feedback
Feedback continued

• Great Western Hospital Swindon

"The cardiac rehabilitation team at Great Western Hospital have been finding it very helpful to have a much closer working relationship with the IAPT team. At the beginning of the project I invited the team to come and speak at a cardiology clinical governance meeting. This raised the profile of psychology support amongst the wider cardiology team."

"We have been able to easily refer patients directly for one-to-one psychology input with a practitioner and referrals have been made by cardiac rehab specialist nurses, consultant cardiologists and cardiac technicians. We can also signpost our patients to a regular 'Living well with coronary heart disease [CHD]' stress management group."
Forging new referral pathways with physical health services has resulted in an integrated way of working with a range of specialist health services, including; stroke, dermatology, COPD and cardiology. Open lines of communication and referral pathways between mental and physical health services, coupled with a stronger understanding of the roles and remits of each service results in patients receiving a seamless and more informed experience of care and treatment. One particular pathway has been the introduction of Managing Pain and Fatigues courses by IAPT PWP’s within the physical health services and one client said:-

“The course is very helpful and focused. I’m getting more into the mind-set of accepting change as opposed to thinking about what I used to be able to do. The course has made a significant and hopefully lasting impact.”

Provider and Service User
Feedback from GP – co-location

“Forty-six per cent of patients referred to our Psychological Wellbeing Service for a mental health problem also have a physical health long term condition. These patients are used to being seen in their local GP practice, which is a familiar environment, providing both physical and mental health care, and most would choose to have their care provided here.”

“The feedback process, and the regular sharing of information between mental and physical health professionals, works well in multi-disciplinary team meetings, helping to ensure they are patient-centred. Effective communication and coordination of care in the primary care environment should also lead to an overall reduction in the number of patient referrals to secondary care, which releases capacity for patients that do need secondary care.”

“As a GP I consider that an important part of my work is to help make patients’ access to mental and physical health care as swift and easy as possible and that includes informing patients about the options available to access treatments and normalising mental health as part of the GP offer.”
Initial Indications

- El Site in the South has demonstrated so far:
  - 75% increase in specialist nurse use
  - 49% reduction in GP appointments
  - 52% reduction in A & E attendances
  - 80% reduction in X-Rays
Existing coverage

• 16% of all STPs have all CCGs within them commissioning IAPT-LTC services
• 62% of all STPs have at least one CCG who has commissioned an IAPT-LTC service
• 38% of all STPs have no IAPT-LTC service currently commissioned
What are the risks / opportunities?

- Improve mental health outcomes and broaden the range of people who access support
- Show integrating mental health and physical health care is possible: inspiring broader action, reducing stigma and improving parity
- Convincingly show integrated care reduces cost
- Savings profile may be a challenge for CCGs to demonstrate
- Expansion requires ~4000 new therapists: mobilise training capacity, local workforce plans
- Workforce wellbeing is a priority – expansion provides opportunity for staff growth
Supporting documents

- Integrated IAPT FAQs document
- Local evaluation guide
- Data quality guide
- Building the Business Case
- Integrated IAPT Data Handbook
- Evidence Based Treatment Guide for IAPT-LTC
- “How to” IAPT-LTC guide
Integrated Pathways

Toni Mank, IAPT Programme Manager, NHS England & IAPT Head of Service, Sheffield
Integrated Pathways

Sheffield IAPT-LTC: Health and Wellbeing Service

Toni Mank
IAPT Programme Manager NHS England & Sheffield IAPT Head of Service
Five Year Forward View for Mental Health

IAPT Expansion

1.5 million people

By 2020/21
1.5 million people entering treatment in IAPT

Integration

2/3rds of this expansion – integrating physical and mental health: development of Integrated IAPT

Top-up training

National Top-up training curriculum underway for PWP and CBT – for LTC/MUS

Evidence-base

Maintaining integrity to the key characteristics of IAPT and implementing national guidance
Sheffield IAPT-LTC
Early Implementer Wave 2 Site

- Additional investment
  - NHSE investment & CCG commitment to recurrent funding

- Ambitious bid
  - Ambitious and transformational bid to create systemic change

- Pathway approach
  - Whole pathway approach to LTC/MUS from Step1-Step 4: ‘dual trained’ practitioners, psychologists, experienced IAPT staff integrating with physical health workers

- Establish new service
  - Establishment of a Health and Wellbeing Service: integrating with primary care health and medical psychology
10 Condition Pathways

1. Pain/MSK
2. COPD
3. CHD (including non cardiac chest pain)
4. IBS
5. CSF/ME
6. Generic Long Term Conditions (including dermatology)
7. Health anxiety
8. Diabetes (Type 1 and 2)
9. Generic MUS
10. Cancer (following successful treatment)
Key Principles

Whole pathway approach
Integrate Step 1 to 4 psychological interventions within condition specific pathways

Integration
greater parity of esteem- part of the multidisciplinary teams within and across the pathways

Mental health promotion
Increase identification of anxiety and depression in physical health settings enhanced by joint training

Partnership working
work with CCG, primary care and ‘neighbourhoods’ to understand local populations/ key priorities. Developing further partnerships with STH, specialist services & third sector

Close to home
Deliver psychological therapy at ‘Neighbourhood’ level
Why?

- It is the right thing to do
- There is a compelling case for delivering care in a holistic way that ensures a person’s mental health and physical health care needs are met along the whole care pathway
- Integrated care is more cost effective by identifying and treating mental health problems; it can reduce use of physical health services, reducing annual expenditure per person by £1,955. Avoiding hospital admissions, this figure significantly increases
How is IAPT-LTC different to core IAPT?

✔ Working with anxiety and or depression in the context of LTC/MUS
✔ Embedded in physical health pathways: through co-location and MDT working
✔ LTC top up training and ongoing appropriate supervision
Health and Wellbeing Service
Stepped Interventions for LTC/MUS

Step 1
- Joint Training
- Screening
- Identification
- Psycho-education
- Self-Help
- Information
- Leaflets
- Health and Wellbeing Online Hub
- Self-Help and Training Resources

Step 2
- ‘First Line’
  - Adapted Stress Control
  - Living Well with LTC
  - Living Well with Pain
  - Living Well with Fatigue
  - Silvercloud: LTC cCBT

Step 2
- PWP
  - Condition-specific Guided Self-Help
  - Condition-specific Group Interventions (Co-delivery)

Step 3
- CBT
  - Condition-specific CBT 1:1
  - Condition-specific CBT Groups eg CBT for Health Anxiety Group Interventions eg MBSR pilot, MBCT, ACT

Step 4
- Psychology
  - Psychological Assessment, Formulation, Intervention

Specialist MDTs
- Consultation, Case Review, Care Planning

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Community Wellbeing Model

Central Community Wellbeing Hub

Integrate Step 1 to 4 psychological interventions within condition specific
Core IAPT +
SPS
Health and Wellbeing:
LTC/MUS, CFS/ME, LTNC

Primary Care Mental Health
SMI: Access, Recovery,
EIP, HTT, PD
Older Adults, LD
Substance Misuse

Health and Employment

Social Prescription/Third Sector (inc Housing + Debt) Flourish,
Education Exchange ++

North Wellbeing Satellite Hub

South Wellbeing Satellite Hub
Key Challenges

+ Scale and pace
+ Recruitment
+ Estates/ Accommodation
+ IT/Information governance
+ Tracking health care utilisation & demonstrating savings
+ Engagement across the pathways: integrating in to physical health teams
+ Achieving real integration within physical health different to core IAPT
+ Stabilising core IAPT
+ Recurrent and appropriate funding
Our approach to overcome challenges

- Working in partnership with CCG: developing a shared vision
- Understanding local pathways to support integration into physical health pathways: pathway mapping to avoid creating duplicate pathways and parallel processes
- Building on local innovation: understanding areas of excellence, skills and expertise
- High level engagement strategy as well as bottom up approach: chief executive support across organisations in Sheffield, presenting at high level boards with senior representation across the City and multi-agency task and finish group
- Engagement: passionate front line staff, GP champions, primary care, hospital and community services, 3rd sector, service users and carers
Our approach to overcome challenges

Integration: establishing MDTs, shadowing, reciprocal training, co-location and joint delivery of groups

Stabilising core IAPT: preparation is critical - recruiting additional trainees, dual trained practitioners and building local relationships. Service objectives for core IAPT to drive continuous quality improvement

Supervision & consultation: clinical supervision and consultation from health and medical psychologists for all IAPT staff. Clinical directorate restructure within the organisation to support a pathway approach bringing services together

Focus on staff wellbeing: away days centered on a range of wellbeing activities, training provided in addition to LTC top up training to empower all staff in both core IAPT and IAPT-LTC
Initial Partnership Engagement Plan
Sheffield IAPT-LTC: Health and Wellbeing Service

- High Level Board
- Citywide Engagement/Partnership Local & National Delivery Reporting

- Clinical Directors
  - Senior Medical/Nursing/AHPs
  - for each condition pathway

- GPs, Practice Nurses and other primary care staff

- Senior Managers
  - for each condition pathway and/or relevant staff

- Third Sector organisations – initial focus on partnership working within identified services and condition pathways

- Service Users within/across Condition Pathways

- Collaboration with key stakeholders within Condition Pathways – to map and further develop access to evidence-based interventions

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Co-location and integration - examples

Pain/MSK

- PWP shadowing Physioworks
- Senior Physiotherapist co-facilitating ‘Low Back Pain group’
- Physiotherapists trained as PWPs
- Established links with Specialist Pain Services (STH)

Diabetes

- Monthly MDT established in Specialist Diabetes Services (STH)
- ‘Living well with Diabetes group’ to run after Dafne & Desmond in the same location
- PWP attending DAFNE, DESMOND to promote mental health
- PWP/CBT shadowing clinics & groups
- Clinic rooms in Diabetes Service
Co-location and integration - examples

**COPD**

- Established links with the Cardiac & Respiratory MH Team
- PWP/CBT shadowing Pulmonary Rehab Team, Community Respiratory Nursing Team
- PWP attending Respiratory Ward MDT
- Respiratory nurse to attend first and last session of ‘Living well with COPD group’
- Group to be run in GP practice

**IBS**

- Established links with the Gastroenterologists, Pharmacy & Dietician
- ‘Cases approach’ referrals discussed with consultant promoting mental health
- Dietician to attend one group session
- IBS group poster on ‘IBS Network’ website
Co-location and integration - examples

CFS/ME

- Monthly MDT established in CFS/ME services
- PWP & CBT shadowing clinics in CFS/ME services
- Clinic rooms in CFS/ME services
- Psychologist in CFS/ME service to focus step 4 cases, IAPT High Intensity to take over current referrals
- Clinical leadership changes under the new Directorate structure: Clinical Director to lead Core IAPT, IAPT LTC, primary care, CFS/ME, health and medical psychology and Long-term neurological team, health inclusion and OT
Promotion and patient engagement

Website:

• Dedicated section on physical health and mental health on the core IAPT website

• Development of self-help information and material on the core IAPT website

• Online booking system

Promotional material and information leaflets:

• Poster for each pathway centred around feedback and accompanying patient leaflet

• Prescription pad for each pathway based on social prescribing for physical health workers to use

• Developed and designed courses for each pathway and bespoke patient workbooks

• Animations are currently in development to engage with different learning styles
**Examples of posters**

- **Improving Wellbeing Sessions**
  - Understanding and improving how we feel
  - I was feeling really sad and worried with constant headaches, these sessions helped me feel less alone and learn helpful ways to feel better.
  - **10:30am - 1pm**
  - Book for FREE by calling 0114 226 4380
  - Or contact your GP Practice

- **Jarlanat Al-Tahsin Al-Rahma Al-Nafsia**
  - تحسين الراحة النفسية
  - Sessions will take place on
  - Delivered in Arabic and English

- **Sheffield Health and Social Care**

- **NHS England**

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[www.england.nhs.uk](http://www.england.nhs.uk)
Examples of posters

Sheffield Health and Social Care

Living Well with Diabetes

HAVING DIABETES CAN MAKE DAY-TO-DAY LIFE CHALLENGING AND STOP YOU DOING THINGS YOU ENJOY. THIS COURSE CAN HELP YOU REALISE YOU'RE NOT ON YOUR OWN, LEARN NEW SKILLS AND ENJOY LIFE AGAIN.

Book for FREE 0114 271 6568
Find out more at
www.iaptsheffield.shsc.nhs.uk

Hassan

Living Well with IBS

HAVING IBS CAN MAKE LIFE DIFFICULT AND STOP YOU DOING THINGS YOU ENJOY. THIS COURSE CAN HELP YOU REALISE YOU'RE NOT ON YOUR OWN, LEARN NEW SKILLS AND ENJOY LIFE AGAIN.

Book for FREE 0114 271 6568
Find out more at
www.iaptsheffield.shsc.nhs.uk

Emma

Sheffield IAPT
working together to improve your wellbeing

www.england.nhs.uk
Examples of PowerPoint slides

Long term (chronic or persistent) Pain ...

- Carries on after healing has taken place.
- Serves no useful warning purpose – a ‘nuisance’
- Treatment is aimed at relieving pain, not curing it
- Others might not understand
- Medical investigations may not provide a diagnosis or an explanation
- Ongoing and often has a negative and widespread effect on life

www.england.nhs.uk
Examples of PowerPoint slides

Pain and sleeping problems

- Amount changes with age & lifestyle
- 2-3 hours is enough to protect attentional and motor skills for most people
- 6 hours is probably average (Horne 88)
- Media myth of 8 hours
- Range 3-10 hours

Pacing

- Limiting the time spent on an activity to prevent marked increases in pain
- Keep to a regular amount of activity to prevent the problems of too much rest
- Plan activity instead of doing things based on how you feel
Examples of posters

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**ARE YOU LIVING WITH A LONG-TERM PHYSICAL HEALTH CONDITION?**


**IS IT AFFECTING HOW YOU FEEL & WHAT YOU DO?**

**I WAS FEELING ANXIOUS AND WORRIED ABOUT MY PHYSICAL HEALTH CONDITION, SO I CONTACTED THE HEALTH AND WELLBEING SERVICE TO SEE WHAT HELP WAS AVAILABLE TO ME.**

Contact us on 0114 271 6568

or find out more by visiting

www.iaptsheffield.shsc.nhs.uk

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www.england.nhs.uk
Examples of GP update

Sheffield IAPT-LTC: Health & Wellbeing
Enhancing access to evidence-based interventions for people with LTC/MUS and co-existing anxiety and/or depression

Current challenges in General Practice

There is going to be a significant increase in demand in future years for GP appointments from people living with LTCs.

Over 50% of GP appointments are for people living with long term conditions (LTCs).

A high number of people with common mental health problems also have a long term physical health condition.

The NHS Five Year Forward View and CCG policy state that healthcare must be organised to support people with multiple health conditions, with integrated care delivered by skilled practitioners, linking with GPs and delivered in the community. This model of integrated care of physical and mental health needs is expected to reduce GP consultations due to improved self-management of long term conditions and treatment of anxiety/depression.

Royal College of General Practitioners, Longitudinal Care, 2016.

Sheffield IAPT
Working together to improve your wellbeing

Help your patients to better manage their LTC as well as their psychological wellbeing by encouraging them to self-refer to the Health & Wellbeing Service.

Our target population

Overlap between Anxiety, Depression & LTC/MUS

Service open to people with the following conditions:
- Pain & MSK
- COPD
- CHD & Men cause chest pain
- Diabetes
- HFr
- Dermatology
- CFS/ME
- Cancer
- Health Anxiety
- Persistent physical symptoms/MUS

Groups available now:
These take place in community venues across the city, to help your patients manage their conditions and improve psychological wellbeing.

- Lineby Well with COPD
- Lineby Well with Diabetes
- Lineby Well with HFr
- Lineby Well with a chronic condition
- Mindfulness for Health

Sheffield IAPT
Working together to improve your wellbeing
Examples of GP update

HABING A LONG TERM HEALTH PROBLEM MADE LIFE DIFFICULT AND STOPPED ME GOING OUT. THIS COURSE MADE ME REALISE I'M NOT ON MY OWN AND I LEARNED NEW SKILLS TO ENJOY LIFE AGAIN

To refer

Please ask & encourage your patients to ring the admin team to book a place on to these courses on 0114 271 6568

New IAPT service for people with Long Term Conditions – open for referrals now!

As an expansion of your IAPT service, this new service offers evidence-based talking therapies to adults and older adults living with Long Term Conditions and/or persistent physical symptoms (PTSD) who are also experiencing anxiety and/or depression.

Groups are already being delivered at Step 2, over 8-10 weeks, focused on helping patients to live well with several conditions. See below for more details and how to refer.

Individual assessments can be offered to identify how the Health and Wellbeing service can help patients who experience anxiety and/or depression alongside their long term condition or persistent physical symptoms. There are now practitioners now in post and ready to receive referrals.

To access the service - Please ask & encourage your patients to ring 0114 271 6568 to book a place on to these courses or request an assessment.
Some examples of leaflets

COPD Wellbeing sessions are open to all patients with COPD who would like to learn proven techniques to overcome common symptoms of stress, anxiety and low mood, as well as boosting self-esteem.

**SESSION 1**
Understand how COPD affects your physical health, your feelings & learn ways to relax.

**SESSION 2**
Exploring links between breathlessness and feelings of stress and anxiety, and how to make changes for the better.

**SESSION 3**
Exploring links between how you feel when you have COPD and what you do. Focusing on what is important to you.

**SESSION 4**
Coping with the ups and downs and frustrations of COPD, and improving relationships.

**SESSION 5**
How to stay well in the future, learn about managing your medicines, sleep and COPD flare-ups.

Sessions will be run at Dovercourt Medical Centre Starting Monday Sept 11th From 1.30-4pm
Please call 0114 271 6568 to book on to this, or the next course.

Five afternoon sessions delivered by two NHS professionals, you will have an opportunity to learn how to make some positive changes and meet other people with COPD who may share similar feelings to you.

www.england.nhs.uk
Some examples of leaflets

Living well with a Skin Condition

Did you know that:

Living with a skin condition such as psoriasis, eczema, etc. can feel burdensome.

In some cases stress can contribute to the worsening of a skin condition.

Skin conditions can have an impact on social life, work, and relationships.

Is your wellbeing currently affected by your skin condition?

Join us and other people living with skin conditions at our wellbeing sessions.

We are currently running wellbeing sessions for people living with a range of skin conditions. The group is suitable for people with skin conditions that may be visible, uncomfortable, and itchy or painful.

Are you feeling anxious, low, stressed, or embarrassed?
Have you stopped doing things you enjoy because of your skin?
Do you have worries about the appearance of your skin condition?
Evaluation
Local evaluation from outset vital

Purpose
• Explore impact of new IAPT-LTC service
• Provide evidence of benefits achieved - tell us whether an intervention worked, how and why
• Identify areas for modification/improvement
• Inform commissioning
• Contribute to evidence base

Methodology
• IAPT-LTC Local Evaluation Support Guide – on Yammer
• Support from local universities, CLAHRCs
Patient Feedback

I have been given lots of ideas and tools to take away and try/use – it was very useful and information was easily accessible.

‘I’ve had pain for 12 years and this is the most helpful thing I’ve been on’.

Helped with trying to come to terms with my condition and to share my condition with others.

Good range of subjects covered with practical applications.

‘I’ve had pain for 12 years and this is the most helpful thing I’ve been on’.

www.england.nhs.uk
The atmosphere created by staff was welcoming and encouraging.

I started the sessions feeling very low and the course has helped me get through a very bad time and has set me up going forward. I feel much more positive now knowing I have the tools to help me cope.

It was helpful to share thoughts and realise you are not on your own.

I found all the hand-outs very useful in helping me cope with my condition and will help in the future for further reference.
Living well with Pain – Patient Feedback

Link: https://youtu.be/7YCw4YlcZEc
Time for some lunch?

See you in 1 hour!
Challenges / Concerns
Table Top Discussion
All
Challenges/Concerns
Table Top Discussion

Please consider the 3 questions below, spending 10 minutes on each, and capture the key points from your discussions to feedback to the group.

**Key challenges and concerns:**
1. What are your main challenges and concerns for implementing IAPT-LTC services?

**Possible solutions:**
2. What are the possible solutions to your main challenges and concerns?

**Key stakeholder relationships:**
3. What stakeholder relationships do you need to develop to deliver your possible solutions?
Data Linkage and Evidencing Savings

Mike Woodall
Integration Analytics Lead, Midlands and East Lancashire CSU
Data Linkage and Evidencing Savings

Mike Woodall
Integration Analytics Lead
Why evaluate

• Identify what works and what doesn’t work
• Understand key components of success / failure
• Evidence improved outcomes
• Evidence savings
Available Support

• Evaluation Guide focusing on:
  • Data Quality
  • Evaluation Design
  • Information Governance (IG)
  • Data Linkage
  • Outcome Metrics

• Slides from regional workshops

• Data specifications and reports from NHS Digital - http://content.digital.nhs.uk/iapt
Defining your theory of change

**Inputs**
- Staff
- Training
- Facilities
- Equipment
- Administrative support

**Activities**
- Assessments
- Face to face contacts
- Telephone contacts
- Take up of self help

**Outcomes**
- Reduction in A&E attendances.
- Improved wellbeing
- Increase in appropriate healthcare usage
Defining the evaluation question

Effect of *the intervention*

Relative to *not having the intervention*

On *X*

Measured as *X*

Amongst *people that have been exposed to the intervention*

Against *people that have not been exposed to the intervention*
Defining the evaluation question

Effect of *Integrated IAPT service*
Relative to *no Integrated IAPT service*
On *healthcare utilisation*
Measured as *A&E attendances*
Amongst *people that have been seen by Integrated IAPT services*
Against *people that have not been seen by Integrated IAPT services*
## Metric Selection

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<th>Type</th>
<th>Metric</th>
<th>Diabetes</th>
<th>COPD</th>
<th>Asthma</th>
<th>Other Respiratory Disease</th>
<th>Heart Disease</th>
<th>Cancer</th>
<th>MSK</th>
<th>Chronic pain</th>
<th>Epilepsy</th>
<th>Skin conditions</th>
<th>Digestive tract conditions</th>
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<td>Acute</td>
<td>Emergency Inpatient admissions</td>
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Diabetes

The evidence around Diabetes shows that psychological interventions can be successful at reducing HbA1C and therefore reducing activity related to suboptimal management and complications of Diabetes. No specific healthcare utilisation metrics are highlighted in the studies but the Integrated IAPT Programme is likely to have an impact on the following metrics if it improves how patients manage their condition and reduces complications:

1. Emergency Inpatient Admissions
2. Unplanned hospitalisation for chronic ambulatory care sensitive (ACS) conditions (adults)
3. A&E Attendances
4. GP Consultations

References - NHS Confederation (2012) Investing in emotional and psychological wellbeing for patients with long-term conditions

(http://www.lse.ac.uk/businessAndConsultancy/LSEEnterprise/pdf/PSSRUFeb2011.pdf)
Medically Unexplained Symptoms \ Chronic Pain

One study looked at the impact of Cognitive behavioural therapy (CBT) on patients with medically unexplained symptoms (MUS). The study showed savings on the following metrics over a 3 year period with the proportion of savings attributed to each metric shown in brackets.

1. Emergency Inpatient Admissions (52%)
2. A&E Attendances (22%)
3. Primary Care Consultations (16%)
4. Outpatient attendances (5%)
5. Prescribing (5%)

The metrics are applied to all medically unexplained symptoms


Selecting the right method
Linking datasets

IAPT Data

Healthcare Utilisation Data
Key people to involve

- Information Governance Experts
- Provider Data Team
- Clinical Leads
- Commissioners
- Analysts
Key actions required

• Develop a theory of change
• Identify outcome metrics
• Identify evaluation methodology
• Assure quality of Integrated IAPT data
• Undertake a Privacy Impact Assessment
• Identify who will link the data and undertake the analysis
• Decide on the Legal Basis for sharing data
• Develop Data Sharing Agreements
• Share data
• Link the IAPT and healthcare utilisation datasets
• Undertake analysis
Time for a break?

20 minutes only please!
Wave 1
Provider/Commissioner Presentation

Calderdale CCG and Insight/SWYPFT
IAPT LTC Calderdale

Insight Healthcare & SWYT Calderdale IAPT
• The background

• The story so far

• GP pathway: Practitioner perspective

• Chronic Pain pathway: A clients journey

• What's next for Calderdale
The background

- Insight Healthcare and SWYT Calderdale IAPT are two providers in Calderdale that offer IAPT talking therapies. We were asked by the commissioners to work together on this pilot.

- Initial talks with the CCG led us to focus on A&E and respiratory pathways as it was seen that this could generate the most savings.

- However, after a challenging few months getting this set up we took the difficult decision to move in a different direction and focus on Chronic Pain and early intervention on all LTC’s within GP practices.
The Story so Far

November – February 2016/2017
- Planning with the CCG
- NHSE Visit
- Providers working together

March – May 2017
- A&E and Hospital Discharge Pathway
- Respiratory Pathway
- Chronic Pain Pathway
- GP pathway

June – October 2017
- Strengthening relationships
- Working on barriers to referral numbers
- MSK Pathway
- Increasing resource and expansion plans
How our pathways look

- **GP Pathway**
- **CORE Pathway**
- **Hospital pathway**
- **Chronic Pain/MSK Pathway**
- **CORE Pathway**

- **Insight**
- **Chronic Pain group**
- **Calderdale IAPT**
GP Pathway: Practitioner perspective

- Setting up pathways
  - What to think about before setting it up

- Benefits of these pathways
  - Referrals
  - Finances
  - Relationships
  - Treatment outcomes (clinical and attendances)

- Challenges
  - Admin time & resources
  - Building relationships
  - Appropriate referrals
What the service users think….

“I realise that I have had a bad time with the illness I have had but thanks to you I feel much more capable of handling it. I thank you from the bottom of my heart for what you have done for me”

“Your service helped me to identify and address problems and issues that were unknown to me and that were spotted by my GP. After referring I found that [my practitioner] talked me through my issues with compassion and helped me to formulate a plan of action that I could not only understand but also implement with very little effort. I am immensely grateful for all the help I was fortunate to receive”

“The Service was very helpful and has changed my way of thinking/acting completely. I was very comfortable at my appointments and with my practitioner and I am a much happier person than I was entering the service . Thank you”

“I found the sessions very helpful. When I first came I was a bit sceptical and in a mess and now I feel the relief and I have benefited from the experience of somebody else helping me.”

“100 % great experience, feel so much better now compared to how I felt before seeing [my practitioner]”
Chronic Pain Pathway: A client’s Journey

45 years old, father, husband.

Rheumatoid Arthritis

Depression

Anxiety

Low self-esteem, low confidence

Chronic pain

Dyslexia
Client has a check up with a Rheumatology Consultant every 6 months.

Client had an integrated assessment in the pain clinic.

“I am not doing stuff because of the pain, my life lacks quality I am frightened to do stuff in case I might make the pain worse and I am missing out on everything”

Client attended the Chronic Pain Group run in partnership with SWYPFT and Insight Healthcare.

Regaining Quality of Life…
Chronic Pain Group

- Pacing
- Mindfulness
- Compassion
- Assertiveness
- Unhelpful thinking styles
- Relaxation
Work and Social Adjustment Scale

IAPT Assessment

WandSA Total Score

13/7/2017
27/7/2017
10/8/2017
24/8/2017
7/9/2017

Improving the mental health and wellbeing of the people we serve

South West Yorkshire Partnership
NHS Foundation Trust

With all of us in mind.
Other Outcome Measures

CSRI

Start of treatment: 11 contacts in the previous 3 months

End of treatment: 8 contacts in the previous 3 months
Quality of Life Continues…

"Pacing has had a massive impact, it's had a massive impact on all of us as a family and what we can do”.

Client managed to use pacing to get to build up to playing a game of laser quest with his sons.

“It’s like having our old dad back”.

Improving the mental health and wellbeing of the people we serve

With all of us in mind.
What about the local evaluation…

- It was agreed early on that the CCG’s business intelligence team were better placed to complete the local evaluation.

- They are using the SUS and IAPT data via their DSCRO as a focus of the evaluation, however there are barriers with accessing the LTC IAPT data.

- We are working closely with them to provide any data they need including CSRI analysis, referral numbers, case studies, PEQ feedback as well as the IAPT LTC data.
How our overall results are saying so far….  

Calderdale’s target was **1140** referrals in 2017/2018.

- **Current numbers:** 595
- **Recovery rate:** 56%

### CSRI Early results

- 48%: Decrease in physical health appointments
- 36%: Same amount of physical health appointments
- 16%: Increase in physical health appointments
What advice we can give...

- Project Leads/Service leads to have regular meetings with the CCG
- Use the support of NHSE and Yammer
- Have a plan and a trajectory from the get go. Look at this weekly until confident the pathways are set up and running efficiently (we are still looking at this weekly!)
- Ensure open communication between practitioners, project lead and a nominated person in the physical health service
- Be proactive in overcoming any barriers to the success of the pathway
- Gather patient feedback from the start to help bring to life your pathway (especially if the financial savings aren't what you might have hoped)
- Think about marketing early on
- Sell the opportunity to physical health services as something they need rather than the benefits to MH and IAPT
Our Commissioners advice…

• Joint working and ownership throughout the project is crucial to success

• Have a joint plan that you review regularly

• Agree a trajectory and manage against it

• Support your providers in making contacts and relationships with those working in physical health services

• If something isn’t working, look into it but if there is no chance of things changing quickly, start looking at other options

• Get arrangements in place early for measuring the impact of the service on utilisation of healthcare as it can take some time
What’s next…

- 3 HI’s and 3 PWP’s have joined the Insight Team
- Plans for 3 new GP practices in the pathway are underway
- Calderdale IAPT practitioners to move over to the MSK clinics and become involved in MDT assessments
Any Questions
Wave 2
Provider/Commissioner Presentation

North East Lincolnshire CCG and NAViGO
Improving Access To Psychological Therapies (IAPT) For People with:

**COPD, Cardiac Disease & Diabetes**

Fiona Wilkinson  
IAPT Clinical Lead LTC NAViGO CIC  
Angie Dyson  
Service Lead NHS NE Lincolnshire CCG
NEL Footprint

- Population of approx 167,000
- Older people represents a higher percentage of total population (20.7) then seen in Yorkshire and Humber as a whole
- High levels of deprivation top 1% nearly 40% of residents of NEL live in most deprived area
- Life expectancy 12.7 years lower for men and 9.3 years lower for woman
Our Journey

- 2012 – 2014 Two year grant awarded from the Burdett Trust For Nursing to NAViGO CIC’s IAPT Service with 1 PWP and 1 high Intensity CBT Therapist focusing on COPD targeting A and E.

- 2015 – Additional staff 1 Interpersonal Psychotherapist, and another High Intensity CBT Therapist. Service expanded to develop Integrated Pathways for the Assessment and Treatment of Depression & Anxiety in People with COPD and some expansion into Diabetes and Cardiac Disease in NE Lincs
Benefits of Integrating Services

• Evidence treating depression and anxiety with Cognitive Behavioural Therapy (CBT) is effective (NICE, 2009, Howard et al, 2010).

• Using CBT within an integrated service to treat depression, anxiety and panic in people with COPD can reduce hospital admissions and improve mental and physical health and quality of life (NICE, 2009, DH, 2011)

• Can result in reductions in emergency admissions, A&E attendances and bed days (Howard et al 2010, Dupont et al 2011)

• Can reduce other health related costs such as ambulance/rapid response call outs and medication (Kings Fund, 2012)
Implementing IAPT-COPD

• 3643 people with COPD (links to deprivation).
• Hope Street COPD Service (Care Plus) ‘One Stop Shop’ Pulmonary Rehab (PR) programme approx. (Average 300 referrals a year).
• Acute services for COPD – Diana Princess of Wales Hospital (average 190 emergency admissions acute exacerbation in a year, 4 a week)
• Worked closely in partnership with professionals at Hope Street and Diana Princess of Wales Hospital to develop & refine proposal
• Developed close links with Complex Case managers, practice staff and district nurses
The Outcome

• **Pre and Post Treatment questionnaires:**

• **100% ‘Very Satisfied/Satisfied’** with overall experience of service.

• **88%** Felt that the information given to them had ‘almost always’ helped them to manage the effects that having COPD can have on overall mood and wellbeing.

• **73%** can now manage their anxiety symptoms without needing to contact emergency/out-of-hours services such as Rapid Response or an ambulance where they had done previously.

• **20%** reduction in medication use e.g. oxygen/ nebulizers/ inhalers.
1. Decisions must be locally led
2. Care must be based on the best available evidence
3. Services must be designed in partnership with people who have mental health problems and with carers
4. Inequalities must be reduced to ensure all needs are met, across all ages.
5. Care must be integrated - spanning people’s physical, mental and social needs.
6. Prevention and early intervention must be prioritised
7. Care must be safe, effective and personal, and delivered in the least restrictive setting
8. The right data must be collected and used to drive and evaluate progress
Scope of Integrated IAPT & LTC Project

• Continuation of Initial COPD Service
• Clinical Lead in post – end of July 2017
• New focus: **COPD, Cardiac Disease & Diabetes only**
• Project Officer in post – October 2017
• Focusing on integrating with primary care (5 of the 30 GP practices in the locality) as identified by NELCCG with highest prevalence
• Developing links with Consultants and Nurse Specialists
• Statistics for NE Lincs:
  • 63’587 people with Type 2 Diabetes, 121’299 high risk
  • 3643 people with COPD
  • 4th highest rate of premature mortality from CVD
Pathway

Self-referral
In person or by telephone

SPA Team
Referral

GP Referral
or any other
professional (i.e.
Consultants and
Nurse Specialists)

Core IAPT Team
Referral

Register referral for Open Minds LTC Team

Suitability assessment undertaken – if not suitable refer or signpost on to the appropriate service

Individuals with COPD
and Anxiety and/or
Depression

Step 2:
Psycho-education
Self Help
Individual Sessions
Group

Individuals with Diabetes
and Anxiety and/or
Depression

Step 2:
Psycho-education
Self Help
Individual Sessions
Group

Individuals with Cardiac
Disease and Anxiety and/or
Depression

Step 2:
Psycho-education
Self Help
Individual Sessions
Group

Step 3:
Cognitive Behavioural Therapy (CBT) – for Anxiety /Depression
Interpersonal Therapy (IPT) – for interpersonal issues
Eye Movement Desensitisation and Reprocessing (EMDR) – for trauma
# Improving Access to Psychological Therapies (IAPT) for people with Long Term Health Conditions

**IPAT-LTC Stepped Care Model for individuals with**

- Cardiac Disease and/or depression and anxiety

### Step 1 Health Care Professionals
- GPs, practice nurses, district nurses, consultants, cardiac rehabilitation and other health care professionals (HCPs).
- Routine screening for anxiety and depression in hospital and community sites and support for patients with LTC.

### Step 2 – Psychological Wellbeing Practitioner:
- CBT psycho-education session embedded in the Cardiac rehabilitation group.
- Screening & risk assessment.
- Mindfulness-based CBT classes for cardiac patients.
- Telephone and face to face guided self-help.
- Signposting to computerised CBT.
- Step 2 Anxiety and Depression courses for cardiac patients.

### Step 3 – High Intensity CBT/IPT Therapist:
- 1:1 CBT/IPT for patients with cardiac disease who have depression and/or anxiety in health care settings.
- EMDR (Eye Movement Desensitisation & Reprocessing) for trauma (not including childhood sexual abuse).

### Supervisors and Clinical Leads.
- Provide review and advice to clinicians for complex cases and patients who have not responded to treatment at Step 2 & 3 in GP practices and as part of primary care and as part of Cardiac MDT.
- Provide regular Clinical Supervision & Training for IAPT and Healthcare workers.

**IAPT-LTC eligibility criteria:** patients who have moderate to mild anxiety and/or depression and Cardiac Disease. Patients who are under the care of another mental health service or who have severe presentations, or are at risk, or have substance use problems would need to be referred to other services.

**Self-referral & Practitioner referrals:** patients can self-refer by telephone or face to face, or be referred. Practitioner’s can refer into the service by completing the LTC referral form and sending it via e-mail to: NAV.openminds-LTC@nhs.net
Barriers

**Delivery of Service**
- Delays in appointing Clinical Lead & Project Officer.
- Difficulties in setting up key meetings with GPs, practice staff etc. to establish the service.
- Home visits due to limited clinical room / space
- Financial delays with CCG & GP Practices
- Core IAPT stability / Integrated IAPT Staffing capacity

**Slow uptake of Referrals:**
- Issues being operational / room space in identified priority practices
- Well-being practitioners and in-house Councillors

**Data Analysis**
- Data Linkage: Issues in obtaining and analysing data relating to Primary care and hospital admissions.
- National information sharing agreement for CCGs?????
Progression

- Referrals are increasing
- Operational in Hope St & Roxton Practice
- Links with:
  - DPOW & A&E
  - Community specialist services
  - SPA & Access Team
  - Other NAViGO services
  - County Health Psychology links
- Plan:

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<td>Extra number of people accessing treatment</td>
<td>145</td>
<td>181</td>
<td>400</td>
<td>544</td>
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<tr>
<td>Total prevalence met</td>
<td>15.8%</td>
<td>16.8%</td>
<td>19%</td>
<td>22%</td>
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• Data Linkage

• Sustainability and increasing referrals

• Marketing

• Staffing capacity

• Streamlining pathways
Striving For Excellence
Feedback

I felt like I would have 'gone under' without this service, I can cope with COPD now! Being able to talk to someone has really helped me.

My only complaint is that this service was not available to me sooner...

This helped me a lot and was well worth my time, the service was 10 out of 10!

We have Rose* on the course at the minute, I am working with her on meds and she's just got the confidence to come off nebulisers after years of poor management. She also said it's now easier to get out of the house with less panic attacks since seeing Judy.
“A Journey Of A Thousand Miles Begins With A Single Step.”

Lao - Tzu
Thank you

Contact:

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T: 01472 252760

Angie Dyson:
Service Lead
NHS NE Lincolnshire CCG
E: angie.dyson@nhs.net
Q&A Panel Discussion

All Speakers
Summary of the Day and Evaluation

Andy Wright, IAPT Advisor, Yorkshire and the Humber Clinical Networks
Thank you for Attending!

Please remember to fill out your evaluation forms!