NHS
Aylesbury Vale
Clinical Commissioning Group

NHS
Chiltern
Clinical Commissioning Group

Prevention in Primary Care - does IAPT have a role to play ?

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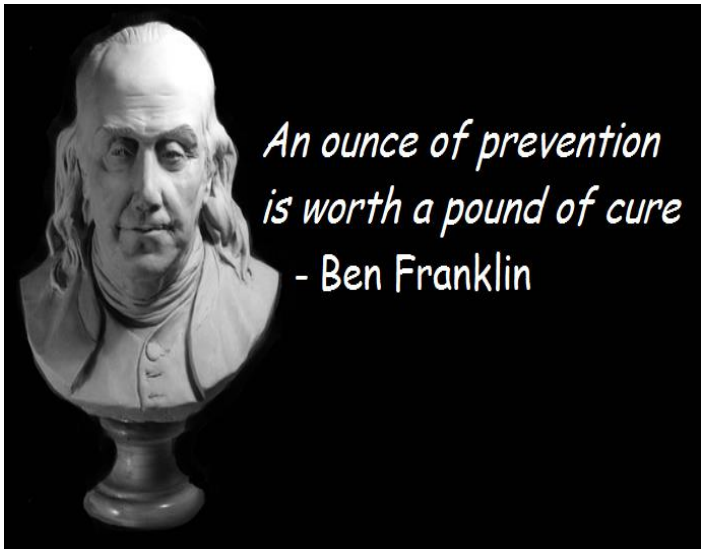
Overview

- Thinking and moving - preventing our own ill health!
- Levels of prevention
- Commissioning priorities and considerations
- Buckinghamshire PC Strategy – role of IAPT
- Live Well Stay Well & Healthy Minds
- What can we learn from IAPT ?
- Introduction to PAM
- Combinatorial Test Bed - Preventative 'Eco' System
- Does IAPT have a role to play ?



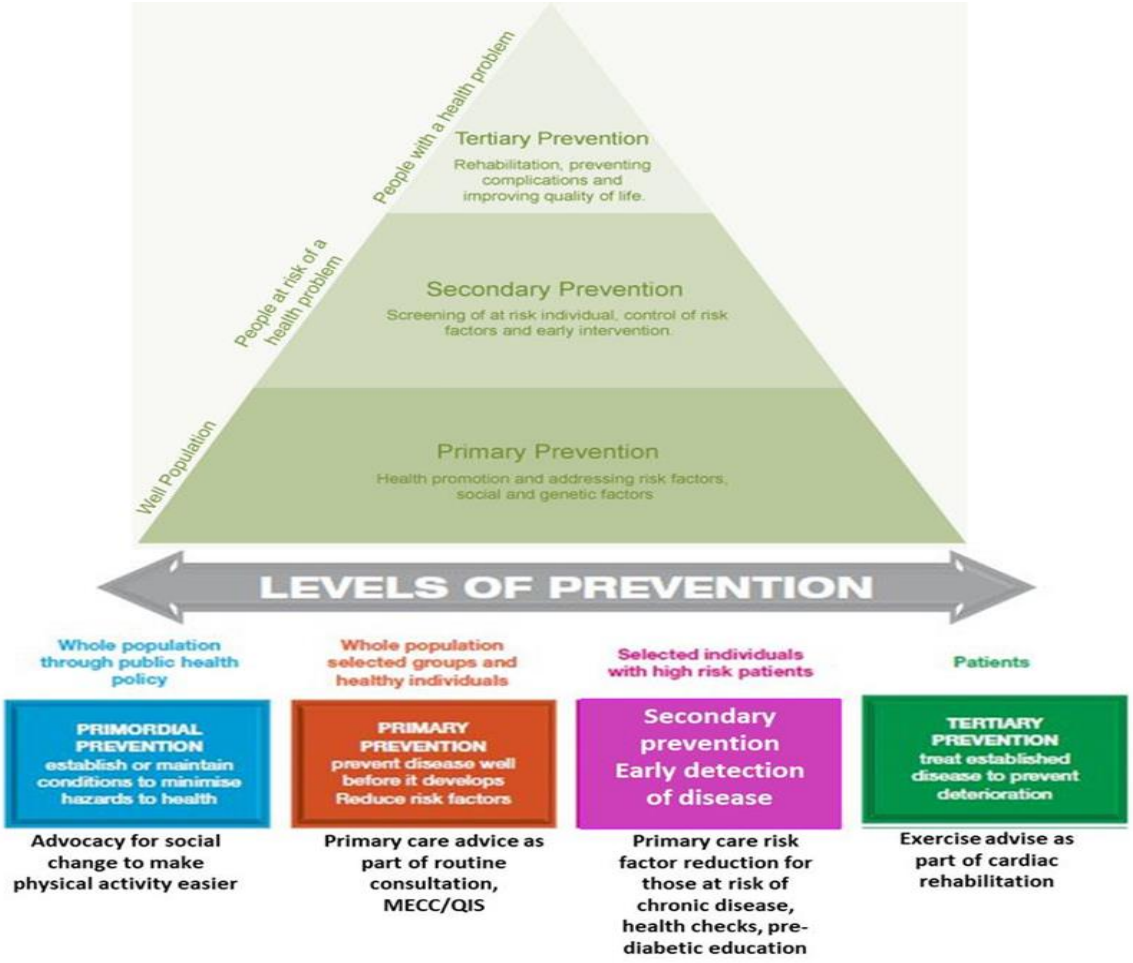
BENJAMIN FRANKLIN WAS ON THE CUTTING EDGE OF WELLNESS PROGRAMMING EVEN IN THE 1700'S.

HE KNEW THEN THAT PREVENTION IS THE BEST SAVINGS PLAN. AND.. NOT JUST MONETARY SAVINGS, BUT ALSO LIFE SAVING!

When all our PWPs and HI Therapists are Commissioning Managers …….

WHAT WILL IAPT LOOK LIKE IN 30 YEARS TIME ?

Leavell and Clark´s Levels of Prevention



A Commissioning Perspective

Five Year Forward View

- *'Derek Wanless's health review warned - take prevention seriously or face a sharply rising burden of unavoidable illness*
- *'Breakdown barriers between …..physical and mental health'*
- *'developing new test bed sites for world wide innovations'*
- *'services organised …to support people with multiple health conditions not just single diseases'*
- *'offering opportunities for better health through increased prevention and supported self care'*

NHS England 2014

Annual report: CMO PH

- mental health is **just as important** as physical health
- **more needs to be done to help people with mental illness stay in work,** as since 2009, the number of working days lost to 'stress, depression and anxiety' has increased by 24% and the number lost to serious mental illness has doubled
- there is **no robust evidence that a population approach to improving wellbeing will have any impact on the prevalence of mental illness**
- Obesity –almost **two thirds of adults** and one third of children under 18 are overweight or obese.

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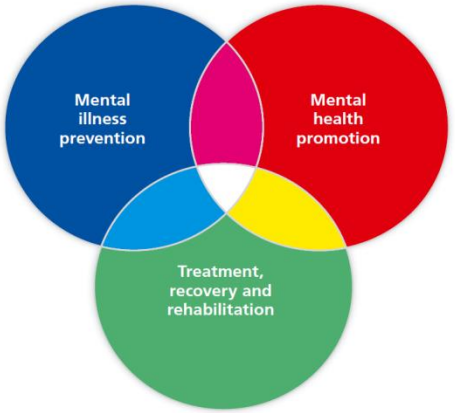
Chief Medical Officer
- public MH
DH September 2014
&
Chief Medical Officer
- state of the public's health
DH March 2014



Primary Care Strategy

Scale of the Challenge

Modern healthcare

A need for **integration** of health and social care if the NHS is to remain viable for those that need it, we need to provide **solutions** and **support** for those whose attendances could be avoided.

64% are overweight or obese. Almost a quarter of people are inactive.

If we carry on like this, by **2023** there will be:

54% increase in diabetes

28% increase in high blood pressure

18% increase in heart attack

5% increase in stroke

Numbers in training to become GPs has dropped, and almost **20%** of GPs in Bucks are over **55**

The number of older people with care needs will **increase by** **60%** in the next **twenty years.**

What patients want

A **co-ordinated approach** across all providers, increased **access to GP services**, greater **use of technical solutions** and **help to self-care.**

In 2013-14 there were attendances at **A&E** **108,604**

This is expected to rise by **10%** in 2015-16

the typical cost of attending **A&E** is **£100**

General practice

8.39% is the amount general practice has of the NHS budget

95% is the amount of urgent care needs handled in general practice.

The average emergency admission charge is around **£2,200**

90% of **patient interaction** with the NHS occurs in **primary care**

There are **536,442** **people registered with a GP**

Aylesbury CCG received **£965** **per person**

Chiltern CCG received **£856** **per person**

...the England average is **£1,115**

Aylesbury Vale General practices are allocated around **£113** **per patient** per annum

Chiltern General practices are allocated around **£110** **per patient** per annum

more than **16%** of **residents are** **aged over 65** and this will rise to more than **20%** by **2025**

New Approach needed

- Shared responsibility for health with patients and carers focusing on education, **prevention and healthy lifestyle choices**
- Care for the **whole person** and not just a bunch of LTCs
- **Collaboration** with other agencies and services to meet patients needs
- **Meaningful information and support**, at the level the patient (& their family) can understand to **help them self care**

House of Care - CSP

What has IAPT to offer ?

- Which service has capability to share CBT skills and support behavioural change ?
- Which workforce is present and ‘accessible’ in large numbers to support Primary Care ?
- Which service is well thought of by patients and PC clinicians ?
- What workforce was an early adopter of new technologies to increase capacity?
- What service has begun to co – locate and is well placed to influence?

Conversely…..

- What workforce is asked to account for every hour and every contact?
- What service is required to meet national targets - waits and no's people seen?
- What workforce is measured by outcomes reliant on movement from 'caseness '?
- What service needs to maintain fidelity to treatment protocols ?

Commissioning Considerations

- Should we focus solely on IAPT LTC if funds limited?
- Can LTC IAPT increase access to harder to reach groups?
- How can we integrate psychological therapies into all clinical pathways?
- What could/should IAPT contribute to the wider health care system?
- When is IAPT not IAPT ?

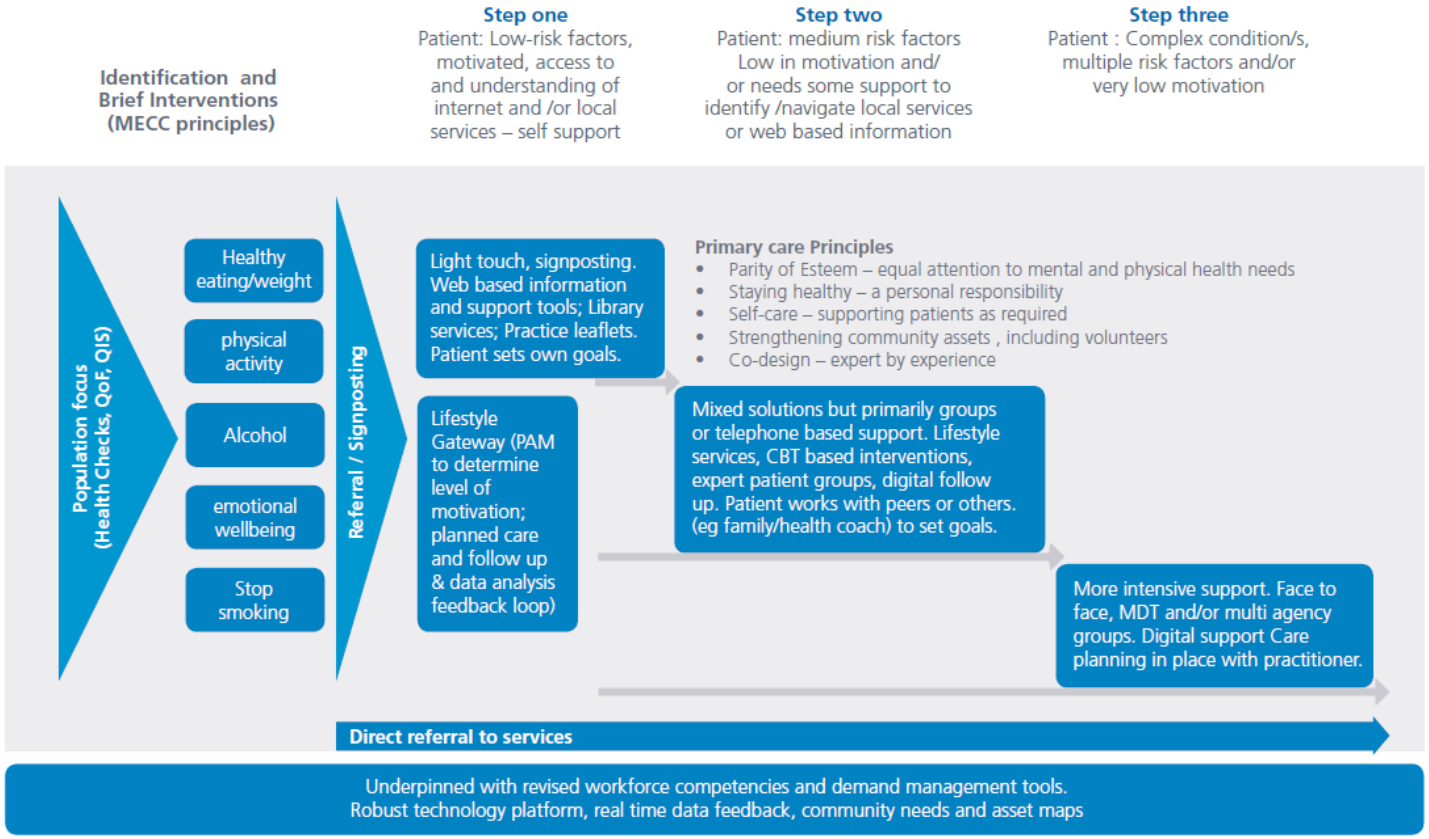
Strategic Commissioning – IAPT

Financial incentives - Quality Premium , NHS England targets

- IAPT originally for WAA – regain/retain employment
- Move to LTC would 'shift' demographic
- LTC Pathfinder - not able to articulate economics – evaluation not forthcoming
- Require strong clinical leadership - solid foundation
- Relapse prevention - reducing recurrence - ? Prevent depression
- Competing agenda ?? SMI
- Life before IAPT : PC MH Teams - what did we learn& what did we forget?
- what model of change can will optimise integration of physical and mental wellbeing?
- What role can / should IAPT play?

Live Well Stay Well

Live Well Stay Well : A prevention model for Primary Care

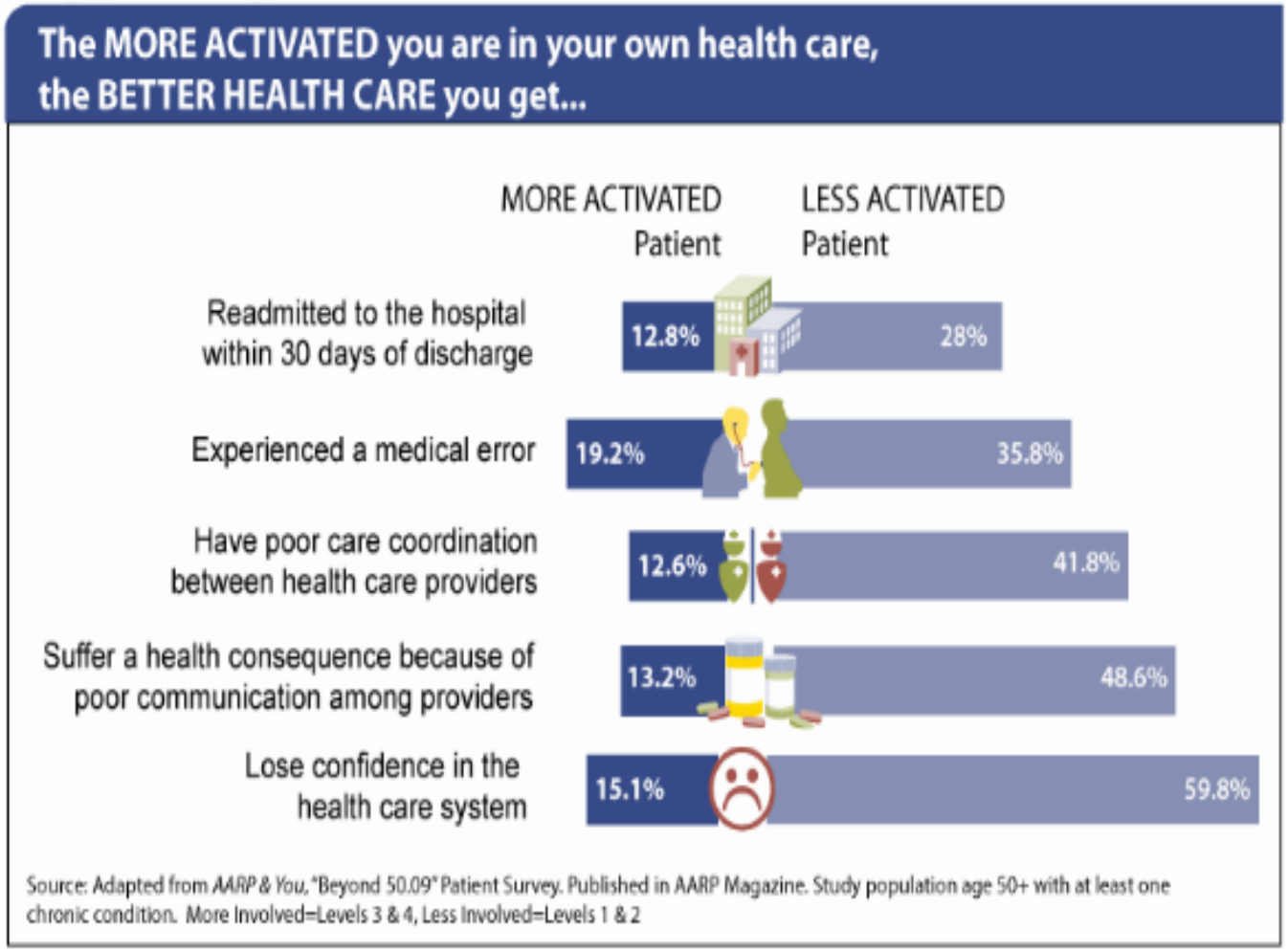


What can we take from IAPT ?

- ‘To improve outcomes we must define and measure them’ *William Osler*

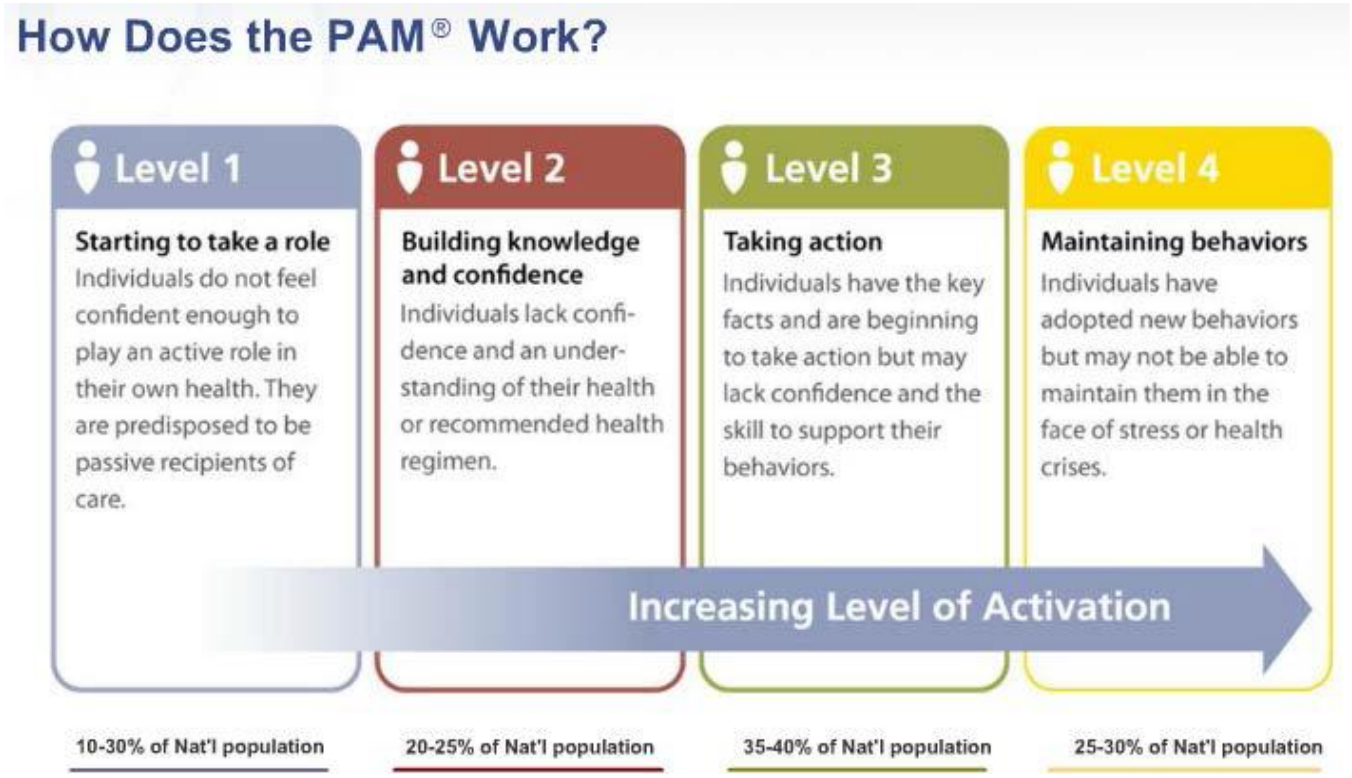
- ‘What gets measured gets done’ *Peter Drucker*

Welcome to PAM
Patient Activation Measure

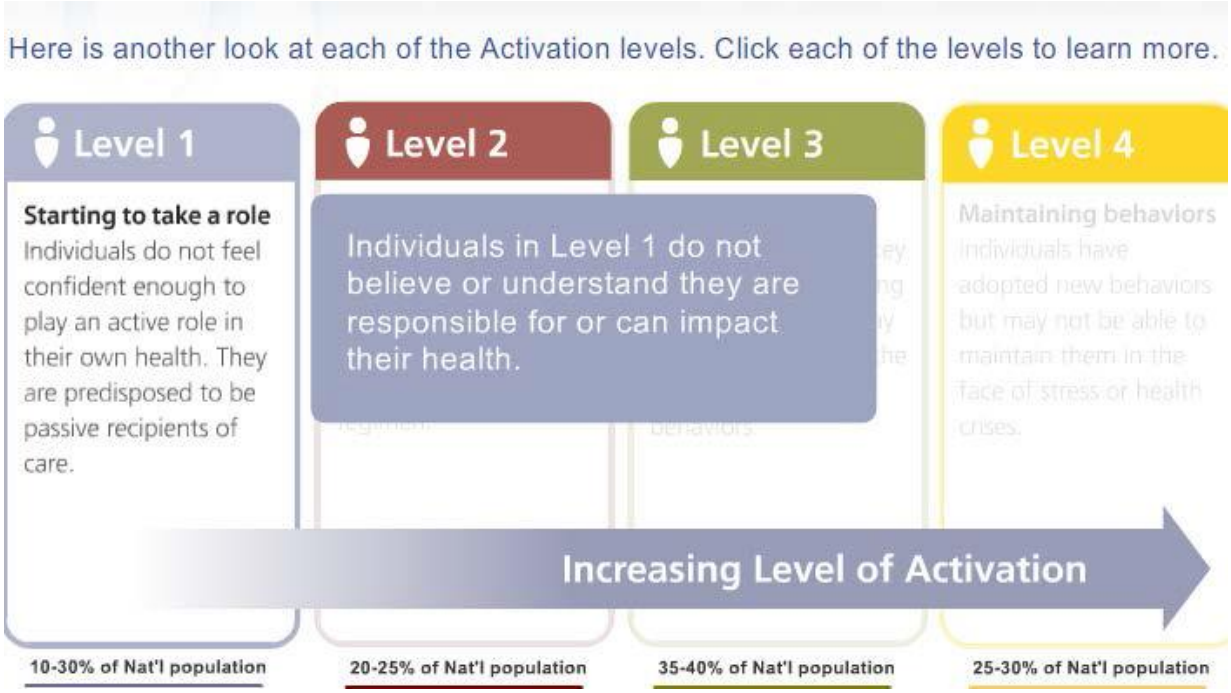


PAM both guides practice and measures outcome

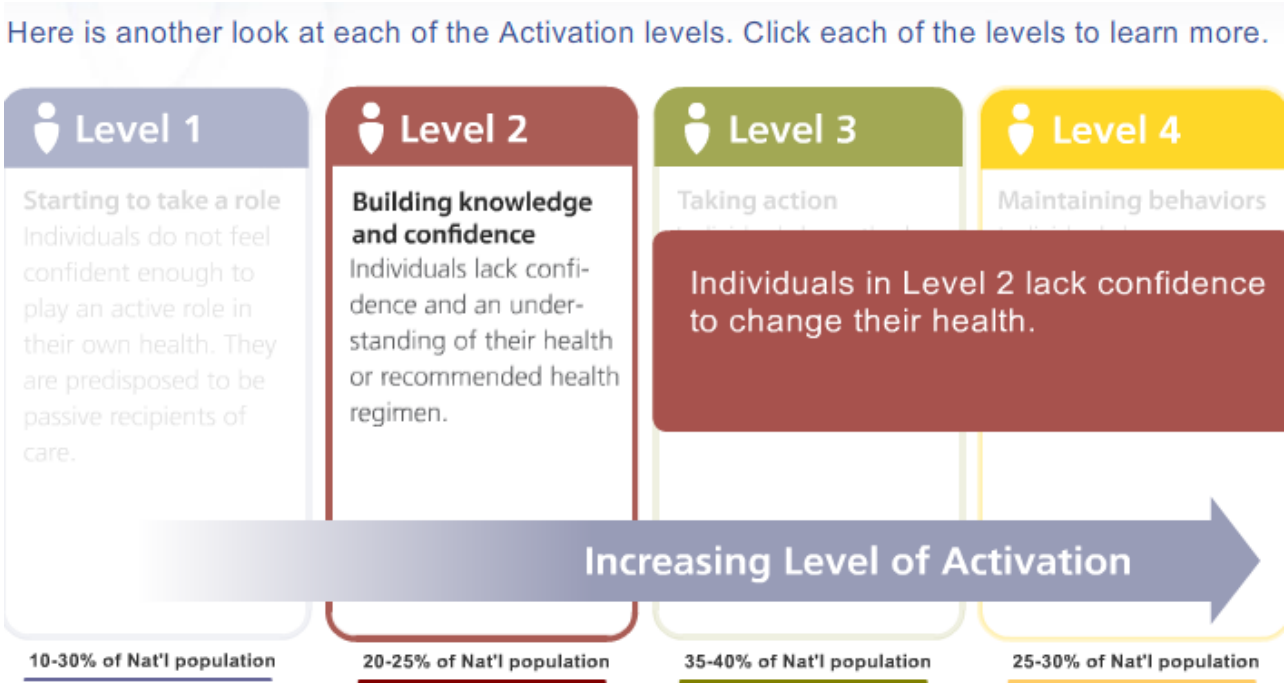
Patient Activation Measure



Level 1


Here is another look at each of the Activation levels. Click each of the levels to learn more.
Level 1
Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.
Level 2
Level 3
Level 4
Maintaining behaviors
Individuals in Level 1 do not believe or understand they are responsible for or can impact their health.
Increasing Level of Activation
10-30% of Nat'l population
20-25% of Nat'l population
35-40% of Nat'l population
25-30% of Nat'l population

Level 2

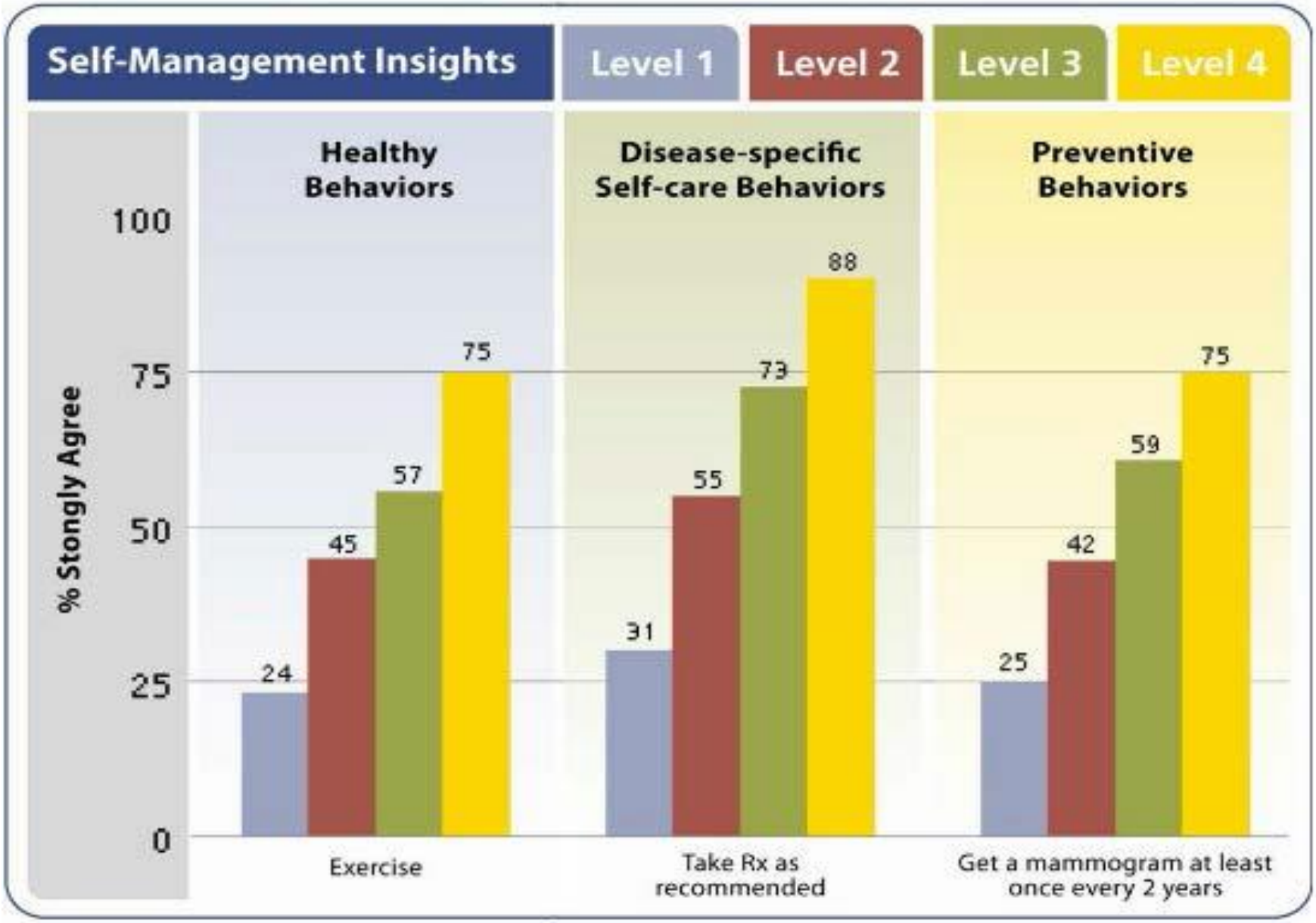

Here is another look at each of the Activation levels. Click each of the levels to learn more.
Level 1
Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.
Level 2
Building knowledge and confidence
Individuals lack confidence and an understanding of their health or recommended health regimen.
Level 3
Taking action
Level 4
Maintaining behaviors
Individuals in Level 2 lack confidence to change their health.
Increasing Level of Activation
10-30% of Nat'l population
20-25% of Nat'l population
35-40% of Nat'l population
25-30% of Nat'l population

Level 3


Level 1
Starting to take a role
Level 2
Building knowledge
Level 3
Taking action
Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.
Level 4
Maintaining behaviors
Individuals in Level 3 understand they are key to their health but are not sure where to get started or how to keep going.
Increasing Level of Activation
10-30% of Nat'l population
20-25% of Nat'l population
35-40% of Nat'l population
25-30% of Nat'l population

Level 4


Level 1
Starting to take a role
Individuals do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.
Level 2
Level 3
Level 4
Maintaining behaviors
Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.
Individuals in Level 4 have a solid hold on how to stay healthy. They are in maintenance mode but slip up occasionally.
Increasing Level of Activation
10-30% of Nat'l population
20-25% of Nat'l population
35-40% of Nat'l population
25-30% of Nat'l population


Self-Management Insights
Level 1
Level 2
Level 3
Level 4
Healthy Behaviors
Disease-specific Self-care Behaviors
Preventive Behaviors
% Stongly Agree
100
75
50
25
0
24
45
57
75
31
55
73
88
25
42
59
75
Exercise
Take Rx as recommended
Get a mammogram at least once every 2 years

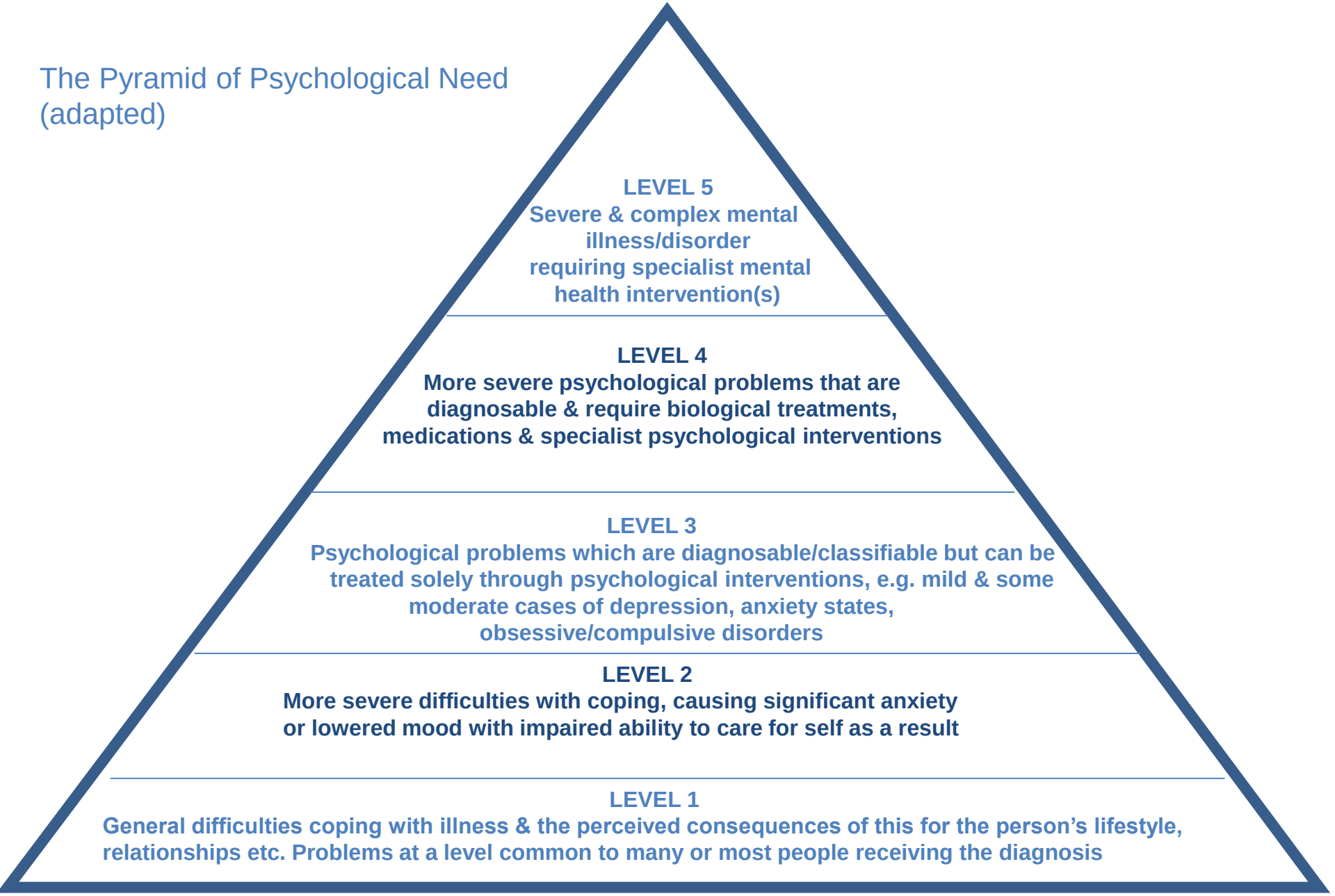
Live Well Stay Well Programme

- Heavily influenced by IAPT
- Commissioning model – stepped care
- Large volume - low intensity
- High intensity - low volume
- Embracing technology
- Educational component – shared delivery

Psychological needs in PC – LTC

- What are the psychological needs of patients with an LTC ?
- What psychosocial barriers do they face to successful management of their LTC?
- How could psychological approaches help?
- Who has had difficulty accessing psychological care for people with diabetes or other physical health conditions?
- How prepared are your GP and practice staff to have ‘difficult’ conversations with patients?

The Pyramid of Psychological Need (adapted)



Adapted from *The pyramid of psychological need.* [35] [36]

Preventing Diabetes

Treating 100 adults who are high risk of Type 2 diabetes, with an intensive lifestyle intervention can….

- Prevent 15 new cases of type 2 diabetes[1]
- Prevent 162 missed work days[2]
- Avoid the need for BP/Cholesterol pills in 11 people[3]
- Add the equivalent of 20 good years of health[4]
- Avoid £57,000 in healthcare costs [5]

1. Knolwer et al (2002) Reduction in the incidence of type 2 diabetes with lifestyle intervention or metformin. N Engl J Med; 7: 346(6):393-403
2. DPP Research Group (2003) Within-trial cost-effectiveness of lifestyle intervention or metformin for the primary prevention of type 2 diabetes. Diabetes Care;26(9):2518-23
3. Ratner et al (2005) Impact of Intensive Lifestyle and Metformin Therapy on Cardiovascular Disease Risk Factors in the Diabetes Prevention Program. Diabetes Care 28 (4): 888-894
4. Herman et al (2005) The cost-effectiveness of lifestyle modification or metformin in preventing type 2 diabetes in adults with impaired glucose tolerance. Ann Intern Med. 2005;142:323-32
5. Ackermann et al (2008) Translating the DPP into the community. Am J Prev Med 35 (4), pp. 357-363; estimates scaled to 2008

IAPT ACCESS 2014/15								
CCG	Q1		Q2		Q3		Q4	
	Q1 Planned	Q1 Actual	Q2 Planned	Q2 Actual	Q3 Planned	Q3 Actual	Q4 Planned	Q4 Actual
Aylesbury Vale	3.34%	3.92%	3.46%	3.77%	3.6%	4.3%	3.77%	4.7%
Chiltern	3.34%	3.84%	3.46%	3.48%	3.6%	3.7%	3.77%	4.05%
IAPT RECOVERY 2014/15								
CCG	Q1		Q2		Q3		Q4	
	Q1 Planned	Q1 Actual	Q2 Planned	Q2 Actual	Q3 Planned	Q3 Actual	Q4 Planned	Q4 Actual
Aylesbury Vale	50%	60.0%	50%	59.2%	50%	66.1%	50%	66.25%
Chiltern	50%	65.5%	50%	64.1%	50%	60.9	50%	66.89%

ACCESS & RECOVERY ABOVE EXPECTATION

Participant Demographics

Demographic	Breathe Well Clinic , Modified Pulmonary Rehab & Housebound Interventions
Number Assessed	470
Number Treated	370
Age (Assessed patients)	Mean: 70.06 Range: 36-94 65 or over: 76.8%
Gender (Assessed patients)	Male: 54.7% Female: 45.3%

Perinatal MH

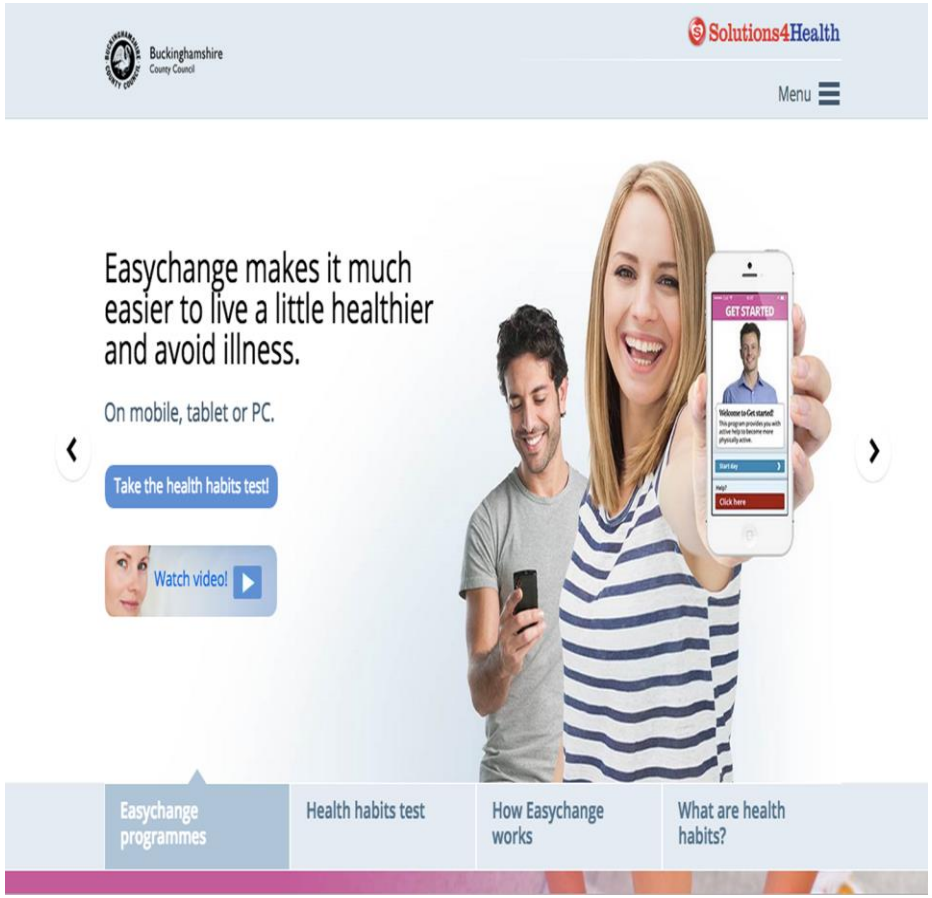
Healthy Minds (IAPT Service)

- The Postnatal Wellbeing groups continue to be run jointly with HV's Minor modifications following pilot
- There is a steering group meeting 30.09.15.
- Micro-skills training have started for HVs and planning has commenced for Midwives.
- Psychological therapists to work one day per week with the specialist team and Healthy Minds.

Combinatorial Test Bed

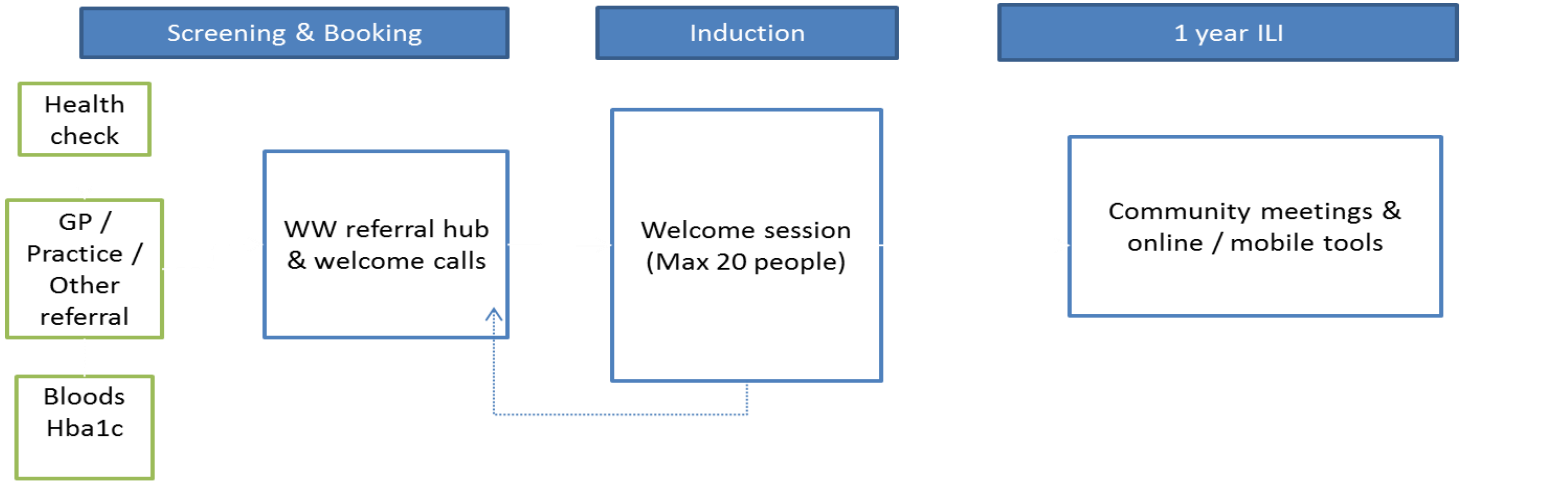
Target Population	Population size (Bucks)	Target size to treat	Innovator
Obese/Over Weight	300,000	60,000	Changetech
Pre-diabetes	50,000	750	Weight Watchers
Diabetes	35,000+ (expected) 25,000 (on QOF register)	25,000	Map my Health (25,000) Weight Watchers/Oviva (500)
Newly diagnosed diabetes	1,500pa	1,500	Map My Health (1,250) Weight Watchers (250)
Co morbid LTC (complex/high risk)	TBC	500	Oviva, Live Well Health Navigators
Test Bed Treatment Total	-	87,750	Innovations combined with new workforce and existing projects

Changetech



- Norwegian
- New method for behavioural change (across lifestyle)
- All major public health areas
- Fully automated
- For mobile, tablet or PC
- 100% evidence based
- Proven efficacy (Cochrane)
- An up an running service
- 60,000 have used 1 or more programs
- A self explanatory user portal

Weight Watchers



- Screening for readiness to change
- Motivational interviewing to improve outcomes
- All admin from point of referral taken care of
- Waiting list management & follow up if DNA from a booked induction

- 2 hour welcome session to raise the issue of pre-diabetes and offer solutions and personal goals for intervention
- If patient lapses supported to re-engage in remaining available courses (1 year)
- NICE compliant programme
- Trained Leaders on DPP programme
- DPP programme materials for patients

- Core, evidence based DPP treatment programme
- 24/7 access to 'expert chat' leaders for DPP related queries or support requirements
- Full scheme reporting on engagement, outcomes and satisfaction for patients
- Patient satisfaction reporting
- Trained community leaders to support DPP patients
- If patient reaches healthy weight at any point– free WW membership for life. Incentives & rewards for motivation/ engagement

Oviva

A modern solution for lifestyle change

- Daily advice, motivation and accountability
- Simple & effective data logging: photos for food, wireless trackers for weight and activity
- Efficient for patient and dietitian

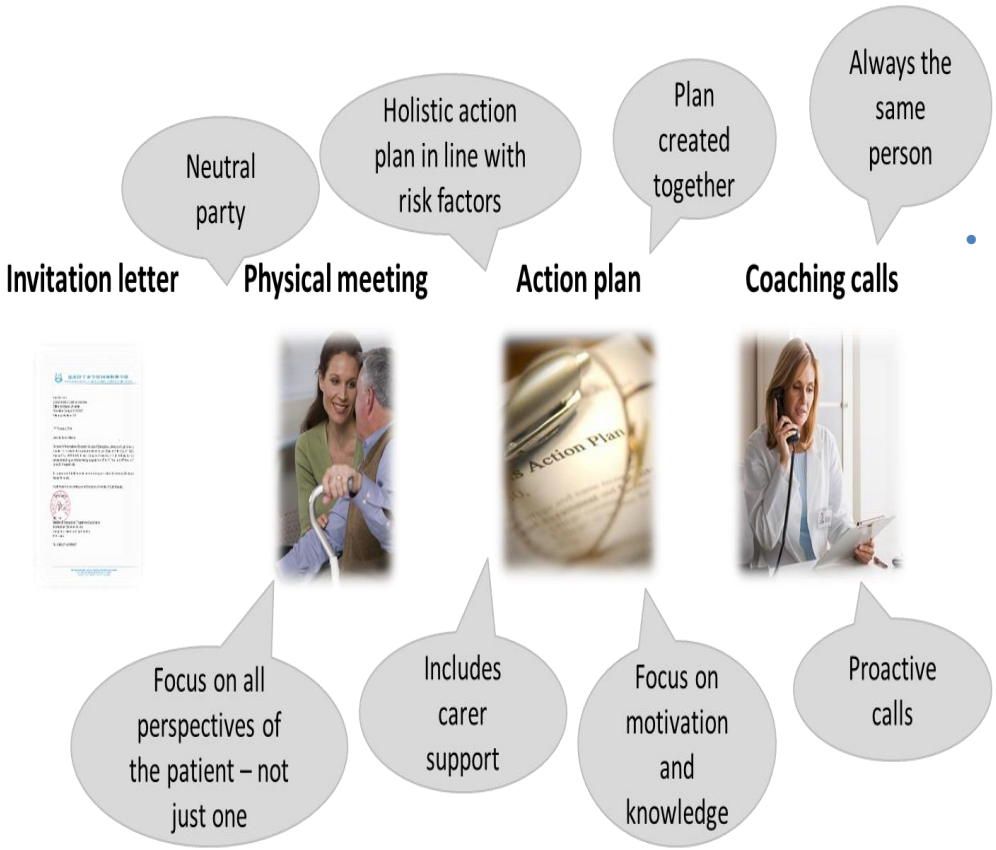
Map My Health

Map my Diabetes

Patient Self-Management

- On-line learming programme
- Type 2 (long standing and newly diagnosed)
- Pt goals and progress sent to practice as required/permissions

Health Navigators (Proactive Health Coaching)



- Proactive Health Coaching is a **temporary, individualized support** which is performed by a specialized trained nurse, also called Health Coach

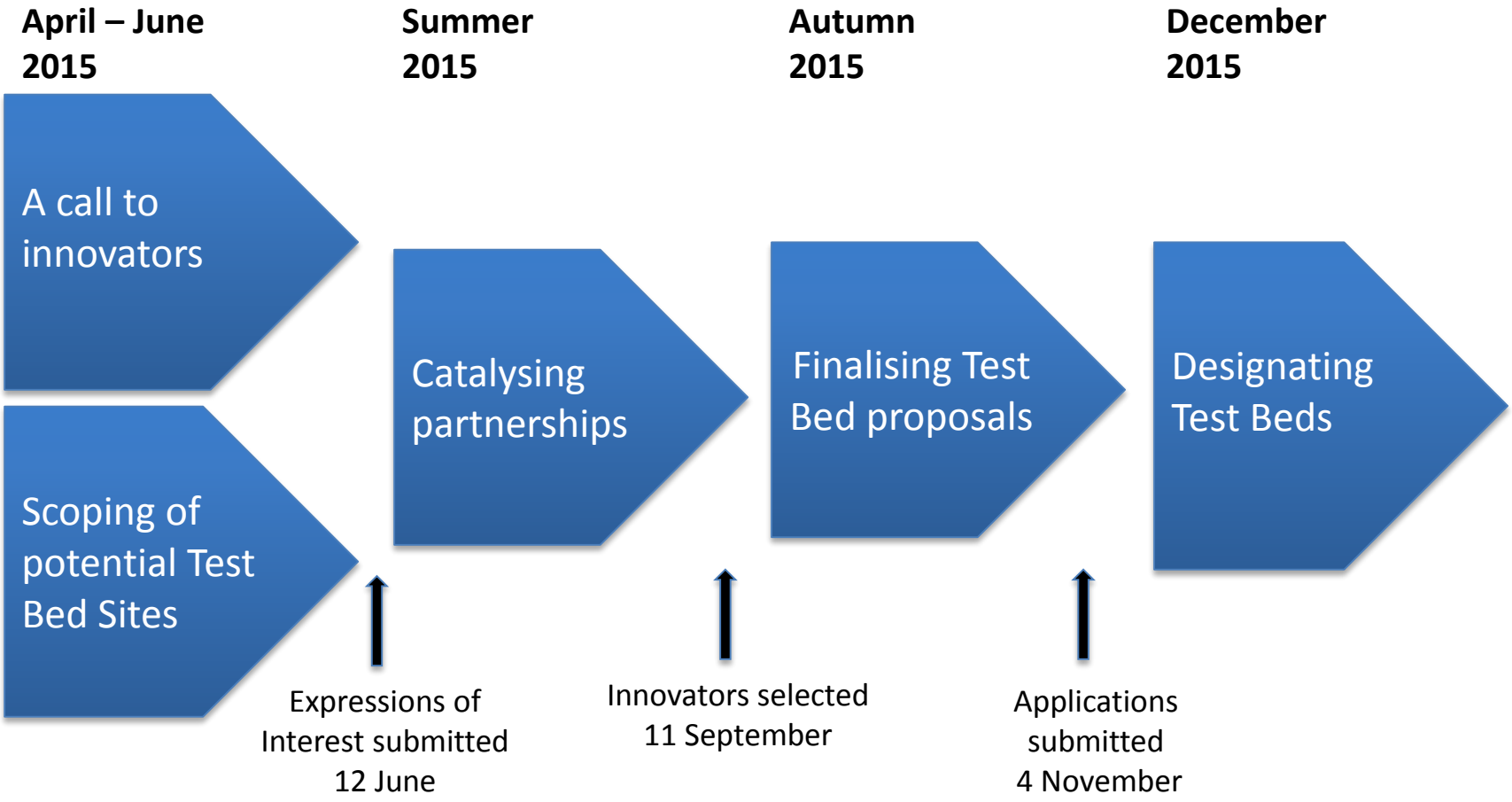
- The patient and the health coach creates a **personal plan** together out from the patients' current situation – all to **proactively prevent future acute care need**. The patient get **advise, coaching, support to self-care** and help to **coordinate healthcare- and social care contacts** through regular and **planned phone calls**

- Proactive Health Coaching is a **complement to regular healthcare** and social care for patients with heavy and complex care needs. The intervention ends when the patient no longer has a risk for avoidable inpatient care, and when regular care contacts works properly for the patient. The overall goals are **improved quality of life, improved self-sufficiency and sense of security** and **decreased avoidable (acute/non-elective) inpatient care**

Oxford Academic Health Science Network

WESSEX ACADEMIC HEALTH SCIENCE NETWORK

Programme Timeline:



Oxford Academic Health Science Network

WESSEX ACADEMIC HEALTH SCIENCE NETWORK

Thames Valley & Wessex Programmes

1. **Improving health and social outcomes for patients with LTC and reducing the number of people at risk of developing LTC using innovative psychological therapies and digital technologies**
2. **Reducing hospital admissions and improving quality of life in people with respiratory disease, using precision medicine, diagnostic and digital innovation**
3. **Applying innovation across the stroke care pathway to reduce mortality, disability and improve quality of life, and increase the amount of time patients spend at home after experiencing a stroke**

More learning from IAPT

- Integrate within pathway - patient experience enhanced
- Robust education and supervision – PPiPC well placed to support PC
- Improving capacity and competency - raising confidence and 'psychological literacy' in PC
- Protect IAPT 'business as usual' - 'name and brand' LTC to differentiate

Live Well Stay Well roll out

2015/16

Programme Board -preventative programmes agreed – IAPT 'glue' in 'eco system'

- **November : Combinatorial Test Bed innovators - implementation plan (successful or not)**
- **December : Economic evaluation with AHSN & CSCSU**
- **December : Lifestyle gateway evaluation**
- **January : Roll out Central Locality AVCCG & x2 more localities in Q4 2015/16**
- **BC for final roll out of IAPT LTC Programme**

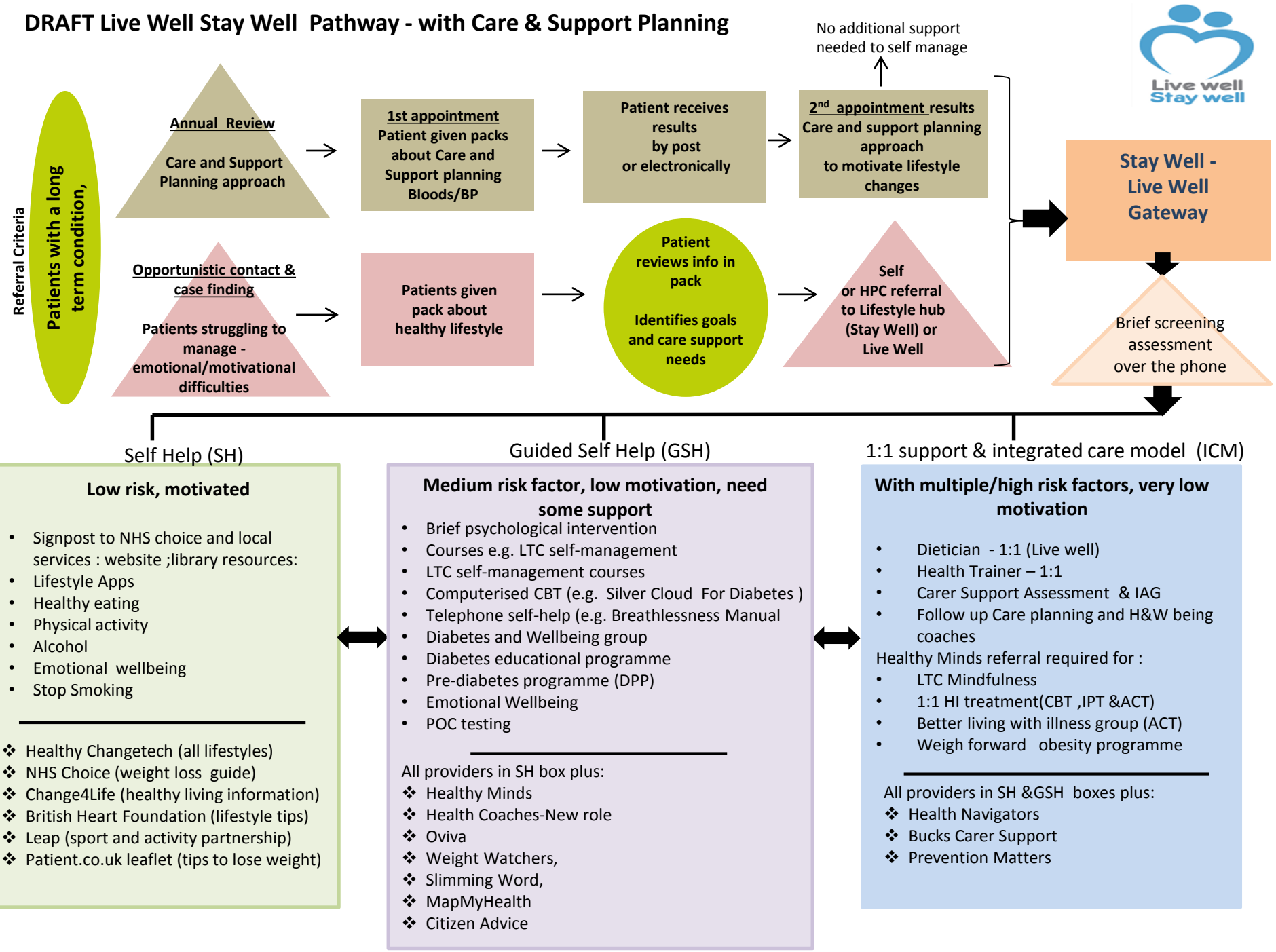
Live Well Stay Well roll out

2016/17

Workforce development planned supported by IAPT Service:

- New role of PC Health & Wellbeing Coaches to increase capacity. competencies inc. (behavioural change; motivation; LTC ; PH competencies –
- Conversation not consultation (PPiP Care plus)
- PC QIS - Prevention Incentive - referral to lifestyle gateway etc.
- Lifestyle change/self care - Care and Support Planning

DRAFT Live Well Stay Well Pathway - with Care & Support Planning



Self Help (SH)

Low risk, motivated

- Signpost to NHS choice and local services : website ;library resources:
- Lifestyle Apps
- Healthy eating
- Physical activity
- Alcohol
- Emotional wellbeing
- Stop Smoking

- ❖ Healthy Changetech (all lifestyles)
- ❖ NHS Choice (weight loss guide)
- ❖ Change4Life (healthy living information)
- ❖ British Heart Foundation (lifestyle tips)
- ❖ Leap (sport and activity partnership)
- ❖ Patient.co.uk leaflet (tips to lose weight)

Guided Self Help (GSH)

Medium risk factor, low motivation, need some support

- Brief psychological intervention
- Courses e.g. LTC self-management
- LTC self-management courses
- Computerised CBT (e.g. Silver Cloud For Diabetes)
- Telephone self-help (e.g. Breathlessness Manual
- Diabetes and Wellbeing group
- Diabetes educational programme
- Pre-diabetes programme (DPP)
- Emotional Wellbeing
- POC testing

All providers in SH box plus:

- ❖ Healthy Minds
- ❖ Health Coaches-New role
- ❖ Oviva
- ❖ Weight Watchers,
- ❖ Slimming Word,
- ❖ MapMyHealth
- ❖ Citizen Advice

1:1 support & integrated care model (ICM)

With multiple/high risk factors, very low motivation

- Dietician - 1:1 (Live well)
- Health Trainer – 1:1
- Carer Support Assessment & IAG
- Follow up Care planning and H&W being coaches

Healthy Minds referral required for :

- LTC Mindfulness
- 1:1 HI treatment(CBT ,IPT &ACT)
- Better living with illness group (ACT)
- Weigh forward obesity programme

All providers in SH &GSH boxes plus:

- ❖ Health Navigators
- ❖ Bucks Carer Support
- ❖ Prevention Matters

We covered

- Thinking and moving - preventing our own ill health!
- Levels of prevention
- Commissioning priorities and considerations
- Buckinghamshire PC Strategy – role of IAPT
- Live Well Stay Well & Healthy Minds
- What can we learn from IAPT ?
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Prevention in Primary Care - does IAPT have a role to play ?

WHAT DO YOU THINK ?