North West Leadership and Innovation Forum

Ursula James
NHS England National IAPT Clinical Delivery Manager

23rd May 2018

- **IAPT Expansion – FYFV Commitment**
- **Overview of Early Implementer work**
- **The IAPT Manual – assuring quality**

The commitments:-

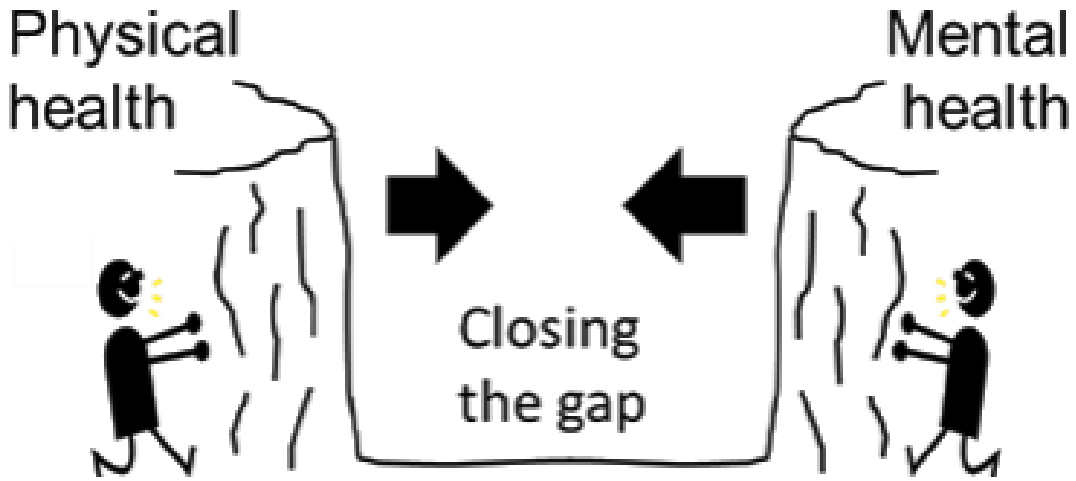
- CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21.
- To meet the increase in access (66%), providers will need an additional increase in staff of at least 50%.
- Overall planning of workforce should include increasing the number 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

Delivering the IAPT Workforce Expansion

- In 2016/17 and 17/18 the expansion in talking therapies was supported by a combination of central HEE and NHSE funding
- As set out in the 5YFVMH the responsibility and funding to support the expansion posts (including trainee posts) has been **transferred to CCG allocations from March 2018**
- HEE has agreed to **continue to fund all tuition fees for IAPT training** (ie both replacement and expansion) to deliver an additional 6,500 trainees for the period 2016-2021
- Services are expanding, and increasingly offering a choice of therapies where this is supported by the evidence – 24% of all treatments for those completing therapy in 16/17 annual report
- Capacity has been increasing through significant additional investment in training
- Staff retention – the PWP leaver rate went down from 25% in 2014 census to 22% in 2015. HI therapist leaver rate is 12%.

Why IAPT-LTC?

30% people with a long term physical health condition also have a co-morbid mental health problem, mostly anxiety and depression. In addition, up to 70% of people with Medically Unexplained Symptoms also have depression and/or anxiety disorders. These common mental health disorders are detectable and treatable



Key partners in the expansion include:-

- **Liaison mental health services (including core 24)** which provide care in general hospital emergency departments, inpatient units and outpatient clinics
- **Clinical and health psychology services** which work as part of healthcare teams within general hospital
- **Integrated primary and acute care systems** (PACS) which aim to improve physical, mental and social health and wellbeing, and reduce inequalities with general practice at their core
- **Specialist physical health services** which may be based in either inpatient or community settings

GENERAL PRACTICE FORWARD VIEW

APRIL 2016

NHS England

"Invest in an extra 3000 mental health therapists to be working in primary care by 2020 to support localities to expand the Improving Access to Psychological Therapies (IAPT) programme" ***GPFV***

There are an additional 633 IAPT practitioners working in primary care as a result of the expansion

True Integration

Access to evidence based psychological therapies for people with LTC or MUS by providing;

Care genuinely integrated into physical health pathways working as part of a multidisciplinary team

Therapists who have trained in IAPT-LTC/MUS top up training

Providing evidence based treatments collocated with physical colleagues

Why integrate?

By using NICE-approved psychological therapies in physical healthcare settings and addressing mental health issues earlier, talking therapies help to improve patients' health outcomes so they become more able to self-manage their condition. Seeing individuals as a whole person, with both mental and physical health needs will deliver better patient care and improved outcomes.

- Improved outcomes
- Less reliance on services
- Promotes self management

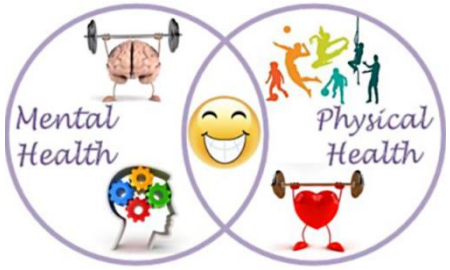
- Co-location provides an opportunity for physical and mental healthcare professionals to share knowledge and good practice in order to focus on holistic care for patients

How is this different to core IAPT?

- Co-location – one pathway
- Attendance at MDTs
- Working with physical health care professionals
- Joint booking systems
- Joint training
- Joint supervision
- Not signposting! Particularly key when services are integrating with Primary Care

Successes

- Truly integrated care
- Combined booking systems
- Increased confidence and competence in staff
- Improved quality of patient care
- GP champions
- Data linkage in primary care (is tricky)
- More appropriate referrals in to IAPT
- Reduced stigma
- Improved access for hard to reach groups
- GPs/ practice nurses/physical health care staff using screening questionnaires



Early Implementers Learning:- 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 Implementers Learning:- 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)

Financial Savings	GP (NHS Channel Shift Method)	Physiotherapy	Specialist Nurse (Cardiac etc)	A&E (Accident & Emergency)?	Hospital Inpatient Admissions	Total
Cardiovascular	£5,100.00	£1,581.00	£20,475.00	£2,688.00	£58,194.00	£88,038.00
Diabetes	£5,775.00	£1,224.00	£16,730.00	£1,120.00	£31,360.00	£56,209.00
Respiratory	£11,775.00	£2,448.00	n/a	£1,568.00	£32,880.00	£48,671.00
All Pathways	£22,650.00	£5,253.00	£37,205.00	£5,376.00	£122,434.00	£192,918.00

Early Implementers Learning:- 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

There have been beneficial discussions that have helped with the anxiety I can experience, which may be linked to my heart condition. I was finding this difficult to identify and understand the reasons for- and I now do. I am an extremely satisfied customer. I believe in what the service is doing."

I am delighted to recommend the treatment

My diabetes has 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.

I am joining in with life again, I am noticing things around me

It made me realise how much I had been ignoring the family around, my health is in control and I have my life back'

I was referred by my GP and the whole thing went very smoothly

I am able to make more effort and can do so much now without experiencing any stress at all

I have found this first class and it has been a big help

Delivering consistent quality through the IAPT Manual

- **Single source for all information on the IAPT programme (workforce, measures, therapies, outcomes, supervision, service improvement)**
- **Guide for commissioners, IAPT service managers and therapists working in IAPT**
- **Aim to reduce variation in provision and the quality of IAPT services across the country – dispelling myths and correcting drift**
- **Supporting increased investment in IAPT to deliver growth**

Common Myths

- IAPT is only for mild to moderate cases
- IAPT will not work with anyone with suicidal ideation and those involved with secondary mental health care are excluded from access
- IAPT staff do not need to have successfully completed an accredited IAPT training
- People with co-morbid drug and/or alcohol use cannot access IAPT
- IAPT cannot offer home treatment

Areas of Drift

- Interventions not being offered to a range of conditions
- Adequate dose of therapy not provided
- People with a history of childhood trauma are excluded from treatment
- Counselling being offered for people with anxiety disorders
- IAPT should only offer NICE approved evidence based treatments
- Inappropriate use of “mixed anxiety and depression” as a problem descriptor
- Hidden waits – use of assessment and treatment coding

ANNEXES

KLOEs for 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 HEIs 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?

KLOEs for Core 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?
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- 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)
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Resources

- IAPT-LTC Pathway
- A competence framework for psychological interventions with people with persistent physical health problems.
- A map to show the locations of the wave one Integrated IAPT early implementers. These sites were launched in September 2016 and are supported by additional funding to develop mental health services within long term condition care pathways. Included in this wave are services for people with diabetes, respiratory, cardiac and medically unexplained conditions.
- Descriptions of early implementer sites projects
- Announcement of second wave of integrated IAPT sites