Mind and body healthcare: delivering the vision

@kingshealth

#mindbodycare
Mind and body animation – don’t separate the inseparable: https://youtu.be/d5h28ZvXgr8
Dr Matthew Patrick
Dr Jonty Heaversedge

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#mindbodycare
The evidence base

Professor Matthew Hotopf
Director, NIHR Biomedical Research Centre at the Maudsley

Professor of General Hospital Psychiatry, Institute of Psychiatry, Psychology and Neuroscience, King’s College London
Whole-person care: from rhetoric to reality
Achieving parity between mental and physical health

Occasional paper OP88
March 2013
Bringing together physical and mental health
A new frontier for integrated care

Authors
Chris Naylor
Preety Das
Shilpa Ross
Matthew Honeyman
James Thompson
Helen Giburt

March 2016
g parity of outcomes

May 2014
Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study

Karen Barnett, Stewart W Mercer, Michael Norbury, Graham Watt, Sally Wyke, Bruce Guthrie

Lancet 2012

Figure 3: Physical and mental health comorbidity and the association with socioeconomic status
On socioeconomic status scale, 1=most affluent and 10=most deprived.
Life expectancy at birth of people with specific mental disorders (N = 31,719)

http://journals.plos.org/plosone/article?id=info:doi/10.1371/journal.pone.0019590
Cumulative mortality for depressed and nondepressed patients. MI indicates myocardial infarction.

Frasure-Smith, JAMA 1993
Estimated unadjusted mean outcomes by baseline depression/anxiety (with standard error bars) for DAS-28/ HAQ.

Faith Matcham et al. Rheumatology 2015;rheumatology.kev306
Chronic low mood predicts healthcare costs: 803 patients with CHD recruited from primary care and followed over 3 years

Palacios et al, submitted
Cardiovascular risk factors in people with psychosis
Gardner-Sood et al, Psychological Medicine, 2015

Participants were 450 randomly selected outpatients with psychotic illness recruited from 5 mental health trusts in England
Data on 7878 general hospital out-patients with long term conditions screened by IMPARTS

- Smokers (%)
  - No depression
  - Mild depression
  - Major depressive disorder

- Smokers who want help quitting (%)
  - No depression
  - Mild depression
  - Major depressive disorder
So far, no evidence of genetic pleiotropy

Strong correlations between metabolic disorders and health behaviours

No correlations between T2D or CAD and Psych disorders

Strong correlations between psych disorders
Depression progressively worsens during IFN-α and Ribavirin Treatment

Su et al., 2008

![Bar chart showing the percentage of IFN-induced depression over weeks of IFN treatment.](chart.png)
Biologics may reduce depressive symptoms
Tyring et al, Lancet 2006

Phase III trial of etanercept (soluble TNF-α receptor) in treatment of psoriasis

*Figure 2: Improvement from baseline in BDI over time*

*p* values for comparison between etanercept and placebo groups.
Environmental pleiotropy?

Danese et al. JAMA Psychiatry 2009

![Graph showing effect size, Cohen's d, for different groups.](chart.png)
Treat as One
Bridging the gap between mental and physical healthcare in general hospitals

@ncepod
#MH
Reduced quality of care in CVD disease for patients with SMI: Record Linkage

Woodhead et al, BJGP, 2016

% with optimal care

- Beta blocker in heart failure
- ACEI/ARB in heart failure
- Beta blocker in CHD
- Quadruple therapy in CHD

No-SMI SMI
A cohort study on mental disorders, stage of cancer at diagnosis and subsequent survival

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<th>Diagnosis</th>
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<th>HR for mortality**</th>
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* Adjusted for age, gender, PCT, ethnicity, deprivation score, type of cancer, year of cancer diagnosis
**Adjusted for age, gender, PCT, ethnicity, deprivation score, type of cancer, year of cancer diagnosis and stage of cancer
Fig. 2 Kaplan–Meier curves of cumulative probability of cardiac events for myocardial infarction patients with depression allocated to antidepressant intervention or care as usual. ——— care as usual; ——— intervention; vertical ticks indicate censored data.
Recruited patients with poorly controlled DM or CHD plus depressive symptoms. Physical parameters – hypertension, raised LDL cholesterol, and raised HbA1c.
Rayner et al. *General Hospital Psychiatry* 2013

**Routine outcomes collection in clinical practice**
**IMPARTS: Integrating Mental and Physical Health – Research Training and Services**

**Informatics**
- Routine collection of patient-reported outcomes with advice on care & referral

**Care pathways**
- Development of mental health care pathways for patients identified via screening

**Training**
- Training in mental health skills with ongoing supervision from a mental health specialist

**Self-help**
- Portfolio of bespoke self-help materials, tailored to specific long-term conditions

**New treatments**
- Development of new low cost psychological treatments – e.g. e-health
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## Groupings by prevalence of probable MDD

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<td>ICU follow up</td>
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Active Digital Interfaces:
myhealthlocker
Stay in touch

MatthewHotopf@kcl.ac.uk

NIHR BRC at the Maudsley: @NIHRMaudsleyBRC
IMPARTS project: @IMPARTSP
Hotopf @MatthewHotopf
King’s Health Partners @kingshealth
Mind and body healthcare: delivering the vision

@kingshealth

#mindbodycare
A personal perspective – the mind/body disconnect
April 1943

I had a surgery this a.m. & have another this evening – saw 40-50 patients this morning which gives you an idea of the class of practice – the non-panel ones are 2/6-3/0, paid down & 1/ for certificates – that bit’s a little too like shopkeeper for my liking. I don’t dislike the work for a while – the patients are mostly the “hospital class” & you know how good-natured they are – as I’ve told you most of it isn’t really medicine & of course unfortunately with a full waiting room there simply isn’t the time to give them the sort of hearing they really want – conditions in war/industry are responsible for a good many, especially girls from shops & hairdressing etc. who are now doing heavy machine & lathe work & who simply can’t cope & men working 12 hours a day & elderly men doing young men’s jobs - & then of course the women with their husbands away who are suffering from “insomnia” & “nervous debility” & wanting to bash the kids’ heads together – heaven knows they have all my sympathy but as for treatment – “a bottle of the red medicine did me good last time doctor” – you know – so what it boils down to is tact & sympathy & I suppose a little crude psychotherapy (very crude I’m afraid). Anything approaching a clinical problem one simply has to send to hospital because there’s neither time nor facilities for any sort of proper investigation – I probably overdo this as I’m not doing any visits & my conscience won’t let me pack many of them off with a bottle of medicine & soothing words if I’m a bit suspicious. Of course I’m assured that wartime conditions are responsible for a good deal of this state of affairs & also it’s true that at least half the patients who come to a surgery aren’t really ill or have something v. obvious like ‘flu or a skin condition (lots of these & they really are quite interesting – tho’ you know how much I know about skins).

Well he paid me 10 guineas a week i.e. £17 for the week & 4 days – he considered that the fact that he wasn’t providing board & lodging balanced the fact that I wasn’t doing full time.. On the whole I think it was generous.

Dr Norah Johns - born in 1914 and trained at Kings College.
A patient’s perspective – who cares?
A commissioner’s perspective – what are the enablers?

We are changing the way we work and the ways that we commission services so that we:

- Emphasize populations rather than providers
- Focus on total system value rather than individual contract prices
- Focus on the ‘how’ as well as the ‘what’

Arranging networks of **services around geographically coherent local communities**

Moving away from lots of separate contracts and **towards population-based contracts that maximize quality outcomes** (effectiveness and experience) for the available resources

Focusing on commissioning services that are characterized by these attributes of care, **taking into account people’s hierarchy of needs**

**System value**
- **Effectiveness**
  - Life outcomes
  - Clinical outcomes
  - Clinical safety
- **Experience**
  - Citizen
  - Carer
  - Staff
- **Cost**
  - Per capita cost
  - Total system cost

**EMPOWERING ACTIVATING ENABLING**
- **HOLISTIC AND CO-ORDINATED**
- **PROACTIVE PREVENTATIVE OUTCOMES FOCUSED**
We are developing better ways to work together at scale. LCNs will be multispecialty provider collaborations covering natural communities.

Supporting the development of multi-specialty models of service delivery through Local Care Networks.
Dr Geraldine Strathdee

@kingshealth

#mindbodycare
Dr Shelley Dolan

@kingshealth

#mindbodycare
Graeme Groom
Fiona Squire

No slides, but watch a short film with Fiona Squire talking about how mind and body care helped her through limb reconstruction surgery: https://youtu.be/iq_YEbin7Tk

@kingshealth

#mindbodycare
Integrated Psychological Care in the Diabetes Clinic

Stephanie Singham
Specialist Medical Psychotherapist
Why do we offer psychological care in the diabetes clinic?

- Type 1 Diabetes is a condition which requires the individual to actively self-manage their condition 24/7 alongside...

- Anxiety & Depression
- Socio-Economic Issues
- Loss & Trauma
- Disordered Eating
- Emerging Adulthood
- Family & Relationship Issues
- Diabetes
Presence of psychological and emotional difficulties can render an individual either unable or unwilling to carry out the positive health-care behaviors necessary to maintain good diabetes control.

Therefore we have integrated diabetes psychological care sitting in clinic alongside Doctor, Nurse, Dietician...
What does an Integrated Service look like?

- Presence of psychological and emotional difficulties can render an individual either unable or unwilling to carry out the positive health-care behaviors necessary to maintain good diabetes control.

- Therefore we have integrated diabetes psychological care sitting in clinic alongside Doctor, Nurse, Dietician...
What are the Benefits of integrating physical and mental health care in the Diabetes Clinic?

- Enables patients to have their physical and mental health needs met within one clinic
- Normalises mental health and reduces stigma
- Routine IMPARTS screening alerts HCP’s to the existence of mental health issues enabling team to identify most appropriate treatment pathway
- Cost-effective: prevents unproductive overuse of referrals to other HCP’s
Mind and body healthcare: delivering the vision

@kingshealth
#mindbodycare
Integrated Heart Failure Service
Lambeth and Southwark

Dr Adam McDiarmid  Heart failure consultant, GSTT
Julia DeCourcey  Heart failure consultant nurse, KCH
Heart Failure Key Facts

**UK**

- **900,000** people are estimated to be living with heart failure in the UK
- **11 days** average length of stay for a heart failure admission
- **£3,000** approximate cost per heart failure hospital admission
- **30-40%** of patients diagnosed with heart failure die within a year

**Locally**

- **9,000** people are estimated to be living with heart failure in Southwark and Lambeth but **less than 3000** are known to services

  Estimated prevalence for Southwark & Lambeth is 1.5% of population

With early and accurate diagnosis, access to heart failure specialists, prescription of evidence-based therapies and coordinated care we can significantly improve prognosis, and quality of life.
Mortality in CHF REF Trials

![Annual Mortality %]

- Placebo
- ACEi
- ACEi + BB
- + CRT
- MRA

Annual Mortality %
Our goal: People with LTCs, one of which is heart failure, living longer with a better quality of life in their homes

1. Early and accurate diagnosis of heart failure
   - to ensure more patients are diagnosed and receive the treatment they need as soon as possible

2. Equitable access to specialist care
   - evidence shows that to improve outcomes in heart failure patients need to have access to specialists and be prescribed evidence based treatment that can halve mortality rates

3. Good long term condition management and patient centred holistic care
   - to ensure all of a patients’ needs are met in the most efficient and effective way

4. Unnecessary hospital admissions avoidance
   - to keep people at home in their communities wherever possible
New models of care in Southwark and Lambeth
How are we doing this?!

GST charity
- Integrated Heart Failure
- Feb 2016-Feb 2018

Health Foundation
- 3DLC
- Sept 2016-Sept 2018
Challenges of Heart Failure

• Patients are often older and can have significant other multiple co-morbidities

• Only cardiovascular condition that is increasing in the UK

• Multiple admissions

• **Higher** mortality rate than most common cancers (excluding lung cancer)

• High cost
Challenges of Heart Failure

• 21.5% of heart failure patients have major depression disorder, and up to 40% of patients are depressed
• Approx 60% of patients have anxiety post ICD and 40% have depression
• For patients with a history of depression there is:
  • Worse prognosis
  • Functional decline
  • Re-hospitalisation
  • Increased risk of mortality
• Specific heart failure issues to be depressed and anxious about?
NICE 2010 states that:
The diagnosis of depression should be considered in all patients with heart failure.
So what have we done so far?
### Introducing a stepped-care model with 3DLC

<table>
<thead>
<tr>
<th>Focus of the intervention</th>
<th>Nature of the intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1:</strong> All known and suspected presentations of depression</td>
<td>Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 2:</strong> Persistent subthreshold depressive symptoms; mild to moderate depression</td>
<td>Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 3:</strong> Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression</td>
<td>Medication, high-intensity psychological interventions, combined treatments, collaborative care(^2), and referral for further assessment and interventions</td>
</tr>
<tr>
<td><strong>STEP 4:</strong> Severe and complex(^1) depression; risk to life; severe self-neglect</td>
<td>Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multiprofessional and inpatient care</td>
</tr>
</tbody>
</table>

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NICE Guidance: Depression in adults with a chronic physical health problem: recognition and management
Clinical guideline CG91 Published date: October 2009
It’s early stages...

- Clinical psychologist and psychiatrist in post
- Attending weekly MDMs
- Caseload review to understand patient needs
- Providing clinical advice and joint appointments
- Launching clinic
- Piloting regular screening questions for depression and anxiety
- Increasing referrals to IAPT
Case study: patient story

Julia deCourcey
43 year old male

- MI / Heart attack
- LVSD / HFrEF severely impaired systolic function (EF 34%).
- Frequent admissions with decompensated heart failure
- Coronary artery bypass
- Diabetic
- Obesity
- Sleep apnoea
- Asthma
- Chronic renal failure
- Gout
Drug therapy

- Clopidogrel Tablet 75 mg
- Lansoprazole 15 mg
- Aspirin 75 mg
- Hydralazine 25 mg bd
- Hydrocortisone 10 mg od
- Amlodipine 5 mg od
- Bisoprolol 10 mg
- Bumetanide 2 mg and 1 mg pm
- Atorvastatin 40 mg
- Ezetimibe 10 mg
- Isosorbide Mononitrate SR 30 mg od
- Sodium Bicarbonate 500 mg tds
- Salbutamol Aerosol Inhaler
- Symbicort 400/12
- Ketoprofen Gel 1 Application
- Allopurinol 100 mg od
- Folic Acid 5 mg od
- Insulin Novomix 30
- Insulin Novomix 30
- Citalopram 40 mg od
- Fluconazole 200 mg every: Prophylaxis against candidiasis.
- Paracetamol 1000 mg QDS
- Codeine Phosphate 30 mg
- Laxatives
Hospital admissions

Driven by fear and anxiety
One drug change impacting on another
Conflicted by advice given
Fluid restriction for HF versus adding fluids for low BP
Fear of renal dialysis
Living alone / isolation

- Reduction in LVSD prognostic drugs
- Fluid overload / decompensated HF
- Low BP - fluids advised
- Worsening decompensated HF with further reduction in BP
- Further reduction in LVSD drugs
Assessment and screening of HIS beliefs and needs

- Medication advice sheets reiterating concern re erectile dysfunction
- Medication advice sheets driving fear of renal failure / side effects
- Heart failure’ associated with negative beliefs about illness and poor prognosis
- Assessed for the presence and symptoms of psychological distress

Active listening
Normalise for him but minimising the effect on him
Goal setting and problem solving
Assess and educate/support his needs

- One to one teaching
- Rapid access/walk in clinic
- Double sessions twice monthly
- Use various tools for education
- Joint consultations - renal and diabetic during admissions
- GP contact/shared plan and goals
- Cardiac rehabilitation to reduce fear/anxiety of exerting himself
- Building rapport led to further fact finding

Active listening
Normalise but do not minimise
Goal setting and problem solving
### Address level 1-2 care

- Address low level problems
- Address mild to moderate symptoms
- Referral to Erectile dysfunction clinic
- Refer for social service support
- Sign posted to SAIL
- Vitamin D replacement
- Skin care plan
- Referral to cardiac rehab exercise programme (had to miss sessions)
- Had access to clinical psychologist

#### MINNESOTA LIVING WITH HEART FAILURE® QUESTIONNAIRE

Please consider completing this Questionnaire as it helps guide management and care.

The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the number 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.

<table>
<thead>
<tr>
<th>Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by...</th>
<th>No</th>
<th>Little</th>
<th>Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Causing swelling in your ankles or legs?</td>
<td>0</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by -</th>
<th>No</th>
<th>Very Little</th>
<th>Very Much</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Causing swelling in your ankles or legs?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>2. Making you sit or lie down to rest during the day?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>3. Making your walking about or climbing stairs difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>4. Making your working around the house or yard difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>5. Making going places away from home difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>6. Making your sleeping well at night difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>7. Making your relating to or doing things with your friends or family difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>8. Making your working to earn a living difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>9. Making your recreational pastimes, sports or hobbies difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>10. Making your sexual activities difficult?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>11. Making you or less of the foods you like?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>12. Making you short of breath?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>13. Making you tired, fatigued, or low on energy?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>14. Making you stay in a hospital?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>15. Costing you money for medical care?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>16. Giving you side effects from treatments?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>17. Making you feel you are a burden to your family or friends?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>18. Making you feel a loss of self-control in your life?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>19. Making you worry?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>20. Making it difficult for you to concentrate or remember things?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>21. Making you feel depressed?</td>
<td>0</td>
<td>1</td>
<td>2 3 4 5</td>
</tr>
</tbody>
</table>
Heart Failure Patients – Tools used to assess Psychosocial needs / QOL

<table>
<thead>
<tr>
<th>MLWHF</th>
<th>Date</th>
<th>Emotional score (x / 25)</th>
<th>Physical score (x / 40)</th>
<th>Total (x / 105)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Q 17, 18, 19, 20, 21</td>
<td>Q 2, 3, 4, 5, 6, 7, 12, 13</td>
<td>(include all plus 1,8,9,10,11,14,15,16)</td>
</tr>
<tr>
<td>Initial review</td>
<td>Jan 2015</td>
<td>19/25</td>
<td>33/40</td>
<td>79/105</td>
</tr>
<tr>
<td>3 month review</td>
<td>April 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 month review</td>
<td>July 2015</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 month review</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 month review</td>
<td>Jan 2016</td>
<td>20/25</td>
<td>19/40</td>
<td>52/105</td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DEPRESSION ASSESSMENT**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. During the last month, have you often been bothered by feeling down, depressed or hopeless?</td>
<td>Yes ☐ No ☐</td>
<td>If the patient has answered “Yes” to either questions 1 or 2 plus “Yes” or “Yes, but not today” to question 3 then in the Discharge Letter ask the GP to review the patient and perform a further depression assessment (e.g. PHQ-9, HADS or BDI as used for the QOF DEP4).</td>
</tr>
<tr>
<td>2. During the last month, have you often been bothered by having little interest or pleasure in doing things?&quot;</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td><strong>If patient answers “Yes” to either of the above questions, then also ask:</strong></td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td>3. Is this something with which you would like help?</td>
<td>Yes ☐ No ☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Yes, but not today ☐</td>
<td></td>
</tr>
</tbody>
</table>
Building rapport which led to further fact finding

- Issues with fear due to sexuality
- Fear of ever returning to country of birth
- Isolation here in London and from family
- Fear that life was not worth living

Discussed with clinical psychologist and GP who advised 3DLC
Joint review with diabetic team

Plan
- 3DLC (with psychiatrist)
- Joint MDMs
- MDM included the patient
- **Key community worker**
- Session with clinical psychologist who liaised with clinical teams
- Provided hand held notes / drug advice sheets and a hand held care plan
- Ongoing clinical care / investigations

Key community worker
- Daily medication support
- Key contact for all teams
- Attended various clinics
- Used public transport which included some walking
- Added in incremental exercise plan
- Added structure to his day
- Able to complete exercise rehab
- Blood sugar control has improved
- Fewer admissions

Ongoing care with HIV team
Case study: patient story

Dr Adam McDiarmid
Monitoring physical health in mental health settings
Common Symptoms

- Shortness of breath
- Fatigue
- Swelling of feet & legs
- Swollen or tender abdomen with loss of appetite
Other Symptoms

- Persistent Cough
- Fast heart rate
- Dizzyness
- Increases urination at night
- Difficulty sleeping at night due to breathing problems
- Confusion and/or impaired memory
If having completed breathlessness algorithm on DXS there is...

Suspected new diagnosis of heart failure?

- Chest X-ray & ECG
- Do NOT book open access echo
- Labs (FBC, U&E, HbA1c, CHOL, TFTs)
- NT Pro-BNP

- NTPro-BNP <400
  - Unlikely HF consider alternative diagnosis

- NTPro-BNP 400-2000
  - Requires assessment by specialist and echo
    - NHS e-referral seen within 6 weeks

- NTPro-BNP >2000
  - Requires assessment by specialist and echo
    - NHS e-referral seen within 2 weeks

Prior history of MI

At KCH and GSTT refer to 2 week or 6 week Heart Failure Clinic on NHS e-referral service (for 2 week select ‘urgent’ filter).
Non-Pharmacological & Self Management I

- Weight
- Diet & fluid intake
- Device Therapy
- Exercise and activity
- Psychological
Pharmacological management
Questions?
Mind and body healthcare: delivering the vision

@kingshealth

#mindbodycare
GSTT Psychology Service: Joined up mind/body holistic care – solutions/approaches

Nicky Thomas and Heather Rawle
Clinical Health Psychology: Our focus:

**Responses to Illness/ Beliefs & Representations**

The ways that people are affected by:

- Becoming ill
- Dealing with bad news (health related)
- Coping/Adjusting to long-term illness, including pain
- Treatment adherence
- Take account of how health & health behaviour change over life span.
Long history of integrating mind/body

Significant number of applied psychologists in health (clinical, health, counselling, neuro & educational)

Working in many clinical areas (Children and Adults services) as well as excellent psychologists within the liaison psychiatry team providing input where there are no embedded psychologists.

We have built/developed sustainable CHP services – Haematology is one example.
Psychological issues in Haematology

- Sickle cell disease, haemophilia (HIV; Hep C), other haematological disorders e.g. myeloproliferative neoplasms, antiphospholipid syndrome
- Inherited disorders; chronic conditions
- May affect all parts of body/functioning (e.g. 1 patient can have SCD + stroke + renal failure + chronic and acute pain + mobility problems + sleep apnoea + eye problems)
- Life threatening and life limiting
- Traumatic stress, mood, quality of life, relationships, work/studies, treatment decisions, needle phobia, hospitalisations, multiple appts, behaviours that challenge staff ....
HPS in Haematology

• 20 years old; First in UK
• Normal visible part of MDT
• 3.0 wte psychologists plus 0.2 assistant
• CBT, ACT, MI, SFT, Neuropsych
• 1-1; support group; outpatient; inpatient
• Take referrals external to GSTT
• Staff support; consultation; training
• Contribution to policy, research, guidelines.
Clinical interventions

Interventions address more specific health and treatment related concerns.

- helping patients come to terms with or adjust to their illness and treatment;
- improving the uptake of medical treatment and adherence to complex treatment regimes;
- helping to reduce psychological distress where this is interfering with treatment and recovery from treatment;
- assisting patients and health care professionals in decision making about treatment;
- helping to reduce unwanted side effects of a treatment (e.g. pain and nausea); and
- assisting patients to make lifestyle changes that maintain and improve health.
Successes – Mission Statement

- **Needs led** – needs assessment vital; review needs; respond to needs of staff (collaborative)
- **Evidence-based** – Service data and research show psychological support (for people with SCD) is associated with reductions in distress, improvements in coping, improvements in confidence and self-esteem, and reductions in length and frequency of hospital stays (Thomas et al, 1999, 2000, 2001); NICE; HPS Annual Report. Benefits assessed- standardised measures-
- N=17; GHQ-28: Baseline score: 18.41 (SD 6.72); Discharge score: 9.53 (SD 5.46) \( t = 5.32, p < .000 \)
Confidence in Coping with Pain

![Chart showing confidence levels before and after intervention. The chart compares baseline and post-intervention PSEQ scores, with a significant increase post-intervention.]
Successes – Mission Statement

• **Patient-centred** – expert patients; collaboration; feedback; support group; awareness days; Xmas party

• **Visible and accessible** – fully integrated in team, located in dept, ward rounds, clinics, meetings, informal and formal support, be flexible and responsive; HPS Annual Report;

• **Normalise** psychology - destigmatising

• **Role model** psychology in action - communication strategies; motivational interviewing; holistic approach
Creative approaches

- Show not tell (be helpful to colleagues; role model rather than teach)
- Care plans to manage behaviour that challenges
- Volunteer student placements
- Audit, evaluation and research
- Professional education & debriefing/support
- Collaboration inside & outside trust (KHP psychologist, psychiatry colleagues).
- BPS SIG in sickle cell (Forum for sharing good practice- ensuring consistency; normalising psychology- national concept.)
Case Example: 28 year old female

Sickle cell disease; stroke age 9 - residual weakness and balance difficulties
  - needed to learn to read and write again
  - required PT for walking; still balance difficulties
• missed school through illness (50%)
• sister died of SCD age 4 years old

3 referrals to HPS at different time points:
1. Cognitive assessment and low mood (age 21)
2. Decision to have Exchange Blood Transfusion (age 26)
3. Removing her femoral line without medical supervision

3\textsuperscript{rd} referral - low in mood; not working; asked to leave her college course (tearful); debt (payday loan companies); used by friends to buy alcohol and drugs (difficulty saying no; reports she doesn’t want to use but ends up doing so)
Case Example: 28 year old female

Neuropsych testing (age 21 years old)

• FSIQ = low average (VCI = average; POI = average; WMI = low average; PSI = extremely low)
• Memory = verbal memory + faces: average; family pictures ex. low
• Executive = low average, esp response inhibition Hayling

Intervention:

SCD clinic, day unit, 1-1 psychology appts
Joint sessions with team members – treatment decision
Adjustment to ongoing health issues; CBT/ACT for low mood – behavioural activation; family members in session; grief; health anxiety
Assertiveness; support group
Referral to SCD welfare advisor
Liaison with college tutor
Adapt support according to cognitive impairments
Quotes from HPS evaluation 2016: How has the psychologist helped you?

- Trying to give me different options to control my life
- Help provide tools to cope with issues such as anxiety
- Helps patients to deal with the psychological effects of the illness using other therapies apart from medications
- Helping me learn to cope with challenging situations in day to day life. Being there when times have got tough as a person to talk to
- Sorting out the thoughts in my head with health and life in general
- I’m very grateful for the fact that I am able to contact the HPS to come back when I need to as I still have some issues.
- Different ideas into helping (me to) get back to university and managing to help me work
- Psychologist understands you and listens to you, respects you
- Support group – ‘I’m not the only one’; ‘It made me think in a different way about problems’
A Parent’s feedback

Hello Mina

I’ve been meaning to email you for ages and yesterday I was reminded why. James is doing so much better now. .......It’s like I’ve got him back again! ....... I know he may have other wobbles, but he’s stopped screaming at me/hitting me/throwing things and trying to blame me for the way he feels. ......... He no longer feels that everything is worse now that he has a little brother.

I just wanted to say a big “thank you” for all your help. I’d like to hope we won’t need it again, but if we ever did I’d personally feel so reassured to know it was you who would be unlocking him for us.

I hope you have a lovely Christmas with your family.
Dear Mina,

I have been reflecting a lot on our sessions and have found them to be helpful and practical at the stage I am now with my health.

It has however made me realise that when first in hospital (St Mary's) with VTE undergoing various operations and medical interventions -that I would have really benefited from psychological interventions at this point. I recall feeling very unsure, anxious and panicked during and for a long time after my stay there.

Additionally, whilst I appreciate operations I have had recently and am scheduled to have are usually day/overnight stays - I feel many people in my situation would benefit greatly from psychological services. I feel as though I would have greatly profited from help with adjusting to my new situation as well as having someone to talk through the negative thoughts and emotions I experienced at the time and thereafter. I am fortunate with how positive other areas of my life are which has been a huge influence on how I handle these instances, however, I am aware of others affected by thrombosis that require assistance in coping and adjusting.

I feel having had a clearer picture and any help at all with my mood/adjustment to my health condition(s) in the first instance may have reduced or even eliminated the need for me to have interventions now at this later stage when my negative thoughts and emotions have progressed further.

Again, I really appreciate the sessions we have right now and am very grateful for having been referred to you by Mr Black. I’d like to raise awareness for this need for psychological services for thrombosis and would appreciate your opinion as to whether this is possible or if there is any more I can do.

Best Wishes,
Hello Caroline

I have been discharged since yesterday and now I'm still continuing to recover at home.

Although I will see you again as an in-patient because that's just what the illness is about and I know you probably think it's only your job your doing but, I just wanna say thank you for dropping by on all of the occasions you saw me at my last admittance (I think it was three times).

Most medical professionals are compassionate for the people they deal with, some are not. Again, you may personally think it's only your job your doing so there is no need for me to say thank you but I'm saying thank you because you reminded myself of who I am by saying how well you think I'm doing and what my future plans were. Hearing stuff like that from people in general really uplifts me it really opens my eyes. Seriously Caroline, thank you.

I know you guys don't work in the same department but if you do see her again please say thank you to Ruth too, (the doctor that got you to come and talk to me that day when I felt so rubbish). I also appreciated her help and her words of encouragement, so please if you can please tell her thank you from me.

Tom isn't my psychologist but he did see me a day before I was admitted when he was doing the ward walk around with the Haematology dept which was nice because, after they had gone he had taken time to talk to me, please say thank you from me.
Staff quotes

• “The psychology team are an integral part of the team. I cannot imagine how teams look after patients with sickle cell disease effectively without a psychologist as part of their MDT”. (Dr Howard)

• “Access to psychologist can be extremely helpful for both the clinical team and the patient. This can be via separate or joint consultations. Managing patients’ suffering at the time of diagnosis or struggling to change health behaviours, managing difficult family dynamics and unravelling patient beliefs and customs concerning medication that may impact upon for example compliance” (Prof Harrison)

• “I would view the role as being pivotal in helping some of our patients manage the new diagnosis of a chronic 'blood cancer' and its impact on them, their lives and families which can be life changing. This is an integral part of the holistic care we should be providing all patients and are fortunate enough to have the psychologist as part of out MPN team. They also provide invaluable support to the team - Nursing and medical staff”. (Dr Radia)

(This demonstrates high degree of understanding of psychologist’s role)
Future challenges

• How to remain accessible and responsive with increased demand, fewer resources and more stressed out staff .....
THANK YOU

Health Psychology

Guy’s and St Thomas’ NHS Foundation Trust
Mind and body healthcare: delivering the vision

@kingshealth
#mindbodycare
The use of simulation in the teaching and improvement in mind and body health care
What is simulation?

Simulation is a form of experiential learning, offering the opportunity to develop technical and non-technical skills in a safe environment.
Mental health simulation

• Use of actors
• Creation of high fidelity environments
• Debrief forming essential part of learning

• Bringing together different health professionals
The benefits of simulation in mind & body training

• Broadening knowledge and skills in physical and mental and health
• Experience working with less familiar client groups
• Experience working in multidisciplinary or shared care situations
• Recognising the person as ‘whole’

• Aligned with the five year forward view for mental health in relation to;
  – Breaking down barriers in care between physical and mental health
  – Supporting people with multiple health conditions
Simulation Workshop at the Mental-Physical Interface: Children and Young People (SWAMPI-CYP)

• This course focuses on the assessment and management of patients with both mental and physical health co-morbidities. The scenarios are set in the general hospital, community and mental health setting.

• The following scenario is based around engagement and management of 15 year old with Anorexia.
Perinatal Mental Health

• This course focuses on the care of women with mental health problems, both during pregnancy, and following delivery.

• The following scenario is based on the assessment and management of young woman with post-partum psychosis following emergency c/Section. Staff and family are present.
Police and Ambulance Mental Health Awareness

• The course is for police and paramedics who are keen to improve their knowledge and confidence in how to assess and manage patients presenting in a mental health crisis.

• The following scenario is based on a 75 year old female who has been diagnosed with dementia. The police have been called to her house as she has reported a break in.
PsychED
Mental Health Crisis in the Emergency Department

• This course focuses on the assessment and management of patients experiencing a mental health crisis in the Emergency Department. The course is for a wide range of professionals working in the Emergency Department.

• The scenario is based on a 55 year old gentleman who has paranoid schizophrenia, alcohol problems and a range of physical health problems (type II diabetes, high blood pressure, chronic foot ulcer).
Medically Unexplained Symptoms

- Participants involved in a series of simulated scenarios assessing and managing patients with medically unexplained symptoms.

- The following scenario is based on a 15 year old girl who has non epileptic seizures. The task is to discuss diagnosis with the patient and mother.
Evaluation

• Pre & post quantitative measures, and follow-up (3 months)

• Post-course qualitative feedback

• Follow-up interviews (3-6 months)

• Incident reporting rates
Findings

- Increased confidence, knowledge, attitudes (RIPLS)
- Increased teamwork skills (TeamSTEPPS)
- Increased healthcare skills/human factors (HFSHI by KCL)
  - Maintained at follow-up

- Qualitative themes:
  - Reflective Practice
  - Communication
  - Leadership & Teamwork
  - Confidence/Validation
  - Motivation/Impetus
  - Resilience
  - Interprofessional Collaboration
  - Empathy

- 33% increase in incident reporting
  - Physical health in mental health inpatient settings
Questions?

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Leonie.williams@slam.nhs.uk
Chris.attoe@slam.nhs.uk

www.mausdleysimulation.com

Thank you!
Mind and body healthcare: delivering the vision

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#mindbodycare
Improving Physical Health in South London and Maudsley NHS Foundation Trust

Delivering the vision through adoption of the National Early Warning Score

King's Health Partners

An Academic Health Sciences Centre for London

Pioneering better health for all
Where we were...

- Paper records
- Modified early warning score (MEWS)
- Standard offer for in-patients—
  - Twice daily: days 1 - 3
  - Daily: day 4 - 7
  - Weekly unless otherwise indicated
  - Escalation protocol of informing a senior clinician
What we heard...

“What we heard...”

“Staff zone in on mental stability, not physical stability.”

“I think physical health is as important as mental health...but staff are programmed to get certain information...”

“As long as we walk and breathe... as long as we’re alive, staff think we’re fine.”

“It is very important to have good physical health...it helps you mentally to be healthy in your body, in your heart...”
What we did...

ES2 Ward and Johnson PICU - Adopted National Early Warning Score (NEWS)

Electronic recording of vital sign observations (eObs)

Developed and tested local escalation protocols

Increased standard offer for in-patients

Aim of improving clinical safety and outcomes for psychiatric in-patients
Before implementation
(service user survey)
Benefits

Reaffirms significance of vital signs as an objective clinical measure in presence of mental illness

Validated vital sign parameters and scoring system

Scores-based clinical responses and escalation protocol

Aligned with acute trust partners and emergency ambulance providers

eObs affords ward dashboard view of scores-based medical risk
Outcomes to date

• Results from the pilot wards so far showed significant increase in the observation completion rates

• No identified patient safety issues
  – miscalculation of risk score
  – failure to escalate based on risk scores
  – IT failure
  – No emergency transfers of deteriorating patients

• No reversion to paper since the project began
Next steps

• Continue to monitor patient outcomes

• Using quality improvement methodology roll-out across all trust in-patient wards

• Review service user experience (repeat service user survey)
Mind and body healthcare: delivering the vision

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#mindbodycare
Whole person care: learning disabilities – delivering the vision

Dr Jean O’Hara, SLaM, National Clinical Director for learning disabilities
Dr Emily Handley, SLaM, family carer
What’s so special about people with learning disabilities?

Their physical & mental health care needs are **no different** from those of the general population, BUT…

Unique issues make it more difficult to meet those needs …

- Leading to **inequalities** in healthcare
- **Delays** in diagnosis & access to care pathways
- Avoidable, premature mortality

Be aware of **diagnostic overshadowing**
Treating everyone the same

Reasonable Adjustments
Communication
Insight and understanding
Complex social circumstances & poor experiences
Range of family, friends, care staff and professionals
Mental capacity and decision making
Symptoms masked by unconventional behaviour
High incidence of mental health problems
Multiple co-morbidities

image © Books Beyond Words
www.booksbeyonwords.co.uk Slide courtesy of Irene Tuffrey-Wijne
Accessible e-learning & blended learning opportunities

Maudsley Simulation: intellectual disabilities day
Disease prevalence

Figures show standardised prevalence ratios with national general population figure as reference rates.

NB Logarithmic scale
In PWLD - earlier deaths; more avoidable deaths

- Age at death: from death certificates, 2005-2009 (Glover and Ayub, 2010)

- CIPOLD (2013): 65yr cf 78, 63yr cf 83; 42% ‘premature’; 39% avoidable cf 11% general population
Getting it right charter

See the person, not the disability

All people with a learning disability have an equal right to healthcare.
All healthcare professionals have a duty to make reasonable adjustments to the treatment they provide to people with a learning disability.
All healthcare professionals should provide a high standard of care and treatment and value the lives of people with a learning disability.

By signing this charter, we pledge to:

☑️ make sure that hospital passports are available and used
☑️ make sure that all our staff understand and apply the principles of mental capacity laws
☑️ appoint a learning disability liaison nurse in our hospital(s)
☑️ make sure every eligible person with a learning disability can have an annual health check
☑️ provide ongoing learning disability awareness training for all staff
☑️ listen to, respect and involve families and carers
☑️ provide practical support and information to families and carers
☑️ provide information that is accessible for people with a learning disability
☑️ display the Getting it right principles for everyone to see.

For guidance on implementing this pledge, please visit www.mencap.org.uk/gettingitright
Richard’s story: unmanaged constipation in people with learning disabilities

10 October 2016

Emily Handley is a senior clinical psychologist in the mental health and learning disabilities service at South London and Maudsley NHS Foundation Trust. She describes how a joined up focus on the mental and physical health needs of her brother Richard could have prevented his tragic death from unmanaged constipation. This piece first appeared as the foreword to the Public Health England report ‘Making reasonable adjustments for people with learning disabilities in the management of constipation’ in August 2016.

My brother Richard had Down’s syndrome, psychosis and a mischievous sense of humour. He loved theme parks, theatre classes, watching ‘Mr Bean’ and tickling people’s toes! Richard also had constipation from birth. There’s nothing glamorous about ‘poo’ but my parents understood Richard’s needs and did their best to make toileting fun! Laughter could be heard from the bathroom every night, as my parents helped Richard to relax and encouraged bowel movements.
Mind and body healthcare: delivering the vision

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#mindbodycare
CFS / Persistent Physical Symptoms Care Team
KHP Conference: Mind and Body healthcare: delivering the vision

Muj Husain, Consultant Liaison Psychatrist
March 2017
Medically Unexplained Symptoms

• Physical symptoms with no known pathological cause
• Also known as functional disorders or somatisation
• Including specific conditions:
  • Chronic Fatigue Syndrome
  • Fibromyalgia
  • Non-cardiac chest pain
  • Irritable bowel syndrome
  • Chronic pelvic pain
  • Chronic back pain
  • Hyperventilation or Dysfunctional breathing
  • Irritable Bladder Syndrome

• Trans-diagnostic approach
• Persistent Physical Symptoms
MUS – 5 key facts

1. Unexplained symptoms are common
   • 20-40% of presentations in primary care
   • Can be up to 50% in secondary care clinics

2. The symptoms are real and the distress is real

3. There is no greater risk of missing underlying organic pathology
   • MUS is a stable diagnosis
   • Misdiagnosis rates are the same as other neurological disorders 4% at 5 years – Stone, Carson 2015

4. MUS can and does get better + treatment is available

5. Overlap with pre-existing physical health conditions is common
   —eg. Epilepsy and non-epileptic seizures; Asthma and dysfunctional breathing; non-cardiac chest pain after MI
The challenge

• The King’s Fund: Bringing Together Physical and Mental Health Report (2016):

  “The NHS in England is estimated to spend at least £3 billion each year attempting to diagnose and treat medically unexplained symptoms (Bermingham 2010).

  Much of this expenditure currently delivers limited value to patients; at worst, it can be counterproductive or even harmful.”

• Joint Commissioning Panel for Mental Health (2017):

  “MUS accounts for approximately 10% of total NHS expenditure for the working age population in England”
The impact

• PPS patients have a disproportionately high usage of health services including outpatient referrals

• Sufferers consume large amounts of health care and welfare benefits (Dirkzwager and Verhaak 2007)

• Left untreated, the prognosis of these patients is poor (Deary et al., 2006)

• Significant distress and impaired functioning for patients

• Around 50% of sufferers have co-morbid anxiety and depression (Nimnuan et al., 2001)

• High stress levels for clinicians
• High costs to the healthcare system
What works?

- CBT is an effective treatment for health anxiety and MUS (Barsky & Ahern, 2004; Kroenke, 2007)
- Improves medical symptoms and associated symptoms of depression and anxiety (Greeven et al., 2007)
- Medium to large effect sizes for more specific syndromes
  - Non-cardiac chest pain (Chambers et al., 2014; Johnsbu et al., 2011)
  - Chronic fatigue syndrome (CFS) (Quarmby et al., 2007)
  - Neurological symptoms, including non-dissociative seizures (Goldstein et al. 2010)
  - A meta-analysis by Kleinstauber et al. (2011) found similar results across studies (including 10 systematic reviews)
The PRINCE Program
PRINCE Programme

• Persistent Physical Symptoms Reduction Intervention: a System Change and Evaluation
• 3 strands, 2 clinical trials
  1. **Primary Care**: Feasibility Study, training GPs to undertake 10 minute CBT with PPS patients
  2. **Secondary Care**: RCT of Specialist CBT vs Treatment as usual
     – Working with neurology, rheumatology, cardiology, gastroenterology, respiratory and pain medicine
  3. **Service development and Health economic evaluation**

• Currently recruiting patients, training at practices and delivering CBT
PRINCE PRIMARY
Trial Design

- Randomised trial comparing integrated GP care with a waiting list control group for adults with PPS.

- Randomising by practice
- Recruiting patients using an MUS screening tool

- Follow-ups at 12, 24, 36 and 48 weeks once baseline measures have been obtained.

- Those on the waiting list will be crossed over to the intervention arm at 24 weeks.
Search Tool

**GP Practice**
- Computerised search of medical records using EMIS Web
- GP practices

**Computerised Eligibility Criteria**
- adults (≥18- ≤65yrs)
- patients who have had 6 or more consultations with the GP in the last year;
- The patient should not have dissociative seizures
drug or alcohol addiction dependence

**Persistent Physical Terms**
- A wide spread search of a number of persistent physical symptoms
- PPS terms must be present at least 2 times within the 6 consultations in the last year
The intervention

Integrated GP Care

- Training in 10-minute CBT
- Supervision
- Guidelines for GP’s
- Self-help materials for patients
- Case management discussions

Aims of Intervention

- Setting an Agenda
- Sleep management
- Three Systems Model
  - Cognitive
  - Behavioural
  - Physiological
- Self monitoring of activities not symptoms
Trial Outcomes

Psychosocial Functioning
- Work and Social Adjustment Scale
  Mundt et al 2002

Physical Symptoms & Psychological Distress
- PHQ-9 & PHQ-15
  Kroenke et al 2001, 2002

Objective Measure of Health Service Use
- ICD-10 codes

Cost Effectiveness (Service)
- Client Service Receipt Inventory: Beecham & Knapp 2001; & EQ-5D; EuroQol Group 2008

Mediators of treatment outcome
- Cognitive Behavioural Responses Questionnaire
  Moss-Morris & Chalder 2003

Global outcome and Satisfaction
- Clinical Global Impression
  Guy 1976
PRINCE SECONDARY
Aims

To evaluate the clinical and cost effectiveness of a

Cognitive-Behaviour Therapy (CBT) (+SMC) vs Standard Medical Care (SMC)

for adults with Persistent Physical Symptoms (PPS)

2-arm Randomised Controlled Trial
Sample:
450 participants required with PPS to be randomised

Recruitment via:
• Consultants/clinical staff in Secondary care clinics
• GPs from Primary care Practices

October 2014-2017
Participants and Outcomes

Patients with Persistent Physical Symptoms (PPS) in Secondary Care

- **NEUROLOGY**: e.g., weakness, abnormal movements (excluding headaches, non-epileptic seizures)
- **CARDIOLOGY**: non-cardiac chest pain
- **RHEUMATOLOGY**: fibromyalgia
- **GASTROENTEROLOGY**: irritable bowel syndrome
- **RESPIRATORY**: Dysfunctional breathing

- Inclusion/Exclusion criteria and Outcome Measures similar to PRINCE Primary
SERVICE DEVELOPMENT
‘Rebranding’ – Persistent Physical Symptoms

- Chronic Fatigue Service, established up in 1993
- Chronic Fatigue Syndrome and Persistent Physical Symptoms (PPS) Care Team
- Terminology preferred by patients
  - Survey of healthy population – preferred term was Persistent Physical Symptoms (PPS) (Marks, Hunter 2014)
  - Survey of CFS patients in specialist clinic in secondary care – preferred term was PPS, then Complex Physical Symptoms (Picariello 2015)
- Avoids labels, unexplained/explained divide which can discourage patients
Who we see and what we offer

• We are an ageless service
  • Adults of any age
  • Adolescents over 11 years old
• Failure to respond to measures in primary care
• More than three months’ illness
• Disability and functional impairment
• Special circumstances (for example: young age, job at risk)

• Out patient CBT or Graded Exercise therapy
• Home based assessment and treatment for severely affected
• Family focused CBT for adolescents (joint working with CAHMS)
PPS pathway for local CCGs- Stepped care

- Primary Care: Positive Explanation of Diagnosis and Guided Self-help
- IAPT: CBT provided by local services
- CFS / PPS Care Team
- PPS pathway for local CCGs- Stepped care
What our patients say...

• From our latest PEDIC report:

  • The team are friendly and always helpful with any issues or questions I have. My sessions are always tailored to my needs and I always find them paramount to my recovery.
  • The team are very caring and friendly, and I feel like I am making personal progress in becoming well again.
  • We have consistently received helpful and constructive support.
  • Positive, understanding and very supportive.
  • ----- is wonderful and has been really helpful and all the staff are friendly.
  • I feel very very fortunate to be treated in this clinic.
What our patients say...

How likely are you to recommend our service or team to friends and family if they needed similar care or treatment?

- Extremely likely
- Likely
- Neither likely nor unlikely
- Unlikely

Are staff kind and caring?

- Yes, definitely
- Yes, to some extent
- Neither kind nor caring
When to refer to specialist services

• Not responding to first line treatment (ie. IAPT)
• Complex picture
• Multiple persistent physical symptoms
• Co-morbid depression, anxiety or other mental health issues
• Risk of self-harm
• Employment / Education at risk
• Housebound / mobility difficulties
• Frequent attendance at GP, A&E or multiple referrals / specialists involved

• Chronic Fatigue and Persistent Physical Symptoms Service, Mapother House, Denmark Hill, London, SE5 8AZ
• Mujtaba.husain@slam.nhs.uk
Mind and body healthcare: delivering the vision

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#mindbodycare
Improving Liaison Psychiatry Services

Dr Alice Ashby
Consultant Liaison Psychiatrist, University Hospital Lewisham
Associate Clinical Director, Liaison Psychiatry, SLaM
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Expanding services
Current expansion in liaison psychiatry

“By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.”

£249m new funding over 4 years from 2017/18 to expand liaison mental health in acute general hospitals
Key Statements

• When I experience a mental health crisis in an emergency department or on a general hospital ward, I receive a timely and compassionate response from trained and competent professionals in liaison mental health.

My physical and mental health needs should not be seen as separate from each other and I receive effective care for both in a general hospital setting.

If I am an older adult I will receive specialist support from a team skilled in working with older people. I am treated with kindness, compassion and dignity and in accordance with my legal rights.

When I visit hospital experiencing a mental health crisis and I require help and support, this is treated with as much urgency and respect as a physical health emergency and I am able to get a response no matter what time of the day it is, or which day of the week.
Key Statements

• Within one hour of a liaison mental health service being contacted, I have received a response and know that help is on its way.

Depending on my situation:
• I have had a full assessment of my physical, psychological and social needs, and an urgent and emergency care plan is in place, and
• I am on my way to another service or location, if needed, or I have been accepted for follow-up care by another service

When I am on a general hospital ward and require an urgent response from a liaison mental health service, I receive a full assessment within 24 hours.

EBTP STANDARD
Within 4 hours of arriving at an emergency department or being referred from a ward, any person experiencing a mental health crisis should have received the appropriate response or outcome to meet their needs and have an evidence-based care package (informed by NICE) in place.

OR
• I have started assessment under the Mental Health Act.
• If I feel better within four hours, I can go home.
Figure 1: Summary of the pathway for an emergency response from liaison mental health services

1. **EBTP 4 hour clock starts**
   - Person arrives in ED
2. **Referral to liaison mental health service**
   - ED triage staff
   - Referral received by the liaison mental health team
   - Contact liaison mental health service
3. **Step 1**
   - Liaison mental health service conducts a full biopsychosocial assessment
   - Liaison mental health service responds to referral. Initial risk assessment performed and a decision taken on the next steps and who needs to be involved
4. **Step 2**
   - Liaison mental health service conducts a full biopsychosocial assessment or if required a Mental Health Act assessment
   - If the person leaves the ED
   - If the person is discharged if the crisis has resolved
5. **EBTP clock stops**
6. **EBTP standard**
   - Commencement of Mental Health Act assessment, safeguarding alert or social care assessment and UEMH care plan is in place; follow-up care is scheduled
   - Within 4 hours: receive a full biopsychosocial assessment or Mental Health Act assessment if appropriate, and have an UEMH care plan in place and be en route to the next location (if geographically different) or follow-up care accepted and scheduled, advice or signposting provided
Figure 2: Summary of the pathway for an urgent response from liaison mental health services

- **EBTP 24 hour clock starts**
- **Referral to liaison mental health service**
- **Step 1**
  - Liaison mental health service conducts a full biopsychosocial assessment or when the person’s mental health deteriorates or requires an emergency response consider use of a Mental Health Act assessment.
- **Step 2**
  - Liaison mental health service conducts a full biopsychosocial assessment or when the person’s mental health deteriorates or requires an emergency response consider use of a Mental Health Act assessment.
- **EBTP clock stops**
- **EBTP standard**

- **Person on a general hospital ward**
- **General hospital ward staff**
- **Contact liaison mental health service**
- **Referral received by the liaison mental health team**

**Within 24 hours:**
- receive a full biopsychosocial assessment or Mental Health Act assessment if appropriate, and
- have an UEMH care plan in place and be en route to the next location (if geographically different) or
- follow-up care accepted and scheduled, advice or signposting provided.
Mind and body healthcare: delivering the vision

@kingshealth
#mindbodycare
Healthlocker

@MaudsleyNHS   @MollieCourtenay   @Mindwave_
myhealthlocker - lessons learnt

Healthlocker must address everyone’s needs (service users, clinicians, carers and researchers)

The sign up process must be easy

User experience should be personalised and simple

Allow a user to connect to their care network
Opportunities & aims

Shift balance from service users ‘receiving care’ towards supported self management

Improve communication between service users, clinicians and carers

Meet national directives around the digital transformation of care

Be a pioneer in the development of PHR

Enable users to access information, advice and support

Create opportunities to engage with and contribute to existing clinical record

Invite users to connect and share information with each other

Allow access to data for academic researchers

Build in an open source, modular way that allows for future integrations
Our approach & work to date

Using agile development processes

User-led design approach

Iterate through build, test and learn cycles

700+ hours spent with users

181 service users

50 carers

442 clinicians

40 researchers
Key user needs

**Service Users**
- To be inspired & motivated to stay well
- To learn more about themselves and their mental health
- To be supported to keep moving forward
- To feel like they are not alone

**Carers**
- To contribute information to a service user’s care team
- To feel like they are not alone
- To learn more about mental health

**Clinicians**
- To make informed decisions
- To have rich information fed into their existing processes
- To bring efficiencies to their day-to-day work

**Researchers**
- To drive forward research in mental health
- To align research with front-line delivery of care
- To access a greater repository of data and participants
Where we are now

Development sprint 4 of 8.

**Beta test:**
13th March for 3/4 weeks
*(Development will continue during Beta)*

**Beta testers:**
6 Clinical teams and service users
myhealthlocker 1 users
Others

**Activities:**
1:1 usability testing sessions
Use then discuss (1 week)

**Launch date:**
15th May 2017
Development priorities

- Priority 1 (sprint 1&2)
  Inspire and motivate people to stay well

- Priority 2 (sprint 3&4)
  Enable SLaM service users to access parts of and contribute to their health record

- Priority 3 (sprint 5)
  Ensure carers can be heard

- Priority 4 (sprint 6 & 7)
  Provide opportunities for people to learn about themselves and get feedback

- Priority 5 (sprint 7)
  Enable users to build a support network

- Priority 6 (sprint 8)
  Enable researchers to engage people with their studies

- Priority 7
  Supporting people to develop a routine
Priority 1: Inspire and motivate people to stay well

Access information and advice (tips, stories and what to do in a crisis)
Find out about Healthlocker and why to sign up
Priority 2: Enable SLaM service users to access parts of and contribute to their health record

Sign up, log in and consent choices (e.g., usage and C4C)
View Care Plan and interact with goals and coping strategies
Create new goals and coping strategies and share updates with SLaM clinicians
Display the contact details of the care team

Enable clinicians to access Healthlocker directly from ePJS
For clinicians to recommend tips and information to service users
Priority 3: Improve communication between service users, clinicians and carers

Enable a close family member, friend or carer to write and share notes with the care team
For clinicians to acknowledge / reply the note
For users to be aware when their note has been read
For users to access and share evidence based information about medication, treatment and diagnosis
Priority 4: Provide opportunities for people to learn about themselves and get feedback

Add data to track mood, sleep, activity etc
Review and share data entries over time

Clinicians to access service users’ real-time tracking data
Give researchers the ability to access tracking and usage data of consenting users
Priority 5: Enable users to build a support network

Build a circle of people and organisations that provide support
Nominate a contact as someone to call in a crisis
Priority 6: Enable researchers to engage people with their studies

Researchers to create study advertisements and promote them to users
To alert researchers when users have stated their interest
Service user to be prompted to consider joining the (C4C) register

Priority 7: Supporting people to develop a routine

Enable users to create a personalised weekly plan and schedule SMS reminders
Enable clinicians to suggest ideas or reminders to a service user’s schedule
Roadmap: Features and integrations on the development roadmap

BETA TEST - 13th March
Usability testing
Optimisation and tweaking
Development of priorities 3,4,5
Communications and roll out planning
Update T&Cs and PIA
Develop the service model

LAUNCH - 15th May
Engage and onboard users

ePJS API
Patient recorded outcome measures (PROMS) and surveys
Appointments from ePJS
Push into the KHP local care record
Request access to part of ePJS record
Access to letters / documents from ePJS

Integration with other services (e.g. eOBS, IAPT, EMIS, RiO)
Wearable devices
AI engine
Promote communication with PALS
Visual timeline or journey of care
Questions:
mollie@mindwaveventures.com
Table discussions

1. Thinking about what you’ve heard today, what could you do differently in your job?

2. What support or further information would be helpful?

3. How else could we make mind and body care a reality?

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