NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

UCL

IAPT-LTC Early Implementers Programme

Report on the implementation and process evaluation of Wave 1 early implementer sites

November 2018

The National Collaborating Centre for Mental Health (NCCMH) at the Royal College of Psychiatrists and the Centre for Outcomes Research and Effectiveness (CORE) at University College London (UCL)

Katherine Clarke, Katarzyna Furmaniak and Stephen Pilling

Contents

Acknowledgements

We would like to acknowledge the funding and support provided by NHS England and particularly the helpful comments provided by the national IAPT team.

We also thank the NCCMH for their work on the final report, particularly Kate Lorrimer, Clare Taylor and Kasia Trojanowska for commenting on and editing drafts of the report and Helen Greenwood for her help with illustrations.

Finally, we thank all the healthcare staff and service users who shared their experiences with us.

Disclaimer

All views expressed in this report are those of the authors and not those of NHS England.

Executive summary

This evaluation was commissioned by NHS England to examine the experience of Wave 1 early implementers of IAPT-LTC services (Improving Access to Psychological Therapies for people with Long-Term Conditions and Medically Unexplained Symptoms). The report is structured in five parts.

Part 1: Implementation

- The implementation was more effective where sites built on their established links with psychological or physical health services and their experience in delivering care to people with long-term physical conditions (LTCs) or medically unexplained symptoms (MUS).
- The pace of implementation varied across sites, but by June 2017 all sites were seeing service users.
- Prompt access to training and a focus on well-developed pathways were associated with improved performance.

Part 2: Description and mapping of Wave 1 IAPT-LTC sites

- Sites ranged between 3 and 35 whole-time equivalent (WTE) staff, who worked in a range of care pathways and were co-located predominantly in GP clinics and community settings.
- Co-location in acute healthcare settings was more limited and more challenging to establish.
- IAPT-LTC sites often worked closely with core IAPT: 17 had shared systems and working space and 14 had clinicians working in both core and IAPT-LTC services.
- A range of different LTCs were seen, with diabetes the most common.
- Around half of patients were self-referred (similarly to core IAPT nationally) and a quarter were referred by a GP.
- Services were generally closely aligned to the IAPT-LTC model, co-located with physical healthcare services, and had close links with core IAPT and physical healthcare services.
- Problems were encountered with the timeliness of training, the use of case recognition tools and adjustments to the criteria for entry to IAPT-LTC services, which were not in line with national policy.

Part 3: Staff experience

- There was strong ownership of the IAPT-LTC model across all participating staff groups.
- Frustrations were expressed at delays in training and the impact of the IAPT-LTC model on core IAPT staffing.

Part 4: Service user experience

- People were positive about the care they received in IAPT-LTC services, particularly regarding easy access, the impact on their everyday home and work lives, and the management of their LTCs/MUS.

Part 5: Conclusions

- The development of clear protocols for the delivery of services, coupled with well-defined expectations of co-location and integrated working, provided a sound framework to guide implementation.
- The national support team, and associated training and supervision, had an important role in sharing learning, supporting effective implementation and ensuring delivery of high-quality services.
- The major problems encountered were organisational in nature – slow funding release, timing of training programmes, variation in criteria for offering treatment and availability of clinical space.
- Staff experience was generally positive. By the end of the first year of the Wave 1 pilot, all staff had a good understanding of the IAPT-LTC model.

Introduction

Background

IAPT services deliver evidence-based treatments to around 1 million people in England who experience common mental health problems each year.[1] The Five Year Forward View for Mental Health set out a commitment to further expand these services, to reach an additional 600,000 people by 2020/21.[2–4]

An important objective of this expansion is to provide better care to people with common mental health problems who also have LTCs or MUS (see Table 1). Mental health problems that co-occur with LTCs or MUS may result in poorer physical health outcomes and increased costs of care.[2,5] IAPT-LTC services, which specifically focus on treating people with LTCs/MUS, will mean that more people with these conditions receive integrated high-quality care. It is expected that with effective implementation, the IAPT-LTC model will lead to improved clinical outcomes and reduced use of physical healthcare services by this group.[5]

IAPT-LTC services

IAPT-LTC services are based on the core IAPT model.[6] They offer a range of effective, evidence-based treatments delivered in a stepped-care model by trained and supervised therapists as well as session-by-session outcome monitoring (for full details, see the IAPT and IAPT-LTC guidance[5,6]). In addition, they aim to:

- be co-located and integrated with physical healthcare services; this includes joint working, joint meetings, reciprocal training and using integrated systems
- encourage physical healthcare staff to use mental health case recognition tools in routine practice
- use revised assessment protocols to reflect the increased complexity associated with the assessment of depression and anxiety in people with LTCs or MUS
- have close and effective links with the wider system, including liaison mental health services and clinical and health psychology services.[5]

Table 1. Conditions in the IAPT-LTC pilot

Long-term conditions (LTCs)	Cancer
	Cardiovascular disease
	Chronic pain, including fibromyalgia
	Diabetes
	Gastrointestinal problems
	Epilepsy
	Musculoskeletal disorders
	Obesity
	Respiratory diseases including chronic obstructive pulmonary disease (COPD) and asthma
	Dermatological conditions including eczema
	Stroke
Medically unexplained symptoms (MUS)	Chronic fatigue syndrome/myalgic encephalopathy
	Irritable bowel syndrome
	Other MUS

Wave 1 early implementer sites

IAPT-LTC services were set up in phases to enable learning from the first early implementers in 2016/17. A decision-making panel was established, consisting of NHS England national teams and regional leads. They assessed all IAPT sites based on management data and local intelligence from regional NHS England teams and the NHS Improvement Intensive Support Team. Sites that were performing well across several key indicators, such as service access and recovery rates, were shortlisted.

Shortlisted sites submitted bids to NHS England. The bids included the site's plans for implementation and a forecast of expected cost savings arising from reduced physical healthcare use. The bids were assessed by a second panel, comprising NHS England, Health Education England and regional as well as service user representatives.

As a result, 22 sites were selected for the Wave 1 pilot; they included 25 service providers (see Appendix 1). Implementation work began in September 2016 and the sites aimed to start service delivery from January 2017. NHS England provided support with set-up, funding for LTC top-up training for staff in core IAPT services and funding for trainees to backfill core IAPT services. They held national workshops and set up a social network platform (Yammer) to share learning across sites and the national team. They also commissioned NHS Digital to assign additional outcome measures for LTCs and MUS (for full details, see the IAPT-LTC guidance[5]).

Part of the implementation process was an evaluation of IAPT-LTC services.

Method

Theoretical framework

Implementing new services is a complex process that involves a number of different elements and affects service leaders, clinical staff, affiliated staff and service users. Normalisation process theory (NPT)[7,8] provides a framework to identify and assess that work. It has been applied in similar healthcare settings, for example to evaluate collaborative care for depression in primary care.[9] NPT posits that:

- new services are best implemented and integrated by working collectively
- implementation is a continuous process and work does not stop once a service has been established
- it is important to consider local contextual factors when looking at how new services can be implemented.

NPT can also be used to structure an assessment, where a researcher assesses evidence of staff participation for each of four key areas of work:

- coherence (making sense of the new model)
- cognitive participation (engaging with the new model)
- collective action (putting the model into place)
- reflexive monitoring (appraising the model's effects).[8]

A self-report survey (the NoMAD[10]) can also be applied to assess how individuals are working towards implementation.[11,12]

Approach to the evaluation

This evaluation aimed to provide a multi-layered picture of the experience of Wave 1 sites and the whole implementation process. To do this, we employed a mixed-methods approach and drew on multiple sources of data. We used NPT to first structure ideas about factors that are important in successful service implementation and then to evaluate service implementation.

We were guided as to what a 'model' service looks like by relevant policy guidance and associated service specifications developed by NHS England. For example, we focused on how services were embedded within existing physical healthcare services (e.g. through co-location), and on building relationships across different healthcare settings (e.g. referral pathways and joint working).

We explored all evaluation questions using both qualitative and quantitative data where possible, for example, by using local service descriptions and service use statistics (referral rates) as well as conducting staff and service user interviews at key sites (see Data collection, 5. Staff and service user interviews). To guide data collection and evaluation, we focused on a series of questions, grouped here into five domains.

1. How have Wave 1 IAPT-LTC services been implemented?

- What was the context into which services were introduced? Did sites build on existing experience?
- What were the main elements of the implementation process?
- What affected the ability of services to complete this process?
- Was implementation successful according to normalisation process theory? Were services and individuals doing the work necessary to achieve functioning and sustainable services?

2. What did the services look like once they started delivery?

- What were the characteristics of the new IAPT-LTC services?
- How integrated were they?
- How much did services differ from each other?
- How closely did sites meet the IAPT-LTC service criteria?

3. What was the experience of delivering these services?

- What did staff find helped or hindered implementation?
- What were the common themes in staff experience?
- What examples of effective leadership were there?

4. What was the experience of receiving care in these services?

- How did people learn about the service?
- What was the experience of receiving care like?

- What was the impact of the service on service users?

5. What can we learn from this?

- What has not worked as intended and what can we learn from this?
- What lessons can we learn about successful implementation?
- What do services wish they had been able to do, in hindsight, that would have improved the service?

To examine these questions, we were flexible in our approach, with initial findings informing subsequent data collection. We first looked at the national picture, collecting publicly available national data and information provided by NHS England. We then chose targeted questions for each site. This was followed by a survey circulated to staff in, or affiliated with, IAPT-LTC services. Finally, we interviewed staff and service users about the key themes that emerged from the evaluation.

The sites are anonymised in this report.

Data collection

There were five main sources of data for this evaluation.

1. Publicly available national data

The national data came from two main sources:

- NHS Digital IAPT monthly reports for information on uptake of IAPT-LTC services. While the reports covered the period from January to November 2017, we used data from June 2017, by when all services were reporting.
- NHS England clinical commissioning group (CCG) outcome tool for local demographic data for CCGs in 2016. This includes information on the local prevalence of LTCs.

2. Wave 1 site data from NHS England

NHS England provided three types of data:

- **Site bids:** the proposals by individual sites who applied to the IAPT-LTC Wave 1 pilot. They contain information on the local healthcare context, need and proposed service characteristics.
- **Site monitoring reports:** reports submitted quarterly to NHS England by each site between September 2016 and September 2017. They informed on progress, challenges and any specific issues that required assistance from NHS England.
- **NHS England figures:** data on agreed activity levels, staff and trainee numbers as well as funding for each site.

3. Local service data

In September 2017, a service lead from each of the 25 providers completed a form (see Appendix 2 in the Appendices section) about individual service configuration in June 2017, such as LTCs/MUS pathways, staffing and working

arrangements. Sites with multiple services submitted separate forms for each. June was chosen to give a 'snapshot' of services, as it was the first point at which all services had commenced delivery.

4. Staff experience survey

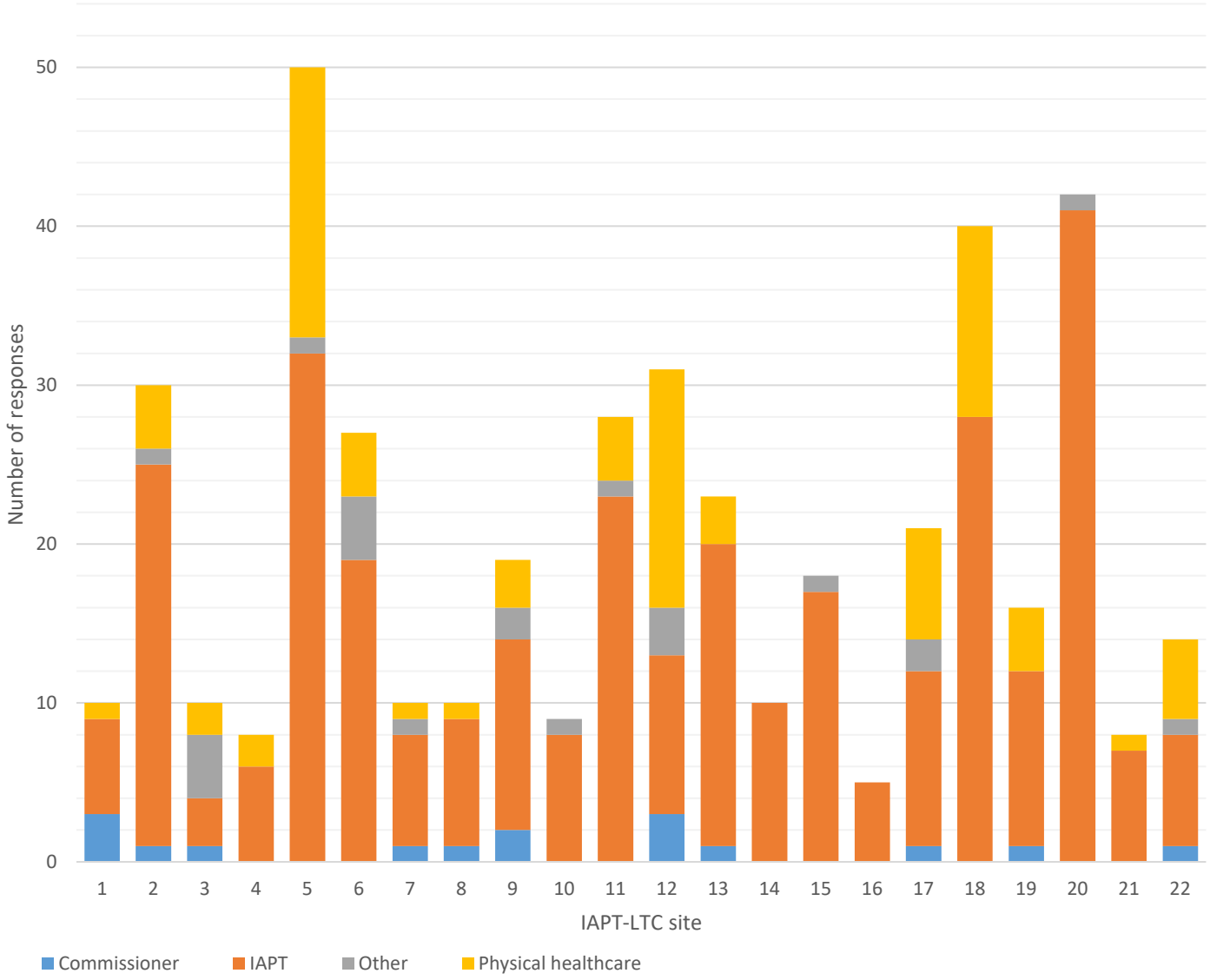
The IAPT-LTC staff experience survey (see Appendix 3 in the Appendices) ran throughout December 2017. It was an online survey circulated by email to service leads, who then disseminated it locally and on Yammer.[13] It was sent to IAPT-LTC practitioners and managers, core IAPT practitioners, physical health staff involved with IAPT-LTC services (GPs, nurses, LTC specialists, managers) and commissioners. Participation was optional and so there was not a complete sample of respondents.

The survey was based on the instrument from the NoMAD Study.[10] It asked about current practice, top-up training, factors affecting implementation and the impact on other services. There was also the opportunity to make free-text comments throughout.

In total, 439 surveys were used in the analysis (see Figure 1).

- We received 515 responses; 69 did not have a complete NoMAD section and these were excluded; a further 7 were excluded as key identifiers were not provided (e.g. the site was not specified).
- IAPT staff (core and LTC IAPT) comprised 73% of respondents, 20% were affiliated physical healthcare staff, 4% were commissioners and 5% were 'other'.
- Every pilot site was represented and, in each, at least 40% of the IAPT-LTC workforce responded to the survey.

Figure 1: Survey responses by staff type for each site



5. Staff and service user interviews

Semi-structured interviews were conducted with staff (n = 19) and service users (n = 4) in February 2018 on a purposive sample of sites ('key sites'). These sites were selected to further explore key themes, which were based on findings from previous parts of the evaluation. Staff interviews focused on:

- co-location
- transitioning between services
- training
- data linkage
- leadership.

Service user interviews focused on the person's route into, and experience of, IAPT-LTC care. They covered the:

- nature of the person's problems
- route into the IAPT-LTC service
- treatment received
- impact of treatment.

Analysis

Part 1: Implementation

We synthesised the monitoring information that sites sent to NHS England every 3 months, from September 2016 to June 2017, to describe the main elements of the implementation process. We recorded any milestones achieved and any delays reported by each site at each time point and looked for any patterns across sites and over time. We focused on *when* sites achieved elements of implementation and *how* they related to each other in the timeline.

To assess the work at the site level, we reviewed the monitoring information for evidence of work related to the four areas of the NPT. We conducted an NPT assessment and gave each site a 'green', 'amber' or 'red' rating for each area. To assess the work of individual staff members, we used the NoMAD survey. As NPT and NoMAD are qualitative tools for exploring implementation, statistical analysis was not considered appropriate.

Part 2: Description and mapping of Wave 1 IAPT-LTC sites

In Part 2 of the evaluation, we assessed the sites in June 2017. We described site characteristics at this time point, including staffing, configuration, co-location arrangements and referral sources.

To classify the sites based on their key characteristics, we used cluster analysis. This method builds on previous work on classifying healthcare systems[14] and was chosen to explore possible commonalities between services.

We also assessed how closely sites were aligned to the national guidance on IAPT-LTC as rated by individual staff members. This allowed us to gain a picture directly from those delivering the service.

Part 3: Staff experience

To assess staff experience of the pilot, we conducted a thematic analysis[15] of the responses to the staff survey as well as staff interviews. The themes were cross-checked independently and agreed by two researchers.

Responses to two key survey questions – what helped and what hindered the implementation of IAPT-LTC – are illustrated by 'word clouds' (Figure 8 and Figure 9), where the relative size of the word represents the number of times that word was mentioned.

Part 4: Service user experience

We selected a purposive sample of service users and undertook a semi-structured interview focused on their experience of IAPT-LTC services. The feedback was positive, with users feeling they especially benefitted from the expertise of IAPT-LTC staff in mental health care and targeted symptom management.

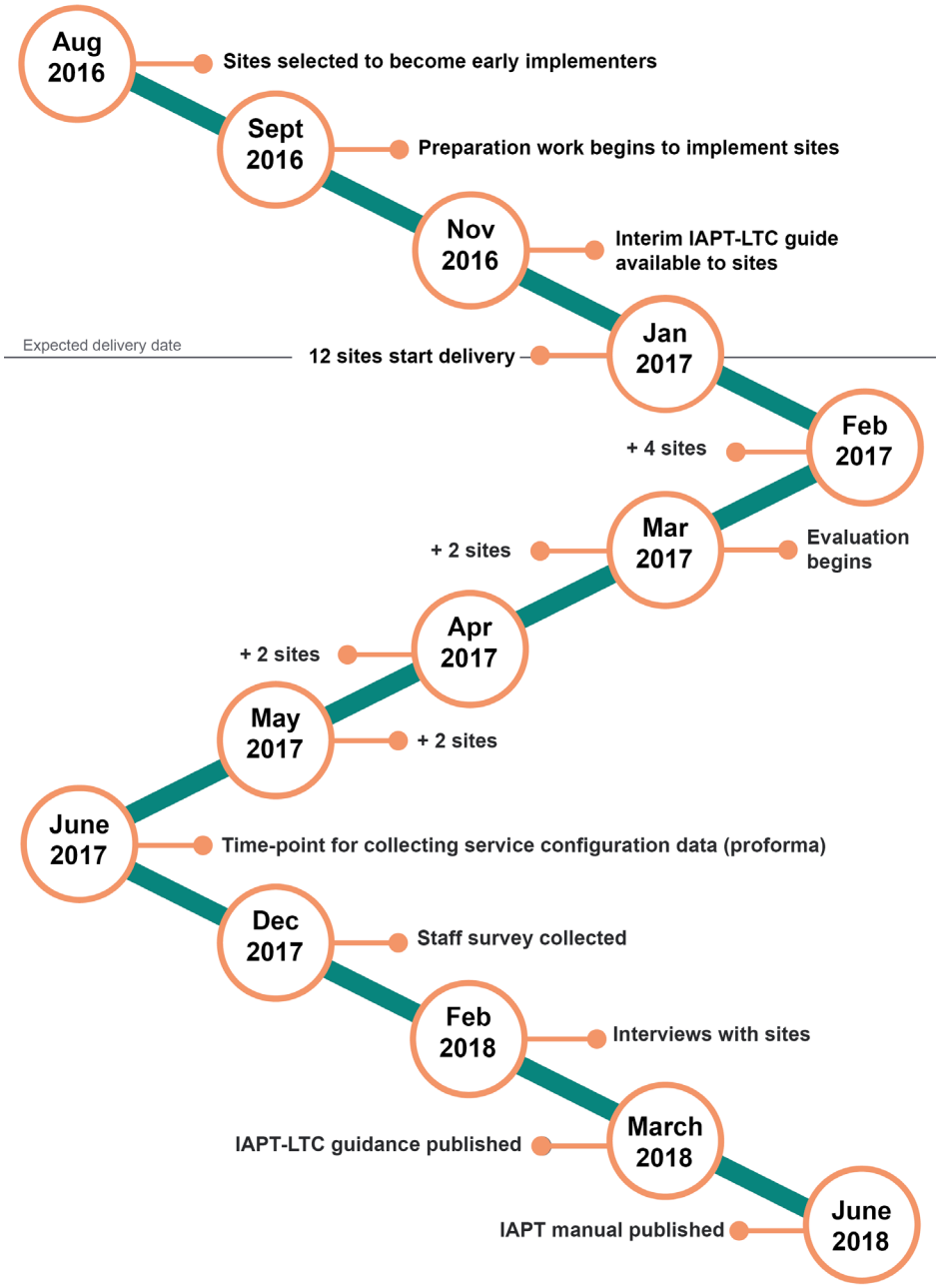
Part 1: Implementation

This section outlines the process followed by Wave 1 sites to establish IAPT-LTC services, from site bid acceptance (late 2016) to the point when all sites were offering a clinical service (June 2017). This includes:

- the context prior to the implementation process
- the key features of the implementation process
- the assessment of the implementation process using NPT.

A chronological summary of key points of implementation and evaluation is presented in Figure 2.

Figure 2: Overview of the implementation and evaluation processes



Context before implementation

In 2011, the Department of Health's LTC Pathfinder Project[16] recruited 15 IAPT teams to pilot the delivery of psychological therapies to people with LTCs/MUS. Of these, seven overlapped with Wave 1 IAPT-LTC sites. Those sites that had not previously been Pathfinders built on their existing provision, such as:

- most sites had experience of working with service users with LTCs within the core IAPT service
- some sites had existing LTC specialist staff within core IAPT who had begun work in hospital rehabilitation teams and community services
- some sites had established routine screening programmes for depression and anxiety in a small number of services
- some had built links through outreach to physical healthcare teams using mental health training days.

The sites submitted bids by the end of July 2016 and the early implementer sites were announced by mid-August 2016. This was at a time of increased focus within the NHS on the provision of mental health care and of locally focused and integrated services, emphasised in The Five Year Forward View for Mental Health.[2] To meet the new access targets, Implementing The Five Year Forward View for Mental health[4] sets out the requirement for at least 4,500 more high-intensity therapists and psychological wellbeing practitioners to be employed.

The implementation process

To describe the Wave 1 implementation process, we used the quarterly monitoring reports that sites submitted to NHS England. They included information on recruitment, referrals, local evaluations and local steering groups. Reports were:

- recorded at the time rather than retrospectively
- naturalistic – collected for a real-world purpose and not just for the purpose of research
- in a common format and had common time points, which enabled comparison across sites.

The limitations of this data source were that: (a) information was self-reported; (b) it only gave a partial account of the factors that affected implementation at the management level; and (c) the level of detail varied across the sites (for instance, if an issue was reported across all but one site, we could not assume that it was not present at that site). With this in mind, analysis of the monitoring information is used as a starting point for identifying common patterns across the sites and is supported by data from multiple sources in the latter parts of the evaluation (Parts 2 and 3).

We cross-tabulated the monitoring information by inductively coding any factors affecting implementation that occurred in more than one site at any point in time. Sites achieved milestones at different times, but the overall process can be described through five interrelated stages:

1. **Collaboration** underpinned the other four stages. It involved working closely with physical healthcare teams, other psychological teams and commissioners.
2. **Sign-off** occurred once targets had been agreed and funding released by CCGs.
3. **Development** involved work with key decision-makers to map out pathways, arrange co-location and work out the logistics.
4. **Set-up** involved practical preparations, including appointment of staff, training and procedures.
5. **Delivery** started when the service had been rolled out, treatments offered and data returns made.

In addition to these steps, the sites were also required to undertake local evaluations to build a business case for continued investment in IAPT-LTC after the pilot year. Although this was not a part of service implementation, sites spent substantial time and resources gathering evidence for the business cases in the early stages of implementation. This had an impact on the wider implementation and is therefore discussed here.

Collaboration

This was an overarching feature of good implementation. Sites began engaging with relevant clinical pathways and making arrangements for co-location of clinical space. Most started developing their pathways very quickly, but seven sites had problems that continued until February 2017, and three continued to report problems in June 2017. This was largely due to lack of clinical space in hospitals, clinics and GP services, or GPs requiring payment for use of clinical space. Issues with co-location were less common in community and third-sector settings than in acute or primary care settings.

There were a number of examples of innovative collaborations, such as setting up GP training events and CCG-wide network meetings, instituting IAPT-LTC staff attendance at multidisciplinary team meetings and GP practice meetings, and implementing joint supervision with core IAPT, clinical and health psychology or physical health teams. Some sites moved to new administrative spaces or collaborated with other services, introducing co-location on selected days.

Staff enthusiasm for the pilot and good relationships with other partners were reported by every site as facilitating implementation. All sites spoke of the importance of having good existing relationships with commissioners, providers and hospital and community organisations.

Sign-off and development

Six sites were affected by delays in sign-off and funding release in the first 2 months of implementation. Considerable effort was involved in achieving sign-off, particularly when working across several CCGs and deciding on a clinical focus to meet local priorities. Contracts occasionally needed to be clarified between NHS England, IAPT service providers and commissioners.

In the first few months of implementation (particularly September 2016 – January 2017), 15 sites credited support from their trust, CCG or NHS IAPT as important, particularly with the development of pathways and seconding staff. Sites also

valued workshops, where they were able to talk to the national team and learn from other sites undergoing the same process.

Set-up

Only five sites were able to begin recruiting for new staff in October 2016. Others took longer, with three sites still waiting for confirmation of training places, or for training to commence, in March 2017.

The sites recruited additional staff to backfill the core services in the first 3 months of implementation. Five sites were still trying to fill vacant posts in March 2017.

Nearly all sites experienced difficulties with data-sharing and collection across agencies, including:

- obtaining permissions to share information between services for the local evaluation
- obtaining access for IAPT-LTC staff to physical healthcare data systems
- obtaining good quality data for the additional IAPT-LTC measures (this was mixed at the start and required significant work to establish).

Delivery

All sites saw their first IAPT-LTC service users between January and the beginning of June 2017 (see Figure 2).

Although we had expected that all sites would be seeing people by January 2017, significant delays occurred. These arose mainly from getting sign-off, recruiting and training staff, and securing co-location space. This made it challenging for sites to meet their activity targets by the end of the financial year (April 2017).

Of the 22 sites, 12 reported that referrals were lower than service-set targets. Typically, this occurred in the first months of delivery, but in two sites, this persisted longer than 4 months. This can be partially attributed to slow build-up of pathways at the start. Other reported reasons included:

- difficulties engaging or maintaining the initial interest of physical healthcare practitioners
- waiting until space was confirmed to start engagement work with physical care staff.

Sites actively engaged with referrers through continued communication and developing and distributing LTC-related leaflets and materials. Where referrals were assessed as not appropriate for the service, this was addressed by providing further information, discussions and education sessions to physical healthcare staff.

Six sites reported higher numbers of referrals than they were able to manage. This issue occurred most often from April to June 2017, when practitioners were attending training.

NPT assessment of the implementation process

Was there evidence of good work at a whole-site level?

NPT emphasises the need to consider the local context and work done by individuals in understanding an implementation process. It goes beyond logistics or raw outcomes and suggests four areas of importance when attempting to implement a sustainable innovation or a new service. We looked for evidence of activity in the monitoring information submitted by each site and assigned ratings (see Figure 3) across these four areas:

- **coherence:** people involved have a shared understanding of the new service, how it differs from current practice, its utility and its evidence base
- **cognitive participation:** people are invested and committed to implementing the service
- **collective action:** people do the operational work to enact the new service
- **reflexive monitoring:** people assess the effects of the service, appraise how it is working and update their practice.

There was evidence of good or exceptional work in most sites for all four constructs and evidence of some good work with minor issues in the remaining sites. There were no areas in any site that were given a red rating.

Coherence was rated as good in 50% of the sites, although minor issues were reported in the remaining 50%.

Interestingly, GPs and practice nurses often had a good understanding of what the IAPT-LTC model involves and which service users are most appropriate for referral; therefore, the issues observed could not be simply or solely attributed to non-IAPT-LTC staff.

There appeared to be more problems with achieving coherence in specialist physical health teams, where staff were sending referrals that were not appropriate for IAPT-LTC services. This was addressed through additional co-education sessions between the physical healthcare and IAPT-LTC teams.

Cognitive participation was good in 70% of sites. Issues that arose were often resolved by training and supervision, such as:

- nurses participating in mental health awareness and IAPT-LTC training events
- links with acute services and supervision from health psychologists.

However, other issues, such as high vacancy rates in local GP surgeries, meant their capacity to collaborate was limited and this also impacted on referrals.

Figure 3: Site ratings in four areas of importance for successful implementation (NPT)

Site	Coherence	Cognitive participation	Collective action	Reflexive monitoring
1	G	G	G	G
2	G	G	**G+**	G
3	A	G	G	
4	G	A	**G+**	
5	G	A		
6	A	A	G	G
7	A	G	**G+**	G
8	A	A	**G+**	G
9	A	G	G	G
10	A	A	A	G
11	G	G	G	G
12	G	G	G	G
13	G	G	G	**G+**
14	A	G	G	A
15	G	G	G	G
16	G	A	G	
17	A	A	G	G
18	G	G	G	G
19	A	G	G	
20	A	G	G	G
21	G	G	G	A
22	G	G	G	

G (green) = good work, no evidence of issues; G+ (green, bold) = green with examples of exceptionally good work or innovation; A (amber) = generally good performance, but with minor issues; R (red) = one or more major issues which persisted over time. Blank boxes = areas with insufficient evidence.

Collective action was good across the board. Examples of innovation were:

- management, physical health staff and IAPT-LTC practitioners promoting the service, including running marketing campaigns and developing condition-specific information flyers for service users
- physical healthcare and IAPT-LTC practitioners jointly delivering interventions for specific LTCs/MUS
- services arranging reciprocal training and supervision between IAPT and physical healthcare staff
- co-working with core IAPT so that people with LTCs/MUS presenting to the core service were assigned an IAPT-LTC-trained practitioner.

Reflexive monitoring was good but there was insufficient evidence to assess six sites. Work in this area included:

- involving service users in the steering group that reviewed the implementation to improve the service
- reviewing service progress in early pathways to inform a better roll-out for subsequent pathways
- reviewing numbers and types of referrals in services to assess which pathways were working
- reviewing mixed LTCs/MUS group sessions and trialling condition-specific groups in particular services.

NPT suggests that for implementation to be successful good work is needed in all four areas. Based on this, most of the sites appear to have the potential to become sustainable and operational.

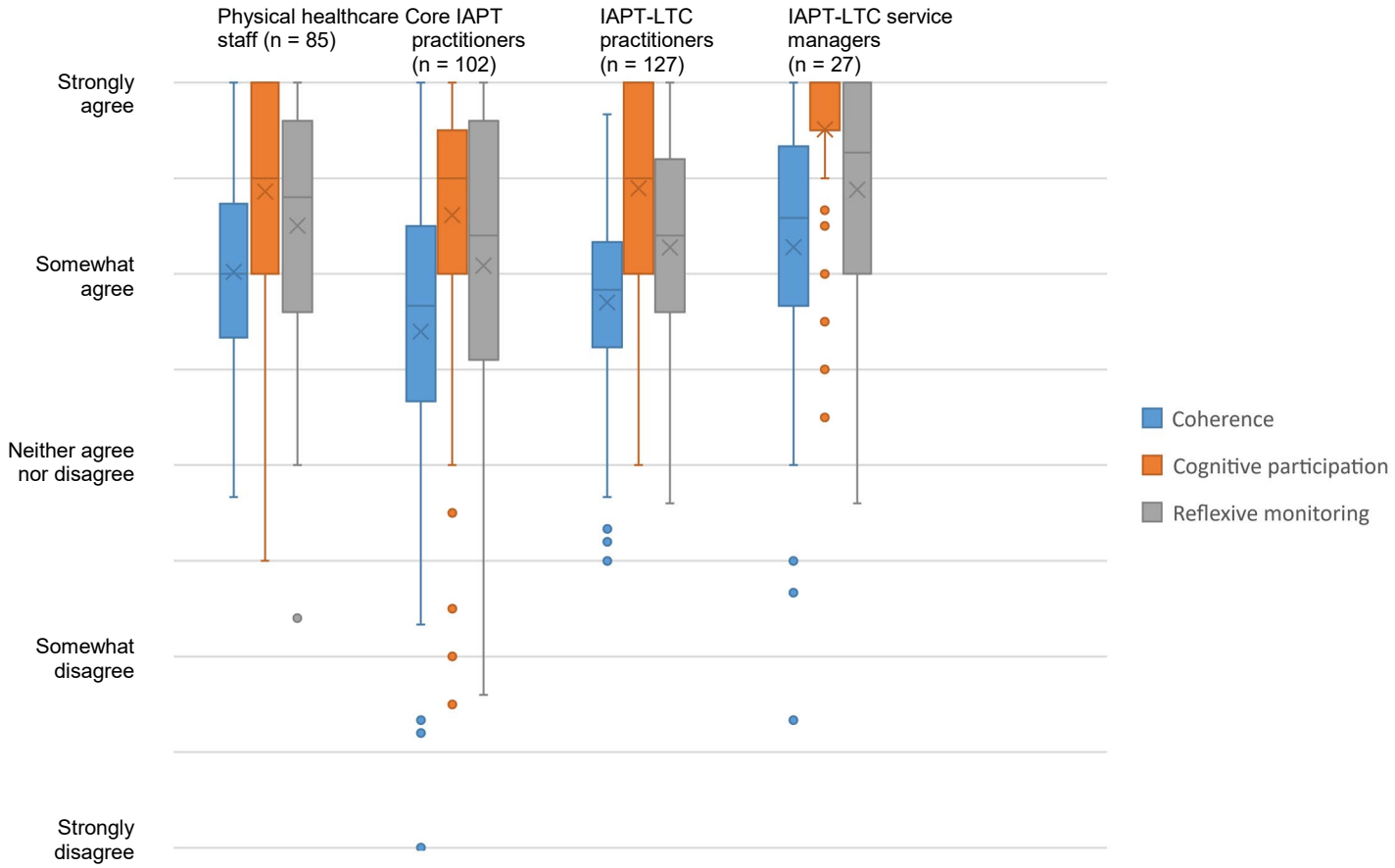
Reliable performance data from NHS Digital were not available for the period covered by this monitoring information analysis. Outcomes from June 2017 onwards are incorporated into Part 2.

Was there evidence of good work from staff in and around the sites?

For an innovation in healthcare to become a routine, sustainable practice, NPT suggests that as well as the practical operational work (collective action), staff must do important mental work. This was assessed by a staff survey (see Appendix 3).

Responses for each staff group are given in Figure 4.

Figure 4: Average responses to the NoMAD questions in the staff survey, by staff role



Note: The bars represent the interquartile range (where 50% of responses lie), with x marking the mean response. The vertical lines mark the upper and lower limits and the dots represent the outliers.

Staff generally understood the IAPT-LTC model and were able to reflect on its impact on their practice. The responses are largely consistent across staff groups, although there were some differences.

- **IAPT-LTC practitioners** were supportive of the model, but there was variation, with some being strongly on board and some less so. Their understanding of the model was not as strong as in IAPT-LTC service managers, but agreement with the model remained high.
- **IAPT-LTC service managers** were more consistently supportive of the model. They were the most involved with setting up the service (writing the bids, involving the stakeholders and relaying information between NHS England, IAPT and physical healthcare practitioners).
- **Core IAPT practitioners** had mixed responses. They were the least directly involved in the service and may have been negatively affected as a result of IAPT-LTC expansion.
- **Physical healthcare staff** were generally more supportive of the model than core IAPT staff. This may indicate that they are working closely with LTC staff and seeing the benefits of the service.

There were also some minor differences in the overall agreement across the four areas, principally with **coherence**, which was overall less positive than the other constructs. It may be that changes to the model and delivery plans in the pilots affected the clarity of the model for some staff groups.

A full breakdown of responses to the NoMAD questions, by staff category and site, can be found in Appendix 4.

Part 1 summary

- The sites varied in the extent of existing work with LTCs/MUS. Some sites had been involved in a previous Pathfinder project,[16] while others already had links with physical healthcare services.
- There was evidence of good work in all sites towards implementing a sustainable service. The NoMAD implementation tool showed that staff generally understood and agreed with the IAPT-LTC model. However, coherence of the model was less positive than the other three NPT constructs, with more variation between staff groups.
- All sites began seeing service users by June 2017, which represented a significant delay for some services. The majority of sites had been established by early 2017 and four were delayed into the late spring (recruitment problems and access to training were often responsible for these significant delays).
- The number of services located within hospital settings was more limited than expected; practicalities, such as lack of available clinical space in hospitals, probably had a role in this.
- A major contributor to the delay in establishing services was local difficulty with the release of funding, which also affected recruitment. Achieving integration or access to different electronic healthcare systems (e.g.

secondary healthcare or primary healthcare) also presented challenges to a successful set-up.

- In terms of initial referral targets, these were not achieved by 12 of the 22 sites. This was caused by the overall delays, difficulties engaging with particular healthcare staff and the availability of co-located space.
- There was a strong emphasis on effective collaboration and generally a positive relationship between IAPT-LTC, core IAPT, physical healthcare staff and commissioners. Providing teaching programmes, advice and support to physical healthcare staff was important in achieving this. Support from commissioners was key in engaging providers where services had previously not had strong links.
- The four NPT areas of positive service implementation were rated ‘good’ in most sites. In terms of cognitive participation, there was good understanding of the service and a commitment to its implementation from most healthcare practitioners and commissioners. In terms of collective action, there are a number of examples of positive collaboration between IAPT-LTC and physical healthcare teams. Strong links with core IAPT and clear protocols developed for the IAPT-LTC programme supported effective reflective monitoring.
- Questions on the IAPT-LTC model showed that it is well embedded in current practice, but the use of case recognition tools was not as consistent as other aspects of the model. Staff experience of IAPT-LTC training was mixed, particularly where there were delays in its provision.

Part 2: Description and mapping of Wave 1 IAPT-LTC sites

This section provides a snapshot of the sites in June 2017.

We combined national data from NHS England, Public Health England and NHS Digital with primary data from each site. We describe the sites' key characteristics, their relationship with core IAPT services and their referral numbers. This is coupled with information on service delivery, including the criteria for offering treatment, referral characteristics and numbers of people offered treatment. Finally, we use the site characteristics to explore whether there are different 'types' of services.

Mapping

Wave 1 sites spanned the length of England and covered a range of rural and urban settings. The estimated local need (number of people with LTCs in the local population) varied between 38,000 and 366,000 (mean 123,000) (NHS England CCG Outcome tool). This estimate includes those with diabetes, asthma, chronic obstructive pulmonary disease (COPD), heart disease, cancer, epilepsy, osteoporosis and rheumatoid arthritis. The majority of sites were made up of one IAPT-LTC service provider within one CCG. However, five sites included multiple CCGs but only one provider, three included multiple CCGs and multiple providers, and two had multiple providers within one CCG (see Figure 5). For a full list of CCGs and service providers see Appendix 1.

Site characteristics in June 2017

Site characteristics are detailed in Table 2.

Staffing

Site size (staffing numbers) varied tenfold, with between 3 and 35 WTE high-intensity therapists (HITs) and psychological wellbeing practitioners (PWPs) (mean 13.1). The proportion of PWPs to HITs also varied considerably, with some services having no PWPs and some with a majority of 76.9% of PWPs (the average across the sites was 41.9%). This means that many diverged from the intended 40% PWPs and 60% HITs recommended for an IAPT-LTC service.[5] However, this relates to posts funded by LTC expansion only and may not reflect the actual composition of the total IAPT-LTC workforce in each site. By the June 2017 time point, in seven sites all the HITs and PWPs had received LTC top-up training, and nine sites had trained at least half their HITs and PWPs (average 69.4%), which is what had been expected of the pilot sites.

Figure 5: Location of Wave 1 sites

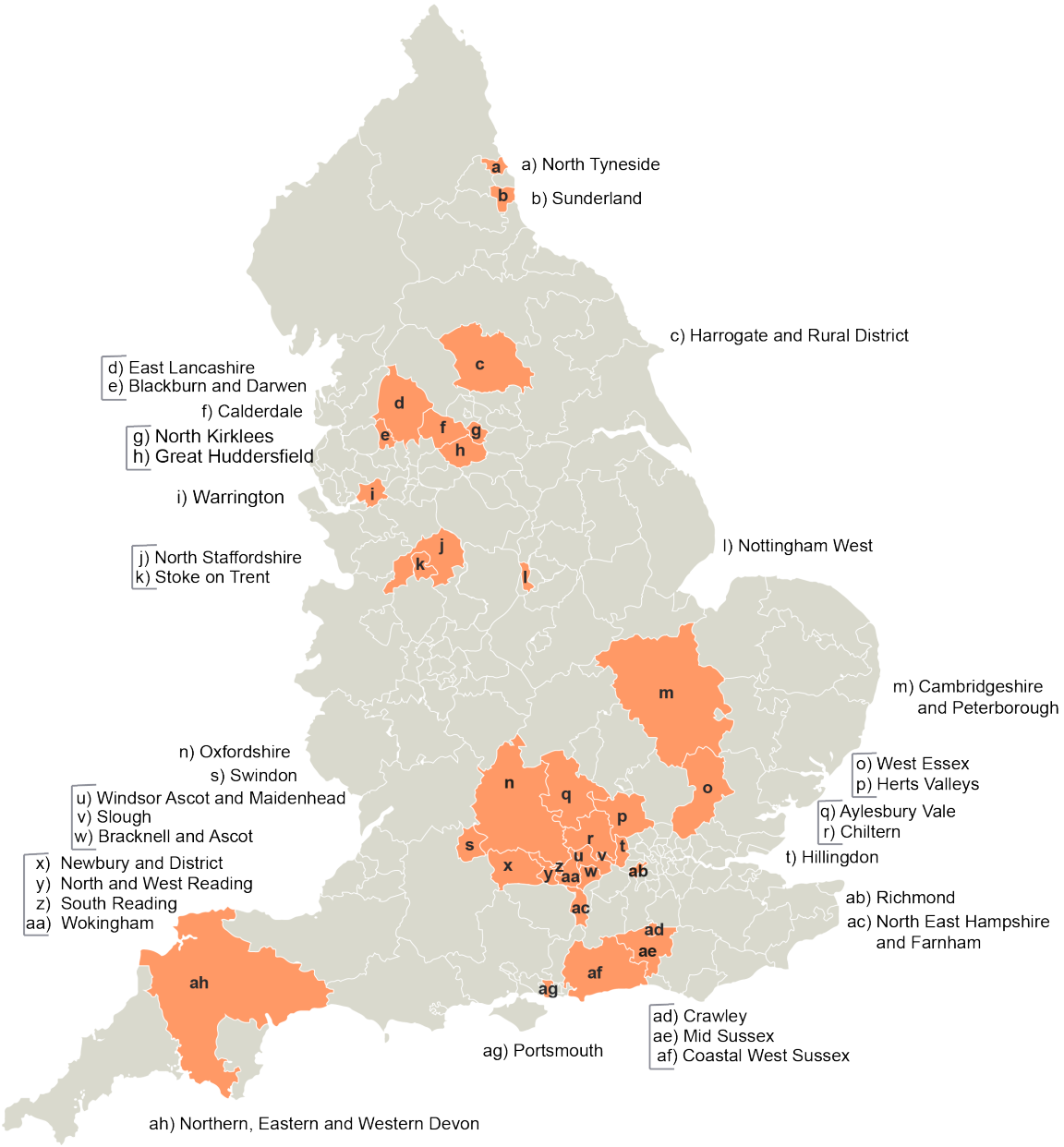


Table 2. Site characteristics

	Staffing			Service configuration		Co-location settings			
Site	HIT + PWP WTE[a]	Proportion of PWP to HIT	Staff with LTC top-up training	IAPT-LTC practitioners work in core IAPT	LTCs treated at the service	GP	Hospital	Community	Average number of delivery locations (staff survey)[b]
		(%)	(%)		(n)				(n)
1	4.5	33.3	100	Yes	4	√		√	3.0*
2	17	25.0	71	Yes	5	√	√	√	2.4
3	3	66.7	100	Yes	5	√			NR
4	5.8	50.0	80	Yes	5	√	√	√	2.0*
5	14.4	31.6	100	No	4	√	√	√	4.1
6	23	76.9	28	Yes	7	√		√	2.7*
7	3	0.0	63	Yes	9	√	√	√	3.0*
8	8.5	36.4	100	No	6	√	√		3.5*
9	4.4	40.0	80	No	8	√	√	√	3.5*
10	35	47.4	17	Yes	4	√		√	2.7*
11	14	23.5	100	No	6	√		√	3.3
12	15	58.8	88	No	3	√	√	√	4.4
13	18	50.0	17	Yes	9	√		√	2.7
14	6.5	76.9	46	No	10	√	√	√	3.0*
15	5	60.0	100	Yes	7	√	√	√	2.6
16	2.8	40.0	100	No	4			√	3.0*
17	18	63.2	44	Yes	9	√	√	√	3.2
18	16	29.4	71	Yes	5	√		√	2.5
19	12	53.8	54	Yes	7	√	√	√	2.9
20	30.4	48.4	47	Yes	11	√	√	√	2.7*
21	12	50.0	58	No	6	√		√	1.8
22	30	43.3	63	Yes	6	√			4.3*

GP = general practice, HIT = high-intensity therapist, LTC = long-term condition, MH = mental health, NR = no response, PWP = psychological wellbeing practitioner, WTE = whole-time equivalent

[a.] Excluding trainees and other therapists.

[b.] n = 125 practitioners.

*n < 5 responses.

Service configuration

In 14 sites, IAPT-LTC practitioners were working in both core and IAPT-LTC services, and 17 shared premises with the core service. On average, survey respondents worked in IAPT-LTC services 62.4% of the time; in ten sites they split their time between the services almost evenly; in nine sites they worked mostly in IAPT-LTC (>70%); and in three they worked mostly in core IAPT services (<40% LTC).

Out of the 22 sites, 21 were co-located with primary care and 19 had a strong community basis. There was a degree of overlap between these two categories. In primary care, coordination was managed directly with a GP or a practice-based specialist nurse (e.g. cardiac or diabetes nurse). In a number of community settings (n = 10), IAPT-LTC staff were integrated into community teams, which often had a specific focus on a disease group (e.g. musculoskeletal or respiratory). There was stronger integration in those services with team meetings and care planning than in standard primary care. A significant number of sites (n = 12) had links with hospital-based services, although problems with space availability often prevented patients being seen at acute sites, which limited the degree of interprofessional working. However, there were also examples where IAPT-LTC services were co-located with acute services and contributed to inpatient as well as outpatient care. This led to better integration of care.

Typically, IAPT-LTC practitioners worked across two to four care settings, including core IAPT services. Occasionally, practitioners worked across multiple settings, with the maximum reported by one person as eight. This can mostly be accounted for by placement in multiple primary care settings.

The number of LTCs varied considerably, from 4 to 11 (the higher number typically associated with working in GP surgeries). A large majority of sites reported working with people with diabetes, and respiratory and cardiovascular conditions. A significant number worked with people with chronic pain or musculoskeletal conditions and half worked with MUS. Less frequently, sites worked with people with cancer (n = 5), obesity (n = 3), dermatological conditions (n = 2), stroke (n = 2), gastrointestinal conditions (n = 1) and epilepsy (n = 1). These services tended to be associated with specialist hospital or community teams.

Site referral characteristics and sources in June 2017

Table 3 describes referrals to sites during the first month in which all services were running. Overall, 1,777 service users were seen across all sites in that month (site mean = 80.1). Of these, 762 were self-referred (43%). This is slightly lower than the national core IAPT self-referral rate (57.4% in 2016–2017[17]), but this is unsurprising given that IAPT-LTC services encouraged direct referrals from physical healthcare teams.

Table 3. Site referral characteristics (self-reported)					
Site	Total referred	Self-referred	GP	Other physical healthcare service	Other (core IAPT and other MH services)
	(n)	(%)	(%)	(%)	(%)
1	13	85	NR	15	NR
2	94	29	30	12	30
3	70	57	30	NR	13
4	35	69	NR	31	NR
5	148	37	24	30	8
6	29	72	10	NR	17
7	72	43	38	14	6
8	48	2	NR	NR	98[a]
9	50	82	4	10	4
10	NR	NR	NR	NR	NR
11	116	32	19	25	23
12	41	61	15	24	NR
13	94	60	20	2	18
14	156	83	NR	12	5
15	90	24	53	17	6
16	30	3	53	40	3
17	33	42	33	12	12
18	145	14	80	NR	5
19	147	14	31	7	48
20	201	70	14	1	13
21	76	13	58	4	25
22	89	37	43	11	9

GP = general practice, MH = mental health, NR = not reported
[a.] Reported 75% of total referrals from core IAPT.

Referrals from GPs were around two-and-a-half times more frequent than from other physical healthcare services (514 versus 199). The most common condition referred was diabetes (24% of all referrals), followed by asthma (10%) and cardiac problems (7%); service users with MUS made up 16% of referrals for this period.[a]

Progress in 6 months following June 2017

Routinely collected data on the outcomes of all Wave 1 sites were available on NHS Digital from June 2017 onwards. The 6 months from June to November 2017 were used to assess sites' progress against the targets set by NHS England for the 2017/18 financial year.[18] It was evident that nine sites had exceeded their targets for treating service users, four had not met their targets and nine had been substantially below their targets.

Criteria for offering treatment

All sites used standard IAPT criteria for anxiety and depression caseness in the presence of LTCs or MUS, but interpreted them differently.

All 25 services required referrals to experience LTCs/MUS and to meet standard IAPT inclusion criteria. In 11 services the LTCs/MUS had to 'interact' with the

[a] Note that in many cases, data systems did not allow for accurate reporting of service user LTCs/MUS breakdown uniformly across services (26.21% of reported users did not have their LTC category specified).

identified mental health problem, with some specifying the direction of the interaction: in six LTCs/MUS had to affect the mental health problem and in two the mental health problem had to affect the management of the LTCs/MUS. These additional criteria are not part of national policy and should not be used to limit access for people with LTCs/MUS, who should be able to access IAPT-LTC services.

The reasons for introducing these criteria are not clear. They may have arisen from a misunderstanding of policy or as a means of limiting referrals or discontinuing existing pre-IAPT-LTC policies. This needs to be addressed across all sites.

Were there groups of similar services?

In order to explore whether any 'types' of IAPT-LTC services emerged, we performed a cluster analysis.[19] This method has been used to map and classify European healthcare systems[14] based on descriptors such as 'health expenditure'.

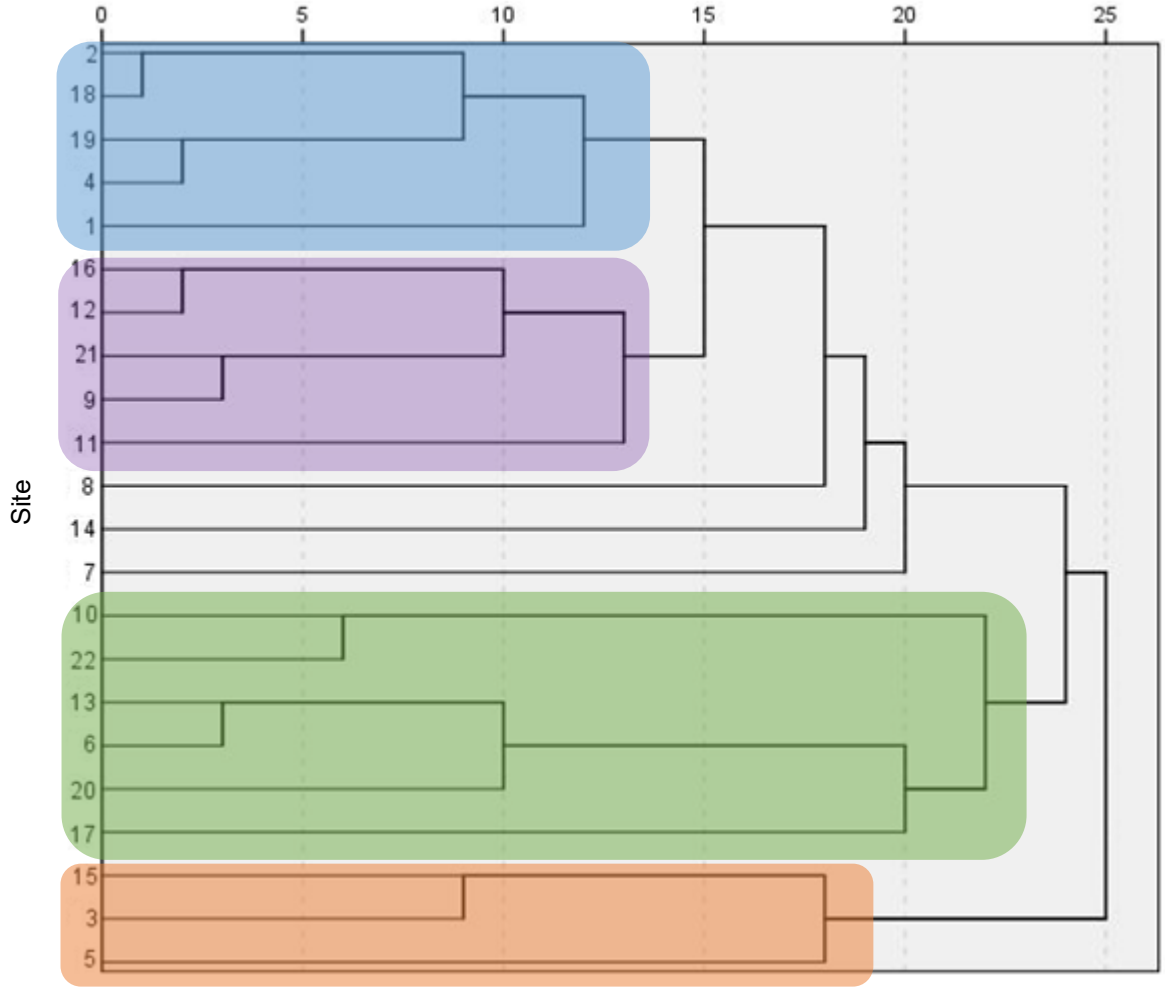
We identified eight service descriptors (see Appendix 5) and analysed how similar services were based on these descriptors. The degree of similarity is indicated in the 'tree diagram' (or dendrogram; see Appendix 6). We also looked at recovery and access rates for these clusters; the overall recovery rates were 54% (range 51.4% to 56.7%).

The cluster analysis (see Figure 6) suggests four site types (for summary statistics for each cluster see Table 4).

- **Blue cluster – higher proportion of HIT.** Sites had a higher ratio of HITs to PWPs than other clusters and good integration with core IAPT services; some had difficulty in achieving access targets but had higher than average mean recovery rates (56.4%).
- **Purple cluster – independent IAPT-LTC services.** LTC practitioners did not work closely with the core service and tended to underperform in terms of access targets but achieved higher than average mean recovery rates (56.7%).
- **Green cluster – large, varied sites.** They had a large workforce and saw a range of LTCs/MUS. They were more likely to be early starters, there was large variation in meeting access targets, and recovery rates tended to be somewhat lower (51.8%).
- **Orange cluster – late starters.** They were later than other sites to start seeing service users, but were meeting access targets and had reasonable recovery rates (53.1%).

It is worth noting that blue, purple and orange clusters had somewhat higher than average recovery rates, a high proportion of top-up trained staff and fewer than six different conditions treated at the service. Green and uncategorised clusters had the lowest proportion of trained staff and were the largest services in terms of WTE staff and number of conditions treated.

Figure 6: Clustering of IAPT-LTC sites based on eight site descriptors



Note: The sites that are not shaded shared some characteristics with both blue and purple clusters.

Table 4. Summary statistics of each of the four service clusters								
Cluster	Month of delivery	HIT + PWP WTE	Proportion of PWP to HIT	Staff with LTC top-up training	IAPT-LTC practitioners work in core IAPT	LTCs treated at the service	Ratio of primary to secondary care settings	Average recovery (June – November 2017)
			(%)	(%)		(n)		(%)
Overall mean	**February**	**13.1**	**44.1**	**69.4**	**Y**	**6.4**	**Primary skew**	**54.0**
Blue	January	10.9	38.3	75.1	Y	5.2	Balanced	56.6
Purple	January	9.6	42.5	85.3	N	5.4	Primary skew	56.7
UC	January	8.0	37.8	77.2	Y	7.8	Secondary skew	51.4
Green	February	24.4	50.5	35.9	Y	7.7	Primary skew	51.8
Orange	April	7.5	52.8	100	Y	5.3	Strong primary skew	53.4
UC = uncategorised.								

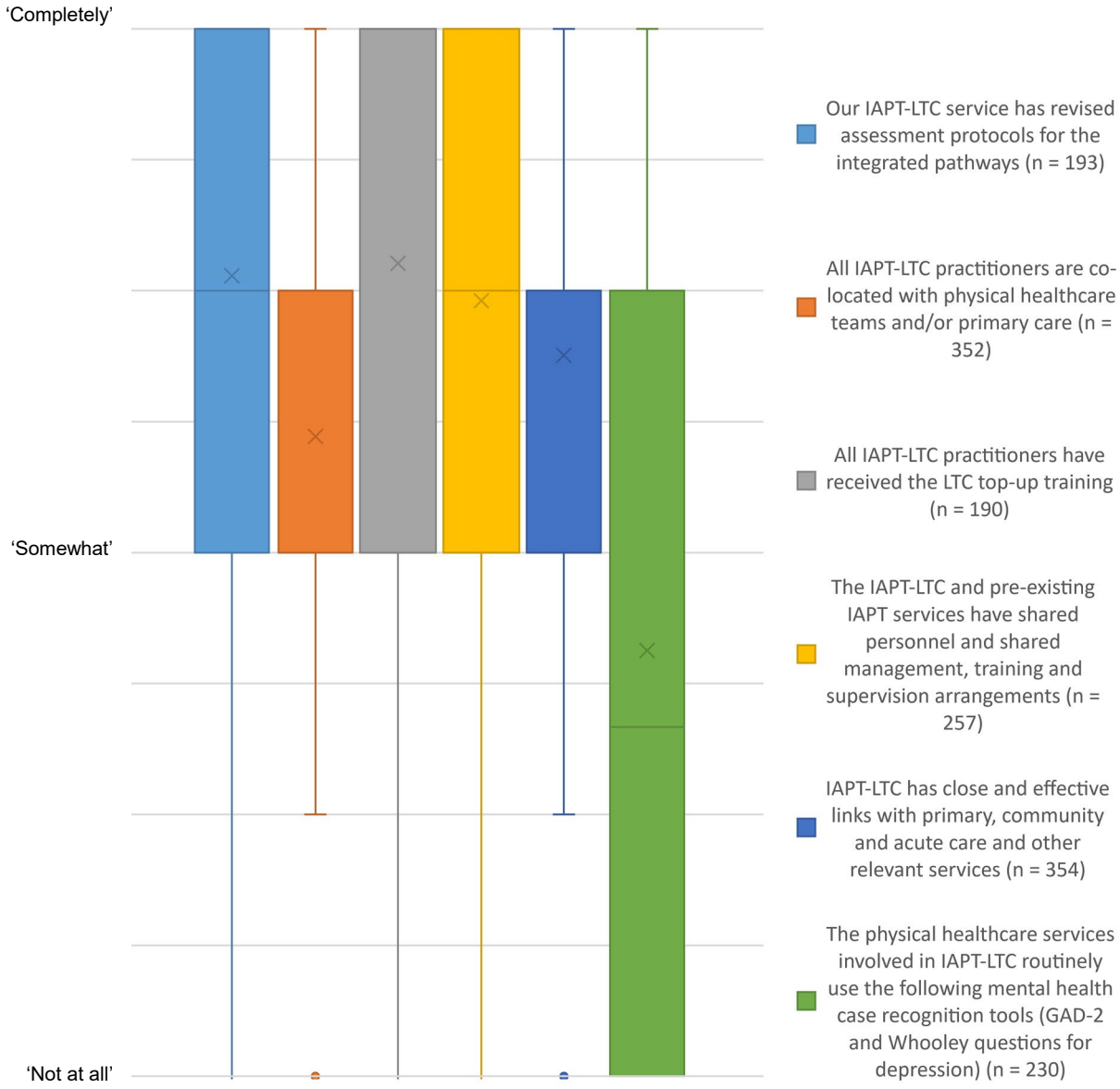
How well did sites deliver against IAPT-LTC service criteria?

In order to gain an accurate picture of how the IAPT-LTC model was being delivered, we surveyed staff with varied involvement in IAPT-LTC services. We asked them to consider key IAPT-LTC delivery criteria and assess how well their service matched them on a 5-point scale, from 'not at all' to 'completely'. The criteria related to:

- use of case recognition tools
- revised assessment tools for integrated pathways
- co-location
- LTC top-up training
- shared arrangements with core IAPT services
- close links with services outside IAPT.

Responses are presented in Figure 7.

Figure 7: Staff responses to 'To what extent do the following descriptions match your current practice?'



Note: The bars represent the interquartile range (where 50% of responses lie). The upper and lower limits are represented by the vertical lines, with outliers marked as coloured dots. The x marks the mean response. Responses to the case recognition tools 'Mini-Social Phobia Inventory' and 'other' were excluded due to low response counts.

As can be seen from Figure 7, staff views on assessment, top-up training and integration with existing IAPT services were very positive. Co-location and working relationships with physical healthcare services were also generally positive. However, there was a much less positive view of the use of case recognition tools.

Working with other mental health services

A key feature of IAPT-LTC services described in the IAPT-LTC guidance[5] includes 'close links with primary care, specialist mental health services and employment support' and 'close links with existing IAPT services, core 24 liaison mental health services and clinical and health psychology services'. While examples of working with physical healthcare services have been evident throughout the evaluation, evidence for links with other psychological services have been more limited.

There were a number of examples of working with clinical and health psychology teams, particularly in terms of supervision and training. These are further explored in 'Working with new teams and systems' (p. 38). There were also examples of working with other secondary mental health teams:

> *Following the development of our integrated care pathway for diabetes we are collaborating with colleagues in secondary mental health care to deliver a training programme for colleagues in physical health settings, educating them on the remits of our services and referral pathways. We anticipate this will facilitate referrals into the wider pathway.*
>
> (IAPT clinical lead)

In contrast, there were few examples of significant joint working between IAPT-LTC and liaison mental health services. In part, this arises from the inpatient or emergency focus of liaison mental health services, whereas the majority of IAPT-LTC services had stronger links and greater presence in primary care and outpatient and community services. For example, two services attempted to establish the IAPT-LTC model within emergency departments, but this proved unsuccessful. In other cases, links were established with liaison mental health teams; for example, liaison mental health and IAPT-LTC teams worked together to develop a joint integrated pathway, but considerable differences in the severity of disorders in the service user population in the liaison mental health teams presented a challenge to more integrated working.

The limited engagement of liaison mental health teams with IAPT-LTC services was confirmed by the small number of responses from liaison mental health staff in our survey (<1%). One possible explanation for this is the limited coverage of both liaison mental health and IAPT-LTC teams in acute inpatient settings. A 2018 report by the Royal College of Psychiatrists' Faculty of Liaison Psychiatry on integrated care for LTCs/MUS[20] reported that of the 80 hospitals that responded, only three had hospital-based IAPT-LTC services, one of which was a Wave 1 service. The site reported positive views of joint working but challenges arose from the absence of shared electronic record systems and the lack of appropriate clinic space within the hospital.

Part 2 summary

- The established services varied considerably in the number of staff, ranging between 3 and 35 WTE. Less than 50% of IAPT-LTC staff had received the top-up training by June 2017.
- Half of the services had strong links with core IAPT services.
- The mean number of LTCs that services worked with was 6.4, which may be higher than expected, but could be accounted for by the fact that the majority of services were co-located in non-condition-specific settings (e.g. primary care).
- The most common presenting disorders were diabetes and cardiovascular disease. A significant number of services also worked with service users presenting with chronic pain or musculoskeletal conditions.
- The criteria for acceptance into the services also varied considerably, with some not in line with existing IAPT-LTC policy. For example, of the 22 sites, 11 specified that the LTCs must interact with mental health, with some determining the direction of interaction.
- Services also differed in the proportion of HITs and PWPs. Again, it is not possible to identify a specific pattern, but the proportions varied, from having all HITs to having a majority of PWPs. The average proportion of PWPs was 41.9%, which is not far off the 40% PWPs recommended in the national guidance.
- Although the time of service commencement varied, the issues which accounted for this were not always within the control of IAPT-LTC services (e.g. release of funding). Nor was this an indication of poor performance, as evidenced by the fact that some late starters surpassed other services in terms of targets.
- A major problem identified in the programme – the limited use of case recognition tools – was perhaps not within the control of the IAPT-LTC services. Case recognition tools were intended to promote better recognition and better referral to IAPT-LTC services. Improvement in this area should be considered a priority for future IAPT-LTC implementation.

Part 3: Staff experience

Here we explore the experience of staff during the period September 2017–February 2018, and combine findings from the staff survey and interviews. We first look at staff experience of the pilots, and then describe key themes that emerged from staff feedback.

The implementation of Wave 1 services involved the work of hundreds of staff, both in delivering IAPT-LTC services and in working alongside them. Staff experiences are important in understanding what happened in Wave 1, and what future services should consider in their own implementation. Staff involved included commissioners, service leads, managers, clinicians, support personnel and affiliated healthcare workers. They reported on both organisational and personal factors that affected their experience.

What helped implementation?

We performed an initial word cloud analysis of survey responses to identify possible themes associated with facilitation of, and obstacles to, implementation, and analyse them below.

Figure 8: Word cloud of staff-reported factors that helped the implementation (252 responses). Produced at www.wordclouds.com

Figure 8 shows that the most frequent factors reported as helping implementation were related to people. Specific roles were mentioned, but also teamwork, good working relationships with other teams, and support from those not working

directly in IAPT-LTC services. When analysing staff responses, words such as ‘leadership’, ‘links’, ‘support’, ‘teams’, ‘supervision’ and ‘management’ featured heavily. These are some of the staff comments:

Service lead:

Identifying lead clinicians who believed in the value of the service and were able to understand the value and limitations of an IAPT service.

(IAPT-LTC service manager)

Leadership:

Strong partnerships with commissioners and key stakeholders. High level of confidence in local leadership and strong track record of performance of IAPT service sustained over many years.

(Physical healthcare practitioner)

Service links:

Good links and cross-working within and across the local clinical and health psychology department.

(IAPT-LTC service manager)

Support:

Support and encouragement from the national team and recognition that this was a tough challenge.

(IAPT-LTC service manager)

Teams:

Co-locating with the physical health teams and developing sound working relationships. Delivering training to physical health teams around case recognition and likewise they have delivered training to our services.

(IAPT-LTC service manager)

Supervision:

LTC top-up training, supervision and care pathways for the LTC cases.

(High-intensity therapist)

Management:

Management focused on innovation and being brave enough to try something new.

(High-intensity therapist)

What hindered implementation?

Figure 9 shows that the most frequently reported factors which hindered implementation were related to logistical problems.

Figure 9: Word cloud of staff-reported factors that hindered implementation (244 responses). Produced at www.wordclouds.com

Every task within the complex practical arrangements of setting up new services was mentioned: clarification of roles, setting up data-sharing, recruiting appropriate staff and establishing referrals within a new pathway. Changes were seen as frustrating, along with problems with clarity and communication. The words ‘space’, ‘lack’, ‘time’ ‘data’ and ‘questionnaires’ featured heavily in staff comments. Some of the individual comments were:

Space:

Difficulties obtaining room space for co-located clinics with healthcare teams.

(High-intensity therapist)

Training:

A lack of top-up training and clear instruction from senior management.

(High-intensity therapist)

Time:

Time pressures to gather information quickly, accompanied by additional pressure for positive results within such a limited time frame. It's difficult to establish a service under such pressure.

(High-intensity therapist)

Questionnaires:

Too many questionnaires to complete at initial screening, and questionnaires being too long, containing non-relevant questions.

(High-intensity therapist)

Interestingly, 'training' was one of the most frequently mentioned words both in what 'helped' and in what 'hindered' implementation. People's experiences of the availability and quality of training varied. For some, the most helpful factor in implementation was the 'high-quality top-up training' they received, while others found 'training at university was not very helpful and didn't prepare us for the role'. However, it is clear that staff felt good-quality training was important and should be readily available.

There were several factors that one service viewed as positive and another service viewed as negative. One example was in the relationship between IAPT-LTC and core IAPT services, where some found the opportunity for LTC training in core IAPT to be beneficial, whereas others felt that the expansion of IAPT-LTC services placed higher workload demands on practitioners. Staff had varied experiences. We identified themes that occurred frequently or that were particularly important to staff and then explored these in staff interviews.

Themes

The themes broadly encompassed three elements: the implementation process, working with new teams and systems, and working with service users with LTCs/MUS. These are described below.

The implementation process

Theme 1: Team enthusiasm, knowledge of LTCs and clear steer from leaders enabled the process

Enthusiasm for the pilot and a strong belief in the need for expansion into LTCs/MUS was widely reported as driving implementation forward. There were frequent examples of individuals with experience of (or enthusiasm for) working in LTCs/MUS enabling and driving implementation.

[We had] an amazing high-intensity therapist who used to be an [occupational therapist] … Without this knowledge and experience I felt we would be very much further behind where we are now.

(IAPT-LTC service manager)

Specifically, these individuals were able to lead on the innovations necessary to the pilot, such as establishing new pathways. Leaders who had previous

experience in LTCs/MUS or physical healthcare acted as supervisors and were very effective at linking in with other teams.

> *A lead allocated to LTC [meant that we had a] nominated professional that staff are aware of to discuss cases with [and] a professional to liaise with physical health teams and build sound links.*
>
> (IAPT-LTC service manager)

Core IAPT staff, IAPT-LTC staff and physical healthcare practitioners reported that having a clear steer from leaders helped their understanding of the pilot, service criteria and working arrangements. Having dedicated leads for the LTC team, or for each condition or pathway, was also reported as being useful.

> *We received strong and clear guidance from our service lead. Appointing a team lead for LTC has been positive, and impactful.*
>
> (IAPT-LTC service manager)

Theme 2: National support helped services to learn from each other

Members of IAPT-LTC service management and commissioning reported that national workshops organised by NHS England had been helpful during implementation. The impact seemed to extend to clinicians and to positively affect staff morale.

> *[NHS England] conferences […] seem to be really useful […] management will go, [and feed back] information from other services, what's worked well, what hasn't worked well. So, there's sharing good practice […] but it's also reassuring to know that other services are sometimes having the same problems that you are.*
>
> (IAPT-LTC service manager)

Services reported using Yammer, an online platform provided by NHS England, which was used to share materials and best practice examples and learn from experiences. They also met in person.

> *Meeting with our neighbouring services who were also Wave 1 pilot sites helped.*
>
> (IAPT-LTC service manager)

Generally, conversations between services [for instance, on] Yammer, so going on there and seeing what other people are up to and what they've found works well.

(IAPT-LTC service manager)

Use of Yammer has enabled sharing of info and best practice examples.

(IAPT-LTC service manager)

Theme 3: Being a pilot site had its difficulties: there were changes to protocol, a need for a lot of communication and time pressures

Most staff groups reported that changes to the protocol had an impact on their work.

There have been a number of changes regarding classification of LTC. In the early stages this possibly hindered the clarity with which appropriate service users were identified.

(IAPT-LTC service manager)

At the very beginning it was, 'Okay let's expand the IAPT service into LTCs' […] We submitted a bid [and then were told that we also need to] recruit all these trainees.

(IAPT-LTC service manager)

Time spent solely on communication was much longer than for existing services.

For each condition (pathway) you can imagine the number of stakeholders you have. […] the traction comes from the relationships and where you get buy-in, and room space, and so on. But you've got to do enormous amounts of work across all those conditions to try and make that work in a very tight time frame.

(IAPT-LTC service manager)

Dealing with this amount of communication, alongside the logistical tasks, was stressful within the tight time frame.

So there is a lot of high speed fast and furious, everyone trying to do everything for tomorrow. And the practical side of it is a real challenge, because you're trying to get rooms in places where they'd say 'yes, we've got rooms' and then you'd find that something may've happened and they

need those rooms for something else and it's all under very tight time frames at the same time across many different providers.

(IAPT-LTC service manager)

Theme 4: Availability and quality of top-up training was mixed

When asked what helped and what hindered implementation, top-up training featured heavily on both sides.

Attending the LTC top-up training and being able to share this information within the core team was helpful.

(High-intensity therapist)

The training was mostly good. Since I have experience already, a lot was a refresher which is still very helpful and a good way to make sure I was on track with the national way of working. I also did learn new things.

(High-intensity therapist)

Poor training for low intensity CBT workers meant that we learnt nothing new to equip us for our new role as specialists in LTC.

(Psychological wellbeing practitioner)

A common theme was that the training provided knowledge about LTCs (though limited for MUS), but did not provide much in the way of adaptations to treatments.

I felt that there was a lot of emphasis on the condition rather than how we would work with it.

(High-intensity therapist)

Training was most beneficial when combined with personal learning and effective supervision.

The top-up training was helpful to an extent. It was very brief in content, but guided me to understand what areas I would need to consider and practise. I used the course as guided self-approach and used my own personal time to further my understanding and increase my confidence. I also effectively use supervision to continue my learning of the topics covered in the course.

(High-intensity therapist)

Theme 5: Good networking was crucial

Good networking meant reaching out and making contacts with other services, as well as capitalising on existing links and relationships. Leaders have emphasised that key individuals and links with other services have been crucial to developing pathways in the planning stages:

> *We've had key people like the long-term health commissioners [...] She was in a transformational role […] where it's worked best is where she's done that work behind the scenes already across the different acute and community providers […] She would have already had key meetings with the key leads in those teams and services and evolved a pathway for service users and then brought us in as a key player in that. So […] where it's worked reasonably is when you've had someone like that and really functional teams.*
>
> (IAPT-LTC service manager)

Good relationships with commissioners were also often key in involving other providers where there were no direct links:

> *You need influence. I think without [the commissioners] we would really have struggled to set things up because you needed that influence, that knowledge of the wider picture really.*
>
> (IAPT-LTC service manager)

Clinicians delivering care in established pathways still had to maintain a focus on networking:

> *We recruited staff who will sit in a team and communicate and talk and work in that team […] this talking and liaising and standing up in front of teams and telling them what they do […] It's not everybody's cup of tea.*
>
> (IAPT-LTC service manager)

Working with new teams and systems

Theme 1: Ways of working differed in each physical health setting

IAPT-LTC clinicians adapted their ways of working to integrate within different physical health settings. Clinicians often used existing systems within the physical health setting to book service users. Joint working and detailed collaboration was sometimes possible to a greater extent in co-located acute clinics than in GP settings or emergency departments. To illustrate this, here are examples of IAPT-LTC practitioners' experience in five different settings: (a) GP

surgery, (b) musculoskeletal, (c) cardiac rehabilitation and (d) diabetes clinics, and (e) an emergency department.

a) GP surgery:

My diary is usually already set up for me. If the GPs want to book in a new service user for an assessment, they will look at my diary, and where there is a blank slot they'll book somebody in. If I'm booking somebody in for treatment, I will book it in myself. And then, in a day, I'll see about five to six service users.

(Psychological wellbeing practitioner)

b) Hospital musculoskeletal clinic:

…originally […] a practitioner would go in and sit in the consultant clinics and basically add on an assessment to the consultant's assessment. And really it didn't work… [Now,] the [musculoskeletal] multidisciplinary team clinic [has a PWP], an advanced physio practitioner and a pain nurse. (In one clinic) we see three service users each.

(IAPT-LTC service manager)

c) Cardiac rehabilitation clinic

At first we were just trying to […] invite [the PWP] into the room [during the appointment with the cardiac nurse] but then it ended up being a longer appointment. So now PWPs would hang around the clinic and introduce self-assessment 'quizzes' – just a kind of light touch tool: 'How are you doing? How are you feeling?' rather than a 'Here is a mental health assessment' […] It's kind of changing the language a little bit so it becomes part of normal healthcare.

(IAPT-LTC service manager)

d) Diabetes clinic

One of the things that we do is: [have the nurses] give one of our questionnaires, with an information sheet at the beginning to everybody. The other way is: having [the PWP] in the clinic and say to the nurses [and consultants], 'If you've got any concerns with anyone's mood or anything, just send them in to me and we can have a chat'.

(Psychological wellbeing practitioner)

e) Emergency department

[An emergency department] seemed like the perfect place […] so we really, really tried hard to be a part of it and to intervene […] then, towards the end, it wasn't working, it wasn't feasible, we were just there doing

nothing, really […] we had nobody to see […] We're not based there anymore.

(Psychological wellbeing practitioner)

Theme 2: Implementation was smoother with support from psychology services, or where there was an obvious gap in psychological provision from liaison mental health services and clinical and health psychology services

There were several instances where support from local health psychology teams was helpful to the implementation. Some sites felt that the lack of support from other psychological providers presented a barrier.

Good links and cross-working with and within the local clinical and health psychology department [helped us].

(IAPT-LTC service manager)

The local health psychologists […] supervise our CBT [therapists] and then our CBT [therapists] supervise our PWPs, which works really well.

(IAPT-LTC service manager)

I suppose two of their concerns: one is that we take service users that they are working with that maybe we ought to be working with. And two is that we start working with people that we then need to step up and they haven't got the capacity to treat. Hopefully […] that will improve.

(IAPT-LTC service manager)

Theme 3: Proactive IAPT-LTC staff were effective at building relationships within new pathways

The majority of comments from physical healthcare staff on what helped implementation pointed to some form of communication with the IAPT team, mostly joint meetings. Meeting the practitioners in person was important in 'putting a face to a name'.

[The PWP] came to one of our team meetings and explained to everybody what she did. […] [It was] in a setting where you're not distracted so people could sit and listen and ask any questions if need be.

(Physical healthcare practitioner)

IAPT-LTC staff were willing to come out to locality to meet [physical healthcare] staff and introduce the IAPT service to our service.

(Physical healthcare practitioner)

A few respondents also mentioned being co-located, having joint training or supervision and co-delivering treatment groups. IAPT-LTC staff appreciated opportunities to ask physical healthcare staff questions about service users and LTCs/MUS.

> *Sometimes, if I don't know, because I've not heard of some of these conditions, ever, and I try to google it and it just doesn't make sense! So, I can ask the GP…which is really helpful, because then I can feel more confident when I'm talking to the service user.*
>
> (Psychological wellbeing practitioner)

Theme 4: It could be difficult to identify who to initially contact in other services or trusts

It was often difficult to identify individuals to contact in the other services or trusts when developing new pathways and when attempting to link data.

> *A lot of the problem […] is actually finding the right person to actually make any kind of progress.*
>
> (IAPT-LTC service manager)

> *Initially, it was identifying key people to be able to work with, and not already working within particular healthcare settings it's really difficult to know who's the lead, because they have leads for this and leads for that. And then just getting to the right person and […] where to pitch it.*
>
> (IAPT-LTC service manager)

One service had an innovative approach to finding a person to contact:

> *You can't always find who you want. I trawled and trawled and trawled on the hospital website but you find it's outdated and they've left, or they've moved sector or they've moved position altogether, and you're emailing and you don't get a response. [We took] the direct route in, just straight into Twitter. […] From there he got us in, and we had meetings with quite a few lead people.*
>
> (IAPT-LTC service manager)

Working with service users with LTCs/MUS

Theme 1: Specialist supervision was valued

More supervision, with supervisors experienced in LTCs/MUS, was seen as beneficial.

> *…the most important person is our supervisor. She's also trained in LTC […] and […] is already co-located in a surgery, so she had experience in all avenues that we needed. Sometimes you can't take [a problem with an LTC service user] to a core practitioner and you can't take certain questions to your normal supervisor or to just any other senior staff.*
>
> (Psychological wellbeing practitioner)

> *The need for training and LTC-specific supervision for the high-intensity therapists has been way underestimated.*
>
> (High-intensity therapist)

Supervision from clinical and health psychology teams has benefitted service implementation and when working with service users with complex needs.

> *There needs to be better provision and access to step 4 services for LTC clients (which vary from location to location).*
>
> (High-intensity therapist)

> *We need more funding for step 3 core and step 4 [as there are] too many inexperienced LTC trainee PWPs.*
>
> (High-intensity therapist)

In addition, IAPT-LTC practitioners often commented that having the same amount of time for clinical contacts as in core IAPT made the work challenging. Others appreciated being able to work more flexibly.

> *The flexibility of the way in which the LTC team work with service users, e.g. home visits, has been an advantage.*
>
> (IAPT-LTC service manager)

Some have proposed that having a mixed core and LTC IAPT workload may lessen the impact on practitioners.

It would also be more effective to ensure that there is perhaps a mix of core and integrated service users to avoid burnout.

(Psychological wellbeing practitioner)

Theme 2: Practitioners felt recovery rates on the minimum dataset would be lower for IAPT-LTC service users

Despite the fact that national outcome data show equivalence of outcomes between core IAPT and IAPT-LTC services, there was widespread concern that the new services would be less likely to meet agreed recovery rates.

[I was] concerned that LTC will affect recovery rates as may not expect same recovery in terms of the core IAPT minimum data-set.

(High-intensity therapist)

Recording it on questionnaires is just really difficult and it's just not representative half the time. We sit in a session with a service user and they're a completely different person and they're telling you all this really good stuff that they're doing, but then they haven't met recovery on the minimum data set.

(Psychological wellbeing practitioner)

Things are changing and [service users are] getting the benefit, but the questionnaires are not showing that, so that can be quite difficult.

(Psychological wellbeing practitioner)

It is interesting to contrast the concerns of staff about the outcomes of people with LTCs/MUS in IAPT and the available data. It could be that these concerns arise from uncertainty about the new ways of working (possibly related to delays in training and supervision) or limited direct experience of working with people with LTCs/MUS. This would be an interesting issue to raise early in future training programmes.

Part 3 summary

This section incorporated information from the staff survey and interviews to explore experiences of individuals implementing and delivering the IAPT-LTC model. It focused on what helped and what hindered staff in terms of their work. A total of 5,515 staff completed the questionnaire. Teamwork, effective relationships among healthcare teams, strong networking and access to health psychology services were generally all rated highly and were associated with more effective implementation and development of pathways.

Themes emerging from the surveys and staff interviews demonstrated how issues were resolved throughout and how the services operated in practice. Most measures and feedback indicated that implementation went well overall, and that the IAPT-LTC services are operational and reaching their intended population. The qualitative work highlighted areas for consideration in developing future services.

IAPT-LTC practitioners felt that leadership from senior clinical staff was important. Senior staff were responsible for ensuring positive working relationships with healthcare commissioners. Services also appreciated the support provided by the national team. Supervision and training were also highly valued, although some raised concerns about the timing and quality of training. Perhaps the most significant problem experienced by many IAPT-LTC services was acquiring suitable space to allow co-location with physical healthcare teams.

There was some concern about potentially poorer recovery rates of individuals presenting with LTC, but the outcome data from the Wave 1 services did not bear this out. There appeared to be some uncertainty about using LTC-specific assessments because of the additional time needed to complete them.

Part 4: Experiences of people receiving care in Wave 1 IAPT-LTC services

Some of the first people to be treated within IAPT-LTC services agreed to share their experiences of care. We interviewed four individuals with different LTCs and mental health needs. They came from different settings, including GP surgeries, community clinics, LTC specialist clinics and hospitals. In their care they valued:

- having an opportunity to talk about their mental health problems
- receiving help from a practitioner who understood their LTCs/MUS and from peers within a group setting
- being offered interventions in familiar and convenient locations.

Most importantly, all saw clear benefits of the service in terms of managing their conditions and overall quality of life. We include excerpts from the interviews illustrating what IAPT-LTC care looked like. For reasons of confidentiality, identifiable details were removed or substituted.[21]

Reasons for seeking help

> *I have been diagnosed with diabetes a few years ago and I was on oral medication at that stage. [I was] introduced to [the IAPT-LTC practitioner] by the specialist nurse when I was due to talk about moving on to insulin. […] it was really quite daunting […] I felt my condition was controlling me, rather than me controlling the condition.*

> *I have [an LTC] and for the first few years or so it was fine but then it got to a point where I just kept getting [complications and pain] and then it lowered my mood. Last year, I went through a bit of a bad time where I tried to take my life so I ended up in hospital. I took [my medication] on and off and I was just at a low point in my life basically.*

> *I started feeling quite poorly, well, probably a few years ago, but didn't really know what was wrong. I had a lot going on. And I went to the doctors, and I just got the usual, you know, 'Take some paracetamol'. But I started suffering really bad headaches. And I already knew that I had [a different condition] but I knew that there was more. […] I was dragged around every different hospital in the area. So eventually, after lots of toing and froing and [no help from doctors], I eventually got somebody to listen to me.*

> *I was going through a bit of depression after my heart attack. My dad died at my age of the same thing, and I'd got it into my head that I was going to die […]. I was very short-tempered; I was very restless, I couldn't do anything; I just didn't want to do anything. But I didn't want to die.*

Routes into IAPT-LTC

My nurse from the doctor's surgery recommended [the IAPT-LTC service]. She asked me questions and then gave me a questionnaire […] I didn't realise that I was actually depressed until I'd filled them in.

The [IAPT-LTC practitioner] came to see me [at the hospital] and she spoke to me about the service. When I [felt slightly better] I went to see them and it really helped me.

It was the senior practitioner [at my GP surgery who] suggested that I contact the IAPT team. There wasn't [an IAPT practitioner at the GP, so] I had to sort of ring outside of my practice. The [IAPT service] was really easy to find […].

[The IAPT-LTC practitioner] was sitting in on the clinic [...] And it was good to have met her at the clinic because it just felt there was somebody else you could turn to other than the really busy specialist nurses [...].

Experience of IAPT-LTC care

We planned on having weekly calls, where we would talk about particular issues and almost put systems in place to try and get me back to my old self. It gave me the opportunity to explain how I was feeling and the impact it was having on my life. [The treatment involved] talking about things I might be doing which would get me out the house with my [partner] or with my children and so on; talking about [complications]. […] It was about the reality and realism of it, rather than my just perceived ideas of what they were going to be. To me that was absolutely key.

I thought, 'Well, if I go and it doesn't help, then at least I can go back to them and say, "Right, that's not worked".' But it did. It is helping me a lot.

The one thing which was brilliant [was the IAPT-LTC practitioner's] knowledge of [my long-term condition] because it was as good as speaking to a specialist nurse […] She really got it and really understood the issues and how they were impacting on my life.

Impact

[My treatment at the IAPT-LTC service] gave me confidence to manage [my condition] much better. […] things have continued to roll on since then […].

If I hadn't […] had that service I think I still would have been going through the depression. Me and [my partner] wouldn't have survived anyway, because you take it out on your nearest and dearest […].

I was trying to look for work. Nobody was helping me. [..] So when I went to the long-term conditions group, and they gave me lots of pointers, and it gave me the confidence to sort of say 'Well, I'd like to – I want a job'. But I know I could only work part-time. [The IAPT-LTC practitioner] mentioned that the IAPT team have put in employment people in place. And actually that would have been really useful to me.

I'm a [medical professional] and when I was first diagnosed with [my LTC], I went down the route of redundancy. […]. I then regretted having left […]. Recently I've reapplied to go back and have been accepted. [I] don't think I'd have had the courage or probably the desire to do it [if it had not been for my IAPT-LTC practitioner], which was crazy because […] I love my job.

Part 4 summary

The service users we interviewed had a positive experience during treatment, which had an impact on their everyday functioning, work and family lives, and their ability to manage their physical health conditions. It is important to note that some people struggled to have their mental health problems recognised before coming into this pathway. The benefit of this model was that service users felt that IAPT-LTC practitioners generally had an understanding of their conditions, which contributed to a feeling of confidence in the treatment and management of their symptoms. Sharing of expertise, joint working practices and seamless links between services were evident in the service users' accounts, which highlighted the impact these factors have on care.

Part 5: Discussion

Choosing the pathway

NICE guidance[5] recommends that services should conduct a review of any established local links with disciplines relevant to IAPT-LTC services. Sites that used these links (for example, with clinical and health psychology) were quicker to implement their IAPT-LTC service than others. Although the model was applied successfully in different LTC pathways, some settings were more suitable than others. For example, fully integrated joint working was achieved in specialist clinics, pathways were quickly established in GP surgeries (but with less joint working), but attempts to integrate IAPT-LTC services into emergency departments were not successful. Sites that considered the pace of the setting and adapted to existing systems in that setting were able to implement and start seeing service users quickly.

> *I think because [a GP surgery is] a more structured setting anyway, compared to A&E, which is very floating about. […] For myself, both of my [GP] surgeries, they've allocated a room for me, so I know every week where I'm going.*
>
> (IAPT-LTC clinician)

It was important to engage physical health staff before identifying a possible pathway, or as soon afterwards as possible. Some sites did not do this and later found that the pathway was difficult to establish or that referrals were very low.

Criteria for offering treatment

We have found that the Wave 1 IAPT-LTC sites varied in terms of the criteria they used to determine eligibility. All services used the standard core IAPT inclusion criteria plus the presence of LTCs/MUS. However, 50% of sites narrowed the criteria further, specifying that there had to be an interaction between the person's mental health and their LTCs/MUS. This has potentially significant implications for the number of people who can be helped or accepted to treatment by IAPT-LTC services. As these criteria are not in line with national policy, they must be addressed and clarified as new IAPT-LTC services are established.

'Starting small'

A phased implementation was useful in several sites. Sites started with one pathway or one LTC and later added another. Some also 'started small' within a pathway, for example getting established in one location before extending to others. It allowed for clarification of referral pathways and consolidation of joint working practices, along with effective use of senior clinician and management time.

I think [in the new surgeries] we sold it differently, I don't think we were as rushed with our delivery […] We also went in with a better offer because we had some learning and some evidence. So we sold it to them as something that they need.

(IAPT-LTC service manager)

Data-sharing and systems agreements

Effective data-sharing arrangements and, where possible, integration of shared records systems would support joint working and care planning. In some cases, access to primary care electronic medical records did support integration but had some limitations. Therefore, addressing the issue of data-sharing and record systems is an important first step in the development of new services. This proved challenging in many sites and took considerable time. In the Wave 1 sites this was complicated by sharing agreements for local evaluations rather than the development of the clinical service per se. This issue may not be relevant to future sites, unless they carry out evaluations using external data (e.g. from CCG). Another barrier involved granting access for IAPT-LTC practitioners to systems used by physical healthcare staff, to enable close integrated working. A successful set-up often involved senior staff in the physical health provider service arranging access for IAPT practitioners.

Reaching out

Engaging with other mental health providers in the area

The implementation guidance for the IAPT-LTC pathway emphasises the importance of reaching out to other mental health providers: 'It is critical that those implementing the IAPT-LTC pathway are aware of the valuable contribution of these services and establish clear arrangements for joint working' (p. 7).[5] The experience of pilot sites supports this. Sites that liaised with other teams (such as clinical and health psychology and liaison mental health) early on, before any other preparation or planning, were able to adapt to the needs of other services and form excellent working arrangements. They were able to discuss and agree referral pathways that would allow both services to meet the needs of service users effectively. Some sites expanded into services with no psychology provision, and this went smoothly. In some sites, lack of engagement of other psychological providers presented a barrier to implementation. Future services may find that reaching out to other psychological providers is crucial to the smooth establishment of an IAPT-LTC service.

Flexibility

There was no 'one size fits all' solution, and services adapted to their local healthcare context during the implementation process. All sites experienced local logistical challenges, which took time to resolve. During this period, proactive and strong leadership drove the process forward. Some staff members were frustrated that plans seemed unclear and were liable to change, although in a pilot this is perhaps inevitable, particularly in a complex healthcare system in which there is increasing demand. After the implementation phase, services moved into something more closely resembling normal delivery, although sites

were continuing to pursue optimal ways of working a year after delivery had started.

Communication

Communication was particularly important given the flexibility required in the implementation process. Good networking (that is, reaching out and making contacts in other services) was crucial. This was not always straightforward: staff members reported not knowing whom to contact when making new arrangements, particularly when working across trusts or CCGs. Sites mitigated some of this difficulty by initially building on existing links, so that quick expansion could be achieved.

Targets and time scales

Given the need for flexibility and the unpredictable nature of the implementation process, staff were concerned about meeting access and recovery targets. There were examples of sites making unsustainable decisions in order to meet targets in the short term, and this hindered the implementation process. A cluster of services started delivery later but actually performed very well after this period. It may be that the additional preparation time allowed them to meet targets as soon as delivery began.

Physical health staff using case recognition tools

The specific case recognition tools (GAD-2, the Whooley questions for depression and the Mini-Social Phobia Inventory) suggested in the IAPT-LTC and NICE guidance[5,22] were not used consistently across pilot sites. Some sites used other tools that were already established within physical health settings (such as the Hospital Anxiety and Depression scale[23]). It is possible that adapting to existing systems was a good way to implement quickly, but the question remains about the utility of the measures. Other sites developed or adapted tools to remove language associated with mental health problems, such as depression and anxiety, which they felt discouraged some people from seeking help. This was in an effort to encourage referrals.

Although use of case recognition tools was low, there was some evidence that the presence of, and discussion with, IAPT-LTC staff had begun to change physical healthcare staff behaviour. Healthcare staff reported enquiring about the service user's mental health verbally and referring them to a co-located IAPT-LTC practitioner for a further informal chat. There was also a feeling that introducing new tools was not possible given time constraints:

> *I don't think they've really got the time to be having those conversations with people, because you can't really just give someone a questionnaire and not say anything […] And obviously we've got the information on the front, but the service user is bound to say, 'Okay, why are you giving me this. What's going on?' So, to do it properly, it does take a few minutes, at least.*
>
> (Psychological wellbeing practitioner)

Evaluation limitations

There are several limitations to this evaluation. Some of the issues we have explored may be specific to the first pilot sites. For example, availability of LTC top-up training hindered the implementation of services in Wave 1, but may not be important for future implementation as higher education institutions gain experience in offering and delivering this training, and as time frames for implementing new services are less pressured.

The data we have used in the evaluation are limited in a number of ways. Data quality was mixed because data linkage systems were often in the early stages of development. However, we cross-checked findings with a variety of sources where available. We used a combination of data types, for example: prospectively collected monitoring information, retrospectively collected staff experience measures, and quantitative and qualitative data from varied sources (publicly available national data, service information from service leads, experience of individual staff members within and around IAPT-LTC services, and the experience of service users). Although individual issues with data quality must be acknowledged, the triangulation of these data types and sources increases confidence in findings.

In this evaluation, we mainly comment on the process of implementation and the factors that helped and hindered it. At this stage, it is difficult to be certain about the impact of the implementation on the overall outcomes of the IAPT-LTC programme.

Conclusions

From an implementation perspective, the Wave 1 IAPT-LTC programme can be regarded as a success. Pilot sites were able to establish IAPT-LTC services and start seeing service users by June 2017, although a number of sites experienced a significant delay in fully establishing the service. The presence of clear national guidance, support from the national IAPT team (pulling together core IAPT experience and specialist LTC knowledge), and the development of clear protocols for the delivery of services, coupled with agreed expectations about joint working and co-location of services, provided an important basis for success. The speed of the implementation process was dependent on local challenges, but all sites eventually performed well in engaging staff, encouraging referrals and setting up sustainable services. There was some evidence that where all objectives were met (e.g. effective implementation, ownership of the programme) this was associated with better performance, particularly in terms of a greater number of people taking up treatment.

Sites were often located in primary care and varied in the types of LTCs/MUS they saw. Staff understood and were enthusiastic about the IAPT-LTC model, and implemented it well. Those who used the service found it to be highly valuable. We hope that future sites may learn from the experience of pilot sites when implementing new services. Commonly experienced problems, such as delays in sign-off (often linked to uncertainties about funding or related decision-making processes), the availability of space, data system integration and the timing and quality of top-up training can be resolved in future sites with adequate planning and support.

Key considerations for future services

Establishing the service

- Build on existing links with other services and engage all stakeholders, not forgetting core IAPT and specialist mental health services.
- Establish a programme of training and a detailed timetable for the delivery of training as part of the agreed set-up plan. This may require flexibility from higher education institutions in the delivery of training.
- Joint education and training programmes (both with IAPT-LTC and core IAPT services and across the healthcare system) and CCG-wide education and information sessions help build ownership of the system and the local case for change.
- Early attendance and participation in multidisciplinary meetings facilitates future effective joint working.
- Allow time and seek senior support for the development of pathway protocols and to secure co-located space (particularly in acute care settings).
- Ensure IAPT-LTC staff have access to relevant electronic record systems.
- Consider an initial narrower focus of a smaller number of LTCs/MUS pathways before branching out.
- Build strong links with clinical and health psychology and liaison mental health services to avoid unnecessary waits for assessment and treatment.
- Clearly reinforce the criteria for access to treatment (as set out in the IAPT-LTC guidance) in the service so that people with LTCs/MUS are not restricted from receiving care (i.e. ensure services do not specify an interaction between mental health and LTCs/MUS as a service access criterion).
- Review how best to implement case recognition tools with physical healthcare colleagues, with consideration for the time and resource involved in administering them.

Training and support

- Agree timetables and secure training spaces as a priority, preferably before the service is fully operational, as this may determine how many people the service can treat, and when.
- Reinforce training with access to high-quality, experienced specialist provision.

Definitions

Abbreviation	Full term
HIT	high-intensity therapist
IAPT	Improving Access to Psychological Therapies
IAPT-LTC	Improving Access to Psychological Therapies for people with Long-Term Conditions and Medically Unexplained Symptoms
LTC	long-term conditions
MUS	medically unexplained symptoms
PWP	psychological wellbeing practitioner
WTE	whole-time equivalent

References

1. Community and Mental Health Team. Psychological Therapies: Annual Report on the use of IAPT services – England, 2016-17. NHS Digital; 2017.

2. Mental Health Taskforce. The Five Year Forward View for Mental Health. Redditch: NHS England; 2016. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

3. NHS England. Five Year Forward View for Mental Health: One Year On. Redditch: NHS England; 2017. Available from: https://www.england.nhs.uk/wp-content/uploads/2017/03/fyfv-mh-one-year-on.pdf.

4. NHS England. Implementing the Five Year Forward View for Mental Health. Redditch: NHS England; 2016. Available from: https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf.

5. National Collaborating Centre for Mental Health. The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms - Full Implementation Guidance. London: NCCMH; 2018. Available from: http://www.rcpsych.ac.uk/pdf/IAPT-LTC%20_Full_Implementation_Guidance.pdf.

6. National Collaborating Centre for Mental Health. The Improving Access to Psychological Therapies Manual. London: NCCMH; 2018. Available from: https://www.rcpsych.ac.uk/pdf/The%20IAPT%20Manual.pdf.

7. May C, Finch T. Implementing, Embedding, and Integrating Practices: An Outline of Normalization Process Theory. Sociology. 2009;43:535-54.

8. Murray E, Treweek S, Pope C, MacFarlane A, Ballini L, Dowrick C, et al. Normalisation process theory: a framework for developing, evaluating and implementing complex interventions. BMC Medicine. 2010;8:63.

9. Coupe N, Anderson E, Gask L, Sykes P, Richards DA, Chew-Graham C. Facilitating professional liaison in collaborative care for depression in UK primary care; a qualitative study utilising normalisation process theory. BMC Family Practice. 2014;15:78.

10. Finch TL, Girling M, May CR, Mair FS, Murray E, Treweek S, et al. NoMAD: implementation measure based on Normalization Process Theory [measurement instrument]. NPT; 2015. Available from: http://www.normalizationprocess.org.

11. McGee-Lennon M, Bouamrane M-M, Grieve E, O'Donnell CA, O'Connor S, Agbakoba R, et al. A flexible toolkit for evaluating person-centred digital health and wellness at scale. In: Duffy VG, Lightner N, eds. Advances in Human Factors and Ergonomics in Healthcare. Cham: Springer; 2017. pp. 105-18.

12. McEvoy R, Ballini L, Maltoni S, O'Donnell CA, Mair FS, MacFarlane A. A qualitative systematic review of studies using the normalization process

theory to research implementation processes. Implementation Science. 2014;9. DOI:10.1186/1748-5908-9-2.

13. Yammer IAPT Network. Microsoft; 2018. Available from: https://www.yammer.com/iaptnetwork/#/home.

14. Wendt C. Mapping European healthcare systems: a comparative analysis of financing, service provision and access to healthcare. Journal of European Social Policy. 2009;19:432-45.

15. Braun V, Clarke V. Using thematic analysis in psychology. Qualitative Research in Psychology. 2006;3:77-101.

16. de Lusignan S, Jones S, McCrae N, Cookson G, Correa A, Chan T. IAPT LTC/MUS Pathfinder Evaluation Project Phase 1: Final report. Guildford: University of Surrey; 2013. Available from: https://www.uea.ac.uk/documents/246046/11991919/LTCMUS-pathfinder-evaluation--phase-1.pdf/842c7eb3-9d97-4a24-9ad4-f86aac50ecf4. Accessed: 20 November 2018.

17. NHS Digital. Data request: IAPT referrals and self referrals for patients with Long Term Conditions – National, financial year 2016/17.

18. NHS Digital. Report on Integrated IAPT services pilot (January 2017 to November 2017) - Data tables: November 2017. NHS Digital; 2018. Available from: https://files.digital.nhs.uk/publication/3/k/iapt-int-rep-data-tab-jan-17-nov-17.xlsx.

19. Everitt B, Landau S, Leese M, Stahl D. Cluster Analysis. 5th edition. Chichester: John Wiley & Sons; 2011.

20. Bolton J. RCPsych Faculty of Liaison Psychiatry Internal Report. Integrated Care for Long Term Physical Health Conditions and Medically Unexplained Symptoms: A Survey of Liaison Psychiatry Services. London: Royal College of Psychiatrists; 2018.

21. Saunders B, Kitzinger J, Kitzinger C. Anonymising interview data: challenges and compromise in practice. Qualitative Research. 2015;15:616-32.

22. National Institute for Health and Care Excellence. Social Anxiety Disorder: Recognition, Assessment and Treatment. NICE clinical guideline 159. London: NICE; 2013.

23. Stern AF. The Hospital Anxiety and Depression Scale. Occupational Medicine. 2014;64:393-4.

Appendices

1. Wave 1 IAPT-LTC sites, mapped to CCGs and service providers
2. IAPT-LTC early implementer sites pro-forma
3. Staff experience survey
4. Breakdown of NoMAD survey responses by question and staff group
5. Site descriptors used in cluster analysis
6. Interpreting dendrograms in cluster analysis

Appendix 1. Wave 1 IAPT-LTC sites, mapped to CCGs and service providers

Note: highlighted cells mark multiple CCGs or providers

CCGs	Service providers
Windsor, Ascot and Maidenhead Bracknell and Ascot Slough	Berkshire Healthcare Foundation Trust
Wokingham Newbury and District South Reading North and West Reading	Berkshire Healthcare Foundation Trust
Blackburn with Darwen East Lancashire	Blackburn Centre Minds Matter
Chiltern Aylesbury Vale	Healthy Minds
Calderdale	Calderdale IAPT service (South West Yorkshire Partnership Foundation Trust; SWYFT) Insight Healthcare Calderdale
Cambridge and Peterborough	Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) Psychological Wellbeing Service
Greater Huddersfield North Kirklees	Kirklees IAPT (SWYFT)
Harrogate and Rural District	The Briary Unit (North West Yorkshire IAPT)
Herts Valleys West Essex	Waverley road (Hertfordshire IAPT) Healthy minds (West Essex IAPT)
Hillingdon	Mill House (Central and North West London NHS Foundation Trust (CNWL) Talking Therapies)
Horsham and Mid Sussex Crawley Coastal West Sussex	Time to Talk
North East Hampshire and Farnham	TalkPlus
Northern, Eastern and Western Devon	Talking Health

North Staffordshire; Stoke on Trent	Healthy Minds Stoke-on-Trent (South Staffordshire and Shropshire Healthcare NHS Foundation Trust) North Staffordshire Wellbeing Service (North Staffordshire Combined Healthcare)
North Tyneside	Wallsend Health Centre (North Tyneside Talking Therapies)
Nottingham West	Insight Healthcare Nottinghamshire Let's Talk Wellbeing
Oxfordshire	TalkingSpace Plus (Oxford Health NHS Foundation Trust)
Portsmouth	Talking Change (Portsmouth IAPT)
Richmond	Richmond Royal Hospital (Richmond Wellbeing Service)
Sunderland	Sunderland Psychological Wellbeing Service
Swindon	LIFT Psychology
Warrington	Warrington Pain & Fatigue Management (Warrington Psychological Service)

Appendix 2. IAPT-LTC early implementer sites pro-forma

Introduction

Q1.1.

Integrated IAPT (IAPT-LTC) Early Implementers' Site Pro-forma
For completion by integrated IAPT service leads or senior management staff.

Thank you for agreeing to complete the following form for your Early Implementer service. The information you provide will supplement information from NHS England, NHS Digital and input from staff and service-users. This will be used to map out what the integrated IAPT services look like and describe the barriers and facilitators to their implementation, which will in turn be used to guide the further national roll-out of the integrated IAPT programme. This work is part of the integrated IAPT Early Implementer Evaluation commissioned by NHS England.

Please note:

- To complete the form you will need access to information on staff numbers, training, physical care pathways, service locations, referrals, interventions.
- The form takes approximately 45 minutes to complete.
- You may need to ask colleagues for any information you do not have.
- We welcome any additional comments or elaboration on any of the questions, there will be a text box provided at the end of the form.
- The form will allow you to go back and add or amend responses at any time within 2 weeks of starting. Once you click "complete" you will not be able to come back and change any of the answers.
- If you have any questions or need help with any part of the form, do not hesitate to contact Kasia Furmaniak, katarzyna.furmaniak.13@ucl.ac.uk. We are also happy to schedule a time to help with the pro-forma as it is being filled out, over the phone, if it may make the process easier.

Please submit the completed form by 29 September 2017.

Participant information

Q2.1. Participant information

Q2.2. Please select the Integrated IAPT Early Implementer **site** with which you are associated:

Note: "Site" refers to the project site put forward in the Early Implementers bid to NHS England. Each site may consist of one or more CCGs and one or more different IAPT providers. If unclear about which site you belong to, please contact Kasia Furmaniak, katarzyna.furmaniak.13@ucl.ac.uk.

▼

Q2.3. What is the name of the integrated IAPT service you work for?

Q2.4. Please provide your contact details, in case we require further clarification on any of the answers.

Name	
Job title	
Email address	
Contact telephone number	

Bid

Q3.1. We would like to understand why your site chose to bid to become an Early Implementer site. Please briefly describe the factors which influenced your choice to apply to become one of the Early Implementer sites:

Integrated IAPT staff

Q4.1. Integrated IAPT staff

Q4.2. How many staff are **currently** employed in the integrated IAPT team?

	Total number	Total WTE	Number LTC top-up trained	Number not LTC top-up trained
High Intensity CBT Therapists				
Other High Intensity Therapists				
Psychological Wellbeing Practitioners				
Other mental health staff (e.g. counsellor, health psychologist, psychiatrist) - please describe below				

	Total number	Total WTE	Number LTC top-up trained	Number not LTC top-up trained
Other physical health staff (e.g. specialist LTC staff such as: specialist nurse, occupational therapist, physiotherapist, speech and language therapist). Please describe below. **N.B:** do not double-count integrated IAPT staff above who are dual-trained in physical and mental healthcare.				
Support staff (e.g. administrators, managers, data personnel)				
Other (please describe)				

Q4.3. How many of the above staff have completed supervisor training?

Q4.4. Are any of the staff 'dual-trained' - have a background or training in an area of physical or mental healthcare additional to the one they are currently working in? For example, a HIT who is also trained as an Occupational Therapist/physical health nurse).

Yes | No | Unsure | Other

Q4.5. If yes, how many?

Q4.6. If yes, what is their dual-training (primary role in the integrated IAPT service and other health background(s)/training)?

	Role in integrated IAPT				
	HIT	PWP	Other	If other, please describe:	Other health background(s)/training
Staff member 1	☐	☐	☐		
Staff member 2	☐	☐	☐		
Staff member 3	☐	☐	☐		
Staff member 4	☐	☐	☐		
Staff member 5	☐	☐	☐		

Q4.7. If your service employs data personnel, do they work exclusively for the integrated IAPT service or are they shared between various services?

Exclusively integrated IAPT

Shared with core IAPT

☐ Shared with other service(s) (please describe)

☐ Other (please describe)

Q4.8. If shared between services, what is the WTE dedicated to the integrated IAPT service.

☐

Q4.9. Where do the integrated IAPT clinicians see their clients? Please select all that apply.

Acute hospital

GP practice

Core IAPT service team base

Community service (please describe)

Specialist LTC service (please describe)

Other (please describe)

Other 2 (please describe)

Working with others

Q5.1. Working with others

Q5.2. Which LTC/MUSs does your service focus on? Please select all that apply.

Diabetes

Chronic Obstructive Pulmonary Disease

Asthma

Other respiratory disease

Heart disease

Cancer

Musculoskeletal Disorder

Chronic pain, including fibromyalgia

Epilepsy

Skin condition including Eczema

Digestive tract conditions

Other LTC

MUS: Irritable Bowel Syndrome

MUS: Chronic Fatigue syndrome/Myalgic Encephalopathy

Other MUS

Q5.3. Does your service currently have any policy, care pathway or working agreement documents specific to integrated IAPT?

Yes | No | Still under development | Other (please describe)

Q5.4. **If yes, please e-mail a copy of the document(s) to: katarzyna.furmaniak.13@ucl.ac.uk . If you have an amended IAPT standard operating procedure document, please provide only the sections relevant to integrated IAPT.**

Q5.5. Do the core IAPT service and integrated IAPT have a single point or separate points of access at referral stage?

Single point of access for core and integrated | Separate points of access for core and integrated | Other system (please describe)

Q5.6. Do the integrated IAPT staff go to **any** joint meetings with physical health staff? (e.g. clinical, management, business meetings)

Yes | No | They are being planned | Other

Q5.7.

	Please describe meeting type	Which LTC/MUS do they address?	How often do they take place?

	Please describe meeting type	Which LTC/MUS do they address?	How often do they take place? per month
Meeting type 1			per month
Meeting type 2			
Meeting type 3			
Meeting type 4			
Meeting type 5			

Q5.8. Do the integrated IAPT staff provide any training to the specialist LTC/MUS and physical health staff associated with the IAPT service?

Yes | No | They are being planned | Other

Q5.9. If yes, please describe below (including how often they take place, who they are aimed at and delivered by, and what is covered):

Q5.10. Do the specialist LTC/MUS and physical health staff associated with the IAPT service provide any training to the integrated IAPT staff/ clinicians?

Yes | No | They are being planned | Other

Q5.11. If yes, please describe below (including how often they take place, who they are aimed at and delivered by, and what is covered):

Q56. **Please click next**

Patients

Q6.1. Core IAPT clients with LTC/MUS

Q6.2. How many of the clients who **completed treatment*** in the **core IAPT** service in the month of June were classed as having a LTC/MUS?

*completed treatment - discharged with two or more treatment appointments which were **NOT** integrated IAPT appointments.

Q6.3. Integrated IAPT clients

Q6.4. Please enter the date when the integrated IAPT service in your site started accepting client referrals (dd/mm/yyyy):

Q6.5. How many people were **referred** to **the integrated IAPT service** in the month of June?

(**Note**: if your service has a single point of access for core and integrated IAPT at referral stage, please report total referrals here)

Q6.6. How many people were **triaged** by the integrated IAPT service in the month of June?

(**Note**: if your service has a single point of access for core and integrated IAPT at referral stage, please report total referrals here)

Q6.7. How many people were **offered an initial contact*** at the integrated IAPT service in the month of June?

*including phone or in-person assessment, or treatment appointment

Q6.8. How many people **attended their offered contact*** at the integrated IAPT service in the month of June?

*including phone or in-person assessment, or treatment appointment

Q6.9.
In the **month of June**, how many people per each LTC/MUS were seen at integrated IAPT from each of the following referral sources?

	Referral source								
	Self-referral	Carer	GP	Specialist LTC service*	Other physical health service*	Core IAPT service	Other mental health team*	Other*	* Please give details
Other									
» Diabetes									
» Chronic Obstructive Pulmonary Disease									
» Asthma									
» Other respiratory disease									
» Heart disease									
» Cancer									
» Musculoskeletal Disorder									
» Chronic pain, including fibromyalgia									
» Epilepsy									

	Referral source								
	Self-referral	Carer	GP	Specialist LTC service*	Other physical health service*	Core IAPT service	Other mental health team*	Other*	* Please give details
» Skin condition including Eczema									
» Digestive tract conditions									
» Other LTC									
» MUS: Irritable Bowel Syndrome									
» MUS: Chronic Fatigue syndrome/Myalgic Encephalopathy									
» Other MUS									

Q6.10. Does the integrated service accept eligible referrals from all GP practices within your site, or a specific subset?

All GP practices

Majority of practices (restricted geographically)

Majority of practices (restricted by working agreement)

Only a subset of practices with which there is a working agreement

No GP practices (referrals come through different sources)

Q6.11. Please list which practices you accept referrals from:

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

Q6.12. Does the integrated service accept eligible referrals from all hospitals within your site, or a specific subset?

All hospitals practices

Majority of hospitals (restricted geographically)

Majority of hospitals (restricted by working agreement)

Only a subset of hospitals with which there is a working agreement

No hospitals (referrals come through different sources)

Q6.13. Please list which hospitals you accept referrals from:

1

2

3

4

5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	

Q6.14.

Please estimate the percentage of your integrated IAPT clients who receive physical health care in each of the following settings, by LTC/MUS category:

	Service setting						
	GP	Community centre	Hospital outpatient	Hospital inpatients	Client's home	Other (describe in the box to the right)	If other, please describe
» Diabetes							
» Chronic Obstructive Pulmonary Disease							
» Asthma							
» Other respiratory disease							
» Heart disease							

	Service setting						
	GP	Community centre	Hospital outpatient	Hospital inpatients	Client's home	Other (describe in the box to the right)	If other, please describe
» Cancer							
» Musculoskeletal Disorder							
» Chronic pain, including fibromyalgia							
» Epilepsy							
» Skin condition including Eczema							
» Digestive tract conditions							
» Other LTC							
» MUS: Irritable Bowel Syndrome							
» MUS: Chronic Fatigue syndrome/Myalgic Encephalopathy							
» Other MUS							

Q6.15. Are there any other services not mentioned above which are associated with the new integrated IAPT service?

Yes (please describe)

No

Q6.16. If yes, please note the type of referrals (LTC/MUS group) received from these services and the respective proportions:

Q6.17. Please describe, what criteria do you use to decide who to accept and who not to accept on to integrated IAPT service caseload? If necessary, describe the criteria by each LTC/MUS category or treatment type.

Q6.18. Who usually carries out initial client screening or triage at your integrated IAPT service?
Please select all that apply:

Administration/support staff
Trainee PWP
PWP
Trainee HIT
HIT
Clinical Psychologist
Other

Q6.19. If other, please describe:

Q6.20.

Which of the following treatments does your integrated IAPT service offer? Please select all that apply.

Guided self-help

Computerised CBT

Behavioural activation

Structured group physical activity programme

Psycho-educational groups

High intensity cognitive behavioural therapy

Specialised cognitive behavioural therapy (please describe)

Interpersonal therapy

Couples therapy

Counselling

Dynamic interpersonal therapy

Mindfulness-based cognitive therapy

Eye movement desensitisation reprocessing therapy

Graded Exercise therapy

Other

Other 2

Q6.21.

As a service, please indicate what proportion of clinical time is spent delivering each of these treatments:

	Proportion (%)
» Guided self-help	
» Computerised CBT	
» Behavioural activation	
» Structured group physical activity programme	
» Psycho-educational groups	
» High intensity cognitive behavioural therapy	
» Specialised cognitive behavioural therapy (please describe)	
» Interpersonal therapy	
» Couples therapy	
» Counselling	
» Dynamic interpersonal therapy	
» Mindfulness-based cognitive therapy	

	Proportion (%)
» Eye movement desensitisation reprocessing therapy	
» Graded Exercise therapy	
» Other	
» Other 2	

Q6.22. How many people are **currently** on your integrated IAPT treatment waiting list?

Thank you

Q7.1. Thank you!

Q7.2. Thank you for taking the time to complete this form and helping us with the integrated IAPT Early Implementers Evaluation.

Q7.3. Please remember, if you have answered yes to question: "Does your service currently have any policy, care pathway or working agreement documents specific to integrated IAPT?" **please e-mail a copy of the document(s) to: katarzyna.furmaniak.13@ucl.ac.uk . If you have an amended IAPT standard operating procedure document, please provide only the sections relevant to integrated IAPT.**

Q7.4. Please use this text-box if you would like to add any additional comments to any of the questions in this form, or any additional information you would like to provide about the integrated IAPT service in your site which may be relevant but was not captured by this form.

Q7.5.

Please make sure you have completed all of the relevant information: once you click complete, you will not be able to come back and change any of the answers.

Q7.6. Tick if you have completed all the relevant information to the best of your knowledge:

Yes

Appendix 3. Staff experience survey

Intro

Staff experience survey

We know that every staff member has a key role in the delivery of services so we would like to hear from you. This includes all staff involved with the Wave 1 IAPT-LTC Early Implementer services (commissioners, service leads, managers, clinicians, support staff and affiliated healthcare staff).

This survey asks for your experiences and views on setting up your IAPT-LTC service, so you may want to take some time to reflect on this.
The answers you provide here will be vital to understand what has happened in Wave 1 so far, and lessons for the future of IAPT-LTC. It forms a part of the IAPT-LTC Wave 1 Implementation/Process Evaluation carried out by the National Collaborating Centre for Mental Health and UCL.

Please note:

- Throughout the survey "physical healthcare staff/services" will refer to staff or services within primary, secondary or community health care.
- The survey takes approximately 15-20 minutes to complete. You will be able to see your progress in a yellow bar on top of the page.
- Your answers will be kept securely with the research team at UCL and will not be shared with your service. Any information presented in the final report will be completely anonymised.
- We welcome any additional comments, there is a text box provided at the end of the form.
- The survey will allow you to go back and amend responses at any time within 2 weeks of starting (subject to using the same device and browser). Once you click "complete" you will not be able to come back and change any of the answers.
- Once completed, you will be given the chance to enter a raffle to win an iPad tablet!

If you have any questions, please contact Kasia Furmaniak, katarzyna.furmaniak.13@ucl.ac.uk .

The survey will close on **30th of November 2017.**

Please pass this survey link on to any colleagues associated with the IAPT-LTC service.

About yourself

Part A: About yourself

N.B. Any information presented in the final report will be completely anonymised.

Which IAPT-LTC service are you associated with?

CCG

Service

If Other, please specify

Which best describes your role? Please tick more than 1 if they apply.

IAPT-LTC clinician	Mental health commissioner	Community healthcare staff (please describe role)
IAPT-LTC management	Other healthcare commissioner (please describe)	Other healthcare staff (please describe role)
IAPT-LTC support staff	Primary healthcare staff (please describe role)	Other (please describe role)
IAPT-LTC service lead	Secondary healthcare staff (please describe role)	Prefer not to say
Core IAPT clinician		

What is your primary therapeutic model?

What is your clinical role in the service?

HIT	PWP	Other

If Other, please specify

In a normal week, how many days do you work in:

	days
the core IAPT service?	
the IAPT-LTC service?	

From how many different locations do you deliver IAPT-LTC interventions?
e.g. core IAPT base, 2 GP practices = 3.

0 1 2 3 4 5 6 7 8 9 10

How long have you worked in:

	Years	Months
IAPT services?		
IAPT-LTC services?		

For the following question you may fill in more than one box and omit any that are not applicable.

How long have you worked in:

	Years	Months
Your current role?		
Mental health?		
Physical healthcare?		
Primary healthcare?		
Your current trust/CCG?		

NOMAD

Part B: Your views and experiences of the IAPT-LTC model

Sections B and C are designed to help get a better understanding of how to set up and integrate new healthcare services. Please take a moment to think about your own understanding of the IAPT-LTC model of working.

	Not at all	Somewhat	Completely	Not relevant to my role

	Not at all		Somewhat		Completely	Not relevant to my role
Do you have an understanding of what the IAPT-LTC model involves?	○	○	○	○	○	○
How familiar does working in the IAPT-LTC model feel?	○	○	○	○	○	○
Do you feel the IAPT-LTC model is currently a normal part of your work?	○	○	○	○	○	○
Do you feel the IAPT-LTC model will become a normal part of your work?	○	○	○	○	○	○

Part C: Detailed questions about the IAPT-LTC model

For each statement please select an answer that best suits your experience.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Not relevant to my role
I can see how the IAPT-LTC model differs from usual ways of working.	○	○	○	○	○	○
Staff in the IAPT-LTC service have a shared understanding of the purpose of the IAPT-LTC model.	○	○	○	○	○	○
Staff in the broader physical healthcare services have a shared understanding of the purpose of the IAPT-LTC model.	○	○	○	○	○	○
Commissioners and decision makers have a shared understanding of the purpose of the IAPT-LTC model.	○	○	○	○	○	○
I understand how the IAPT-LTC model affects the nature of my work.	○	○	○	○	○	○
I can see the potential value of the IAPT-LTC model for my work.	○	○	○	○	○	○

For each statement please select an answer that best suits your experience.

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Not relevant to my role
There are key people who drive the IAPT-LTC model forward and get others involved.	○	○	○	○	○	○

	Strongly disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Not relevant to my role
I believe that developing the IAPT-LTC service is a legitimate part of my role.	○	○	○	○	○	○
I am open to working with colleagues in new ways as part of the IAPT-LTC model.	○	○	○	○	○	○
I will continue to support the IAPT-LTC model.	○	○	○	○	○	○
I believe that the IAPT-LTC model is supported by evidence.	○	○	○	○	○	○
The staff within my organisation agree that the IAPT-LTC model is worthwhile.	○	○	○	○	○	○
I value the effects that the IAPT-LTC model has had on my work	○	○	○	○	○	○
Feedback about the IAPT-LTC model can be used to improve it in the future.	○	○	○	○	○	○
I can modify how I work within the IAPT-LTC model.	○	○	○	○	○	○

Block D

Part D: Your IAPT-LTC service

To what extent do the following descriptions reflect **current practice**?

	The **physical healthcare services** involved in IAPT-LTC routinely use the following mental health case recognition tools:					
	Not at all		Somewhat		Completely	I don't know
Generalized Anxiety Disorder two-item scale (GAD-2)	○	○	○	○	○	○
The Whooley questions for depression	○	○	○	○	○	○
The Mini-Social Phobia Inventory Scale	○	○	○	○	○	○
Other	○	○	○	○	○	○

	Not at all		Somewhat		Completely	I don't know
Our IAPT-LTC service has revised assessment protocols for the integrated pathways.	○	○	○	○	○	○
All IAPT-LTC practitioners are co-located with physical healthcare teams and/or primary care.	○	○	○	○	○	○
All IAPT-LTC practitioners have received the LTC top-up training.	○	○	○	○	○	○
The IAPT-LTC and pre-existing IAPT services have shared personnel and shared management, training and supervision arrangements.	○	○	○	○	○	○
IAPT-LTC has close and effective links with primary, community and acute care and other relevant services.	○	○	○	○	○	○

Please comment on any key differences between IAPT-LTC at present and the statements above:

From your perspective, what factors affected the implementation of IAPT-LTC?
Please include any relevant **personal** as well as **organisational factors**.

Helped implementation

Hindered implementation

Block E training

Part E - Training

Have you completed IAPT-LTC top up training:

Yes No

To what extent do the following descriptions match your experience:

	Not at all 1	2	Somewhat 3	4	Completely 5
The top-up training has increased my understanding of LTC/MUSs and how they relate to mental health issues.					
The top-up training has prepared me for working with clients with LTC/MUSs.					
The top-up training has prepared me for working in the IAPT-LTC service.					

Comments:

Block F

Part F - Impact on other services

In which ways do you think IAPT-LTC has impacted **the core IAPT service**?
You may select multiple options.

Relationship with IAPT-LTC service	Data quality	Accommodation
Staffing	Quality of care	Relationships with primary healthcare services
Staff training	Service capacity to take on cases	Clients' access to service

Patient experience	Patient outcomes	Relationships with community healthcare services
Supervision	Relationships with secondary healthcare services	Other
Patient waiting times	Commissioning	Other 2

Have these impacts been positive or negative?

	Negative impact -2	-1	0	1	Positive impact 2	Not Applicable
» Clients' access to service						☐
» Patient waiting times						☐
» Service capacity to take on cases						☐
» Staffing						☐
» Supervision						☐
» Quality of care						☐
» Patient outcomes						☐
» Staff training						☐
» Relationship with IAPT-LTC service						☐
» Relationships with primary healthcare services						☐
» Relationships with secondary healthcare services						☐
» Relationships with community healthcare services						☐
» Patient experience						☐
» Accommodation						☐
» Data quality						☐
» Commissioning						☐
» Other						☐
» Other 2						☐

Comments:

In which ways do you think IAPT-LTC has impacted **physical healthcare services**?
You may select multiple options.

Patients' management of their long term condition	Patients' access to mental health services	Accommodation
Relationships with IAPT service	Patients' use of services	Commissioning
Patient experience	Awareness of IAPT service	Other
Quality of care	Staff training	Other 2
Collaborative working between professionals	Understanding of mental health problems	

Have these impacts been positive or negative?

	Negative impact -2	-1	0	Positive impact 1	2	Not Applicable
» Understanding of mental health problems						☐
» Patients' use of services						☐
» Patients' access to mental health services						☐
» Quality of care						☐
» Patients' management of their long term condition						☐
» Staff training						☐
» Collaborative working between professionals						☐
» Patient experience						☐
» Relationships with IAPT service						☐
» Awareness of IAPT service						☐

	Not Applicable
» Accommodation	☐
» Commissioning	☐
» Other	☐
» Other 2	☐

Comments:

End

Thank you for taking the time to complete this survey!

Please use this text-box if you would like to add any additional comments to any of the questions in this form, or any additional information you would like to provide about IAPT-LTC in your site which may be relevant but was not captured by this survey.

Please make sure you have completed all of the relevant information: once you click complete, you will not be able to come back and change any of the answers.

Please pass the survey link on to any colleague associated with the IAPT-LTC service who may wish to also share their views.

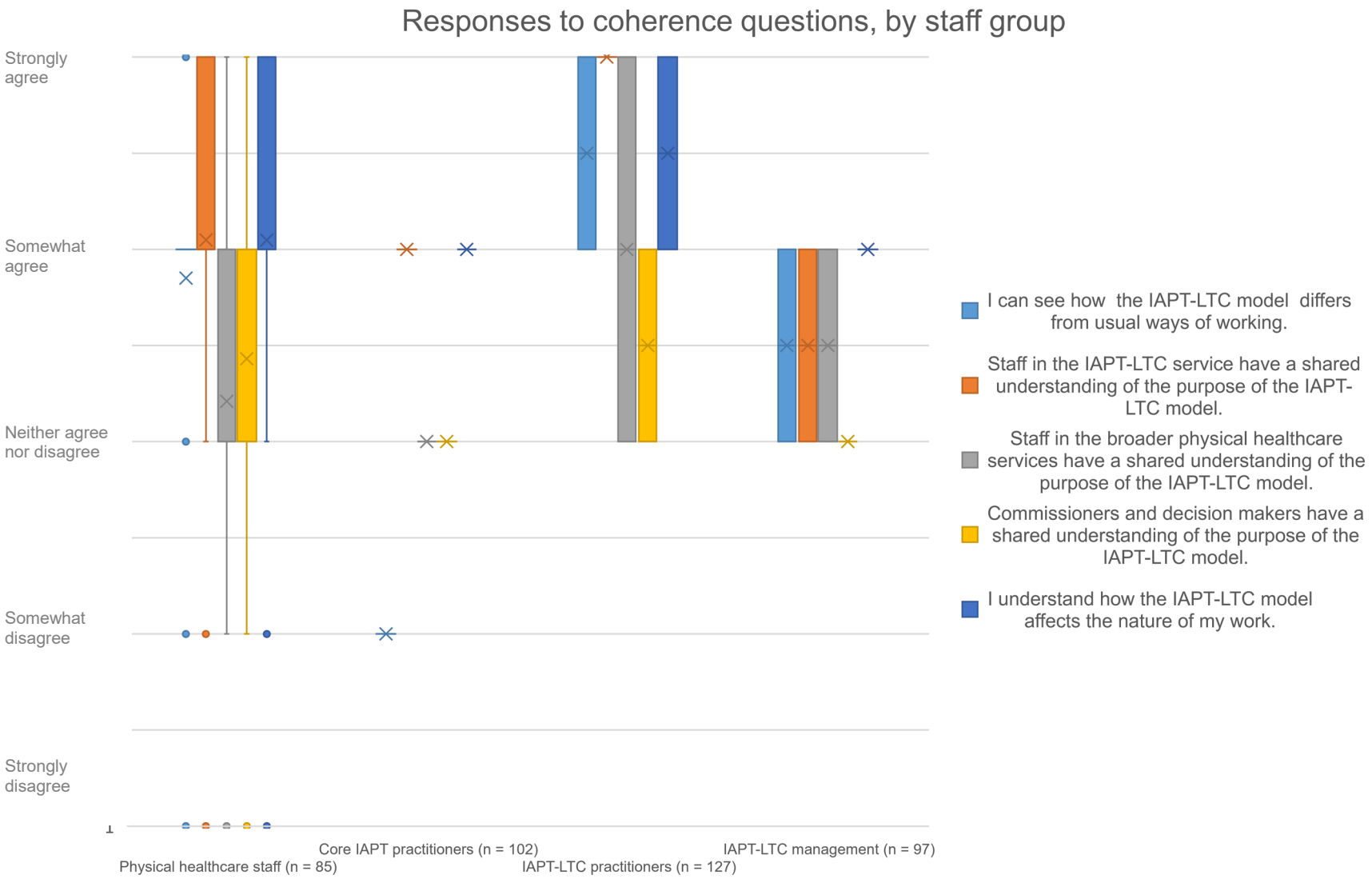
This is the end of the survey, tick "yes" if you are happy with your answers. You will not be able to come back to your responses after this page.

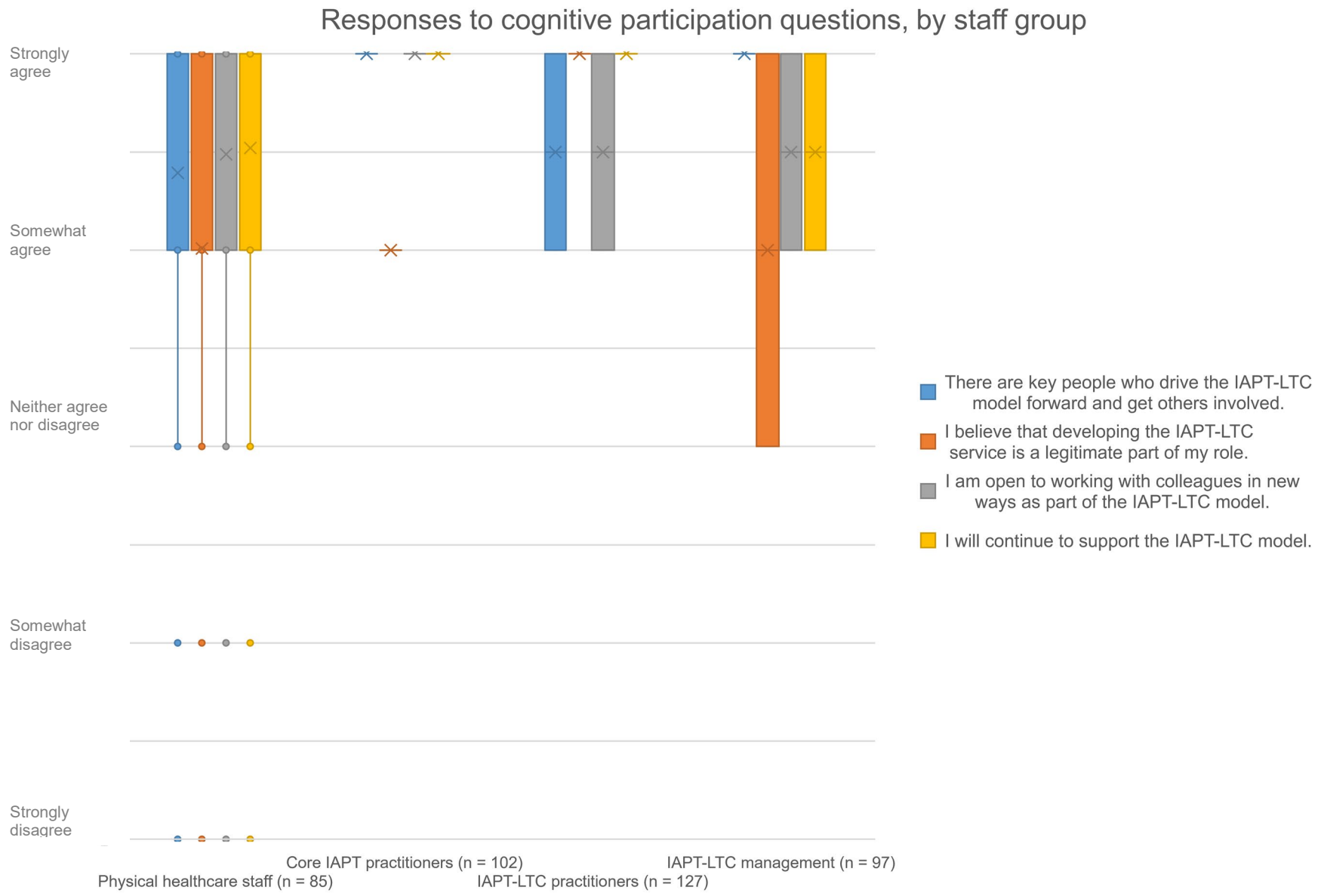
Yes

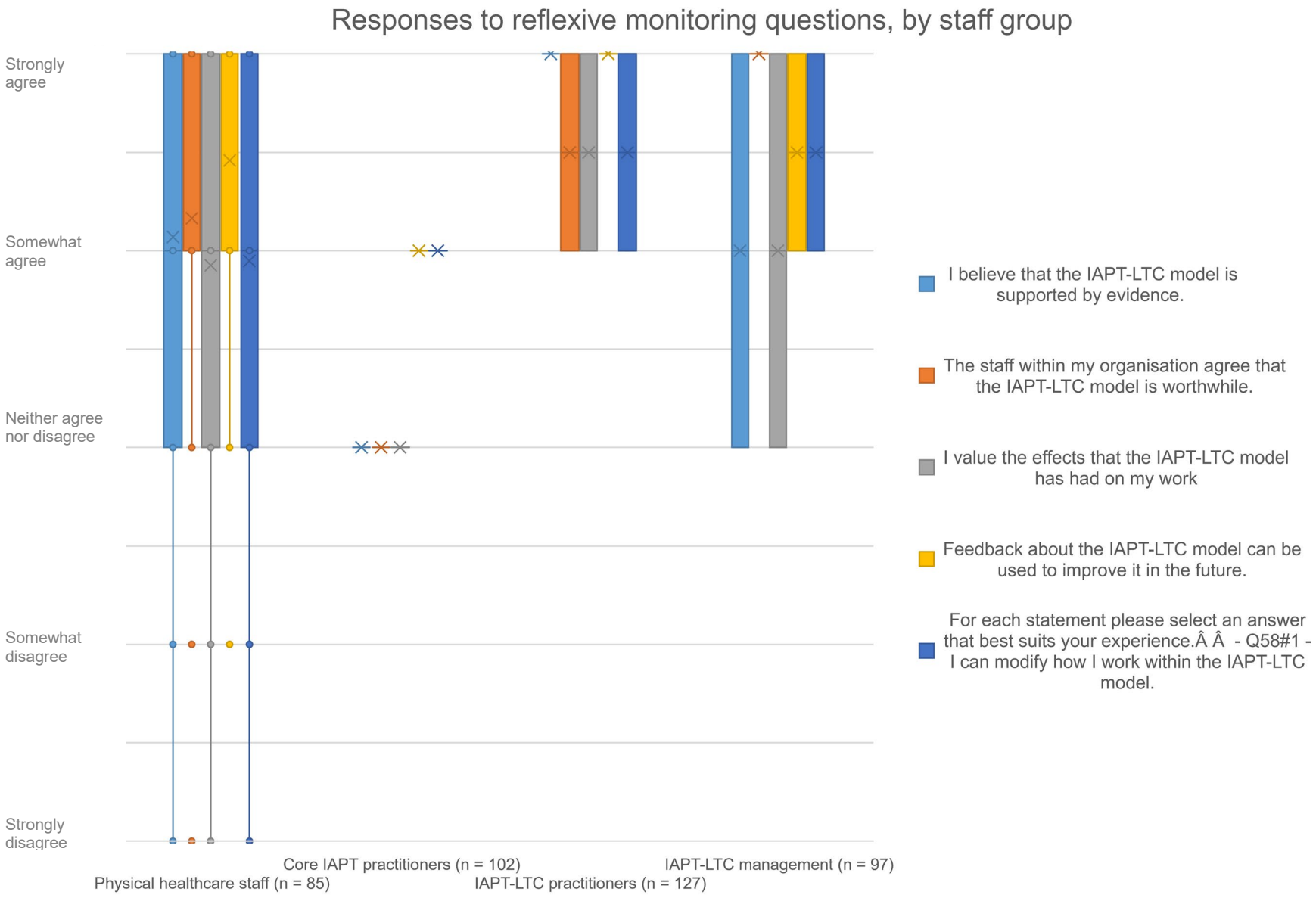
Please follow the link below if you would like to enter a raffle for a chance to win an iPad!
This will ask for your details separately to this survey so that your responses here remain anonymous.

https://uclpsych.eu.qualtrics.com/jfe/form/SV_5A9CImgy64pf5GZ

Appendix 4. Breakdown of NoMAD survey responses by question and staff group


Responses to coherence questions, by staff group
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree
Physical healthcare staff (n = 85)
Core IAPT practitioners (n = 102)
IAPT-LTC practitioners (n = 127)
IAPT-LTC management (n = 97)
I can see how the IAPT-LTC model differs from usual ways of working.
Staff in the IAPT-LTC service have a shared understanding of the purpose of the IAPT-LTC model.
Staff in the broader physical healthcare services have a shared understanding of the purpose of the IAPT-LTC model.
Commissioners and decision makers have a shared understanding of the purpose of the IAPT-LTC model.
I understand how the IAPT-LTC model affects the nature of my work.


Responses to cognitive participation questions, by staff group
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree
There are key people who drive the IAPT-LTC model forward and get others involved.
I believe that developing the IAPT-LTC service is a legitimate part of my role.
I am open to working with colleagues in new ways as part of the IAPT-LTC model.
I will continue to support the IAPT-LTC model.
Physical healthcare staff (n = 85)
Core IAPT practitioners (n = 102)
IAPT-LTC practitioners (n = 127)
IAPT-LTC management (n = 97)


Responses to reflexive monitoring questions, by staff group
Strongly agree
Somewhat agree
Neither agree nor disagree
Somewhat disagree
Strongly disagree
Physical healthcare staff (n = 85)
Core IAPT practitioners (n = 102)
IAPT-LTC practitioners (n = 127)
IAPT-LTC management (n = 97)
I believe that the IAPT-LTC model is supported by evidence.
The staff within my organisation agree that the IAPT-LTC model is worthwhile.
I value the effects that the IAPT-LTC model has had on my work
Feedback about the IAPT-LTC model can be used to improve it in the future.
For each statement please select an answer that best suits your experience.Â Â - Q58#1 - I can modify how I work within the IAPT-LTC model.

Appendix 5. Site descriptors used in cluster analysis

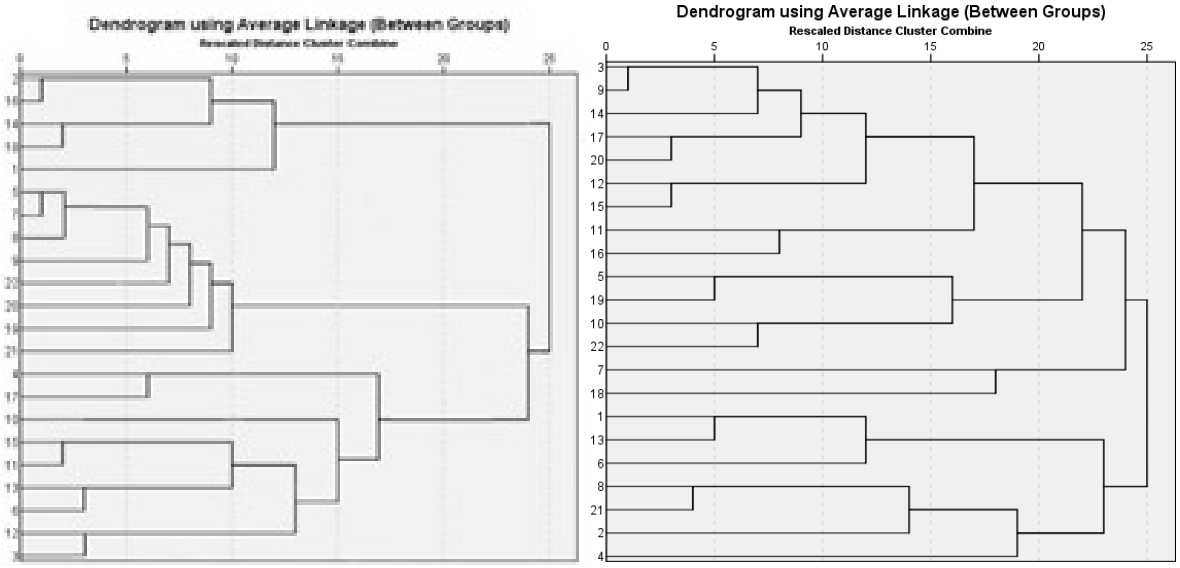
We used eight descriptors for the cluster analysis of Wave 1 sites. They were chosen to contribute to a full picture of key site characteristics but were also individually valuable in the analysis. The descriptors were not correlated.

1. When a site started delivery (month)
2. The size of the service in June 2017 (total number of HIT/PWP WTE)
3. The balance of HIT to PWPs in June 2017 (ratio)
4. The coverage of LTC training in June 2017 (percentage top-up trained)
5. Relationship with the core service (whether staff were shared between the core and LTC service)
6. The range of LTCs/MUS seen in June 2017 (total number of conditions)
7. Site co-location settings (ratio of primary to secondary care settings)
8. Meeting delivery targets (percentage of targets met for people seen between June and November 2017)

Appendix 6. Interpreting dendrograms in cluster analysis

The items being compared on a dendrogram (or a 'tree diagram') other appear as rows on the left side of the diagram. The 'tree' then extends to the right. The sites are linked by lines. Sites that appear to form 'clusters' are similar in terms of a combination of the data used in cluster analysis. If there are no apparent clusters there may be no particular groups.

For example, here are two tree diagrams:



In the first example, 3 clear clusters are visible. The short horizontal lines within the clusters mean the groups are very similar, and the long lines between them mean they are very distinct from each other.

In the second example the horizontal lines are all different lengths. No clear clusters emerge.