Improvement Lab

In partnership with mind for better mental health

Exploring the experiences of people living with both mental health problems and persistent back and neck pain, and how care can be designed to best meet their health and wellbeing needs

Why this topic matters

There is a **complex interrelationship** between mental and physical health, particularly long-term physical health conditions such as persistent back and neck pain. Research has highlighted that **people with long-term physical health conditions are two to three times more likely to experience mental health problems** than the general population, yet research shows that our health services are failing to effectively address people's physical and mental health at the same time, and this is **unsustainable** to our health system.

What we're learning about mental health and persistent back and neck pain

The research highlights the relationship between mental health and persistent back and neck pain is influenced by the **social determinants of health** as well as **biological** and **psychological** factors.

This includes research which highlights the fact that **people with pre-existing mental health problems** are at higher risk of experiencing persistent pain and face specific challenges in navigating the health system, managing their own health and responding to common treatments or support for persistent back and neck pain; as well as research that highlights how **people with persistent back and neck pain** are at higher risk of experiencing mental health problems such as depression and anxiety.

While this interrelationship will **not be new to people who work in this area**, research suggests that it is **not sufficiently understood**. **Organisational siloes**, a history of **inadequate training**, **funding** and **competing priorities** have made it difficult for consistent changes to be made to improve the experiences of, and outcomes resulting from, health and care information, support and services for people with mental health problems and persistent back and neck pain.

Who contributed to the research:

100 Lab participants

140 responses to survey to help us to identify current work in this area, and people's current experience

Desk research to review published research, policies, evaluations

25 participants in **5** research sessions to go into more depth about people's current experiences and work in this area

6 interviews with people with different lived experiences, conducted by **3** lab participants with their own personal experiences of the topic

25 telephone interviews with practitioners and professionals working in this area

Identifying opportunities for improvement

The research has led us to identify three areas where we see opportunities for improving care for people living with both mental health problems and persistent back and neck pain.

High level problems	Opportunities for improvement
Understanding and education The interconnection between mental health and persistent back and neck pain, and the long-term and changing nature of both conditions, is not well understood by a range of audiences, including the public, people who are newly diagnosed with these conditions and some non-specialist health care professionals. We're interested in increasing this understanding and ways to embed this within services to improve care.	1. Make **education** about the connections between mental health problems and persistent back and neck pain, and how to manage living with both, much more widely available and accessible. This could be for patients, health care professionals, carers, families, workplaces and the public. Services could start by targeting those most at risk, or people who are frequently attending services because they haven't found adequate solutions or support. 2. Support people to **find out about and access a range of evidence-based interventions** and services that enable people to come to terms with the long-term nature of their conditions and **effectively self-manage** their mental health problems and persistent back and neck pain. This should recognise the interconnection between the conditions and how this will change over the course of someone's life, and the role of their carers and support networks. 3. Improve support for health care professionals so they are **confident supporting people's holistic needs outside of their specialism** (recognising the challenges around risk, more complex needs and how to effectively signpost).
Health service design Despite widespread recognition of the interconnection between mental health and persistent back and neck pain, and increasingly inclusion in clinical policy and guidelines, many health services are not designed to support people with mental and physical conditions at the same time. While changes may take time, there are some practical opportunities around communications or more substantial service redesign.	1. **Improve connections between different health care services**, including opportunities around communication, integration, multidisciplinary team working and how referrals are made. 2. **Improve communication between patients and health professionals**. Whether perceived or real, individuals living with persistent back and neck pain and mental health problems highlight a feeling of not being heard by their health professional. It's therefore important to provide the right tools and opportunities for health professionals and patients to have better conversations (including opportunities around consultations, non-medical interventions and making every contact count) to better meet people's holistic care needs. Different approaches, skills or specialist support may be required for people with more complex communication needs, including learning disabilities and dementia.
Workplaces Mental health problems and persistent back and neck pain are particularly prevalent in the working age population, and are the two most common reasons for people to be on long-term sick leave. There is variation in the way that organisations and employers support people's health and wellbeing.	1. Improve the ability of **workplaces to support employees** with (and potentially preventing development of) mental health problems and persistent back and neck pain. There is an opportunity to look at how NHS workplaces could take a leading role in this. 2. Delivering **services directly to and in partnership with workplaces** (including opportunities around peer support from colleagues and mental health awareness training).

Understanding and education

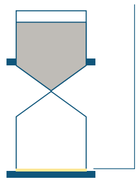
The interconnection between mental health and persistent back and neck pain, and the long-term and changing nature of both conditions, is not well understood by a range of audiences, including the public, people who are newly diagnosed with these conditions and some non-specialist health care professionals. We're interested in increasing this understanding and ways to embed this within services to improve care.

Why this is a problem

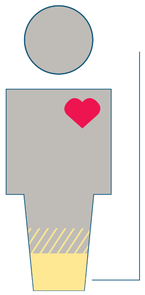
- **Ineffective or delayed care:** Through a lack of knowledge of their conditions and cultural perspectives on illness **people wait too long** to access appropriate services or treatments. People will often begin a long journey of tests, investigations and surgical or medical interventions with expectations of a diagnosis or cure. Consequently, it can take a long time to **develop coping strategies** that work for them: they may struggle to **adhere to an intervention**; or the treatment offered may fail to address their **holistic needs** or presents unwanted side effects. This can be detrimental to people's health and wellbeing, their family relationships, social networks and work. It can also impact on their confidence in the health system and their response to subsequent treatment and care that move beyond the 'medical model' of pain and mental health.
- **Unnecessary demand**: People may find themselves **looping** through different services or '**getting stuck**' between services. This is not just a problem when someone is first diagnosed, but occurs **throughout their life** as their mental and physical health changes.

Evidence

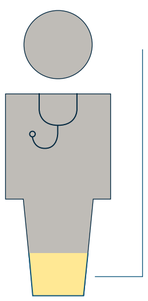
Research highlights that patients with comorbid depression and pain experience more challenges in developing self-management skills and adopting healthy behaviours. People told us that their experience of pain is worse when they are stressed, depressed, anxious or have been through a traumatic event, and their mental health is worse when their pain is bad.



Patients with long-term conditions spend **under 1%** of their time in contact with health professionals. The majority of their care comprises tasks they or their carers manage on a daily basis.[1]



Just **13%** of patients with long-term conditions reported feeling knowledgeable about their health condition and said they were able to engage in healthy behaviours and confidently plan their care. In contrast, **22%** of patients were likely to feel overwhelmed by the demands of their long-term condition and not take an active role in their own care.[2]



45% of all GP appointments and half of all new visits to hospital clinics in the UK include presentation of 'medically unexplained symptoms', which can include people experiencing persistent back and neck pain.[3] Construing pain in this way can lead to misunderstanding and ineffective management.

16% of people with persistent pain feel their pain is so bad that they sometimes want to die.[4] A person living with pain will have a very poor quality of life - much worse than other conditions, and as bad as significant neurological diseases such as Parkinson's.[5]

[1] Deeny, S., Thorlby, R. and Steventon, A. (2018) Briefing: Reducing emergency admissions: unlocking the potential of people to better manage their long-term conditions. London: The Health Foundation.
[2] ibid
[3] Medically unexplained symptoms [online] https://www.nhs.uk/conditions/medically-unexplained-symptoms/ (accessed 5/2/19)
[4] Donaldson L. (2009) Chief Medical Offer 2008 Annual Report. London: Department of Health

System and policy context

- The **NHS Long Term Plan** states that personalised care will become 'business as usual' across the health and care system. **Universal personalised care: Implementing the Comprehensive Model** outlines how the NHS will do this. This incorporates shared decision making, personalised care and support planning, social prescribing and community based support and supported self management.
- **Making Every Contact Count (MECC)** is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief or very brief discussion on health or wellbeing factors to take place. At its core it includes a focus on mental health and wellbeing and instils the principle of 'no wrong door': providers have an open door policy for individuals to make every contact count.
- The **British Pain Society** produced evidence-based patient pathways to support consistent care and commissioning of pain services. Patient education and supported self-management is recommended from an early stage.
- The classification of **'medically unexplained symptoms' (MUS**) can include symptoms of persistent back and neck pain. Unexplained symptoms can cause distress and anxiety for patients, and can cause dissatisfaction for GPs caring for these patients.[6] Currently, IAPT teams are tasked with managing people with mild to moderate MUS, however this does not meet the needs of patients with more complex problems. The IAPT guidance on MUS is not considered to be acceptable by pain specialists who are concerned that patients with chronic pain will be referred to IAPT practitioners, who they believe do not have adequate training in pain management. They are concerned that it is not based on a biopsychosocial model for understanding pain and that it will overwhelm the IAPT service and lead patients to inappropriate treatment.[7]

[5] UK Pain Messages (2016) Chronic Pain Policy Coalition. Available from www.policyconnect.org.uk
[6] Chew-Graham, C., Heyland, S., Kingstone, T., Shepherd, T., Buszewicz, M., Burroughs, H. and Sumathipala, A. (2017) Medically unexplained symptoms: continuing challenges for primary care, British Journal of General Practice
[7] Williams, A. and Johnson, M. (2011) 'Debate and Analysis: Persistent Pain: not a Medically Unexplained Symptom' British Journal of General Practice, October 2011; and British Pain Society (2008) Response to the Department of Health's IAPT Documents.

Lived experience stories

The experience of living with persistent back and neck pain and mental health problems is individual to every person, influenced as much by how they experience the conditions as their context, including where they live, work and personal relationships.

"It was only years later that I looked back and recognised that I'd been depressed." Q Lab interviewee

"I've had all kinds of things done to my back […] and none of it really helped. Then I did a pain management programme, which was superb and really helped me. I have been doing really well. They taught me to really manage my fibro[myalgia] and I've been doing really well." Q Lab interviewee

"I live a fun packed life […] The people I saw unfortunately used language that painted an MSK problem and that I should protect and strengthen my weak/damaged/degenerative lower back. They lacked the skills to delve into other basic health care advice and to teach me 'self efficacy' and 'self management.'" Q Lab participant, living with persistent back pain

"I have experienced both back pain and mental health problems. One of the best 'interventions' for depression is exercise and back pain can prevent engaging in exercise. Not being able to do a sport that you have been doing can mean a loss of social interaction and social contacts." Q Lab survey respondent

"I think when you live with chronic pain, it is a part of life, always a part of life […] So you do only go and ask for things and seek things or end up turning up at A&E because you are really worried about this [or] because you have gone so far outside your limits that you know you cannot manage it." Q Lab interviewee

"Pain medication is only one part of the solution. Developing appropriate 'for me' resilience tools from self-care/management, ensures that 'I am in control', and this is provided by a mixed method of approaches." Q Lab participant, living with persistent pain

Health practitioner stories

"Unlike many illnesses where national guidelines determine a patient's pathway, the [persistent physical symptoms] patient pathway is strongly mediated by the quality of the health professional-patient relationship."
Joanne Smithson, Dr Vincent Deary, Dr Michaela Fay, Northumbria University, 2015 *We need to talk about symptoms: an introduction Information for health professionals on Persistent Physical Symptoms*

"[It's important to] normalise the responses we have to pain. Developing a persistent pain problem often comes with a lot of losses (health, self-confidence, job and friendships) and as human beings we react to loss by grieving. So many of the symptoms of mental ill health are a part of us adjusting to a change in our health circumstances." Q Lab participant, health professional

Learning from good practice

- The **'Triangle of Care'** was developed by the Carers Trust to improve mental health acute services, to improve the involvement of carers and families. It is a working collaboration, or "therapeutic alliance" between the service user, professional and carer that promotes safety, supports recovery and sustains well-being.
- Northumbria University and AHSN North East North Cumbria have been undertaking research to work within **General Practice to Improve Pathways for People with Persistent Physical Symptoms**. They ran a small pilot with two GP surgeries to train GPs to make a positive diagnosis and to undertake proactive work with patients presenting with Persistent Physical Symptoms to address their needs.
- The Pain and Fatigue Management Centre at Bronllys in **Powys Teaching Health Board** runs a variety of programmes for people with persistent pain. Programmes are either held at the Centre or run in the community, and they are increasingly using telehealth options (such as via Skype) for patients unable to access services.
- **Health Innovation Network's Joint Pain Advisor** approach to support people manage chronic knee, hip and back pain. Participants attend up to four face to face consultations over a six-month period with a physiotherapist based in GP surgeries, as an alternative to a consultation with a GP. It has been piloted with Health Trainers upskilled to deliver the service in community settings. HiN's evaluation has highlighted the benefits for people to better understand and manage their pain, and valued the personal, holistic approach.
- The **Keele STarT Back Screening Tool** is a prognostic questionnaire widely used and endorsed by NICE, that helps clinicians to systematically identify patients at risk of persistent pain symptoms to inform shared decision making about stratified management.
- Public Health Wales fund a **Chronic Pain Self Management Programme**, adapted for the UK and based on an evidence-based model developed by Stanford University. It has been designed to enhance regular treatment and is available in the majority of Health Boards across Wales.
- **Pain Management Programmes** are based on biopsychosocial management to fully address the needs of individuals. However, Pain Management Programmes are not consistently delivered across the country, and historically are offered to people who have failed previous medical interventions. Research has suggested that a less intensive form of intervention may be both effective and cost-effective if delivered at an early stage, and that non-specialist staff can be trained to deliver low-intensity or brief psychologically informed pain management interventions, focused primarily on improving physical functioning and self-management skills.[8]

[8] The British Pain Society (2013) Guidelines for Pain Management Programmes for adults. An evidence-based review prepared on behalf of the British Pain Society. London: The British Pain Society.

What else do you know of?
What does good practice mean to you?

Opportunities for improvement

I. Make education around the interconnection between mental health problems and persistent back and neck pain, and how to manage living with both, much more widely available and accessible. This could be for patients, health care professionals, carers, families, workplaces and the public. Services could start by targeting those most at risk, or people who are frequently attending services because they haven't found adequate solutions or support.

II. Support people to find out about and access a range of evidence-based interventions and services that enable people to come to terms with the long-term nature of their conditions and effectively self-manage their mental health problems and persistent back and neck pain. This should recognise the interconnection between the conditions and how this will change over the course of someone's life, and the role their carers and support networks.

III. Improve support for health care professionals so they are confident supporting people's holistic needs outside of their specialism (recognising the challenges around risk, more complex needs and how to effectively signpost).

How can we respond to these opportunities?

What do you think?

Add a green sticker to what you agree with

Add a red sticker when you disagree or have a different experience

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Health service design

Despite widespread recognition of the interconnection between mental health and persistent back and neck pain by health professionals, and increasingly inclusion in clinical policy and guidelines, many health services are not designed to support people with mental and physical conditions at the same time. While changes may take time there are some practical opportunities around communications or more substantial service redesign.

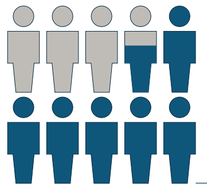
Why this is a problem

- **Missed opportunities to support people effectively: Short appointment times** in primary care are not sufficient to discuss mental health for people with complex physical health needs. Furthermore, shared symptoms between mild and moderate mental health problems and persistent back and neck pain can prevent recognition of co-existing conditions or **'diagnostic overshadowing'** as a person's description of their symptoms is not considered seriously. This can lead to **unnecessary demand**, with people attending multiple services multiple times as they have not adequately met their needs as well as **over-prescription** of medications that fail to address underlying issues and lead to unwanted side effects.
- **Lack of joined-up care:** People have to **retell their stories** and may have to navigate conflicting health advice. Health professionals may not know about community services available to ensure people are able to access appropriate services that are right for them. This results in **poor patient experience** which can have a detrimental impact on their health and quality of life and lead to unnecessary demand on GPs and emergency care.
- **Stress or anxiety:** People have a burden of responsibility to co-ordinate their care, which can be particularly difficult when they are feeling unwell and have poor mental health.

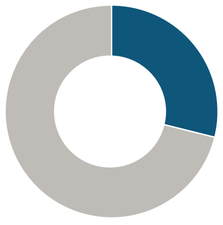
Evidence

Research highlights that people with multiple health conditions account for substantially higher rates of hospitalisation, prescription costs and appointment times. They rely on GPs more than any other NHS service.

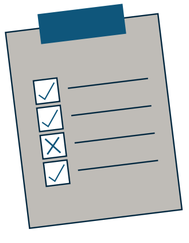
45% is the average increase in cost of providing care for people with long-term conditions if they also develop mental health problems.[9]



66% of people attending A&E seeking help with pain had more than three visits to a healthcare professional in the preceding six months.[10]



29% of CCGs did not commission a multidisciplinary pain service (defined as a minimum of a doctor, physiotherapist and a psychologist) according to a 2013 survey.[11]



Less than half of respondents to the Big Mental Health survey felt able to discuss physical health issues in the same appointment with a GP when discussing mental health issues.[12]

[9] Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., Galea, A. (2012) Long-term conditions and mental health The cost of co-morbidities. London: The King's Fund and Centre for Mental Health

[10] Price, C., Hoggart, B., Olukoga, O., Williams, A., Bottle, A. (2012) National Pain Audit Final Report 2010-2012, Dr Foster Research

[11] The Royal College of General Practitioners (2013) Pain Management Services: Planning for the Future - guiding clinicians in their engagement with commissioners

[12] Mind (2018) Big Mental Health Survey 2017 Headline Findings. London: Mind

[13] Integrated Care Systems [online] https://www.england.nhs.uk/integratedcare/integrated-care-systems/ [accessed 5/2/19]

System and policy context

- Sustainability and Transformation Partnerships (STPs) have started to evolve into **Integrated Care Systems** to enable better collaboration and management of resources.[13]
- **Improving Access to Psychological Therapies (IAPT)** services are now required to be commissioned by every CCG in England to provide a course of NICE-recommended psychological therapy to over half a million people each year for people who need treatment for depression and anxiety-related disorders. The IAPT-LTC service has been developed to better integrate and coordinate people's physical and mental health care needs.
- **Five Year Forward View for Mental Health**, published by the Independent Mental Health Taskforce in 2016 and accepted by NHS England, cites an integrated mental and physical health approach as a priority action for the NHS and speaks of parity between mental health and physical health.
- The **General Practice Forward View (GPFV)**, published in April 2016, commits to an extra £2.4 billion a year to support general practice services by 2020/21 across the following key areas: Investment, Workload, Care redesign, Practice infrastructure, Workforce.
- The **NHS ten year plan**, published in January 2019 made key commitments to improve care in mental health services and to continue work to coordinate local services better.
- The Government's action plan: **Closing the gap: Priorities for essential change in mental health**, builds on the 2011 strategy paper 'No Health without Mental Health', which set out how to improve the mental health and wellbeing. It outlines a priority to increase access to mental health services, improve the quality of mental health services and to integrate physical and mental health care.
- **NICE** guidelines for low back pain recognises physical and psychological treatments for assessing and managing persistent low back pain.
- In 2018/19 the **Welsh Government have consulted on a new Persistent Pain Framework**, updating 2008 guidance. This guidance, which brings together experiences from patients, their families and health professionals with current policies on health and social care in Wales, to provide a focus for Welsh health boards to improve the range and quality of services for people living with persistent pain.
- In November 2018, the **Arthritis and Musculoskeletal Alliance (ARMA)**, which has 40 member organisations, published a policy paper on MSK and mental health, signalling this as a key priority for their members.
- The **Faculty of Pain Medicine** analyses the trends relating to the pain workforce in England and Wales, this is currently being updated. They also published non-mandatory **Core Standards for Pain Management Services** as a guide numbers of staffing and what services should be available.
- The **Royal College of GPs** published pain management services commissioning guidance for clinicians. This work came out of the 2011 English Pain Summit.
- The **British Pain Society**, which is an alliance of professionals who aim to increase the understanding and management of pain publish evidence-base guidelines for Pain Management Programmes. These guidelines are currently being updated.

Lived experience stories

“It’s such a fight to get help. You have to be very determined and people who are ill are too busy fighting their illness to actually fight to try and get the help.” Q Lab Interviewee

“My pain service referred me back [into Primary Care]. They can’t really do anything for me. At the moment I’ve been bouncing between primary care and mental health and pain.” Q Lab Interviewee

Health practitioner stories

“The clinician’s own specialism can become a barrier, limiting person-centred care, for example, focussing on what a blood test shows, or on medication, but not addressing the impact of the MSK condition on the person’s life or their mental health needs.” ARMA, Policy Position Paper Musculoskeletal and Mental Health, 2018

“It is people who have a Medically Unexplained Symptom with a mental health diagnosis that we have most difficulty supporting. No one agency want to take a lead on the parts of care that is required from them. These patients have extremely poor service and they are constantly knocking on closed doors.” Q Lab participant, health professional

“Before the collaborative service was launched, the care of patients living with chronic pain could be disjointed, with each provider managing their own episode of care in isolation to other healthcare colleagues. This often led to duplication of information and multiple visits for patients.” Dr Antoni Chan, Rheumatology Consultant at the Royal Berkshire Hospital on their Integrated Pain and Spinal Service (IPASS)

“I think with advances in neuroscience and our understanding of connectivity disorders and microbiome, the neurobiology of our nervous systems and the impact that stress and trauma has on us is becoming more apparent and really the separation of physical and mental health is an illusion that doesn’t serve our patients very well.” Q Lab participant, health professional

Learning from good practice

- **Integrating Mental & Physical healthcare: Research, Training & Services (IMPARTS)** within King's Health Partners is a package for physical healthcare settings designed to support clinical teams in providing timely, tailored, evidence-based care to patients. It is a screening tool that is integrated with a patient's electronic health record to facilitate routine collection of patient-reported outcomes, with real-time feedback to guide clinical care. Mental health care pathways are put in place for patients identified through the screening to ensure their needs are met and they are referred on appropriately. Alongside this, the clinical teams are given training in core mental health skills and ongoing support and supervision from a mental health specialist, and bespoke self-help materials are developed for the patients.
- **Pennine Persistent Pain Service** launched in June 2015 to provide holistic, integrated, interdisciplinary, person-centred care which meets the physical, psychological and social needs of adults with persistent pain. The pathway was redesigned through a collaborative, evidence-based approach and development included referral guidelines, workshops for GPs and practice managers and training. The service now has a single point of access and is delivered as an Integrated Pathway Hub.
- **The Integrated Pain and Spinal Service (IPASS)** developed through a collaborative process with clinicians, commissioners and patients at Berkshire West NHS Trust. It provides multi-disciplinary specialist assessments and treatments for patients with back and generalised persistent pain. It uses a holistic approach to address the physical and mental needs of patients through a range of programmes with the aim of improving quality of life, function and mental health.
- **Frequent Attenders programme** in Wales brings together partners across the NHS, public sector and third sector who work with people who frequently use emergency services. This programme integrates the work of different agencies and enables communication and information sharing. This ensures a patient-specific plan can be developed that doesn't just focus on the immediate crisis, but looks at the patient's health and social care needs in a rounded way.

What else do you know of?
What does good practice mean to you?

Opportunities for improvement

I. **Improve connections between different health care services**, including opportunities around communication, integration, multidisciplinary team working and how referrals are made.

II. **Improve communication between patients and health professionals**. Whether perceived or real, individuals living with persistent pain and mental health problems highlight a feeling of **not being heard** by their health professional. Therefore, it is important to provide the right tools and opportunities for health professionals and patients to have **better conversations** (including opportunities around consultations, non-medical interventions and making every contact count) to better meet people's **holistic care needs**. Different approaches, skills or specialist support may be required for people with more complex communication needs, including learning disabilities and dementia.

How can we respond to these opportunities?

What do you think?

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Workplaces

Mental health problems and persistent back and neck pain are particularly prevalent in the working age population, and are the two most common reasons for people to be on long-term sick leave. There is variation in the way that organisations and employers support people's health and wellbeing.

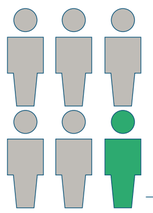
Why this is a problem

- People being out of work: if people are **not well supported** by their employer people may end up taking time off work or having to leave employment completely.
- **Missed opportunities to intervene:** there may be many people **at early stages** of living with mental health and persistent back and neck pain who could be better identified and supported with early interventions through their workplace, rather than through health services.

Evidence

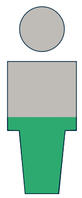
- A person's mental health is shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental health problems are associated with social inequalities: people living with mental illnesses often face higher rates of poverty, unemployment, lack of stable housing, and social isolation. These social factors increase the vulnerability of developing chronic physical conditions and worsen mental health.
- People who lose their jobs are more likely to suffer from significant physical and mental health problems. Most people who are out of work due to chronic illness would like to resume working in some capacity.
- The National Pain Audit highlighted the fact that many people in their survey were of working age and reported the biggest impact as their ability to work.[14] Employed adults are less likely to have a common mental health problem than those who are economically inactive or unemployed.

42.5m working days lost due to musculoskeletal conditions and stress, depression and anxiety in 2017.[15]



1 in 6 British workers are affected by mental health problems each year.[16]

49% of respondents to a Mind survey felt their employer supports their mental health and only **41%** felt their organisation encourages openness and discussions about mental health.[17]



41% of people who attended pain clinics report that their pain has prevented them from working, and **13%** have had to reduce their hours.[18] **25%** of people with chronic pain lose their jobs.[19]

System and policy context

- The Department for Work and Pensions' **Improving lives: the future of work, health and disability** report published in 2017 sets out the government's strategy on the future of work, health and disability.
- In 2019, £4 million of funding was awarded under the **Work and Health Challenge Fund**, a joint initiative between the Department for Work and Pensions and the Department of Health and Social Care. It has funded projects with a focus on mental health and musculoskeletal conditions.
- Assisting retention and return to work is considered an essential part of **pain management programmes**.
- **Mind's Workplace Wellbeing Index** enables employers to celebrate the good work they're doing to promote staff mental wellbeing and get the support they need to be able to do this even better.

[14] Price, C., Hoggart, B., Olukoga, O., Williams, A., Bottle, A. (2012) National Pain Audit Final Report 2010-2012, Dr Foster Research
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[16] Mind (2014) Mind YouGov Poll 2014, quoted in Mind's Workplace Wellbeing Index 2016/17 - Key insights
[17] Mind (2017) Mind's Workplace Wellbeing Index 2016/17 Key insights.
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Learning from good practice

- **Health and Work Champions** is project between Public Health England and the Royal College of Occupational Therapists involves 60 occupational therapists and other professionals who are training the healthcare workforce to ask about health and work.
- The **Prevention Concordat for Better Mental Health**, coordinated by Public Health England, aims to facilitate local and national action around preventing mental health problems and promoting good mental health.
- **Public Health England** commissioned an economic tool to compare the return on investment of interventions for the prevention of musculoskeletal conditions that affect working age populations, including back and neck pain. The tools return different assessments on the return on investment for healthcare savings to commissioners, and wider societal outcomes of increased productivity by reducing work days lost. The interventions in the model that showed having the greatest impact on work days saved are:
  - **STarT Back (Stratified Risk Assessment and Care)**, for back pain;
  - **Yoga for Healthy Lower Backs**;
  - **Vocational advice** from physiotherapists in primary care.

The other interventions in the model are:

- **Cognitive Behavioural Therapy (CBT)** including exercise, for back pain;
- **Self-referral** to physiotherapy for all MSK conditions;
- **PhysioDirect** (Early telephone assessment and advice);
- **ESCAPE-pain**, for knee pain.

What else do you know of?
What does good practice mean to you?

Opportunities for improvement

I. Improve the ability of workplaces to support people with (and potentially prevent development of) mental health problems and persistent back and neck pain. There is an opportunity to look at how NHS workplaces could take a leading role in this.

II. Deliver services directly to and in partnership with workplaces (including opportunities around peer support from colleagues, mental health first aid training).

How can we respond to these opportunities?

What do you think?

Add a green sticker to what you agree with

Add a red sticker when you disagree or have a different experience

Add comments on post-its when you want to respond and add your experiences...