Mind & Body (Education):
Striving for excellence in KHP

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On behalf of the King’s Health Partners’ Mind & Body Programme Board
Supported by the Education Academy’s Mind & Body (Education) Committee
Executive Summary

Introduction

- King’s Health Partners’ (KHP) Mind & Body Programme hopes to capitalise on the renowned expertise of its partner organisations by pioneering innovative approaches to ‘treating the whole person’ - addressing overlap between physical and mental healthcare needs of patients.

- National strategy, policy, and academic literature highlight the importance of adopting such approaches, and the role of education and training in successful implementation.

Aims

i. Identify current training within KHP that supports working with Mind & Body.

ii. Establish need for enhancing existing and developing new training.

iii. Develop a training strategy & recommendations to embed Mind & Body care.

Key findings

- There is exemplary care & training provision for Mind & Body, however, this is sporadic and not universal across professions, services and organisations.

- There is the need, interest, and opportunity for development of training practices to support staff to work with Mind & Body.

- Existing best practice and the views of students, staff, senior professionals, & service users, identified potential developments to training around Mind & Body, the subsequent support required, and a strategy to embed positive change.

Recommendations

1. Establish a clear theme or ‘brand’ to represent the training for overlapping physical and mental health, e.g. Mind & Body Programme or IMPARTS.

2. Collate and fund an editorial board or committee to project manage and oversee Mind & Body training (e.g. Mind & Body (Education) Committee), representing and disseminating KHP expertise in this area.

3. Build on the Mind & Body training strategy presented in this report (p.23), adopting an implementation model, e.g. the 4-tier or flowchart models (p.20-21).

4. Ensure contact and support from all KHP stakeholders, fostering collaboration.

5. Review all existing internal Trust training for Mind & Body content and relevance.

6. Develop new training packages and products to support clinical practice around Mind & Body.

7. Increase support for UG & PG teaching on overlapping physical and mental health needs.

8. Increase opportunities for UG & PG exposure and placements in services addressing Mind & Body, through collaboration between KCL and Trusts.

9. Support restructure of nursing training & core trainee placements, offering expertise & opportunities when possible.

10. Support simulation and experiential learning for current UG & PG programmes.
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Terminology:

A collaborative approach to overlapping physical and mental health remains a relatively restricted standpoint in healthcare (with notable exceptions), both in clinical practice and academic literature. As such the accompanying terminology is unclear; mental/physical interface, Mind & Body, integrated healthcare, holistic care, have all been used in this area. For the purpose of this report, ‘Mind & Body’ will be utilised, although clarification of this terminology should be a priority for moving forward in this area.
Introduction

King's Health Partners (KHP) Background

• One of six Academic Health Science Centres (AHSCs) in England, KHP brings together a world-leading research led University (King's College London), with two prestigious Acute Foundation Trusts (Guy’s & St Thomas’, King’s College Hospital), and Europe’s largest mental healthcare provider (South London & Maudsley NHS Foundation Trust).

• KHP aims to merge internationally renowned research, education and clinical practice for the benefit of patients, staff, and students.

KHP’s Mind & Body Programme: Treating the whole person

• This initiative aims to capitalise on the unique partnerships within KHP by breaking new ground in approaches to addressing physical & mental healthcare needs concurrently, rather than in traditional, disconnected silos.

• In endeavouring to ‘treat the whole person’, this programme shares the values of the Department of Health’s No Health Without Mental Health strategy, Quality, Innovation, Productivity, and Prevention Programme, and NHS England’s Parity of Esteem Programme.

Mind & Body in the academic literature

• Literature abounds on the ‘inextricable nature of mental and physical health’, in general, physical, or mental health settings (Doherty & Gaughran, 2014; Weiss et al, 2009). Those with mental health conditions have increased risk of physical ill-health, with delayed diagnoses and higher mortality rates, while those with physical health conditions have increased risk of mental ill-health (BMA, 2014). Those with physical and mental ill-health have poorer quality of life and increased morbidity & healthcare utilisation (BMA, 2014).

• A 2014 BMA report found that 30% of people with long-term physical conditions have a mental health condition, while 46% of people with a mental health condition have a long-term physical condition, around 4.6 million people. Recommendations to better address Mind & Body are numerous, from radical structural overhauls, to adopting biopsychosocial models.

Education & Training in Mind & Body literature

• Education and training is often cited in literature, policy, & guidelines as a tool by which to improve care for Mind & Body, albeit a tool to be implemented alongside others [Blythe & White, 2012; Lawrence, 2010].

• While a lack of education and training for Mind & Body has been identified in some professions and services, impacting on knowledge, understanding, & skills, recommendations for and examples of valuable and successful training initiatives do exist [Blythe & White, 2012; Kathol et al., 2009; Pomerantz et al, 2009]. These vary from under- & postgraduate teaching and clinical experience, to simulation sessions and awareness of practice in other professions [Cubic et al., 2012; Wilson et al., 2009].

Current Mind & Body practice within KHP

• King’s Health Partners boasts excellent examples of both clinical delivery, and education and training that successfully address the Mind & Body to the benefit of both patients and staff. These initiatives provide innovative, integrated, and patient-centred approaches to improving patient outcomes while delivering value-based care.

• However, it may be the case that both clinical care and training practice around Mind & Body could be further improved across professions, services, and organisations.
Aims

1. Establish current education and training practices, across all professions, that address both Mind & Body in KHP and other centres of excellence
2. Identify the need and opportunity for enhancing existing and developing new training to better support Mind & Body practice across all professions
3. Develop a strategy to improve Mind & Body training delivery
4. Present direct and impactful recommendations for training that will embed Mind & Body practice

Methods

Scope
The project included all staff (clinical & non-clinical), health faculty students, service users, and KHP stakeholders, and all stages of career training, from undergraduate to continued professional development.
Key externals were contacted, including from Health Education South London (HESL), local Clinical Commissioning Groups (CCGs), and other AHSCs.
The project considered Mind & Body bilaterally and bidirectionally, with equal importance afforded to physical healthcare in mental health, and mental healthcare in physical health.

Participants & Procedures
To ensure a thorough scoping of educational practices yielding rich, informative data a mixed-methods design was selected, comprising of surveys, focus groups, and interviews.

Surveys
A survey schedule was developed to represent the main aims of the project, including questions concerning awareness, confidence, previous training, and desired training on Mind & Body. The online survey was piloted on staff from Psychological Medicine and Psychosis CAGs, before being finalised on SurveyMonkey and distributed.

Respondents were recruited by advertising the survey weblink to all staff via internal Trust and Health Faculty communications channels, as well as the KHP communications team. This involved weekly and fortnightly bulletins, news digests and social media updates. A survey invitation was emailed to all CAG Leads and Education & Training Leads requesting distribution to all staff. Six ‘roadshow’ events to recruit participants and raise awareness were held at Guy’s, St Thomas’, King’s College, Maudsley, Lambeth, and Bethlem Royal hospitals, where 1000 flyers with project and survey details were distributed, among other KHP and Trust materials.

753 members of staff completed the survey, with all major professional groups, KHP stakeholders, and CAGs represented (see Figures 1-3 below).
Figures 1 & 2: Percentage of survey respondents by profession and KHP organisation

Focus groups & semi-structure interviews

The focus group topic guide and interview schedule were adapted from the survey structure, capturing more comprehensive data on key areas of knowledge and personal experience, such as the efficacy of training previously received and factors that aid training initiatives in effecting change. The topic guide and interview schedule were piloted through the Mind & Body Education Workstream, and retained flexibility to accommodate varying professions and expand on specific areas of knowledge and interest.

Recruitment for groups was via the same channels as the survey, as well as opportunistic hosting at the end of existing meetings, and replacing teaching sessions. Interviewees were recruited through purposive sampling, with prospective interviewees identified by positions of educational influence, such as CAG E&T, Trust E&T, and Professional Leads, before being contacted via email. Externals, from HESL, Southwark and Lambeth CCGs, and other AHSCs were also approached via email.

109 participants attended 19 focus groups, representing a range of professions from researchers, educators, and students, to nurses, psychiatrists, allied health professionals, and service users. 84 individuals were approached for interviews, with 53 consenting, from a range of professions, services, job roles, and interests within KHP and externally.
**Information searching**

Independent information searching was conducted online and through targeted individuals to supplement survey, focus group, and interview findings. This involved successful training initiatives and exemplary clinical services internally, practices in external organisations such as AHSCs, and patient satisfaction surveys.

**Data analysis**

Descriptive statistics were used to analyse the quantitative survey data. Thematic analysis was used to analyse the qualitative focus group and interview data to categorise, summarise, and identify themes from respondents’ accounts with researchers cross-referencing respective findings (Green & Thorogood, 2004). Thematic analysis was then supplemented with a mapping and interpretation process to constitute framework analysis to guide future recommendations and strategy (Green & Thorogood, 2004).

**Findings**

Quantitative survey data yielded interesting findings concerning respondents’ awareness, confidence, perceived importance and benefits of addressing Mind & Body, as well as previously received versus preferred method and stage of training delivery.

Qualitative interview and focus group data provided interesting findings regarding existing Mind & Body training, potential for future training initiatives, and the benefits, challenges, and logistics of utilising training to embed changes in practice.

**Quantitative findings**

While 87% of respondents reported being aware of the overlap of physical and mental health needs (see Figure 4), only 58% of respondents were ‘confident’ or ‘very confident’ in addressing these needs (see Figure 5), suggesting that there could be an impact on patient care and an opportunity to improve staff confidence levels.

28% of respondents had received postgraduate training relevant to Mind & Body, while 30% had at undergraduate level, and just over a third had in the workplace. A similar number of respondents reported receiving no training for overlapping physical and mental health.

However, 72% of respondents reported that staff *should* receive such training at undergraduate level, 61% at postgraduate level, and 89% in the workplace, with only 1% selecting no training. This demonstrates a considerable disparity between training received and training deemed necessary by staff, particularly in the workplace. This again suggests that there may be an impact on patient care, which represents an opportunity for implementation of training across entire career pathways.
At 72% lectures, seminars, and presentations were comfortably the most common form of training received on Mind & Body, while conferences were second with 28%, and interdisciplinary initiatives, supervision, and department-specific training were reported by a quarter of respondents. 'Championing' initiatives and simulation training were the least commonly received training methods.

Lectures, seminars, and presentations were the highly preferred method of training, but with the smallest difference from training received of +7%. Conferences also had a small difference (+14%), while ‘championing’ and simulation initiatives had the most substantial differences (+34%, +38%). The remaining training methods all showed considerable differences between actual and preferred delivery, again demonstrating a significant training need and opportunity to bolster provision, as well as the potential to include a wide array of complementary training methods.
Respondents felt that training to address Mind & Body is of considerable importance, as 99% responded that such training should be mandatory or highly desirable, with only 1% viewing this as optional or unnecessary. Regarding the potential benefits of Mind & Body training, 91% of respondents felt that quality of care would be improved, while only slightly fewer participants believed that care would be more integrated and patient-focused. Safer care and greater equality also scored highly.

These findings demonstrate that across all healthcare settings, staff deem Mind & Body training as important and of considerable benefit to care, again highlighting an opportunity to harness staff interest and commitment in training provision and workforce development.

In summary, although awareness of Mind & Body in care is high, a lack of confidence in addressing overlapping health needs is evident and may be impacting on patient care and staff experience. There are considerable disparities between received and preferred training delivery for both the stage of career and method utilised, while staff also rate such training as highly important and beneficial to care. These findings represent a significant opportunity for increased provision of a variety of training initiatives across career pathways of all staff.

**Qualitative findings**

Thematic analysis of qualitative interview and focus group data resulted in four clear ‘themes’ emerging: existing initiatives, best practice case studies, training opportunities, practicalities – support required. Subsequent framework analysis facilitated strategy development.

**Existing initiatives**

This first theme evident in the data, ‘existing initiatives’, follows from enquiry around current training practices to support staff in working with Mind & Body. There were eight sub-themes identified within this theme.
Excellence - services: Excellence in specific services, both training and practice, was evident throughout KHP. These services exemplify best practice in addressing mental and physical health needs concurrently, employing a varied multidisciplinary team from physical and psychological backgrounds to implement biopsychosocial models of care. Such examples are expanded on in 'best practice case studies', providing providing learning opportunities for other clinical and training initiatives.

Excellence - training: Excellence also exists specifically within training practices, demonstrating exemplary training deliver to support staff in considering mental and physical health needs concurrently. These range from highly regarded simulation workshops, to collaboratively organised study days. Such enterprises present an opportunity to build and formalise interface training by upscaling, expanded, and harnessing the interest, enthusiasm and creativity of KHP workforces and individuals, to deliver improved learning to wider populations.

Embedded professionals: The benefits of embedding professionals of varying backgrounds in services were clear, not only for care delivery but also staff development. Whether Clinical Psychologists in Acute Health settings, GPs in CAMHS, or specialist general nurses in Mental Health services, this resource provides direct training such as teaching and supervision, as well as a transferral of skills, knowledge, and expertise from inter-professional working. This resource can be further supported with contracted time, even dedicated roles, for training provision, and has the benefit of being coordinated internally.

Cross-service collaboration: Benefits were also clear from cross-service collaboration, not only around care provision, but also discrete training delivery and general sharing of knowledge, expertise and skills. Examples included Psychiatry Liaison in Emergency Departments (no counterpart exists in Mental Health services), and the twinning of 'equivalent' wards in Acute and Mental Health Trusts, such as Older Adults and Mental Health of Older Adults. Simply understanding how other services and professionals approach care was highly desirable and carries significant benefits for service delivery.

“Attending Diabetes ward round has encouraged trainees to choose Psychiatry”
“My adult nursing course has great mental health teaching, but more would help!”
“Motivational Interviewing training revolutionised my renal outpatients clinic”
“We now have a tissue viability nurse specialist working with our RMNs”
In summary, there are examples of excellence both for stand-alone initiatives and in-service training, exceptional opportunities at UG and PG level, and outstanding practice delivered by individuals, services, and resources in the workplace. However, training provision can be sporadic and variable between services, suggesting that leadership, direction, and resources are required to improve the prevalence, impact, and success of Mind & Body training.
**Best practice case studies**

This theme encompasses exemplary services and training (not an exhaustive list) that support care for Mind & Body, highlighting these as examples from which future initiatives in this area can learn.

**Integrating Mental & Physical Healthcare: Research, Training & Services**

IMPARTS exemplifies an innovative and successful initiative that brings together KHP stakeholders to improve healthcare provision around Mind & Body, representing a key learning prospect.

- Informatics system
- Care pathway development
- Bespoke, ongoing training
- Self-help materials
- Research resource

IMPARTS offers flexible, needs-based, expert-delivered training to suit demanding clinical schedules, and a 5-day KCL-accredited module focusing on clinical skills using case-based examples tailored to recipients' experiences. Training aims to provide tangible benefits in practice for staff and patients, as well as ongoing support and supervision, and although delivered mainly for mental health in acute settings, is being expanded into mental health services for physical healthcare.

Importantly, training is delivered alongside clinical support, in the form of informatics, care pathways development, and self-help materials, as well as research support, linking back to informatics. This exemplifies best practice in the direct linkage between care provision, training, and research.

Two particular strengths highlighted were the IMPARTS ‘brand’ and position within KHP stakeholders. As an initiative that unites the research capacity, reputation, and accreditation of KCL with the clinical expertise and training proficiency of the Trusts, IMPARTS represents a KHP-endorsed brand that can be seen as a recognisable authority on integrating physical and mental healthcare, or Mind & Body.

**Cancer Care Four-Tier Model of Psychosocial Support**

NICE guidelines present clear recommendations for psychological support in cancer care, outlining the graduated role of every staff member in the recognition and care of mental health needs. The model’s clarity around role expectations of each staff population is accompanied by training delivery to the appropriate level.

This model has benefits ranging from reduced depression, anxiety, pain, to improved self-management, coping skills, quality of life, as well as efficiency and cost savings for health and social care systems. Currently the Psychological Support Team at the Dimbleby Centre, GSTT, provide level 2 training, with plans to expand provision.

This evidence-based, inclusive model of care and training provision with numerous benefits presents a learning opportunity for the development of Mind & Body training.
<table>
<thead>
<tr>
<th>Level</th>
<th>Group</th>
<th>Assessment</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All Health and Social Care Professionals</td>
<td>Recognition of Psychological Needs</td>
<td>Effective information giving, compassionate communication and General Psychological Support</td>
</tr>
<tr>
<td>2</td>
<td>Health &amp; Social Care Professionals with additional experience</td>
<td>Screening of Psychological Distress</td>
<td>Psychological techniques Such as Problem Solving</td>
</tr>
<tr>
<td>3</td>
<td>Trained and accredited Professionals</td>
<td>Assessment of Psychological Distress and Diagnosis of some Psychopathology</td>
<td>Counselling and specific psychological interventions such as anxiety management and solution-focused therapy, delivered according to an explicit theoretical framework</td>
</tr>
<tr>
<td>4</td>
<td>Mental Health Specialists</td>
<td>Diagnosis of Psychopathology</td>
<td>Specialist psychological and psychiatric interventions such as psychotherapy, including cognitive behavioural therapy (CBT)</td>
</tr>
</tbody>
</table>

Figure 10: The NICE four-tier model of psychological support in cancer care

### 3 Dimensions of Care for Diabetes (3DFD)

A ground-breaking, award-winning Diabetes service, 3DFD employs a biopsychosocial model to provide excellent care for their patients’ physical and mental health needs. This exemplary care delivery is supported by varied training and research agendas.

The clinical team regularly delivers inter-disciplinary training opportunities, such as journals clubs, case presentations, study days, focusing on the interaction of diabetology and psychology. An e-learning module on Diabetes & Depression, equivalent to one hour CPD, that is self-assessed and encourages reflective practice is available through KHP’s Education Academy, and externally with support by the South London Health Innovation & Education Cluster. All nurses are currently training in motivational interviewing and cognitive behavioural techniques, relating to ongoing research and the development of a manual for all diabetes professionals on addressing physical and mental health needs.

Teaching on psychological care is provided on KCL’s Primary Care for Diabetes MSc, again introducing motivational interviewing, while more sporadic teaching opportunities are afforded to medical students. Junior doctors on psychiatry rotation can attend diabetes ward round and clinics, which anecdotally has a positive effect on selecting psychiatry, with the interaction of physical and mental health being attractive. Development is also underway on an applied doctorate in diabetes management to be offered overseas.

The variety of training opportunities offered in diabetes care that are closely linked to clinical teams and delivery, as well as ongoing research, represent exemplary practice and could serve as a template for future training provision in other long term physical conditions and wider services.
Mental Health of Older Adults & Dementia – Tissue Viability

MHOAD CAG staff recognised that an increasing number of patients across inpatient and specialist care services were developing or admitted with pressure ulcers. Mental health nursing staff, although highly capable, did not have the training necessary or systems in place to identify, report, treat, and prevent severe pressure ulcers, potentially resulting in poor and inadequate care.

To improve training and practice in care delivery around tissue viability nursing staff were given training on recognition, reporting, treatment, and prevention of pressure ulcers, including a tissue viability masterclass from a European expert, face to face skills sessions, and uploading photographs to case notes. This training was supported by consistent leadership from senior staff, acceptance of a need for cultural change, and a clear procedural pathway. The latter included a tool for weekly pressure area assessment (Waterlow chart) of all patients, logging of all tissue viability concerns on datix, instigation of a skin care bundle with weekly photograph uploads to the notes if required, and weekly meetings with senior and direct care nurses to monitor datix reporting and pressure ulcers, logging this on relevant care plans. Subsequently a service level agreement was reached between SLaM and GSTT to provide a specialist tissue viability nurse to support these ongoing processes.

This initiative succeeded in allowing staff to integrate mental and physical healthcare provision with the benefits of this approach evidenced in the graph below, as grade 3 and 4 ulcers have been reduced since the inception of this work, while grade 1 and 2 ulcers initially increased (due to new reporting procedures) before consistently declining – demonstrating direct patient benefit.

![MHOA&D: All New Pressure Ulcer Incidence by Grade by Month](image)

Figure 11: MHOAD CAG pressure ulcer incidence rates by grade, April 2012-present
In summary, within KHP there is exemplary training and care provision in certain areas, presenting significant learning opportunities for the future of training provision for Mind & Body, from close links between training and care delivery, to training frameworks and packages, to service user involvement.
Training opportunities

The third major theme, ‘training opportunities’, refers to information garnered about future developments in training initiatives for Mind & Body across all healthcare professions, with subthemes of ‘need’ and ‘interest’ in future training, desired ‘method of delivery’, ‘content’, and ‘key features’ of such training, and finally it’s ‘origin’.

Need:
The majority of professionals and services reported considerable need and scope for improving training and care delivery, to the benefit of both staff and service users.

Need was demonstrated through clinical audits, reporting of serious incidents, and personal experience and recognition by senior and direct care staff. These mediums sometimes evidenced poor or inadequate care relating to interdependent physical/mental health needs, difficult working conditions for staff, and inefficiencies in healthcare systems.

Need was also evidenced by interviews with staff and volunteers possessing lived experience of healthcare services, as well as analysis of patient satisfaction data, providing evidence of care lacking in the consideration of both physical and mental health needs. Descriptions of the impact of this on service users ranged from “inconvenient” and “frustrating” to “terrible”.

However, it was clear that while time and resources are expended via education and training, another priority should be the removal of any practical and structural barriers to staff delivering care for Mind & Body.

Interest:
Interest was gauged by examining interest and uptake of existing initiatives, from focus groups, survey open questions, and senior staff interviews.

Interest in existing training to expand skills and knowledge of clinical practice around Mind & Body was very good, with examples ranging from collaborative study days between core Medicine and Psychiatry trainees, to Mind & Body simulation training, to twinning wards across Trusts. The indication was that this interest and uptake would continue should more opportunities be provided, while the importance of how training is advertised to staff was highlighted.

Staff unanimously expressed interest in such initiatives, including senior staff with reference to the services and professionals under their guidance. The key factors named behind this motivation or interest were staff observing need, awareness of potential benefits, and the intrinsic drive within healthcare professionals to provide quality care, and in some instances professional interest.

Although interest was reported to be prevalent, the difficulties and methods of harnessing this interest were stressed as key.

Origin:
An important subtheme that was often raised as a major consideration for future training provision was the question of ‘origin’, or where the range of Mind & Body training initiatives required to meet the need and interest should be derived.

Many participants stressed that the key to implementing the above suggestions around training in an efficient, effective, and powerful way, was to ascertain a clear ‘origin’ of the project management, brand, and force behind such an initiative.
"We're noticing an increase in patients presenting with physical and mental health"
"My colleagues in Acute Medicine would certainly be interested in this sort of training"
"Skills-based, interprofessional, and using real examples - like simulation"
"Training needs to be from a basic level to specialist"    "Where will it come from?"

**Method of delivery:**
Due to ongoing work on medical and nursing curricula, certain participants raised using these changes to embed knowledge and skills for Mind & Body. **Traditional teaching methods**, increased **skills-based and experiential learning** such as simulation, and **exposure** to Mind & Body practice, with **mentoring, modelling, and supervision**, are all important. Increased **service user collaboration in training** could promote a person-centred Mind & Body approach, and increased **interprofessional collaboration** could build links in care delivery.

In the workplace service user involvement and inter-professional collaboration were popular, with **training in clinical teams highly regarded**. This linked to "bite-sized" training - **brief, flexible, needs-focused**, and **delivered on wards**. Exposure to Mind & Body in practice was highly regarded, including rotations or ward twinning schemes to give staff varied experiences, as well as supervision and debriefing. Closely linked was the idea of **staff support networks**, to access expertise and advice, and maximise learning opportunities presented by cross-service collaboration. Individual training methods were raised, such as **local and Trust inductions**, **Schwartz Rounds** and **Grand Rounds** on Mind & Body, the use of 'Champions' or staff responsible for directing care around Mind & Body, and **e-learning**, although reservations were expressed with suggestions that this be used to complement other training. Finally, **simulation training** was widely reported as highly desirable.

**Content:**
Referring to the subject matter of training on Mind & Body, it was generally agreed that there should be a **variety of training to impart knowledge and skills** from a **basic to a specialist level**, including as many staff as possible on this spectrum, as well as specific areas that may need additional focus.

The most basic training would cover **awareness** of Mind & Body, including a patient perspective, and could be built upon with **recognition, communication and information giving skills**, followed by **screening and assessment** with the ability to **highlight this need and refer on** if necessary, before the introduction of competencies in delivering **low-level interventions** where appropriate, and finally skills around **specialist and intensive interventions**.

Further specifics emerged around **tools or formats for screening and care planning**, knowledge of **medications**, and understanding the **roles of other services and professionals**. Finally, there were discussions of Mind & Body training personally for staff. A coherent structure from basic to specialist knowledge and skills around Mind & Body emerged, accompanied by specific topics, with the notable area of staff wellbeing also.

**Key features:**
Participants identified key features of Mind & Body training to ensure meaningful impact on clinical care, from past experiences of receiving, delivering, and commissioning training.

Certain key features, such as **bespoke, flexible training**, **delivered to teams or inter-professional groups**, a focus on **skills and competencies**, and **service user collaboration**, have been mentioned previously. Additionally, training support should be **ongoing, to allow continued development**, as well as closely linked to **practice** to ensure that staff can implement knowledge and skills, for example training using a specific screening tool supported by the availability, opportunity, and incentive to use this resource clinically.

Training should be **case-based, using real examples** that staff can relate to, while benefits to staff and patients should be clearly outlined and advertised. All **clinical and non-clinical staff and professions should be offered training**, at least to some degree, while the most effective training initiatives extend **across the primary-secondary care divide**.

Participants painted a clear picture of the key features required for training to be impactful and effect change in clinical care around Mind & Body.
Report: Applied Psychology in Health (APH), Clinical Models & Care Pathways
Nicky Thomas, Head of Psychology, GSTT

APH services referred to are GSTT, KCH & SLAM clinical/health psychology, varying according to setting, referral, & care pathway. There are differences and similarities between the various services, depending on context, among other factors. In APH, psychology is embedded in MDTs and is therefore routine in patient care. Signs of psychological distress beyond appropriate levels can be addressed in line with patients’ needs in a stepped-care way. This helps to prevent worsening of psychological distress, which can negatively impact patients’ physical care plan (e.g. medication adherence) & mental health.

Fig 1: Stepped-care model from Manual for Cancer Services

Fig 2: Psychological care model in physical & mental health settings

Principles of APH - Offer direct assessment and formulation (individual, joint, MDT), clinical interventions (individual, group, couple), joint/MDT working, supervision, staff training, research, service evaluation.
- Provide comprehensive and accessible services, consistent with DoH guidelines, that cater to different levels of need at different points in a patient journey. Typically focus on the person coping with physical symptoms or illness, and often family/carers, with QoL, adherence, and mood generally considered.
- Employ ‘biopsychosocial’ models to position beliefs, symptom and illness experience, attributions and help-seeking behaviour, and mood, as key processes which vary on a continuum.
- For mental health unrelated to physical health, patients are usually referred to MH services, e.g. SLaM mental health liaison or IAPT services, largely due to the resource and remit of APH.

Therapeutic intervention in physical health - Aims: enhance patients’ understanding of illness & experience of symptoms; help patients use strategies to manage symptoms; respect patients’ values & context; achievement of patient-centred goals.
- There is a broader focus on adjustment throughout the lifespan and negotiation of life transitions, with more flexibility for individual formulation & number of sessions, compared to other settings.
- CBT and third wave models, such as ACT, predominate in conceptualisation and treatment, while systemic, narrative therapy, motivational interviewing, couple & group therapy may occur.
- CBT includes: psychoeducation; cognitive therapy on beliefs about self; self management, e.g. exercise, behavioural activation. CBT is cost-effective in managing chronic illnesses, e.g. SCD and associated psychological problems, e.g. depression (DoH, 2001; Thomas et al. 1999; 2001).
- APH subscribes to 3 key themes of clinical health psychology: accessibility to non-psychologists; improving communication in healthcare; making services & MDTs more psychologically minded.

Care pathways - There are differences in the positions of APH services in physical and mental health care pathways, Fig 2.
- Certain APH services are more referral based, e.g. clinical health psychology in SLaM liaison services, with others embedded in MDTs, usually condition-specific physical services, where psychologists proactively assess all patients, address pain & deteriorating health, and identify people with severe/complex problems.
- APH see patients in a range of settings; e.g. satellite (dialysis) clinics, A&E, inpatients wards, outpatient clinics; and also provide input to IAPT, voluntary organisations, and community rehabilitation programmes.
Practicalities – support required
The final theme of ‘practicalities’ encompasses the different areas and methods of support that will be required for to support and deliver a comprehensive, impactful, and sustainable programme of training around Mind & Body: ‘commissioning’; ‘cultural shift’; ‘organisational collaboration’; ‘direction’; and ‘branding’.

Commissioning

• Considerations ranged from having the resource and means to attract commissioning support, to ensuring that education and training goals are in line with clinical strategy and commissioning; on local, national, and international levels.

• A Mind & Body education and training initiative should be designed, implemented, and advertised with clinical outcomes and targets in mind. Locally it is important to consider key performance indicators at service, Trust, and University level, as well as other local Trust targets. The challenge is balancing patient outcome-focused Trust goals, and student performance and satisfaction-focused University goals.

• CQUIN and clinical commissioning targets must be supported by training, working collaboratively with CCGs attempting to set targets to allow care providers to take ownership to improve patient outcomes and focus on goals that measure physical and mental health needs, e.g. older adults spending more days at home, less in hospital.

• The aims and values of training commissioning bodies, such as HESL & HEE, must be considered and incorporated in training strategy; e.g. ensuring innovative approaches in development of training products and packages, and delivering consistent training throughout career paths, from UG through to continued professional development.

Culture shift

• A ‘cultural shift’ in KHP workforces may be required for the successful implementation of Mind & Body training and care, partly encouraged by training and education itself, but also by the leadership of KHP stakeholders.

• To facilitate a cultural shift towards considering both physical and mental health needs, support is needed from executive directors of KHP organisations. This could come in many forms, such as a top-down mandate with regards to training and competencies, or increased support for exemplary, innovative best practice for a bottom-up approach.

• Culture in terms of an organisation’s expectations of its workforce is key also, linking in with organisational values and ethos, priorities and targets, performance monitoring and appraisal, and even design of job roles and descriptions. The role of senior management and staff is important not just administratively and governmentally, but also in example setting and role modelling.

• The necessity and role for senior staff and management buy-in could not be over-emphasised with regards to the success of a training and support programme around Mind & Body.
Organisational collaboration

- Collaboration between organisations is key to realising the potential of an AHSC partnership, and while there are excellent examples of collaboration in training and practice, more could yet be achieved potentially with central leadership across KHP.

- Compatible IT systems, security, software, and information sharing would increase staff collaboration and support across Trusts, as could common sites, locations or staff areas, and even wards or services across Trusts.

- Cross-Trust links can facilitate Mind & Body learning opportunities, from twinning wards and allowing staff rotation between Trusts, to service level agreements aimed at Mind & Body, and more inter-Trust training provision. This collaboration relates to finances, permissions, contractual considerations, and training and clinical strategy.

- Consistency of training from UG to the workplace is important, resting on Trust-KCL collaboration to maximise professional and academic expertise, and placement opportunities. Closer fusion of KCL degree course provision and workplace training was posited, incorporating UG and PG training with workplace offerings in a way that maximises the credibility and incentive of KCL with professional expertise of the Trusts. However, this raises the challenge of marrying clinical Trust goals with student-led KCL goals, as well as issues around funding and profit sharing.

- KHP is key to stakeholder collaboration: instilling cultural values; removing physical & technological barriers; leading on structural integration; and balancing interests.

Direction

- To ensure the success and effectiveness of Mind & Body training the responsibility of laying solid foundations around strategy and goals needs to be shouldered by a selected channel, body, or group. Subsequently, any initiative can be purposefully project managed, with funding, resource, and expertise sought to support strategy.

- It was suggested that a specific location or centre could be introduced to centralise the wealth of expertise available, as well as making support on this matter easy to locate for staff that have an interest or request for assistance.

- Alternatively, or additionally, an editorial board of experts could be assembled to edit, support, and deliver existing training, as well as develop new packages, while supporting these skills and knowledge in clinical practice, and monitoring, evaluating, and researching training provision. This could be a structure similar to that of IMPARTS, linking in a body of professionals with interested services to deliver informatics, training, research, and clinical support on an ongoing basis.

- Decisions on the ‘direction’ and oversight of Mind & Body training are surely the logical and essential next steps in the process of developing formalised KHP-wide Mind & Body training initiatives and best practice in this area.
In summary, the major practical considerations upon which hinge the success of a Mind & Body training programme are:

- Aligning with clinical and educational commissioning targets
- Aiming for a cultural shift both within and between KHP stakeholders
- Developing a brand and direction or channel for project management

Participants’ valuable and detailed views on how to achieve each of these aims are clearly outlined and could form the basis of a strategy.

**Mind & Body training models**

Explicit data collected and general interpretation of findings highlighted possible models and frameworks that may be useful in the implementation of Mind & Body training initiatives. These representations of the structure, outline, and goals of Mind & Body training programmes can guide and clarify the objectives, strategy, and implementation required to effect change around the overlap of mental and physical health needs.

1. **Four-tiered model of Mind & Body training:**

   This model, adapted from the NICE four-tier model of psychological support in cancer care, aims to replicate the inclusion of all healthcare professionals in clearly outlining graduated role and training expectations from basic awareness to specialist intervention, closely linking training with practice in meeting physical and mental health needs.

   Adaptation has included considerations for physical as well as mental health and wellbeing, ensuring that this model would be applicable in acute, mental health, and primary care settings.
This model could guide development and provision of future training, and with links to appraisals and CPD, even clinical care, potentially reproducing the benefits seen in cancer care, such as improved psychological and physical health outcomes, and efficiency and costs savings to healthcare systems.

2. **Flowchart model of workplace and university Mind & Body training**
   This model aims to depict an opportunity for closer collaboration between Trust and KCL training, where *workplace-based shortcourses are accredited by KCL* to contribute towards completion of university modules and ultimately higher educational qualifications.

Consequently, KCL students would have increased opportunities for training traditionally completed in the workplace, while Trust staff would have increased access to KCL-accredited training and possibly qualifications.

In bringing university and workplace training together, students will finish their training better prepared for the workplace, while staff will have opportunities to receive extra internationally recognised education, with both outcomes positively impacting on clinical care.
**Discussion**

Participants from across KHP stakeholders provided a wealth of data and information on existing and future training opportunities regarding Mind & Body, allowing findings to be presented with significant detail on learning from existing initiatives and best practice, staff views on the delivery of future training, and the practical considerations and support that may be required to provide a successful and impactful programme of training.

**Summary of quantitative findings**

With engagement from across KHP, survey findings indicated that although there is an awareness of Mind & Body in healthcare, too few staff are confident in dealing with overlapping physical and mental health, raising concerns around patient care. Significant disparities between the actual and preferred timing and delivery method of training for Mind & Body illustrates a significant need and opportunity, while staff reported such training as being of high importance and considerable benefit to clinical care.

**Summary of qualitative findings**

The first of four themes, ‘existing initiatives’ highlighted excellent practice around the Mind & Body within KHP, from entire services to specific training provision, as well as teaching and placement opportunities at under- and postgraduate level. Examples of current training delivery range from formal and informal learning opportunities afforded by embedding professionals from differing specialities and backgrounds in teams, to formal and informal opportunities resulting from services collaborating in clinical care, as well as specific training and implementation of tools and resources that can be used to improve care provision.

However, training was occurring sporadically and in isolation, with inconsistent provision across services and organisations usually led by individuals or a highlighted need. It was suggested that centralisation and leadership of Mind & Body training would have a considerably beneficial impact on the success and effectiveness of these initiatives.

The second theme of ‘best practice case studies’ outlined some groundbreaking training and clinical initiatives that may present learning opportunities for the future of Mind & Body training.

The third theme, ‘training opportunities’, linked back to quantitative findings in demonstrating that there is a significant need and interest in Mind & Body training, as well as providing valuable information around staff views on the delivery methods, content and subject matter, and key features for success of future initiatives. These findings could represent solid foundations around which a programme of Mind & Body training could be built. However, it was also raised that the origin or source of this training would be pivotal in leading, directing and project managing such a project towards successful outcomes.

Finally, the ‘practicalities’ for support required for the success of a Mind & Body training programme were outlined. Externally, clinical and educational commissioning targets must be aligned with, while internally, cultural shift and the removal of barriers must occur within and between KHP stakeholders. Perhaps most imminently important for the inception and momentum of a Mind & Body training initiative is deciding on direction, leadership, and branding that should take this project forward and oversee its development.
Implications
The findings of this project closely link to many of KHP’s Mind & Body Programme’s aims and commitments, from broadly ‘treating the whole person’ to specific initiatives. Examples include; addressing traditional distinctions between Mind & Body in education to support staff to deliver more integrated care; working closely with commissioners in the pursuit of integrated services; and support and investment in innovative approaches to working with Mind & Body, such as IMPARTS and 3DFD. This demonstrates that in many areas, the views, needs, and experiences of staff and service users around the overlap of mental and physical health needs are reflected in KHP’s Mind & Body Programme.

In this way the findings of this report also link closely to the values and messages of the Department of Health’s No Health Without Mental Health strategy, and NHS England’s Parity of Esteem Programme, providing an encouraging message that the directions suggested in these findings are meaningful and important by their alignment with national goals, targets, and strategy.

Assertions in the literature about the prevalence and importance of overlapping physical and mental health needs are certainly reflected in this report, with a high number of staff aware of these, a reportedly great interest in further knowledge and skills in this area, and a significant need for increased support in working with Mind & Body, illustrated in a variety of formal and informal ways. Anecdotally it was often reported that these overlapping needs seem to have increased in recent times, although it is unclear whether due to an actually increase, or improved recognition, or system and service structuring. Similarly, recommendations from the literature were reflected in this report’s findings, replicating and adding to the variety of suggestions, from radical overhauls of undergraduate and postgraduate training, to large-scale adoption of biopsychosocial models, and even specific training needs and methods.

Findings of educational literature are also replicate in this report, citing its potential benefits in clinical care, as well as the importance to training and clinical strategy being closely linked. Findings regarding a lack of provision were also mutual, as were the significance of knowledge, skills, and understanding, coupled with coherence throughout carer pathways and opportunities such as simulation sessions and inter-professional awareness.

Strengths & Limitations
This report covered a wide range of organisations, professions, and individuals, recruiting considerable numbers of participants who subsequently provided substantial amounts of valuable and informative data, while it is also acknowledged that more backgrounds, perspectives, and individuals could improve this project, particularly externally. This resulting qualitative data was coherently and succinctly organised into themes and subthemes that would be of significance in the development of a Mind & Body training programme. Quantitative data completed a robust mixed-methods approach and was informative to the extent of demonstrating staff views, although had time allowed, more analysis may have revealed more in depth relationships within the data, such as differing views of services and professions.

The findings and their presentation have the significant benefit of potentially forming the basis of strategy, models, and frameworks of a future Mind & Body training initiative, and also relate back closely to King’s Health Partners, Department of Health, and NHS England values and goals. However, while constructive recommendations were made with regards to
developing Mind & Body training, it is acknowledged that this report is unlikely to have been able to uncover all potential views of staff and practical considerations that may lead to the success of such a training programme.

**Strategy development**

1. This aims to briefly outline how training and education around the Mind & Body will be developed and delivered for the remainder of the KHP five year plan “Improving health and wellbeing: Locally and globally 2014-2019”, which encompasses the Mind & Body Programme.

2. The strategic objectives for Mind & Body training, as agreed by the Mind & Body Education Workstream are to:
   i. Build awareness and understanding of the necessity and benefits of considering Mind & Body, and ‘treating the whole person’ in care provision
   ii. Improve service user and staff outcomes and experience of overlapping mental and physical health needs through clinical education and practice
   iii. Gain recognition for dissemination, nationally and internationally, of innovative and effectual training programmes to support the provision of mental and physical healthcare concurrently

3. These objectives apply to all healthcare professions, settings, and organisations, across all stages of professional development, from undergraduate to workplace training

4. To achieve these objectives a raft of short and long term initiatives will be implemented, including but not limited to:
   i. Enhancing existing training by offering support and resource to bring in Mind & Body considerations where relevant
   ii. Expansion and upscaling of current training practices that have proven benefit, are prepared for extension, and may be adaptable to other settings
   iii. Increase the use of skills, team, and experience-based workplace training methods, such as simulation, in educational settings
   iv. Developing new training packages and products to support Mind & Body practice in Acute, Mental Health, and Primary Care settings, both internally and externally
   v. Support medical and nursing curricula reviews and general Health Faculty UG & PG training by making available teaching expertise and clinical placements

5. Successful implementation of these initiatives will be accomplished through the marriage of bottom-up and top-down management. Outstanding provision of care and training addressing the overlap of physical and mental health needs already exists within KHP, driven from the bottom up by the passion, innovation, and dedication of individuals. These powerful forces will be fostered, sustained, and expanded through top-down support.
## Recommendations

These recommendations aim to build on the findings of this report and support strategy development in successful and effectual implementation of Mind & Body training initiatives, making King’s Health Partners a world leader in the care of overlapping physical and mental health needs, and ensuring the best clinical provision possible for its service users.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Resource required</th>
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<tr>
<td><strong>Universal</strong></td>
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<tr>
<td>1. Establish a clear theme or ‘brand’ to represent this area of overlapping physical and mental health, e.g. Mind &amp; Body Programme or IMPARTS</td>
<td>Decision-making and support from the Mind &amp; Body Programme Board to, for example, the Mind &amp; Body (Education) Committee (see Recommendation 2)</td>
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<tr>
<td>2. Collate and fund an editorial board or committee to project manage and oversee Mind &amp; Body training (e.g. Mind &amp; Body (Education) Committee), representing and disseminating KHP expertise in this area</td>
<td>Funding and expertise to support the identification and recruitment of appropriate individuals for this board/committee, possible links to existing structures, e.g. KHP Education Academy</td>
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<td>3. Build on the Mind &amp; Body training strategy presented in this report (p.23), adopting an implementation model, e.g. the 4-tier or flowchart models (p.20-21)</td>
<td>As above for strategy, along with canvassing KHP, Trust, &amp; KCL support for strategy &amp; delivery model (p.20-21) via Mind &amp; Body (Education) Committee</td>
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<tr>
<td>4. Ensure contact and support from all KHP stakeholders, fostering collaboration</td>
<td>KHP to act as facilitator in involving all 4 main stakeholders</td>
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<td><strong>Workplace</strong></td>
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<td>5. Review all existing internal Trust training for Mind &amp; Body content and relevance</td>
<td>Funding to execute, and support to secure cooperation of E&amp;T departments</td>
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<tr>
<td>6. Develop new training packages &amp; products to support clinical practice for Mind &amp; Body</td>
<td>Funding and expertise channelled to the relevant training centres/departments</td>
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<tr>
<td><strong>UG &amp; PG Level</strong></td>
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<td>7. Increase support for UG &amp; PG teaching on overlapping physical &amp; mental health needs</td>
<td>Facilitation of communications between Trusts and KCL regarding teaching links</td>
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<tr>
<td>8. Increase opportunities for UG &amp; PG exposure and placements in services addressing Mind &amp; Body, through collaboration between KCL &amp; Trusts</td>
<td>Facilitation of discussion between Trusts and KCL, and identification of potential opportunities for student exposure to Mind &amp; Body training and clinical practice</td>
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<td>9. Support restructure of nursing training &amp; core trainee placements, offering expertise &amp; opportunities where possible</td>
<td>As above</td>
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<tr>
<td>10. Support simulation and experiential learning for current UG &amp; PG programmes</td>
<td>Facilitate discussion and provision of training between the relevant parties</td>
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Conclusion

Valuable insights into the future of staff training around Mind & Body have been made, based on considerable data and revealing findings. A significant need and interest was evident in the views and experiences of staff, while opportunities for future training have also been outlined. These insights, possible models of training, initial strategy development, and clear recommendations for progress and success, have laid the foundations of a programme of Mind & Body training. These insights were also aligned with policy and values from King’s Health Partners, the Department of Health, and NHS England. Emphasis was placed on the importance of selecting a body and brand to take forward and develop any initiative.

References


