Developing Integrated Pathways for the Assessment and Treatment of Depression and Anxiety in people with Chronic Obstructive Pulmonary Disease (COPD) in North East Lincolnshire

Admissions Data, Estimated Savings, Future Predictions

Funding was provided by The Burdett Trust for Nursing in 2012 to develop integrated pathways between Open Minds/IAPT (NAViGO, providing Cognitive Behavioural Therapy), Hope Street clinic (providing community specialist services for COPD) and acute COPD services at Diana Princess of Wales hospital. Referrals are taken directly from the hospital wards and from Hope Street clinic and people are seen on the hospital wards and in the community (normally in their own homes). In addition, pathways have also been developed with the complex case managers/community matrons and primary care staff (including practice nurses); working collaboratively together in a multidisciplinary team approach.

Furthermore, developments during the second year of the project included developing pathways from the oxygen clinics at Diana Princess of Wales hospital and taking referrals from the heart failure nurses at the hospital. Leaflets and posters have also been designed and have been distributed to GP practices and community settings so that people with COPD and heart failure can also self-refer for treatment.

During the first year of the project 137 people were referred and offered assessment/ individual sessions of CBT and a further 140 people attended the group sessions that were provided as part of the Pulmonary Rehab programme at Hope Street. During the second year, 207 people were referred and offered assessment/individual sessions of CBT and around 144 people attended the group sessions. By February 2015 there had been 509 referrals for assessment, 144 of these had completed individual treatment, and an additional 304 people had attended the Pulmonary Rehabilitation and Cardiac group talks.

The service started in May 2012 and referrals to the service were lower than expected during the first year but have gradually increased and continued to increase during the second year reaching a 53% increase by the end of the second year.

The statistical analysis below was carried out at the end of year two to identify whether there had been any significant differences (reductions) in the number of hospital admissions and A&E attendances for people with a diagnosis of COPD (this also includes people with multiple long term conditions including heart failure) that have been treated using cognitive behavioural therapy (CBT) for depression and/or anxiety as part of this project. Admissions data was provided by the ward clerk on C1 Holles at Diana Princess of Wales Hospital. A&E data was provided by the Information and Benchmarking Analyst based at Scunthorpe General Hospital.

This statistical analysis can only include people that had admissions for acute exacerbation of COPD in the six months prior to beginning CBT treatment and finished CBT treatment at least six months ago (in order to compare 6 months pre-treatment and 6 months post-treatment for potentially preventable admissions). It also excludes people that were receiving pulmonary rehab at the same time (in an

attempt to identify the impact of the CBT intervention on admissions). In the table below 'Pre' refers to admissions and bed days for acute exacerbation of COPD in the 6 months prior to starting CBT intervention and 'Post' refers to those in the 6 months immediately following completion of CBT.

Admissions Data

	COPD Admissions		Bed days	
	Pre	**Post**	**Pre**	**Post**
A	1	0	12	0
B	1	0	6	0
C	1	0	14	0
D	2	0	16	0
E*	2	1	31	4
F	2	0	14	0
G	3	0	26	0
H	1	0	13	0
I	1	0	3	0
M	1	0	10	0
N	1	0	8	0
O	1	0	4	0
P	1	0	2	0
Q	1	0	3	0
Total	**19**	**1**	**162**	**4**
Reduction:	**18**		**158**	

E*: "I thought I was going to die when I was panicking, I couldn't control my breathing, it was an horrendous feeling, **I would ask my wife to call an ambulance**, I knew they would have oxygen and get me to hospital"

"I now know I'm not going to die, I'm more aware of pacing myself and I can keep control of my thoughts and I now realise it's a build-up of adrenalin"

"It would have been helpful to have the service two years ago, **who knows I may not have had as many stays in hospital and been in a better frame of mind"**

- *Client E, high impact user*

The table above show the figures for all the clients and admissions data that met the criteria mentioned at the start of treatment. Client E had the highest figure for both admissions and A&E attendance.

Client E is classed as a high impact user. The A&E data we obtained (shown on the next page) also shows that this client attended A&E 5 times 6 months prior to treatment, and only twice in the 6 months after treatment. Using the average cost information we have found, for this client alone, the difference in the estimated cost of bed days and A&E attendance from pre service to post service is over £10,000 in potential savings.

Client E	Pre	Post
Bed Days	31	4
A&E Attendance	5	2
Average Cost	**£11,977**	**£1,666**
Estimated Saving	**£10,311**	

Estimated using 2010/11 HCHS: average £372 for COPD bed day with oxygen and a recent estimation of A&E attendance cost at £89.

The definition of a high-impact user of services (or 'frequent flyer') is a COPD patient who has had 3 or more emergency admissions for any diagnosis in the past 12 months. The average estimated cost of a high impact user ranges from £3,226 in Solihull to more than £6,000 in inner-city areas around London. This looked at 8,469 GP practices across England.
(http://drfosterintelligence.co.uk/2011/04/05/dr-foster-is-proud-to-launch-the-gp-practice-index-2nd-edition-exploring-variation-in-copd-care-and-cost/)
In December 2010 a report published for The Kings Fund (link included below) highlights the need to identify these high-impact users and those at higher risk of hospital re-admissions in order to avoid unnecessary or unplanned admissions to hospital. This paper looks at what interventions work and found that education plays a big role in understanding and managing an illness. It encourages a shared aim to increase self-management among people with long-term conditions where there is evidence of benefit. The anecdotal evidence we have collected (included at the end of this document) also appears to support this finding:

"It gives you a clearer understanding of how you might feel and what you can do to help yourself a bit more."

"I feel more confident in myself. I can control thoughts and feelings instead of having panic attacks. Very happy not to have them"

"Helped me to be in a better frame of mind regarding my condition and dealing with its problems".

(http://www.kingsfund.org.uk/sites/files/kf/Avoiding-Hospital-Admissions-Sarah-Purdy-December2010.pdf)

A&E Data

Client	A&E Attendance	
	Pre	Post
A	1	0
B	3	0
C	1	0
D	2	0
E*	5	2
F	3	0
G	4	1
H	1	0
I	1	0
J	1	0
K	1	1
L	4	3
M	1	0
N	1	0
O	4	0
P	2	0
Q	1	0
R	0	1
S	2	0
T	1	0
U	2	0
V	1	0
W	0	2
X	0	1
Y	0	1
Z	3	0
AI	1	0

Total	**46**	**12**
Reduction	**34**	

Statistical Analysis

Year 1: 137 Referrals, 26 completed treatment
Year 2: 209 Referrals, 60 completed treatment

To date: **509** referrals, 144 complete, **81%** recovery rate for depression/anxiety *

***based on the use of clinical outcome measures (PHQ-9 and GAD-7) starting above the clinical threshold and reducing to below at the end of treatment.

304 Attendees to Pulmonary Rehabilitation and Cardiac sessions on depression and anxiety

The Admissions and A&E data shown previously and analysed, only includes data that falls 6 months prior to treatment and must also meet the following criteria:

- Client must have completed treatment for 6 months or more
- Does not include clients who had Pulmonary Rehabilitation at the same time
- Admission and A&E data must clearly be related to COPD or exacerbation of COPD (in order to be classed as potentially preventable)

Reasons for low sample size:

- Client Deceased during or shortly after treatment
- Client was receiving Pulmonary Rehab treatment at the same time
- Admissions Data was not complete/accurate
- Client hasn't yet reached 6 months post-treatment (or delay in receiving data)
- No Admissions/A&E Data in the specified time frame

Statistical Analysis of the pre/post data was carried out using SPSS statistical software using a non-parametric paired samples Wilcoxon test. This test is used for data that has a repeated measures design and can be used to analyse data with an intervention – it looks at the data for an individual under two different conditions (pre service and post service) and that have multiple possible outcomes. The goal of a repeated measures design is to determine whether there is a significant change across the two conditions that are being measured.

We wanted to know if there was a statistically significant difference in hospital admissions following CBT/psychological intervention as well as reduction in the total number of bed days. The P value is classed as statistically significant if $P<0.05$. The result for hospital admissions = $P< 0.000$ and the result for the number of bed days pre and post service = $P<0.001$ indicating that both showed a statistically significant

reduction 6 months after receiving CBT intervention compared with the 6 months before the intervention.

The same test was used to analyse the A&E data. The result was P<0.001 which is again statistically significant.

Estimated savings

Using the admissions data and A&E data obtained from Diana Princess of Wales Hospital and NLAG, we have identified the following figures for COPD Admissions, Bed Days and A&E attendances pre and post psychological intervention for clients meeting the necessary criteria. (Comparable data for hospital admissions detailed below accounts for only 18% of all those who completed treatment and comparable A&E data accounts for 34% of all those who completed treatment):

	COPD Admissions		Bed days		A&E Attendance		GP Attendance		Amublance call-out	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Total	19	1	162	4	46	12	108	0	65	13
Reduction	18		158		34		108		52	
Estimated Cost	£1,960		£372		£89		£20		£208	
Estimated Saving	**£35,280**		**£58,776**		**£3,026**		**£2,160**		**£10,816**	
Total Savings:	**£110,058**									

Using the data that shows there has been a reduction of 18 admissions, plus a further reduction of 34 A&E attendances the table above also calculates the minimum potential savings based on the assumption that the data may also indicate a reduction of up to 52 ambulance call-outs. It also includes a saving of at least 4 visits to the GP* for each of those who had an admission/A&E attendance.

*Case Study relating to GP visits

52 year old gentleman diagnosed with COPD 1 year prior to receiving Psycho-education, formulation utilising a Health Anxiety Model and Behavioural Activation treatment with the service. Client had lost touch with family and friends and no longer engaged in pleasurable activities and had become hyper-vigilant to normal bodily sensations leading to an obsession with self-diagnosis using the internet and repeatedly eating the same foods. He visited the GP an average of **4 times** per week in a bid to seek reassurance for misinterpreted symptoms.

On completing treatment this client had reached recovery on depression and anxiety measures and also recovered on the health anxiety inventory and improved significantly on the work & social adjustment scale. He was enjoying a varied diet and had started to go fishing with a friend. He had only attended the surgery **once in the 3 weeks** before discharge.

This equates to a potential minimum saving in primary care use of £220 just for this one person.

Preventing possible A&E attendance and hospital admissions for service users like this gentleman, in much the same way that GP attendances have been prevented, is also a cost-saving measure that cannot be quantified but is clearly evident.

Primary Care: Rolling out the service

There are plans to expand the service by providing the service directly within GP practices, increase the number of clinical staff and to offer the service to people who have COPD, Diabetes and heart failure.

An estimate is given of expected referrals & potential savings in primary care alone (based on an average saving of 2 GP visits per person who completes treatment):

Using the actual number of referrals we received for clients who have a diagnosis of COPD, and the first year increase, we estimated the number of referrals we might receive in the first year of opening the service up to people with diabetes and heart failure based on prevalence data (Diabetes at 59% more prevalent than COPD and heart failure at 66% less prevalent than COPD):

Referrals		2012/13	2013/14	2014/15	2015/16
COPD		**137**	**209**	*263*	*298*
Projections:					
Diabetes				*218*	*333*
Heart Failure				*47*	*71*
Est. No of Referrals				***528***	***702***
Complete Treatment	***70%***			***369***	***491***
GP visits	2			*14,777*	*19,659*
	£20			**£34,436.40**	

This estimate of savings is based on the absolute minimum savings as it does not take into account any reductions in other primary care use such as practice nurse attendances, home visits by complex case managers or possible reductions in the use of medications due to better self-management.

The evidence so far suggests that psycho-education plays a big part in helping to reduce unnecessary health-service use. We can therefore go some way to incorporating people who attended the pulmonary rehabilitation and cardiac talks, receiving a form of psycho-educational intervention, into these savings. Using a minimum of 1 prevented GP visit for each attendee and 1 prevented GP visit for everyone who has fully completed treatment with the service, this generates a further possible minimum saving of £7,400.

GP visits (Avg £20 per visit)	Total for 2 Years	Saving (£)
Group attendees	284	5,680
Completed treatment	86	1,720
		£7,400

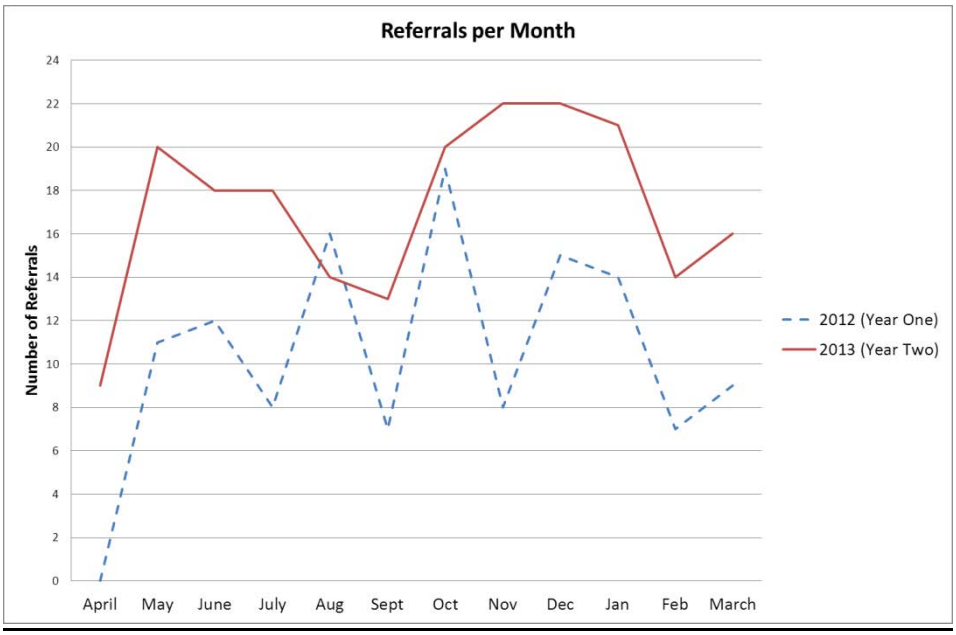
Adding this total to the previously calculated **estimated savings** using data obtained over 2 years this equates to:

£117,458

Given the nature of long-term conditions we can make some reference to the preventative possibilities that CBT (and other evidence based psychological therapies for depression and anxiety) and psycho-education can have on hospital admissions, A&E attendances, GP visits and out-of-hours service-use. There is a natural trend of increasing use of health services by people suffering with COPD and other long-term, progressive, conditions. Using averages calculated from the 18% of people who had comparable admissions and A&E data the table below shows estimated savings per person, using average reductions per person, for the remaining 82% who completed treatment but didn't meet the criteria for comparable data listed previously:

	Average Cost	Average Reduction	Saving Per Person (£)	Total	Overall Potential Savings (£)
A&E Attendance	£89	1.3	115.70	6,016.40	**171,636.40**
Admissions	£1,960	1.3	2,548	165,620	
Or					
A&E Attendance	£89	1.3	115.70	6,016.40	
Bed Stay	£372	11.3	4,203	273,195	**279,211.40**

Going Forward – predictions/saving estimations



In the first year of the service 137 people were referred, almost half of which were not appropriate for the service, were too poorly for treatment to commence or declined the service altogether. 21 people, 17%, completed treatment. By the end of year 2, 209 people were referred and 60 people, 29%, had completed treatment. This is an average of 25% of referrals completing treatment.

Given the intention to expand the service to include people with diabetes and heart failure, we have projected that the number of people who actually complete treatment would rise to an estimated 55%. This is because we would expect the number of people who aren't appropriate for service (not depressed/anxious, too poorly, declined treatment, end of life) to decrease given the prevalence of depression and anxiety amongst this group of people and also given the fact that they are being referred from, and seen, within a primary care setting (sugesting their appropriateness for the service and ability to engage and complete treatment will be higher).

Using the comparable admissions and A&E data from the first 2 years of the service, the average number that hospital admissions and A&E attendances reduced by was calculated as 1.3 (for both an admission and A&E attendance) per person. The admissions data used to average this accounted for 18% of those who completed treatment. The A&E data used for this accounted for 34% of those who completed. Therefore, by multiplying 18% of those who complete treatment by 1.3 and then multiplying this total by the average cost of a hospital admission, we have a total estimated figure for savings in hospital admissions which we can then apply for the next 3 years. The estimated savings for A&E were calculated in the same way except for using 34% in place of the 18%.

For savings in GP visits, the total number of those we would expect to complete treatment was used. This is because we would expect that around 2 visits to the GP could be saved for everyone who completes treatment. Although this isn't something that has been measured specifically, it is something that evidence has suggested to be a real possibility and our service user evaluation indicated to be the case.

Calculating an estimate for an ambulance call-out is more of a challenge since, again, this isn't something we have been able to factually measure to any degree of accuracy. However, for the purpose of projecting future savings it could be said, at the very least, that a quarter of all admissions and attendances to A&E for this group of people would likely occur via the use of an ambulance. These figures do not give any consideration to the fact that not all ambulance call-outs will lead to transporting the patient to hospital but are nevertheless a call-out at a cost. They also do not take into consideration that Rapid Response is also often called out unnecessarily by people suffering the effects of co-morbid conditions, so are based on a very minimum estimate.

Taking all of this into consideration, going forward, the team is currently in the process of expanding with the recruitment of 2 more clinicians (in addition to the two existing therapists) and has now started to accept referrals for people with a diagnosis of Diabetes or Cardiac problems and is integrating with the newly appointed Advanced Community Care Teams (based within North East Lincolnshire).The ACC teams will work with the identified top 2% in North East Lincs that have the majority of admissions. Each person identified has had multiple preventable admissions and long term conditions and will be managed by a team of professionals with input from our team to treat depression and anxiety to promote better self management of the physical health conditions. A further proposal for the service is to expand the team further by next year – recruiting another 2 clinicians

(the business case for recurrent funding to this effect has now been approved by the CCG endorsement panel). The projections for this are displayed in the table below.

In order to project savings from 2015 onwards, we have used the referral data, admissions data and A&E data (on the sample of people who met the criteria for this) that have been collected over the first 2/3 years' of the service, as previously explained. Using these figures against cost estimations we have then projected potential savings over the next 3 years. We have factored in a very minimum saving of 1 GP visit per person completing treatment given the evidence that suggests CBT and other psychological therapies to treat depression and anxiety can also help prevent/reduce those as well as attendances at hospital. The estimated number of referrals has been calculated based on the % increase per year for COPD referrals (calculated using the data from the first 2 years of service) and then halving this amount for each year after that, allowing for a natural levelling out of people referred. Also estimating the number of referrals for Diabetes and Cardiac, based on prevalence within North East Lincolnshire in comparison to COPD and the numbers of referrals we received in the first year for this cohort. This was increased per year in line with team capacity, taking the expansion of the team into consideration.

Referrals:		2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
COPD		137	211	253	*304*	*343*	*367*
Projections:							
Heart Failure					*93*	*140*	*168*
Diabetes					*436*	*653*	*784*
Est. No of Referrals					*832*	*1,136*	*1,319*
ACC Team Referrals	15%				125	170	198
Complete Treatment	*55%*				**458**	**625**	**725**
Potential Savings:			NB: Calculations below are based on the 55% total number of estimated referrals, per year, who complete treatment (shown above)				
GP visits	Visits pp completing treatment	1			458	625	725
	Total No. GP visits saved	**1,808**			**£9,157**	**£12,499**	**£14,509**
	Av. Cost	£20			**£36,164.44**		
Hospital Admissions:							
Hospital Admissions: COPD& Cardiac	Obtained data: % who had hospital admissions	***18%***			*39*	*48*	*53*
Admissions: Diabetes	9 x less than COPD admissions	***3%***			*6*	*9*	*11*
Admissions: ACC Team Referrals	55% complete treatment;expect to save admission for all	***100%***			*69*	*94*	*109*
Hospital Admission Calculations	Per person completing treatment	1			**£223,330.66**	**£295,035.01**	**£338,176.42**
	Total No Admissions saved	**437**			**£856,542.08**		
	Av. Cost	£1,960					
A&E Attendances:							
A&E Attendances: COPD & Cardiac ONLY	Obtained data: % who attended A&E	***35%***			*76*	*93*	*103*
A&E Calculations	Per Person	1			**£6,797.49**	**£8,271.71**	**£9,161.96**
	Total No A&E visits saved	**272**					
	Av. Cost	£89			**£24,231.16**		
Ambulance Call Outs:							
Amublance call-outs	Est. % of admissions/A&E visits via ambulance	**25%**			48	61	69
	Total call-outs	177			**£9,896.67**	**£12,660.37**	**£14,325.08**
	Av. Cost	£208			**£36,882.12**		
Total potential savings per year:					**£249,181.44**	**£328,466.36**	**£376,172.01**
Total potential projected savings:					**£953,819.80**		

Anecdotal Evidence Suggests…

Difficulties in gaining average cost estimates have meant that we have not been able to include cost savings within the areas we have identified below. However, there is evidence both anecdotally and within the scores collected using quality of life measures that suggest there are also potential savings being made within these areas:

- Medicines – e.g. Oxygen/Nebulisers

- Out-of Hours Service Use – e.g. Rapid Response, Ambulance, GP Services
- Social Care Costs – e.g. Clients reporting on coping better around the home/being more independent which is reflected in the reduction of score using the Work & Social Adjustment Scale measure (results to follow):

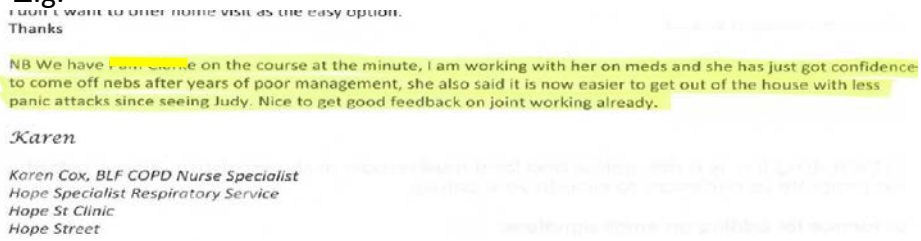
60% of clients who have completed treatment so far have shown a reduction (indicating improvement) in the area measuring Home Management on the Work and Social Adjustment Scale (W&SAS).

77% showed a reduction in the area measuring Social Leisure (indicating improvement).

<u>Using Pre/Post Service Questionnaire</u>:

72% noted that they had previously used out-of-hours services but hadn't done so since seeing their therapist.
(The out of hours services listed on the questionnaire are as follows: Practice Nurse, GP, Attended A&E, Complex Case Manager, Phoned Ambulance/Rapid Response)

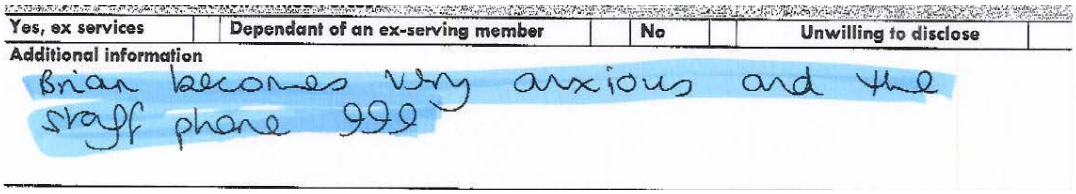
40% of clients who completed the questionnaire also noted a reduction in the use of medication. E.g.


Thanks

NB We have [illegible] on the course at the minute, I am working with her on meds and she has just got confidence to come off nebs after years of poor management, she also said it is now easier to get out of the house with less panic attacks since seeing Judy. Nice to get good feedback on joint working already.

Karen

Karen Cox, BLF COPD Nurse Specialist
Hope Specialist Respiratory Service
Hope St Clinic
Hope Street



- Nov 2013 Referral from Community Matron

<u>Service User Satisfaction Survey - client feedback</u>:

When asked how the service has most helped/benefited, responses can be summarised to the following:

- ✓ Now go out more
- ✓ Feel better, more confident and more relaxed
- ✓ Feel less panicky/Less panic attacks

- ✓ Now have a better understanding that helps with accepting, coping with and managing their illness.

When asked what was liked best about the service, responses can be summarised to the following:

- ✓ Home visits and 1:1 aspect
- ✓ Personal care and attention to individual needs
- ✓ Having someone to talk to who about living with the condition who can understand and advise.

Actual Feedback: "How has the service most helped you?"

✓ I can now leave the house again
✓ Helped me in every way, I'm more confident
✓ Shown me how to feel able to cope
✓ More relaxed when I go out
✓ Has helped me know more on how to cope with my health
✓ Helped me to have a different outlook on life. I no longer ruminate. Thank you for all the help you have given me
✓ I'm more confident. I now go out on my own and go out for more meals.
✓ Helped me with breathing, pacing and worrying less.
✓ All the information that has been explained to me.
✓ It has helped me a lot, well worth it.
✓ It has put things in my mind to help me feel better
✓ I have a better understanding of it all now.
✓ I feel more confident in myself. I can control thoughts and feelings instead of having panic attacks. Very happy not to have them.
✓ I apply what I've been taught to help manage my panic attacks.
✓ I felt like I would have 'gone under', I can cope with COPD now, it's really helped me.
✓ I have a better understanding of how my mental wellbeing is affected by COPD. I know now when I have bad days, my thoughts and feelings are put into place and can cope with them. I now take on tasks around the home with more confidence. I cope with tiredness better and before this treatment, only drove around town - now i feel we can go further afield and plan days out. I was able to relate with my wifew all about the visits and as a couple we can now plan ahead to the future, it's put something back which we didn't have before. I thank Jan for her help and putting my life back into perspective.
✓ I go out more and meet new people.
✓ Greater Understanding of Feelings & Anxiety
✓ Helped me mentally a lot. It's got the chip off my shoulder, I've stopped feeling sorry for myself
✓ It gives you a clearer understsanding of how you might feel and what you can do to help yourself a bit more
✓ I liked the 1:1. It was like talking to an old friend which made me feel more relaxed and I also think I could cope better if I have a panic attack or a coughing fit. I can walk a little bit further slowly but not panicking.

- ✓ To leave the house again.
- ✓ Helped to clear my mind to focus on other topics.
- ✓ It has helped me to pace myself a lot more and not to ask so much of myself.
- ✓ Helped me to get back to normality, doing things that everyone else does.
- ✓ Helped me to be in a better frame of mind regarding my condition and dealing with its problems.
- ✓ It's helped me a lot. I was able to ask questions and get the right answers
- ✓ At the present time, I can cope more with having to do less, without feeling the NEED to go out.
- ✓ The tutorials I've had are interesting and informative.
- ✓ I have become more confident in myself and more able to cope with any setbacks I might have. I am more open with people and more confident when going out and meeting people
- ✓ Gave me more confidence to do things.
- ✓ I can cope with the problem now
- ✓ Knowing you can have someone to talk to is very helpful. I think you do a wonderful job with you caring and explaing and the time you take.
- ✓ Gained confidence and accepted the condition more.
- ✓ Breathing control instead of panicking
- ✓ Almost everything
- ✓ I had a panic attack, I was very upset and Judy showed and told me how to get through it. I recently went to Scarborough with my son and I have never felt so well, even getting ready I would normally panic but I was very calm.
- ✓ It's helped me get my life back on track. It's relieved the stress so much and I honestly believe I have a future now.
- ✓ Helped me to understand more.
- ✓ I feel very positive about my condition as I was very grumpy about it before therapy sessions, I have accepted it more.
- ✓ I feel better.
- ✓ Jan has helped me realise that I can do things with a little control, she has helped me combat my panic and fears and shown me how to control them, although they are still there.
- ✓ Handle worries/fears better with the aid of breathing and reacting to pain differently.
- ✓ Taught me how to keep cool and not to worry if I can't do anything about things.
- ✓ They have helped me control my depression and avoid situations that cause it. I now rarely get any signs of it happening. The service has helped me to accept situations that I can't change through one on one discussions and positive suggestion.

What did you like best about the service?

- ✓ Informal and Friendly - keep up the good work
- ✓ Having someone to talk to.
- ✓ like to talk and have someone to listen who is able to understand
- ✓ The way it was all handled and delivered

- ✓ The one-to-one therapy sessions with therapist - this service is excellent
- ✓ Easy to talk to and confide in
- ✓ The honesty, support and good guidance
- ✓ Home visits and Conversation
- ✓ I can put my point of view over and it is listened to.
- ✓ Service was 10 out of 10, the therapist was brilliant and knew her job.
- ✓ Talking to somebody who listens, all very good for me, it really helps.
- ✓ Good at explaining things, cheerful therapist.
- ✓ One-to-one in my own home. It's relaxed.
- ✓ Listening to problems that apply to me
- ✓ Being able to talk to someone
- ✓ The one-to-one chats in my home, it was relaxed and informal.
- ✓ Having someone to talk to who's willing to listen.
- ✓ Home visits and someone listening to my needs.
- ✓ Knowing that I'm not alone.
- ✓ Not too intrusive, ints about you and subject and the involvement with your health.
- ✓ Any questions I asked I received a satisfactory answer or explanation to the best of her ability and to my understanding.
- ✓ The Therapist (Judy) is a very good listener and seems to understand how I feel and didn't lecture like from a script.
- ✓ Informative and friendly
- ✓ Very friendly.
- ✓ Jan has helped me a lot, just by talking and her helping me to control my breathing better.
- ✓ The understanding.
- ✓ The 1 to 1 aspect.
- ✓ The person that comes to see me. It's been a great service.
- ✓ Non Judgemental.
- ✓ Overall everything! All round friendliness.
- ✓ Firstly, the friendliness of everyone involved and their helpfulness. Secondly, so much of the advice has been practical and of immediate help - and certainly more useful than previous therapies have been.
- ✓ The pleasant way Jan talked to me.
- ✓ Understanding and advice.
- ✓ Having someone who understands what the problem is.
- ✓ Everthing I said, Judy listend to. Everything was well done.
- ✓ It did help a lot. It calmed me down. I now think about other things or try to when I feel a panic attack coming on.
- ✓ You're always there, I can rely on you. It's a First class service. I can't fault it - all due to my therapist.
- ✓ The Therapist (Judy)
- ✓ The personal care and attention given at each session. Making me feel better about myself.
- ✓ I didn't know what to expect but I found it very useful.
- ✓ Being able to talk freely about how I feel.

✓ I was able to be honest about feelings/fears and I felt understood. I was given 100% attention and felt comfortable. Thank you for the help I have been given!
✓ Friendly therapist.
✓ one on one discussions

What can be improved?

- Publicised better – more widely available
- Service offered as soon as diagnosed
- Not as many questionnaires
- More group work