North Cumbria
Integrated Care
NHS Foundation Trust

CUMBRIA PERSISTENT SYMPTOMS SERVICE

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What We're About

- Taking a whole-person view of the life of people with physical health conditions
- Acting with compassion
- Understanding the person on their own terms
- Moving away from diagnosis to living a meaningful life: '**Living Well**' with physical health problems
- Recognising the role of adversity in shaping people's difficulties

"This really is an innovative approach, but I'm afraid we can't consider it. It's never been done before."

Collaboration and integration

- Within PPSS we have:
  - Persistent symptoms pathway
    - Medicines optimisation
  - Familiar faces

Integrated with:

- Core MSK
- Specialist MSK - all spinal pain
- New Pain service

Have a shared Clinical director, Electronic patient record and Governance arrangements

Persistent Symptoms includes:

- Chronic Pain
- Chronic Fatigue / ME
- Medically unexplained symptoms
- Functional Neurological presentations
- Why?

These diagnoses share:

- 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.
- Usually wide variation in symptoms and diagnostic criteria
- The conditions cause patients psychological distress and social disability

Persistent Physical Symptoms Service (PPSS) – background in 2015 Cumbria Pain service was:

- Previously acute-dominated pain services
- Outlier for spinal injections/admissions
- Outlier for opioid prescriptions
- Expensive
- Over-medicalised
- Did not meet NICE guidelines and therefore had limited benefit
- No MDT working, Limited integration with physio and primary care

Evidence Base for change and improvement

- Evidence Base for effective treatment is immense
  - NICE:
    - ➢ME/CFS
    - ➢Back Pain,
    - ➢NICE 91
    - ➢Draft Chronic Pain 2020
  - ➢NHSE Value based commissioning
  - ➢Faculty of pain medicine Improving the lives of People with Complex Chronic Pain 2020
  - Guidelines for Pain Management Programmes for adults, 2013, British Pain Society

Staffing

- Clinical Psychologists
- Counselling psychologists
- CBT therapists
- Advanced Physiotherapists
- Occupational therapist
- Living well coaches
- GP with special interest

Living well coaches

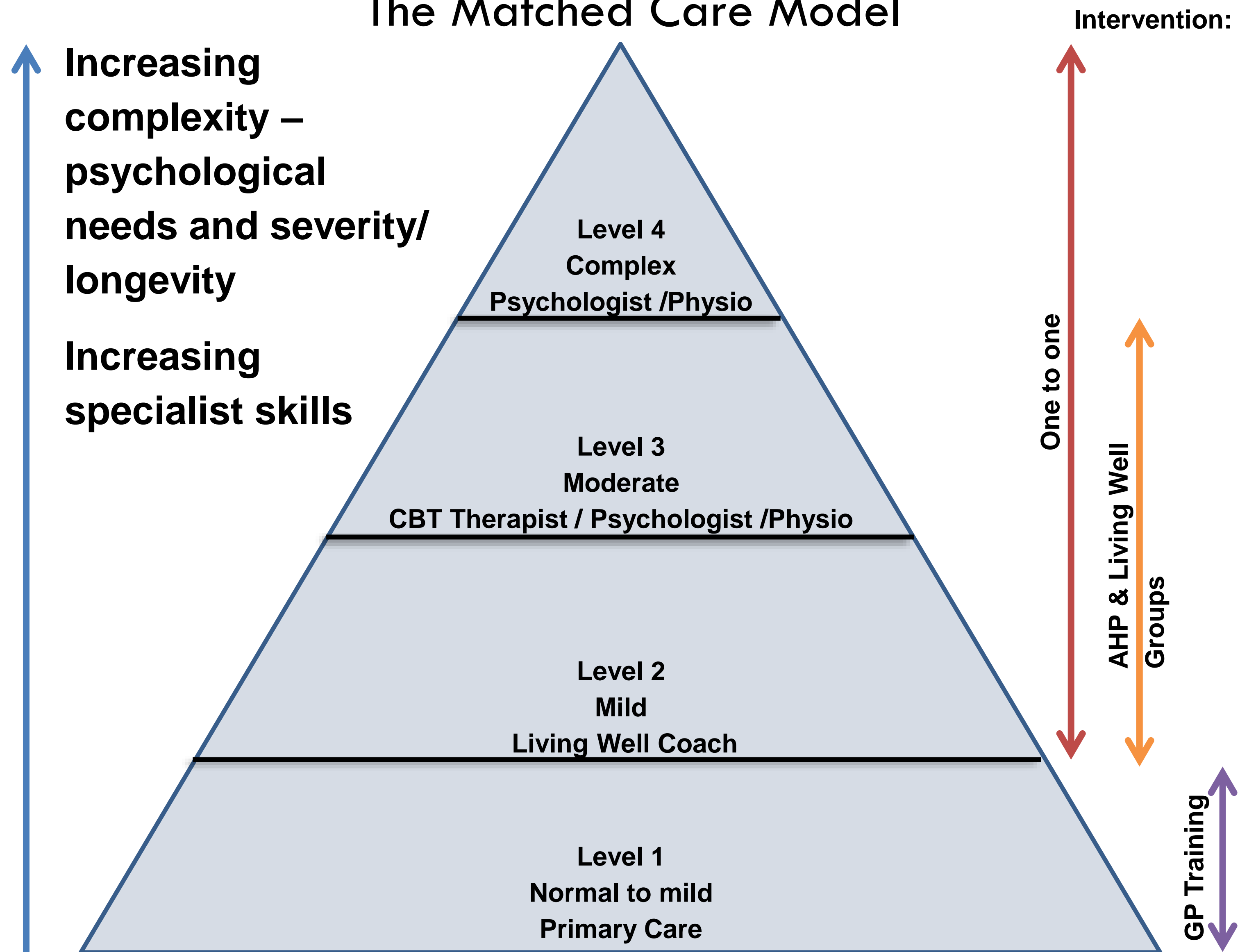
- New role, with supervision from Qualified staff
- Developing skills and competencies in:
  - Assessment including risk
  - Psychological models of therapy
  - Coaching conversations
  - Linking with social prescribing
- Supporting groups
- One to one care

Referrals

- Primary care
- Secondary care Consultants
- Physiotherapy
  - Including Complex MDT discussions
- Information from referrers
  - Exclusion of “red flags” for other conditions
  - Previous care with Mental health

Approach

- MDT assessment – 45 minutes with psychology practitioner and physio or OT
- Matched care plan agreed with patient
- 1:1 input and groups
- Consultation and advice
- Training across the system


The Matched Care Model
Intervention:
Increasing complexity – psychological needs and severity/ longevity
Increasing specialist skills
Level 4
Complex
Psychologist /Physio
Level 3
Moderate
CBT Therapist / Psychologist /Physio
Level 2
Mild
Living Well Coach
Level 1
Normal to mild
Primary Care
One to one
AHP & Living Well Groups
GP Training

Living well programme

- Includes the essential elements of Pain management, focuses on living the values and more including:
  - Biopsychosocial model
  - Understanding pain
  - Therapy models
    - CBT
    - Acceptance and commitment
    - Compassion focused
  - Pacing, Sleep, Activity, Fatigue
  - Problem solving
  - Communication
  - Medication
  - Managing set backs

Outcomes

- Improvement in:
  - Depression
  - Anxiety
  - Quality of life – EDQ 5
- Patients report:
  - Increased activity
  - Return to work
  - Enhanced quality of life and return to hobbies

Learning lessons

- The complexity of psychological needs much higher than anticipated:
  - Results in longer periods of care
  - Solutions:
    - Increase in psychological resource
    - Increasing variety of clinical models
      - Acceptance and commitment therapy
      - Compassion focused
      - Trauma related work
        - EMDR
  - Patient Engagement
    - Familiar faces
  - Patients on Polypharmacy

Medicines optimisation

- Patients working in PPSS who have a wish to address polypharmacy
- In Cumbria we are in the 94th centile for opiate prescriptions over 120 mg
- Many Primary care colleagues struggle to manage these patients and there is a long history of unhelpful interactions with health care services
- Cases indicated that often the medication is a relatively minor problem of complex trauma, social difficulties and health comorbidities
- MDT clinics with GPSI, Living well coach + or – Physiotherapy, Psychology
  - Patients medical history, scans, investigations all reviewed and then discussed the time line with patients
  - How they have got to where they are
  - Their goals, values and aspirations
  - Medication review and next steps

Education required

- *The system needs to develop a consistent narrative for Patients based on the evidence base*
- For Medical colleagues
  - Primary care
  - Secondary care
    - Still in some areas a focus on a “medical solution”
    - Lack of Holistic model
- AHP – we have done a lot of CBT training, intermediate skills, for colleagues to support psychologically informed care.
- The Population
  - Many patients for years have had repeated procedures
  - Distress that these may now be limited in availability
  - Support to shift to a Biopsychosocial approach
  - Need to enlist Community communication challenges

Familiar Faces

- Developed to address the needs of ‘Frequent Attenders’
  - Based in **primary care**
  - Embedded in GP surgeries and integrated care communities
  - Working across the system (e.g., with A&E, ambulance service)

- MUS and persistent physical symptoms

- Clinical Psychologists and Living Well Coaches

Familiar Faces - background

- ‘Frequent attenders’
- Have medically Unexplained Symptoms (MUS)
- Use a disproportionate amount of health care resources across the health care system
- Suffer harm as a result of poorly integrated care, invasive procedures, investigations and excessive medications
- Often have complex psychological and physical difficulties
- Do not necessarily perceive their consulting behaviour as unusual or problematic
- Struggle to engage in more traditional services

Approach

- List of **top 1%** of attenders for GP surgery/ICC

- In depth biopsychosocial assessment

- Intervention as appropriate
  - 1:1 psychological therapy
  - Low level interventions with Living Well Coach (LWC)
  - Supported by LWC to access other agencies/support services
    - Social prescribing links, ASC
  - Care plans shared across system
  - Complex MDT assessments

System Wide Working

One to one patient contact will not address the problem of frequent attenders.

- Consistent management

- Staff with training to identify "vulnerable" patients, for example those with ACEs

  For example, in a 12 month period, adults with four or more ACEs are twice as likely to have visited their GP six or more times, twice as likely to have attended A&E and three times as likely to have experienced a hospital stay. For adults, this increased usage is evident from age 18 and continues until later life (age 70+).

- System co-ordination e.g. A & E

GP Feedback

- This is a fantastic service. I have referred some of my most challenging patients whose lives have become stuck and totally dysfunctional, usually because of interplay between physical health issues and associated psychological difficulties.
- The input from Familiar Faces has enabled the patients to unlock their situation and pick up their lives again to start moving forward. This has been achieved by the combination of skill and time that the Familiar Faces team have been able to offer.
- This has also released GP time to meet my other demands as often the patients seen by Familiar Faces are at the extreme end of appointment demand upon our service.

Patient Feedback

- Knowing I wasn't alone, didn't think there would be any answers. When I met the clinician I didn't feel silly. Just helpful to talk to someone who understands.
- I don't feel like I am on my own. It has been helpful with my loneliness because it can feel like the end of a tunnel. Having the extra support has been beneficial and the EMDR is helping a lot. It has lifted something that has happened in my childhood, It’s been great.
- Sometimes need that push from the clinician especially when I am lonely.

Further work

- Developing the new pain pathway and service
- Looking at Public health issues related to Pain:
  - Obesity
  - Adverse child experiences
  - Activity and exercise
- Staff training and Supervision
- Psychologising the work force