Integration of Psychological and physical health care in Cumbria; across providers and conditions

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CUMBRIA

Population  **496,200**
Over **6,768** km², 3\(^{rd}\) largest county,

1 CCG,
4 DGHs

Vanguard and Success regime

Poor infrastructure
Service

• Fully integrated service offering care across the Health economy for patients with complex physical and psychological difficulties

• Many pathways some will be described in detail, but with shared:
  – Vision and ambition
  – Leadership
  – Governance
  – Skills
  – Outcome measures
Team includes:
Psychologists - clinical, health, counselling, neuro.
Psychological practitioners, Nurses, Social Workers, CBT therapists
Consultant Anaesthetist
Physiotherapists and Rehabilitation staff

Persistent physical symptoms
Long term conditions
Cancer Fear of recurrence
Psychosexual
Paediatrics

SUPERVISION, TRAINING, CONSULTANCY, REFERRALS TO AND FROM

Inpatient Units eg stroke unit
Palliative care, hospices
Cancer Tumour specific teams
Community MDTs incl COPD Diabetes
Primary care, incl Community Beds
Long term health conditions

- Long term health conditions account for £7 in every £10 spent in the NHS

- By interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem. (Naylor et al Kings Fund Long-term conditions and mental health: The cost of co-morbidities Feb 2012)

- Unhelpful to have diagnostic specific care as patients often have multiple co-morbidities and as a result get excluded from care with unitary pathways or IAPT
Persistent Physical Symptoms

• There are a collection of conditions which share many features including CFS, Fibromyalgia, Chronic Pain and MUS, in that:
  ➢ They are usually diagnosed by exclusion
  ➢ They are syndromes rather than having unique features
  ➢ Medical management offers little benefit, in fact can cause further harm. The condition often causes patients psychological distress and social disability, 30% have comorbid psychiatric presentations
Medically unexplained symptoms

• Patients utilise a disproportionate amount of health care resources, in primary and secondary care, 20% of GP consultations relate to MUS, MUS costs £3.1 Billion per annum in the UK in health care costs, 50% of medical outpatients have MUS

• The conditions are often maintained by patients unhelpful beliefs and resultant behaviours which lead to further symptoms and disability
Evidence base for effective treatment is immense:

- PACE trial for CFS – Graded exercise and CBT
- NICE:
  - ME/CFS
  - Back Pain,
  - NICE 91
- Guidelines for Pain Management Programmes for adults, 2013, British Pain Society
What are effective interventions?

• There is increasing evidence that all patients with these conditions benefit from:
  ➢ Accurate and Helpful information, that explains their condition and the causes
  ➢ Consistent management from all professionals, who are suitably trained
  ➢ Identification of unhelpful beliefs and behaviours, with appropriate challenging of these
  ➢ Psychological therapy CBT, ACT, Mindfulness, EMDR
Process of service development
"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."
CCG, Quality and Spending

• The Royal College of Surgeons Dashboard Cumbria is an outlier in respect to the rate of injections for back pain.

• The national average is 84 per 100,000 Cumbria is 155.4 per 100,000 - 84% more than the national mean.

• Cumbria CCG is ranked 185 out of 211 CCGs across the country
• NICE have generally concluded that injection therapies are of little or no benefit in sub-acute or chronic back pain (lasting > 6 weeks but < 1 year).

• CCGs across the country have restricted the use of injections by classifying them as interventions of limited clinical value.
May 2015 CCG executive agreed to realign resources to a new pathway, utilising the money from stopping interventions of limited clinical value, £900,000.

To be invested in a Biopsychosocial evidenced base model for a range of conditions, consistent with NE guidance

8% of budget for training across the county
• Training all staff in active psychological care
• Team of experts for people with highest level of need
• Cumbria wide approach
• co-ordinated care for a defined group

Integrated Population based

Every contact counts

Individual
WHOLE SERVICE

- Promoting psychological care for patients with Physical health problems across the health economy
- Shared outcome data
- Self management
ACROSS CUMBRIA HEALTH ECONOMY

- Across all providers
- Pathway redesign for:
  - Neurorehabilitation
  - Persistent physical symptoms
  - MSK to increase psychological care
- Supported by shared E record
- Single point of access
- Consultation hour for advice
- Groups for living well with long term conditions
MODEL OFFERS

• Rolling programme of Psychological skills training in CBT
• One day, 6 day
• All staff across trusts at minimal charge
• Physio, OT, GPs, SALT, Consultants, Clinical Nurse specialists, Health visitors, Dieticians
• Remain in supervision
• Training includes:
• CBT fundamentals
  – Questioning styles
  – Formulation
• Simple interventions for:
  • Depression
  • Anxiety
  • Panic
  • Fear of recurrence
  • Trauma
• Risk assessment
• Goal planning, pacing
Interventions

- MDT assessment
- Group, ACT
- One to one psychology and physiotherapy
- Psychological interventions
  - Including
    - CBT
    - ACT
    - Mindfulness
    - EMDR
Standardised materials

- Referrers leaflets and forms
  - exclude red flags

- Patient information sent with opt in letters
  - information on what is on offer
  - What to expect
  - 96% opt in
  - Evaluation and baseline measure

- Patient workbooks for the groups to use after they complete the programmes
Outcome measures

• **PPSS**
• CFQ-14 (Chalder Fatigue Scale)
• PHQ-9 - Depression
• GAD-7 - anxiety
• EQ-5D-5L & EQ-VAS
  Quality of life scales

• *Health psychology additional*
• Health Concerns Questionnaire
• Fear of Recurrence Scale 4
• Impact of event scale
Current outcomes

• Commissioning since implementation 1/4/2106
  ➢ Reduced activity in Pain clinic and other providers
  ➢ Reduced specific prescriptions
  ➢ No out of area spend
• Referral rates and opt in higher than expected
• Exceeding popular with GPs
“I think it is very exciting and long awaited development in Cumbria. It should fill a large hole for patients who in the past have had nowhere to go.”

“Thrilled about such a positive resource for patients.”

“It sounds like a really useful and rounded resource for managing so very difficult to help patients”

“Hallelujah! At last we have some support in managing these challenging patients. I look forward to working with the PPSS team to improve the lives of these patients.”

“Seems too good to be true. Already have a list of patients who would benefit.”
Patient outcomes

• Reduction in symptoms of depression
• Improved function and quality of life
• High patient satisfaction
• “It made me feel as though my condition has been recognised and ‘worthy’ of help. Being with other people makes you realise that you are not alone and that what I have to cope with in daily life is tangible and real and not in imagination!”
• “I have found that having two professionals in their areas running the sessions and putting things across in a way that they have has enabled me to look at and address (try) things in a different way.”
What next?

• Further investment in current service
• Paediatric pathways development
• Further development with:
  ➢ Neighbouring health economies
  ➢ Integrated care communities
• Meets the pressure for:
  ➢ Working differently and developing new models and pathways
  ➢ Improving patients quality of life and outcomes
  ➢ Financial recovery
• Demand significantly higher, incl opt in:
  ➢ Need to maintain access and quality
• Training others making this accessible:
  ➢ Challenges when staff are under pressure to take time out
  ➢ Using very flexible and innovative approaches
    ➢ Video roles plays freely accessible
  ➢ Evidence base to encourage attendance