Development and evaluation of an online training programme for primary care staff to facilitate a shared understanding of symptom perpetuation in those with Medically Unexplained Symptoms (MUS) and complex Long Term Conditions (LTC)

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What is NHS Education for Scotland?
Special Health Board

Training and career long development of NHS staff

Scottish Patient Safety Programme
What is MUS?
“Persistent and distressing somatic symptoms for which adequate somatic explanation does not reveal sufficient explanatory organic pathology”

- Shaefert et al, 2013
Vague symptoms, polypharmacology, high distress, insistent and frequent attendees.

Irritable Bowel Syndrome, Chronic Fatigue Syndrome, Fibromyalgia.
Key Figures
• 20% of Primary Care consultations
• Up to 50% in Secondary Care
• High levels of distress and disability
• 60% also have a diagnosed Long Term Condition
• 2% of Primary Care patients attend persistently
• £3.1 billion cost annually in UK
Interventions
Reassurance/Psychosomatic ideas may not be helpful

Evidence to support CBT-based interventions (Van Dessel et al 2014)

Enhanced generalist care may be helpful (Rosendal et al 2013)

Biopsychosocial perpetuation…(formulation vs diagnosis)

Personally relevant, mechanical explanations best (Burton (Ed) 2014)
• Increase primary care staff skills and confidence in managing the problems faced by those with MUS,

• Evaluate the effectiveness of a training module designed to improve care for people with MUS and complex long term conditions (LTC) in primary care and thereby avoid potentially harmful onward referral to secondary care,

• Influence GP referral intentions and attitudes.
Building a Shared Understanding:
Taking the strain out of medically unexplained symptom (MUS) and complex long term condition (LTC) consultations

- A straightforward plan for GPs and other health professionals
- Use many of your existing skills
- An online tool for staff working with patients experiencing unexplained or persistent physical symptoms
• An online interactive module based on the CBT model of MUS,

• Featuring:
  – a case study accompanied by questions,
  – video clips of real-life consultations,
  – resources that can be used in practice,

• To encourage GPs to use a “four systems” approach, outlining the way symptoms, mood, thinking and activity may interact with each other to maintain the patient’s symptoms.
The module was summarised within the acronym PESTO:

- **Person**-centred statements about the patient’s symptoms,
- **Eliciting** the effects of physical symptoms,
- **Summarising** what the patient has said,
- **Bringing it all Together** for a shared understanding,
- **Options**: encouraging self-management.
A suggestion about what might be going on

**Symptoms**
- E.g. Pain
- Tingling
- Weakness
- Headache

**Mood**
- E.g. Worry
- Low Mood
- Anger
- Frustration

**Thinking**
- E.g. This is getting worse
- It will never get better
- What if...

**Activity**
- E.g. Less walking
- Given up hobbies
- Stopped work
- Not as fit
- Less social contact
Evaluation
Pre-training:
• Working with MUS and LTC: Confidence and familiarity questionnaire,
• Attitudes to Specialist Referral for MUS (ASRMUS) Questionnaire.

Post-training:
• Working with MUS and LTC: Confidence and familiarity questionnaire,
• ASRMUS Questionnaire intention items,
• Implementation Intentions statement.

Follow-up:
ASRMUS intention items.

Questions addressing:
• Whether the approach had been implemented with the patient specified within the implementation intention,
• Whether any barriers preventing its implementation had been experienced.
Findings
Participants
98% qualified GPs (86% qualified 10+ years)

71% female

57% aged over 45
Confidence and Familiarity
<table>
<thead>
<tr>
<th>Item</th>
<th>Confidence</th>
<th>Familiarity</th>
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<tbody>
<tr>
<td></td>
<td>Pre-training</td>
<td>Post-training</td>
</tr>
<tr>
<td>Working with patients who have MUS or complex long term conditions</td>
<td>24% (12/51)</td>
<td>76% (16/21)*</td>
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<td>Using person-centred communication skills</td>
<td>4% (2/51)</td>
<td>67% (14/21)*</td>
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<td>Identifying emotional and behavioural consequences of symptoms</td>
<td>20% (10/51)</td>
<td>71% (15/21)*</td>
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<tr>
<td>Summarising information provided by patients</td>
<td>18% (9/51)</td>
<td>71% (15/21)*</td>
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<tr>
<td>Using a “4 systems” approach to explain symptom maintenance</td>
<td>0% (0/51)</td>
<td>67% (14/21)*</td>
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<tr>
<td>Signposting patients to self management strategies</td>
<td>18% (9/51)</td>
<td>52% (11/21)*</td>
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*p<0.05
Attitudes to Specialist Referral Items
<table>
<thead>
<tr>
<th>Item</th>
<th>N (% Agreement)</th>
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<tbody>
<tr>
<td>If I refer Mary to secondary care for further medical investigation I would feel that I am providing her with some form of reassurance that there is no underlying organic pathology relating to her pain</td>
<td>20% (10/51)</td>
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<td>I would feel under social pressure to refer Mary to secondary care for further medical investigation</td>
<td>55% (28/51)</td>
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<td>I would be confident that I could refer Mary to secondary care for further medical investigation, if I wanted to</td>
<td>53% (27/51)</td>
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<tr>
<td>Referring Mary to secondary care for further medical investigation would be harmful</td>
<td>51% (26/51)</td>
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<td>I would want to refer Mary to secondary care for further medical investigation</td>
<td>6% (3/51)</td>
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<tr>
<td>Referring Mary to secondary care for further medical investigation would be an effective approach to take when I feel under pressure</td>
<td>31% (16/51)</td>
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<td>Other GPs would refer Mary to secondary care for further medical investigation</td>
<td>39% (20/51)</td>
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<tr>
<td>Doing what other GPs think I should do is important to me</td>
<td>47% (24/51)</td>
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<tr>
<td>I would expect to refer Mary to secondary care for further medical investigation</td>
<td>1% (1/51)</td>
</tr>
<tr>
<td>I would be more likely to refer Mary to secondary care for further investigation if I felt under pressure during the consultation</td>
<td>86% (44/51)</td>
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<tr>
<td>Referring Mary to secondary care for further investigation would be a good way to reassure her that there is no underlying organic pathology</td>
<td>18% (9/51)</td>
</tr>
<tr>
<td>I would intend to refer Mary to secondary care for further medical investigation</td>
<td>1% (1/51)</td>
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Predictors of intentions to refer
Attitudes-believing referral was a good way of providing reassurance (B=0.886, C.I. 0.46-1.31)

Perceived behavioural control-believing that referral was an effective approach to take under pressure (B=0.39, C.I. 0.03-0.77).

Significantly predicted intentions to refer to secondary care [R²=0.40, Adjusted R²=0.37; F(2,48)=15.66, p≤0.05].
Intentions to refer
Significant reductions (p≤0.05) post-training [t(20)=4.017, p≤0.05]

Significant reductions were maintained at follow-up [t(8)=0.918, p=0.386]
Use of skills within clinical practice
• 76% (16/21) likely to use skills in practice
• 86% (18/21) committed to use skills
• 33% implemented skills with a selected patient, including:
  - PESTO
  - Eliciting effects of symptoms
• Challenges included:
  - Patient resistance
  - Managing time

• Barriers to implementation included:
  - Lack of opportunity
  - Lack of time
Conclusions
• Brief online training may be an effective way of helping GPs develop a collaborative relationship with their patients with MUS.

• Training focusing on symptom perpetuation within MUS may help improve familiarity and confidence working in this area and may result in increased management of patients within primary care.
Recommendations
Future work would benefit from examining the impact of the training on GPs' actual practice in terms of their interaction with people with MUS and subsequent referral rates.

Training should:

• Provide instruction as to with whom the training could be implemented
• Include information and advice addressing how to include aspects of the PESTO approach into consultations when feeling under pressure
Questions?