NHS England

Guidance on co-locating mental health therapists in primary care

NHS England INFORMATION READER BOX		
Directorate		
Medical	**Operations and Information**	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Strategy & Innovation
Finance		

Publications Gateway Reference:	**08376**
Document Purpose	Guidance
Document Name	Guidance on co-locating mental health therapists in primary care
Author	NHS England/Mental Health/Improving Access to Psychological Therapies
Publication Date	August 2018
Target Audience	CCG Clinical Leaders, CCG Accountable Officers, GPs, GP Practice Managers
Additional Circulation List	
Description	This guidance seeks to assist GPs, practice managers and commissioners who are integrating mental health therapists into primary care pathways by providing information on how to do this, flagging some of the principal organisational and financial issues which need to be considered.
Cross Reference	N/A
Superseded Docs (if applicable)	N/A
Action Required	N/A
Timing / Deadlines (if applicable)	**N/A**
Contact Details for further information	NHS England, Mental Health Policy and Strategy Team Skipton House 80 London Road London SE1 6LH england.mentalhealthpmo@nhs.net

Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Guidance on co-locating mental health therapists in primary care

First published: August 2018

Prepared by: NHS England Strategic Communications (Mental Health)

Classification: OFFICIAL

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request. Please contact Kevin Smith on 0113 825 3387, email: Kevin.Smith6@nhs.net

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

- Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and
- Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

Contents

1 Introduction

The number of patients needing help with mental health problems is increasing. A survey of more than 1,000 GPs by charity Mind (June 2018) found two in five appointments involved mental health, while two in three GPs said the proportion of patients needing help with their mental health had increased in the previous 12 months. Research also shows that every week one in six adults experiences symptoms of a common mental health problem, such as anxiety or depression, and one in five has considered taking their own life at some point. The Adult Psychiatric Morbidity Survey (2014) also found nearly half of adults believe, in their lifetime, they have had a diagnosable mental health problem, yet only a third have received a diagnosis.

The economic impact of mental health can be measured in terms of lost employment, health and social care costs. Mental health problems cost the UK economy an estimated £70 to £100 billion annually (2013). Mental health problems are responsible for the largest burden of disease in the UK – 28 per cent – compared to 16 per cent for cancer and 16 per cent for heart disease (Fundamental Facts About Mental Health, Mental Health Foundation, 2015).

For many people, GPs are the first port of call for accessing support for mental health in the NHS, increasingly however, patients are able to self refer to mental health services and to be signposted to services by practice reception and care navigation staff. This has been supported by research findings about mental ill-health prevalence and the impact on GP workload show the need for a significant increase in mental health therapists directly linked to practices to make it easier for people to access care. Commissioners and providers need to ensure GPs are as prepared as they can be to deliver care to their patients, whether presenting with physical or mental health issues.

Workload was identified by a 2015 British Medical Association (BMA) survey as the single biggest issue of concern to GPs and their staff. The General Practice Forward View (GPFV) contains practical and funded steps on a number of issues facing GPs – including workload, steps which include increasing the scope of the primary care team to include mental health therapists. The GPFV also sets out investment in staffing to reduce GPs' workload including 3,000 additional, fully-funded, practice-based mental health therapists working in primary care by 2020. And the benefits go wider than alleviating workload pressure on GPs. Strengthening the primary care workforce enhances the whole team's capability to provide accessible and holistic care, promotes mental health awareness, faster diagnosis, and can reduce some patients' use of physical health services.

This guidance seeks to assist GPs, practice managers and commissioners who are integrating mental health therapists into primary care pathways by providing information on how to do this, flagging some of the principal organisational and financial issues which need to be considered.

2 National context

NHS England aims to deliver a transformation in mental health services by 2020/21, with an ambition of putting services on an equal footing with those for physical health in the NHS. New models of care for adults with mental health needs are set out in the Five Year Forward View for Mental Health. This document also commits the NHS to further expanding the Improving Access to Psychological Therapies (IAPT) programme so that 1.5 million people will be seen by the programme by 2021. This will only be possible if commissioners plan for a substantial expansion of the workforce in line with Health Education England's Stepping Forward to 2020/21: The Mental Health Workforce Plan for England.

NHS England's commitment in the General Practice Forward View (chapter 2: workforce) to investing an extra 3,000 mental health therapists in primary care is linked, operationally, to the expansion of IAPT services. It is anticipated that the majority of the extra 3,000 therapists will be IAPT therapists working in the new IAPT-Long Term Condition (LTC) services which support people with depression or an anxiety disorder with a co-morbid long-term condition or medically unexplained symptom (MUS). It is expected where these new IAPT-LTC services are delivered in primary care the IAPT therapists will be most effective if co-located and integrated into the primary care team. There will also be contributions to the additional 3,000 mental health therapists from the expansion of core IAPT services and local developments as new models of care and roles emerge in, for example, enhanced primary mental health care teams and national plans to increase access to psychological therapies for people with Severe Mental Illnesses or Personality Disorders.

3 Benefits of workforce integration

Co-location of mental health therapists supports the drive to strengthen the primary care workforce by offering a broader range of integrated services for patients in their communities. It is expected that the mental health therapists will be full members of the primary healthcare team receiving not only self-referrals from patients but also from all members of the team - GPs, clinical pharmacists, practice nurses and Health Care Assistants. Mental health therapists should be expected to attend practice meetings, provide specialist advice and liaise with clinicians across other mental health, social care, and physical health services on behalf of the patient and practice.

The referral model and referral criteria will vary depending on locally agreed arrangements. However, the pathway will continue to underpin current IAPT access and waiting time standards. By working in a more integrated way we expect referral routes to be more streamlined, e.g. via direct booking systems. Some early implementer sites have worked with primary care to develop screening tools that may be helpful to identify suitable patients. This sets the conversation about a person's mental health within the physical health pathway, identifying people who may need additional support from IAPT colleagues. The use of screening tools for mental health needs by physical health colleagues will be determined locally. Patients will still have the option to self-refer. Further information about the pathway can be found in the IAPT-LTC pathways document.

A key aspect of co-location is the opportunity it provides for closer working between mental and physical health professionals, facilitating mutual learning. It supports good practice, ensures an integrated and patient-centred approach to delivering care and that health inequalities are addressed. Nationally, there are a range of good practice models.

CASE STUDY 1. Sheffield: IAPT in primary care

In Sheffield, IAPT practitioners have been co-located in primary care since 2008, regularly utilising rooms in GP surgeries to support their patients. GPs report that not only does co-location assist in the direct care of individual patients but the opportunity for professional conversations provides invaluable opportunities for informal learning and information sharing. These discussions provide an efficient way to resolve referral or risk issues, improving care and reducing administrative burden for GPs.

Dr Charles Heatley, a senior partner at Birley Health Centre in Sheffield and Clinical Director for Planned Care at Sheffield Clinical Commissioning Group, states in his experience “co-locating mental health therapists in GP surgeries, and broadening the range of services for patients, means local health services are better equipped to deal with patients’ physical and mental health needs. By intervening at an earlier stage and addressing common mental health issues the IAPT programme is helping to improve patients’ health outcomes”.

CASE STUDY 2. North East Hampshire and Farnham: TalkPlus

Successful workforce integration creates new relationships, networks and ways of working. For example, co-location gives an opportunity for intervention at an early stage to break the link between a patient’s poor physical and mental health. TalkPlus and GP practices in North East Hampshire and Farnham are working towards integrating mental and physical healthcare for patients diagnosed with chronic obstructive pulmonary disease (COPD) as part of the IAPT-LTC expansion. IAPT therapists communicate with GPs and practice nurses at the beginning and throughout treatment which supports shared decision-making. Routine liaison and attendance at multi-disciplinary team meetings across the primary care team offers opportunities to explore both the physical and mental health needs of patients.

Training sessions run by IAPT therapists for practice nurses have helped establish a positive working relationship between the IAPT therapists and practice nurse team. We know from the IAPT-LTC expansion that these closer working relationships have resulted in primary care staff feeling more skilled and confident in identifying the mental health needs of their patients.

CASE STUDY 3: Islington, iCope

A major driver for successful workforce integration is a clear focus on delivering better health impact and outcomes, improved patient access and experience of care. iCope, an IAPT service in Islington, found that more integrated working, mutual feedback and learning between GPs and IAPT therapists in one GP surgery led to more carefully considered referrals, resulting in higher recovery rates for patients.

Introducing skilled and dedicated psychological support in primary care should enhance the quality of these discussions and enable consideration of mental health issues earlier to improve overall health outcomes so that patients become less reliant on primary and emergency care. iCope also offers new trainee GPs brief teaching sessions on inclusion and exclusion criteria for the service and provides refresher sessions for established GPs.

Established as part of the GP Forward View, the General Practice Development Programme recognises that growing numbers of practices are looking at broadening their workforce to reduce demand on GP time and connect the patient more directly with the most appropriate professional. Part of the Development Programme is helping GP practices to adopt 10 High Impact Actions to release 'time for care' with an estimated 10 per cent of GP time being freed up through this change programme. One of the 10 High Impact Actions, 'Develop the team' demonstrates how groups of practices can broaden their workforce in order to connect the patient directly with the most appropriate professional while reducing the demand for GP time. All GP practices can access this service from NHS England. See Releasing time for care and General Practice Development Programme for further information.

4 Quality assurance and governance

The IAPT programme is supported by a national training programme which ensures all psychological wellbeing practitioners (PWPs) and high-intensity therapists (HITs) receive accredited training, overseen by Health Education England. PWPs and HITs working as part of an IAPT-LTC service receive specialist top-up training enabling them to work with patients with LTCs and MUS, using NICE-approved psychological treatments. This assures a high level of competence in the delivery of these treatments within IAPT and IAPT-LTC services. It is anticipated that combinations of both grades of staff will be co-located into primary healthcare teams depending on the size of individual practices. As IAPT staff are not employed by general practice, but will be co-located and working within the practice team, relevant governance policies and procedures will need to be adhered to by IAPT staff and local monitoring arrangements should be in place.

To be most effective, IAPT practitioners need to be able to access relevant clinical and other information and also ensure their data can be viewed by other clinicians within the practice team. In Sheffield, IAPT practitioners provide updates on the patient record on GP systems at each appointment. This provides the GP with useful

information on how the patient is progressing and enables the GP to have a fully informed conversation with the patient about their physical and mental health. Patients give consent at the start of IAPT treatment, for information and progress relating to their treatment to be shared with their GP.

In Calderdale, the IAPT service uses the GPs' diary system, enabling staff at the practice to book appointments directly in the IAPT clinician's diary. IAPT practitioners receive weekly case management supervision from qualified IAPT supervisors in the IAPT service. Local arrangements will determine the extent to which systems are interoperable and the extent to which information is shared. If data systems are not compatible there may be local arrangements made to ensure that some information is shared with the GP data system so that GPs are kept up to date on the progress of their patients. In circumstances such as this the patient's core IAPT record will sit within the IAPT service.

5 Co-located mental health therapist funding

The fundamental principles of IAPT are that skilled practitioners are appropriately trained, as set out above, deliver NICE-approved therapies and routinely monitor patient outcomes. To deliver services in this way a certain scale of operation is required to provide adequate therapist supervision and continuous professional development whilst offering the full range of NICE-recommended treatments across the various levels of severity, complexity and types of anxiety and depression. Co-location is a fundamental principle within this approach so that services are offered seamlessly to all practice patients with minimal friction between primary and community pathways.

6 Managing co-location premises costs

How mental health therapists are best co-located within general practice will be determined by a range of factors including accessibility for patients, the size and location of practices and the space available to accommodate them. Opportunities may arise for co-locating within single practices or within a primary care network serving a number of smaller practices. See Appendix 1 for further information on this topic, including use of void space, capacity within the primary care estate, accommodation already approved for delivery of General Medical Services, and use of space on a commercial basis.

7 Balancing the costs of co-location with wider benefits

NHS England has collated initial findings from 16 CCGs who were IAPT-LTC Early Implementer sites. These areas have established IAPT-LTC services that are truly integrated into physical healthcare pathways (including community teams, acute hospitals and GP surgeries). Early findings have confirmed significant savings as a result of patients' lower use of primary and secondary healthcare services.

Cambridgeshire and Peterborough CCG analysed the self-reported outcome measures of 446 people who went through the integrated pathway and found A&E attendances fell by 61 per cent, hospital inpatient admission fell by 75 per cent and

GP appointments for diabetes, cardio-vascular and respiratory fell by 73 per cent. Initial findings from other sites demonstrate similar reductions in GP appointments. The IAPT service in Calderdale has found a 48 per cent reduction in GP appointments as a result of IAPT-LTC practitioners co-locating in primary care, and Buckinghamshire has shown a 33 per cent reduction in GP appointments from this patient cohort. These early results show the benefits that can be delivered to GP practices where there is facilitated co-location of mental health therapists.

These initial local evaluations are encouraging and seem to confirm the cost of service expansion and integration of mental health therapists in primary care will be more than off-set by benefits to patient experience and outcomes, more efficient use of GPs' time and a reduction in patient appointment volumes.[1]

8 Mental health co-location case studies

- Islington iCope – making the most of a close working relationship with GPs.
- Calderdale - integrating mental health therapy in primary care.
- North East Hampshire: setting up an integrated GP clinic.
- Psychological therapy helps people with long-term conditions to Live Well in Buckinghamshire.

9 GP blogs

- Delivering effective mental health therapies in primary care for anxiety and depression on a group or self-guided basis. Dr John Hague.
- Improving health outcomes through mental health co-location. Dr Charles Heatley.
- Integrating mental and physical health in primary care. Dr Emma Tiffin.

10 Further reading

- The NHS Clinical Commissioners report *Of primary importance*, showcases programmes that are embedding mental health in primary care.
- The Improving Access to Psychological Therapies Manual.
- The IAPT pathway for people with long-term physical health conditions and medically unexplained symptoms.

[1] A national evaluation of healthcare utilisation has been commissioned from Imperial College and is expected to be published in winter 2018/19.

Appendix 1. Managing co-location premises costs

GP contractors receive reimbursement of premises costs from the NHS under their contract. This provides for rent (or notional rent if the premises are owned by the partners), business rates, water and clinical waste which are typically reimbursed in full. All other premises running costs fall to the GP practice to fund as business costs. IAPT teams do not currently fall within the model of core primary care services and so there is no contractual obligation on NHS England or clinical commissioning groups (CCGs) to support the premises costs for this service; instead, provision for premises costs should be included within the contract price or tariff. However, the opportunity for co-location and integration within the primary care team and the benefits this offers are well understood and encouraged and, by agreement, hosting of the IAPT service may be included in the reimbursement where it is reasonable to do so and where there is an assurance the system is not paying twice for the accommodation.

Co-location may extend to a dedicated space for the mental health therapy team, or perhaps ad-hoc use of a clinical room or surgery accommodation. It may also extend to the use of NHS estate owned by Community Health Partnerships (CHPs) or NHS Property Services Ltd (NHSPS). Primary care may be able to offer some space at full or part cost – this may extend to a full rent, or may be as little as a reasonable contribution towards running costs. In terms of managing the costs associated with the service there are a number of ways in which this can be addressed:

Appendix 1.1. Use of existing void space

Consideration of use of existing void space across the local estate, already funded by commissioners but left as unoccupied or under-utilised space, would facilitate better utilisation of NHS estate. Opportunities to locate a community-based service for a town or locality may therefore exist. Commissioners would prefer to see operational/clinical estate fully occupied with providers taking direct tenancy agreements and where a proposal is made by the IAPT service, commissioners may either agree to release the void space to enable the IAPT service to enter into a tenancy arrangement with NHSPS or CHP; or continue to fund this accommodation direct, or; arrange for an accommodation fee to be offered by the IAPT service to offset the costs already incurred by the CCG. Schedules of current void space can be obtained from the Strategic Estates Planners for the two NHS property companies.

Appendix 1.2. Capacity within the primary care estate

An alternative is to consider current capacity already within the primary care estate where it is not intended or currently approved to be used for the delivery of core primary care services. This may be the case in owner-occupied estate and may provide dedicated facilities or sessional use of clinical, admin or meeting space – all of which may be deemed suitable for IAPT service provision. The IAPT service will be required to pay a rent and a reasonable contribution towards all other running costs (gas, electricity, cleaning, general maintenance, telephony, support services). Each case should be negotiated between the CCG, IAPT and the GP practice and formally documented under a standard property Licence Agreement which sets out the terms between the parties.

Appendix 1.3. Accommodation approved for GMS

Where a practice agrees to host the service in accommodation already approved for delivery of General Medical Services (GMS) and it is approved by commissioners and is eligible for reimbursement of costs under the Premises Costs Directions, the Commissioner will need to agree to the proposed arrangements. Where the IAPT service is sharing the accommodation with the GMS use of the building they may agree that no payment for rent needs to be made, and the IAPT service can use the space on a sessional basis. The practice can only ask for a contribution towards its service charges in this scenario. If the IAPT service has exclusive use of part of the building then the commissioners may determine the IAPT service is to fund its own accommodation costs. In these circumstances the reimbursement of premises costs to the practice will be reduced to offset any income received from the IAPT service – this is to prevent a situation where the premises are paid for twice (i.e. reimbursement to the practice and charged to the IAPT service). A Licence Agreement is desirable to set out the terms agreed. Local Medical Committees (LMCs) have experience and historical knowledge about how to get the best from these arrangements for all parties. In terms of the use of the surgery premises, additional capacity could also be provided across lunchtimes, early mornings, evenings and weekends as well as the use of GPs' rooms when they are not working, so shared use of existing space is possible.

Appendix 1.4. Use of space on a commercial basis

In the event that none of the above is suitable or available, some general practices may decide to offer space which is available on a commercial basis, where they have vacant accommodation which sits outside the approved GMS space and where any tenancy arrangements allow. Where this is an option, the rental charge should be negotiated between the IAPT service and general practice. The costs agreed may need to be considered by the commissioner when agreeing the contract for the IAPT service. It is likely that commissioners would wish to be involved in these discussions as purchaser of the service, to know where the service was being delivered from, and to facilitate discussions between parties.

LMC representatives are a key source of local knowledge and expertise relating to contractual arrangements for co-location. They have considerable experience of supporting practices, third-party providers and commissioners to negotiate, and can play a key role in gaining engagement from all constituent practices. They will be familiar with those practices in their area that need most support in terms of transformational change and will be able to help.

Appendix 2. Estates funding of extensions & improvements

While the Estates and Technology Transformation Fund (ETTF) is fully committed, there may be opportunities to apply for funding to increase the capacity of a practice via the annual capital allocations, termed 'Business as Usual' capital funding which is available via NHS England. There is a planning cycle so this will require forward planning and submission of formal applications via CCGs.