



Psychological Professions Week

From Hospital to Community: The role of Health Psychologists

Presenter(s):

**Dr Liz Jenkinson, Dr Kate Swainston,
Mr Niall Anderson, Dr Matt Cooper, Dr Lorelle Dismore**

Acknowledgements:

**Dr Adrian Whittington for early slides
Experts by Experience Colleagues**



This session



- The NHS 10-year plan: From hospital to community
- The role of Health Psychologists
- Case studies
- Discussion/Q&A



UK Government

NHS

FIT FOR THE FUTURE

10 Year Health Plan
for England

Three Shifts



Psychological
Professions Week

Analogue to Digital

Hospital to Community

Sickness to Prevention

02

From hospital to community

The Neighbourhood Health
Service designed around
you



- **Neighbourhood health centres**
- Longer hours, In communities, Range of services working together
- Piloting “Neighbourhood Mental Health Model”: **24/7 mental health hubs**, six currently trialling
- 100% coverage of **assertive outreach** care and treatment in 10 years
- Commitment to **85 new Mental Health Emergency Departments**, with **up to £120 million** investment

Three opportunities for psychological healthcare in the shift from hospital to community

01

Embed psychological approaches to long term condition management and rehabilitation

02

Enable a paradigm shift in mental health crisis response

03

Address the psychological treatment gap

The role of Health Psychologists



Health Psychologists are HCPC regulated health professionals and practitioner psychologists

We apply understanding of the psychological processes underlying health and illness to:

- ✓ the promotion and maintenance of health
- ✓ the analysis and improvement of the health care system and health policy formation
- ✓ the prevention of illness and disability
- ✓ the enhancement of outcomes for those who are living with illness and/or disability

Behaviour change, psychological interventions, teaching and training, research, consultancy





- Diabetes care
- Cardiac rehabilitation
- Weight management
- Smoking Cessation
- Sexual Health
- Adherence to medication or vaccination
- Exercise
- Healthy Eating
- Sleep
- Drug and alcohol use
- Health or Dental Anxiety
- Stress Management
- Disability

- And many more

[DHP case studies-28Apr
2021.pdf \(bps.org.uk\)](https://bps.org.uk)

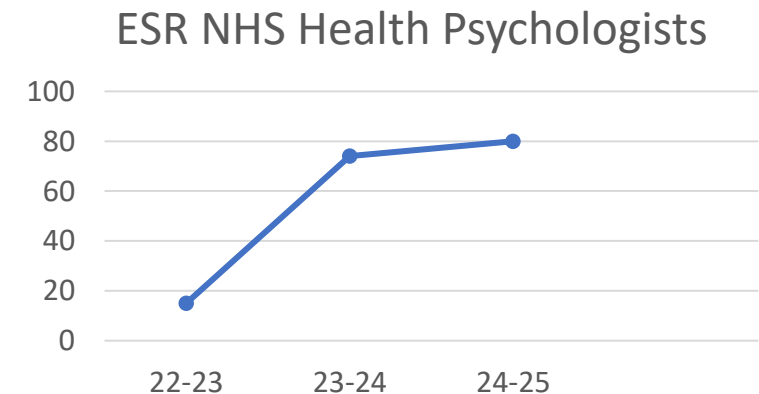
Health Psychologists in the NHS



- Growing opportunities for Health Psychologists in NHS practice was an aspiration of the Psychological Professions Workforce Plan for England (*NHS England, 2021*).

- Approaching 200% growth according to NHS ESR:

Years	FTE
22-23	15
23-24	74
24-25	80



>22/23 jump is also product of more accurate logging but overall signs of growth

Health Psychologists in the NHS



But....

- Current workforce estimates are inaccurate, and the contribution of Health Psychology and Health Psychologists within the NHS underestimated.....
(see Bhutani, Jenkinson, Kalsy-Lillico & Moore 2024)
- Further scope- over 600 on HCPC register and est. only about a sixth NHS employed
- We have the skills required of the Three Shifts- all of which require workforce, patient/public, and systemic behaviour change and psychologically informed approaches!

Shining a light on Health Psychologists shifting NHS care from hospital to community



Three case studies:

Lorelle Dismore:

Living and coping with persistent physical symptoms

Matt Cooper:

Young@Heart, and Workforce Development

Niall Anderson:

A pilot Diabetes service in Derbyshire

Case Study 1

Living & coping with Persistent Physical Symptoms (PPS): Co-design of community-based, health and wellbeing solutions.

Dr Lorelle Dismore

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Case study 1: Overview

- ▶ Existing evidence around PPS
- ▶ The Co PPS Project (NIHR, RfPB)
- ▶ The role of Health Psychology

PPS - Persistent (long-term) Physical Symptoms

Distressing somatic complaints – regardless of their cause.

6 groups of symptoms but people often have more than one:

- 1. General** – *across the body*
- 2. Cardiopulmonary** – *heart and lungs*
- 3. Gastrointestinal** - *stomach*
- 4. Musculoskeletal** – *bones, joints and muscles*
- 5. Nervous system** – *brain, spinal cord and nerves*
- 6. Genitourinary** – *urinary and sex organs*

The impact of PPS

- **Affects ~20%** of the population
- Accounts for **≥15% of GP consultations**
- Drives **30–50% of specialist referrals**
- **Costs NHS £18 billion/year** — comparable to dementia (£17 billion)
- More common in people with experiences of adversity

What are the challenges around PPS?

- **The System**
- **Umbrella term** — complex and difficult to understand
- **High healthcare utilisation** with siloed, fragmented care
- Significant **costs to the NHS** and impact on individuals' quality of life

- **Patients' Perspectives**
- Feel like “**medical orphans**”
- Experience **delayed diagnosis** and medical errors causing worry, chaos, and uncertainty
- Symptoms often **worsen over time**
- Often **disappointed by healthcare experiences**

- **Psychological & Social Challenges**
- Need to **feel understood**
- Struggle with **searching for explanations**
- Strong links to **mental health and mind-body experiences**

Psychologically Informed Interventions

Received: 8 February 2022 | Accepted: 17 June 2022

DOI: 10.1111/bjhp.12613



ARTICLE

What psychological interventions are effective for the management of persistent physical symptoms (PPS)? A systematic review and meta-analysis

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²Northumbria Healthcare NHS Foundation Trust, North Tyne General Hospital, North Shields, UK

³School of Social Sciences, Humanities & Law, Teesside University, Middlesbrough, UK

Abstract

Objectives: Presentation of persistent physical symptoms is associated with increased health care utilization, yet clinical outcomes often remain suboptimal. This systematic review aimed to determine whether psychological interventions are effective for the management of PPS and if so, what are the

RESEARCH

Open Access



Clinical skills development for healthcare practitioners working with patients with persistent physical symptoms (PPS) in healthcare settings: a systematic review and narrative synthesis

Stacie Thursby¹, Lorelle Dismore¹ and Katherine Swainston^{2*}

Abstract

Background The complexity and uncertainty around Persistent Physical Symptoms (PPS) make it difficult to diagnose and treat, particularly under time-constrained consultations and limited knowledge. Brief interventions that can be utilised in day-to-day practice are necessary to improve ways of managing PPS. This review aimed to establish (i) what training primary and secondary healthcare practitioners have undertaken to develop their clinical skills when working with PPS, (ii) what training techniques or theoretical models have been used within these interventions, and (iii) how effective was the training.

Method A systematic literature search was undertaken on eight databases to identify professional development interventions for healthcare practitioners working with PPS, were of any study design, and at a minimum were single measure studies (i.e., training outcome alone). Studies were assessed using the Mixed Methods Appraisal Tool (MMAT) and narratively synthesised.

Results Despite high methodological heterogeneity across the six included studies, they all aimed to improve healthcare practitioners' communication skills through educational (theory, awareness, attitudes, assessment, treat-



Article

Persistent Physical Symptoms—Healthcare Workers' Experiences of Current Models of Care

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Abstract: Persistent physical symptoms (PPS) are frequently seen in most medical specialties. Healthcare provision for PPS patients has been largely ineffective due to an outdated biomedical approach and failure to encompass the multifaceted nature of PPS, despite the guidelines recommending multidisciplinary care involving medical, social and psychological provision for the management of PPS. There are unresolved challenges and associated costs with PPS, suggesting needs are not being met. The aim of this research was to explore the current management of PPS patients, to provide insights into the opportunities for interventions to better manage PPS. A qualitative study was used, applying semi-structured interviews with sixteen healthcare practitioners including ten General Practitioners in the



There is a role for community-based initiatives...but how?

But we don't understand enough about how to provide good PPS support

- How people live and cope with PPS in their communities?
- What community resources (i.e., groups) are available and are relevant for people living with PPS?
- Could healthcare staff work better with existing community colleagues and resources?
- How we might all work together to do something differently, to help improve the health and wellbeing of people with PPS?

Better Support for Persistent Physical Symptoms (PPS) - A Community-Based Approach (The Co-PPS Study)



Have you experienced physical symptoms for a while, that health care professionals can't explain?

We want to hear from you!

We are inviting people from Blyth, Ashington & Newbiggin to take part in a project to understand more about living with ongoing symptoms, such as pain, stomach problems & physical discomfort.

Stakeholders

- Northumberland City Council
- Healthcare sector
- Community voluntary organisations
- Academic partners
- Patient and Public Involvement Group

Living and coping with persistent (long-term) physical symptoms: co-design of community-based health and wellbeing solutions.

Living with long term physical symptoms* is a huge challenge that affects many people. It's not just a physical problem; it's a complicated mix of physical feelings, thoughts, and even how we connect with others. This can be incredibly frustrating for those who experience it. In response, the NHS is trying to make things better by focusing on care that's closer to home and more connected to local communities.

Our project is all about listening to people who have this lived experience to understand how community support can help with long term physical symptoms*. By working together, we want to find out what really makes a difference and help create better, more effective ways for people to manage their symptoms. Our goal is to help individuals and make sure they feel supported and heard.

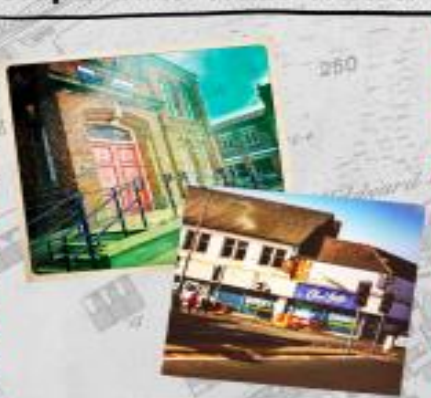
[*A symptom is something that does not feel right in your body - like pain, feeling tired all the time or tummy problems]

Step 1: 'My Experience'



In this stage, we'll focus on your personal journey with persistent (long term) symptoms. We'll explore your day-to-day life, looking at what a good day and a difficult day look like for you, and what helps you feel supported.

Step 2: Who-What-Where?



This stage is about mapping out the wider picture. We'll discuss the people, places, and resources—from healthcare professionals to community groups—that are part of your support network, and identify any gaps that exist.

Step 3: Co-Design Solutions



In our final stage, we'll use everything we've learned to create new ideas together. We'll work together to design and develop new ways for community-based care to better meet the needs of people living with persistent symptoms.

New insights into challenges and opportunities, leading to...

Practical and life-changing improvements for those living with persistent (long term) physical symptoms in the community.

If you want to know more (and if you want a plain language information sheet) you can contact the team on **0191 293 4087** or ResearchAndDevelopment@northumbria-healthcare.nhs.uk

We are being helped on the project by health leaders who will listen and take action, and a group of local people who are guiding us.

Led by

NHS
Northumbria Healthcare
NHS Foundation Trust

With

 **Northumbria University**
NEWCASTLE

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Northumberland

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Living and Coping with Persistent Physical Symptoms (PPS): An introduction to Activity 2

In Activity 1, we are having conversations with you about your experience of living with PPS. In Activity 2, we ask you to **show us your everyday life in a visit or a community walk**.



Let's look at hidden barriers that interviews can miss. You might show us a journey that doesn't look long on a map, but is difficult for you, or see an example of a problem we can try to take action on. Going to see examples and details help us understand what you have to deal with so we can work on them in activity 3 (workshops).

Why walk or visit?

Your body knows things you might not have told us in an interview.

Moving through spaces, touching things, hearing and smelling things all switch on different types of memory and awareness.

Instead of 'I struggle with access' it becomes 'See this? the door handle is too high', or 'There's nowhere to rest near here'.

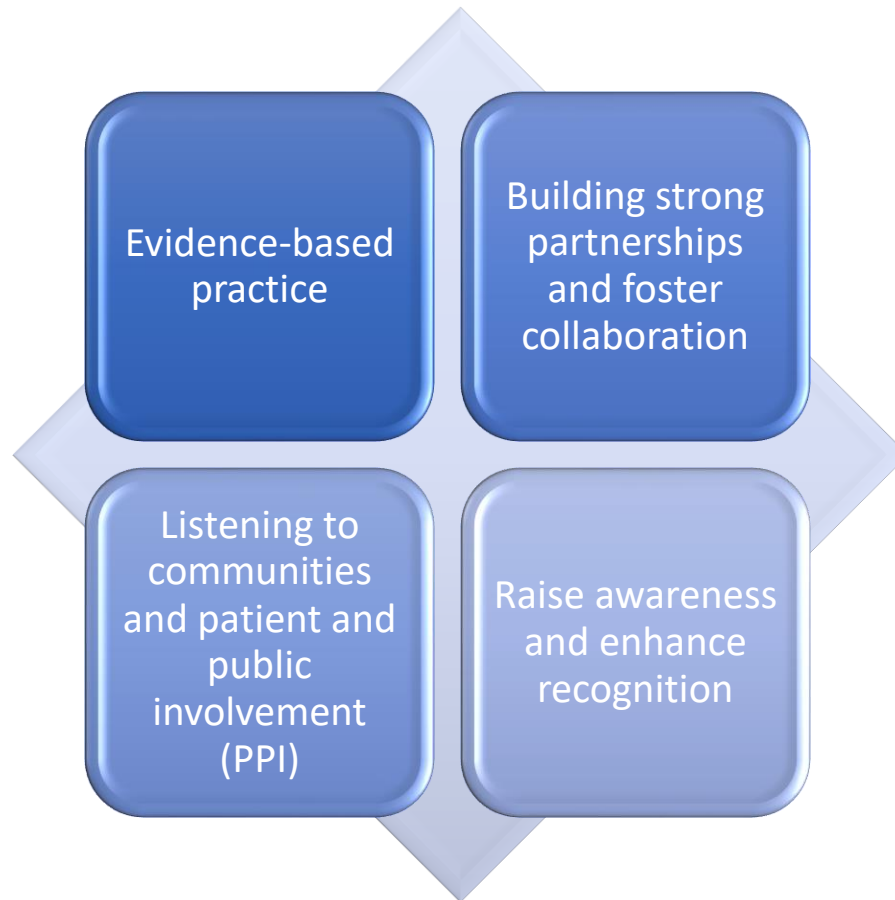
On a walk or visit, you are the expert showing a researcher your world.

...and why does this make our research on persistent physical symptoms better?

- * symptoms are affected by things like weather, surroundings, distance and timing.
- * things that might help exist in place + time.
- * Solutions need to be specific

Talk to us about a walk or visit that would show details of living with PPS. If you are not mobile, you can even show us things in your home or garden. If you want to invite a friend, that's OK too.

Role of Health Psychologists



- **Train** healthcare professionals in the biopsychosocial model
- **Work with social prescribers and locality coordinators**
- Develop materials and interventions to support **behaviour change**
- Lead **impactful participatory research** and **evaluate interventions**

Case Study 2: Young@Heart, and Workforce Development

Dr Matthew Cooper
matthew.cooper2@ncl.ac.uk



Application of Health Psychology



Application of Health Psychology

Case Study 1



Clinic Development

- Focus on lifestyle interventions
- Behaviour change
- Clinical staff and students
- Growth capacity

Case Study 2



Workforce Development

- Working with primary care, third sector, and charities
- Upskilling workforce in psychological theory to inform practice



Consultancy

- Psychological theory to evaluate practice
- Impacting the commissioning of services within the region

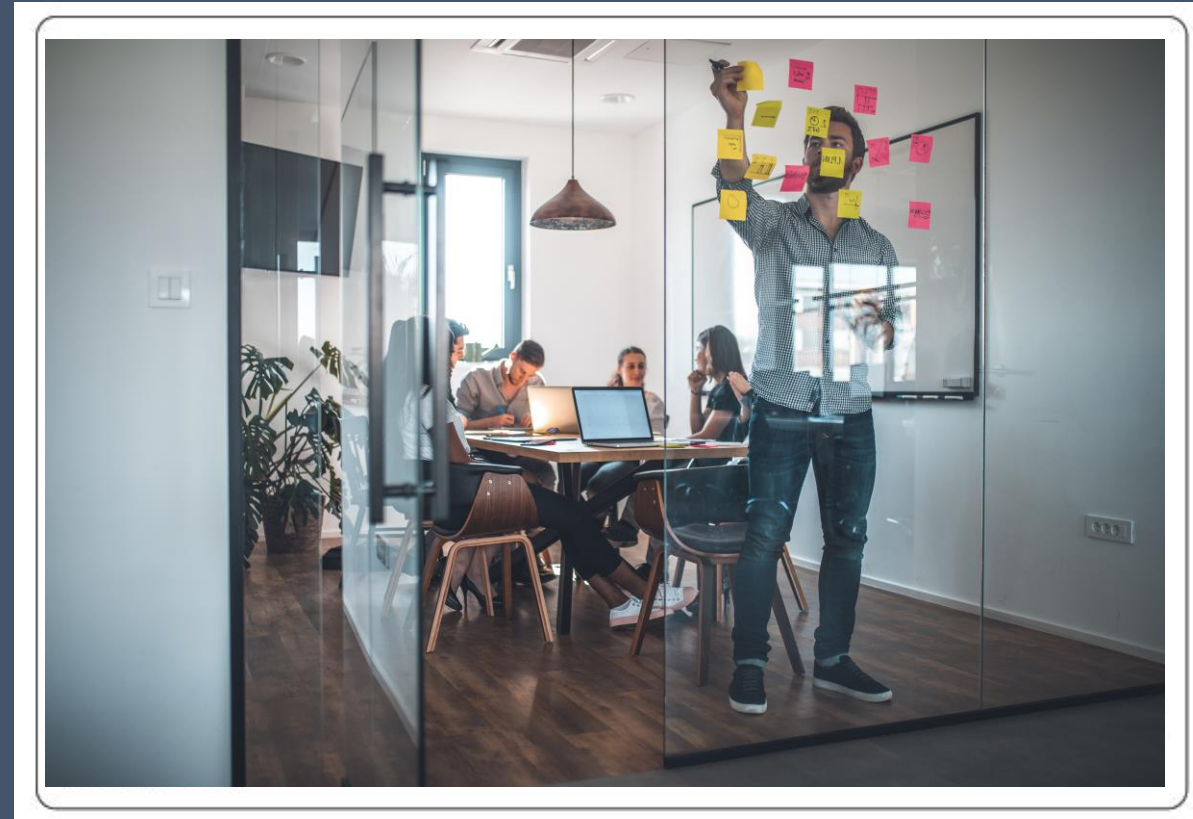
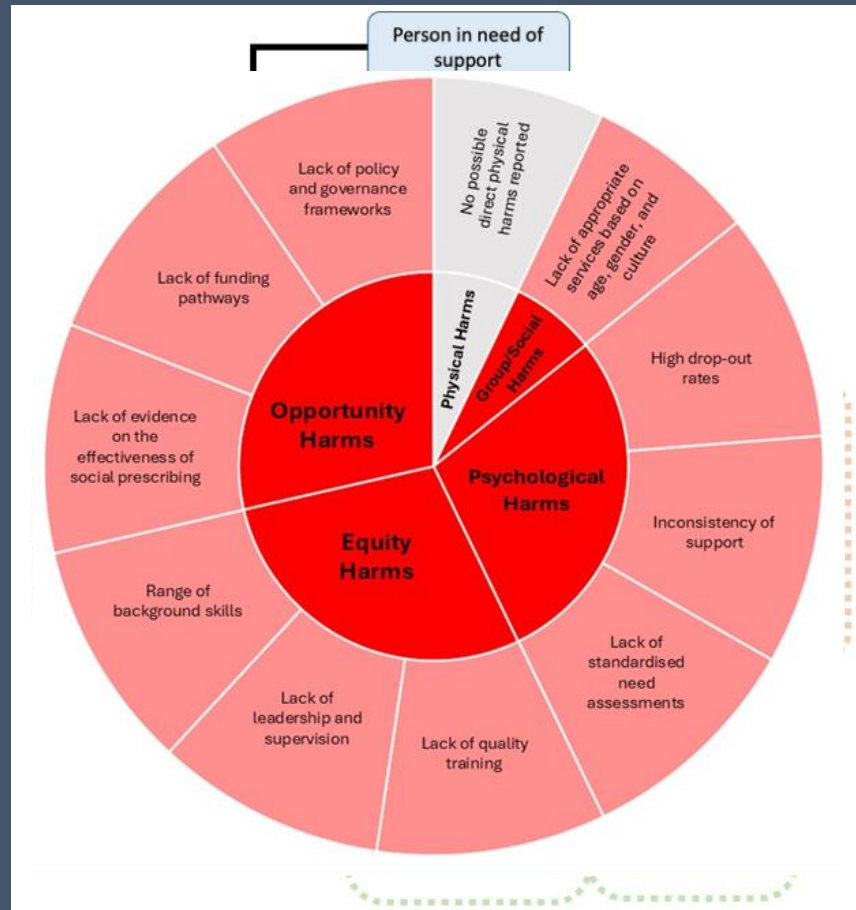
Example 1: Young@Heart

Young@Heart



Example 2: Workforce Development

Workforce Development



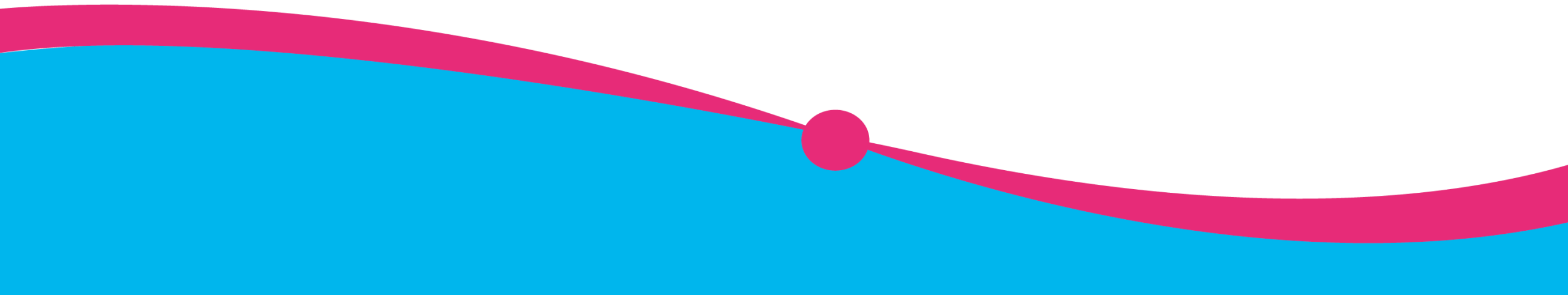
Case Study 3: A Pilot Diabetes Psychology Service in Derbyshire

Mr Niall Anderson
niall.anderson1@nhs.net





What is the problem?





Diabetes is a key NHS challenge

In Derbyshire, over 70,000 people (8%) live with Type 2 Diabetes and over 7,000 (1%) with Type 1 Diabetes.

6% (£10.7bn/year) of the NHS budget is spent on diabetes (£18bn/year forecast by 2025) with 60% on complications.

Difficulties managing diabetes increases healthcare costs, with a 11mmol/mol (1%) rise costing 4.4% more.



Living with diabetes is hard

1 in 3 people living with a long-term condition live with a co-morbid diagnosed mental health condition.

3 in 4 people experience an increase to anxiety or depression symptoms because of living with diabetes

People living with pre-existing mental health concerns have worse health outcomes and engagement with healthcare.



Specialist input can make a difference

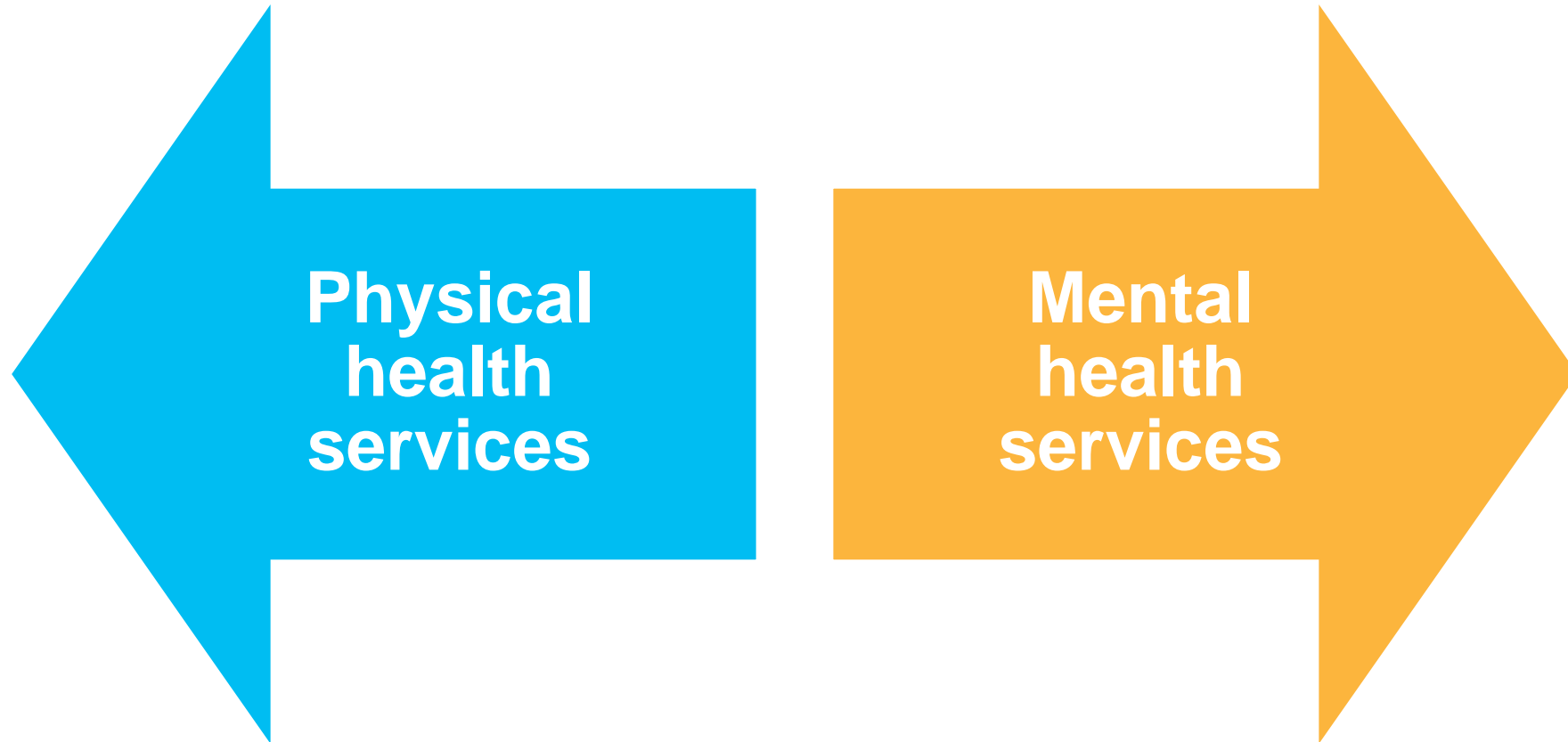
Reducing HbA1c by 11mmol/mol (1%) may reduce total healthcare costs by 13%.

The Hillingdon wellbeing service improved HbA1c by 12mmol/mol, reducing costs by 34% at 12-months.

If all patients were offered psychology, it was estimated £551,224 could have been saved in avoidable complications.

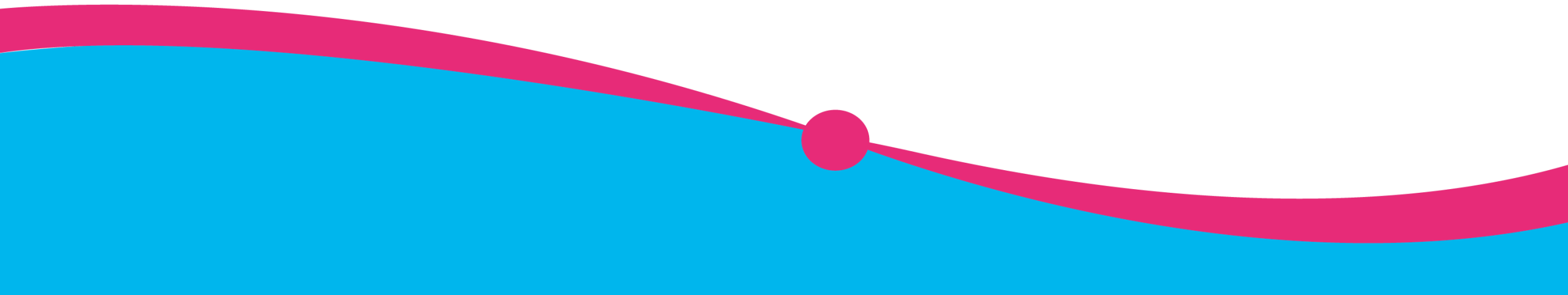


What's the problem?





What did we do?

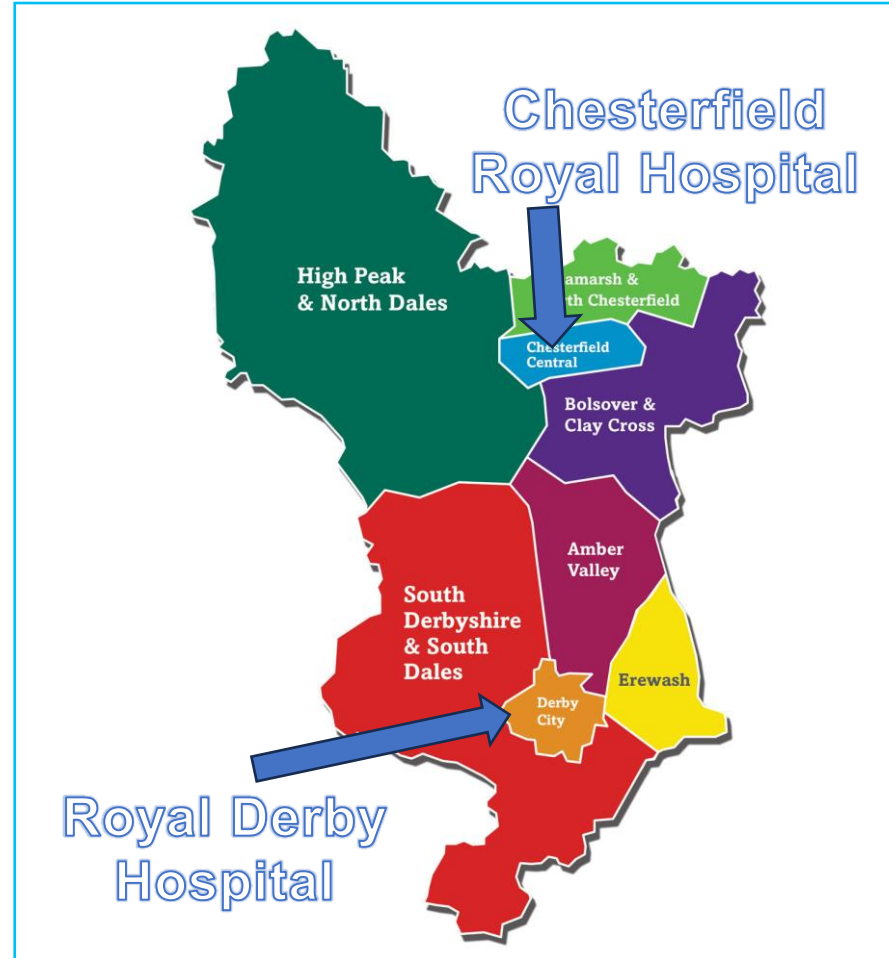




Derbyshire & Beyond

Sheffield Hospitals

Stockport
Hospitals



Nottingham
Hospitals

Queen Hospital Burton

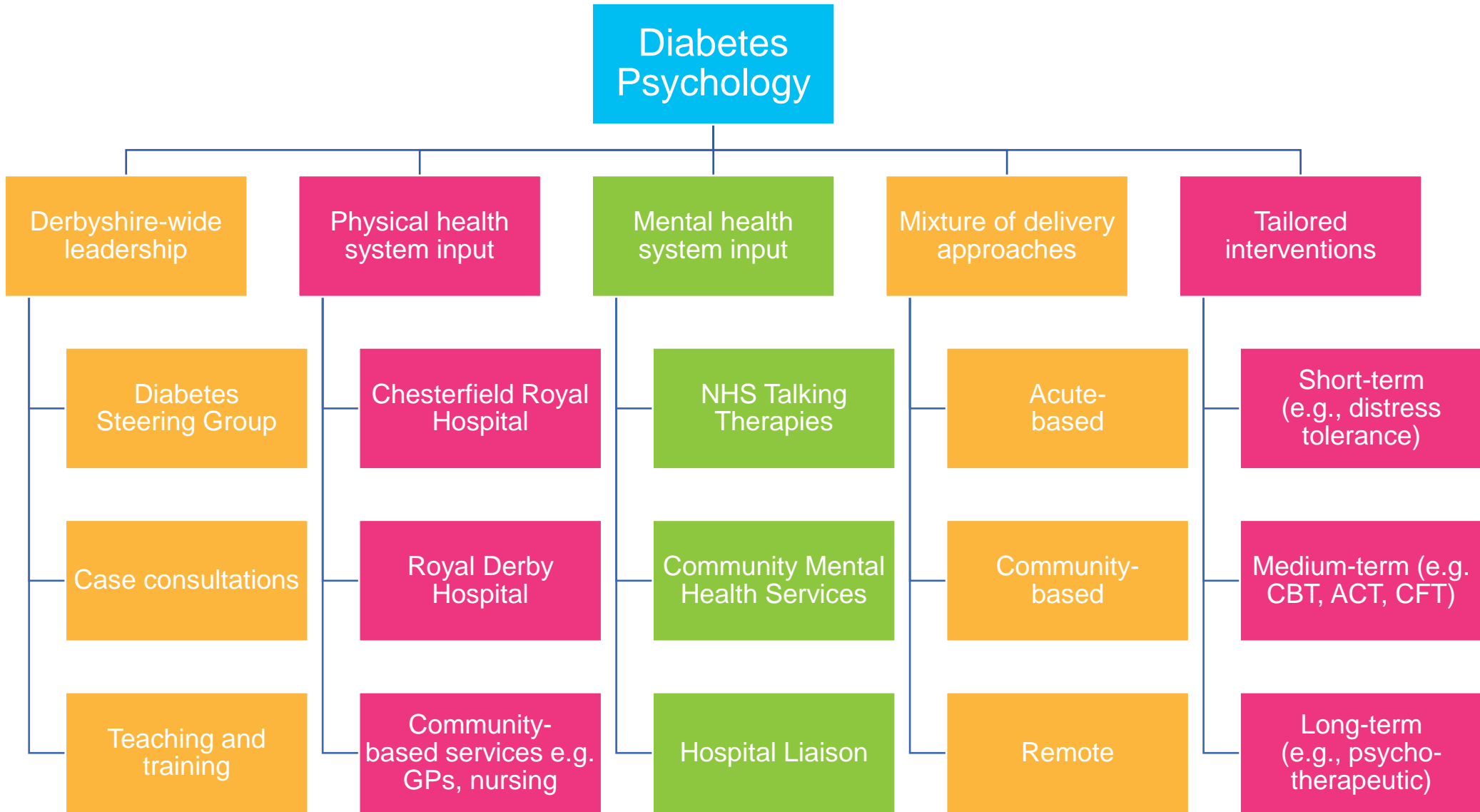


What we did

Innovative approach using DCHS as a host organisation working with hospitals to move care to community.

Service co-designed with diabetes services across Derbyshire to agree on pathway, processes, offer etc.

Combination of acute, community and remote offer of clinical and indirect roles with a view to impacting diabetes care.





What this looked like in practice



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graph TD; A[Case studies] --> B["(A)  
Male.  
Late 20s.  
T1D diagnosed  
as a child.  
Frequent DKA."]; A --> C["(B)  
Female.  
Early 20s.  
Recent T1D  
diagnosis.  
Diabetes distress."];
```

Case studies

(A)

Male.
Late 20s.
T1D diagnosed
as a child.
Frequent DKA.

(B)

Female.
Early 20s.
Recent T1D
diagnosis.
Diabetes distress.



Case Study: 'John'

Background

- Male.
- Late 20s.
- Diagnosed with Type 1 Diabetes as a child.

Physical

- High Intensity User (many recent A&E/HDU).
- No insulin routine (often guessing).
- No meal routine (snacks and sporadic meals).

Social

- Limited family support.
- Familial physical and mental health issues.
- Limited engagement with diabetes teams.

Psychological

- Long-term low mood.
- High diabetes-related distress.
- Low quality of life and wellbeing.



Case Study: 'John'

Input

- 8 sessions.
- Cognitive Behavioural Therapy (CBT).
- Improved self-management of insulin.

Physical

- Improved management (2 meals/day, insulin).
- Improved HbA1c (approx. 45mmol/mol drop).
- No A&E/HDU for ≥ 7 months ($\geq \text{£}9,000$ saving).

Social

- Better productivity (e.g., engaging with care).
- Increase in activities important to them.
- Making plans to enhance quality of life.

Psychological

- Increased coping tools for future difficulties.
- Reduction in low mood symptoms
- Reduction in diabetes-related distress.



Case Study: 'Jess'

Background

- Female.
- Early 20s.
- Newly diagnosed with Type 1 Diabetes.

Physical

- Good engagement with diabetes team.
- Difficulty adjusting to and accepting diagnosis.
- Difficulty injecting (HbA1c \geq 170mmolmol).

Social

- Supportive family.
- Close relative having health-related treatment.
- Person close to them died from health issue.

Psychological

- Long-term input from mental health services.
- Awaiting neurodivergent-related assessment.
- High diabetes distress.



Case Study: 'Jess'

Input

- 10 sessions.
- Emotion regulation and coping with distress.
- Tolerating needles, improving medication use.

Physical

- Continued engagement with A&E/HDU input.
- Improved HbA1c (approx. 90mmol/mol drop).
- 100% long- and $\geq 70\%$ short-acting insulin.

Social

- Better productivity (e.g., joined-up care).
- Improved relationships with close family.
- Increase in valued activities (e.g., walks dog).

Psychological

- Improved understanding/coping with distress.
- Maintained 100% mental health medication.
- Improved psychological/diabetes distress.



What staff said

“Diabetes is a chronic condition and patients face challenges every day. From long term health and health economics reasons, clinical psychology had positive influence and there are data to support”

“Psychological well-being has a massive impact on the ability of people to self-manage their diabetes. Effectively supporting these patients with psychological support will have a huge impact in terms of reducing their future impact on healthcare usage, due to reduced surrounding complications.”

“Diabetes is associated with ongoing psychological stress, can lead to burn out, and ongoing diabetes distress, these patients without a psychology support may have worse outcomes , hospital admissions etc.”



What staff said

Domain	Sub-domain	Existing Mental Health Services e.g. NHS TT, CMHT	Diabetes Psychology
Capability	I know which service(s) to refer to.	31%	92% (+61%)
	I have the skills needed to refer.	31%	82% (+51%)
Opportunity	I have the time needed to refer	31%	58% (+27%)
	I have the resources/help needed to make appropriate referrals.	8%	50% (+42%)
Motivation	Referring people is part of my role.	92%	100% (+8%)
	Referring people will make a positive difference.	62%	92% (+30%)



What staff said

Domain	Existing Mental Health Services e.g. NHS TT, CMHT	Diabetes Psychology
Improves quality of life	40%	90% (+50%)
Improves psychological distress	40%	90% (+50%)
Improves relationships with diabetes services	20%	90% (+70%)
Improves joined-up, holistic care	20%	90% (+70%)
Improves diabetes-related distress	0%	90% (+90%)
Improved adherence to recommended diabetes treatment	0%	90% (+90%)
Reduces preventable ED usage and non-elective admissions	20%	60% (+40%)
Reduces preventable healthcare usage	0%	60% (+60%)



What changed for patients

Measures	Improvements	
	All patients*	Patients with starting HbA1c > 75mmol/mol*
Diabetes control (HbA1c)	17%	27%
Blood pressure	5%	7%
Cholesterol	14%	8%

*For patients' whose data was available on their physical health records



What changed for patients

Measures	Improvements
Psychological distress (CORE-OM)	32%
Daily health rating (EQ VAS)	26%
Health-related quality of life (EQ-5D)	36%
Diabetes distress (T1_DDAS)	25%

*For patients' whose data was available on their physical health records



Our key learning

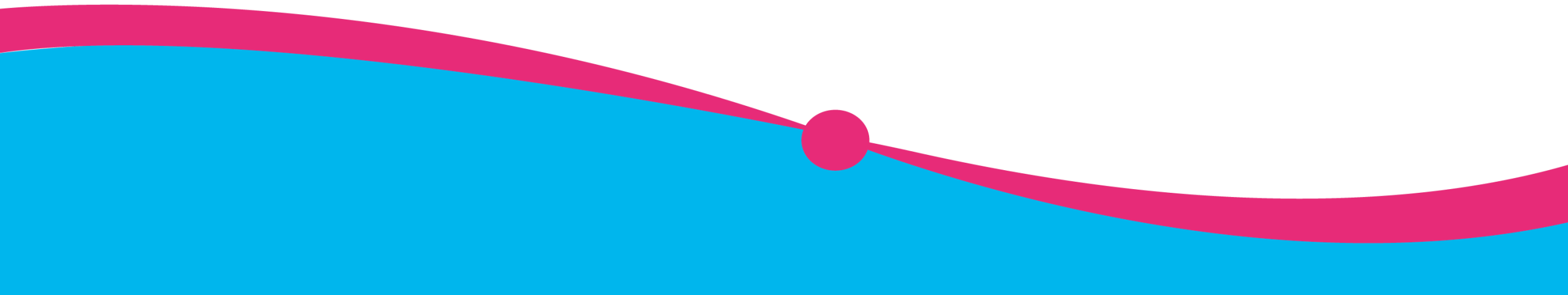
The need for specialist Diabetes Psychologist exists, and if available staff and patients want to and do use it.

Diabetes Psychology effectively moved care from hospital to community by improving self-management and hospital use.

Without services the need still exists and is not met, keeping pressure on hospitals and slowing transitions to community.

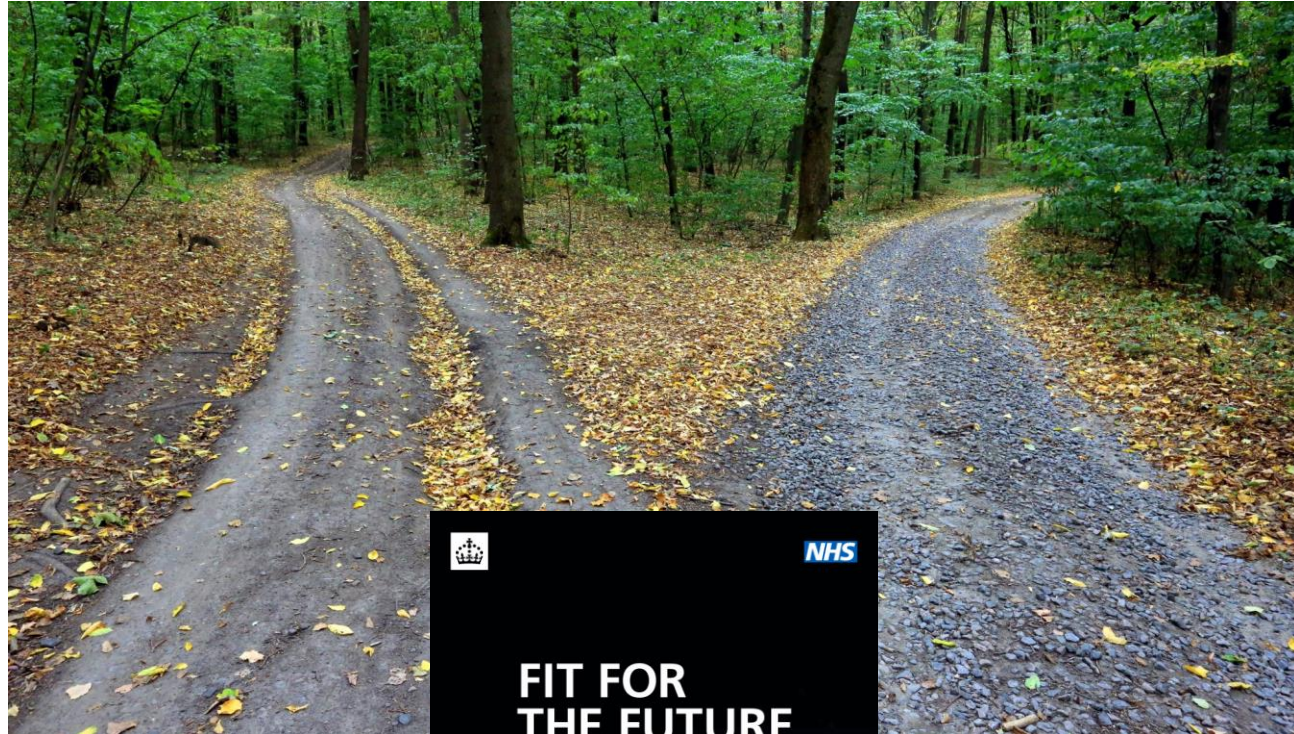


What now?





Psychological improvements



Q&A with presenters

**Liz Jenkinson, Kate Swainston,
Lorelle Dismore, Matt Cooper,
Niall Anderson**





Thank you

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www.ppn.nhs.uk

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