Berkshire Healthcare NHS
NHS Foundation Trust

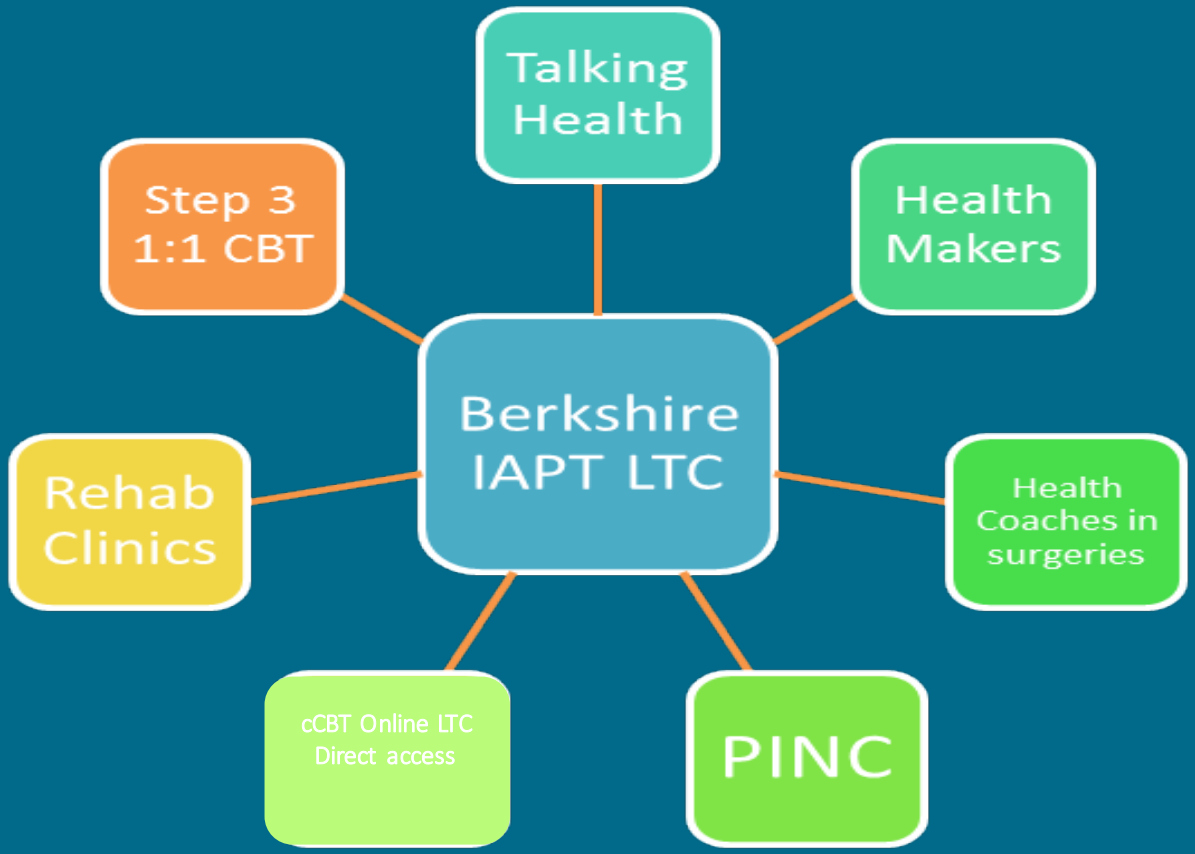
Psychology Interventions and Community Nursing (PINC) Project : Accessing the hard to reach

Healthcare from the heart of your community

www.berkshirehealthcare.nhs.uk

Berkshire East IAPT-LTC

(wave 1 early implementer pilot site)



IAPT-LTC

- **Talking Health** – 1:1 GSH taking LTC into account, F2F, telephone or online support
- **HealthMakers** – LTC Self-management courses
- **Health Coaches** – CBT and GSH integrated in local GP surgeries as part of the primary care team
- **PINC** – support for housebound clients
- **Online cCBT LTC Direct access** – Online CCBT
- **Rehab Clinics** – Educational sessions and support
- **Step 3 1:1 CBT** – CBT taking LTC into account, F2F, telephone or online support

Initial Pilot WAM 2015/6

A joint project between psychology and community/district nurses targetting those with long term conditions who are housebound, have high usage of health services, psychological problems and not accessing IAPT or CMHT.

The Kings Fund have highlighted the overlap between mental health and well-being, and long term conditions. They estimate costs of managing people with long term conditions and underlying co-morbid mental health conditions as between £8bn and £13bn in England each year.

Naylor et al
(King Fund, 2012)

NICE CG91 Guidance

STEP 3: Persistent subthreshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression	**Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions**
STEP 2: Persistent subthreshold depressive symptoms; mild to moderate depression	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions

This Kings Fund paper suggests that by working in a more collaborative way, primary care professionals can be supported by specialist mental health workers to support people with LT conditions in a more holistic and cost effective way.

•Naylor et al
(King Fund, 2012)

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Project Plan

A number of reports have emphasised the importance of linking physical and mental health care with suggestions that benefits would be improved recovery /rehabilitation, and reduced re-admissions and use of health care. This short pilot project would aim to do this by:

1. Use high intensity therapist/psychology assistant to review and use psychological approaches with 4-6 patients each placing a high demand for input on community/district services.

2. Provide anxiety/depression management workshop for community/district staff, and 3 monthly reflective practice consultations concerning work with patients.

3. Develop a clear pathway between community/district services, IAPT, and psychology services in the CMHTe

Clinical outcome measures

Anxiety – GAD7
Depression – PHQ9
General Health – GHQ and CORE
Self Efficacy – GSE
Cost/Benefit Analysis – GP contact/Community Nurse contact/ Hospital admission

Sara Fantham – Head of Community Nursing
East Berkshire

“PINC is helping provide more holistic care for patients “

Small investment , great savings

Mary's story

- Multiple falls & fractures
- Osteoporosis
- Housebound for 3 years

https://vimeo.com/166348519/615e3dd8b6

Clinical Outcomes: Significant reductions in Depression & Anxiety.

Name	Commenced pilot	Date Discharged	Onward referrals	No of sessions complete	Pre GHQ	Post GHQ	3 month follow up	Pre CORE	Post CORE	3 month follow up	Pre PHQ-9 *	Post PHQ-9 *	3 month follow up	Pre GAD-7 *	Post GAD-7 *	3 month follow up	Pre GSE	Post GSE	3 month follow up
Patient 1	29/01/2016	18/03/2016		8	2	1					12	5		10	1				
Patient 2	22/01/2016	18/03/2016		9	10	8		24	22										
Patient 3	15/04/2016	22/06/2016	OPMH	8	10			15	18		16	18		14	9		21		
Patient 4	08/02/2016	21/03/2016	Befriending	5				18	18		4	13		3	6		23	13	
Patient 5	25/01/2016	21/03/2016		7	9	0	0	13	2	0	16	0	0	17	1	1	34	35	37
Patient 6	25/01/2016	21/03/2016	Befriending	7				25	21		15	12		1	11		14	15	
Patient 7	01/02/2016	24/03/2016		8	1	0	0	8	2	1	8	1	1	11	1	0	33	30	
Patient 8	01/02/2016	24/03/2016		8				12	5	4	13	5	5	4	3	1	30	38	
Patient 9	12/02/2016	18/03/2016		6							7	6	8	6	0	0			
Patient 10	08/02/2016	21/03/2016	day centre	6				4	4		2	1		1	1		32	32	
Patient 11	25/04/2016	13/06/2016		4	5	3		12	5		15	3		18	5		36	35	
Patient 12	20/05/2016	24/06/2016	CPE	4	10			21			25	6		14	9		25		

*p <.05

The big impact of small interventions

- Suffered with constipation since child hood
- Long history of nausea, vomiting & vertigo
- Surgery considered

- Dorothy's story: https://vimeo.com/166349431/f47882b69d

Small idea, big £££ savings

Identifier	Health Economy Savings						
	Pre GP emerg. contact (no)	Post GP emerg. contact (no)	Pre CM contact (min)	Post CM contact (min)	Unsch hosp adm pre (no)	Unsch hosp adm post (no)	Cost savings approx (£)
Patient 1			190	170	5	0	11,286
Patient 2	15	8	125	35	1	0	3,447.50
Patient 3	11	2	135	205	0	0	490
Patient 4	2	2	200	5	0	0	323.25
Patient 5	1	7	65	160	3	2	161
Patient 6	3	1	155	15	1	0	2,641
Patient 7	13	0	600	150	3	0	6,045
Patient 8	NK	NK	65	35	0	1	-300
Patient 9	5	2	65	65	1	0	1,632
Patient 10	5	2	75	120	0	0	105
Patient 11	3	3	180	400	3	0	1,124
Patient 12	0	0	65	35	0	0	40.25

£8K Project costs = £27K savings

East Berkshire Project 2017

- **Extended from WAM to the whole of East Berkshire alongside IAPT (Improved access to Psychological Therapies) to offer a home visit based service for patients with long term health conditions to complement their office , telephone based service and planned GP Surgery based services. PINC will give access over the next year to 120 patients who cannot access IAPT due to being housebound, having multiple health conditions, or having mobility or communication difficulties. This patient initiative will give access to a service for those most in need who currently use community and physical health services and who otherwise would not have access to such joined up care. Staff are embedded in the community teams, use IAPT outcome measures, and liaise closely with community.mental health and IAPT services. Staff are receiving training as one of the UKs early implementer sites alongside IAPT staff.**

February-August Referrals

- **A total of 101 referrals. The average age of patients referred is 76 (range 21-97), with 38 males and 63 females.**

Referrals and assessments.

	WAM & Bracknell	Slough	TOTAL
No. of referrals	**65**	**36**	**101**
No. of Patients Assessed	**35**	**29**	**64**
No. of Patients not assessed & discharged	**16**	**3**	**19**
No. of patients declined assessment	7	0	7
No. of patients died before assessment	3	1	4
No. of patients not appropriate for PINC	6	2	8
No. of patients assessed but had no treatment	**13**	**10**	**23**
No. of patients declined treatment after assessment	9	8	17
No. of patients signposted elsewhere	0	1	1
No. of patients stepped up to CMHT	2	0	2
No. of patients died after assessment	1	0	1
No. of patients assessed and referred back to referrer	1	1	2
No. of patients entered treatment but dropped out/did not engag	**6**	**1**	**7**
No of patients completed treatment & discharged	**7**	**6**	**13**
No. of patients on caseload	9	12	21
No. of patients on waiting list awaiting assessment & treatment	**14**	**4**	**18**

Reliable improvement and recovery rates.

Depression PHQ9 WAM/Bracknell 22% Slough 60% Improvement

WAM/Bracknell 11% Slough 20% Recovery

Anxiety GAD7 WAM/Bracknell 33% Slough 60% Improvement/recovery

For those who complete interventions biggest impact is on anxiety levels

Video example

Case Example

- **Individual example, male aged 45 referred with diabetes causing blindness, depression, suicidal thoughts, isolation and alcohol misuse.**
- **Initial scores on IAPT measures PHQ 9 of 19 indicating depression of moderate severity GAD7 of 15 indicating severe anxiety, and WSAS of 18 indicating significant functional impairment.**
- **End of treatment scores:- PHQ 9 score of 6 indicating minimal depressive symptoms, GAD7 score of 0 indicating no anxiety and WSAS score of 10 which is on the borderline of the normal population score.**
- **The scores would fit in with the patient's account of less fear of leaving his home, and consequently increased trips out with family and friends, more interests, and less drinking. This patient has developed a particular interest in mindfulness.**

PINC so far....

- **If the correct patients are identified eg those with long term conditions and co-morbid anxiety and depression who require a home visit based service PINC can make a real difference to these patients lives and functioning, significantly reduce depression and anxiety and reduce the need for use of services.**
- **Engagement can be a problem with some patients, seeing them at home and if necessary being introduced by a nurse can help with this, even with this for some patients it remains a problem.**
- **Some referrals are unsuitable for PINC either needing to be stepped down (because they don't have any symptoms) to activity/clubs available in the community or up to CMHT as they have complex mental health problems beyond the remit of PINC (eg PTSD). A leaflet is being produced to outline to referrers and patients PINCs remit.**
- **Sustainability of improvement may be an issue for some patients who may need further input from IAPT or Healthmakers post PINC.**

PINC so far…

- **Community Nurses referrals, don't like filling in forms, task orientated don't always consider psychological component, talk to matron.**
- **High cancellation rate due to ill health**
- **Sessional IAPTUS measures off putting esp if have communication issues.**
- **PINC can be part of a complex system of care.**
- **If you would like to know more about PINC contact :- chris.allen@berkshire.nhs.uk**