Psychological Therapies for Depression and Anxiety Disorders in People with Long-term Physical Health Conditions or with Medically Unexplained Symptoms

Guide for setting up IAPT-LTC services

1. Aims

The purpose of this guide is to support providers and commissioners in setting up an IAPT-LTC service. In 2016/17 and 2017/18 NHS England is supporting a number of areas that are 'early implementers' of these services (details of these can be found on the NHS England website). From 2018/19 all areas are being asked to commission integrated IAPT services. This guide contains information and learning from the early implementer sites which may be helpful to those who are to commence in April 2018.

This guide provides local services with examples of what works in integrated IAPT services, headline areas which should be considered and "lessons learned" by those who have been through the process. It further provides advice on developing integrated IAPT and physical health pathways.

Commissioners, service managers, clinicians, patients and carers directly involved in designing and delivering local integrated IAPT pathways should read the full Psychological Therapies for Depression and Anxiety Disorders in People with Long-term Physical Health Conditions or with Medically Unexplained Symptoms implementation guidance. This has been produced by the National Collaborating Centre for Mental Health (NCCMH) in conjunction with the National Institute for Health and Care Excellence (NICE) and NHS England.

There is an FAQ document which provides answers to many of the queries and concerns raised so far in this process which is available along with guidance of completing local evaluations to evidence savings in the wider health system.

Addressing inequalities in access and experience of mental health services was set out as a priority in the Five Year Forward View for Mental Health. Further detail is contained in the full implementation guide, including resources on commissioning mental health services for people from BAME backgrounds, older people, and addressing the physical health needs of people in the Integrated IAPT pathway. Local services should be co-designed with local communities and the provision of IAPT treatments should be tailored to people's personal circumstances, considering culturally specific beliefs, needs and values.

Around one-third of people with LTCs, such as diabetes, cardiovascular disease and respiratory disease, will also experience a common mental health problem, with an even higher proportion experiencing poor mental health. Coexisting mental and physical health problems are associated with a poorer prognosis and considerably higher healthcare costs. Despite the distress to the individual and costs to health and social care services and the wider society associated with mental health problems; they are often under-recognised and under-treated in people with LTCs and MUSs.

Integrated care, as well as being reported consistently as preferable to non-integrated care by people who receive it, has also been shown to improve outcomes and be cost effective.

There are many examples of excellent IAPT services nationally who are already providing treatment for people with Long Term Physical Health conditions within their core IAPT service. This document highlights the significant opportunities to deliver integrated evidence based psychological therapies within physical healthcare pathways.

2. Setting up an IAPT-LTC service

In order for the LTC service to perform effectively the core service from which it will branch needs to be stable and performing well. The core IAPT service should be strong with good leadership, retention of staff, good access and recovery rates and short waits for treatment. It should be a service that has good data quality (including accurate problem descriptors and sessional measures) and offers evidence–based psychological treatments with regular weekly supervision for staff.
The Core IAPT service needs the support of the CCG and so it is important to develop strong links with GP and physical health commissioners as well as the mental health commissioner for IAPT. Having a healthy Core IAPT service will be the basis for the IAPT-LTC expansion and it is important to maintain the strengths of this service when transferring some staff into the IAPT-LTC team. HI (High Intensity) and PWP (Psychological Wellbeing Practitioner) trainees will be used to backfill staff who transfer across to the IAPT-LTC service, and services may need to be creative to ensure that both core and IAPT-LTC services are viable and adequately staffed with experienced as well as trainee staff. This may mean developing in a phased way, or starting IAPT-LTC in only one or two physical health pathways in order to start seeing patients.

The IAPT-LTC service will require the following:-

- High performing Core IAPT service
- Strong leadership
- CCG support
- NHSE support
- Local networks (e.g., Clinical, AHSN)
- Established workforce
- Clinical supervisors
- Administrative support
- Data collection, quality and data linkage (CSU, IG)
- Accommodation & equipment
- HR for recruitment
- Peer support e.g., with other site

3. Integrating into Physical Health pathways

The early implementer sites had variability in the appetite from physical health systems to the integration. Many initially found that though physical health staff were keen to work with the IAPT team, the process of doing so was challenging. Some sites have encountered difficulties in integrating into pathways in acute settings where local arrangements and engagement had not previously been attempted. In all of the sites a dual approach has been helpful, particularly working both “top down” and “bottom up” within the system.

A “top down” approach involves working with colleagues at a senior level to embed transformation and agree pathways within the system, the following have been suggested by our early implementer sites:-

- Review STP and CCG priorities and ask to join LTC/MUS Project Boards

- Develop strong links with Mental health, Physical health, GP commissioners
- Develop links with the Director of nursing, Allied Health Professional Lead, Locality leads etc.
- Engage with local Vanguards/ACS (Accountable Care Systems)/ACO (Accountable Care Organisations)

Conversely, working with staff who directly provide care can also be a helpful approach to take, but increasingly so if done in conjunction with senior engagement. Early implementer learning demonstrates that the ideas below can be a useful way of encouraging engagement from the physical health care staff who will already be working with the cohort of people whom you need to access the LTC service:-

- Link with key professionals to champion integration
- Offer to meet and share ideas
- Book engagement meetings and training events
- Offer clinical supervision & consultation about cases

As part of this process of encouraging engagement and developing relationships both at a senior and ground level it will be important to jointly develop:

- An implementation plan
- A risk plan
- Strategy for engaging patients

It will also be important to have regular 2-4 weekly Implementation meetings with key staff and stakeholders to push the plan forward and mitigate risks (commissioners, clinicians, services leads, data lead, community and primary care physical health care leads etc.).

Key staff and stakeholders in the project may include:-

Hospital–based

- Lead matrons, specialist nurses, consultant physicians and allied health professionals (specialist physio, dietician, etc.) working in hospitals with the patient group you want to access. Be mindful of existing services seeing patients with mental health problems e.g. liaison psychiatry and clinical health psychology services and how you are going to work collaboratively across the pathway. **NB Hospital–based professionals will be working with patients who have high health-care utilisation costs**

Community-based

- District nurses, specialist nurses (e.g., heart failure nurses, diabetes nurses), practice nurses, GPs, community workers, exercise programmes leads, and allied health professionals.

In setting up the new service and prior to seeing patients it will be important to ensure that a review and modification of standard operating procedures is completed to include the LTC part of the service. The data system will need to be set up to collect all of the necessary data, including the additional LTC/MUS outcome measures. Initially NHS Digital will not be able to capture the extra four data file extracts as part of the usual download which forms the monthly IAPT reporting, however, this will inevitably be added to the reporting requirements and you will need to clarify, through your data lead, that all necessary systems are able to comply. As the service begins to see patients it is prudent to increase data quality checks to ensure that the system is reporting accurately and/or that staff understand the requirements.

The experience from the early implementers has shown that IAPT services can adversely delay delivering a clinical service whilst waiting for everything to align and be “just right”. Unfortunately many of the processes need to run in parallel and the first few months will be challenging. Patients can start to be seen very soon after experienced staff have been identified to work in the IAPT-LTC service using the skills and training they have already developed (transferrable skills). They will work as a collective team and start to develop pathway links, increasing their understanding of working with patients with long term physical health conditions and distressing symptoms and learn from physical health care colleagues in addition to attending LTC top-up training.

4. Recruitment

Alongside the requirement to setting up an IAPT-LTC service, therefore increasing access to meet the additional national access to 1.5 million per year, there is a requirement to increase the workforce. It will not be possible for services to increase their access with staffing levels appropriate to meet the 15% national standard in 2015. This will require a combined commitment from CCG’s (Clinical Commissioning Group), STP’s (Sustainable Transformation Partnership), HEI’s (Higher Education Institute), HEE (Health Education England) and Providers. All STP’s are expected to develop their workforce plan to include the Five Year Forward View commitment to training an additional 4,500 IAPT therapists. Areas will need to ensure that there is a recruitment plan with target numbers of trainees. If the service will operate over a number of geographies, or CCG’s can work in collaboration with neighbouring CCG’s it would be appropriate to consider recruiting collaboratively, perhaps in one location, with recruited staff being distributed fairly. This will guard against competitive recruitment which may result in services being under staffed. Ensure that the timeline of training is mapped to allow adequate processing and completion of necessary personnel procedures, it is often helpful to work backwards from the course start date in order to incorporate the time necessary for advertising posts, interviewing and notice periods for new recruits.

5. IAPT-LTC Top Up Training

The best outcomes in IAPT-LTC services are achieved with adapted assessment, formulation and treatments that take account of the LTC. The treatments should be embedded in the physical health care pathway for patients. There are manualised treatments for some MUS (e.g. CFS, IBS) and manualised groups for breathlessness and cardiac rehab have been very successful in the early implementer sites.

Randomised Control Trials (RCTs) have shown that psychological therapies are effective. The therapies provided are mainly based on CBT principles and build on the core competencies of the IAPT workforce but include additional competencies for working with patients with LTC/MUS. In core services, people accessing IAPT demonstrate lower recovery rates (by 3% in most recent NHS Digital annual report), however, the emerging data from the early implementers demonstrates recovery on a par with non LTC patients. We understand that this is due in part to the collaborative MDT (Multi - Disciplinary Team) approach offered by IAPT-LTC and also the LTC top up training which has been designed to optimise the understanding of the physical health condition and contextualise this within IAPT treatment.

The LTC top up training is offered for both HI's and PWP's, and staff who are transferring either full or part time into the LTC service will require the top up training. Staff attending the top up training will need to be able to commit to attending a minimum of 80% of the training, will be able to complete practice-based learning which is common to IAPT. Any senior staff who may be supervising members of the LTC team should also attend the top up training.

6. Branding and LTC Service Publicity

Many of the early implementers would recommend an early start in terms of engaging the local community and ensuring that local residents are aware of the new service. Some of the sites have branded their LTC service separately from the core IAPT service in order to increase engagement from people with long term health conditions who may not consider accessing a service delivering interventions for "mental health". This is entirely a local decision, however working with local condition specific groups eg. Diabetes UK or Stroke Association, relevant to your local pathways, will improve engagement and also act as publicity to the cohort you are intending to work with.

Below you will find some examples that two of our early implementer sites were happy to share:-

Confidentiality

Confidentiality is important to our service. This means that the information you provide to us will only be shared with other agencies with your permission or in exceptional circumstances. All information following your therapy session is recorded on an NHS secure information system. Data is collected nationally and is anonymised which is used to help improve the service. If you have any questions, or would like more information, please speak to your wellbeing specialist.

0300 123 0907 option 2
info@healthy-minds.org.uk
www.healthy-minds.org.uk

Healthy Minds is a partnership between North Staffordshire Combined Healthcare (NHS Trust), North Staffs Mind and Changes Health & Wellbeing.

North Staffordshire Combined Healthcare NHS
NHS Trust
Cognitive Behavioural Therapy (CBT)

Changes
Health & Wellbeing
Guided Self-Help & Educational Programmes

mind
for better mental health
North Staffs
Counselling for Depression

How to contact us...
0300 123 0907 option 2
www.healthy-minds.org.uk

healthyminds Stoke-on-Trent
Psychological Services

Are you experiencing physical health problems, that are causing you to feel Stressed? Worried? On Edge? Or Feeling Low & Fed-up? Sleeping Problems?

For Adults 18 years and over with no upper age limit.

A fast acting service for people worried about their physical health which aims to improve your wellbeing.

Leaflet - Diabetes and Emotional Wellbe

Leaflet - Respiratory Wellbeing - Pantone 5

Long-term Conditions leaflet - 120617.pdf

7. Developing Pathways

As the fundamental approach for this project is to create integrated working within physical health pathways a key requirement is to ensure that however the pathways are developed locally, they are developed to ensure that access to psychological interventions is part of "care as usual" in the physical health setting. If this is kept in mind it will guard against the LTC service drifting to a signposting model of care. Co-location is absolutely essential in integrating the care within physical health.

Experience from our early implementers has shown that local knowledge of disease prevalence, and of where there have been historically gaps in health psychology provision, can be a helpful starting point in deciding which pathways to target. It is also useful to work with MSP (Multi-Specialist Provider) hubs locally if these exist as they already are working in a collaborative and transformative way.

Many of our sites have indicated that staff working in the physical health pathways benefit from being "badged" as part of that specialist physical health team as this creates seamless transition and acceptance, and the treatment received is part of the normal "package of care".

One of our early implementer sites has agreed to share their pathways for Cardiac, COPD (Chronic Obstructive Pulmonary Disease), and Diabetes, see below:-

8. Increasing Referrals Once IAPT-LTC is Live

As with core IAPT, a new service will take time to develop, embed and demonstrate results. Due to the restricted timescales involved in the Early Implementer Programme, the services were keen to demonstrate early on the impact upon the wider health system of the new services, and to do this they needed patient numbers at scale. There were a variety of ways that the sites were able to increase patient numbers accessing the IAPT-LTC service. Please refer back to item 5 – branding and publicity is an important part of developing the service and there needs to be maintained lines of communication and engagement to ensure the idea becomes embedded both in the stakeholder and local community. Clearly defined pathways will demystify the service to health care colleagues, this will aid referrals. Ensuring simple and easy access routes which do not burden physical health staff are also a quick win. Giving "live" feedback to GP's will remind them of the service and regular routes of communication, perhaps through the CCG will also encourage referrals.

Local radio, television, and newspapers will often do "health segments", it can be very useful to have a member of staff who will confidently speak with reporters about what the service offers and how the treatments can help.

Providing training to physical health staff about mental health and the service in general will also encourage referrals, some of our sites also offer "taster" sessions to physical health staff to allow them to experience the LTC service offer from a patient point of view.

A key top tip from our sites is that communicating and providing information about the LTC service is not a single completed item, it needs to be repeated and embedded within the stakeholders and local community.