NHS England IAPT Programme

Physical and Mental Health Treatment Pathways

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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)

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.

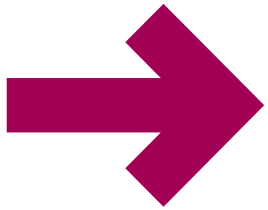
Great prospects for patients and their families

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

Why focus on people with LTCs?

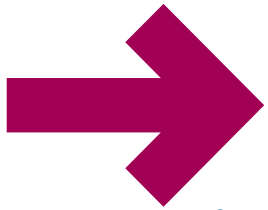
Economic Sense for the NHS (Layard & Clark 2014, Ch 11)

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

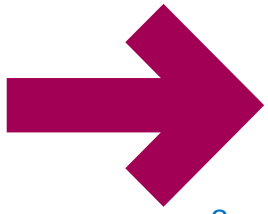
The most common LTCs that are likely to be seen in new integrated IAPT services

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

Lessons from the research literature and IAPT to date: why integrate?

LTCs

- People with depression and/or anxiety disorders who also have LTCs are already being seen in IAPT but have been under-represented
- Treating mental health problems reduces physical **health care costs by around 20%** and mainly pays for itself (Layard & Clark, 2014). Local example: Hillingdon & COPD.
- **Best outcomes** are achieved with adapted treatments that take into account the LTC and are embedded in its care pathway (LTC Pathfinder Results).



Lessons from the research literature and IAPT to date: why integrate?

MUS

- 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
- Engagement in treatment can be a challenge, many of the key principles have already been touched upon in HI training of health anxiety and panic disorder: e.g. positive evidence for psychological modulation, using the right terms (symptom management)

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.

IAPT-LTC Definition

NHS England

What defines an Integrated IAPT service?

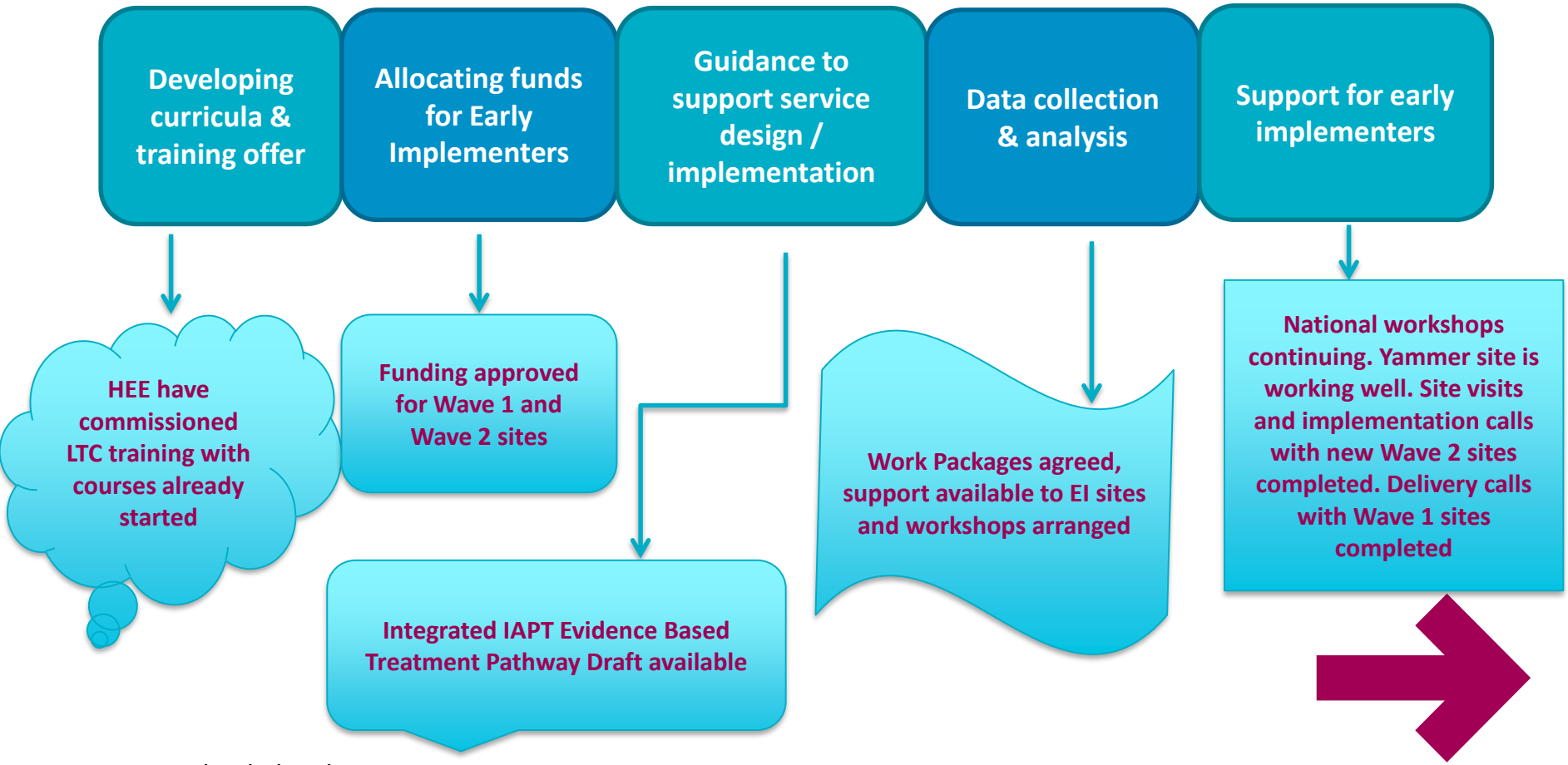
An integrated service will expand access to psychological therapies for people with long term health conditions or MUS by providing care genuinely integrated into physical health pathways working as part of a multidisciplinary team, with therapists, who have trained in IAPT LTC/MUS top up training, providing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



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

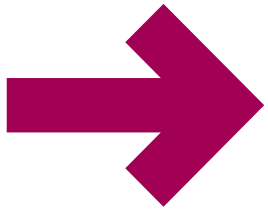
- Joint working across NHS England national and regional teams, HEE, and the MH IST has strengthened the process and results from early implementers

- 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.

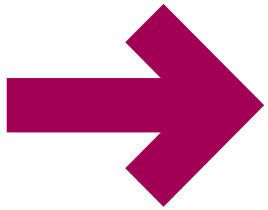
Learning from EI's- Commissioners

- 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



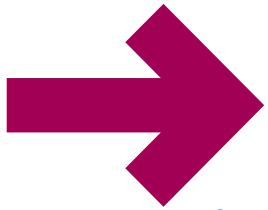
Learning from EI's- Commissioners (2)

- 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

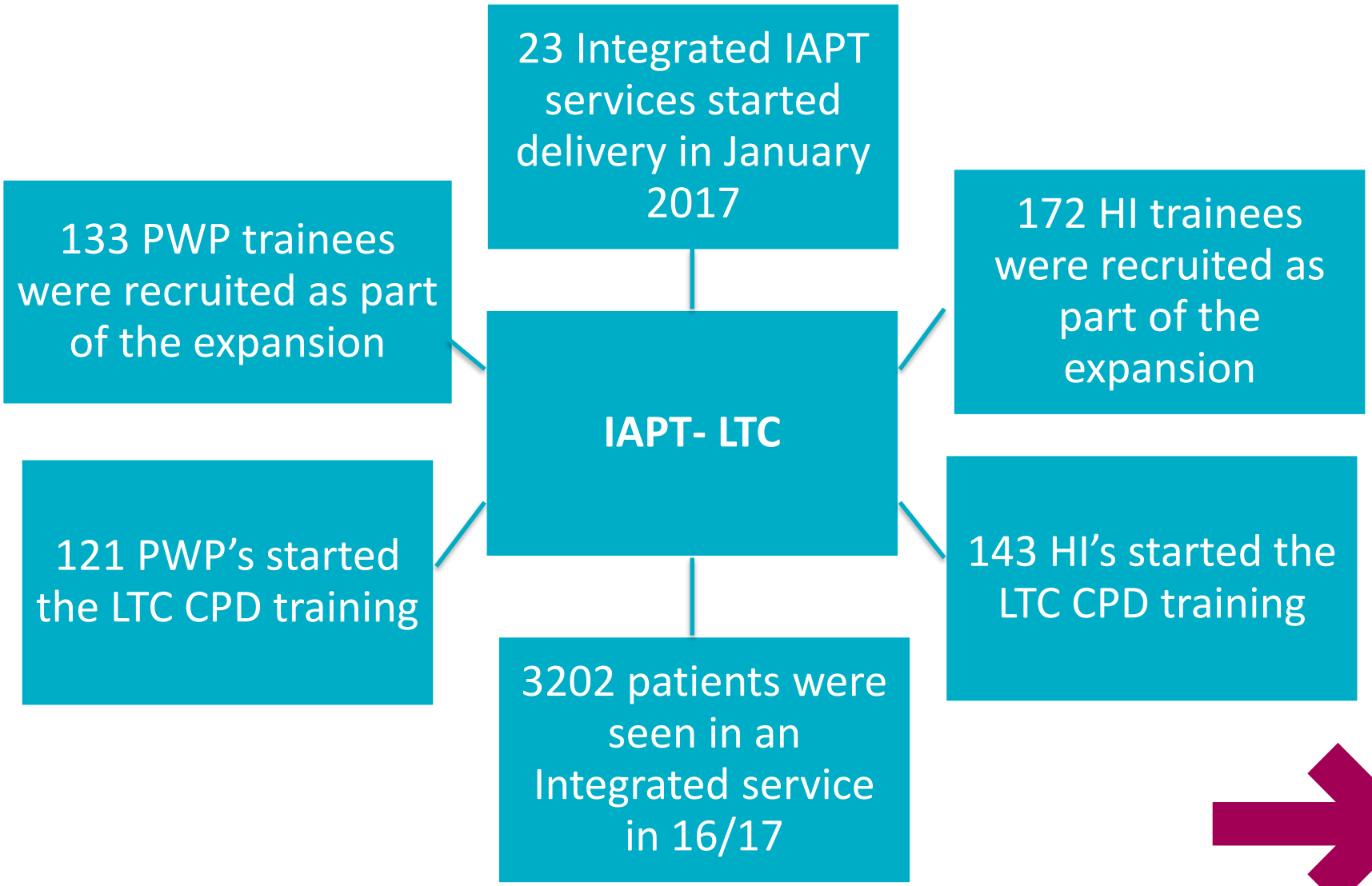
- Start early- Engagement, relationships and development of pathways does take time
- Make links top down and bottom up
- Cast your net widely
- Don't underestimate the important of publicity and marketing- start this early too
- How should you brand your service to appeal to the target audience



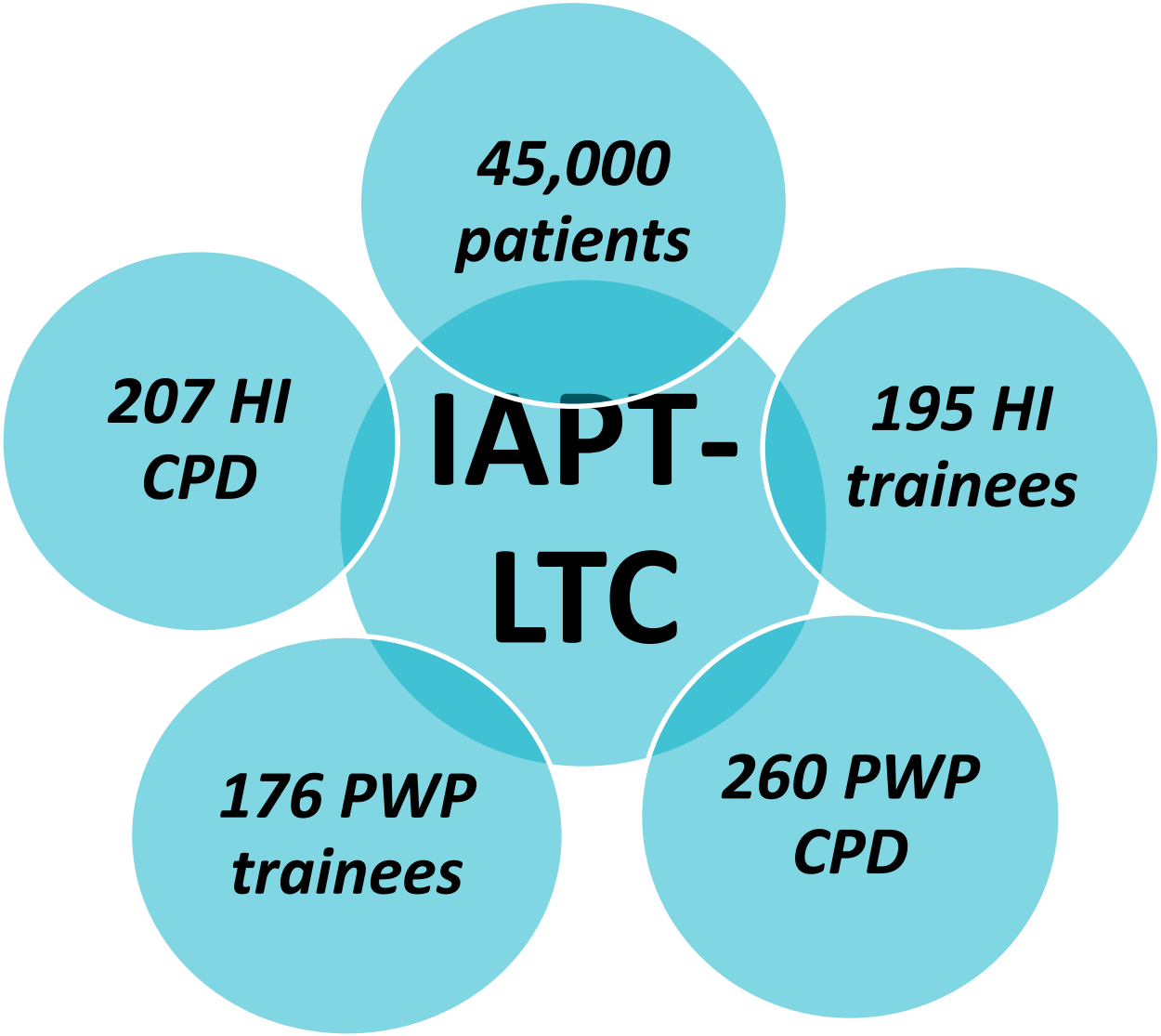
Learning from EI's- Providers (2)

- 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



Plan for 17/18



NHS Operational Planning and Commissioning Guidance 2017-2019

- 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.

NHS Operational Planning and Commissioning Guidance 2017-2019

- Overall planning of workforce should include increasing the numbers of therapists co-located in general practice by 3000 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 a 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

Ensuring Rollout

- Commissioning IAPT-LTC events in every clinical network
- Suite of guidance produced
    - FAQs
    - Evidence Based Treatment Pathway
    - Developing the business case document
    - “How To” guide
    - Local evaluation guide – evidencing savings
    - Data handbook

Thank you

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