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Clinical Commissioning Group

Warrington IAPT Expansion

The Story So Far …….

Rachel Plant, Service Manager
Simon Hammond, Commissioning Manager

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How Did We Get Here

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Five Year Forward View

Main Policy Driver for the expansion of IAPT services to integrate with Physical Health

Better service provision for service users

Helps achieve increase in access targets

NHS England Expansion Wave 1 Bid

27th June Invite to bid for place in wave 1 expansion came out.

Co-produced bids due for submission 21st July

Timelines shifted, but our bid was successful

Some additional funding secured from CCG

Bid Content

Medically Unexplained Symptoms (Primary Care)

Diabetes

GP Cluster Level Delivery

CCG Service Collaboratively working

Stepped Care Model

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What Next

- Consideration of service name.
- How to engage appropriate clients.
- How to engage with primary care
- Staffing, recruitment, keeping core service viable

What Next

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- GP Read Codes (for evaluation)
- Data Sharing & Linkage
- Privacy Impact Assessment
- Project Steering Group
- Theory of Change

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Training and Trainees

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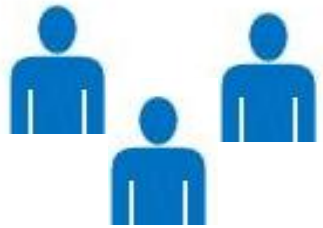
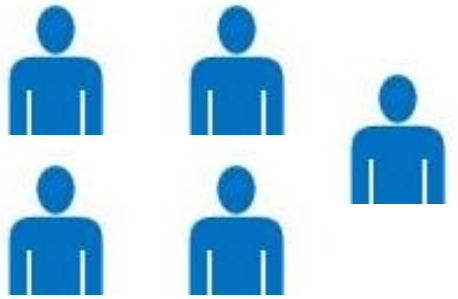
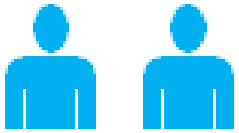
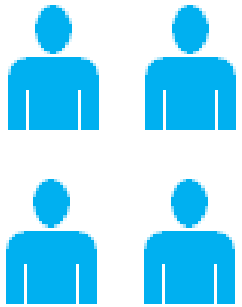
		Top-Up Training	Backfill Trainees
PWP's		5 Days UCLAN	
HITs		10 Days Prestwich	

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Accessing Service - MUS

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GP Identify patients

- Aristotle – frequent attends (remove certain groups)
- GP "Gut instinct"

Initial Consultation

- "Script" explaining benefits of service
- Healthcare utilisation – structured interview

Referral into Service

- Patient can decline offer
- Specific referral pro-forma for GP
- Integrated service contact details given to patient

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What Happens Next

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- Nurses screen referrals - if inappropriate referral refer onto the most appropriate service and contact client.
- Text message asking client ring us to book an appointment.
- If no response to text, send a letter.
- If no contact discharge 14 days after referral received.

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What Happens Next – After Entry Assessment

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- At the Entry Assessment, practitioners will recommend a treatment based upon the clients presentation.

- All practitioners working with clients who have diabetes or a condition that cannot be medically diagnosed, have received additional training.

- The main principle of a stepped care approach is least intrusive intervention first. Clients can be moved seamlessly between the Steps if needed.

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MUS Additional Measures

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Condition(s)	MDS Questionnaires (every session)	LTC/MUS Questionnaire	Frequency	Caseness
Chronic Fatigue Syndrome/ME F45	PHQ-9, GAD-7, WSAS, Phobia Scales	Chalder Fatigue Questionnaire	Every Session Used to calculate recovery	19 or more
Irritable bowel syndrome F45	PHQ-9, GAD-7, WSAS, Phobia Scales	Fancies IBS Symptom Severity Scale	Every Session Used to calculate recovery	75 or more
MUS not otherwise specified F45	PHQ-9, GAD-7, WSAS, Phobia Scales	PHQ 15	Every Session Used to calculate recovery	10 or more
CSRI – First and Last Session				

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LTC Additional Measures

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Condition(s)	MDS Questionnaires (every session)	LTC/MUS Questionnaire	Frequency	Caseness
Diabetes	PHQ-9, GAD-7, WSAS, Phobia Scales	Diabetes Distress Scale	First and Last Session Not used to calculate recovery	N/A
COPD	PHQ-9, GAD-7, WSAS, Phobia Scales	COPD Assessment Test (CAT)	First and Last Session Not used to calculate recovery	N/A
Chronic Heart Disease	PHQ-9, GAD-7, WSAS, Phobia Scales	N/A	N/A	N/A
Any other LTC	PHQ-9, GAD-7, Phobia Scales, WSAS	N/A	N/A	N/A
Chronic pain, including fibromyalgia	PHQ-9, GAD-7, WSAS, Phobia Scales	Brief Pain Inventory	First and Last Session Not used to calculate recovery	N/A

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NB. ADSM's should continue to be used for diabetes, COPD, chronic heart disease and any other LTC eg. SPIN for social phobia.

Local Evaluation - After Treatment

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Using the Pseudo NHS Numbers CCG Information Analysts can pull health care utilisation data for services users that have received the intervention.

Will look at:

- A&E Attendances
- Non Elective Admissions
- Out patient appoints (first / follow-ups)
- Primary Care usage (GP/Practice Nurse Appointments)

Pre and Post intervention

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IMPACT LEVEL	Integrated Service Provision for patients with Medically Unexplained Symptoms Identified through Primary Care											
Long term outcomes	Health Care Utilisation reduced for cohort of patients - R.O.I matches investment required				Recovery rates improve for Integrated service therefore overall rates improve				staff co-located within GP Clusters and accessing primary care systems for patient records			
Intermediate outcomes (12-18 months)	Further reduction in GP Appointments and out of hours healthcare utilisation				Further reduction in Prescribed medications				Reduction in OP appointments (?? Other secondary care			
Early outcomes (6 - 9 months)	Reduction in number of prescribed medications				Reduction in OOH usage by Cohort				Reduction of GP appointments utilised by Cohort			
Immediate outcomes (0 - 6 months)	Flow of patients from initial practices established			PDSA Cycle applied to next group of practices and referrals commencing			Reduction in recovery rates for overall service (local data to demonstrate Core Vs. Integrated)			GP and Practitioner feedback of the impact of the intervention		
Outputs	Number of patients referred, accepted and accessing service		Recovery Rates - Relevant ADSMs / Condition specific measures		Number of Sessions attended		Waiting lists - Demand and Capacity		Routine reporting through agreed mechanisms		DNA and Cancellation Rates	
Inputs	Wave One Integrated IAPT site	Additional funding from NHS England	Additional Funding CCG	GP Buy in and Integrated Service Branding	Identification of cohorts - Read Codes & Processes	Privacy Impact Assessments	Data Sharing Agreements	Training for integrated staff	Additional Support Staff - Admin, SPA nurses	PDSA Cycle of Review	Pathways into and out of service	Collective knowledge and sharing
Context	5YFV - Expansion of IAPT services		GPFV - co-located Mental Health Staff		Increase in IAPT access rates to 25%		Financial viability - Integrated service should become self-funding		Warrington Brand - Local Enhanced Service		STP Plans - development of MUS services	

Challenges for delivery:

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- Project slip at beginning of process – procurement of training places
- Round 2 of training – lack of communication for start dates etc
- Integration vs Co-location
- Size of service and need to keep core service viable = small number of staff put forward for top-up training
- Keeping Expansion going (sickness and leavers)
- Evaluation – ability to link any reduction to savings
- Evaluation – not all outcomes will be a reduction in usage
- Evaluation – impact on overall service performance (recovery)

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Thank You

Any Questions?

Rachel Plant: Rplant@mhm.org.uk
Simon Hammond: simon.hammond3@nhs.net

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