Haringey LONDON

NHS Haringey Clinical Commissioning Group

Commissioning services for treating depression in long term conditions

Commissioning?

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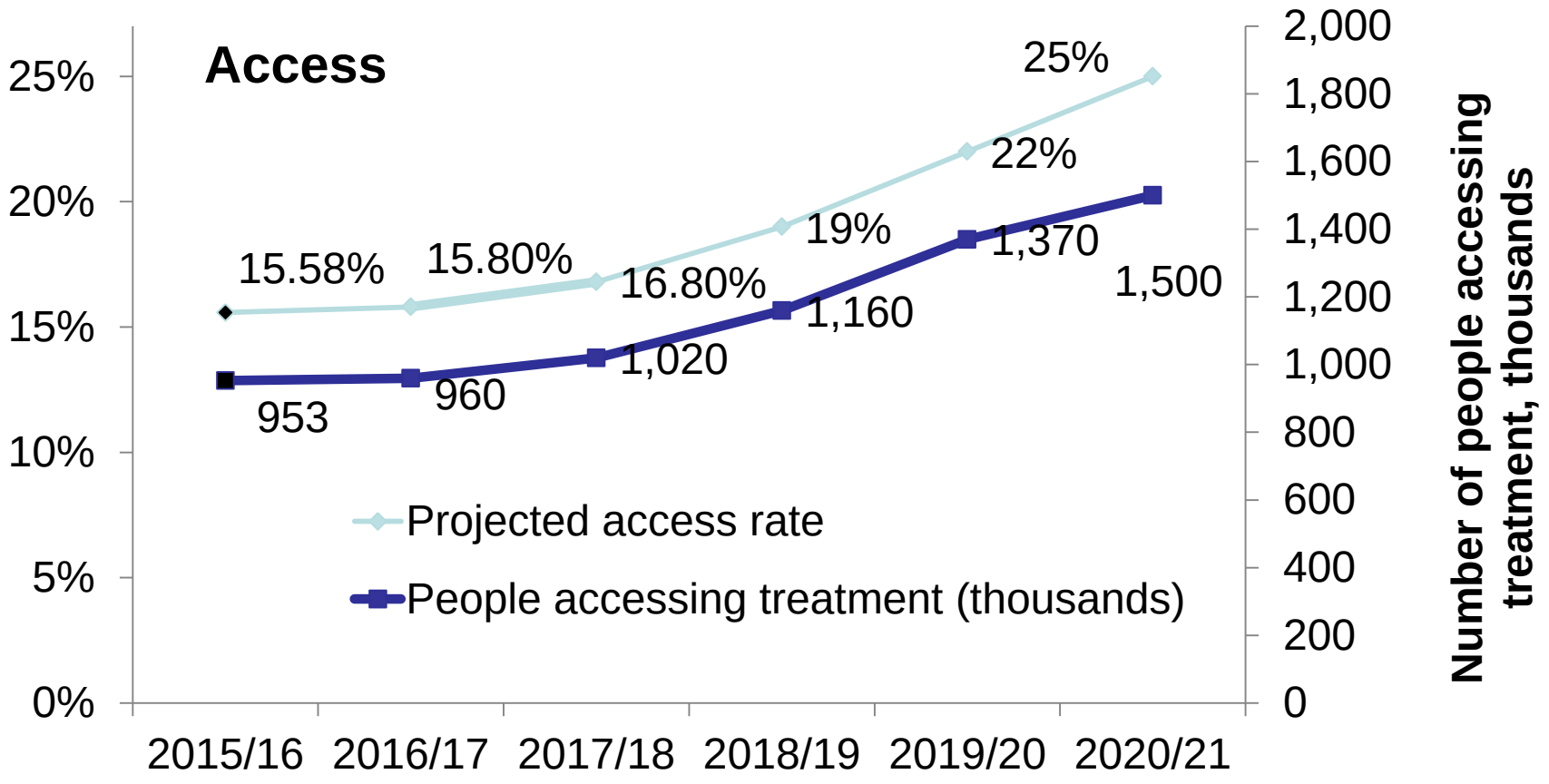
Plan and fund services which make the best of use of local resources to meet local needs

Constrained by many factors - skill, knowledge, capacity, resources, culture.

A key role in also defining pathways, fostering partnerships and unblocking barriers.

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Five Year Forward View



Why?

Fairness
Currently under-represented. 21% of people treated in IAPT services but 40% of cases in the community.

Great prospects for patients and their families
NHS Digital data shows outcomes as similar to people without LTCs (43% vs 46% recovery in 2015/16 LTC vs Non-LTC)

Economic Sense for the NHS **(Layard & Clark 2014, Ch 11)**
LTC healthcare costs 50% higher in people with depression and/or anxiety disorders
Psychological therapy reduces physical healthcare costs by average of 20% (meta-analysis of 91 studies)
When data is available on cost of psychological treatment and physical healthcare savings exceeds costs

How?

Co-located physical and mental healthcare

NICE-recommended therapies, adapted for people with LTCs and delivered by properly trained therapists. **Hence the need for CPD courses for IAPT Hi & PWPs**

IT systems support outcome monitoring for all (mental health symptoms, disability, perception of physical health problems).

Suitable accommodation.

All IAPT's existing quality standards.

Closely linked to, and managed with core IAPT (don't try to reinvent the wheel)

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 ***co-located with physical health colleagues."***

Integration

- Hot topic! Still!
- It's hard: lots of reasons not to do it – cultural, practical, governance, technical
- With whom?
- Uncertain

"while it has been possible to identify general principles and core components, it cannot be concluded that one model best supports integrated care.
"Any integrated model development is strongly contextually-bound, nearly impossible to replicate and can only be successful if it does account for unique needs and characteristics of the population it aims to serve."

World Health Organisation. Integrated care models: an overview. 2016

What have we found?

- Co-location ≠ Integration
- Requires significant effort to promote service and engage patients and clinicians – AP role
- Demand is there, but so far we have
  - 70% Step 3
  - 75% diabetes; 25% COPD
  - COPD – high proportion of housebound people
  - Recovery rates looking as expected

Discussion

- How could integration with general practice and community physical health services work in your area or your own practice?

Some future scenarios

- Growth of pure IAPT would need ~ a 50% rise in staff by 2021
- Expansion of use of voluntary sector to deliver iapt step 2
- A widening of what is considered to be an IAPT intervention, e.g. a primary care mental health team brief intervention
- Deeper integration of physical and mental health - e.g. PWPs screening first contacts with diabetes community teams.
- Increase of digital interventions