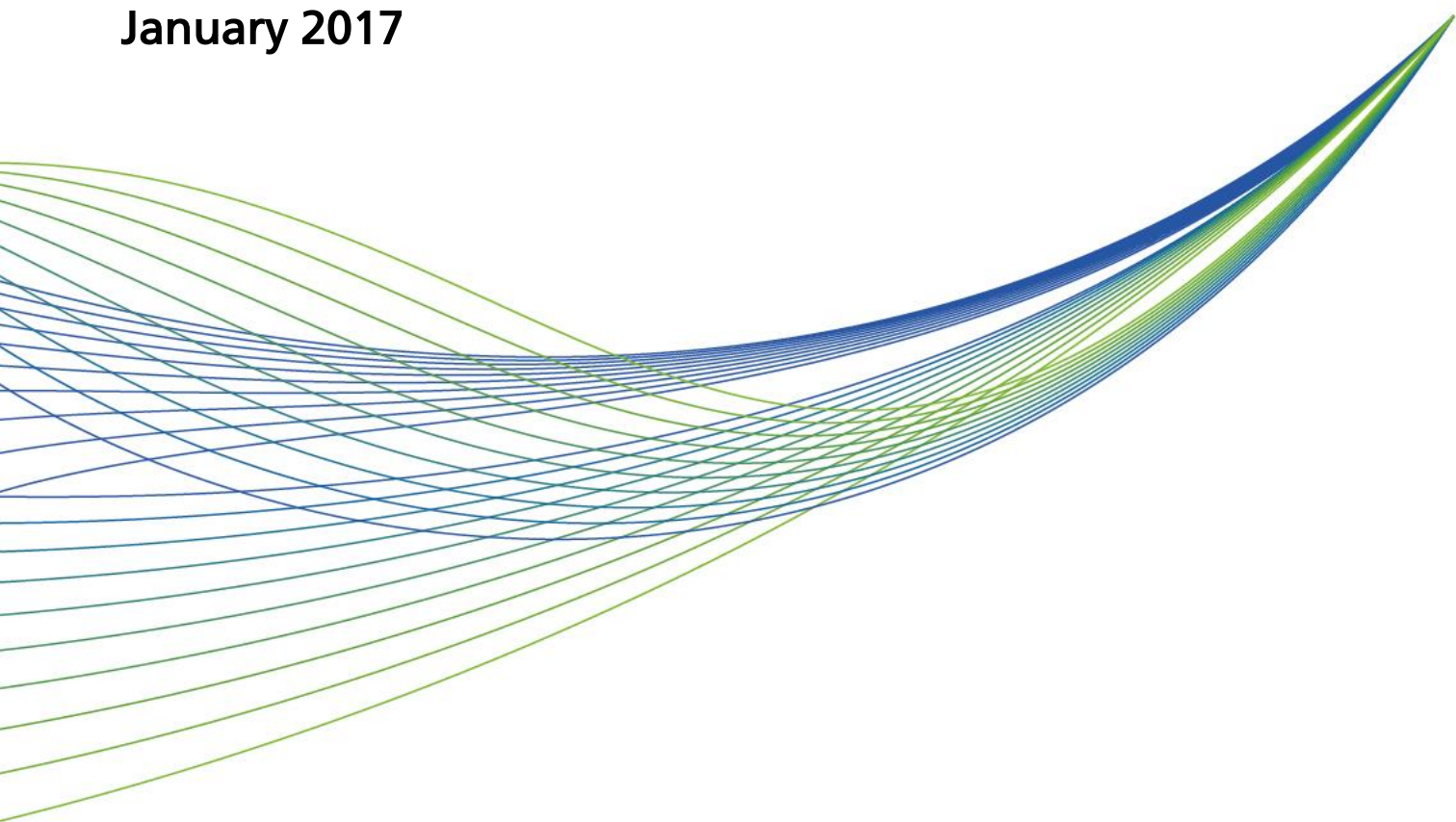


# Cumbria's new persistent physical symptom management service – improving value for patients, the population and the NHS

**NHS Rightcare Casebook Series**

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## Executive summary

The new persistent physical symptom management service (PPSS) introduced by Cumbria CCG in April 2016, offers GPs a single point of access to a biopsychosocial symptoms management service, whatever the patients' diagnosis. Early evaluation shows it is improving access; has high patient and GP satisfaction; and there is positive improvement on core measures for Improving Access to Psychological Therapies (IAPT) depression and quality of life outcomes. Early financial indicators, whilst not the key driver, look to show measurable cost savings.

**Is there opportunity for your CCG to do the same?**

## What Cumbria did and why

The NHS RightCare [Commissioning for Value](#) 'Where to Look' pack highlighted musculoskeletal (MSK) services as one of Cumbria CCG's key opportunities for improvement, with the pain service as a key component.

Addressing significant issues in the local acute-dominated pain management service was one of a number of MSK work streams.

Other local comparator data showed that the pain management service provided by anaesthetists working within an acute provider and by other private providers:

- was expensive
- had an over medicalised-model of care that did not meet NICE guidance
- had very limited integration with physiotherapy and primary care services
- had a high intervention rate, with all interventions recorded as medical procedures, some of which were seen to offer limited clinical value
- had no access to psychological models of care
- accepted referrals directly from GPs with no appropriate local triage

The NHS RightCare Commissioning for Value 'Where to Look' pack highlighted musculoskeletal (MSK) services as one of Cumbria CCG's key opportunities for improvement, with the pain service as a key component.

It was an opportunity for all participants to come together and organise a planned approach to a new model of care.

In recognition of these factors, combined with a capacity crisis in the local acute service due to consultant retirements, it was agreed between the CCG and local providers that a radically different solution was needed – one that could provide improved access, quality of outcomes, and at a lower cost. It was an opportunity for all participants to come together and organise a planned approach to a new model of care and introduce a new NICE-compliant pathway.

## Cumbria findings

Cumbria CCG had a high spend for back pain injections and lower spend for radicular pain injections compared to their most similar ten CCGs.

## Where they looked and what they changed

The NHS RightCare Commissioning for Value MSK focus pack for Cumbria CCG, showed that the CCG had a high spend for back pain injections and lower spend for radicular pain injections compared to their most similar ten CCGs ([back pain pathway on a page, page 12](#)). The focus pack also highlighted that Cumbria had higher admissions/day cases for both, compared to the best five of their similar ten CCGs (pages 49 & 50).

A review of back pain services in the North East and Cumbria<sup>1</sup>, along with a recent analysis of activity relating to pain and spinal specialities, showed that better performing CCGs had all introduced new NICE compliant pathways.

As a result, early work focussed on back pain but it was soon clear that a new service model could equally be applied to patients who had other pain, chronic fatigue, medically unexplained symptoms and functional neurological conditions. This decision was supported by the fact that the [NHS RightCare Neurological focus pack](#) showed that Cumbria CCG also had considerably higher spend (£1.8m) for

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<sup>1</sup> This review of the back pain services across the North East and Cumbria was undertaken by the *North East Quality Observatory Service* (NEQOS) to support the North East Regional Back Pain Pathway Programme led by Professor Charles Greenough (National Clinical Director for Spinal Disorders). Reports available to download from [http://www.neqos.nhs.uk/article\\_page/back-pain/](http://www.neqos.nhs.uk/article_page/back-pain/)

chronic pain admissions compared to the average of the best five of the ten most similar CCGs (page 13).

The evidence base for care for all conditions pointed to a biopsychosocial model of care that comprises a range of intervention options, including cognitive behaviour therapy (CBT); acceptance and commitment therapy (ACT); and appropriate physiotherapy or re-enablement. This is particularly suitable for patients for whom musculoskeletal (MSK) physio has not been effective due to the combination of psychological and physical difficulties.

The direction of travel was entirely consistent with NICE guidance which emphasises a combined physical and psychological programme of care in preference to acute intervention and invasive treatment. The original NICE Guidance from 2009 was updated and reissued in November 2016 under the reference NG59 'Low Back Pain and Sciatica in over 16s: Assessment and Management'. This latest guidance<sup>2</sup> places particular emphasis on the type of treatment offered by the new service.

The new service is in line with the [North of England back pain and radicular pain pathway](#) and addresses the issues raised in the King's Fund publication, [10 priorities for integrating physical and mental health](#) - Priority 3: Improving management of medically unexplained symptoms in primary care (King's Fund, March 2016).

The CCG estimated that there were also potential cost savings to be made from reducing the costs associated with spinal injections associated with back pain, (especially facet joint injections) from the current Cumbria average of £2,010 per 1000 population to the average of the 13 CCGs across the North and East (£1,310), and then further to the rate of the nine CCGs whose providers operate within NICE Guidelines (£982). These estimated savings are shown in table one below.

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<sup>2</sup> <https://www.nice.org.uk/guidance/NG59/chapter/Recommendations#invasive-treatments-for-low-back-pain-and-sciatica>

## NICE guidance

The direction of travel was entirely consistent with NICE guidance which emphasises a combined physical and psychological programme of care in preference to acute intervention and invasive treatment.

## The case for a combined pathway

Traditionally someone with three diagnoses goes to three different pathways. However, clinical evidence shows that the treatment pathway is the same. In rural populations that causes significant challenges - patients may be waiting a long time for a condition specific 'group' to meet their particular problems – but with generic groups, there are economies of scale, demonstrating quality and efficiency.

**Table 1: Potential savings based on benchmarked data**

Source – North of England Commissioning Support Unit

	Average cost /1000 pop'n	Potential Saving £000
Cumbria	£2,010	£0
North of England Average (exc Cumbria)	£1,310	£350k
Average top 9 CCGs with new pathways in place	£982	£514k
	Average cost /1000 pop'n	Potential Saving £000

In addition to the reductions in acute activity, the investment was also expected to address high levels of acute drug prescribing (Nabilone £90k per annum)) and the volume of patients being sent out of county for treatment (£60k per annum). Addressing this latter issue was important, both from a financial perspective, but also very much from a patient experience perspective with many patients having to make a round trip of up to 200 miles or more for their appointments in Newcastle.

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## How they changed

The CCG brought all the players together to design an optimal care pathway and the outcome was the persistent pain service.

The service encompasses chronic/persistent pain, chronic fatigue symptoms (CFS) and medically unexplained symptoms (MUS). It is designed around a biopsychosocial model for both physical interventions (such as pacing and graded exercise advice) and psychological interventions such as CBT and 1:1 psychology.

With the exception of 'red flag' referrals (for urgent, more complex cases), the standard referral is to a community-based service based on a matched care model of delivery. Following assessment, patients are rapidly seen by the most appropriate part of the service to meet their needs, rather

than having to go through numerous steps in the process to get to the most appropriate care.

Key aspects of the new service include:

- a single point of access, via email, whatever the patient's condition and possible diagnosis
- triage by senior clinicians
- a multi-disciplinary face to face) assessment with physiotherapist and senior psychological expert (psychologist, psychological practitioner or CBT therapist), including a review of a self-assessment questionnaire that the patient brings to the first appointment (this has a 96% uptake by patients).
- patients are matched to the right level of therapy e.g.
- one to one psychology; CBT therapy, physiotherapy or occupational therapy; or guided self-help with rehabilitation assistant; or patients are offered a group intervention based on CBT, ACT and mindfulness
- an eight-week programme for groups with a physiotherapist and senior psychological practitioner (this involves six to seven groups on the go at any one time across North Cumbria).

If at the first assessment, there are cases where this model of care is not delivering results, there are options for onward referral into secondary care. However, the default access into secondary care is via onward referral from the community service rather than directly from GPs.

## What has changed as a result?

To date the following outcomes have been identified:

**Improved patient care** - in line with NICE guidance.

Outcome data for the first six to seven groups shows high patient satisfaction and significant improvement on

- core outcome measures that are also used for evaluating the Improving Access to Psychological Therapy (IAPT) programme to measure depression (PHQ9) and quality of life (EQ-5D).

**Outcome data for the first six to seven groups shows high patient satisfaction.**



- **Improved access** – reduced waiting times for appointments and more local access to treatment. Initially the target was for a four week turnaround from referral to first appointment. However, the success of the service, plus a number of highly complex patients, have pushed waiting times to around 12 weeks. The capacity of the service is being reviewed in the light of this and additional appointment capacity is likely to be provided to ensure that the service continues to meet its access targets.
- **GP satisfaction with the service**– Although there have been no formal surveys of GPs in relation to the service, the repeated comments in meetings, GP Forums, and in direct feedback to the service is extremely positive with many GPs being relieved that a significant gap in service provision has been addressed by the new pathway. Many GPs have been unconvinced by the health benefits of acute-led injection therapies, but, until the new pathway was introduced, had little alternative available to them.
- **Increased capacity in primary care** – Evidence from areas that have adopted similar new pathways show a reduction in the number of repeat attendances at GP surgeries for patients with persistent and/or medically unexplained symptoms. Although the CCG does not yet have any quantified evidence of how many GP consultations have been avoided, the consistent message is that the new service has been able to pick up patients who have been frequent repeat attendees in primary (and secondary) care. The CCG is working with GPs to address patients with repeat attendance due to persistent and unresolved symptoms, and this will be monitored during 2017 using data extracted from GP clinical systems.
- **Shift in referrals from secondary care** – the service is starting to show a significant shift in referrals from secondary care, and it is assumed that the updated NICE guidance (NG59) issued in November 2016 will result in a further shift to the new service. Because of the duration

The consistent message is that the new service has been able to pick up patients who have been frequent repeat attendees in primary (and secondary) care.

The service is starting to show a significant shift in referrals and it is assumed that the NICE guidance to be issued in Autumn 2016 will result in a greater shift to the new service.

of each course of treatment, the CCG does not yet have firm outcomes data; however, early indications are that patients who have been seen in the new service are not reverting to seeking secondary care. This will be fully tested once the service has been running for a longer period when the enduring sustainability of the improvement seen by patients can be tested. The service is now receiving around 100 referrals per month that would otherwise have been sent to secondary care.

- **Supporting patients** - patients often have 'misguided' beliefs about persistent symptoms acquired over a long period of time which can be constructively challenged in the right care setting. Training has been provided for GPs and other staff with 140-150 allied health professionals having received a CBT skills course, plus around 350 primary care staff have attended one day CBT introductory level days. In addition, training videos for GPs have been developed and leaflets for both GPs and patients made available to practices. The CCG is willing to share these to other interested health professionals
- **Reduction in drug prescribing** – before the start of the service the main north Cumbria provider was spending around £90k per year on the Payment by Results-excluded high cost pain related drug, Nabilone. As part of the new pathway, the regime for prescribing this drug was reviewed and, since the inception of the service, the use of this drug has been eliminated with no substitution.

**Since the introduction of the new pathway, spending on the high cost pain related drug, Nabilone has been eliminated with no substitution – a saving of around £90k a year.**

## Challenges and lessons learnt

Cumbria CCG faced a number of challenges and learnt lessons that may be useful for other CCGs, including:

- the new service was put in place using existing partners so it was about amending contracts rather than introducing new ones – migration between providers rather than full procurement. This shortened the resulting implementation timescales.

- they achieved buy in from providers as they were involved in co-production and also delivery of the service
- as the outcome was known and clear from the outset, they could migrate to where they wanted to be and it was easier to mobilise the new service
- the biggest driver was the GP community who were desperate to have a service they could refer into
- there has been some limited resistance – but the CCG fell back on the question about ‘how could this not be the right thing to do as the service is evidence-based, community-based, and aligned to NICE guidelines and best practice?’ This meant that if they did get into a conversation where the service was challenged, they could fall back on the clinical evidence and the compelling case for change.

**The biggest driver was the GP community who were desperate to have a service they could refer into.**

Some of their challenges included:

**Frustrations of not having a county-wide service** – the original plan was for the service to be county-wide but it wasn't deemed a priority for other CCGs in the local 'Better Care Together' programme. Now the success is evident, the model is being introduced county-wide.

**Service for under 18s** – there is ongoing discussion regarding making the service accessible for secondary school aged children with chronic fatigue.

**Digital solutions** – there were a number of technical issues with integration to GP systems. There have also been IT challenges in implementing the [Painsense](#) health app, which allows patients to measure pain and activity and feeds the data into GP EMIS to allow clinicians to monitor patients. This is now scheduled for introduction in 2017.

**Changing established practice** – it has sometimes been a challenge to change the culture from silo to collaborative working. The new service has been set up based around the principles of partnership working with staff from acute services integrating into the new community service to

provide elements of the new service. The initial service design and mobilisation was managed by a health system-wide delivery group, supported by the CCG. One of the over-riding principles of this group was to first consider the form of the service, and only then consider the organisational boundaries. This has stimulated a 'mature' approach to cross-organisation working, supported by service agreements for a number of the operational staff.

**Information Governance** – was more complex than anticipated so any CCG setting up a similar service should involve their Information Governance Lead at an early stage and leave enough time to get the issues resolved early in the project set up.

**Demonstrating viability** - coding was quite varied for a number of conditions so it was not an exact science. However, the CCG was able to identify high cost drugs and individual funding requests out of the county. The business case was on 'entrepreneurial risk' on the basis that the evidence seemed to say there would be a small saving and more possibly. This has been borne out in the positive financial impact since the service commenced with the savings that were anticipated in the reduced volumes of acute referrals, reduced numbers of joint injections, reduced out of county referrals, and reduced cost of drugs all being achieved.

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## Conclusion

The implementation of the service, has been a financial and clinical success.

The challenges in terms of sourcing comprehensive data across the whole spectrum of services has presented challenges of consistency and quality. The new integrated service is collecting a range of agreed high quality data, encompassing baseline, post treatment and follow up information including:

- activity levels

- health care utilisation, GP appointments, accident and emergency attendance, secondary care, drug use
- quality of life
- psychological well-being, including health beliefs.
- Proposed performance indicators being developed for the service include:
  - reductions in referrals to acute based pain management clinics
  - intervention rates for secondary care surgery and injections
  - cost savings delivering new pathway costs
  - reduction in the distress/emotional impact of chronic pain and enhanced coping
  - increase in patients' self-reported levels of functional gain
  - reduction of demand on health care resources
  - reductions in referrals to acute based pain management clinics
  - reduction in GP consultations needed for persistent symptoms reduction in drug prescribing.

Following the early favourable performance results seen during the first few months of operation, 2017 will be the year in which the sustainability of the of the improvements is measured and tested.

Thank you to colleagues in Cumbria CCG for sharing their experience.

For more information and support about how NHS RightCare can help get best value for your population, go to [www.england.nhs/rightcare](http://www.england.nhs/rightcare) or email [rightcare@nhs.net](mailto:rightcare@nhs.net)