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

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Jackie Prosser, Programme Lead
Primary Care MH & Ill Health Prevention
AV CCG & Chiltern CCG
Jackie.prosser@nhs.net
Mobile: 07770 678 324
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!
WHAT WILL IAPT LOOK LIKE IN 30 YEARS TIME?

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

Live well
Stay well
Leavell and Clark’s Levels of Prevention

- **Primary Prevention**: Health promotion and addressing risk factors, social and genetic factors.
- **Secondary Prevention**: Screening of at risk individuals, control of risk factors and early intervention.
- **Tertiary Prevention**: Rehabilitation, preventing complications and improving quality of life.

**Levels of Prevention**

- **Whole population through public health policy**
- **Whole population selected groups and healthy individuals**
- **Selected individuals with high risk patients**
- **Patients**

**Primordial Prevention**

- Advocate for social change to make physical activity easier

**Primary Prevention**

- Primary care advice as part of routine consultation, MECC/QIS

**Secondary Prevention**

- Secondary prevention: Early detection of disease
- Primary care risk factor reduction for those at risk of chronic disease, health checks, pre-diabetic education

**Tertiary Prevention**

- Exercise advice as part of cardiac rehabilitation
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

Primary Care in Buckinghamshire

Our strategy for proactive, co-ordinated, out-of-hospital care.

NHS Aylesbury Vale Clinical Commissioning Group and NHS Chiltern Clinical Commissioning Group
Modern healthcare 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 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

- Organisational and supporting processes
- Engaged, informed individuals and carers
- Person-centred coordinated care
- Health and care professionals committed to partnership working
- Commissioning
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: A prevention model for Primary Care

Step one
Patient: Low-risk factors, motivated, access to and understanding of internet and/or local services – self support

Identification and Brief Interventions (MECC principles)

Step two
Patient: Medium risk factors
Low in motivation and/or needs some support to identify/navigate local services or web based information

Step three
Patient: Complex condition(s), multiple risk factors and/or very low motivation

Primary Care Principles
- Parity of esteem – equal attention to mental and physical health needs
- Staying healthy – a personal responsibility
- Self-care – supporting patients as required
- Strengthening community assets, including volunteers
- Co-design – expert by experience

Mixed solutions but primarily groups or telephone based support. Lifestyle services, CBT based interventions, expert patient groups, digital follow up. Patient works with peers or others. (eg family/health coach) to set goals.

More intensive support. Face to face, MDT and/or multi agency groups. Digital support. Care planning in place with practitioner.

Direct referral to services

Underpinned with revised workforce competencies and demand management tools.
Robust technology platform, real time data feedback, community needs and asset maps.

Healthy eating/weight
physical activity
Alcohol
emotional wellbeing
Stop smoking

Population focus (Health Checks, QOF, QPS)

Light touch, signposting. Web based information and support tools. Library services, Practice leaflets. Patient sets own goals.

Lifestyle Gateway (PAM) to determine level of motivation; planned care and follow up & data analysis (feedback loop)
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

The MORE ACTIVATED you are in your own health care, the BETTER HEALTH CARE you get...

<table>
<thead>
<tr>
<th>MORE ACTIVATED Patient</th>
<th>LESS ACTIVATED Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmitted to the hospital within 30 days of discharge</td>
<td>12.8%</td>
</tr>
<tr>
<td>Experienced a medical error</td>
<td>19.2%</td>
</tr>
<tr>
<td>Have poor care coordination between health care providers</td>
<td>12.6%</td>
</tr>
<tr>
<td>Suffer a health consequence because of poor communication among providers</td>
<td>13.2%</td>
</tr>
<tr>
<td>Lose confidence in the health care system</td>
<td>15.1%</td>
</tr>
</tbody>
</table>

Source: Adapted from AARP & You, "Beyond 50.09" Patient Survey. Published in AARP Magazine. Study population age 50+ with at least one chronic condition. More Involved=Levels 3 & 4, Less Involved=Levels 1 & 2
Patient Activation Measure

How Does the PAM® Work?

**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*
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 have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

**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
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**

Individually do not feel confident enough to play an active role in their own health. They are predisposed to be passive recipients of care.

10-30% of Nat'l population

Level 2

Individuals in Level 1 do not believe or understand they are responsible for or can impact their health.

20-25% of Nat'l population

Level 3

35-40% of Nat'l population

Level 4

Maintaining behaviors individually have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

25-30% of Nat'l population

Increasing Level of Activation
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.

10-30% of Nat'l population
20-25% of Nat'l population
35-40% of Nat'l population
25-30% of Nat'l population

Increasing Level of Activation
Level 3

Individuals in Level 3 understand they are key to their health but are not sure where to get started or how to keep going.

Taking action
Individuals have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

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

Individuals in Level 4 have a solid hold on how to stay healthy. They are in maintenance mode but slip up occasionally.

Maintaining behaviors
Individuals have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Increasing Level of Activation

- Level 1: 10-30% of Nat'l population
- Level 2: 20-25% of Nat'l population
- Level 3: 35-40% of Nat'l population
- Level 4: 25-30% of Nat'l population
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)

**LEVEL 5**
Severe & complex mental illness/disorder requiring specialist mental health intervention(s)

**LEVEL 4**
More severe psychological problems that are diagnosable & require biological treatments, medications & specialist psychological interventions

**LEVEL 3**
Psychological problems which are diagnosable/classifiable but can be treated solely through psychological interventions, e.g. mild & some moderate cases of depression, anxiety states, obsessive/compulsive disorders

**LEVEL 2**
More severe difficulties with coping, causing significant anxiety or lowered mood with impaired ability to care for self as a result

**LEVEL 1**
General difficulties coping with illness & the perceived consequences of this for the person’s lifestyle, relationships etc. Problems at a level common to many or most people receiving the diagnosis

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 diabetes¹
• Prevent 162 missed work days²
• Avoid the need for BP/Cholesterol pills in 11 people³
• Add the equivalent of 20 good years of health⁴
• Avoid £57,000 in healthcare costs⁵

### IAPT ACCESS 2014/15

<table>
<thead>
<tr>
<th>CCG</th>
<th>Q1 Planned</th>
<th>Q1 Actual</th>
<th>Q2 Planned</th>
<th>Q2 Actual</th>
<th>Q3 Planned</th>
<th>Q3 Actual</th>
<th>Q4 Planned</th>
<th>Q4 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aylesbury Vale</td>
<td>3.34%</td>
<td>3.92%</td>
<td>3.46%</td>
<td>3.77%</td>
<td>3.6%</td>
<td>4.3%</td>
<td>3.77%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Chiltern</td>
<td>3.34%</td>
<td>3.84%</td>
<td>3.46%</td>
<td>3.48%</td>
<td>3.6%</td>
<td>3.7%</td>
<td>3.77%</td>
<td>4.05%</td>
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</table>

### IAPT RECOVERY 2014/15

<table>
<thead>
<tr>
<th>CCG</th>
<th>Q1 Planned</th>
<th>Q1 Actual</th>
<th>Q2 Planned</th>
<th>Q2 Actual</th>
<th>Q3 Planned</th>
<th>Q3 Actual</th>
<th>Q4 Planned</th>
<th>Q4 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aylesbury Vale</td>
<td>50%</td>
<td>60.0%</td>
<td>50%</td>
<td>59.2%</td>
<td>50%</td>
<td>66.1%</td>
<td>50%</td>
<td>66.25%</td>
</tr>
<tr>
<td>Chiltern</td>
<td>50%</td>
<td>65.5%</td>
<td>50%</td>
<td>64.1%</td>
<td>50%</td>
<td>60.9%</td>
<td>50%</td>
<td>66.89%</td>
</tr>
</tbody>
</table>

**ACCESS & RECOVERY ABOVE EXPECTATION**
<table>
<thead>
<tr>
<th>Demographic</th>
<th>Breathe Well Clinic, Modified Pulmonary Rehab &amp; Housebound Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number Assessed</td>
<td>470</td>
</tr>
<tr>
<td>Number Treated</td>
<td>370</td>
</tr>
<tr>
<td>Age (Assessed patients)</td>
<td>Mean: 70.06</td>
</tr>
<tr>
<td></td>
<td>Range: 36-94</td>
</tr>
<tr>
<td></td>
<td>65 or over: 76.8%</td>
</tr>
<tr>
<td>Gender (Assessed patients)</td>
<td>Male: 54.7%</td>
</tr>
<tr>
<td></td>
<td>Female: 45.3%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Population size (Bucks)</th>
<th>Target size to treat</th>
<th>Innovator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese/Over Weight</td>
<td>300,000</td>
<td>60,000</td>
<td>Changetech</td>
</tr>
<tr>
<td>Pre-diabetes</td>
<td>50,000</td>
<td>750</td>
<td>Weight Watchers</td>
</tr>
<tr>
<td>Diabetes</td>
<td>35,000+ (expected)</td>
<td>25,000</td>
<td>Map my Health (25,000)</td>
</tr>
<tr>
<td></td>
<td>25,000 (on QOF register)</td>
<td></td>
<td>Weight Watchers/Oviva (500)</td>
</tr>
<tr>
<td>Newly diagnosed diabetes</td>
<td>1,500pa</td>
<td>1,500</td>
<td>Map My Health (1,250)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Weight Watchers (250)</td>
</tr>
<tr>
<td>Co morbid LTC (complex/high risk)</td>
<td>TBC</td>
<td>500</td>
<td>Oviva, Live Well</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Health Navigators</td>
</tr>
<tr>
<td>Test Bed Treatment Total</td>
<td>-</td>
<td>87,750</td>
<td>Innovations combined with new workforce and existing projects</td>
</tr>
</tbody>
</table>
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 and running service
- 60,000 have used 1 or more programs
- A self explanatory user portal
Weight Watchers

Screening & Booking
- Health check
- GP / Practice / Other referral
- Bloods Hba1c

Induction
- WW referral hub & welcome calls
- Welcome session (Max 20 people)

1 year ILI
- Community meetings & online / mobile tools

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 learning 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.
A call to innovators

Scoping of potential Test Bed Sites

Expressions of Interest submitted 12 June

Catalysing partnerships

Innovators selected 11 September

Finalising Test Bed proposals

Applications submitted 4 November

Designating Test Beds

Programme Timeline:

April – June 2015

Summer 2015

Autumn 2015

December 2015
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**

**Referral Criteria**
- Patients with a long-term condition,
- Patients struggling to manage - emotional/motivational difficulties

**Annual Review**
- Care and Support Planning approach

**1st appointment**
- Patient given packs about Care and Support planning
- Bloods/BP

**Patient receives results by post or electronically**
- Patient reviews info in pack
- Identifies goals and care support needs

**2nd appointment**
- Results Care and support planning approach to motivate lifestyle changes
- Self or HPC referral to Lifestyle hub (Stay Well) or Live Well

**Stay Well - Live Well Gateway**
- Brief screening assessment over the phone

**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)

**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

**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
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• Buckinghamshire PC Strategy – role of IAPT
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Prevention in Primary Care - does IAPT have a role to play?

WHAT DO YOU THINK?