NHS
Brighton and Hove
Clinical Commissioning Group

NHS
Sussex Partnership
NHS Foundation Trust

GP Persistent Symptoms service

Brighton and Hove

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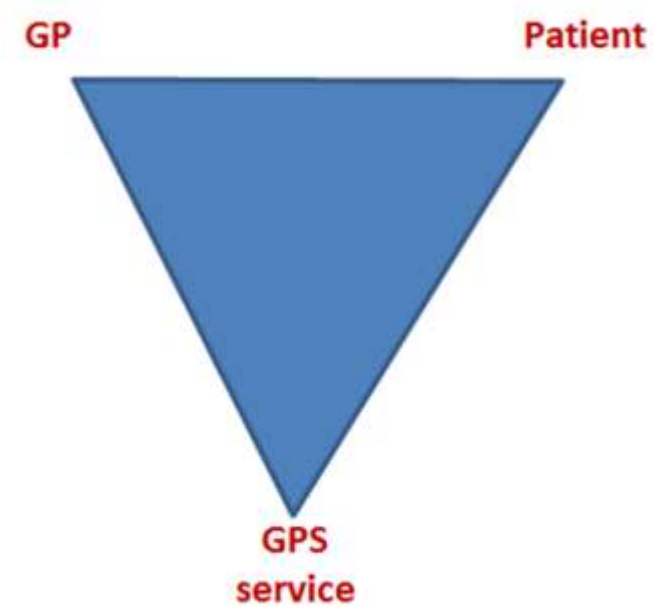
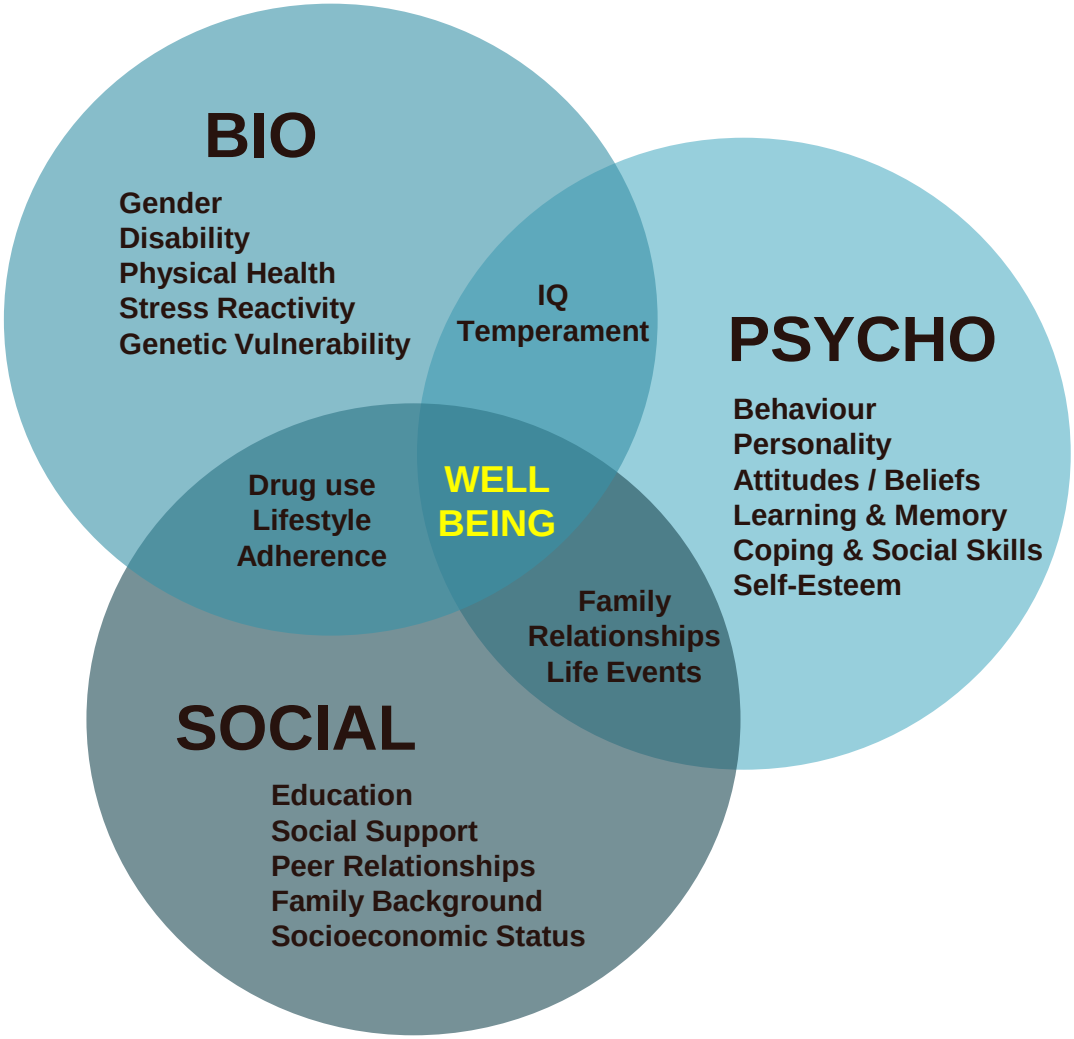
The GP Persistent Symptoms service (GPS)

- Complex MUS
- Gap between primary care and adult mental health.
- Multi-disciplinary team



Bio-psychosocial formulation and working



Integration and a systemic overview

- Next Steps on the Five Year Forward View (2017)
- Bringing together physical and mental health, King's Fund (2016)
- Guidance for Commissioners of Services for people with MUS (2017)

Multi-disciplinary team

- Who we are
- What do we do in the team?
- What do we bring?
- What does that look like in practice?

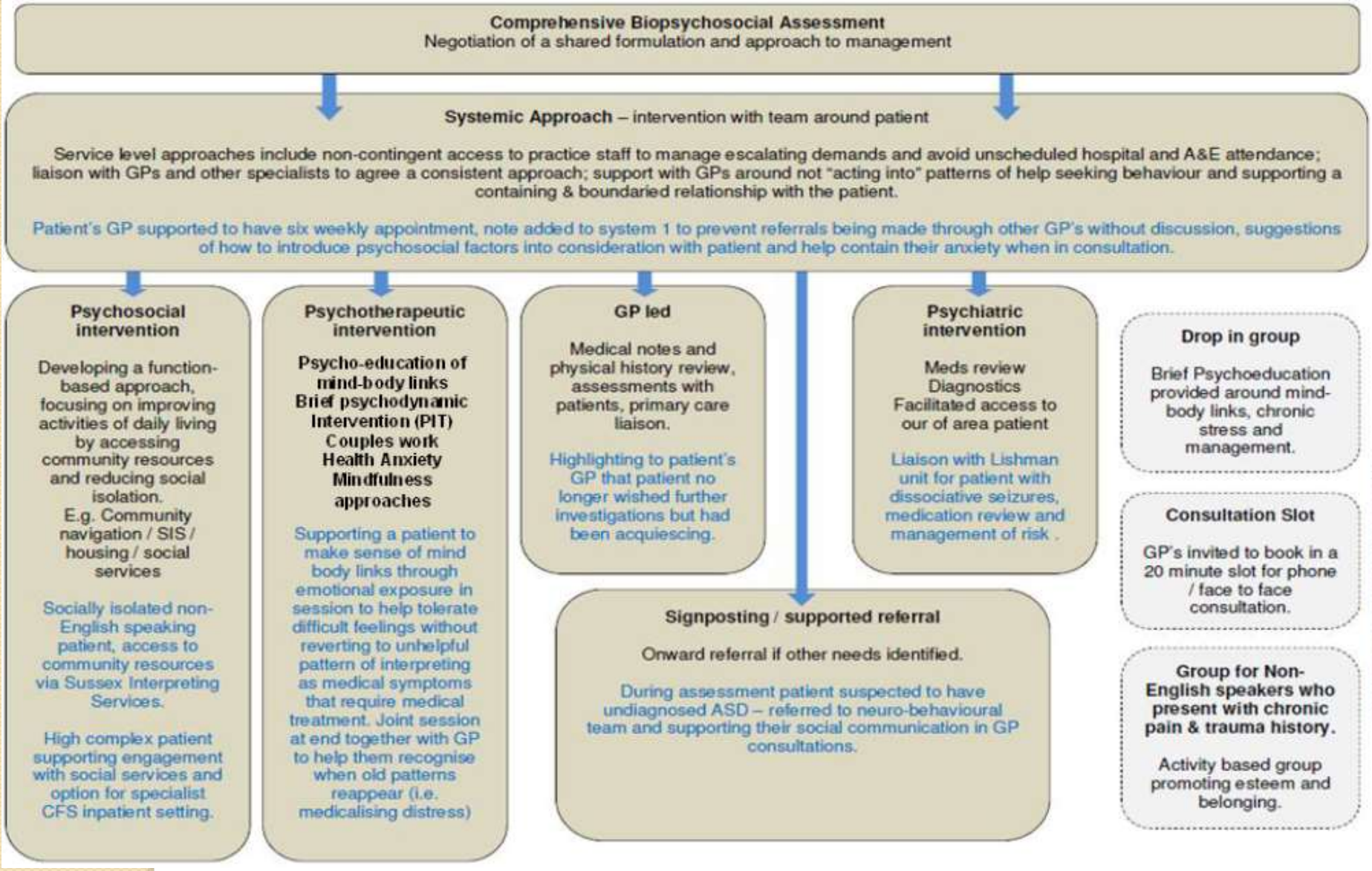
- Team administrator
  - Main point of contact
  - Liaison with GP administrators
  - Room bookings
  - Data gathering
  - Minute taking and office management

- Liaison Psychiatry
  - Risk
  - Medication
  - Diagnostic queries
  - Links with national services
  - Links to secondary care, acute and A&E

- Medical Psychotherapy
  - Supervision
  - Links in with other services nationally
  - Diverse range of approaches and models
  - Service model – belonging and values

- Clinical Psychology
  - Engagement and formulation
  - 1-1 interventions
  - Attend GP clinical meetings
  - Drawing on multiple models according to patient need
  - Evaluation reporting
  - Service development and linking in with commissioners

- General Practitioner
  - Understanding patient experience of healthcare services
  - Advocate for where GP's would be coming from.
  - Advice around pragmatic approaches in primary care and working cultures.
  - Full review of GP system notes
  - Local relationships with GP's and local knowledge of population and practice culture.


Comprehensive Biopsychosocial Assessment
Negotiation of a shared formulation and approach to management
Systemic Approach – intervention with team around patient
Service level approaches include non-contingent access to practice staff to manage escalating demands and avoid unscheduled hospital and A&E attendance; liaison with GPs and other specialists to agree a consistent approach; support with GPs around not "acting into" patterns of help seeking behaviour and supporting a containing & boundaried relationship with the patient.
Patient's GP supported to have six weekly appointment, note added to system 1 to prevent referrals being made through other GP's without discussion, suggestions of how to introduce psychosocial factors into consideration with patient and help contain their anxiety when in consultation.
Psychosocial intervention
Developing a function-based approach, focusing on improving activities of daily living by accessing community resources and reducing social isolation.
E.g. Community navigation / SIS / housing / social services
Socially isolated non-English speaking patient, access to community resources via Sussex Interpreting Services.
High complex patient supporting engagement with social services and option for specialist CFS inpatient setting.
Psychotherapeutic intervention
Psycho-education of mind-body links
Brief psychodynamic Intervention (PIT)
Couples work
Health Anxiety
Mindfulness approaches
Supporting a patient to make sense of mind body links through emotional exposure in session to help tolerate difficult feelings without reverting to unhelpful pattern of interpreting as medical symptoms that require medical treatment. Joint session at end together with GP to help them recognise when old patterns reappear (i.e. medicalising distress)
GP led
Medical notes and physical history review, assessments with patients, primary care liaison.
Highlighting to patient's GP that patient no longer wished further investigations but had been acquiescing.
Psychiatric intervention
Meds review
Diagnostics
Facilitated access to our of area patient
Liaison with Lishman unit for patient with dissociative seizures, medication review and management of risk .
Signposting / supported referral
Onward referral if other needs identified.
During assessment patient suspected to have undiagnosed ASD – referred to neuro-behavioural team and supporting their social communication in GP consultations.
Drop in group
Brief Psychoeducation provided around mind-body links, chronic stress and management.
Consultation Slot
GP's invited to book in a 20 minute slot for phone / face to face consultation.
Group for Non-English speakers who present with chronic pain & trauma history.
Activity based group promoting esteem and belonging.
Planned additional interventions

Integration – mental & physical health

- Challenges faced – cultural differences
- Move away from 'refer & fix' to managing together
  - Training primary care staff
  - Pragmatic interventions (e.g. joint consultations)
  - Formulating for GP's
  - Attending clinical meetings
  - Perspective taking of other professionals involved in their care
- Where team based & patients seen
- Access to primary care data
- Easy lines of communication
  - e-mail / phone / face to face
- Coffee Club and Christmas Party invites

- So . . . what do we mean when we talk about Medically Unexplained Symptoms?

"I'm afraid you've had a paradigm shift."

What do we mean when we talk about Medically Unexplained Symptoms?

Speciality	Functional somatic syndrome
Allergy and others	Multiple chemical sensitivity (MCS), hypersensitivity to electricity, hypersensitivity to infrasound
Anaesthesiology	Chronic benign pain syndrome
Gastroenterology	Irritable bowel syndrome (IBS), non-ulcer dyspepsia
Gynaecology	Pelvic girdle pain, premenstrual syndrome (PMS), chronic pelvic pain
Infectious medicine	Chronic fatigue syndrome (CFS, ME)
Cardiology	Atypical or non-cardiac chest pain, syndrome-X
Respiratory medicine	Hyperventilation syndrome
Neurology	Tension headache, pseudo-epileptic seizure
Odontology	Temperomandibular joint dysfunction, atpyical facial pain
Orthopaedic surgery	Whiplash-associated disorder (WAD)
Psychiatry	Somatform disorders, neurasthenia, conversion disorder
Rheumatology	Fibromyalgia, lower back pain
Ear, nose and throat	Globus sensation, vertigo, tinnitus

(Functional Disorders & MUS, Der Fink & Rosendal, 2015)

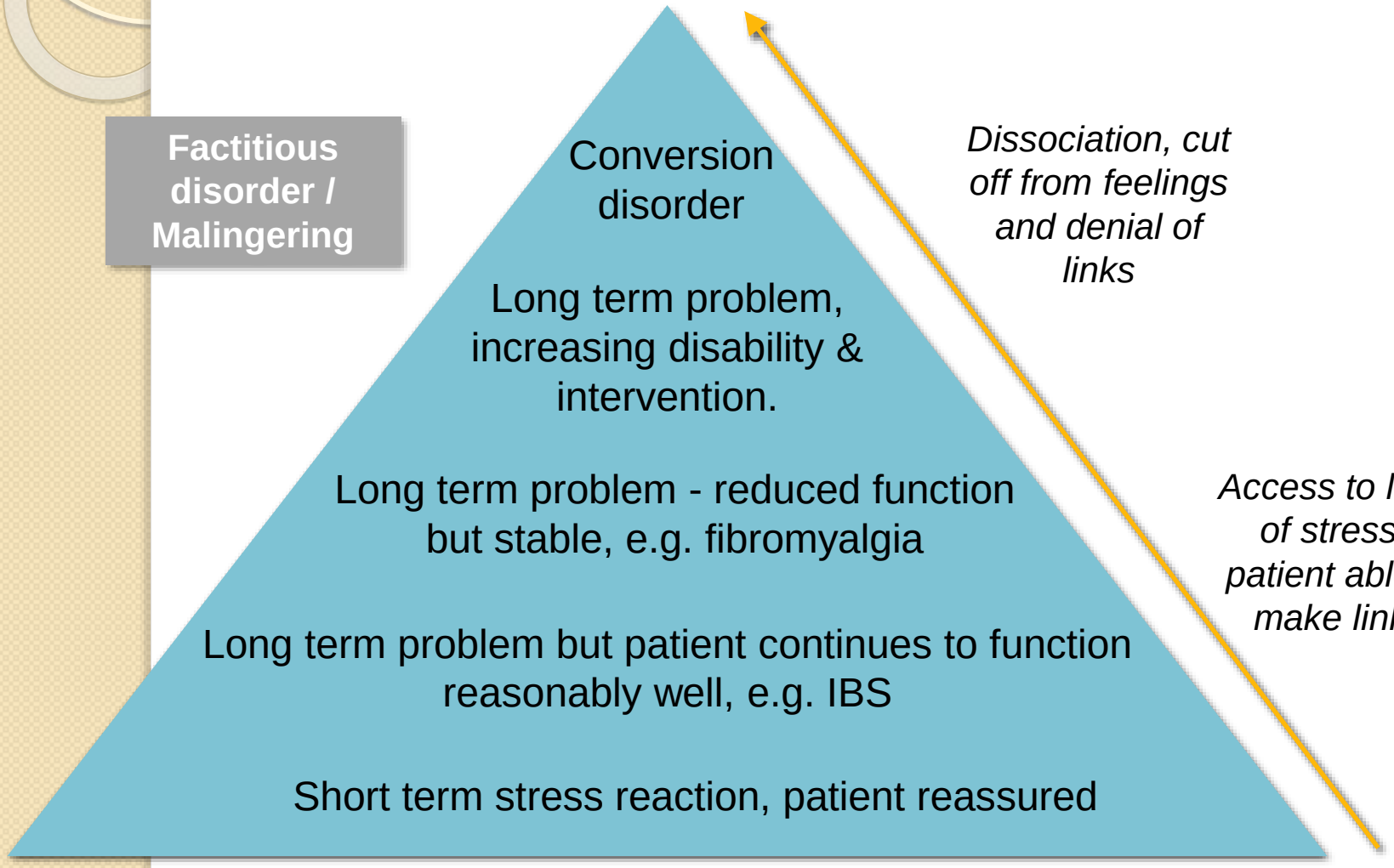
- Postural Orthostatic Tachycardia Syndrome (POTS)
- Dysautonomia
- Chronic Lyme
- EDS Type 1&2

What do we mean when we talk about Medically Unexplained Symptoms?

- Known by various terms, from hysteria, conversion disorder, functional disorders, bodily distress disorder, somatoform disorder, persistent physical symptoms, medically unexplained symptoms and somatic distress.

- *"By highlighting MUS, doctors may use it as a diagnosis, but this is best avoided. It is better to focus on the symptoms, the consequences and the functioning, not the name."* (RCGP guidance for MUS, 2014)

Pyramid of complexity: Mind-body links



(with thanks to Dr Alison Jenaway)

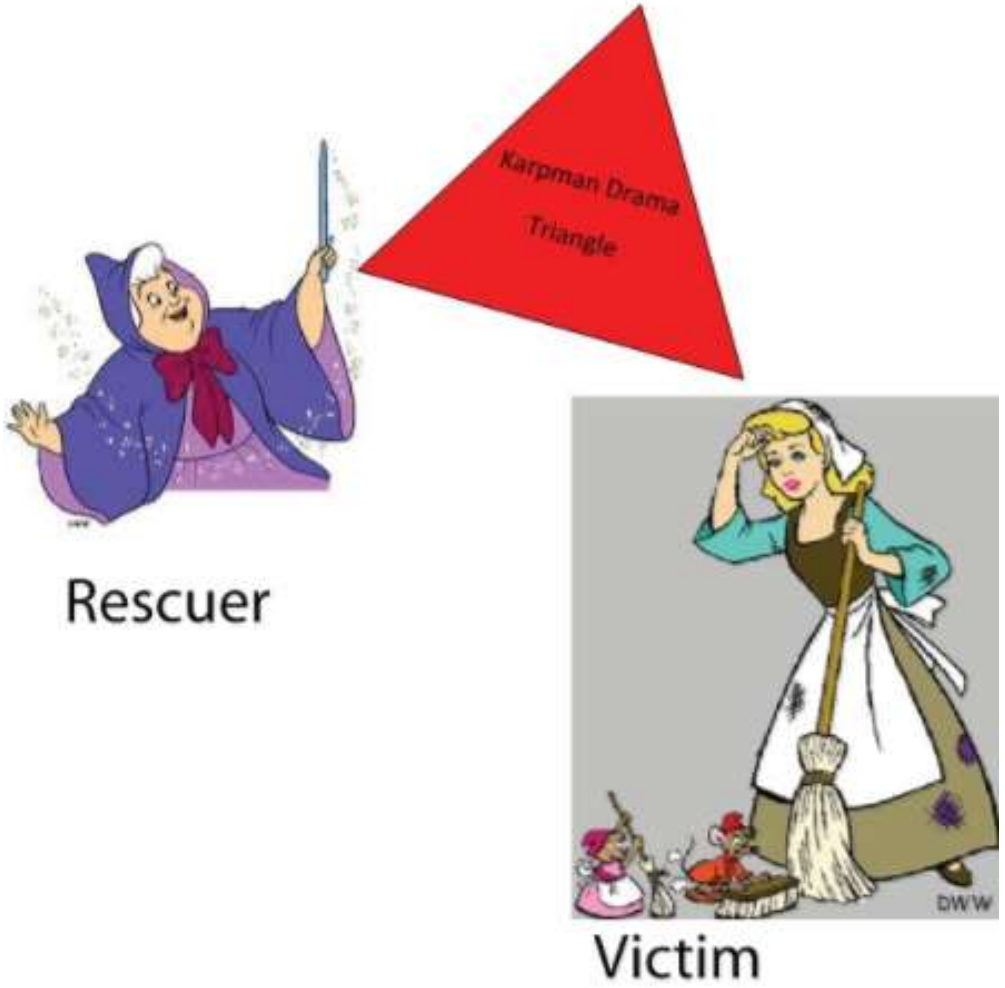
Vignette

- Symptoms / Impact / Coping
- Family / early life history
- Experience of health care services
- View of difficulties / their understanding of symptoms
- GP view & experience of patient

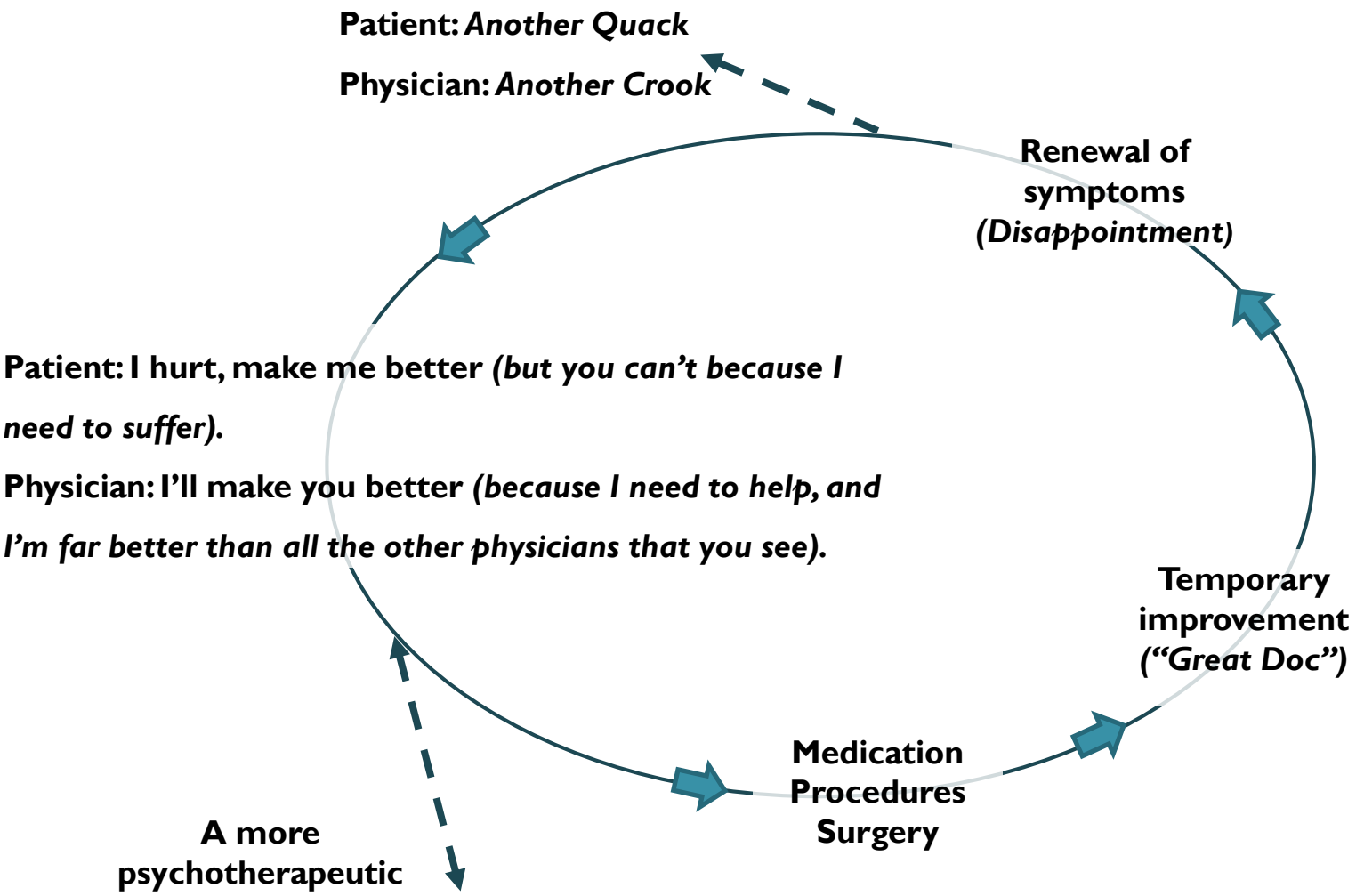
Dynamics in the consultation:

The Drama Triangle

Persecutor



Is there a mismatch?



Vicious Cycle in Doctor-Patient contact

Modified after Sternbach & Quill

Is there a mismatch?

- Between what is offered by the system and what is needed by the patient?
- With a system set up to manage biomedical problems rather than biopsychosocial complexity?
- Between GP and patient expectations of the consultation?

Psychodynamic Interpersonal Therapy (PIT)

- Based on 'the conversation model' by Robert Hobson, as described in 'Forms of Feeling'
- "The goal of PIT is to foster a particular kind of conversation that enables the therapist and client to relate to one another as people: a meeting between persons"
- Staying with the feelings and symbolical transformation

PIT approach in GP consultations

- **Use statements rather than questions** – this focuses on them feeling heard rather than information exchange.

- **Name feelings** if possible, and validate their experiences both of symptoms and experiences of health care.
  - *I can see this is very painful for you to talk about, and it is important that it is taken seriously.*

- Hold in mind **what is happening to them currently in their wider life**.

- **Tentative**, negotiating style of speaking.
  - *Many people I see have found that …..And I'm wondering if you sometimes feel a bit like that too.*
  - *Let's see if we can begin to make sense of this by making some links together …*

- **Use the patients language** – their metaphors can be very helpful to elaborate on their experience.

Some mind body links – but cues need to come from them

The role of mood on perception of symptoms and how stress can impact on health, i.e. headaches and muscle tension.

The link between anxiety and increased intestinal contractions, with an explanation that there is a very strong nerve supply to the gut from the emotion controlling part of the brain.

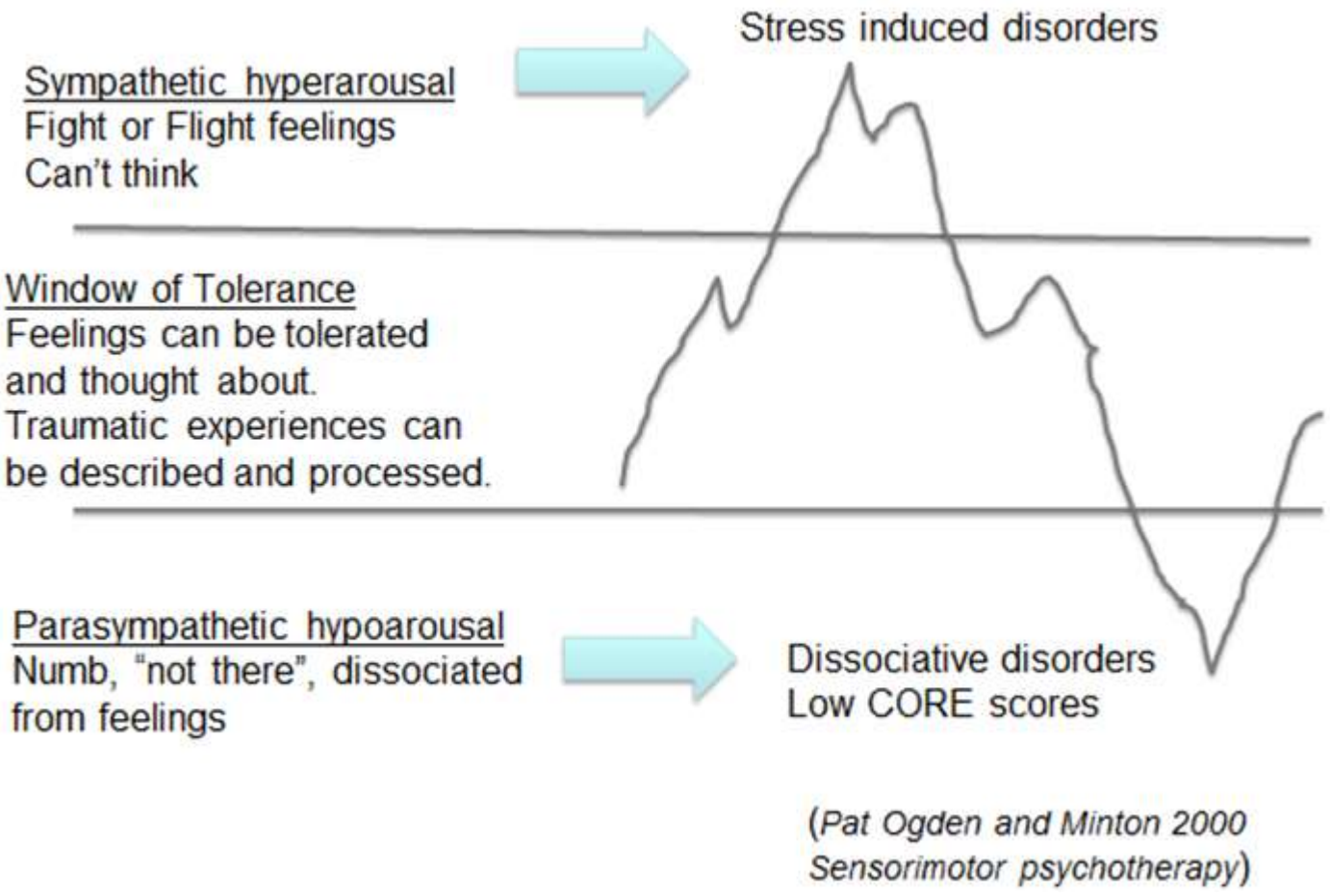
Describing how the fight/flight response affects the body when under threat. How if this is experienced as alarming this can become a feedback loop.

Explicit explanations of the role that anxiety and depression (which may well be due to the symptoms) play in the reinforcing feedback loop that occurs and accentuates pain.

How long term exposure to stress hormones can have an impact on the immune system.

How some fatigue can persist by over-exertion leading to collapse, then seeking to catch up on lost time during the collapse through further over exertion.

Meeting the patient where they're at



(*Pat Ogden and Minton 2000 Sensorimotor psychotherapy*)

Systemic management

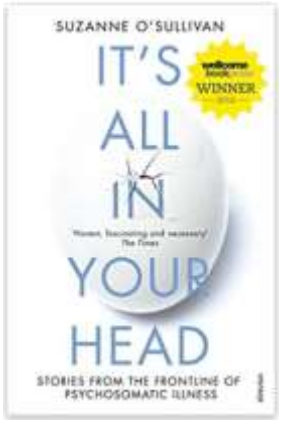
- Having a named GP, and an agreed management approach with the patient.
- Having planned appointments every 6 weeks – 3 months.
- System 1 / E-Miss Web – have a note that all referrals to secondary care be discussed with named GP before being completed.
- Where scans / investigations are made – helpful to frame with patient that these are expected to come back negative, and what to do then.
- Focus is on improving wellbeing with a shared curiosity of what biopsychosocial factors ameliorate / exacerbate symptoms.
- Having an agreed plan with other services - e.g. practice receptionists / ambulance service / liaison psychiatry etc

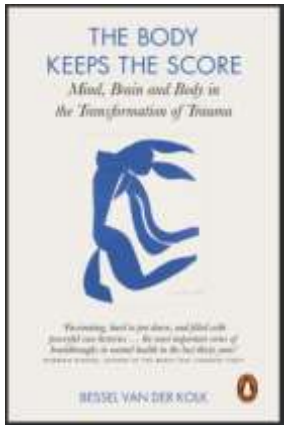
- This is about connection during the consultations, helping the patient to feel heard, believed and taken seriously.
- What role in the Drama triangle are you invited to have?
- Space to reflect with others is vital for good practice and your own wellbeing – especially where there are complex dynamics.

Thank you

We can be contacted at: **spnt.gpsservice@nhs.net**

For further information





- **www.neurosymptoms.org** – helpful website by a Neurologist covering a range of functional difficulties.

- **https://www.rcpsych.ac.uk/files/pdfversion/CR152x.pdf** - The management of patients with physical and psychological problems in primary care: a practical guide.

- RCGP guidance for MUS (2014 update) available from the GPS service – contact **spnt.gpsservice@nhs.net**

- For further information about Psychodynamic Interpersonal Therapy → **http://www.pit-sig.uk/index2.html**