Cognitive Functional Therapy

Author: Chris Newton, Extended Scope Practitioner Sponsor: Julie Smith, Chief Nurse Trust Board paper E

Introduction

Low back pain (LBP) is a ubiquitous public health problem. It is the primary cause of years lived with disability worldwide, is the most expensive health care problem that continues to burden the NHS and society and costs more than coronary heart disease and diabetes mellitus combined.[1,2] In response, the last 20 years have seen an exponential rise in magnetic resonance imaging, pharmacological treatments, therapies, spinal injections and surgical procedures used to identify and target proposed biomedical causes of LBP. Despite this increase, it is paradoxical that, at the same time, poorer health outcomes, including greater disability and work absenteeism have followed the same trend.[3] To date optimal care remains a challenge, with disability and the economic burden of LBP continuing to rise[1]. In Leicestershire more than 100,000 people are estimated to be living with severe and debilitating LBP.[4]

Contemporary understanding is clear that LBP is a complex multi-dimensional bio-psychosocial disorder. It is characterised by a wide range of physical, cognitive, emotional, social, lifestyle and co-morbid health related factors that uniquely interact to maintain pain and disability within each individual.[5] Negative beliefs, stress, anxiety, fear and depression are stronger predictors of pain intensity and disability levels than physical factors alone which may explain why biomedical management has failed to reduce this burden.[6]

Based on current evidence, Cognitive Functional Therapy (CFT) is an innovative and comprehensive bio-psychosocial approach to LBP which utilises a multi-dimensional clinical reasoning framework to target management.[5] Briefly, this management consists of three main arms:

1. A personally-relevant multidimensional understanding of pain

2. Exposure training directed to pain provocative, feared and/or avoided personally-relevant goals, during which *pain control* is explicitly targeted by challenging negative cognitions and modifying how the person physically performs the task (via body relaxation, control and extinction of protective and safety behaviours)

3. Addressing unhelpful lifestyle factors (physical activity, sleep hygiene and dietary advice).[5]

Patient Story

This patient story focuses upon Karen's experiences within the Trust and is in two parts.

First Karen describes how six months ago she was highly disabled with persistent LBP; she had experienced numerous failed interventions, was on long-term sick leave, needed elbow crutches to walk and was unable to socialise or take part in sports. She had lost faith in healthcare and was fearful that she would never return to a normal life. Her story highlights the inadequacies of current practice for Karen and how it contributed to her disability and on-going pain.

Then Karen goes on to outline her subsequent experience of CFT. Karen describes her transition in and out of pain and disability and how CFT enabled her to reclaim all aspects of her life.

Why Has This Patient Story Been Selected For Trust Board?

CFT is a pioneering approach to managing LBP, which, in recent international research has shown promise over and above traditional management.[7] Chris Newton (Physiotherapist) and the UHL team are the first clinicians to implement this approach within the NHS, showing promising results

in recent and on-going local research.[8] This approach will likely demonstrate significant value to the health economy, with recent analysis estimating a cost-saving of £120 per patient in comparison to traditional care. Further trials are underway.

What Are The Key Themes In The Patient Story?

Karen presents her story well and the main points she raises are:

- Karen had suffered from LBP for ten years which worsened in 2015 following surgery. Karen explains how current practice inhibited her recovery. She was left in severe pain and unable to participate in a meaningful or functional lifestyle.
- She was treated by a physiotherapist trained in CFT who enabled her to understand and control her pain. Her treatment was individualised, targeting underlying physical, lifestyle, cognitive, emotional and social factors. Within ten weeks, seven sessions of CFT (approximately seven hours of physiotherapy time) Karen had returned to full-time work, has ran a 10KM road race and returned to her martial arts. She is no longer taking prescription medications and is living a full life again.
- Further research is underway to evaluate CFT further.

What Are The Key Learning Points To Improve The Quality Of Patient Care/Experience, And How Will They Be Measured And Monitored In Future?

1) Current methods of treating LBP are at times ineffective and may contribute to the longevity of disability and pain. CFT has demonstrable results in improving pain and function and will be evaluated in future clinical trial in Leicester.

2) Explore future opportunities within CMG's (CSI, MSK and ITAPS) for support towards a dedicated CFT service for the financial year 2018/19.

Conclusion

Karen's story highlights the innovative approach that targets the multi-dimensional nature of LBP that has been implemented by physiotherapists at UHL, showing promising results in international and local research. This is an NHS first and has the potential to improve care of people with LBP and significantly reduce associated costs.

References

1. Vos T, Flaxman AD, Naghavi M et al (2012). Years lived with disability (YLDs) for 1160 sequelae of 289 diseases and injuries 1990-2010: a systematic analysis for the Global Burden of Disease Study. *Lancet*, **380**, 2163-2196.
2. Maniadakis N, Gray A (2000). The economic burden of back pain in the UK. *Pain*, **84** (1), 95-103.
3. Deyo R, Mirza S, Turner J, Martin B (2009). Over-treating low back pain: Time to back off? *Journal of American Board of family Practice*, **22**, 62-68.
4. Arthritis Research. Musculoskeletal calculator: Prevalence of back pain in England and Leicestershire. ARUK. Available from: http://www.arthritisresearchuk.org/arthritis-information/data-and-statistics/public-health-bulletins.aspx. Accessed August 2017.
5. O'Sullivan P (2012). Is it time for change with management of nonspecific low back pain. *British Journal of Sports Medicine*, **46**, 224-227.
6. Boersma K, Linton S (2005). Screening to identify patients at risk: Profiles of psychological risk factors for early intervention. Clinical Journal of Pain, 21, 38-43.
7. Fersum K,O'Sullivan P, Skouen JS, Smith A, Kvåle A. Efficacy of classification-based cognitive functional therapy in patients with non-specific chronic low back pain: A randomized controlled trial. *European Pain Journal.2013*; 17, 916-928.
8. Newton C, Singh S, Watson PJ. Implementation of classification-based cognitive functional therapy for people with non-specific chronic low back pain into an NHS physiotherapy service. *The Bone and Joint Journal*. 2014;96-B,(34, supp 4).
9. Spinal Taskforce for the Department of Health (2010). Organising quality and effective spinal services for patients: A report for local health communities by the spinal taskforce. DOH.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Yes
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Not applicable
Financially sustainable NHS organisation	Yes
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register — Not applicable

b. Board Assurance Framework — Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken:

This patient story consists of feedback directly from a patient about their experience of care within the Trust and the subsequent actions and learning from this and similar experiences.

4. Results of any **Equality Impact Assessment**, relating to this matter: N/A

5. Scheduled date for the **next paper** on this topic: N/A

6. Executive Summaries should not exceed **1 page**. My paper does

7. Papers should not exceed **7 pages.** My paper does