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<b>Meeting:</b>	ICS Board
<b>Report Title:</b>	Patient Story – Persistent Physical Symptoms. Primary Care Psychological Medicine
<b>Date of meeting:</b>	Thursday 13 June 2019
<b>Agenda Item Number:</b>	4
<b>Work-stream SRO:</b>	N/A
<b>Report Author:</b>	Helen Smith
<b>Attachments/Appendices:</b>	Appendix 1: Patient Story
<b>Report Summary:</b>	

The patient story is presented to illustrate the impact on outcomes of a patient with complex persistent physical symptoms of:

- A person centred approach
- Assessment and formulation based on a biopsychosocial model
- The equal acknowledgement of mental and physical health components to the person's presentation

Recommendations for a service to address this group of patients' needs are made by the Joint Commissioning Panel for Mental Health (2017) and is highlighted as one of the ten priorities for change by the Kings Fund in their report 'Bringing together physical and mental health' (2016).

The patients seen by the service become not only more independent in managing their condition, using healthcare services less frequently, but have been able to return to purposeful and meaningful roles at home and work, reduce carer burden and reliance on benefits.

These patients were seen by the Primary Care Psychological Medicine service, developed to address a need identified within Principia Multispecialty Community Provider Vanguard to provide an intervention for people with complex persistent physical symptoms that were too complex to be managed by Improving Access to Psychological Therapies (IAPT) providers and whose symptoms were not responding to intervention from physical health input.

Nottinghamshire Healthcare Foundation Trust provided the team to test this model of delivering liaison psychiatry in the community for this group of people within Rushcliffe CCG, funded by Vanguard monies.

In the first two years the service saw 211 patients who presented with significant physical symptoms (96<sup>th</sup> centile on PHQ-15), moderate to severe depression (PHQ 9) and moderate to severe anxiety (GAD 7).

To understand the impact of the service patient reported and clinician reported outcomes measures were recorded. Actual patient level primary care and secondary care activity was also analysed. The findings were independently evaluated by the Centre for Mental Health and showed significant improvement in



patient and clinician reported outcome measures and a reduction in use of secondary physical health care services and primary care attendance equating to annualised savings of £222k for a service whose staffing costs are £140k.

As the service does not see people in a specific diagnostic care pathway it can be difficult to understand the patients seen by the service. The patient story is intended to illustrate this.

**Action:**

- To receive
- To approve the recommendations

**Recommendations:**

**Key implications considered in the report:**

Financial	<input checked="" type="checkbox"/>	The report summarises the financial and activity impacts
Value for Money	<input checked="" type="checkbox"/>	Independent evaluation shows value for money
Risk	<input type="checkbox"/>	
Legal	<input type="checkbox"/>	
Workforce	<input type="checkbox"/>	
Citizen engagement	<input checked="" type="checkbox"/>	To engage patients who have benefitted from the service in sharing their experience where until now there has been a gap in their treatment and management
Clinical engagement	<input checked="" type="checkbox"/>	To engage clinical leaders across the ICS in acknowledging the need for parity of esteem. It reinforces the wider ICS work around personalisation.
Equality impact assessment	<input checked="" type="checkbox"/>	A full EQIA has been completed and is available. It shows a positive impact on health outcomes and access.

**Engagement to date:**

Board	Partnership Forum	Finance Directors Group	Planning Group	Workstream Network
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Performance Oversight Group	Clinical Reference Group	Mid Nottinghamshire ICP	Nottingham City ICP	South Nottinghamshire ICP
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Contribution to delivering the ICS high level ambitions of:**

Health and Wellbeing	<input checked="" type="checkbox"/>
Care and Quality	<input checked="" type="checkbox"/>
Finance and Efficiency	<input checked="" type="checkbox"/>
Culture	<input checked="" type="checkbox"/>



**Is the paper confidential?**

Yes

No

Note: Upon request for the release of a paper deemed confidential, under Section 36 of the Freedom of Information Act 2000, parts or all of the paper will be considered for release.

## **BACKGROUND PAPER FOR PATIENT STORIES – PERSISTENT PHYSICAL SYMPTOMS, PRIMARY CARE PSYCHOLOGICAL MEDICINE**

**13 June 2019**

### **The Service**

1. The Principia Multispecialty Community Vanguard identified a gap in service provision for people with complex persistent physical symptoms and so developed and tested a service model for the patient group. Those consulted in the development of the model were GPs and local CCGs, Department of Psychological Medicine (DPM) staff, Nottinghamshire Healthcare NHS Foundation Trust, Nottingham University Hospital colleagues, the Centre for Mental Health (CMH), the Royal College of Psychiatrists Liaison Faculty and, most importantly, several DPM patients who shared the index diagnoses. Primary Care Psychological Medicine Service was initiated and funded by the Vanguard in Rushcliffe and commenced in September 2016.
2. The service offers a holistic, integrated service to improve the management of patients identified by the primary care clinician falling within the following:
  - Complex Persistent Physical Symptoms
  - Diagnosis of complex mixed medical and psychiatric morbidity such as patients with complex persistent physical symptoms for example (but not limited to), patients with multiple sclerosis or motor neurone disease where the physical health intervention has not produced results; in this case exploration of psychological aspects of the illness may well lead to symptom improvement
  - Multiple referrals to secondary services
  - Distress and functional impairment
  - Patients who have frequent admissions as inpatients where a clear diagnosis has not been made
  - Patients with negative diagnostics which have failed to show a cause for the symptoms being presented
  - Polypharmacy
3. This group of patients has a wide variety of presentations that are seen across all areas of health services. It should therefore follow that by managing this diverse group of people's symptoms in a more systematic and holistic way, capacity would be realised within primary care, outpatients and inpatient facilities.
4. Due to the wide range of services these people can be in contact with, it is difficult to appreciate the complexity of the group of patients as they do not fit into a NICE guideline or simple diagnostic treatment pathway. Also as the combination of health presentations can make it challenging for their care to be met by a mental health or physical health service alone.



5. The team providing the service, delivered in a primary care/community setting, are 2.0 WTE experienced mental health liaison nurses and 2 sessions of a liaison psychiatrist who also work in the local acute trust. The team are supported by admin and data analyst staff.
6. As part of the Vanguard, the service was required to be evaluated for impact. The Centre for Mental Health was commissioned to independently evaluate the service using actual patient service utilisation data; patient reported outcome measures and clinician rated outcome measures.
7. Patient reported outcome measures used were :
  - Patient Health Questionnaire 15-Item Somatic Symptom Severity Scale (PHQ-15) is used to assess the impact of physical symptoms
  - Patient Health Questionnaire-9 ( PHQ-9): A measure of depression
  - Generalized Anxiety Disorder 7 (GAD-7): A measure of anxiety
  - EQ-5D-5L: A measure of physical and mental well-being
  - Thermometer: A measure of general well being

Statistically significant improvements were seen in these measures.

8. The headline figures based on **actual** secondary care patient activity showed:
  - 33.3% reduction in hospital admissions,
  - 38.9% reduction in emergency admissions,
  - 31.7% reduction in ED attendances,
  - 32.4% reduction in outpatient appointments
9. Primary care actual activity showed:

• contacts	-2.4%
• referrals	-20.5%
• investigations	-2.7%
• acute appointments	+29.9%
• sick notes issued	-31.3%
• ambulance usage	-71.5%

10. The Centre for Mental Health's analysis found that prior to intervention the cost per month of each patient was £175.41. After discharge these reduced to £86.38 per patient per month. This was calculated to equate to annualised savings of £222k for a service whose staffing costs are £140k (18/19 pay rates). It should be noted that costs related to investigations, prescriptions and nationally commissioned services are **not** included.

11. As well as delivering savings and releasing capacity in primary care, the service improves the quality of care received by reducing the potential risks associated with unnecessary treatment or investigations.



12. Acknowledgment of the service is reflected in being a finalist in both the Health Service Journal and British Medical Journal awards. It is also referenced in the Kings Fund Mental Health and New Models of Care: Lessons from the Vanguard (Kings Fund, 2017) and is featured in the mental health and primary care resources from the Kings Fund Learning network on Integrated care (<https://www.kingsfund.org.uk/courses/integrating-physical-mental-health-care/resources>).

### **Patient Stories**

13. It can be difficult to describe the patient cohort the service sees due to the variety of diagnoses and presentations of the patients. The purpose of sharing this story is to articulate the clinical impact, system impact and wider impact on the participation of people seen by the service in work and life roles, reducing their care and needs on their network of support.

14. In her own words one of the patients describes her experience. See Appendix 1. She will present her story within the meeting.

15. Another patient, who wanted to remain anonymous, has recorded a video describing the significant improvement in her condition and functioning with this approach which is available on request. Consent has been provided to share this to support commissioning processes.

### **Key Messages and Learning**

16. The pilot has shown that treating people holistically to meet physical and mental health needs is having a positive impact on patients' symptoms, function and their families and carers.

17. It has demonstrated:

- Improved patient outcomes
- Integrated mental health and physical health
- Integrated hospital care and brought it into primary care
- Reduced secondary care attends
- Reduced primary care attendances
- Savings based on CCG Healthcare Resource Group (HRG) 4+ code individual level patient data.

18. There are opportunities in the future configuration of the system for this model to be rolled out with a phased approach at PCN level if tailoring to meet the needs of particular populations. Extrapolated annualised savings including proportionate decay =

**£1,200 net saving (after staff costs accounted for) per suitable patient per year**



**Net savings of this rollout, once steady state is achieved, (staffing costs accounted for) would be £520k per annum.**

It should also be taken into account that unmeasured direct costs, e.g. prescription costs and investigation costs would multiply this by a factor of 1.5 = £780K

Indirect service costs would increase this further, e.g. clerical, telephone calls, waiting lists etc.

### **Next Steps**

19. The service is currently funded until 31 March 2020 to continue delivering the service in Rushcliffe. Activity is underway locally to secure financial sustainability for April 2020 onwards. The original business case is being further refined to support this process.
20. Spread of the service beyond Rushcliffe was agreed in principle during Greater Nottingham Clinical Commissioning Executive group in December 2018.
21. The roll out of this service could pilot the ambition of the ICS Mental Health strategy of a service that is commissioned in an integrated way, rather than from a solely mental or physical health commissioning perspective.
22. A pathway with local IAPT providers and secondary care providers will be developed to ensure the right people are seen by the right service.

### **Conclusion**

23. This service is demonstrating beneficial health outcomes for patients who hitherto have not had their health needs adequately addressed and whose GPs have struggled to manage. Furthermore it is showing promising financial benefits and an impact of releasing primary care time and resource. The patient stories demonstrate the significant impact a relatively modestly resourced service can have on patients and their lives.



## Appendix 1

### Patient Story

#### History and background of symptoms

In October 2015, my whole life changed. I woke up unable to communicate. My face muscles seemed droopy. My jaw muscles were involuntarily contracting, thus making me bite my tongue and cheeks. Mentally and emotionally, I was a wreck due to the 24-hour pain of biting my tongue and cheeks, which was deeply cut, bleeding and blistered. (Scars can be seen from this to date). I could not stop clenching my jaw shut. I could not open my mouth. I had constant pain on the left side of my head, especially just above my ears. I felt frustrated and lonely, as if no-one really cared about me. I have dextrocardia situs inversus to complicate matters.

#### What was your quality of life and how were you functioning day to day?

I couldn't eat, sleep, do housework, cook, shop, have a shower, drive a car or even look after my little 4-year-old. I also suffered from insomnia. I couldn't go out of my home. I couldn't stop crying. My poor son had thought he done something wrong. Communication was very difficult for me, due to the jaw spasms. I could only communicate by wedging my mouth open with something (E.g. pen, pen lid, lollipop stick, lipstick, etc.), so that my jaw would not snap shut. It was difficult to open my jaw without using a spoon or fingers to do so. My brother even bought me a boxing glove, as my fingers were extremely sore from biting on them and trying to prise my jaw open. It just clenched shut and continuously kept pushing against my teeth. I was even having problems with my memory. I could not remember simple things. I also started wetting myself.

What hurt the most, was not being able to take care of my son; simple things like reading to him, playing with him or even taking him to school.

#### What was the treatment and management approach prior to your referral to PCPM?

The first time I went to the doctor, I was asked to see my dentist. My dentist referred me back to my doctor, who then referred me back to the dentist! For quite some time I visited my doctor every other day. All I was given was strong painkillers. My doctor also suggested counselling. She referred me to a health visitor because she was concerned about my weight and diet.

I was then seen by the Maxillofacial Team at the QMC and then the Pain Management Team instead.

I had spent a lot of money on prescriptions, trying different painkillers and trying herbal remedies. My sister even paid for me to go to hypnotherapy, cranial massage and head massage.

At this point, I had just about had enough. I had this condition with no name for a year now and going from one department to another within the NHS was really not helping me mentally or physically. I decided to write a letter to my doctor regarding how fed up I was and that I had enough with the NHS. I was then referred to



psychological medicine. By now I had lost 3 of my teeth from clenching already. 1 front tooth and 2 back teeth.

**What approach did PCPM take and how did it help?**

I was very dubious about the Psychological Medicine Team. Their care was very different to that of GPs, Doctors, Counsellors and Health Visitors. It's difficult to explain in terms of words, but it was more as if nurturing my way of thinking; my outlook on why I woke up like this.

I had appointments every week and sometimes twice a week with them. Mainly, I was visited at home by the Mental Health Liaison Nurse. She helped me in various ways such as; trying to encourage me to get out of the house for a short walk; mindfulness; The Psychological Medicine Team Doctor had prescribed me with some psychological medicine that could only be prescribed by them and not the GP. The medicine helped ease some of my symptoms by directing my mind away from the pain but was not a full cure.

I felt they listened to me and talked to me like no other professional did; they seemed more concerned for my well-being; they seemed to take part in my sadness and worries; I did not feel alone anymore; they were sympathetic to my needs; helped me feel more relaxed; I felt they gave me the information I needed to help me get better and understand why and what was happening to me ; They agreed plans with me on short terms goals to take one step at a time and also ensured my GP were aware of these; I felt they fully engaged with my management; They made me realise the cause of my symptoms and how I could help myself; They helped me build my self-esteem and self-confidence. I did not feel worthless anymore; They helped to direct my doctors in contacting the speech therapist, who has helped me with better communication. I now just need to focus on managing to eat: Throughout my time with them, nearly 2 years, I have felt reassured by them, as I was taken seriously; I felt they understood my concerns more than anyone else.

I am able to communicate better and not clenching or biting my tongue or cheek anymore.

I was prescribed a better anti-depressant by them and slowly, but surely was on the mend. I could not have done it without the help of the Psychological Medicine Team.

**Patient Reported Rating scales**

	<b>Initial assessment</b>	<b>Last</b>
<b>EQ-5D-5L</b>	11	7
<b>GAD 7</b>	15	3
<b>PHQ 9</b>	8	4
<b>Thermometer</b>	0	80

**What was the impact on your family and carers of how you were?**

My neighbour, whose son was in the same School and class as my son, kindly took him to school and back home every day for a year for me. My parents and sister helped look after my son. They also helped by doing the grocery shopping and housework. My family supported me financially, although they were not well off themselves. I lost my livelihood and my home.



### **How are you now? Quality of life, day to day functioning and frequency of health appointments**

I am now working part time and have bought a new property. I can care for my son independently and we have been on holidays. My mood is good and I sleep well. I hardly see the GP and have occasional appointments with the liaison nurse from PCPM. I no longer need to see the psychiatrist. I manage my own health and have a better understanding of how to cope and function in day to day life. I am positive in my outlook. I can communicate and I'm in less pain in my jaw.

### **What has this meant to your family and carers?**

I am less dependent on my family to help me with shopping and day to day activities. I can take my son to school and do activities with him. We have recently been to Morocco on holiday and people worry about me less.

### **References:**

Joint Commissioning Panel for Mental Health (2017) Guidance for commissioners of services for people with medically unexplained symptoms [online] available at : <https://www.jcpmh.info/wp-content/uploads/jcpmh-mus-guide.pdf> Accessed March 2018

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**03 June 2019**