# Suffolk Improving Access to Psychological Therapies - Long Term Conditions Service

**Agenda Item No.** 11  
**Reference No.** IESCCG 19-17  
**Date** 26 March 2019  
**Title** Suffolk Improving Access to Psychological Therapies - Long Term Conditions Service.

**Lead Chief Officer** Richard Watson, Deputy Accountable Officer & Chief Transformation Officer  
**Author(s)** Hannah Neumann-May, Senior Transformation Lead for Mental Health

**Purpose** To describe the key benefits of providing psychological therapies for people with depression and anxiety disorders in the context of long term physical health conditions, and outline the proposed costed service offer to deliver the national IAPT target from 15% to 25% by 2021.

<table>
<thead>
<tr>
<th>Applicable CCG Clinical Priorities:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To promote self-care</td>
<td>x</td>
</tr>
<tr>
<td>2. To ensure high quality local services where possible</td>
<td>x</td>
</tr>
<tr>
<td>3. To improve the health of those most in need</td>
<td>x</td>
</tr>
<tr>
<td>4. To improve health &amp; educational attainment for children &amp; young people</td>
<td>x</td>
</tr>
<tr>
<td>5. To improve access to mental health services</td>
<td>x</td>
</tr>
<tr>
<td>6. To improve outcomes for patients with diabetes to above national averages</td>
<td>x</td>
</tr>
<tr>
<td>7. To improve care for frail elderly individuals</td>
<td>x</td>
</tr>
<tr>
<td>8. To allow patients to die with dignity &amp; compassion &amp; to choose their place of death</td>
<td>x</td>
</tr>
<tr>
<td>9. To ensure that the CCG operates within agreed budgets</td>
<td>x</td>
</tr>
</tbody>
</table>

**Action required by Governing Body:**

Discuss and agree to option one within the business case for additional investment in the IAPT and Wellbeing Service to ensure the service meets the national must dos to achieve a 22% access rate in 2019/20 and 25% in 2020/21. The investment amount being £898,596 in 2019/20 (part year effect) and £1,702,362 in 2020/21 (full year effect).
1. **Background**

1.1 Suffolk CCGs have commissioned Improving Access to Psychological Therapies (IAPT) services since 2008. This was one of the 1st wave services in England, which has been delivered by NSFT successfully, transforming the treatment of depression and anxiety related disorders for people aged 16+ years. The service has reliably and consistently met key performance indicators, currently successfully treating the relevant population within nationally specified waiting time targets and achieving the key outcomes of recovery for over 50% and reliable improvement for over 60% of people treated in the service.

1.2 The *Five Year Forward View for Mental Health* and the *NHS Long Term Plan* set out the commitment to expand IAPT services and improve quality further, with a view to increasing access to psychological therapies from 15% to 25% for people with common mental health problems by 2020/21.

1.3 Two thirds of increased expansion of IAPT services is achieved by integrating services into physical health care pathways. 40% of people with depression and anxiety disorders also have a long term physical health condition (LTC). Currently, people often receive their mental and physical health care in separate services that are rarely coordinated. This is inconvenient for patients, costly to the NHS and likely to produce sub-optimal outcomes.

1.4 Within the IAPT-LTC care pathway, mental and physical health providers work in a coordinated way to achieve the best outcomes for their patients, ensuring that a person’s mental and physical health needs are valued equally and recognition of the need to ensure that care is delivered in a coordinated and integrated way. This expansion will see IAPT services co-located in existing primary and secondary care physical health pathways.

1.5 During 2016/17 and 2017/18, a targeted approach has been in place nationally to deliver IAPT-LTC services in Wave 1 and Wave 2 ‘early implementer’ sites. All CCGs must roll out IAPT-LTC services as a key mechanism to ensure the delivery of IAPT from 15% to 25%. These national targets are outlined in the NHS Operational Planning and Contracting Guidance 2017-2019 published by NHS England and NHS Improvement, and is reiterated within the NHS Long Term Plan published in January 2019.

2. **Discussion / Key Issues**

2.1 Key benefits of providing psychological therapies for people with depression and anxiety disorders in the context of LTCs include:

- improved patient experience and service user satisfaction
- improved patient choice by receiving physical and mental healthcare in the same setting
- greater efficiencies through reducing duplication and the need for multiple assessments
- increase the availability of expertise for the provision of physical and mental healthcare and symptom management in the medical setting
- improved clinical outcomes
- reduced use of physical health care services, including acute and emergency care
- improve access to psychological therapies
- supports the strategic move towards Integrated Neighbourhood Teams

2.2 The IAPT-LTC expansion support needs have been highlighted by Public Health Suffolk, which stated that around half of all hospital inpatients have a mental health condition and that there needs to be more integration between physical and mental health for people in Suffolk. Developing IAPT services throughout physical health care pathways (spanning primary care, community and acute health settings), means the whole person is cared for. People can access the right emotional and physical help in a timely manner to prevent mental ill-health and help people live the lives they want to continue living (see Fig.12 Suffolk’s 15 Ways to Wellbeing diagram on the following page).
2.3 The system in Suffolk is in a good position to develop IAPT-LTC. It will require engagement across the health system and involvement of multiple stakeholders. The treatment of common mental health disorders in people with long term physical health conditions not only improves mental wellbeing and mental health recovery, but has been shown to improve patients’ physical health outcomes also.

Fig. 12: Suffolk’s 15 Ways to Wellbeing

2.4 The expanded service is proposed to focus in 2019/20 on three long term conditions:

- For **Diabetes**, addressing psychological needs has been shown to improve glycosylated haemoglobin (HbA1c) by 0.5 to 1 per cent in adults with type 3 Diabetes. Further benefits include reduced psychological distress and anxiety, improved mood and quality of life, improved relationships with health professionals and significant others, and improved eating related behaviours.

- For **COPD**, treating a person’s anxiety and depression helps them manage their illness, shortness of breath, improves cognitive attributions, and improves independence and exercise tolerance, with less time spent in hospital, less use of medication, decreased impact on employment and improved quality of life.

- For **Chronic Heart Disease**, benefits are generated both through acknowledging that cardiovascular disease can have psychological consequences and vice versa, and by offering evidence-based interventions for identified mental health problems. Patients with chronic heart failure and depression have been shown to experience 50% more acute exacerbations per year and have increased mortality rates.

Proposed IAPT-LTC Pathway:
Proposed Service Offer:

- IAPT-LTC practitioners will be co-located with physical healthcare practitioners in settings across (primary, community and acute health care settings), e.g. LTC practitioners running clinics with diabetic specialist nurses to provide a fully integrated package of care.
- The core wellbeing service will support health promotion across the community around the benefits of supporting mental health alongside physical health using its vast range of experienced staff e.g. therapists, community development workers and peer support workers.
- When people present in any setting and identify themselves as having a specific LTC for which there is an existing IAPT-LTC pathway developed and are experiencing signs of anxiety and/or depression they will have access to information about the support available through IAPT-LTC as part of their core support for recovery for their LTC.
- Patients presenting in physical health settings e.g. primary care, acute and community outpatient clinics, to be offered co-located IAPT-LTC practitioner clinics.

2.5 The attached business case (Appendix 1) describes Option 1 which delivers 22% intervention rate by Q4 2019/20 and 25% by Q4 2020/21 whilst maintaining the current operational model, thus meeting all national requirements at a FYE cost of £2.603m across West Suffolk and Ipswich and East Suffolk CCGs.

2.6 Option 2 (only included for planning purposes) considers the financial impact of stopping the current link worker contribution to meeting IAPT targets and pulling these staff out. This option has been discounted.

2.7 A governance structure will be set up to oversee the design of the potential model. The project group will be responsible for overseeing the development and will report to CCGs and Suffolk Mentally Healthy Communities Board. A Project Group will oversee the project scope and timescale, and progress against it, escalating potential risks and issues when appropriate, developing the desired service outcomes and broad structure and engaging with appropriate stakeholders, including service user and carer representation.

2.8 The expansion of psychological therapies focuses on cultural change and integration to improve service user experiences and outcomes, and to help sustain their wellbeing at home.

3. Patient and Public Engagement

3.1 The co-production process (#averydifferentconversation), which has underpinned our work to date in producing all elements of the Suffolk Mental Health and Emotional Wellbeing Strategy, has shifted how the CCGs involve partners and signals a different way of working in future. The proposed changes within this business case address a number of the themes raised during the extensive engagement exercise undertaken. Service users will be part of the ongoing development and implementation of this service.

4. Recommendation

4.1 To discuss and agree to option one within the business case for additional investment in the IAPT and Wellbeing Service to ensure the service meets the national must dos to achieve a 22% access rate in 2019/20 and 25% in 2020/21. The investment amount being £898,596 in 2019/20 (part year effect) and £1,702,362 in 2020/21 (full year effect).
1.0 BACKGROUND

Suffolk CCGs have commissioned Improving Access to Psychological Therapies (IAPT) services for 10 years, since 2008 with Suffolk IAPT services being one of the first wave IAPT service providers in England. The services have been delivered by the same provider successfully and have transformed the treatment of depression and anxiety related disorders for people aged 16+ years in Suffolk. The service is reliably and consistently meeting its key performance indicators, currently successfully treating 18.6% of the relevant population within nationally specified waiting time targets and achieving the key outcomes of recovery for over 50% and reliable improvement for over 60% of people treated in the service.

The Five Year Forward View for Mental Health 1 and the Next Steps on the NHS Five Year Forward View 2 set out a commitment to expand IAPT services and improve quality further, with a view to increasing access to psychological therapies from 15% to 25% for people with common mental health problems by 2020/21. Two thirds of the increased expansion of IAPT services is achieved by integrating IAPT services into physical health care pathways. Around 40% of people with depression and anxiety disorders also have a long-term physical health condition (LTC) 3. Currently, people often receive their mental and physical health care in separate services that are rarely coordinated. This is inconvenient for patients, costly to the NHS, and likely to produce sub-optimal outcomes.

Building on the skill and hard work of IAPT’s committed national workforce, the NHS has been developing new integrated IAPT (‘IAPT-LTC’) services, which will ensure that people with mental and physical health problems receive joined-up health care (IAPT Manual). The IAPT-LTC services will ensure people with long-term physical health problems have the same access to NICE-recommended psychological therapies as other people, whilst reducing stigma of accessing a separate mental health service and normalising the experience of common mental health problems alongside physical health needs.

NHS England Key Performance Indicators (KPIs) 2019/20 (must do’s):

| IAPT Expansion | Meet 22% access to treatment target for expansion in IAPT. All areas commissioning an integrated IAPT-LTC service. This involves supporting the commissioning of expansion and replacement mental health therapists to ensure 3,000 mental health therapists are co-located in primary care by 20/21. |
| Maintenance Core Standards | Meet 50% IAPT recovery rate; Meet 75% of people accessing treatment within 6 weeks IAPT waiting time; Meet 95% of people accessing treatment within 18 weeks IAPT waiting time |

There is a requirement to ensure sustained focus on IAPT services so that they continue to meet the core IAPT offer alongside all areas commissioning IAPT-LTC services with a view to this aspect of the service providing two thirds of the increase in access up to 25%.
Within the IAPT-LTC care pathway, mental and physical health providers work in a coordinated way to achieve the best outcomes for their patients. This means that as well as ensuring that a person’s mental and physical health needs are valued equally, there is also recognition of the need to ensure that care is delivered in a coordinated and integrated way. This expansion will see IAPT services co-located in existing primary and secondary care physical health pathways.

During 2016/17 and 2017/18, a targeted approach has been in place nationally to deliver IAPT-LTC services in Wave 1 and Wave 2 ‘early implementer’ sites. From 2018/19, it is expected that all CCGs must roll out IAPT-LTC services as a key mechanism to ensure the delivery of increased access to psychological therapies from 15% to 25% by 2021. This was outlined in the NHS Operational Planning and Contracting Guidance 2017-2019 published by NHS England and NHS Improvement and is reiterated within the NHS Long term plan published in Jan 2019.

Details of full national implementation guidance for IAPT-LTC services for providers and commissioners is included in the document below.

![IAPT-LTC-Full-Implementation-Guidance.png](IAPT-LTC-Full-Implementation-Guidance.png)

### 2.0 IAPT-LTC for Suffolk

The development of integrated IAPT services within long term physical health pathways (IAPT-LTC) is timely for Suffolk as it aligns perfectly with Suffolk’s mental health and emotional wellbeing strategy towards developing a system-wide approach to mental health and wellbeing for 2019-29. This strategy has evolved through involving all stakeholders including residents in Suffolk in a very different conversation around mental health and emotional wellbeing, highlighting the importance of mental health to all, being part of everyone’s business rather than being the responsibility of a set of mental health services.

The IAPT-LTC expansion supports needs highlighted by Public Health Suffolk which state that around half of all hospital inpatients have a mental health condition and that there needs to be more integration between physical and mental health for people in Suffolk.

Through development of provision of IAPT services throughout physical health care pathways (spanning primary care, community and acute health settings) this will support a focus on the whole person, accessing the right emotional and physical help in a timely manner to promote prevention of mental ill-health and promoting self-care to help people to live the lives they want to continue living.

The system in Suffolk is in a good position to enable the development of IAPT-LTC, which will require engagement across the health system and involvement of multiple stakeholders. The system includes the evolution of:

- an Integrated Care System covering North East Essex and East and West Suffolk which means that the whole system across Suffolk and North East Essex (commissioners, statutory and non-statutory providers, partners and regulators) will be working more closely to support the needs of this population
- evolving Alliances in East and West Suffolk including health, local authority and other partner organisations coming together with a common purpose and starting to share resources and blur boundaries between providers
- the focus of services around localities enabling the wrapping of services around, and integrating into, local communities and their integrated neighbourhood team areas.
The Suffolk Mental Health and Emotional Wellbeing Hive diagram (above) illustrates the range of Suffolk mental health and other complimenting services/functions that will support mental health and emotional wellbeing in East and West Suffolk through the ten year strategy. The diagram indicates the range of services that can support individuals and their families/carers with IAPT (including LTC) forming one of the range of segments that will interconnect and offer holistic joined-up care to people in Suffolk.

3.0 WELLBEING SUFFOLK AND IAPT-LTCS: SUFFOLK’S AMBITION FOR A MENTALLY HEALTH POPULATION

3.1 Supporting 15 Ways to Wellbeing

Wellbeing Suffolk already embraces the Five Ways to Wellbeing (New Economics Foundation) within its IAPT provision and with a focus on IAPT for those with physical health conditions with the IAPT-LTC expansion this opens further opportunity to develop this and embrace further integrated provision. Suffolk’s vision outlined in its ten year strategy to extend to 15 Ways to Wellbeing (see below) highlights further the key component of supporting self-care through the interconnections of physical health, emotional health and environmental wellbeing.

3.2 Supporting mental health friendly conversations

As part of the IAPT-LTC roll out, Wellbeing Suffolk will assist others through delivery of training and support to enable people to feel comfortable to talk about emotional wellbeing and mental health particularly when this is linked to physical health conditions. We will support East Suffolk and North East Essex NHS Trust (ESNEFT) working with North Essex’s IAPT provider (Health In Mind) in their corporate objective to be a mentally healthy workplace, as well working with other providers and community groups working with
physical health conditions to help people proactively recognise mental health needs and engage early to provide interventions to meet these needs.

Fig. 12: Suffolk’s 15 Ways to Wellbeing

3.3 Why focus on people with co-morbid physical and mental health problems to achieve this increased access?

A person’s mental and physical healthcare are intrinsically linked. There is clear evidence that the presence of LTCs markedly increases the risk of a comorbid mental health problem and vice versa. Over 16.5 million people in England – around 30% of the population – will be diagnosed with one or more LTCs. Of these people, over 30% will also experience a mental health problem (see Figure 1). This is substantially higher than the prevalence rate in the general population. Comorbid depression and anxiety disorders are most common and there is particularly strong evidence for higher rates of depression and anxiety disorders in people with cardiovascular disease, diabetes and COPD. Left untreated, mental health problems can have a significant impact on the person’s physical health as well as the overall cost of their care.

Figure 1: The overlap between LTCs and mental health problems in England

There is growing evidence that supporting the psychological and mental health needs of people with long-term conditions can more effectively lead to improvements in both mental and physical health - improving
clinical outcomes, quality of life, and overall prognosis. Healthcare costs for those with coexisting mental health problems and LTCS are significantly (around 50%) higher. It is suggested that between 12% and 18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing. This equates to between £8 billion and £13 billion in England each year, or around £1 in every £8 spent on long-term conditions 12.

4.0 THE IMPACT OF DEPRESSION AND ANXIETY DISORDERS IN THE CONTEXT OF LTCS

4.1 The impact on the patient:

Evidence suggests that people are even more unlikely to access treatment for their mental health problem when they also have LTCS. The reasons for this may include:

- Under-recognition of depression and anxiety disorders, with symptoms attributed to a physical cause by the person or their clinician 14
- Stigma 15
- Unwillingness of physical and mental health clinicians to go beyond their professional silos and explore the person's wider needs 16
- Time pressures on physical health care teams and limited availability of, or input from, mental health clinicians 17

Untreated depression and anxiety disorders can lead to a range of adverse psychological, social and employment outcomes for the person. These may include:

- Lower likelihood of engaging with treatment for the physical health problem, reducing the person’s ability to effectively self-manage the problem
- Higher likelihood of unhealthy behaviour such as smoking, alcohol, drug use, poor diets and decreased physical activity
- Higher rates of functional impairment and a heightened risk of premature mortality
- Higher risk of unemployment in people with coexisting mental and physical health problems and for those in employment a high risk of absenteeism,18 poorer performance and lower income 6.

The treatment of common mental health disorders in people with long term physical health conditions not only improves mental wellbeing and mental health recovery, but has been shown to improve patients’ physical health outcomes also.

- For **Diabetes**, addressing psychological needs has been shown to improve glycosylated haemoglobin (HbA1c) by 0.5 to 1 per cent in adults with type 3 Diabetes. Further benefits include reduced psychological distress and anxiety, improved mood and quality of life, improved relationships with health professionals and significant others, and improved eating related behaviours.

- For **COPD**, treating a person's co-morbid anxiety and depression improves a patient's ability to manage their illness and shortness of breath, improve cognitive attributions, and improve independence and exercise tolerance, with less time spent in hospital, less use of medication, decreased impact on employment and improved quality of life.

- For **Chronic Heart Disease**, benefits are generated both through acknowledging that cardiovascular disease can have psychological consequences and vice versa, and by offering evidence-based interventions for identified mental health problems. Patients with chronic heart failure and depression have been shown to experience 50% more acute exacerbations per year and have increased mortality rates.
4.2 The impact on the NHS:

Healthcare costs for those with coexisting mental health problems and LTCs are significantly (around 50%) higher \(^{12}\). A large proportion of this cost is accounted for by increased use of physical health services (not mental health services) \(^{19}\).

There is potential to apply Quality, Innovation, Productivity and Prevention (QIPP) principles to the expansion of psychological therapies in East and West Suffolk. Historically, mental health QIPP approaches have focused on resource and efficiency savings through structural and pathway redesign. The expansion of psychological therapies focuses on cultural change and integration to improve service user experiences and outcomes, and to help sustain their wellbeing at home.

4.3 Potential benefits of integrating mental and physical health care:

- Integrating care enhances the whole team’s capability to provide more comprehensive, accessible and holistic care. This reduces costs through encouraging the prompt uptake of treatment and decreases the likelihood of people not attending appointments.

- Identifying the person’s needs more quickly and accurately can potentially reduce the number of frequent attenders and repeat assessments. Ensuring the right care is delivered can also reduce the length of hospital stays and prevent unnecessary admissions.

- A single jointly developed care plan can lead to greater efficiencies by reducing duplication. It can also lead to improved relationships within teams and services.

- Integrating care is more cost-effective as effectively identifying and treating the person’s mental health problem can reduce their use of physical health services.

In 2016-17, 37 early implementer services were established in two waves, supported by the NHSE national team and transformation funding, to develop schemes and build the necessary workforce at scale. While these services have not yet completed formal evaluations, individual services have begun to demonstrate significant savings in acute and primary care healthcare utilisation. For example:

- A service in the South of England has demonstrated a 49% reduction in GP appointments, 52% reduction in A&E attendance, and 80% reduction in X-Rays, with a 75% increase in specialist nurse use rather than medical resource.

- The Heart2Heart pathfinder service in Oxford has seen savings of £1,979 per patient among people with Chronic Heart Disease treated in IAPT, though the sample is small at only 67 patients.
5.0 PROPOSED IAPT-LTC PATHWAY

Recruitment to the LTC workforce will take place in a phased way. As such, the service proposes to stage implementation of the integrated IAPT-LTC pathways. The basic clinical model has been taken from the IAPT-LTC Full Implementation Guidance and is represented in the figure below:

<table>
<thead>
<tr>
<th>Presentation</th>
<th>Referral</th>
<th>Pathway starts</th>
<th>Assessment</th>
<th>Treatment starts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person presents in the community or primary or secondary care with MUS or depression and/or anxiety disorder in the context of an LTC</td>
<td>Referral or self-referral made to IAPT-LTC service</td>
<td>IAPT-LTC service receives the referral</td>
<td>Person-centred assessment that covers the person’s mental health problems and acknowledges the impact of their LTC</td>
<td>Person starts a NICE-recommended psychological therapy or leaves the pathway following single assessment and advice or discharge</td>
</tr>
</tbody>
</table>

5.1 Phase One (2019/20) Suffolk:

The LTC expansion will begin in April 2019 through the use of the Living Life to the Full (LLTTF) online guided CBT programme specific to those living with LTCs (Reclaim Your Life package). This will provide all those with LTCs across Suffolk access to the public version of LLTTF specific for LTCs (as part of the Suffolk-wide commissioned pilot). If individuals rate their levels of anxiety and/or depression beyond the mild threshold (agreed with CCGs) they will be given the option to access additional guided support over the phone within our core IAPT service.

Between April and September 2019, recruitment to the leadership positions (8a Operational and Clinical Leads) will take place. The service will focus activity on identifying appropriate care pathways and developing working relationships with key stakeholders with a view to fully integrating within these pathways. Stakeholders will include primary care providers, acute and community physical health care providers, liaison mental health professionals and clinical and health psychologists, voluntary sector organisations, and other mental health providers. Co-production will be key for planning and developing pathways with people using the services and their families and carers at all stages. Where appropriate opportunities have synergy we will start to deliver into existing physical health care settings (e.g. co-facilitating with existing physical pathway groups).

In September 2019, the service will launch a 6-week ‘Living with a LTC’ workshop for those with any LTC delivered in integrated community settings across Suffolk and online via a webinar. We propose that the expansion follows the nationally recommended roll out, focusing on Diabetic Medicine, Respiratory (COPD) and Cardiology (CHD and Stroke) in the first year and Cancer, Musculoskeletal and Gastroenterology (IBS) in year two. In the long-term, the service will work towards a single IAPT provision for everyone.

An initial meeting has taken place with the Directors of Nursing for both local acute hospitals, the existing IAPT provider and commissioners in order to agree and develop the integrated approach for the acute hospital environment. Agreed next steps are for the IAPT provider, clinical and medical (including
psychology) staff from the acute trusts and commissioners to meet with specialty leads for Diabetes, Cardiology and Respiratory to develop integrated pathways of care in order to support people with LTCs to have their physical and mental health needs met. The project group will then be established and will engage with appropriate stakeholders, including a range of local service users and carers. The same integrated approach will be developed for the primary care and community environment.

5.2 Proposed service offer for roll out of IAPT-LTC into physical health pathways:

- LTC practitioners will be co-located and working alongside physical health care practitioners in settings across physical health pathways (primary, community and acute health care settings). For example, LTC practitioners would run clinics alongside and with diabetic specialist nurses within the Diabetic pathway to provide a fully integrated package of care.
- The core Wellbeing service will support health promotion across the community around the benefits of supporting mental health alongside physical health using its vast range of experienced staff e.g. therapists, community development workers and peer support workers.
- When people present in any setting and identify themselves as having a specific LTC for which there is an existing IAPT-LTC pathway developed and are experiencing signs of anxiety and/or depression they will have access to information about the support available through IAPT-LTC as part of their core support for recovery for their LTC.
- When patients present in physical health settings e.g. primary care, acute and community outpatient clinics in which there are facilities for IAPT-LTC practitioners to hold co-located clinics physical health care clinicians will give the option to meet with an IAPT-LTC therapist co-located in the clinic on the same visit.
- Where there is no IAPT-LTC practitioner on-site the physical health care practitioner will support a referral to IAPT-LTC to enable an assessment to be arranged with an IAPT-LTC practitioner in an alternative physical health setting.
- Following assessment, people will be offered the full range of IAPT-LTC stepped care according to the patient’s needs and choice. Including: single session and advice/signposting; LLTTF-LTC: an LTC workshop in an integrated community setting; Step 2 guided self-help adapted for LTC, Step 3 therapy or other appropriate IAPT interventions, all provided wherever possible alongside a patient’s physical health care provision. 1:1 psychological therapies can be delivered via telephone, face to face or skype according to choice and availability.
- Completion of the IAPT Minimum Data Set and appropriate anxiety disorder specific measures and/or the relevant LTC outcome measures completed at every contact - continuous review of progress, step up/down/signposting/referral on/discharge as completed as appropriate.

5.3 Proposed offer for all LTCs across Suffolk whilst developing IAPT-LTC into all physical health pathways:

- The service will work with commissioners, primary care and physical health providers to identify appropriate patients on existing waiting lists who could be provided with promotional material on LLTTF and other psychological interventions offered within the Wellbeing Service.
- When people present in any setting and identify themselves as having a LTC and are experiencing signs of anxiety and/or depression they will have access to information on the LLTTF LTC course, Living with a LTC workshop and other core IAPT interventions offered within Wellbeing. A professional or self-referral is made to the Wellbeing Service.
- Once the referral is received, in line with existing IAPT expectations and definitions, the service contacts the patient within three working days of receiving the referral.
- Assessment that covers the person’s mental health problems and acknowledges the LTC is carried out by an experienced clinician – in line with national IAPT standards, 75% of people referred will begin treatment within six weeks of referral and 95% will begin treatment within 18 weeks of referral.
- Patient accesses LLTTF-LTC, the LTC workshop or other appropriate IAPT intervention. All treatment will be delivered in accordance with NICE guidelines and quality standards.
- Completion of the IAPT Minimum Data Set and appropriate anxiety disorder specific measures and/or the relevant LTC outcome measures completed at every contact - continuous review of progress, step up/down/signposting/referral on/discharge as completed as appropriate.
5.4 Evidence-based psychological therapies (informed by NICE guidance) recommended for use in IAPT-LTC Services

To ensure that treatment is effective and recovery is promoted:

- a stepped-care model for the delivery of psychological therapies will be used, whenever appropriate.
- interventions will be guided by the person’s problem descriptor - a range and choice of therapies will be available that cover the full range of severities of depression and anxiety disorders.
- the person should be offered treatment at an appropriate dose (number of sessions).

### Step 2

<table>
<thead>
<tr>
<th>Condition</th>
<th>Psychological therapies</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Individual guided self-help based on CBT, computerised CBT, behavioural activation, structured group physical activity programme</td>
<td>NICE guidelines: CG98, CG91, CG123</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT</td>
<td>NICE guidelines: CG113, CG123</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>Self-help, or guided self-help, based on CBT, psycho-educational groups, computerised CBT</td>
<td>NICE guidelines: CG113, CG123</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>Guided self-help based on CBT</td>
<td>NICE guidelines: CG31, CG6123</td>
</tr>
</tbody>
</table>

### Step 3

<table>
<thead>
<tr>
<th>Condition</th>
<th>Psychological therapies</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>CBT or interpersonal therapy Behaviour activation Couples therapy Counselling for depression Brief psychodynamic therapy Note: psychological interventions can be provided in combination with antidepressant medication.</td>
<td>NICE guidelines: CG90, CG91, CG123</td>
</tr>
<tr>
<td>Moderate to severe</td>
<td>CBT or interpersonal therapy, each with medication</td>
<td>NICE guidelines: CG90, CG91, CG123</td>
</tr>
<tr>
<td>Prevention of relapse</td>
<td>CBT or mindfulness-based cognitive therapy</td>
<td>NICE guidelines: CG90, CG91, CG123</td>
</tr>
<tr>
<td>Generalised anxiety disorder</td>
<td>CBT, applied relaxation</td>
<td>NICE guidelines: CG113, CG123</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>CBT</td>
<td>NICE guidelines: CG113, CG123</td>
</tr>
<tr>
<td>Post-traumatic stress disorder</td>
<td>Trauma-focused CBT, eye movement desensitisation and reprocessing</td>
<td>NICE guidelines: CG26, CG123</td>
</tr>
<tr>
<td>Social anxiety disorder</td>
<td>CBT specific for social anxiety disorder</td>
<td>NICE guidelines: CG159</td>
</tr>
<tr>
<td>Obsessive-compulsive disorder</td>
<td>CBT (including exposure and response prevention)</td>
<td>NICE guidelines: CG31, CG123</td>
</tr>
<tr>
<td>Chronic fatigue syndrome</td>
<td>Graded exercise therapy, CBT</td>
<td>NICE guideline: CG53</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Combined physical and psychological interventions, including CBT and exercise</td>
<td>NICE guideline: CG88</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>CBT</td>
<td>NICE guideline: CG61</td>
</tr>
<tr>
<td>MUS not otherwise specified</td>
<td>CBT</td>
<td>Informal consensus of the ESG</td>
</tr>
</tbody>
</table>
6.0 DATA QUALITY AND PERFORMANCE MONITORING

The IAPT-LTC expansion will be part of the national data collection system for IAPT and will use the IAPT Minimum Data Set. Four domains will also need to be captured for IAPT-LTC services:

- **Mental health outcomes**: this is the primary outcome for IAPT therapy and will be used to calculate key IAPT indices such as recovery, reliable improvement and reliable recovery.

- **Perception of physical health**: it is important to measure patients’ perceptions of their LTC as the therapy progresses in order to ensure that treatment focuses on the whole person. For some people, treatment of mental health problems may directly improve physical health; for others, the negative impact of LTCs on their lives may be reduced.

- **Disability**: the main measure of disability is the Work and Social Adjustment Scale (WSAS), which assesses the extent to which a person’s mental health problem interferes with their functioning at work, at home, at leisure, socially and with their family. Although disability often decreases as symptoms improve, that is not always the case. For this reason, clinicians need to carefully monitor WSAS scores as well as symptom scores to ensure that people have reduced disability once treatment is finished.

- **Healthcare utilisation**: it is expected that the treatment of mental health problems will, in general, reduce a person’s use of other health service resources. Documenting this effect will be important for sustaining IAPT-LTC. The Client Service Receipt Inventory is appropriate for this purpose.

- **Patient-reported experience measures (PREMs)**: It is important to measure the quality of a person’s experience of the service. PREMs should be collected at the end of the last assessment contact (Assessment Patient Experience Questionnaire) and at the end of or after the last planned treatment appointment (Treatment Patient Experience Questionnaire).

Key benefits of providing psychological therapies for people with depression and anxiety disorders in the context of LTCs include:

- improved patient experience and service user satisfaction
- improved patient choice by receiving physical and mental healthcare in the same setting
- greater efficiencies through reducing duplication and the need for multiple assessments
- increase the availability of expertise for the provision of physical and mental healthcare and symptom management in the medical setting
- improved clinical outcomes
- reduced use of physical health care services, including acute and emergency care
- improve access to psychological therapies
- supports the strategic move towards Integrated Neighbourhood Teams

7.0 WORKFORCE FOR IAPT-LTC SERVICES – NATIONAL RECOMMENDATIONS

The right workforce, appropriately trained, with the right capacity and skill mix, is essential for ensuring the delivery of evidence-based (NICE-recommended) interventions as part of the IAPT-LTC pathway. The
IAPT workforce consists of psychological wellbeing practitioners (PWPs) and high-intensity therapists (HITs) who together deliver the full range of evidence-based interventions for people with mild, moderate and severe depression and anxiety disorders, operating within a stepped-care model. It is expected that within IAPT-LTC services 30% of staff will be PWPs and 60% high-intensity therapists (see Table 3 below). This ratio is suggested because it is likely that in IAPT-LTC services a larger proportion of high-intensity interventions will be delivered and more complex assessments conducted. The remaining 10% of staff should have specialist expertise in LTCs and are usually senior therapists (including clinical or health psychologists).

<table>
<thead>
<tr>
<th></th>
<th>IAPT services</th>
<th>IAPT-LTC services</th>
</tr>
</thead>
<tbody>
<tr>
<td>PWPs</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>High-intensity therapists</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>Senior therapists (including clinical and health psychologists)</td>
<td>10%</td>
<td></td>
</tr>
</tbody>
</table>

Training of PWPs outside of an accredited PWP programme is not recognised. For example, training in the Children and Young Peoples' IAPT programme as a Children's Wellbeing Practitioner does not lead to competence as a PWP for adult IAPT, and is not transferable. Adult PWP training also does not equip a practitioner with competences to work in Children and Young People’s IAPT. There are currently no ‘top-up’ routes to PWP training that recognise prior learning. This means that all PWPs in Adult IAPT services need to pass the full PWP training on an accredited programme.

Trained and competent therapists should have completed an IAPT-accredited training programme. To develop competences for integrated pathways, NHS England and Health Education England have developed a specialist training programme for PWPs and HITs.

**8.0 WORKFORCE FOR IAPT-LTC SERVICES – LOCAL RECOMMENDATIONS & OPTIONS**

There are two options available. The pros and cons of these have been detailed below alongside the cost of each option. Each option considers the services ability to reach the required 22% and 25% access target and is based on the national definition that access is one attended clinical appointment (assessment) with the service.

**OPTION ONE TO DELIVER 22% BY Q4 2019/20 AND 25% BY Q4 2020/21:**

**Maintain current IAPT model (including current link worker contribution to IAPT)**

Additional establishment required is:

- 19 CBT Therapists
- 14 PWPs
- 10 Other staff
- 43 Total WTE staff at a cost of £2.6M FYE
The Link Worker activity within the service accounts for approximately 7.5% of the current 19% access. Over the last year, on average, this aspect of the service has delivered access for 370 patients per month. The trajectory below illustrates the expansion required to meet the increasing access target and includes Link Workers in this model moving forwards. It also makes the assumption that the Link Worker aspect of the service will continue to achieve an average of 370 appointments per month.

**Trajectory:**

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Pay Band</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT Therapist</td>
<td>7</td>
<td>7.00</td>
</tr>
<tr>
<td>CBT Therapist</td>
<td>7</td>
<td>12.00</td>
</tr>
<tr>
<td>PWP</td>
<td>5</td>
<td>7.00</td>
</tr>
<tr>
<td>PWP</td>
<td>5</td>
<td>7.00</td>
</tr>
<tr>
<td>CTL</td>
<td>7</td>
<td>2.00</td>
</tr>
<tr>
<td>Manager</td>
<td>8a</td>
<td>1.00</td>
</tr>
<tr>
<td>Lead Therapist</td>
<td>8a</td>
<td>1.00</td>
</tr>
<tr>
<td>Supervisor</td>
<td>7</td>
<td>1.00</td>
</tr>
<tr>
<td>Senior PWP</td>
<td>6</td>
<td>1.00</td>
</tr>
<tr>
<td>Senior PWP</td>
<td>6</td>
<td>1.00</td>
</tr>
<tr>
<td>Admin</td>
<td>3</td>
<td>3.00</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>43.00</strong></td>
</tr>
</tbody>
</table>

The above trajectory shows the current staffing in East and West Suffolk and the number of assessment appointments each staff member is predicted to deliver over the next three years. This assessment number is calculated on a 40 week year to ensure that annual leave, training and short term sickness are accounted for and that a true picture of what can be delivered is given.

The cohort of LTC staff have been listed on a separate tab and are all shown as trainees at this stage. This is to ensure that the trajectory illustrates the high likelihood that the majority of new recruits will require core IAPT training prior to undertaking their full role. PWP and CBT training takes one academic year. During this time the clinician is expected to gradually build their capacity and works at approximately 50% when compared to their qualified counterpart. Following the training, all clinicians follow a brief preceptorship period of three months and build up to 100% over this time. A full time qualified CBT Therapist will offer an average of 15 assessments per month. A full time qualified PWP will offer an average of 36 assessments per month.
The trajectory makes the assumption that the 10 PWPs are recruited in time to begin their core IAPT training in June 2019 (7 places) and March 2020 (7 places) and that 14 places are available for Suffolk on these identified training cohorts.

The assessment numbers tab brings together the detail from the East, West and LTC tabs and compares this to the required access target. Taking April 2019 as an example, the total number of PWP assessments available are 541, the total number of CBT assessments available are 252 and the total number of Link Worker assessments are 370. When these are added together it shows that the service has the ability to offer 1163. A national DNA rate has then been applied to this number as access is only achieved when the patient attends the clinical contact. As such, of these 1163 assessments available, not all will convert to access. The current benchmarking data shows the national DNA rate to be at approximately 14%, when applied, this takes the total number of slots in the month of April to 1000.18. Below this, the number of assessments required per month to meet 22% (1214) and 25% (1379) are illustrated and the deficit or surplus identified.

The model proposed in this trajectory shows existing service staff (including all Link Worker activity), 19 LTC CBT Therapists and 14 LTC PWPs. The number of LTC staff is based on the national recommendations illustrated above and in the LTC full implementation guidance document.

Based on all of the above, this trajectory and proposed staffing structure shows that the service will meet 22% access as of January 2020 and 25% access as of June 2020.

Risks:
- That the Link Worker activity remains within the Wellbeing Service given current transformation plans
- That 33 new clinical staff can be recruited
- That all staff will be trainees and will therefore require core IAPT training
- That 19 CBT training places will be available in the September 2019 core IAPT training cohort
- That 14 PWP training places will be available in the June 2019 (7) and March 2020 (7) core IAPT training cohorts

Required Support infrastructure to support 30 additional staff (option one):

One Clinical Lead (specialising in LTC) Band 8a; One Operational LTC Lead Band 8a; Two LTC Team Leaders Band 7; One LTC CBT Supervisor Band 7; Two LTC SPWP Band 6 and Three LTC Administrators Band 3

One off costs:
Furniture, Laptops, Docking stations, Monitors, Mobile telephones, Desk telephones, ICT equipment e.g. keyboard, mouse, headsets etc. Audio/video recorders for trainee therapists (HITs and PWPs), set up costs for base e.g. N3 connection, change of use application, legal fees, estates work.

Recurring costs:
Estates – base rental and ad hoc room hire – 1:1 Consultations and workshops; Business rates, cleaning, confidential waste management; Ongoing telephone contract charges; ICT Licence costs; Expenses e.g. travel/mileage, car parking as required at physical health venues; Non- pay expenses e.g. photocopying, marketing material etc.

OPTION TWO TO DELIVER 22% BY Q4 2019/20 AND 25% BY Q4 2020/21 (AND COMMISSION ADDITIONAL ACTIVITY CURRENTLY SUPPORTED BY LINK WORKERS)

Maintain the current IAPT model but remove all Link Worker activity and increase the IAPT workforce to mitigate this alongside meeting the required LTC workforce expansion in line with national recommendations.
Additional establishment required is:

- 19 CBT Therapists
- 24 PWPs
- 13 Other staff
- Total WTE staff at a cost of £2.4M FYE

<table>
<thead>
<tr>
<th></th>
<th>WTE</th>
<th>CYE</th>
<th>FYE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Pay</td>
<td>56.00</td>
<td>295,933</td>
<td>1,719,005</td>
</tr>
<tr>
<td>Direct Non-Pay</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indirect</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Overhead</td>
<td></td>
<td>126,066</td>
<td>481,834</td>
</tr>
<tr>
<td>Recurrent Total</td>
<td>56.00</td>
<td>630,329</td>
<td>2,409,169</td>
</tr>
<tr>
<td>Non-Recurrent Pay</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-Recurrent Non-Pay</td>
<td>-</td>
<td>130,228</td>
<td>-</td>
</tr>
<tr>
<td>Non-Recurrent Total</td>
<td>-</td>
<td>130,228</td>
<td>-</td>
</tr>
<tr>
<td>Costing Total</td>
<td>56.00</td>
<td>760,557</td>
<td>2,409,169</td>
</tr>
</tbody>
</table>

This option removes the link worker cost at £1,037k and would require 19 CBT Therapists and 24 PWPs together with the required clinical and operational management to support these posts.

If the Link Worker activity is removed and additional LTC staff are recruited (19 CBT and 24 PWPs) the service will not meet 22% in Q4 2020 but will meet 25% in July 2020. This is illustrated in the trajectory below which follows the same rules detailed in option one.

Trajectory:

The training places required in this option are 19 CBT training places in September 2019, 4 PWP training places in June 2019 and 20 PWP training places in March 2020. 3 PWPs (in SLA baseline) are due to begin their training in the March 2019 cohort and are also included in this trajectory.

Risks:
• The service will not meet 22% in the rolling Q4 19/20 as required
• That 43 new clinical staff can be recruited
• That all staff will be trainees and will therefore require core IAPT training
• That 19 CBT training places will be available in the September 2019 core IAPT training cohort
• That 24 PWP training places will be available (4 in the June 2019 core IAPT training cohort and 20 in the March 2020 core IAPT training cohort

Required Support infrastructure to support 43 additional staff (option two):
One Clinical Lead (specialising in LTC) Band 8a; One Operational LTC Lead Band 8a; Three LTC Team Leaders Band 7; One LTC CBT Supervisor Band 7; Three LTC SPWP Band 6 and Four LTC Administrators Band 3

One off costs:
Furniture, Laptops, Docking stations, Monitors, Mobile telephones, Desk telephones, ICT equipment e.g. keyboard, mouse, headsets etc. Audio/video recorders for trainee therapists (HITs and PWPs), set up costs for base e.g. N3 connection, change of use application, legal fees, estates work.

Recurring costs:
Estates – base rental and ad hoc room hire – 1:1 Consultations and workshops; Business rates, cleaning, confidential waste management; Ongoing telephone contract charges; ICT Licence costs; Expenses e.g. travel/mileage, car parking as required at physical health venues; Non- pay expenses e.g. photocopying, marketing material etc.

9.0 TIMESCALE

The following timescale assumes that the earliest we can access training places will be in June 2019. All attempts would be made to recruit to trained staff, although there is a national challenge of recruiting to trained IAPT staff as all areas are undergoing requirements for IAPT LTC expansion. There are some opportunities locally to attract qualified CBT therapists.

Core IAPT Training places after March 2019 for HITs and June 2019 for PWPs have not yet been confirmed by Health Education England (HEE). The service has provided the number of places for the June 2019 cohort as requested. Although not yet confirmed, future HIT and PWP training is hoped to run in September 2019 and March 2020 so recruitment to LTC expansion posts would need to be in line with this training if we are unable to recruit earlier. Core IAPT training in 2020/21 is yet to be confirmed by HEE as it is commissioned on a financial yearly basis and in line with need across the East of England (not just Suffolk).

The service would need to advertise for HITs and PWPs in March/April 2019 with a view to staff starting in June - August 2019 in time for June PWP and September HIT training. These trainee staff will be able to work at approximately 50% productivity throughout their training and so would not be at full capacity until course completion. This will need to be considered in regard to releasing current qualified staff to undertake LTC work to ensure that it does not adversely impact on the core service.

Based on learning from Wave One and Two sites, we propose that we recruit to the Clinical Lead (specialising in LTCs) and Operational LTC Lead as soon as the expansion is agreed to establish LTC pathways, develop the full project plan and build relationships with physical health pathway leads. Specific LTC Training that staff working with this client group will be required to undertake is arranged for March 2019. The Service has secured 8 places on this training (4 HITs and 4 PWPs). Team Leaders will need to be in post by April 2019 to ensure that they are up to speed with the LTC pathways and service delivery as the LTC specific training comes to an end in July 2019. LTC Supervisors (CBT and SPWP) will need to be in place prior to staff starting and so we would look to recruit to these posts in April 2019.

10.0 DEVELOPMENT & IMPLEMENTATION
10.1 Best Practice & Guidance:

Significant learning has taken place through the early implementer sites. Three key elements reported are:

- Co-location is crucial, with significant benefits acknowledged through ‘corridor conversations’

- Services need to be fully integrated, with IAPT workers part of an MDT approach. IAPT-LTC is not about signposting but integration

- Training – while early findings from wave one and two services have shown that even without CPD training around IAPT for LTC, recovery rates are good. They are higher however where the training has been received. In addition, reciprocal training of mental and physical health staff has aided integration of IAPT practitioners and helped improve the IAPT offer through increased knowledge of the specific long term condition. Some areas have also trained nurses and OTs in LTC services to deliver IAPT therapies to good effect.

10.2 Design & Engagement:

A governance structure will be set up to oversee the design of the potential model. The project group will be responsible for overseeing the development and will report to CCGs and Suffolk Mentally Healthy Communities Board. A Project Group will oversee the project scope and timescale, and progress against it, escalating potential risks and issues when appropriate, developing the desired service outcomes and broad structure and engaging with appropriate stakeholders.

The key issues affecting the implementation of the expansion are:

- Staff training to deliver specific psychological interventions tailored for long term conditions, as well as training new staff. Health Education England (HEE) and NHSE commission these places centrally. Limited places were available and they have so far been taken up exclusively by Wave one and Wave two early implementer sites. We have requested up to 19 CBT places in the September 2019 cohort and up to 7 PWP places in the June 2019. In option one, an additional 7 places will be required in March 2020 and in option two, an additional 20.

- Significant work needs to be undertaken to understand the clinical cultures of different sectors to improve the chances of a successful integration. This may also include the new model operating under a different branding to existing psychological therapies provision.

The implementation plan in the table below reflects a phased approach to developing an expanded model. Phase 1 is dependent on a training cohort that starts in June and September 2019.

<table>
<thead>
<tr>
<th>Development Area</th>
<th>Start Date</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Phase 1 – 2019/20</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment of trained and trainee staff</td>
<td>April 2019</td>
<td>August 2019</td>
</tr>
<tr>
<td>Service development - service for 2-3 LTC pathways, e.g. Diabetes, Respiratory and Cardiology.</td>
<td>April 2019</td>
<td>March 2020</td>
</tr>
<tr>
<td><strong>Phase 2 – 2020/21</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment of trained and trainee staff</td>
<td>January 2020</td>
<td>March 2020</td>
</tr>
<tr>
<td>Service development – additional LTC pathways, e.g. Cancer, Gastroenterology and MSK</td>
<td>March 2020</td>
<td>March 2021</td>
</tr>
</tbody>
</table>
11.0 RECOMMENDATIONS

Suffolk Mentally Healthy Communities Board / Governing Body / Clinical Executive is asked to:

- Agree the commissioning of a psychological therapy service for Ipswich and East and West Suffolk, focusing on the 2-3 pathways in 2019/20 and across primary, community and acute hospital care

- Resource the programme at an appropriate level to ensure the service is sustainable and able to meet the access standard without compromising the core service offer

- Consider this proposal from the existing IAPT provider in East and West Suffolk and agree the outlined development programme

- Recommend commission Option One which would have an associated cost of part year effect £1,374,000 (I&E: £898,596.00 and West: £475,404.00) in 2019/20 and £2,603,000.00 (I&E: £1,702,362.00 and West: £900, 638.00) FYE in 2020/21.
12.0 REFERENCES