**IAPT – LTC : Lessons summary from the event held 9th October 2017**

1. **Available support documentation**

Yammer sharing site

1. Building a business case IAPT – LTC v1.0
2. IAPT LTC - Full implementation guidance
3. “How to” IAPT-LTC guide v1.0
4. Integrated IAPT Data Handbook V4
5. Integrated IAPT Early implementers data quality guide 1.0
6. Integrated IAPT Early implementers local evaluation support guide 1.0
7. Integrated IAPT FAQs v2.0
8. **Definition - What defines an Integrated IAPT service?**
* An integrated service will expand access to psychological therapies for people with long term health conditions or MUS by providing care genuinely integrated into physical health pathways working as part of a multidisciplinary team, with therapists, who have trained in IAPT LTC/MUS top up training, providing evidence based treatments collocated with physical health colleagues
1. **Targets**
* CCGs should commission additional IAPT services, in line with the trajectory to meet 25% of local prevalence in 2020/21
* Two thirds of workforce expansion, by 2020/21, to be ‘Integrated IAPT’ services – integrated with physical health pathways for people with long term conditions or distressing and persistent medically unexplained symptoms.
* From 2018/19, CCGs to commission IAPT-LTC services locally
* Local workforce planning includes the number of therapists needed and that mechanisms are in place to fund trainees.
* Withdrawal of HEE salary support for trainees (60% PWP, 100% HI) 2018/19
* National IAPT team NHSE are calculating each CCG’s share of the additional 4,500 therapists and the 3,000 MH therapists in primary care
1. **Data**
* Integrate data into business as usual (session by session, data view in every supervision, IT system support, digital input).
* Integrated services need to collect some additional data on the perceived impact of the LTC and healthcare utilization (e.g. CSRI)
* Be clear from the beginning about what to collect, when, why, and how data completeness is monitored.
1. **London Wave sites – early implementers**

Wave 1

Richmond

Hillingdon

Wave 2

Haringey

Islington

Brent

Harrow

Central London

West London

Hammersmith and Fulham

Ealing

Hounslow

Wave 1 & 2 information available on location and LTC targeted

1. **Start early!** Engagement, relationships and development of pathways does take time. Providers - Make links top down (decision makers/influencers) and bottom up (implementers). High level Boards, CCG, primary care staff, condition pathway leads, third sector, service users and ‘neighbourhoods’ to understand local populations/ key priorities. Use a patient focus group. Use GP champions.
2. **Develop a good implementation plan** which is co-produced, has both physical and mental health input along with service user collaboration
3. **Think about future** proofing the investment whilst developing the implementation plan, how local evaluation evidences savings
4. **Involve physical health commissioners and clinicians** if possible in identifying your priorities, practically how that model will work, possible benefits and how you can measure them
5. **Early implementer selected a few LTC** to target with a timed roll out for all LTC. Selecting LTC to target based on local need and expertise. Consider what the GP priorities are in terms of conditions Link in with existing work streams in physical health – targeted LTC
6. **When developing pathways, carefully consider local nuance** – where lends itself to integrated working? What do the Right Care packs show? Designing the pathway so that the service can catch people when they are first diagnosed rather than further down the pathway. Whole pathway approach to LTC/MUS from Step1-Step 4: ‘dual trained’ practitioners, psychologists, experienced IAPT staff integrating with physical health workers. Deliver psychological therapy at ‘Neighbourhood’ level.
7. **Understand local pathways**. Mapping exercise to avoid duplicate pathways and parallel processes. Prevent duplicate commissioning. Acute, community, primary care.
8. **Ensure there is clarity re the distinctions** between IAPT LTC, Liaison Psychiatry and health psychology, and that the pathways between all three are clear
9. **Don’t underestimate the important of publicity and marketing**- start this early too. Websites, information leaflets, prescription pads, posters, courses and workbooks
10. **How should you brand your service to appeal to the target audience** – Need to think about how to “sell” this to physical health colleagues to demonstrate the benefits, language options
11. **Training - PHC staff**, can you dual train practitioners. Some service models trained all staff around LTC rather than specific staff. Increase identification of anxiety and depression in physical health settings enhanced by joint training. Clinical supervision and consultation from health and medical psychologists for all IAPT staff. LTC top-up training, specialist training by physical LTC teams, internal training.
12. **Role**: be clear on the design - NOT signposting but treatment - need integration and co-location

**Challenges**

* Recruitment.
* Stabilising core IAPT
* Estates and accommodation
* IT/information governance
* Tracking health care utilisation and demonstrating savings
* Engagement across the pathways: integrating into physical health teams
* Recurrent and appropriate funding