Item No: 5.1 Enc No: 7

South Staffordshire NHS
Primary Care Trust

REPORT TO THE PBC GOVERNANCE COMMITTEE TO BE HELD ON: 10th June 2009

Enclosure:						
Subject:	Seisdon Peninsula Locality Commissioning Group PBC 0809 Annual report					
Lead Director:	Geraint Griffiths					
Lead Officer:	Liz McCourt					
Recommendation:	**For Approval**		**For Discussion**		**For Information**	**x**

PURPOSE OF THE REPORT:

To inform the PBC Governance on Seisdon's achievements in 2008/09. This is a detailed report that will be shared with external partners and public.

KEY POINTS:

In the last year SPLCG has started to shape new services and take forward this agenda. The 2008/09 PBC plan focused on:

- Proactive hospital admissions schemes – Unique care pilot
- Tackling the health prevention agenda – choosing health, primary care mental health, alcohol CPN, health trainers and healthnet.
- Delivering national policies – patient consultation exercise, falls.
- Delivering local PCT objectives – Bilbrook house and integration agenda

IMPLICATIONS:

Legal and/or Risk	None
Standards for Better Health	D2 (a) Patients receive effective treatment and care that conform to nationally agreed best practice D2 (d) delivered by health care professionals who make clinical decisions based on evidence based practice
Financial	Part 2 PBC LES already approved in April
Training	None
PBC	Linked to PBC 08/09 agreed LES plan
Other	

RECOMMENDATIONS / ACTION REQUIRED:

SEISDON PENINSULA
LOCALITY COMMISSIONING GROUP

Practice Based Commissioning Annual Report 2008/09

Seisdon PBC 2008/09 Achievements

Introduction

The Seisdon Peninsula Locality Commissioning Group (SPLCG) consists of 8 member practices covering the areas of Claverley, Kinver, Wombourne, Bilbrook, Codsall, Pattingham and Perton.

The 2008/09 PBC plan focused on:
- proactive hospital admissions schemes
- tackling the health prevention agenda.
- Delivering national policies
- Delivering local PCT objectives

Areas of achievements

In the last year SPLCG has started to shape new services and take forward this agenda. Here are some of the highlights:

- Mental health services – increase in number of primary care mental health workers. "No delays" the service improvement project in the Mental Health Division of South Staffordshire & Shropshire Healthcare NHS Foundation Trust.
- Community alcohol service – new Seisdon Community Alcohol Team (CAT) service.
- Patient & public consultation on identifying gaps in local health services
- Development of musculoskeletal integrated service (MIS) – introduction of new service.
- Lifestyle service – new service of Seisdon health trainers
- Proactive emergency hospital avoidance pilot for people aged 65+ - Unique care, new service
- Integrated care – Bilbrook house. Co location of health and social care staff and additional clinical space for new services.
- Lymphoedema – review of service provision and recruitment of new post/service.
- Childhood obesity team – new posts: school nurse, assistant, physical activity deliverer
- Adult weight management – support to lose weight offered by GP surgeries and a new dietician led service
- Healthnet – creation of a new team and service that proactively identifies people who do not routinely access services.
- Dudley supported discharge nurse – new pilot service at Russell's hall hospital that proactively supports early and planned discharge.
- Falls service – no dedicated service exists. New service will commence in summer 2009 that will offer a fully comprehensive structured educational programme.

Primary care mental health workers

To address the absence of services within parts of the locality for patients suffering with mild to moderate anxiety/depression primary care mental health workers were introduced in 2007/08 and have recently increased from 1.5 to 4 full time posts covering the Seisdon area. This service has received positive comments from both General Practitioners (GPs) and patients. The mental health trust has recently carried out a patient satisfaction survey which included comments such as:

- "helped me through a hard time at work"

- "A very valuable service which should be offered to more people before being referred to a CPN"
- "Sessions were a key in my return to feeling well again".

Comments and suggestions made by service users are being implemented into the current service as it strives to provide a service local Seisdon patients want.

The questionnaire asked patients about their anxiety levels before and after seeing a primary care mental health worker. The increased score rating indicates a positive post therapy satisfaction levels amongst patients.

An example of the type of cases/work undertaken is demonstrated in two case studies (see appendix 1&2).

No delays project

PBC continue to work with the South Staffordshire and Shropshire healthcare NHS Foundation Trust on the "no delays project". "No Delays" is the name of the service improvement project in the Mental Health Division of South Staffordshire & Shropshire Healthcare NHS Foundation Trust. Seisdon are the first PBC group to look at what this means locally for patients. A project group has been meeting to look at mental health services can best serve the Seisdon population. The group consists of representatives from the trust, social services, PBC, carer, service user and mental health local delivery group.

Alcohol Community psychiatric nurse (CPN)

Previous to PBC there were little to no services for alcohol users. Seisdon has invested in a community alcohol team (CAT) model with South Staffordshire & Shropshire Healthcare Foundation trust. Since September there has been a dedicated CPN for the Seisdon practices. Patients now have quick access to a CPN, who can offer home detox if appropriate. As at end of February the service has received 55 referrals. Accumulative analysis is:

Community detox 5
Inpatient stay 1
Declined service 2
Non responder 3
Disengage 4
Abstinence 28
Controlled drinking 39
Successful completions 5

This service is highly rated by practices and patients, previously there was little to none service available.

Patient survey

Within the Seisdon work plan is patient consultation which is largely to ensure that the PBC direction of travel is in line with public and patient views. World Class commissioning requires PCT's to consultant with patients and public. As a result, an independent health questionnaire was sent to 7,500 randomly selected registered patients. A total of 1,915 responses were completed. Over half of the respondents have a long term condition (LTC) and are therefore service users. This may show the results slightly skewed as non service users are often afflicted with apathy until they need help. Those who have responded would therefore help design better care for themselves and the people who have not found their way into the system yet.

The questionnaire was divided into the following sections:
- Being healthy
- Local health services
- Identifying gaps in local health services
- Carers
- Older people

The finding of this questionnaire has been fed into the work plan for 2009/10 and compliments the work PBC has undertaken already. Further work is planned for 09/10 to involve patients in the planning of new services.

Seisdon musculoskeletal integrated service (MIS)

Up to a few months ago the waiting times for routine physiotherapy was 26 weeks. On November 10th Seisdon launched its new service known as MIS. This process took over a years worth of negotiations and agreements with local GPs, local physiotherapy service, orthopaedic consultants, Dudley and Wolverhampton hospitals and orthopaedic triage.

This service is in line with the Department of Health's musculoskeletal framework document. There are agreed care pathways through the service from GP referral to surgery. The aim of the service is to give patients access to a physiotherapy assessment within 48 working hours of referral. All appointments are centrally booked and patients are given a choice of time, day and venue. They are then offered advice, physiotherapy treatment, joint injection and in some cases onward referral to secondary care.

The amount of physiotherapists has increased and now the waiting times are down to the required 2-3 working days.

It is very early days, but initial feedback has been very positive. This is a quality service that aims to improve people's quality of life. This is different from the previous orthopaedic triage system introduced by the former PCT, of which one of the aims was to reduce the number of referrals into secondary care. This new service gives GPs the choice of referring direct into secondary care if appropriate or accessing physiotherapy.

Health trainers

There are 3 health trainers providing a service to the Seisdon practice population. Their role was developed with input from PBC who early on recognised a need to focus on people aged 50+ and to proactively seek out people who are not accessing primary care services. Since the role is focused on being proactive people are encouraged to self refer to the service rather than the traditional GP referral as is the case for other services.

There is also a link between the South Staffordshire district council Health and Wellbeing team, part of their role is to visit workplaces. The council also have access to leisure facilities which the health trainers can refer people to.

The service has been operational since October and as at the end of February 2009 has already seen 117 people. The service offered a range of advice on eating healthily, being more active, losing weight and alcohol intake. 64 people have requested an appointment with a health trainer.

Over two-thirds of client referrals are female with over half (56%) aged 50 and over. The majority of referrals (97%) are from a white background. Over a quarter of referrals are from the Featherstone practice.

Of all client referrals, 95% (61) have had an initial assessment and 80% (51) have created a Personal Health Plan. 27% of client referrals are from the most deprived quintiles (1 and 2).

The primary issues set within Personal Health Plans are:

- Diet – 35 (69%)
- Exercise – 10 (20%)
- Not recorded - 6 (12%)

The majority of these clients are referrals for healthy eating advice and supporting clients that are overweight and needing to increase their physical activity.

The service is receiving self referrals, referrals from other health professionals, support and community workers. They have also seen clients who have been recommended by family and friends.

They have very few clients that do not attend the subsequent sessions which suggests that the service is acceptable to the clients at times dates and venues that suit. Some clients have also brought their partners to the subsequent session wishing to access the service.

Comments have been very positive and clients have stated that they feel better in themselves and can not believe how much weight they have lost. They comment that they have learnt a great deal about diet, portions, exercise, in a format that was easy to understand.

Clients have appreciated the time spent with them.

Two clients from Perton have begun to go to “splash and tone” together and have gained support and friendship as well as increasing their activity levels.

Two ladies who have pre and school age children have lost more than a stone in weight and learnt about healthy eating that has impacted on the family. They both commented that their food bills were less as food was cooked more from scratch rather than rely on ready prepared foods.

One gentleman from Claverley Surgery has lost 23lbs in 10 weeks and is delighted with the service. This weight loss has had a positive impact on his depression and he has subsequently been discharged from the community mental health team at St David’s in Wombourne. The health trainer involved was praised by the Doctor from the team for his input.
Another client from the Dale practice has lost 10lbs in 4 weeks and called the service “inspirational” and he wished that the service had been around years ago.

The Health Trainers have made links with statutory and voluntary services and are beginning to be integrated into the community.

They have been active in raising their profile via Health Awareness Days and are looking forward to reaching more clients in rural areas via the multi agency bus towards the end of March.

They are soon to join the primary care community mental health workers in an awareness day at Codsall Village Hall.

Their service leaflets are now displayed through out the Seisdon area.

Unique care

Unique care is the name given to a project aimed at reducing the number of emergency hospital admissions and admissions to long term residential care for patients aged 65 and over.

The 2 Wombourne practices have been running a pilot for the last year. The team is made up of a community matron, health care assistant and social worker. A self assessment questionnaire consisting of 6 questions was sent to all patients aged 65 and over. This simple assessment allocated people into categories of risk of hospital admission in the next 12 months. The team aimed to concentrate on those in the high and very high categories. There are currently 91 patients on the active caseload.

The pilot has highlighted the need for more chronic disease management skills, in particular there was no dedicated heart failure or respiratory nurse covering the Seisdon practices. To address this shortfall recruitment is underway for these posts. A long term conditions nurse for neurological conditions is also in the pipe line. Further work is currently underway to look at the low level support services that can have a large impact on a person's wellbeing such as help with shopping, befriending etc.

Feedback received from patients has been fantastic. Service users appreciate the service and really benefit having a local contact that is looking at the whole person rather than just health or social care needs.

2 case studies:

Case study	History and assessed needs	Care actions and outcomes
1	65 years of age. Chronic Obstructive Pulmonary Disease (COPD), hypertension, anxiety, schizophrenia, diverticulitis, hiatus hernia. Lives alone, single, no children, elderly relatives, socially isolated a current care package. Frequent emergency admissions – COPD and panic attacks. In the last 2 months before referral to team, emergency admissions x 2, Out of Hours (OOH) GP calls x 6, frequently calling elderly relatives at night due to anxiety.	Key actions: • Advice on inhaler techniques, medicine management, smoking cessation. • Referral to Age Concern, social support • Benefits review • Care plan, contingency plan • Support to purchase discounted furniture • Chiropody referral
2	76 year old Diabetes, dementia, incontinence, frequent Urinary Tract Infections (UTI's), history of falls, menieries disease, pernicious anaemia	• Joint assessment • Care package in place • Occupational therapist and Physiotherapy referral (intermediate care team) • Referral to dietician • Care plan, contingency plan • Medicine management, health promotion activity • Benefits review • Prevention of pressure sores

Bilbrook house

Bilbrook house is a former older people's residential home which is owned by Staffordshire County council. The future of Bilbrook house was consulted on under the social care 'Changing lives' agenda. The outcome of the consultation was to close the residential home transferring the current residents to other accommodation. Local opinion was canvassed and support given to develop an integrated health and social care facility for older people and people with complex needs.

The focus of Bilbrook house is to:

- Reduce unnecessary admissions to hospital and residential care
- Provide a range of rehabilitation and therapy services to enable people to remain living in their own homes and as independently as possible

The aim of integrating health and social care is to develop a flexible workforce. As opposed to spending precious time debating whether this is a health or social care responsibility. By co-locating intermediate care and enablement there will be access to larger pool of staffing and experience and will avoid duplication. The benefit to a patient is they will be allocated the appropriate professional to suit their needs and requirements.

The key to the integration of Intermediate Care services is the development of a single point of access into intermediate care so that appropriate services can be accessed promptly through single referral and single assessment.

PBC are working closely with the Provider arm and Social Services to develop this centre. There is a shortage of community clinical space in the Seisdon area and this development provides opportunities not only to bring together the teams from both organisations but also to free up clinical space to deliver more services. Examples of new services are falls educational sessions, pulmonary rehab sessions, create more capacity for paediatric speech and language therapy and women's health clinics.

Lymphoedema review

Lymphoedema is a long term condition that cannot be cured, but can be treated. It is the swelling of an arm, leg or other part of the body tissue because of an abnormal collection of a fluid called lymph in the body tissues. This has been a long standing issue and PBC identified the need to review service provision in Seisdon and across the whole of the PCT. PBC requested a review from the Lymphoedema Support network and a service manager from the Derby Cancer network. Alongside this a patient questionnaire was put on the PCT website.

The review is now complete and in the process of being shared with the hospices. To free up capacity at the local hospice PBC are currently under discussion with the provider arm to up skill district nurses to take on the role of dealing with mild to moderate conditions.

The risks of doing nothing are that patients can develop cellulites and become hospitalised. This can be mitigated through self care and providing support in the community.

Childhood obesity team

An educational resource package has been commissioned for school nurses. A new team has been recruited in 2008/09. This consists of increased capacity in a part time school nurse, school nurse assistant to deliver enhanced service. In addition a physical activity deliverer has also been employed through South Staffordshire Council. Recruitment of a part time paediatric dietician is underway.

Healthnet

The Health NET project is a partnership service which provides information, advice and support to individuals/families in need, enabling them to address issues within their lives by accessing appropriate support services. The Seisdon service will be jointly funded between health and Social Services.

This service is aimed at individuals and families with multiple or complex needs which make it difficult for them to access available services and has a proven track record of being able to deliver a much needed service to the most disadvantaged members of the community, particularly; people of low income, lone parent families, homeless individuals/families, people with learning disabilities/difficulties and people with mental ill health.

Health NET is now being developed so that it can provide a targeted prevention service rather than the referral basis it has previously operated under.

This shift in service provision will involve pro-active identification of members of the public (clients) in need of support by partner organisations' and community staff. Once identified, information from partners will be transferred to staff at a Health NET contact centre. Health NET staff will undertake an initial assessment, if appropriate; the service will then contact the clients and instigate appropriate comprehensive assessment and supported referral into available services that will enable resolution of clients' needs.

The Seisdon district has recently recruited to 3 project workers who will be based in the Featherstone Children Centre. There is a shared information and call centre with Cannock. This service will be fully operational in April/May 2009.

Dudley supported discharge nurse

A new post commenced in January 2009 that proactively supports early discharge planning and identifies people who can be supported in their own home as opposed to a hospital setting.

To date (April 09), 35 assessments have taken place. Further analysis of assessment outcomes:

Outcome	Number
Offered step down bed	6
Referral to Social Services re care package	15
No further support required	4
Died	1
Not fit for discharge at time of assessment	2
Not fit for discharge	2
Community nursing/intermediate care support required	5
Declined service	2
Suitable for step down bed, but declined service and awaiting social services package	2
Total	35

Falls service

At present in the Seisdon Peninsula area there is no formal Falls Prevention Service. The Intermediate Care Team and Enablement Team assess and treat fallers/ people at risk of falling on an individual basis. Patients are visited at home where they receive an environmental check and are set an individual exercise programme and monitored for up to 6 weeks. These patients are not currently referred to a group setting. Both teams do

frequently receive referrals for patients who are recurrent fallers. It is anticipated that with a more intensive multi-disciplinary service the numbers of these would drop.

To address this shortfall PBC gave worked with Social Services, Intermediate care team and clinical champion to develop a comprehensive service specification to deliver a falls service compliant with the falls national Standard framework. This service specification is recognised as best practice in the PCT.

This service is currently being recruited to and will commence in summer 2009.

<u>What has this meant for the Seisdon patients</u>

- Mental health – increase in primary care mental health workers and sessions available. 165 people have accessed the service.

- Alcohol – 55 people accessed a new service and 5 people received detox in their own home

- Physiotherapy – increase in physiotherapy work force and reduced waiting times from 26 weeks to 2-3 working days. Treatment is offered at more local venues.

- Lifestyle support – new health trainer service providing motivational support for people wanting to make a change in their life. 117 people have contacted the service seeking support on increasing physical activity, healthy eating and losing weight.

- Proactive case management – new pilot for Wombourne patients that proactively identify people at risk of hospital admission and long term residential care. Currently 91 people are receiving a case management service from a community matron and health care assistant with support from other community teams.

- Childhood obesity – new team appointed that will deliver local sessions across the Seisdon area

- Adult weight management programmes offered by GP practices. Specialist dietician service to commence spring 2009.

- Service that will provide information, support to individuals/families with complex or multiple needs. New team appointed that will be fully operational from 1st April 2009.

- Supported discharge nurse at Dudley hospital – new service. Between January to April 2009, 35 people have been assessed, of which 6 were able to access a community bed in a nursing home and supported to go home as opposed to staying in a hospital facility.

- New falls service will commence in summer 2009.

Liz McCourt, Practice Based commissioning lead - Seisdon
Contributions from health trainer co-coordinator and primary care mental health workers

Appendix 1

Primary care mental health worker case study

This report is based on the authors own clinical practice, and has been compiled in accordance with the South Staffordshire and Shropshire N.H.S Foundation Trust confidentiality policies and procedures,

Brief Client History

The client is a 42 year old married woman with one step-daughter who is 11 years old. She works full time as a manager of a retail outlet and reports being under some stress at work due to managerial procedure and policy changes; however she feels that she still enjoys her work. She describes her marriage as being strong, loving and happy. The client moved to the Midlands two years ago from Liverpool due to her husbands work commitments, she states that the decision to re-locate was reached mutually and that she felt under no pressure from her husband to do this. Since moving to the Midlands she feels that they have settled in quite quickly, making lots of new friends and her Step-daughter is doing well at school and is very happy. She keeps in close contact with her family in Liverpool and visits them regularly.

Presenting Problem

The client was referred to our service by her GP who reported that she was suffering from low mood and anxiety. After assessing the client I found that she had been suffering these affects for the last eight months. She described her symptoms as follows; hot flushes, dizziness, palpitations, muscle tension, fatigue and a restless feeling. She states that she is constantly fretting about everything but could not think of anything specific that may have triggered these anxieties.

Whilst drawing up a formulation it was clear that the client had a very happy upbringing without any significant traumas or untoward life events. Therefore we began to look more closely at the recent events that may have had an effect on her cognitions. We discovered that twelve months ago the client’s 33 year old sister was admitted to hospital in Liverpool complaining of stomach pains. It was revealed that her sister had been taking diet pills that she had purchased via the internet and that she had been supplementing her dietary regime with these pills for some time, without the knowledge of her family. Her sister remained in hospital for some weeks and was eventually discharged after making a full recovery.

At the time the client recalls feeling shocked regarding the fact that her sister had been taking these pills and also that her sister had not confided in her or any other member of the family. She stated that she felt helpless and guilty, at the time because she was not there for her sister.

Earlier Sessions

This was our fourth session; the previous sessions were spent gathering assessment history and socialising the client to the Cognitive Behavioural Therapy Model for Generalised Anxiety Disorder. Collaboratively we drew out a conceptualisation and examined the content of the clients worry. I explained the differences between;

- Type1- worry about external daily events or (non-cognitive) internal events
- Type2- worry about worry and its effects/ consequences

We discussed safety behaviours and how the client attempts to control or eliminate their perceived threats such as suppression or reassurance seeking. We created a problem list

and set out the aims of treatment and I elicited the client's thoughts regarding homework. I had given the client daily thought records and weekly activity diaries to complete as part of her homework; she completed these without complaint and appeared to have found them helpful.

Treatment

I began by setting an agenda. We reviewed what had happened to the client in the weeks since our last session and began to examine the homework she had been set. I then began to illicit the clients meta-cognitions surrounding worry. Her positive beliefs about worry were that it helped her to plan and to control situations. We looked at her negative beliefs about worry and found that she thinks that her constant worrying means she is not normal. I attempted to normalise the clients worry and asked her to identify those worries that she thinks are abnormal and those that are normal.

I felt that the clients hot thought was one of losing control of situations rather than one of preventing perceived threats. Her negative thought being that this loss of control may lead to catastrophe. I feel that this may have been triggered by her feelings of helplessness and guilt regarding her sister's hospitalisation and that this has heightened her anxiety regarding her ability to cope in stressful situations. Therefore she now employs worry as coping strategy. I hope to examine this hypothesis further in future sessions. I ended the session by setting the client some homework and asking her how she felt the session had gone.

Outcomes

Through the use of daily thought records, continuity lines and thought balancing techniques the client has begun to challenge her negative assumptions regarding her ability to cope in what she perceives to be stressful (threatening) situations. She has reported a marked improvement in her anxiety affects. This has been supported by the results of the H A D S (hospital Anxiety & Depression Scale) which the client completed upon commencement of treatment which showed a score of 17 for anxiety and 12 for depression. At the time of writing the client now scores 9 for anxiety and 5 for depression.

Appendix 2

Primary care mental health case study no. 2

This report is based on the authors own clinical practice, and sets out to describe how the author applied Cognitive Behavioural Theory with an individual client presenting with panic attacks. The report was compiled in accordance with the South Staffordshire and Shropshire N.H.S Foundation Trust confidentiality policies and procedures, and written consent was obtained from the client.

Brief Client History

The client is a 43 year woman; she has been divorced for the last ten years and has 2 children, a daughter of 15 and a son who is 13 years old. She works full time as a teacher and reports being content, both within her professional and domestic life, at this present time.

Presenting Problem

The client presented with symptoms of panic. She reports that this has been a continual problem for her for the last 18 months. The first major attack occurred in January 07 whilst she was shopping with her daughter in a supermarket. She described her symptoms as follows: Dizziness, nausea, tremors, perspiration, racing heart and a feeling of unreality. On this occasion an ambulance was called and the client was examined by the paramedics. There have been several more attacks since this, causing varying degrees of distress which had begun to have an adverse effect on her daily life.

Initially the client could not identify any trigger to this incident, however upon further investigation we identified that there were a number of stressful life events taking place in the months prior to the incident. The client was experiencing harassment at work and her workload had become excessive, causing her to take work home with her, which had a negative impact on her domestic life, this had been going on for several months. Also her relationship with her then partner was deteriorating due to other unconnected issues. They eventually separated in December 06. Upon reflection of these life events we were able to identify stress as a possible trigger for the panic.

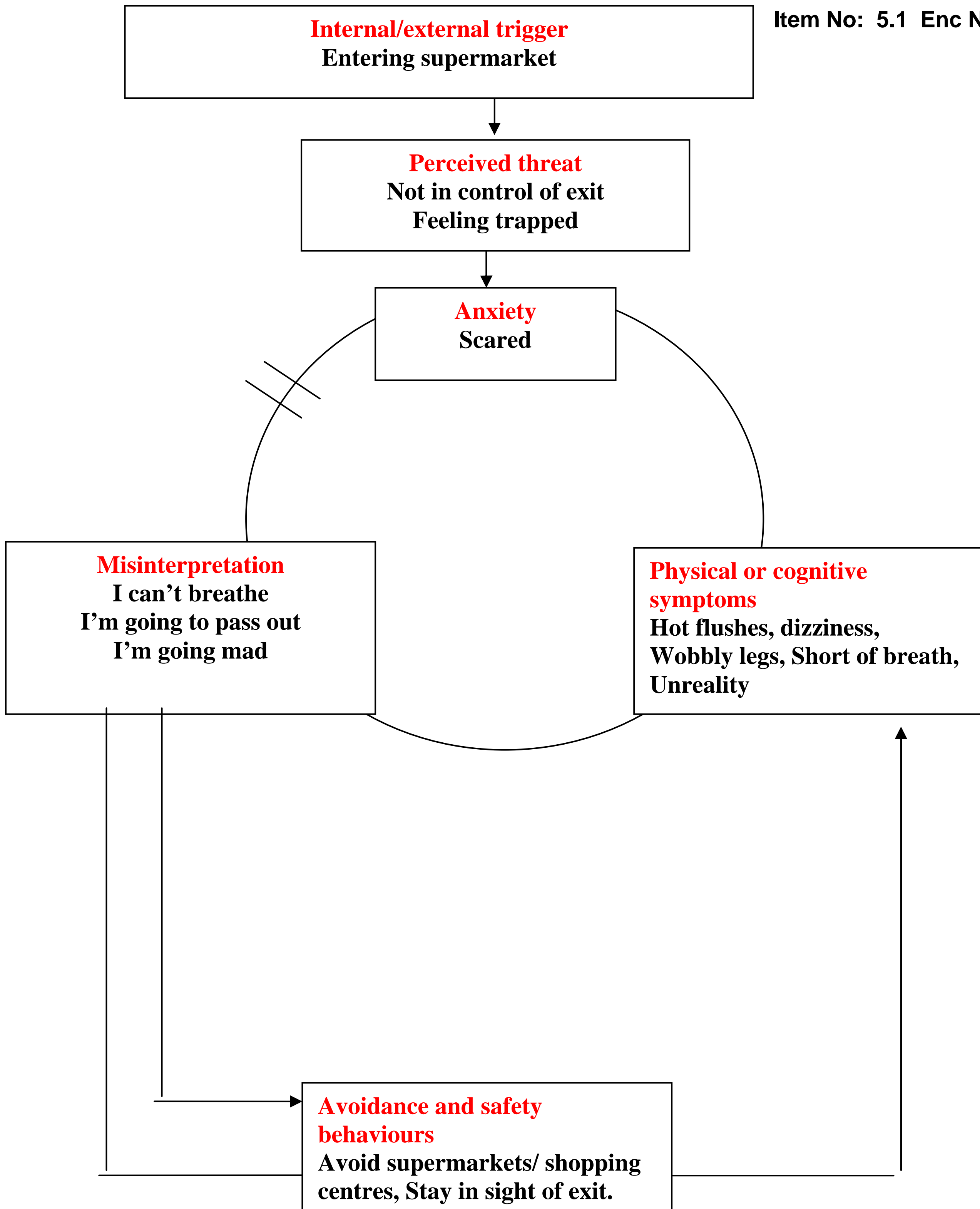
Earlier Sessions

In the previous sessions I spent time gathering assessment history and socialising the client with the Cognitive Behavioural Therapy Model and how the event – thought –emotion sequence works. During these sessions I was able to elicit that the client had no traumatic early experiences and that therefore her schema (core beliefs) and rules were adaptive.

Together we discussed and drew out a vicious circle model which helped the client understand the process of panic. We began to look at the client's avoidance and safety behaviours and also the maintaining factors.

The client reported that since the first attack in January 07 she has now begun to avoid going into supermarkets whenever possible. If she finds it absolutely necessary to utilise the supermarket then she will only venture in so far and must keep the exit in sight at all times. As we explored her cognitions and emotions surrounding this problem the client began to relate more information. It appears that not only does the client avoid going into supermarkets where possible, but that she has also developed avoidance behaviours around a number of other seemingly every day occurrences such as: getting on escalators, trains, lifts, planes and using the motorway.

We identified a possible theme that connects these situations. The need to be in control of an escape route. In the afore mentioned situations the client identified, she is not entirely in control of when she is able to leave /exit the situation. Therefore her possible negative automatic thought may be that she is trapped.


Internal/external trigger
Entering supermarket
Perceived threat
Not in control of exit
Feeling trapped
Anxiety
Scared
Misinterpretation
I can't breathe
I'm going to pass out
I'm going mad
Physical or cognitive symptoms
Hot flushes, dizziness,
Wobbly legs, Short of breath,
Unreality
Avoidance and safety behaviours
Avoid supermarkets/ shopping centres, Stay in sight of exit.

Outcomes

Since beginning treatment the client has reported a noticeable shift in her cognitions. Although she still has some anxieties regarding the affects of her external triggers she has begun to challenge these. This was achieved through graded exposure experiments in which the client was asked to identify situations that may bring about her panic affects, such as entering a supermarket.

We then began to get her to walk further into the supermarket, whilst focusing on her internal affects, dizziness, hot, trembling. As the sessions progressed the client ventured further and further into the supermarket until she reached the stage where she could no longer see the exit. This helped her to understand that her symptoms of panic did not in fact increase the further she ventured but rather began to abate when she realised that her predictions or misinterpretations' of her panic affects did not cause her to pass out.

Currently the client reports that she has visited the supermarket on several occasions and has been able to complete her weekly shop without incident. She now feels able to address the other situations which she felt triggered her panic attacks, such as driving on the motorway and has in fact driven a short distance without any noticeable affects.