A quilt without holes

Our Journey towards a complete primary care mental health service

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Our journey

- This presentation follows our journey towards a complete primary care mental health service that covers all disorders in City and Hackney (population 260,000).
- It follows our steps from the transfer of some secondary care services into primary care towards more comprehensive coverage
- This journey is not complete but we hope sharing our findings, challenges and questions will stimulate discussion

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Primary Care: clinical advantages

1. Integrated physical and mental health. Higher prevalence of physical health problems in SMI and high co-morbidity with LTCs. 35.9% of SMI smoke compared to 10.6% of general population. 14% of SMI population have diabetes. Life expectancy 15-20 years shorter.

2. A normalised environment - reduces stigma

3. Local care – close to home

4. Continuity of care. No time limit on duration of relationship with practice. People and their families often form important long term relationships with their practice.

Changing National Landscape

Five Year Forward View:

- **Integration**: ‘breaking the barriers ..between mental and physical health’
- **Shifting investment** from acute to primary care.
- **Primary care system leadership** through new delivery models: ACOs, PACs, Alliances

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Enhanced Primary Care (EPC)

- **Starting point** was the expansion of the EPC service. This offers people with severe and enduring mental health problems enhanced support through a combination of GP reviews and liaison workers provided by secondary care mental health.
- **Initial service focus** was on c200 people p.a. who were low risk and highly stable (largely stable psychotic disorders).
- **A deep dive analysis** across practices identified the potential for the service to treble to p.a. 600 by accepting increased complexity and slightly higher risk e.g. serve mood disorders and personality disorders.

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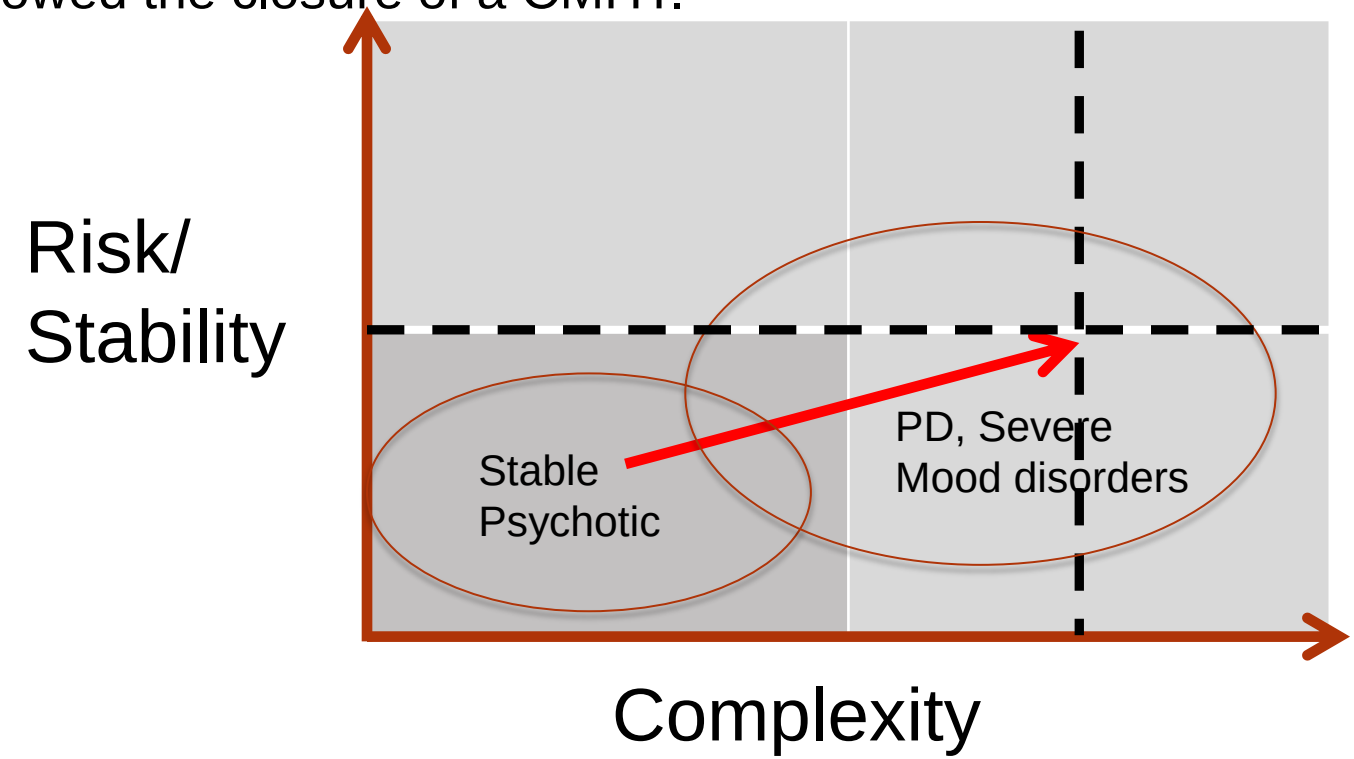
Enhanced Primary Care

The service expanded to c600 patients p.a. within the limits of risk and stability represented by the dotted lines. Re-admission rates to secondary care remained below 10%. Shifting more people into primary care allowed the closure of a CMHT.



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Changing the model

In order to prepare primary care for accepting greater complexity and risk we used the following 4 ‘C’ framework:

1. **Culture** – shift from a medical or management approach to mental health to a ‘recovery’ approach with patient at the centre as a pro-active agent.
2. **Capacity** – use practice nurses, improve GP referrals to rich patchwork quilt of local third sector services to provide a wrap around
3. **Competence** – extensive training programme
4. **Confidence** – clear information systems, rapid access to secondary care support.

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The Recovery/Wellbeing Model

Patients become **active agents** in their own care plan, setting and monitoring their own goals. Our recovery plans were designed by service users and loaded onto to EMIS. They combine physical and mental health goals and incorporate **5 Steps** to wellbeing model:

1. **Connect –** social networks, peer support
2. **Be active and healthy** – exercise and diet
3. **Give and contribute –**voluntary work, and employment
4. **Take notice –** mindfulness
5. **Keep learning –** training, education

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Treating the whole person

Practices also undertake a physical health check, which can help the patient set recovery goals.

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Community wrap around

City and Hackney has a rich patchwork quilt of third sector community resources. This can provide an important '**wrap around**' for more vulnerable patients.

Using the recovery model **GP Practices sign post** patients to services which support the achievement of their goals.

Liaison workers can also support patients engaging.

Training

Aims: to offer training to practices that is accessible and focuses on the needs of the EPC service.

Proposed mandatory core

Core topics need to be covered:

1. The recovery approach
2. Risk and safety
3. Psychotropic medication prescribing & monitoring

Menu for optional training

Choice of topics examples include:

- Specialist areas of mental health – e.g. MUS, PD
- Assessment
- History taking
- Engagement and therapeutic relationships
- Lifestyle interventions
- Mental health culture and diversity

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Information systems

A key part of developing GP confidence was improving the information system.

1. **EPC patients un-coded or inconsistently coded.**

We cleansed systems, established new codes and dashboard

2. **Limited ability to monitor** patient reviews or health improvement.

We created a dashboard to track this.

3. **Inability to share EMIS information** with other organisations e.g. secondary care MH Trust.

IG agreement and EMIS terminals and laptops purchased for secondary care mental health

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Beyond EPC – holes in the service

Building on the reviews of mental health data on EMIS we undertook for EPC we began to look at data issues across the whole of mental health. The results indicated that people are falling through holes.

- 8,500 people in primary care with depression who have not been reviewed for over a year
- A significant no. on anti-depressants with no mental health diagnosis
- 940 people attended practices more than 30X a year many are thought to have undiagnosed mental health problems

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Towards complete coverage

We are now building a complete mental health register and dashboard that will cover all mental health diagnosis in primary care showing:

1. Clean diagnostic coding
2. Mental health screening results
3. When the patient was last reviewed
4. Physical and mental health
5. Recovery goals and outcomes

The register and dashboard is supported by a system of **c4,000 GP reviews** paid for over an above the QOF.

The Wellbeing approach

Underpinning this is a **well being approach**. Whether patients have a common or a more severe problem there are a number of simple relatively low cost steps that can be taken to achieve the Five Ways to wellbeing. NB people with more severe problems may need more help to achieve these. Wellbeing forms the background against which higher cost formal interventions can take place if needed.

We are supporting this with an investment in **online technologies** for guided self help including CBT and Mindfullness. In addition we are using **mental health alliances** to knit organisations together more tightly and to develop a community wrap around without holes.

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Mental Health Alliances

We have created mental alliances to bring providers primary together with providers from the third sector and secondary care, working to shared aims and integrated pathways. The alliances are creating a more complete wrap around for patients in primary care linking them to a network of high intensity and low intensity interventions.

Complex patients are held through:

- **Joint complex care meetings** between alliance partners
- **Joint care packages** across organisations
- **Common standardised systems** of assessment referral
- **Patient information sharing** across the alliance

A complete approach

SMI/Bipolar/ severe mood disorder	QOF. Enhanced primary care. Recovery model with recovery care planning. Close monitoring of physical health. Network of community resources.
Personality disorder/ MUS	Screening based on frequent attenders register. Tavistock and Portman primary care brief psychodynamic interventions. Navigation to community resources e.g. SUN café
Common MH problems	Annual GP reviews beyond QOF. Guided self help. IAPT. Social prescribing. Care navigation to alliance community resources
Dementia	Standardised care plan seen and inputted into by all organisations involved. Care navigation from Alzheimer's Soc. to alliance community resources.
CAMHS	Family Action: assessments and signposting in primary care to CYP who self harm or are on anti-depressants

Unified Dashboard

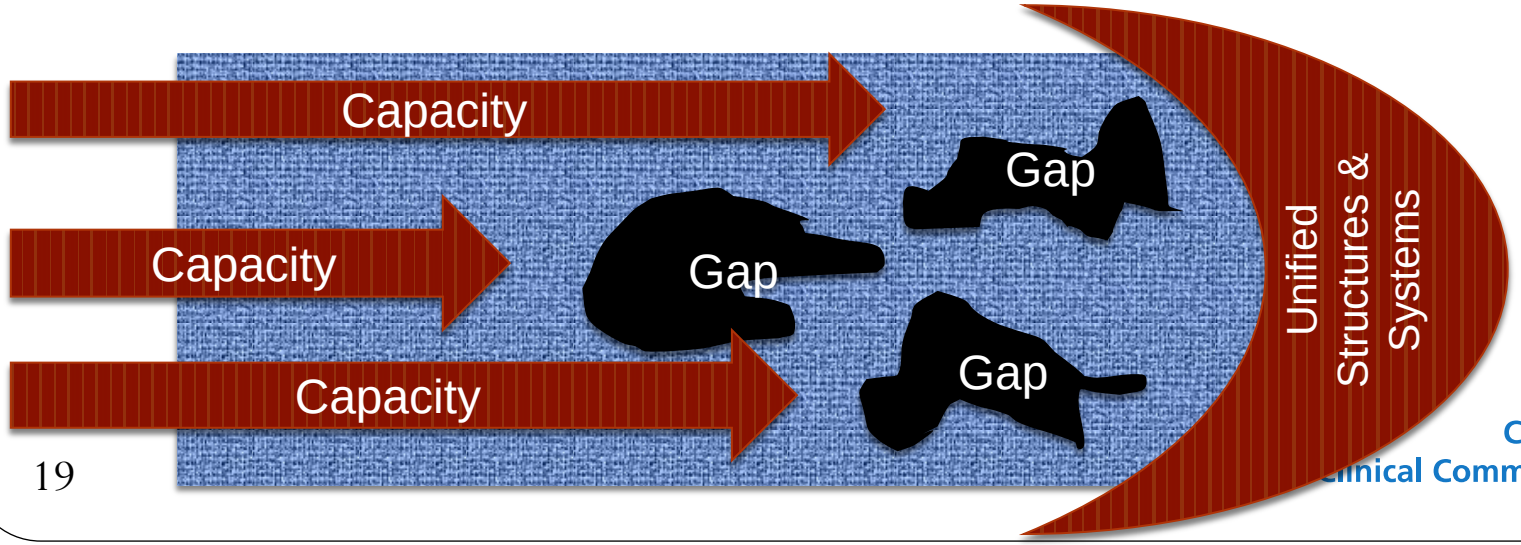
Prevention

1. Increased mental health screening:
   - 16 weeks pregnancy
   - LTCs with poor control or high severity
   - Frequent attenders
2. Use of Five Ways to Wellbeing – website, cards and leaflets
3. 16 year old mental health pack and health check

Conclusion

With increases in co-morbid mental problems and the need to find cost effective alternatives to inpatient bed use, a strong primary care mental service matters more than ever.

However the fragmented nature of the EMIS mental health coding, combined with the complex nature of primary care delivery and third sector delivery could easily lead to a patch work quilt with many holes in it. To create a **quilt without holes** capacity must be freed to fill the holes and overarching systems and structures are needed and to knit everything together.



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Conclusion

- **Culture –** shift from medical and management approach toward recovery and well being approach. Support patients to be proactive agents through online guided self help and recovery goal setting.
- **Capacity:** practice nurses, HCAs, use local community resources to add capacity to the system. Work through structures which link providers together e.g. Confederations, Alliances to knit providers together with shared processes and pathways. GPs become navigators not therapists.
- **Confidence –** GPs must have confidence in easy to use mental health information and access to support – create clean registers and dashboards
- **Competence –** support practices with training and access to expert advice.

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