Collaborative Care

1 Introduction

The Department of Health (DH) Improved Access to Psychological Therapies (IAPT)\(^1\) team is committed to implementing NICE guidelines for adults with depression and chronic physical health problems\(^2\). Collaborative care provides the stimulus to offer holistic and evidence based care to people with chronic physical health problems and depression. This document seeks to provide an interpretation of collaborative care in accordance with the NICE guidelines, a summary of the background research and proposals on how the commissioning of collaborative care may be implemented.

2 What is the National Institute of Clinical Excellence (NICE) model of Collaborative Care?

NICE guidelines were published in October 2009\(^3\) for the management of depression in people with chronic physical health problems. One of the recommendations for treatment was a type of intervention called collaborative care.

Like previous guidelines for depression a “stepped care” approach was recommended (see fig 1), with the collaborative care approach at step 3. The guidance recommends collaborative care for those people with moderate/severe depression and a chronic physical health problem, who have received a high intensity intervention such as medication and/or cognitive behaviour therapy (CBT) and not recovered.

The NICE guidelines (CG91 para. 1.5.4) describe the essential characteristics of collaborative care as:

- close collaboration between primary and secondary physical health services and specialist mental health services
- case management which is supervised and has support from a senior mental health professional
- a range of interventions consistent with those recommended in this guideline, including patient education, psychological and pharmacological interventions, and medication management
- long term coordination of care and follow up.

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\(^{1}\) www.iapt.nhs.uk
\(^{2}\) http://www.nice.org.uk/media/918/B4/2009060DepressionChronicPhysicalHealthProblems.pdf
\(^{3}\) NICE Guideline CG91 www.nice.org.uk
The statements made above are an almost complete verbatim reproduction of the guideline itself and as such provide limited information on an intervention that is not explicitly implemented in the UK. The vast majority of the research on which the NICE guideline is based is derived from the USA, (see section 4 below).

![Figure 1: NICE stepped care approach for depression management](image)

3 Policy context

On 24 May 2010, the new coalition government health policy, ‘The coalition: our plans for government’[^iv], was set out with the key health priorities including:

- reform NICE and move to a system of value-based pricing,
- improved access for patients to the drugs and treatments their doctors think they need as recommended by NICE
- personalised care planning, putting patients in charge of making decisions about their care, including control of their health records.
- helping elderly people live at home for longer through solutions such as home adaptations and community support programmes
- marketisation of the NHS,
- giving patients more choice of health provider,
- cutting administration costs
- strengthening the power of GPs as patients’ expert guides through the health system by enabling them to commission care on their behalf.

• tackling health inequalities through PCTs responsibility to public health and renegotiating the GP contract to support delivery to patients in disadvantaged area
• reconfiguration of community services and community mental health teams in line with local priorities

A white paper will be produced by the government at the end of June 2010.

To support these goals a number of work-streams have been identified and linked to collaborative care guidance, these are set out in appendix 1.

3.1 National Institute for Health and Clinical Excellence (NICE)

NICE guidelines are aimed at improving the interventions for the patients in this client group. Commissioning guides produced should be co-ordinated with NICE. NICE have stated that they will not be producing commissioning guidance for collaborative care in 2010/11. They have already produced guides for CBT and as the DH IAPT programme provides support in other ways, it was not considered a high priority.

3.2 DH Primary Care

The DH Primary Care team have indicated that they will be seeking to deliver a guide for commissioners on ‘Supporting People with Long Term Conditions’ and would wish to work collaboratively with this project to minimise risk of duplication and maximise resources.

A “Commissioning for Mental Health & Wellbeing” guide and an IAPT guide are also being developed and reference to the collaborative care approach should feature as part of these document.

4 Literature review of collaborative care – some early pilots and models

Depression refers to a range of common mental health disorders. It is characterised by a loss of interest and enjoyment in ordinary things and experiences, low mood and a range of associated emotional, cognitive, physical and behavioural symptoms. It is most often accompanied by anxiety. Though it has been thought of as a time-limited disorder lasting on average 4-6 months with complete recovery afterwards, it is now clear that incomplete recovery and relapse are common and some 10% of sufferers have persistent or chronic depression\(^1\). Diagnosis of depression is further complicated by the similarity between symptoms with some physical diseases. For example, chronic obstructive pulmonary disease (COPD) is often associated with tiredness, poor appetite, sleeplessness and lack of energy – all common signs of depression\(^2\).

There are well-documented associations between depression and LTC such as diabetes, Coronary Heart Disease (CHD) and Chronic Obstructive Pulmonary Disease (COPD)\(^1\)(\(^3\))(\(^4\)). These associations are complex and multi-factorial with some evidence of bi-directionality, particularly in the case of diabetes and CHD\(^5\)(\(^6\))(\(^7\)).
Regardless of association or causality it is evident that:

- there is a greater prevalence of depression in patients with long-term chronic health conditions than in the general population, with often between 15-25% of people with chronic disease meeting diagnostic criteria for depression. In the case of COPD, patients can be up to four times more likely to suffer depression than the general population. \(^{(1)(2)(3)(6)(9)(10)}\)

- co-morbidity of depression and LTC adversely affects health risk behaviours and compliance with disease management regimens leading to an increase in the costs of long-term medical care and poorer overall health outcomes. \(^{(2)(9)(11)(12)(13)}\)

- people tend not to have isolated psychosocial risk factors but rather a cluster of behaviours and circumstances which may be causal in or exacerbate both their mental and physical health problems. \(^{(5)}\)

There have been positive developments in services for patients with mental health problems, such as the introduction of IAPT, with subsequent improvement in outcomes. However, there remains a sizeable cohort of patients who do not improve after CBT. IAPT also does not cover all PCTs and the elderly appear to have lower rates of referral into IAPT and other mental health services. For those in these categories who also have a LTC the impact on their overall health outcomes are likely to be significant.

<table>
<thead>
<tr>
<th>Common effects of co-morbidity with depression and / or anxiety disorders</th>
<th>Diabetes</th>
<th>CHD</th>
<th>COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorer adherence to diabetes self care, including diet, medications and blood sugar monitoring</td>
<td>More likely to die within 4 months of a myocardial infarction</td>
<td>3 fold increase in risk of cardiac mortality over 5 years</td>
<td>Poor adherence to treatment plans and more excessive use of as needed medications</td>
</tr>
<tr>
<td>Increased health service utilisation due to poorer disease control</td>
<td>More likely to continue with riskier health behaviours such as smoking, lack of exercise, poor diet.</td>
<td></td>
<td>Negative impact on quality of life with greater disability and impaired functional states.</td>
</tr>
<tr>
<td>Increased perceived symptom load</td>
<td>More lost work days and slower to get back to work</td>
<td></td>
<td>Increased A&amp;E attendance and emergency admissions.</td>
</tr>
<tr>
<td>Increased mortality</td>
<td></td>
<td></td>
<td>Lack of engagement in rehabilitation programmes worsening physical capability</td>
</tr>
</tbody>
</table>

Information in this table is taken from the sources referenced in the preceding bullets.

Co-morbidity of depression and LTCs is therefore costly in terms of patient quality of life and outcomes, but also in direct financial costs to health services. \(^{(4)(11)(13)(14)}\)
Given the multifaceted nature of this co-morbidity, both physiologically and psychosocially, it is likely that a significant number of people will require complex interventions, such as collaborative care, to deliver improvements in both their mental and physical health.

The majority of reported work on collaborative care for depression comes from the United States of America (USA). The most cited examples of which are the IMPACT, Minnesota Diamond and Pathways projects. Each of these studies has reported improved depression outcomes. Only the Pathways project specifically targeted people with a co-morbid chronic physical illness and the results support collaborative care as an effective approach to managing such groups of patients.

Whilst the studies centred on the care of differing patient cohorts there was a commonality in approach. Each study employed case managers with the support of consultant psychiatrists and general practitioners. The case managers were generally nurses with some additional training in case management and psychological inventions. The case managers were responsible for working with individual patients to direct, monitor and adjust intervention and to deliver some of the lower level psychological input. In each study there was a combination of telephone and face-to-face contact varying in frequency.

4.1 IMPACT (1993-2002) - USA

The IMPACT model has been one of the largest treatment trials for depression in the USA. It was run over 20 sites and concentrated on depression in people over the age of 60 years. It is of particular interest when discussing collaborative care for people with depression and co-morbid long term conditions as the prevalence of the latter in this age group is known to be significantly higher than in the general population.

The following table outlines the IMPACT care model.

<table>
<thead>
<tr>
<th>Two processes</th>
<th>Two team members</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Care Manager</td>
</tr>
<tr>
<td>Systematic diagnosis and outcomes</td>
<td>Patient education and self management support</td>
</tr>
<tr>
<td>tracking</td>
<td>Follow-up</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Stepped care</td>
<td>Support of treatment with medications</td>
</tr>
<tr>
<td></td>
<td>Brief counselling (CBT etc)</td>
</tr>
<tr>
<td></td>
<td>Facilitation of treatment change and further referral</td>
</tr>
<tr>
<td></td>
<td>Relapse prevention</td>
</tr>
</tbody>
</table>

Results from this study demonstrated that at 12 months, about half of the patients receiving IMPACT care reported at least a 50 percent reduction in depressive symptoms, compared with only 19 percent of those in usual care. Analysis of data from the survey
conducted one year after IMPACT resources were no longer available, shows that the benefits of the IMPACT intervention persist one year after the intervention has been completed. IMPACT patients experienced more than 100 additional depression-free days over a two-year period than those treated in usual care.

When healthcare costs were examined over a four-year period, IMPACT patients had lower average costs for all their medical care – about $3,300 less – than patients receiving usual care, even when the cost of IMPACT care was included. This suggests that an initial investment in better depression care not only improves health but can actually reduce total health care costs over 4 years. \(^{16}\)

4.2 Minnesota - Diamond Project – USA \(^{17}\)

This project recruited patients from 95 primary care clinics and implemented treatment using evidence based depression guidelines from the Institute of Clinical Systems Improvement.

As with the IMPACT project, care managers were appointed to manager caseloads of patients in primary care clinics. These care managers had a background as certified medical assistants or in nursing, social work or psychology. Each care manager had a caseload of between 100 and 200 clients and had access to approximately 2 hours per week of supervision from a psychiatrist. There was also liaison between the care manager, the psychiatrist and the primary care provider.

Screening assessment and monitoring of depression was done using the PHQ9, which was repeated every time the care manager had contact with the client. Scores were entered into a registry to provide a critical means for the team to monitor the progress and/or alter treatment.

A two-year review of the project demonstrated significantly improved depression outcomes in primary care. Approximately 4,000 people were enrolled in the project during the first 2 years with the average time to depression remission at around 6-7 months. After 6 months 45% of patients were in remission with a further 15% having reduced PHQ9 scores by 50%. At this time there does not appear to be any reported data specifically on outcomes for patients with co-morbid depression and long-term physical health problems. \(^{v}\)

4.3 The Pathways Study – 2001 USA \(^{18}(19)\)

This randomized controlled trial, included 329 participants each with diabetes and co-morbid major depression or dysthmia. The participants were recruited from nine primary care clinics within the same large health maintenance organisation.

The care programme was case-management based with participants receiving an initial choice of two evidence-based treatments with twice monthly 30-minute review sessions (appointment or telephone). The case-management was carried out by registered nurses who had undergone some additional training in collaborative care, stepped care principles, pharmacology and problem –solving treatments. The case managers were

\(^{v}\) [www.icsi.org/health_care_redesign_/diamond](www.icsi.org/health_care_redesign_/diamond)
supported a consultant psychiatrist and a GP. Twice monthly case reviews were undertaken.

The study concluded that depression care and outcomes were improved in this group of patients but this did not lead specifically to improvement in glycaemic control. This latter finding appears contrary to other evidence that depression has a significant association with non-adherence to treatment in patients with diabetes. (17)

4.4 SMaRT oncology 1 - UK (20) (21)

SMaRT oncology 1 was a randomised trial in a regional cancer centre in Scotland aimed at assessing the efficacy and cost of a nurse-delivered complex intervention that was designed to treat major depressive disorder in patients who have cancer. The study introduced a system of care that combined systematic screening with a complex intervention, and integrated management of depression into a patient’s cancer care. This complex intervention was based on the collaborative care model in primary care as trialled in the IMPACT study. However, in this case trained cancer nurses, supervised by psychiatrists, delivered it at the specialist cancer centre. The rationale for using cancer nurses rather than mental health nurses was to maximise acceptability to patients and integration with their existing medical care.

200 patients who had cancer and a prognosis of greater than 6 months co-morbid with a major depressive disorder were recruited to the study and the primary outcome measure was the difference in depressive symptoms.

The outcomes of the trial demonstrated that the intervention improved the symptoms of depression more than did the usual care alone and persisted to 12 months – supporting the clinical significance of this improvement in the primary outcome. It was also found that there were improvements in levels of anxiety and fatigue but not in pain or physical functioning.

The care model proved to be feasible and generally acceptable to patients. Further trials aim to investigate the cost effectiveness of the model on a larger scale and the benefit for patients with poorer prognosis cancers.

4.5 Collaborative care for depression in UK primary care: a randomized controlled trial - UK. (22)

This study recruited 114 participants who were then randomized to ‘collaborative care’ or a usual care control (patient randomized control and cluster randomized control groups). The primary outcome was symptoms of depression (PHQ-9).

The collaborative care model was case manager-coordinated, with medication support and brief psychological treatment, plus enhanced specialist and GP communication.

The trial found that there was clinically significant effect of collaborative care equating to a mean difference between treated and usual care patients of 5 points on the PHQ-9. This change in PHQ-9 scores achieved by the intervention patients from baseline to follow-up equates to a clinical shift of almost two categories of depression severity.
This study was limited by its small size and was affected by some contamination issues with the randomized controls. However the experience of this trial has informed the design for the CADET project. CADET, along with the four stranded NIHR (UPBEAT) study are major research projects which will provide further insight into the effectiveness of the collaborative care approach. Discussion of these projects is included in section ***.

5 Epidemiology

5.1 Prevalence of depression

Figures for the prevalence of depression show some wide ranges, with reported data differing from reporting episodes of unipolar depression only to including anxiety / depression and anxiety disorders.

<table>
<thead>
<tr>
<th>Worldwide</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>By 2020 the World Health Organisation (WHO) predicts depression will be the second greatest health burden on developed nations after cardiovascular disease (^{(1)})</td>
<td>Reported QOF prevalence in England for 2009 was 8.1% (^{(23)})</td>
</tr>
<tr>
<td>Worldwide estimates of the proportion of people who are likely to suffer from depression during their lifetime differ between about 4 – 10 % for major depression and 2.5 – 5% for low-grade chronic depressive symptoms. (^{(1)})</td>
<td>Widely used data from the National Psychiatric Morbidity Survey 2000 puts the figures at between 8-12%. (^{(14)})</td>
</tr>
<tr>
<td>The most recent adult psychiatric morbidity survey (APMS) - 2007 - indicates that around 15% of the UK population meet the criteria for a diagnosis of depression though this includes those suffering mixed anxiety and depression disorder. (^{(23)})</td>
<td></td>
</tr>
</tbody>
</table>

Of particular significance is the 15% prevalence from the 2007 Adult Psychiatric Morbidity Survey. Although the collaborative care model is derived from the NICE depression guidelines there is considerable overlap in primary care with anxiety disorders. Therefore any collaborative care model should be based on the cohort representing all diagnoses of depression, anxiety, anxiety / depression and probably panic disorders as these are of common in the population of patients with COPD. \(^{(25)}\)

Prevalence rates from depression and anxiety / depression have been consistently found to be higher in women than in men, more common between the ages of 35 and 54, and affected by divorce / separation, lone parenting, unemployment and lower social class. However, there do not appear to be significant ethnic differences. \(^{(3)}\) \(^{(24)}\)

One of the difficulties with depression is that people can present with a spectrum of symptoms from feeling sad to major depressive disorder. Defining where normal adjustment to adverse life events ends and depressive pathology begins makes case definition problematic. For example the ICD-10 definition and classification of depression often differs from the case definition from primary care. As a result the last 10 years have seen a number of depression inventories introduced in primary care with the intent of making diagnosis easier for the practitioner, along with additional Quality and Outcome
Framework (QOF) indicators to encourage recording of depression screening. There is argument as to whether these screening tools over or under estimate prevalence (26).

Despite this the commonly held view is that depression is probably under diagnosed by GPs and that coding differences in primary care are responsible for some of the differences in reported prevalence. Diagnosis of depression is further complicated by the similarity between symptoms with some physical diseases. For example chronic obstructive pulmonary disease (COPD) is often associated with tiredness, poor appetite, sleeplessness, and lack of energy – all common signs of depression. (2)

5.2 Prevalence of depression with LTC

Again there is a range of reported prevalence for the common LTC with co-morbid depression of between 15-25% overall. Disease specific differences are significant, ranging with estimates ranging from 1-70% and affected by other physiological and social factors (age, gender, social class, unemployment etc.). For example, people with diabetes overall are around twice as likely to have a depression or mixed / anxiety depression than the general population (11)(12), whereas the figure for those with COPD can be as high four times greater prevalence. (2)(4)

A recent ‘Data linkage study’ at St George’s hospital has been the first to amalgamate data from primary care, secondary care and IAPT databases. The following table lists the prevalence of common mental health disorders [VI] with specific LTCs in a population of 121,199 between the ages of 16 – 74 years, of which 12,210 had a common mental health disorder.

<table>
<thead>
<tr>
<th>Long-term chronic health condition</th>
<th>Prevalence with co-morbid CMH disorder (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>6.30</td>
</tr>
<tr>
<td>CHD</td>
<td>5.30</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0.90</td>
</tr>
<tr>
<td>IHD</td>
<td>4.70</td>
</tr>
<tr>
<td>Hypertension</td>
<td>15.60</td>
</tr>
<tr>
<td>COPD</td>
<td>11.80</td>
</tr>
</tbody>
</table>

[VI] Common mental health disorders in this study include depression, mixed anxiety depression, anxiety and panic disorders.
6 Developing a tool for assessing collaborative care caseloads

NICE Guidelines only partially define the nature of collaborative care, although the concept seeks to bring together within a single service ongoing support for the management of the individual’s physical and mental health conditions.

Existing and piloted models for collaborative care services have been previously described. Evidence from the more established programmes would seem to support collaborative care as an early intervention rather than a next step for patients for whom Cognitive Behaviour Therapy has been unsuccessful.

However, the NICE guidelines suggest that collaborative care services are most likely to be located in the Primary Health Care Team and may include innovate ways of enabling patient choice by considering the options for alternative NICE-approved modalities for the treatment of the individuals’ depression where first-line CBT treatment has not been successful.

The current IAPT services are based on the following assumptions:

- 6 million people identified for IAPT services
- After watchful waiting / improvement 900,000 (15%) require therapy
- Of these people 45% will recover and 45% improve with referral to other treatments.
- The remaining 10% do not improve with CBT.
- Remaining caseload for persistent problems = 900

However, as previously mentioned, IAPT does not cover all PCT and certain patient groups are less likely to be referred. The above calculations are therefore considered a conservative estimate of need.

Given the complex relationships between depression and LTC, the differences in reported prevalence of each and their co-morbidity, any tool for assessing likely caseload also requires a certain level of assumption to be made and should be considered indicative of rather than expressing need. More work is required to improve the robustness of these assumptions and ensure that need is not being underestimated.

The number of people entering IAPT services with a co-morbid diagnosis of depression and a long-term condition is difficult to define in the absence of case related data from the various IAPT teams. However, the recent data, as per the previous table, from St George’s helps to provide a clearer picture and the prevalence figures generated by this study are used in the calculation tool linked to this document (see figure 2). The resulting caseloads will therefore include patients with depression as well as those with anxiety and mixed anxiety depression. Whilst this is not the cohort originally included in the NICE guidelines it is felt that the health benefits will outweigh the costs and also reduce the risk of individuals falling through the net.

The tool is designed to enable commissioners to estimate the number of individuals who are likely to require collaborative care, at either practice or locality level. The tool can be adapted with local prevalence data should this be available and could also be adjusted
to provide estimates of caseload in subsections of a population, for example different age groups

It must be remembered that patients may be on more than one LTC register. For example in a mathematical modelling exercise for CVD and diabetes it was found that, in the patient group studied, almost all those with diabetes also had CVD\(^{(27)}\). Adding up patient numbers on a broad set of chronic disease registers will count many patients more than once and thus inflate predictive caseload figures.

### Assumptions:

1. Based on data from St Georges Study - the proportion of the population (16 years and over) with long term conditions are:

<table>
<thead>
<tr>
<th>Condition</th>
<th>with a LTC and without a CMH problem</th>
<th>with a LTC and CMH problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>5.60%</td>
<td>6.30%</td>
</tr>
<tr>
<td>CKD</td>
<td>4.60%</td>
<td>5.30%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>0.80%</td>
<td>0.90%</td>
</tr>
<tr>
<td>IHD</td>
<td>3.70%</td>
<td>4.70%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>14.30%</td>
<td>15.60%</td>
</tr>
<tr>
<td>COPD</td>
<td>11.00%</td>
<td>11.80%</td>
</tr>
</tbody>
</table>

   All LTCs 26.60% 35.00% all the differences are significant at the p=0.001 level apart from heart failure

2. However this does not allow for double counting - those who have more than one long term condition
3. Does not reflect increased morbidity for over 65s (and low referral rates to IAPT)
4. We have assumed that 80% of a practice population are above the age of 16 years.
5. All those eligible are referred to IAPT (max workload) although this assumption may need to be revisited
6. That 50% of those referred will not recover, and therefore be eligible for collaborative care

### Table: Calculation tool for predicting collaborative care caseloads

<table>
<thead>
<tr>
<th>Assumption</th>
<th>Population</th>
<th>Number of people over 16</th>
<th>Number of people with a LTC and without a common mental health problem</th>
<th>Number of people with a LTC and a CMH problem</th>
<th>Number of people referred to IAPT</th>
<th>Number of people who recovered</th>
<th>Number of people likely to be referred for Collaborative Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>default</td>
<td>100000</td>
<td>80000</td>
<td>106000</td>
<td>86000</td>
<td>1,285</td>
<td>535</td>
<td>3,925</td>
</tr>
<tr>
<td>4 above</td>
<td>10000</td>
<td>6300</td>
<td>6,300</td>
<td>1,575</td>
<td>4,725</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 above</td>
<td>5000</td>
<td>5300</td>
<td>5,300</td>
<td>1,325</td>
<td>3,975</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 above</td>
<td>1000</td>
<td>900</td>
<td>900</td>
<td>225</td>
<td>675</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 above</td>
<td>1000</td>
<td>11800</td>
<td>11,800</td>
<td>2,950</td>
<td>8,850</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Instructions:

1. Insert the population under consideration into the RED Cell (your population)
2. You may alter the proportion referred to IAPT by entering a figure in the pink cell
3. You may alter the recovery rate by entering a figure in the blue cell

The default values are considered to be an assumption which can be amended by local circumstance

**Figure 2: Calculation tool for predicting collaborative care caseloads**
7 Service models of ‘collaborative care’ systems

Section 4 reviewed published trials data. Where possible discussions were held with individuals leading and engaged in those projects, which has given the opportunity to provide a subjective update. These discussions are summarised in appendix 2 i–viii. PCTs and SHA leads identified other pilots being undertaken or at development stage (eg Wandsworth, City & Hackney, Bury, West Sussex, Mid Essex, Bedfordshire, Hull), those that have been operational are also set out in appendix 2.

i) IMPACT  
ii) SMaRT Oncology 1  
iii) UPBEAT - NIHR  
iv) CADET project  
v) Co-creating health initiative- Wandsworth  
vi) Tavistock and Portman Centre with NHS City and Hackney  

vii) Respiratory Well Being Clinic Pilot, South West London and St George’s NHS Trust- NHS Merton  
viii) Macmillan psychological and psychiatric support services project, Sussex

None of the projects identified by this report to date have been found to follow the precise format of NICE guidelines CG91.

The discussions that were undertaken highlighted some key learning, which included:

• using a care manager ensured the follow up and tracking of the patients in a systematic way maximising the effectiveness of treatments
• using more junior grades protects the professionals’ time and increases their job satisfaction
• undertaking the weekly review between health care professionals needs to be a booked session not an ad hoc event
• the care manager should be introduced at an early stage of the patients care planning process
• it is difficult to identify individuals with the full skills base required by the care manager, additional training and support is needed in long term condition management or mental health training
• identifying appropriate clinical supervision is essential, without supervision, the outcomes were ‘treatment as usual’ – understanding how supervision works and who does it is important but relies on where in the health economy the care manager is employed
• there needs to be a team approach developed including all professionals and full support from secondary care into the process
• mental health and well being should form part of all long term condition personal care plans

8 Identification of need for a commissioning guide /tool with commissioners

James Seward  Director, IAPT Programme, attended the SHA Mental Health leads meeting to raise awareness of the guidelines and the project to develop a
commissioning tool. Several PCTs have indicated that they are waiting for SHA guidance before taking forward any collaborative care model.

Correspondence with DH Primary care leads, Dr David Colin-Tome, Jill Matthews and Charlotte Quince supported the project. DH would support joint working to avoid duplication with their commissioning guides and need to be assured it is agreed by the quality board.

The NHS Confederation commented that they would welcome a commissioning guide, recommending a simple and prescriptive format that:

- gives a formula to estimate the appropriate population,
- sets out how to run a service,
- identifies the workforce,
- identifies potential savings
- identifies how to avoid unintended consequences eg increase demand or duplication
- identifies user and financial outcomes.

Christina McArthur Senior Commissioning Advisor for NICE sought views from their mental health commissioner contacts, the response for a guide was positive including the comments:

1) Could it dare address the politics of making sure IAPT investment does offer some support in this direction!
2) This would seem a good idea. There is considerable co-morbidity especially in older adults.
3) I believe a commissioning guide would be useful - in particular what essential elements should be included in a service specification for providers
4) Yes I think it would be a good idea ,happy to be involved
5) I think a commissioning guide would be very helpful to ensure that LTC commissioners and mental health commissioners develop more collaborative care services.

Alan Cohen has held discussions with James Kingsland, in respect of practice based commissioning support.

In the period available for the scoping there were neither SHA Directors of Commissioning nor Primary Care where it was possible to be included on the agenda.

A ‘round robin’ email was sent to all PCT directors of commissioning, however, the response was minimal. This could be explained by the email address being from a personal computer and/or the issues of concern around future PCT configuration, funding cuts or individuals being unfamiliar with the guidance.

A number of personal contacts were made with PCT commissioners, clinicians and SHA leads which resulted in extremely useful input. Overall, there was minimal in depth knowledge of the NICE guidance. However, there was almost a unanimous agreement that a tool was needed, in the context of QIPP, new models for commissioning mental
health services and the recognition of developing primary care further to address WCC
competencies.

9 Commissioning model

The collaborative care intervention is recommended by NICE to be made available in all
PCTs in England. All PCTs need to consider how, and who, is going to commission the
service. There are issues in respect of whether the drive should come from mental
health commissioners, long term conditions leads, secondary care or clinicians within
clinical clusters. In many areas there is continued working in ‘silos’.

There is unlikely to be a single model for the introduction of collaborative care workers.
PCTs are currently at different stages of organisational reconfiguration. The community
services transformation is incomplete. A number of PCTs work across regional/sub
regional arrangements for commissioning mental health services. The PCTs are in some
cases developing more strategic commissioning hubs, in other locations the emphasis is
on devolving down to clinician level.

Discussions with commissioners have highlighted the recognition of a need for mental
health and LTC commissioners to work together, with their clinical leads to ensure
appropriate services and interventions are delivered at the correct time. Clinical
commissioners, currently through PBC, are well placed to undertake this commissioning
activity, as primary care clinicians understand well the relationship between chronic long
term conditions and psychological disorders such as depression and anxiety. With the
coalition government placing an emphasis on clinician engagement and commissioning
a tool that supports their needs is essential.

It is evident there is not a consensus of agreement with the NICE recommendation to
appoint a collaborative care worker at stage 3. There is a strong belief that the
collaborative care worker should be engaged at an earlier stage of the intervention able
to build up the confidence of the patient at stage 2 and ensure a smoother pathway or
earlier discharge. There is also from the references a question of terminology as there
are models developing with expert patients, health trainers, community matrons, liaison
officers and sign posters.

The following framework outlines the key principles that will need to be addressed to
commission collaborative care services:

9.1 Epidemiology and data:

9.1.1 Population that would benefit from collaborative care

Section 4 of this document has provided some background around the current
prevalence and impact of depression when co-morbid with chronic physical health
problems. It is clear from the literature review that there are variations in prevalence
within populations and these will need to be considered at local level.

An Equality Impact Assessment would need to be undertaken to determine the
additional support required for those groups where individuals are more vulnerable to
depression and development of long term conditions. Specifically the commissioning
should focus on individuals with low income, poor educational attainment, unemployed (especially men), those in ethnic populations with cultural barriers to presenting with mental illness, or living alone especially through divorce, separation and widowhood. There should be a focus on older people specifically both because of their higher morbidity and the lower referral rates within IAPT, leaving them as a highly vulnerable group.

The calculation tool provided will assist commissioner in broadly assessing the likely caseloads for collaborative care services and easily adapted to include more robust and specific local information where this is available.

9.1.2 The outcomes that a commissioner should specify when commissioning a collaborative care service.

The outcomes that could be specified will fall into two categories- for all cases there should be:

- a personalised care plan- with motivational targets
- increased patient satisfaction
- reduced pharmacology
- reduced referrals to secondary care
- reduced A&E attendances and emergency admissions
- reduced referrals to intensive psychological services

For each long term condition there will be more targeted outcomes eg for terminal cancer patients a better experience of death, for diabetics improved glycaemic control through reduced anti-depressant medication, for CVD patients weight loss and reduction in smoking

9.1.3 Information and data collection

Commissioners will need to identify the information requirements to ensure there is minimal duplication of collection of patient data. Agreement should be reached on records being accessible to all the providers within the collaborative pathway, potentially across primary, community secondary and social care networks.

The commissioner will need to identify how the interventions are recorded and billed as this will be impacted upon by Payment by Results (PbR) tariffs for secondary, mental health and community providers, additional payments to GP practices or included as part of existing service contracts.

9.2 Workforce:

From models of care that have been developed using a joint mental health and mental health worker input the basic training, grade and skills of the individuals undertaking a collaborative care approach are diverse. There is a general recognition that the individual should have some mental health and psychological training but equally require an understanding of the management of long term conditions. There is the question of potential redeployment / role expansion of community matrons, LTC nurse specialists, CPNs and practice nurses. All of the following questions will need to be answered:
a. What is the job description for a collaborative care manager?
b. Is their role discreet or part of a wider portfolio?
c. What are the knowledge, skills and competencies of the role?
d. What training curriculum/programme is needed based on the competencies?
e. Which organisation will employ the collaborative care managers and in turn provide supervision?

Figure 3: Type of model envisaged

9.3 Commissioning:

The commissioning business case will need to be linked to competencies, QIPP with CQINs developed. The format will depend upon where the collaborative care manager is positioned within the health economy. If part of the acute, community or mental health trusts these are covered by national contracts, if part of the practice organisation a specific enhanced service framework will be required.
As a principle to any developing any commissioning model there is the need to have a clear identification of the economic impact. Key to achieving commitment to the care principle is where will services require additional financial input and where will the savings be delivered? Concern has been raised that by increasing mental health clinicians, savings will be made from reduced the secondary care admissions, lower prescribing and reduced attendance at the GP surgery making savings to their budgets. But how will these savings be reinvested in collaborative care workers unless there is a unified budget?

There has been evidence of economic benefits in some small pilots (‘Invest £1 and save £5’ see appendix 2vii). Many of the schemes will require investment to make future savings, requiring disinvestment in secondary care services.

10 Conclusions

The rationale for producing a guide to support commissioners has been confirmed from the review that there is:

- minimal information available to commissioners to enable their informed provision of a collaborative care service
- currently little consensus amongst stakeholders on any aspect of collaborative care; the service model is unclear, the skills and education needed have not been defined, the professionals involved, and the interventions to be provided have all to be defined
- little knowledge and understanding in the community of the issues that relate to collaborative care.

The guide provided should be:

- linked to other guidance on self care, long term conditions and mental health services
- concise
- provide clarity on what a good service would look like
- demonstrate number of patients likely to require the services
- anticipated health outcomes
- impact of generating additional demand
- costs/savings including any links to PbR and tariffs
- workforce requirements
- demonstrate the capable teams model

The guide should be web based and embedded into the guidance for ‘Supporting People with Long Term Conditions’ the IAPT Commissioning guide and "Commissioning for Mental Health & Wellbeing", to ensure there is a clear recognition of the health outcome and financial benefits of collaborative care.
Policy supporting the development of collaborative care guidance

World Class Commissioning (WCC)\textsuperscript{viii}

The vision for WCC is for commissioners will need to demonstrate better outcomes; adding life to years and years to life, with three key principles:

Better health and well-being for all
- People live healthier and longer lives.
- Health inequalities are dramatically reduced.

Better care for all
- Services are evidence based, and of the best quality.
- People have choice and control over the services that they use, so they become more personalised.

Better value for all
- Investment decisions are made in an informed and considered way, ensuring that improvements are delivered within available resources.
- PCTs work with others to optimise effective care.

PCTs are required to set out their local vision for world class commissioning, and what they will achieve through commissioning better services and delivering better outcomes based on local priorities.

In 2010 A WCC mental health commissioning tool is due to be established.

Quality, Innovation, Productivity and Prevention (QIPP)

The NHS has instigated a focus on quality, innovation, productivity and prevention (QIPP), which will allow commissioners to drive up quality whilst improving productivity - a challenge which means harnessing and spreading innovation and new ideas. QIPP is key to building upon the commitments set out ‘High Quality Care for All’\textsuperscript{viii}.

Patients going through IAPT that do not go into recovery will potentially clock up more expensive treatments downstream. PCTs need to consider the collaborative care approach, which will aim to keep patients out of secondary care and save money.

Quality and Productivity Calculator (QPC)

Primary Care Commissioning (PCC) have commissioned NHS Benchmarking to produce a tool to identify relative levels of investment in primary and secondary care. It enables PCTs to compare their costs against those of other PCTs and peer comparisons of a

\textsuperscript{vii} \url{http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndguidance/DH_080956}

\textsuperscript{viii} \url{http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_085825}
range of services. Using the tool will enable PCTs to measure potential savings from remodelling and recommissioning services.

QPC illustrates there are significant variations between LTC emergency admissions/lengths of stay. Given this evidence PCTs need to reduce reliance on secondary care and work with primary care clinicians to secure community based services.

11 Commissioning for Quality and Innovation (CQUIN) payment framework

The CQUIN payment framework makes a proportion of providers’ income conditional on quality and innovation. Its aim is to support the vision set out in High Quality Care for All of an NHS where quality is the organising principle. The framework was launched in April 2009 and helps ensure quality is part of the commissioner-provider discussion everywhere. The DH produced guidance on the payment framework in December 2008, and an addendum to this guidance for 2010/11 was published in December 2009. ix

For 2010/11, the DH has also worked with NHS colleagues to develop illustrative examples of CQUIN schemes those for mental health services can be seen via the link. x

Suggestions for inclusion in the commissioning tool for collaborative care may be useful.

DH Primary Care

The DH Primary Care team have indicated that they will be seeking to deliver a guide for commissioners on Supporting People with Long Term Conditions and would wish to work collaboratively with this project to minimise risk of duplication and maximise resources.

Clinical commissioning

Practice based commissioning (PBC) has been operating within PCTs for 5 years. The collaborative care model may be cluster focussed and strengthened by local prioritisation and development.

ix

x
Appendix 2

Summaries of discussions with early adopters of models working with patients with long-term conditions and a mental health diagnosis.

i) IMPACT

The Impact study was run over 20 sites across the US, looking at the elderly with co-morbidity, focusing on the implementation of collaborative care. Primary care services in the US are not transferable to the UK model and there are further difficulties drawing comparisons between the HMOs and PCTs.

Collaborative care in practice in US is not as organised as NICE:

- No centralised definition
- No standardisation
- Model covers depression and anxiety with LTC
- The case workers fee is paid for as part of the doctors fee

There is some evidence for using the implementation for all common mental disorders, with other disorders care manager needs more psychiatrists input consulting and providing support 2-4 hours per week.

Figure 4: Care model - IMPACT
The role of the collaborative care worker is to:

- track the patient through the episode and keep things moving
- keep in contact with patient and expert mental health provider
- track medication compliance and effectiveness
- propose alternative treatments- if required

The skills of the primary care clinician vary- some are better at delegating tasks and identifying roles than others

Background training /roles of the collaborative care manager:

- Medical assistants (HCA equivalent)
- Nurses
- May/may not have previous mental health training

Training

- For practice nurses already skilled in LTC management additional 2-3 days training on depression care with a consultant psychologist
- Brief motivational training
- Use of behavioural activation- eg ‘what will you do between now and next consultation?’ ‘how are you taking your medication?’
- Nurses may provide clinical supervision

Team building

1. Identify who can undertake which tasks
2. Identify the skills gaps
3. Identify the work distribution linked to patient population
4. 10% of patients will not cope in primary care and will need expert psychiatrist care

There has been an extensive expansion of psychological treatments including building the collaborative care model into clinics with/without psychiatrists/psychologists.

Numbers

- Need to identify who is in the denominator- look at those who leave the system or get better
- Depression prevalence identified as 100/5000 in an average list.
- Screening is expensive and will not help the patient improve.- start with those patients already identified in the system

Lessons learnt

- The follow up and tracking of the patients provides a systematic way of ensure treatment effectiveness is maximised.
- Using more junior grades protects the professionals’ time and increases their job satisfaction.
- Undertaking the weekly review needs to be a booked session between the health care professionals not an ad hoc event.

Jurgen Unutzer
Department of Psychiatry & Behavioural Sciences | University of Washington
ii) SMaRT Oncology

History of development

Wayne Katon, Seattle, developed a comprehensive care package to improve the management of patients with major depression (severe/moderate). Early studies showed that neither screening patients nor educating GPs provided any significant improvement. However, collaboration between the GP and ‘expert’, with a case manager taking responsibility for managing the day to day care of patients did impact. (See Impact trial). Treatment is a COMBINATION of antidepressant drugs and psychological treatment with a case manager monitoring progress and coordinating delivering treatment under expert supervision.

The research was also interested in the cost effectiveness of the model. More recently looked at patients with long term condition and major depression identifying obese maturity onset diabetics as a group where health could be improved and savings in medical costs potentially made (reductions in stroke, hip replacements, heart conditions)

UK collaborative care models

Edinburgh based studies have adapted the US model for cancer. A cancer nurse delivers care, with expert liaison psychiatrist and links to patients GP. The collaborative care model has a lot to offer the NHS moving services from the secondary to primary care setting.

Identifying patients who would benefit from collaborative care must be linked to a screening system (clinicians are ‘poor’ at identifying depressed medical patients) but there is no point screening unless there is a system for delivering treatment for depression. A more proactive and systematic approach needs to be undertaken. Secondary care can be an effective platform, as people at this stage are accessing specialist services. Edinburgh trials have used computer touch screens plus telephone interviews to make the diagnosis of major depression.

Regardless of the LTC the management of depression will be similar

Key focus

- Depression should not be seen as normal reaction to medical illness.
- There are major potential health improvements and costs savings from treating early.
- To identify those who need collaborative care not best to wait to see who fails IAPT
- People with major depression and LTC should be able to access collaborative care immediately,
- IAPT could potentially be integrated into collaborative care

Model team

- GP
- Liaison psychiatrist
- Case manager
• Patient
Although the Edinburgh study has used cancer nurses as the case managers but could
be others including IAPT therapists.

Cost effectiveness will come from using skilled input, when required through liaison but
limiting face to face contact that is expensive.

Systematic approach
• Identify patients
• Involve an expert
• Follow a manual
• Monitor progress
• Actively change interventions if they are not working

Michael Sharpe  Professor of Psychological Medicine,
Psychological Medicine Research, University of Edinburgh

iii) UPBEAT - National Institute for Health Research programme to understand
the links between coronary heart disease and depression and develop a
primary care case management intervention.

This is a 5-year programme with a grant for four linked studies engaging people with
CHD and depression. It includes a longitudinal study, two qualitative studies and a
randomised controlled trial.

The 4-year longitudinal study follows 801 patients from Lambeth, Southwark and
Lewisham, Greenwich, Bromley and Wandsworth with CHD. The study was original
started in 2007 but full recruitment was delayed because of ethics approval and other
administrative reasons until December 2009. Patients are being reviewed every 6
months to identify issues.

The pilot is designed to assess case management for patients with symptomatic CHD
and depression. Case management will be used as an intervention, based on the results
of the 2 qualitative studies. Two case managers will work with patients over 6 months,
providing an opportunity to identify appropriate interventions and acting as a liaison
point, with tapered input. The intervention is based on individuals describing in the
qualitative studies their pressures of ‘loss’ from impact of CHD and depression e.g. loss
of role as breadwinner, job, sexuality etc, these are mostly men. The pilot of providing
stepped care was intended to be administered by practice nurses, but these
individuals described in their qualitative study how they do not generally have sufficient
training as the qualitative study showed skills required supporting a whole range of
social needs/modalities/dual role in nursing and psychosocial work is necessary. The
pilot will therefore use its own nurses (one is a nurse and health psychologist, one a
CPN) and future studies will address whether the model could be generalised to existing
practice nurses.

The case management model provides the patient with more personalised care and
continuous input from a case manager, who facilitates and orchestrates the access to a
range of interventions that the patients may needs, e.g. CBT, rather than just one intervention which is generally used in collaborative care.

The collaborative care model has adapted considerably from the Seattle collaborative care model, which relies on the charismatic leader/expert running the collaborative team. In this way it differs from CADET which is testing the ‘generalisability’ of the USA model to the UK.

Andre Tylee

iv) CADET project

The CADET project is a £2.2m multi-centred randomised controlled trial of patients recruited using GP registers in Manchester, London and Bristol. It is due to report in 2011.

The CADET protocol has been based on systematic research and the early work of the Doncaster IAPT site. The protocol has not been tested with co-morbidity of depression and managing physical health problems.

Although the model to be trialled is similarly based to that of the IMPACT trial described above the patient cohort includes people from 18 years onwards with a diagnosis of depression who are not suicidal and who would normally be treated by GPs in primary care. Patients with very severe depression under the care of local psychiatric services are excluded from the trial so that the focus is on trying to find out what impact collaborative care can have on the usual care of patients with depression in primary care.

In developing their protocol for the study the researchers undertook a programme of work to explore the views of stakeholders. From this they were able to identify that whilst a telephone delivered mix of medication support and low intensity psychological intervention was generally felt to be acceptable there were significant issues to be addressed. These included the level of training is for case managers (health trainers are probably insufficiently skilled) and the balance of face-to-face and telephone contacts. Case managers need to understand mental health and LTC and the potential effects of the treatments of each on the other. The resulting protocol takes account of these and other issues raised.

The project’s lead researcher has remarked that the NICE collaborative care model will be quite expensive to commission, and so there is a need to concentrate on those who will benefit most from a shared treatment programme and specialist care. There is an issue regarding epidemiology- 60% of those with depression get lost in the system, using collaborative care raised the continued contact from 40% to 70%.

Collaborative care has been found to be effective where there is co-morbidity

David Richards Professor of Mental Health Services Research, School of Psychology, University of Exeter
v) Co-creating health initiative- Wandsworth

Wandsworth has 4200 patients with depression.

Since August 2007 a self-care management programme has been funded by the Health Foundation. The programme runs parallel to ‘medical care’, supporting patients to feel confident about making requests for help or interventions that will help them achieve their goal. Outcomes are defined by the patient and embedded in the process eg want to return to work; want to spend more time with children. The CCHI model is based on the Wagner chronic disease model recognising that neither expert patient nor enhanced clinician skills are sufficient if used alone.

Clinicians undertake an advanced development programme that develops communication skills and motivational interviewing to enable working with patients:

- agenda setting
- goal setting
- goal follow-up

The patients are self referred via the GP and attend 7 weeks of 3 hour sessions, working through peer support (10-15 per session) and input of experts. The dropout rate is quite high and patient numbers have been difficult to recruit, but those completing the course demonstrate significantly reduced depression scores. In secondary care, there has been a noticeable trend in reduced bed occupancy and bed days where this scheme has been incorporated in care, but there are insufficient numbers to be statistically relevant at this stage.

The project is being evaluated by Coventry University and links to seven other sites developing a similar model with diabetes, COPD and CVD, but not run as co-morbidity models.

Ian Petch – Hannah Nettle

vi) The Tavistock and Portman, NHS Foundation Trust

The Tavistock Centre has been commissioned by City and Hackney PBC (East London I C) since May 2009, to develop a model that supports clinicians in handling ‘medically unexplained symptoms’ patients. GPs have the perception that IAPT creates more workload. They recognised there were medical patients with depression requiring additional input, in particular patients with personality disorder and long term psychotics.

This model offers support to clinicians in the frontline where there is a huge impact on the professionals working in this environment with the potential transference of anxiety and depression. The clinicians did not necessarily require an expert to take over the care of the patients but wanted intervention to prevent a breakdown in the relationship between primary medical care provider and patient. Having a network that functions reduces referrals to secondary care. The network model cannot be too prescriptive as all practices need ‘individualised care’. The ethos is based on the ‘Barlint Group model (Michael Barlint / Alexis Brook) who advocate that most people are affected by work, taking issues seriously/personally.
The Tavistock model does not have the intensive psychiatrist input, but is assessed according to the problem.

![Figure 5: Tavistock and Portman collaborative care model](image)

The impact of patients' burdens and physical problems gets in the way of designing a treatment package. The CC role needs to be an expert in understanding psychological and behavioural problems that get in the way of the pathway. There is a need to understand the impact and intervene to maintain good deliver even when the practice is under pressure.

Training: from the Tavistock work there is a 10 week programme for mental health nurses/ counsellors/ psychologists being taught how to develop an assessment and pick up factors that have 'interfered' with recovery. The course costs £10K to train 20 people plus an additional £1K each for ongoing support and supervision. Organisations have individuals able to develop into the CC role.

vii) South West London and St George’s NHS Trust- NHS Hillingdon Respiratory Well Being Clinic Pilot

Between October 2008 and August 2009 the Integrated Primary Care Commissioning (IPCC) practice based commissioning group worked in partnership with South West London & St George’s Mental Health Trust to trial providing a multidisciplinary intervention for people with Chronic Obstructive Pulmonary Disease (COPD) in primary care. The intervention was aimed at enhancing self-management and reducing mental health problems such as anxiety and depression.

All patients with COPD associated with GP practices in IPCC were invited to attend group-based sessions at Figges Marsh Surgery in Mitcham. Over the 12 month trial period, 47 people (10 groups) completed the multi-modal intervention which included elements of cognitive behavioural therapy, education and exercise.

COPD and Mental health
A recent survey found that approximately 25% of IPCC COPD patients had significant mental health problems such as anxiety and depression. Psychological distress can exacerbate patients’ real and perceived physical symptoms. Anxiety and panic in COPD have been related to more frequent hospital admissions, greater use of medication, increased restrictions on mobility and activity levels, and greater dependence on others, regardless of disease severity. Research suggests that by reducing the psychological distress associated with the physical symptoms, reduced service use can be so extensive that 2-3 times the invested costs are saved. The Respiratory Well Being Clinic was modelled on The Breathlessness Clinic at Hillingdon Hospital, where cost savings of approximately £70 000 were found over a 6 month period, through fewer A&E presentations and admissions. Reductions in pharmacy costs and levels of patients’ anxiety and depression were also achieved.

The Clinic
The Clinical Psychology led service received multidisciplinary support from a Respiratory Nurse, Physiotherapist and Occupational Therapist. The team invited patients to attend the clinic after receiving lists of all diagnosed patients from GP practices. Patients who were high users of services were invited first. The intervention was group-based; additional individual sessions being offered when appropriate. Transport and home visits were also offered, and patients experiencing mental health problems had access to additional treatment from Sutton & Merton Psychological Therapies in Primary Care.

Results
The results of this pilot found significant reductions in depression and anxiety symptoms, improved patient confidence and ability to manage their condition effectively across the whole patient group. Amongst the high cost service user subgroup significant cost savings from reduction of unplanned admissions and A&E attendance were also achieved.

This pilot did not target high cost service users specifically; it was available to all patients with COPD, many of whom had had no unplanned admissions and had not presented at A&E. Extracting the results from the high cost service users suggests that targeting this group over one year could have resulted in cost savings of £292,008, or £5 for every £1 invested.
viii) Macmillan psychological and psychiatric support services project
Sussex cancer Network

Background

The Psychological and Psychiatric Support Services Project was originally conceived in July 2004, shortly after the publication of the NICE guidance on Improving Supportive and Palliative Care for Adults with Cancer, which set out specific recommendations for comprehensive, holistic support in cancer services, including a four level model of professional psychological assessment and intervention. At the same time NICE published guidance on the provision of support and treatment for people suffering from anxiety and depression, recommending a model of stepped care similar to the four level model in the cancer guidance.

In spite of the growing recognition of the importance of the psychological domain in cancer, professional assessment, treatment and support for mental distress remains the exception rather than the rule. According to NICE figures, at any one time there may be up to 12,000 cancer patients in the Sussex Cancer Network (SCN) area who would benefit from appropriate mental health support. In addition to this there are probably several thousand carers who are also suffering from significant mental distress, but who are unable to access appropriate support.

It was clear that a more thorough piece of work was needed to map services and design improvements. Accordingly a business case was made for a two year service development project. Funding for the whole post was secured from Macmillan, along with funds for secretarial and administrative support. An appointment was made and the project officially commenced in August 2007. An initial gap analysis carried out on behalf of the SCN had raised a number of concerns about psychological and psychiatric support services for cancer patients and their carers. Many clinical staff did not know what psychological and psychiatric services existed, which clearly raised concerns about appropriate access to specialist support.

Benefits

From a broad and very general perspective, the Psychological and Psychiatric Support Services Project Manage post acted as

- an expert resource for healthcare professionals, carers and patients for patients diagnosed with cancer who have a pre-existing mental health problem and for those who develop serious mental health (e.g. psychosis)/behavioural problems during the course of their cancer journey
- has contributed to the increase in knowledge and skills in the provision of psychologically informed cancer services. This happens through a gradual and organic process of raising awareness, stimulating creative thinking, discussion and dialogue, and sharing and learning good practice in mental health, which in turn leads to better defined care pathways, improved partnerships with key agencies (especially Sussex Partnership Trust) and, overall, better outcomes for patients and carers.
More specifically, the post achieved the following:

- Comprehensive service provision for cancer patients and carers with mental distress: all referrals and requests for advice/information were given appropriate attention and offered a level of service corresponding to assessed need (and complexity).
- Demonstration of the efficacy and efficiency of embedding mental health support in cancer services rather than operating a discrete, externalised service.
- Demonstration of the advantages of a stepped model of resource utilisation: all referrals received prompt responses; the majority received low intensity interventions, and a small number received high intensity input (complex case management).

From the responses to the staff questionnaire the main benefit of the post has been the ready availability of advice and support for patients and carers with mental distress. This has had the effect of: containing anxiety about difficult and complex situations involving mental health difficulties; advising and informally educating staff about mental health interventions; and giving staff more confidence to operate in this area of practice.
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