



# Primary Care Mental Health Service Development

Scoping of the current state of services across the  
thirty two London boroughs

September 2017

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## Working in Partnership

This guide has been produced by the London Clinical Networks and Healthy London Partnership, working together to improve services for Londoners.

Healthy London Partnership is a collaboration of London's health and care system to support the delivery of better health in London. We aim to work with a growing community of people and organisations across London to make it the healthiest global city in the world by 2020.

The London Clinical Networks provide clinical expertise and leadership to drive decision-making, reduce variation and improve services. The vision is to create clinical leadership which links health and social care for consistent, evidence-based, high quality, efficient health and wellbeing for the capital.

## Foreword

We hope our suite of documents on primary care mental health (PCMH) will be a real support to the mental health system in London as we push ahead to develop innovative ways to support and care for those with mental wellbeing or health needs. So, I am delighted to introduce this pan-London scoping of current and planned PCMH services across the thirty-two London boroughs.

It has taken a great deal of dedicated work to pull this review together and we are grateful to those in Healthy London Partnership and the Clinical Network for Mental Health (London Region) who have worked very hard to deliver this product. It is designed to complement the recently published [literature review](#) (evidence base) for new primary care mental health service development.

In this document, we bring together the wide range of current and planned service offers across London, focusing on service development to better meet the needs of those presenting to primary care services with mental health difficulties. In line with the Five Year Forward View and Better Care for London, new PCMH models are being formed which provide care closer to home and include family, friends and carers, and care closer to sources of community support in the less stigmatised setting of the GP surgery.

There is an associated emphasis on supporting those working within the primary care setting to provide timely and effective mental health care to those with increasingly complex presentations, with quick and easy access to specialist advice and clear lines of referral to sources of community-based support.

This document aims to promote knowledge-sharing at all levels across London between key stakeholders, from general practice level up to the level of STPs. A guidance document is also currently being written to support PCMH development in London, promoting more integrated and co-produced mental health services, with individuals with lived experience at the heart of new service development.



Dr Phil Moore  
General Practitioner  
Deputy Chair, Kingston CCG  
Co-Chair, Mental Health Clinical Leadership Group (London Region)

Report authored by Dr Dorothy Newton, Darzi Fellow, Healthy London Partnership

## Introduction

There is increasing interest amongst healthcare providers and commissioners in the United Kingdom in new models of health care. Change imperatives increasing focus in this area include The Five Year Forward View<sup>1</sup>, The Five Year Forward View for Mental Health<sup>2</sup> and The General Practice Forward View<sup>3</sup>. These documents highlight the need for more integrated care provision, care provided closer to home, in the less stigmatised setting of the GP surgery, and closer to friends, family and sources of community-based support. New models of Primary Care Mental Health (PCMH) in London are focussing on joining-up mental health care, in particular merging primary and secondary care so patients experience true seamless care, effectively starting to erode traditional care 'siloes'. Such development represents a significant opportunity for individuals working within different areas of mental health care to share knowledge and benefit from best-practice expertise they can offer each other. Additionally, new models of PCMH represent a significant opportunity to consider in detail how mental health services can be redesigned using co-production: re-designing services in partnership with those who will be using them to better ensure the most effective and appropriate mental health care provision.

This document has been prepared by Healthy London Partnership, in collaboration with the Clinical Network for Mental Health (London region). It draws together details of the current primary care mental health service offer across all thirty-two London boroughs/Clinical Commissioning Groups. The aim of this work is to encourage knowledge-sharing across London, at all levels, from individual general practices to Trusts, boroughs and STPs, so that areas can learn from each other the benefits and challenges of transforming their own service offer.

Data has been provided by each respective borough against a suggested framework of information provision. The pan-London scoping document has been prepared alongside a review of the scientific literature which forms an evidence base for new models of care for PCMH service development. Each London borough has identified a representative within their area who can provide further information on their current or planned PCMH service.

The document is presented in two sections. Section 1 provides an overview of the findings from the scoping exercise and section 2 provides a more detailed description of the service provision from each of the 32 CCGs.

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<sup>1</sup> [Five Year Forward View, NHS England \(2014\)](#)

<sup>2</sup> [Five Year Forward View for Mental Health, NHS England \(2016\)](#)

<sup>3</sup> [General Practice Forward View, NHS England \(2016\)](#)

# Section 1

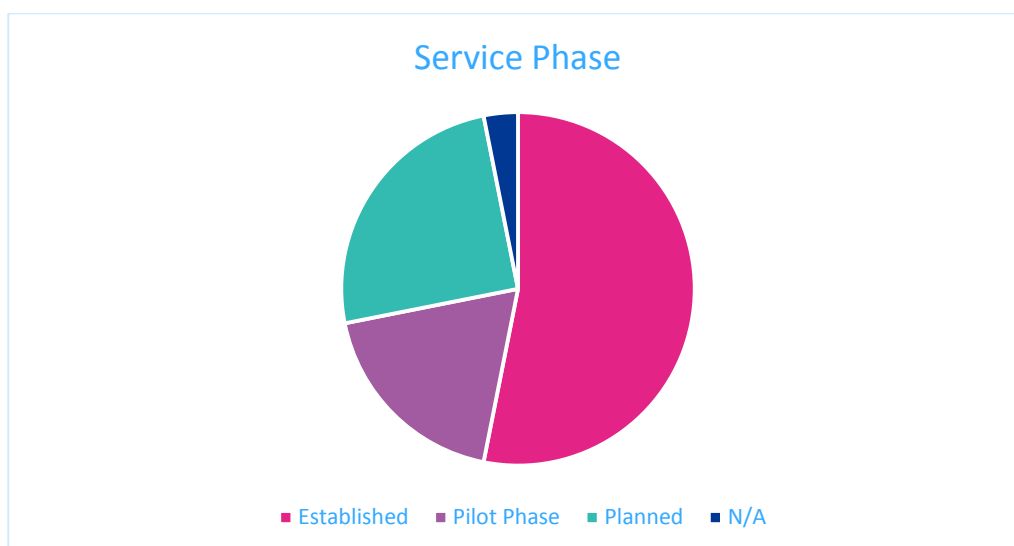
## Summary of Findings

### Primary Care Mental Health Model Types

The primary care mental health London-wide scoping exercise demonstrated significant variability in range and stage of development of new service models across the 32 boroughs, although more than 50% of boroughs now have an established primary care mental health model. New care models which are planned or already in existence sit on a spectrum between a simple attached specialist working within the primary care setting and fully integrated multi-disciplinary teams with members drawn from both primary and specialist services. See Fig. 2 below for a breakdown between established, pilot and planning phase services.

Examples of models developed around London at the present time include a range of collaborative care approaches, such as wrap-around models (e.g. in the Like Minded Collaborative in North West London), and in-reach models of care (such as in Croydon). Most models provide care in a stepped format – whereby the provision of services (and the setting for this), is based upon a careful assessment of individual mental health needs: individuals can then ‘step-up’ or ‘step-down’ within the care pathway as their mental health presentation dictates. Some models focus efforts on increasing skill sets, confidence and capacity within general practices (such as in Southwark). Other boroughs (such as City & Hackney), have sought to draw the expertise of specialist services into co-located teams within primary care - working together in the same physical environment and psychological team ‘milieu.’ Other boroughs have established a network of Link Workers acting as care facilitators and navigators at the primary/secondary care interface (as in Barnet).

**Fig. 2** Number of boroughs with a planned versus established new model of care



Established PCMH service = 56%, Pilot Phase = 19%, Planning Phase = 22%, N/A = 3%

## Service Scope

The majority of boroughs (23) have or are planning broad-based PCMH services (i.e. services offered to those with common mental illness/mental health & wellbeing concerns [SMI+] in addition to individuals with serious mental illness [SMI]).

All services offer support to individuals aged 18 years and over (with the exception of one borough offering a service from age 17.5 years and above). One borough has an upper age limit of 65 years for their service.

The forms of support offered in general have one or more of the following service aims:

- Supporting individuals with psychotic illness who are stable and are transitioning back to primary care from specialist services
- Individuals with mental health difficulties who are currently managed by their GP where advice and support is required from specialists (including to help prevent the need for secondary care referral)
- Individuals with mental health difficulties who are currently managed by their GP who would benefit from referral to community-based sources of support

## New Care Roles

A range of new care roles have been established across the London boroughs (or are planned) to help support individuals with more complex mental health difficulties within the primary care setting. These roles are in most instances part of a multi-disciplinary care team, comprising a range of care roles, such as consultant psychiatrist, primary care nurse (or community psychiatric nurse), social workers, administrators, psychologists, occupational therapists and employment advisers. New care roles are frequently in the form of care liaison workers or support workers who facilitate communication between primary and specialist staff and support joined-up integrated care provision. These individuals are also in many instances providing a care-navigation function, for example, helping individuals access appropriate sources of support based in their local communities (facilitation of social prescribing). The increasing presence of peer-support workers within PCMH teams is also evident.

Individuals fulfilling new care roles within new primary care mental health services are drawn from a variety of backgrounds, including from existing primary care nursing staff, from therapy services and as in-reach workers from specialist settings. The presence of GP-based pharmacists is also evident in existing and planned PCMH services.

## Training

Thirteen boroughs (41%) have regular mental health training established.

## Funding

Approximately 22% of boroughs (7 out of 18 boroughs who shared funding data) have recurrent funding secured for their primary care mental health services.

## Outcome Measures

Seventeen boroughs reported outcome measures having been defined for their primary care mental health services. A further seven boroughs are in the process of planning their outcome measures.

## Psychopharmacology

Boroughs were asked about their psychotropic medication prescribing practices, focussing on the prescribing and monitoring of depot antipsychotic medication within the primary care setting.

Whilst oral psychotropic medication (outside of clozapine) is prescribed by GP's or PCMH staff, depot medication is less available to individuals via primary care, although more boroughs are planning to include this offer via primary care services. Notably, some boroughs are planning primary care-based clozapine and/or lithium clinics. The newly established role of primary care-based pharmacist is noted as being taken forward by one borough (which may increase the breadth of psychotropic medication prescribing within primary care). Two boroughs specifically note the availability of telephone advice on psychotropic medication prescribing for primary care staff by specialists.

### Communication: Shared IT systems

Nine boroughs have shared IT systems between their general practices and the Primary Care Mental health team. This is either EMIS or SystmOne. One borough (Southwark) has developed an electronic shared care record which is accessible by both primary and secondary care staff. The need for shared IT systems is identified below as a potential barrier to more integrated primary care mental health service development across primary/secondary services.

## Key Themes in PCMH Model Development

Despite the differences evident in approach, similar 'themes' relating to the benefits of, and barriers to, PCMH model implementation recur in the models reported across London. Key themes identified through the process of gathering data on primary care mental health services in London are outlined in the tables 1 and 2 below (data was gathered via an online questionnaire, through face-to-face stakeholder meetings, email and telephone conversations and via provision of business plans by providers and commissioners). Themes were identified and chosen for inclusion in the tables below were those recurring most frequently in the data collected.

**Table 1**

<b>Potential Benefits of PCMH Development Identified</b>	
Theme	Stakeholder Feedback
Integration	<ul style="list-style-type: none"> <li>▪ Holistic integration of different sectors involved in mental health care</li> <li>▪ Increased physical health integration with mental health care provision</li> <li>▪ Closer integration of mental health care primary and specialist services with sources of community support, including those provided within the voluntary sector</li> </ul>
Care Environment	<ul style="list-style-type: none"> <li>▪ Care provision in a setting perceived as less stigmatised (i.e. GP surgery)</li> <li>▪ Care in a familiar (GP rather than hospital) setting</li> <li>▪ Care closer to home and closer to sources of community support</li> </ul>
Service Capacity	<ul style="list-style-type: none"> <li>▪ New Primary Care Mental Health (PCMH) models provide the opportunity to meet the mental health needs of individuals experiencing a wide range of presentations – not just SMI but also e.g. medically unexplained symptoms, which may represent a significant time- and resource-saving to GP's</li> <li>▪ Increased flow of patients (and more rapid, easier transitioning), from secondary to primary care and vice-versa as individual needs dictate</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>▪ New role development allowing for creation of e.g. Care Navigators, Mental Health Liaison Workers and Peer Support Workers who work</li> </ul>



	<p>with individuals to help them identify and achieve recovery goals (doing 'with,' not 'doing to' users of mental health services)</p> <ul style="list-style-type: none"> <li>▪ Although recruitment and retention of health care staff can be an issue, there is a sense that the interest in enhanced model development will make the related roles attractive to high-calibre individuals</li> </ul>
Access	<ul style="list-style-type: none"> <li>▪ Facilitated navigation for patients to appropriate sources of education, housing, social care, benefits support etc. by members of primary care mental health teams, recognising that recovery from mental illness requires addressing social determinants contributing to/resulting from mental illness</li> <li>▪ Improved accessibility of mental health services through the provision of enhanced primary care services may attract a 'lost cohort' of individuals back towards the health care system, and be able to address their unmet mental and physical health needs: (Currently, both providers and commissioners report a significant number of individuals with mental health needs who are discharged from specialist services but do not engage with primary care)</li> </ul>
Communication	<ul style="list-style-type: none"> <li>▪ Timely access to specialist advice for primary care staff, enabling individuals with mental health needs to be more effectively supported within the primary care setting and helping avoid the need for secondary care referral</li> </ul>

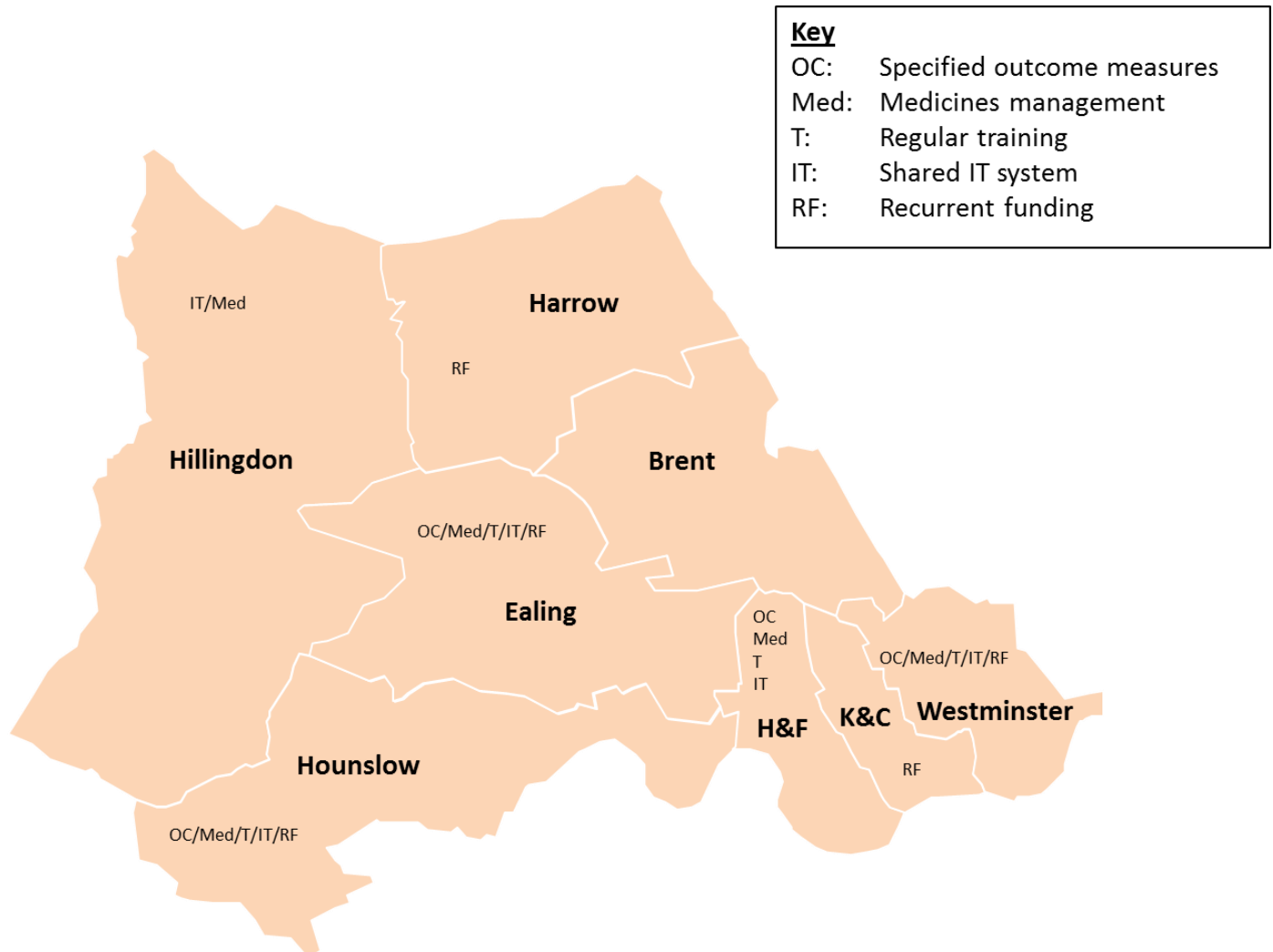
**Table 2**

<b>Potential Barriers and Challenges to PCMH Development Identified</b>	
Theme	Stakeholder Feedback
Integration	<ul style="list-style-type: none"> <li>▪ Concerns around possible 'role-protection' and resistance to change amongst health care professionals</li> </ul>
Care Environment	<ul style="list-style-type: none"> <li>▪ A lack of facilities and capacity within primary care estates.</li> </ul>
Service Capacity	<ul style="list-style-type: none"> <li>▪ A lack of change management skills and delivery/capacity skills within Trusts and Clinical Commissioning Groups to ensure change happens: Translating a general willingness in the system to work better together and be more collaborative into the realities of integrated working is a challenge.</li> </ul>
Workforce	<ul style="list-style-type: none"> <li>▪ Variable levels of confidence and competence within primary care staff across London regarding mental health care provision.</li> <li>▪ Training of all primary care staff needs to be reviewed – e.g. reassessing the level of training needed for reception staff who will engage with patients with potentially more severe mental ill health issues</li> <li>▪ Potential lack of clarity regarding roles and responsibilities within collaborative care teams</li> <li>▪ Psychotropic medication prescribing &amp; monitoring – lack of clarity around who is or should be responsible for this and around financial arrangements between primary and secondary care budgets</li> <li>▪ Depot antipsychotic administration – skill sets and confidence in administering depot medication within the primary care setting needs to be addressed as this is identified as a significant barrier to patients moving out from community mental health teams back into primary care</li> </ul>
Access	<ul style="list-style-type: none"> <li>▪ There is a risk of enhanced primary care mental health services adding to confusion around referral pathways</li> </ul>
Sustainability	<ul style="list-style-type: none"> <li>▪ Concerns exist amongst service users of the potential negative</li> </ul>

	<p>impact of transitioning back into primary care services on their ability to access certain required benefits</p> <ul style="list-style-type: none"> <li>▪ There is a need to address possible ‘myths’ in the minds of patients that primary care staff will ‘mess up’ their medication (and patients are thus not willing to move out of secondary care services)</li> <li>▪ Concerns how PCMH services established via transformation funding will ensure sustainability once this funding ceases</li> </ul>
Outcome Measures	<ul style="list-style-type: none"> <li>▪ PCMH care models need to be outcome-based, but there is lack of clarity and knowledge regarding what ‘measures of success’ to use.</li> </ul>
Communication	<ul style="list-style-type: none"> <li>▪ There is a need for shared electronic data systems to ensure timely and effective communication between team members/care tiers</li> <li>▪ Risk of potential for care record duplication if electronic data systems are not shared or cannot interact effectively</li> </ul>

# Section 2

## NORTH WEST LONDON SERVICES



- ✓ BRENT: (Under development)
- ✓ EALING: Primary Care Mental Health Service
- ✓ CENTRAL LONDON: Primary Care Plus
- ✓ HAMMERSMITH & FULHAM: Primary Care Mental Health Service
- ✓ HARROW: Primary Care Mental Health Service
- ✓ HILLINGDON: Primary Care Mental Health Service
- ✓ HOUNSLOW: Primary Care Mental Health Service
- ✓ WEST LONDON: Primary Care Mental Health Service (being re-developed into Community Living Well)

**Current Situation:** In North-West London, considerable effort has been directed into developing a future model of care and support for people with serious and long-term mental health needs. Efforts across eight boroughs have been pooled to co-develop and co-produce an overarching guidance document citing the vision of care in north west (and central) London: 'Like Minded.'

The case for change described by Like Minded is evidence-based and describes an overall vision for providing care, support and treatment in a way that facilitates consistent outcomes, whilst at the same time allowing for local delivery approaches. Implementation of the Like Minded case for change varies between boroughs.

**Cross-Borough Aims:** Like Minded case for change identifies three ambitions for the future of service provision to individuals with serious & long-term mental health needs:

- Clarify and simplify the pathways for people with serious, long-term mental health needs.
- Develop new community-based care and support models that will improve the quality of care and outcomes for people with serious, long-term mental health needs.
- Rebalance resources from inpatient facilities to innovative community-based support.

## BRENT

**Current Situation:** Brent has existing mental health peer support services and is developing a primary care mental health service led by the local GP Federation. Mental Health commissioning plans have been developed with input from a range of voluntary services, and have involved targeted engagement events with people with mental ill health, as well as general engagement at commissioning intention events. This has led to the procurement of peer support services and procurement of primary care services. Service User representatives were involved in the service design and in the procurement process. IAPT services have been in place for some time within Brent, providing support to those with mental health difficulties, with the majority of sessions taking place within GP practices. Brent's current focus is to involve greater use of Patient Activation Measures in navigating people to resources in their local community that can help build resilience and wellbeing, while working towards the primary care skill mix identified in the Like Minded (North West London collaborative) clinical service modelling.

**Model & Working Style:** In-reach model of care envisaged, with specialist support being provided to GP service leads. Current peer support services are led by voluntary sector peer support workers. The GP Federation and secondary care provider are developing proposals in line with the Like Minded staffing model, with the addition of a GP lead. The low availability of mental health nurses has led to consideration of psychologist, assistant psychologist and occupational therapist roles being incorporated into the care model.

**Aims:** The service being developed aims to support individuals who are transitioning from an episode of secondary mental health care, in particular, work with the local GP Federation is focusing on the implementation of services for non-complex dementia management and the management of stable psychosis. Future work is envisaged to develop crisis prevention services within primary care.

**Scope:** Individuals aged 18 years and above. SMI - the service model being developed is aimed at supporting individuals with psychotic illness (and who may receive oral or depot psychotropic medication) who are currently stable.

**Care Roles:** The proposed service is envisaged as having a GP Lead with support from a consultant psychiatrist, a team of mental health nurses and allied health professionals, working alongside existing peer support workers.

**Mental Health Training:** Not stated (N/S).

**Electronic Record Keeping:** IT systems are currently incompatible between primary and specialist care and this is raised as an ongoing issue.

**Psychotropic Medication Prescribing: N/S****Outcome Measures: N/S**

**Funding:** Funding for the new primary care mental health service is envisaged as coming from the Parity of Esteem funding stream, areas of saving in secondary care being redirected to primary care. Current peer support services are funded from a re-configuration of previously commissioned voluntary sector mental health services, and joint funding from Brent Borough Council.

**Contact:** Dr Sarah Basham, GP Clinical Lead for Mental Health Brent CCG

[Sarah.basham@nhs.net](mailto:Sarah.basham@nhs.net)

**CENTRAL LONDON (WESTMINSTER)**

**Current Situation:** Westminster's primary care mental health team is called Primary Care Plus and was formed four years ago with an initial two-year pilot. The service has gradually evolved since then and is now well established as a non-urgent care single point of access for mental health services in the Central London CCG area.

**Model:** The service is stepped-care/wrap-around collaborative care provision.

**Aims:** Creation of an easy access, pro-active service providing a full range of bio- psycho- and social assessment and services to support service users, their carers and GP's based on principles of empowerment and self-care. The Westminster CCG service has been developed in line with the shared North West London Like Minded Collaborative principles.

**Scope:** SMI+ (all patients with a mental disorder). Adults aged 18 years and above. Patients registered with any Central London CCG practice. Patients are excluded who are open to secondary care services or require urgent or emergency care, or only require GP care.

**Working Style:** The Primary Care Plus team sees patients in GP surgeries, with one Primary Care Mental Health Practitioner (PCMHP) attached to each surgery to facilitate easy communication with GP's. They assess 'step-up' patients with common and serious mental illness diagnoses and agree a service plan as needed (step-up referrals to specialist services are discussed by a PCMHP visiting the Community Mental Health Team on a weekly basis). They also accept 'step-down' patients being transferred out of secondary care and provide an enhanced level of support for GP's for this cohort as part of the GP Out of Hospital Enhanced Service Specification. Transfers out of secondary care are discussed at these meetings and ideally a transfer hand over meeting is arranged between the care-coordinator, PCMHP and the patient.

Patients with serious mental illness or complex common mental illness diagnoses are offered an annual physical health check at the GP practice with follow up at either a GP or the PCMHP regarding their Recovery and Stay Well Plan.

**Care Roles:** Primary Care Mental Health Practitioners are attached to GP surgeries (see above). A key element of their role is in liaising with a wide range of mental and physical health services to streamline the care pathways for their patients. Community Navigators work with Primary Care Mental Health Practitioners and take a lead in the care navigation/liaison function. Community Navigators are seconded from Westminster and Wandsworth MIND.

The Primary Care Plus Team comprises:

- Primary Care Mental Health Practitioner Clinical Team Leader
- Primary Care Mental Health Practitioners
- Social Worker
- Community Navigators
- Administrator
- Consultant Psychiatrist (at 0.5)
- GP Clinical Lead

**Mental Health Training:** Staff within the PCMH service are all seconded from Central and North West London Mental Health Trust. The mental health trust provides mandatory training and other training as required in addition to supervision and Human Resource processes. Internal mental health training also occurs within the PCMH team, at times sourced from an external provider.

**Electronic Record Keeping:** All referrals received by the PCMH service are stored on the Primary Care Plus module of the SystemOne database. This is shared electronically (with patient consent), with the GP record. The PCP team also has read-only access to the secondary care Jade record which provides an essential safety, past medical history and duplication of care check.

**Psychotropic Medication Prescribing:** Psychotropic medication prescribing responsibility remains with the patient's GP whilst patients are with PCP. Depot antipsychotic medication can be administered at the GP surgery by practice nurses, covered by a depot protocol and patient-specific directives. Primary Care Mental Health Practitioners (PCMHP) are able to provide supporting advice on medication and can liaise with secondary care clinicians when an individual receiving depot medication is being stepped down from specialist services. PCMHP also follow-up individuals receiving depot medication who have not attended appointments.

**Outcome Measures:** An evaluation of the service was completed at the end of the two-year pilot in conjunction with the CLCCG user group 'User Focussed Monitoring.'

Current outcome measures within Key Performance Indicators are:

- % Referrals triaged within 5 working days
- % of available appointments utilised
- % of PCMHP assessments completed within 20 working days of referral
- % of care plans sent to patients within 10 working days of appointment
- % of patients transferred to primary care with a care package reviewed each year
- % of PCMHP's meeting with their GP practices quarterly
- Patient experience survey
- Audit of range of signposting options available

In 2016, a total of 58 individuals were stepped down from secondary care to the PCP service. To date in 2017 (Jan 1<sup>st</sup> to May 12<sup>th</sup>), 10 patients had been stepped down to PCP.

A telephone survey is currently being piloted as a means of capturing patient experience of the service. The team has also completed an audit examining which onward services Community Navigators are referring to and for what support needs. This has enabled them to identify and seek out services in areas of previous unmet need.

**Funding:** The pilot was initially funded from bed closures in the CCG area and Trust-expected reductions from contacts from step-down cases to primary care services. The latter were slower to become apparent than anticipated. Funding has since become part of the routine contractual arrangements.

**Contact:** Dr Emma Coore, GP Clinical Lead for Mental Health Westminster CCG  
[Emma.coore@nhs.net](mailto:Emma.coore@nhs.net)

James McMenamin, Acting Primary Care Mental Health Practitioner Clinical Team Leader,  
Central London CCG [James.mcmenamin@nhs.net](mailto:James.mcmenamin@nhs.net)

## EALING

**Current Situation:** A Primary Care Mental Health Service (PCMHS) has been established providing care across three boroughs in West London – Ealing, Hounslow and Hammersmith & Fulham (*see also information under Hounslow and Hammersmith & Fulham sections*). The PCMHS is an integrated part of the existing primary care service and supports the delivery of the Shaping a Healthier Future and Out of Hospital Strategies. The Ealing PCMH Service is as detailed below.

**Model:** Collaborative stepped-care approach.

**Aims:** The PCMHS in liaison with Out of Hospital Services supports patients with a stable mental illness to stay well in the community. As part of the primary care multi-disciplinary team, the PCMHS aims to:

- ✓ Support patients out of secondary care
- ✓ Prevent patients going in to secondary care
- ✓ Provide support and advice for general practice and primary care services

**Scope:** SMI+. Adults aged 18 years and above, registered with a GP from Ealing. The service supports patients with serious and long-term mental health needs who no longer need secondary care mental health services. Patients who have been transferred back to primary care must be stable. The PCMHS does not provide support to patients who are under the care of secondary mental health services.

**Working Style:** The PCMHS offers flexibility for the registered CCG population. The service is offered in community locations, including GP practices and local health centres, ensuring patients can access the service close to their home. The PCMHS offers treatment as part of an integrated partnership approach with primary care services, statutory and non-statutory services.

Referrals are accepted from a range of sources. These include:

- GP's and practice nurses
- Recovery and Early Intervention Teams
- Single Point of Access service
- Other primary care staff, third sector organisations, local authority
- Home Treatment Team – this in Ealing is called the Crisis Assessment and Treatment Team
- IAPT
- Perinatal Services
- Other West London Mental Health NHS Trust Services

Referrals from secondary care: These are facilitated by a secondary care practitioner. Once the GP and patient are in agreement with the transfer of care to primary care, the PCMHS is notified and offers support without the need for additional screening or further assessment. Most complex cases are discussed prior to discharge at the discretion of the secondary care practitioner. PCMHS ensures good links are maintained and open lines of communication established with secondary care. PCMHS assists secondary care practitioners in identifying suitable patients through case discussion and attendance at virtual clinics.

Referrals for GP's: The PCMHS as part of the primary care team provide flexible access through email, telephone and face to face discussions. Primary care professionals contact the PCMHS in the first instance to seek advice unless evident from the immediate outset that a secondary care referral is required.

**Care Roles:** The Ealing PCMHS is made up of a multi-disciplinary team providing a range of interventions. Roles include:

- Consultant Psychiatrist providing
  - Diagnosis and medication reviews
  - Clinical supervision of PCMHS workers
  - Access to regular psychiatry (medical) time within primary care
  - Support for PCMHS workers to manage complex cases
  - Support PCMHS workers and GP's with issues related to medication
  - Key liaison – One-off assessments/advice around treatment for care planning
  - GP/Primary care staff training in partnership with PCMH workers at practice or locality basis
- PCMH worker providing
  - Face-to-face mental health assessments including triage to other services
  - Risk assessment and management
  - Psycho-education
  - Brief solution-focussed interventions
  - Monitoring medication efficacy
  - Promoting social inclusion
  - Coping skills workshops
  - Enabling access to community based and voluntary sector services and mainstream statutory services e.g. housing, employment, financial advice, parenting advice
  - Liaison with secondary care when needed
  - Home visiting in line with the operational policy
- Joint working with social workers and other community services
  - The PCMHS will work closely with local social workers and voluntary sector services to ensure that social care and housing needs are met and links into the wider local authority services are accessible. There is now a clinical psychologist and counsellor in the PCMHS team and there is also the ambition to embed a social care worker in the team.

**Mental Health Training:** Provided by the consultant psychiatrist and mental health nurses to GP's and practice nurses.

**Electronic Record Keeping:** The Ealing PCMHS uses the same IT system as GP's (SystemOne). The PCMHS record all referrals electronically on SystemOne within 48 hours of



receipt.

**Psychotropic Medication Prescribing:** Depot prescribing and administration will be undertaken in primary care when appropriate and will be part of the Out of Hospital SMI GP contract.

**Outcome Measures:** Key Performance Indicators (KPI) are shown below:

	KPI
1.	Patient risk reviewed during treatment
2.	Patients re-referred into secondary care 12 months after discharge into primary care are monitored
3.	Patients will have one outcome measure completed at the end of 1 <sup>st</sup> appointment
4.	Patient will complete PREM and PROM surveys
5.	Patient survey to be conducted every 6 months
6.	Completion of an annual GP satisfaction survey
7.	Patients that have accessed annual mental and physical health review within primary care to be identified
8.	Patients referred to local community services for support with social care needs, education, training, volunteering and employment recorded
9.	Patients have maintained or improved their wellbeing score during treatment
10.	Patients have increased their support network
11.	Carers within the service signposted to local community support services

**Funding:** The service is funded by Ealing CCG as part of the ongoing mental health contract with West London Mental Health NHS Trust, including extra investment to develop the service. The PCMHS aims to be cost effective by:

- Decreasing the duration of treatment in secondary care.
- Increasing the number of discharges from secondary care.
- Decreasing the number of new referrals and assessments in secondary care.

**Contact:** Dr Serena Foo, GP Clinical Lead for Mental Health, Ealing CCG [Serena.foo@nhs.net](mailto:Serena.foo@nhs.net)

Val Wilson, Mental Health Commissioning Manager, West London Mental Health Trust  
[WilsonV@ealing.gov.uk](mailto:WilsonV@ealing.gov.uk)

## HAMMERSMITH & FULHAM

**Current Situation:** A Primary Care Mental Health Service (PCMHS) has been established providing care across three boroughs in West London – Ealing, Hounslow and Hammersmith & Fulham (see also information under Hounslow and Ealing sections). The PCMHS is an integrated part of the existing primary care service and supports the delivery of the Shaping a Healthier Future and Out of Hospital Strategies. The Hammersmith & Fulham PCMH Service is as detailed below.

The Hammersmith & Fulham Primary Care Mental Health Service has been established since 2013. It consists of 4 mental Health nurses (three Band 6 nurses and one Band 7 nurse), employed by West London Mental Health Trust who have a central base but work out of the GP surgeries. They are linked to a network of practices. A signposting and pathway co-ordinator post based in the local MIND was also funded at this time. Primary care is supported by a consultant psychiatrist advice line which is managed on a rota basis by secondary care psychiatrists. The service has not received any new investment but options are currently being explored to expand the service.

**Model:** Collaborative in-reach, stepped-care model.

**Aims:** The original aim of the service was to reduce secondary care caseloads and enable patients to be discharged from secondary care with enhanced support in primary care.

**Scope:** SMI+. Age 18+, registered with GP in the borough

**Working Style:** CPN's based in GP surgeries and pathway co-ordinator post based at MIND

**Care Roles:** 3 x Band 6 Community Psychiatric Nurses  
1 x Band 7 Community Psychiatric Nurses

**Mental Health Training:** No specific training

**Electronic Record Keeping:** SystemOne

**Psychotropic Medication Prescribing:** Consultants offer advice via telephone (on a rota basis).

**Outcome Measures:** No outcome measures currently agreed as part of contract.

**Funding:** No new funding arranged at the present time.

**Contact:** Wendy Lofthouse, Mental Health Commissioning Manager, Hammersmith and Fulham CCG [Wendy.lofthouse@nw.london.nhs.uk](mailto:Wendy.lofthouse@nw.london.nhs.uk)

## HARROW

**Current Situation & Model:** A Primary Care Mental Health (PCMH) service has been developed in the borough. It is closely linked to the Shifting Settings of Care programme, whereby Harrow as one of the eight boroughs of North West London, has been transferring service users approaching the end of their treatment spell back to GP's earlier with the support of a Primary Care Mental Health Team. The PCMH service covers all 35 GP practices in the Harrow borough. Harrow has a collaborative in-reach, stepped care model.

**Aims:** In line with Shifting Settings of Care, the PCMH service aims to move patients to less intensive settings of care as appropriate to their needs, enabling them to live more independent lives. The Harrow Primary Care Mental Health project identifies the potential to achieve significant improvement to the efficiency and effectiveness of mental health service through the development of an integrated, whole systems approach, building on the strengths of GP's in managing adult mental health problems in the community.

The Harrow PCMH service underpins the Shifting Settings of Care project work, with emphasis on increasing the delivery of mental health care in primary settings by increasing GP confidence and capacity.

**Scope:** SMI+. The primary care mental health service remit is mainly covering individuals with mental health difficulties falling within clusters 1-6 and 11. The service overall aims to cover those with severe and enduring mental illness (SEMI) and complex common mental illness (CMI).

Exclusion criteria include acute episodes of mental illness (e.g. florid psychosis) requiring an intensive support not available within the primary care mental health team (necessitating referral to specialist services).

**Working Style:** The PCMH service includes Mental Health Nurses based in the primary care setting as part of the PCMH team. The PCMH service offers rapid access to consultant psychiatric advice to support the transfer of identified patients from specialist mental health services into primary care, reducing activity in secondary care through an improved step-down pathway, and reducing admissions into specialist services.

**Care Roles:**

- There are currently 6 primary care mental health nurses (Band 5 & 6) each aligned to the six GP peer groups of GP practices in the borough. Each nurse has approximately 50 service users on their caseload for whom they provide support over a period of six months
- Service Manager (Band 7) who has a limited patient caseload in addition to their managerial role
- Future plans include development of this team to include a psychiatrist and a mental health prescriber (pharmacist).

**Mental Health Training:** N/S

**Electronic record keeping:** This has been identified as a specific difficulty and barrier to effective and timely communication between care providers within the borough. PCMH nurses are unable to access EMIS remotely and this necessitates the team having to attend an individual's GP practice to access their primary care records.

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** These are currently being formed but aim to include the following-

- Number of service users stepped down with no return to secondary services
- Clusters declined by GP's (and rationale behind these decisions)
- Services most commonly required from individuals stepped down to primary care
- Evaluation of the gaps in community services required by individuals stepped down to primary care
- Level of engagement and provision from partner agencies such as Local Authority and Social Care Services
- Levels of peer support and carer engagement
- Benefits including reductions in the use of A&E

In the borough in 2014/15, there were approximately 100 individuals identified for transfer to PCMH services from secondary care. In 2015/16, this rose to 315. In 2016/17, the target for transfer to PCMH was 315 individuals, with an expected outturn of 290.

**Funding:**

- A GP Local Improvement Scheme (LIS) has been developed which recognises the high demand placed on GP services by individuals with severe and enduring mental illness and also with complex common mental illness. The LIS funds participating GP practices to manage care of patients who have been stepped down from secondary care community mental health services delivered by CNWL.
- For 2014/5 the funding arrangements took place in two phases moving from 3 PCMH Nurses to 6 PCMH nurses
- Funding for 2016/17 was £350,000 and the funding remains recurrent for 2017/18 at £350,000

**Contact:** Dr. Dilip Patel, GP Clinical Lead for Mental Health, Harrow CCG [dilip.patel@nhs.net](mailto:dilip.patel@nhs.net)

Lennie Dick, Head of Commissioning Mental Health, Learning Disabilities and Carers, Harrow CCG [lenniedick@nhs.net](mailto:lenniedick@nhs.net)

## HILLINGDON

**Current Situation & Aims:** Hillingdon currently have a primary care model being developed by the Like Minded team across North West London with the aim of increasing the provision of mental health nurse support within primary care settings. Across the borough there is a small team (6 WTE) providing mental health support in primary care. This is reported to have been of particular benefit in supporting GP's where patients' needs fall between primary and secondary care, to ensure that patients receive care in the most appropriate setting. This service has been in place for 2 years and it is intended to expand the service further in line with the Five Year Forward View strategy.

**Scope:** SMI+. Individuals aged 18-65 years of age with a mental disorder. Priority of care provision within the service is given to patients who have recently transitioned into primary care via the shifting setting of care programme.

Exclusion criteria include all mental health patients who are in receipt of secondary care mental health services.

**Model & Working Style:** The primary care mental health service provided aims to be flexible so that individual members of the team are available at any time to meet the requirements of particular patient needs.

**Care Roles:** The service is staffed as follows and incorporates the new role of Care Navigator-

- Care Navigators 2 Whole Time Equivalent (WTE) (these are non-clinically qualified individuals who assist the shifting settings of care programme by signposting patients who have outstanding non-medical needs when they are discharged from secondary to primary care services)
- Occupational Therapist Team Leader 1WTE
- Mental Health Nurses 3WTE
- Administrative staff

There is currently consideration of employing a dedicated psychiatrist for supervision and clinical support (psychiatric support is currently provided by the secondary care service).

**Mental Health Training:** N/S

**Electronic Record Keeping:** Primary care mental health nurses are able to access GP patient records on the EMIS IT system and also have access to psychiatric records held within secondary mental health services on JADE. Interventions/treatment within the primary care mental health team are recorded on EMIS currently. Difficulties are highlighted in the lack of ability of the different IT systems to communicate with each other.

**Psychotropic Medication Prescribing:** Medication is prescribed by either the GP or specialist with whom the primary care mental health team consults. There are currently no nurse prescribers within the team.

**Outcome Measures:** N/S

**Key Outcomes to Date:** Since its instigation, only 1 in 268 individuals discharged to the re-developed primary care mental health team have required readmission back to secondary care services.

GP’s are reported as being more receptive to secondary care discharges to primary care as, with the provision of the new primary care mental health service model, this is impacting far less on their surgery workload.

**Funding:** The Shifting Setting of Care programme released funding/resources from the secondary care block contract to fund the primary care mental health service developments.

**Contact:** Dr Stephen Vaughan-Smith, GP Clinical Lead for Mental Health, Hillingdon CCG, [Stephen.vaughan-smith@nhs.net](mailto:Stephen.vaughan-smith@nhs.net)

### HOUNSLOW

**Current Situation:** Hounslow Primary Care Mental Health Service was set up in 2013 to support individuals with long-term mental health needs transferring from secondary to primary care. The service was also set up to provide GP’s with general support and advice regarding patients in order to avoid a referral to secondary care. The service is additionally a support for the Hounslow adult IAPT service – for people who are deemed too high risk to be managed by IAPT alone, but not deemed appropriate for secondary care services.

The Hounslow PCMH Service was formed as part of the North West London strategy of shifting settings of care and was planned and developed through co-production with individuals with lived experience. In setting up the system locally, Hounslow had consultation with the Primary Care Mental Health Forum (of service users). There is also ongoing lived experience consultation via a tri-borough group for ‘Planned and Primary Care’ across the Hounslow, Ealing and Hammersmith & Fulham.

Hounslow additionally has a Wellbeing Network (which is a discreet service and not part of the Hounslow PCMH Service). The service aims have a non-clinical focus and include reducing social isolation for people with long term mental health needs and improving wellbeing and physical health. It is a membership organisation that meets regularly, organises events and has a dedicated website. The network runs ‘Let’s Connect’ meetings (which have been very successful with over 100 members, asset-sharing and relationship building) as well as individual one to one work which includes social mapping.

**Model:** Consultation-Liaison model of care based in the primary care setting.

**Aims:** Creation of a fully integrated mental health team within primary care, making the distinction between primary and secondary care much less evident.



**Scope:** SMI+, including common complex mental health needs. Adults aged 18 years and above. The service is aimed at supporting three main groups of service users:

- Those currently in secondary care but with stable enough mental health to be managed in primary care with input from the new service as necessary.
- Those who require assessment and brief intervention and who were previously referred to secondary care.
- Those cases managed by GP's where advice/support or intervention is required.

Exclusion criteria include individuals where risk is deemed to be too high for management in the primary care service and specialist referral is required (although individuals can be assessed by the service initially and then referred to specialist services).

**Working Style:** The service is Recovery-focussed and provides:

- Access to specialist advice and brief interventions, including access to advice on psychotropic medication
- Staffing aligned to GP localities
- Improved access to physical healthcare for service users

**Care Roles:**

- Consultant Psychiatrist (Full time. Roles include seeing patients for assessment and review, supporting nurses, medication prescribing and reviews. Available 9-5pm weekdays for GP phone/email support)
- PCMH\_nurses (8-9 across the borough)
- Clinical Psychologist (Shared with Ealing CCG. Role includes to support the team and run groups for individuals requiring talking therapy but who are not suitable for IAPT services)
- Wellbeing Partners (A role which incorporates peer support and community navigation – there are 4 wellbeing partners who work directly with individuals with long term mental health needs and offer 1:1 wellbeing mapping.)
- PCMH Team Manager (shared between Hounslow, Ealing and Hammersmith & Fulham)
- Administrator (shared between Hounslow, Ealing and Hammersmith & Fulham)

Initially the service consisted of one Band 6 RMN per locality (of 10-13 practices covering a population of 50 000 – 70 000) including a Band 7 nurse who acted as overall manager plus had their own caseload. Later, a Band 8 nurse manager was employed across Hounslow in addition to Ealing and Hammersmith & Fulham, where similar PCMH services were also established.

It is planned that locality mental health social workers will soon be able to link with the PCMH team and that these social workers will be based in primary care and community settings.

**Mental Health Training:** Provided by the consultant psychiatrist and mental health nurses to GP's and practice nurses.

**Funding:** The service is funded by West London Mental Health NHS Trust as part of the ongoing mental health contract with the CCG.

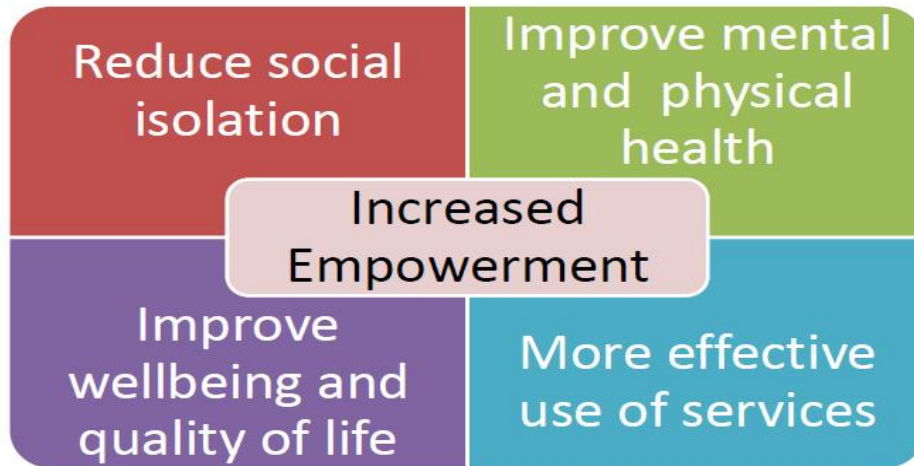
**Electronic Record Keeping:** The PCMHs uses the same IT system as GP's (SystemOne). The PCMHs record all referrals electronically on SystemOne within 48 hours of receipt.

**Psychotropic Medication Prescribing:** Depot prescribing and administration is undertaken in primary care when appropriate and is part of the Out of Hospital SMI GP contract.

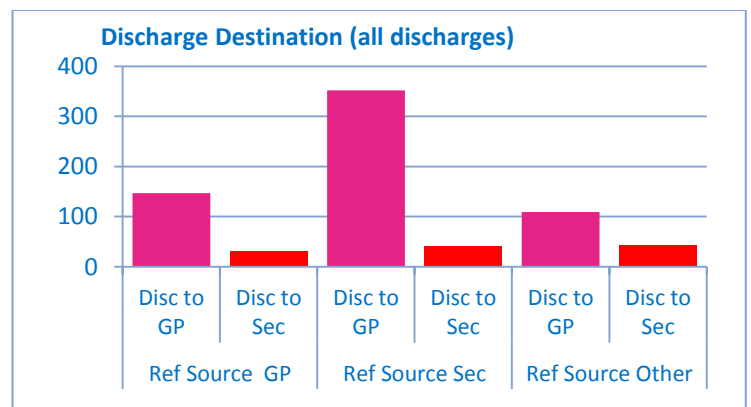
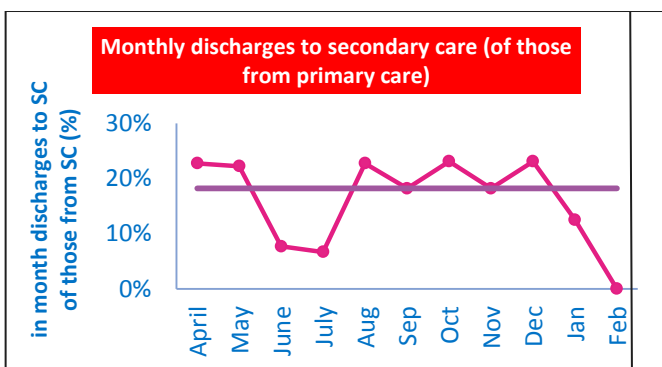
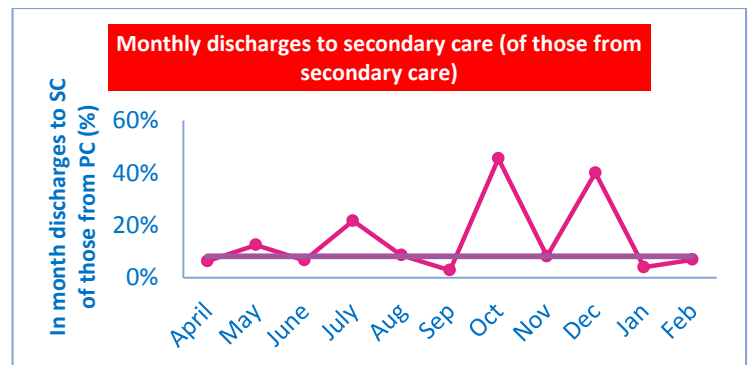
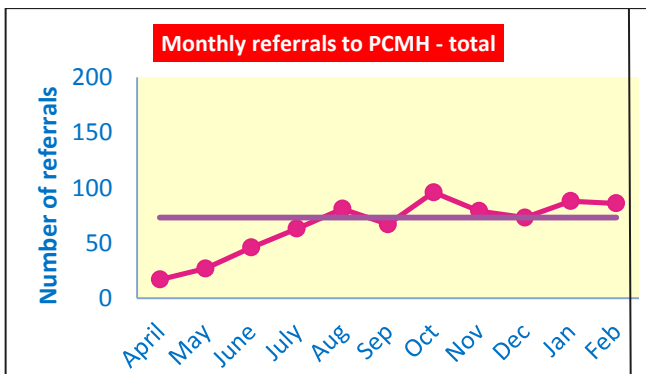
**Outcome Measures:** Data continues to be collected. Key early outcomes are detailed below (April 2016-Feb 2017).



# Outcomes (individual)



- Total referrals received by the PCMHs have been increasing over time
- PCMHs accepts around 30 referrals per month from the SPA and CATT teams, most of which are essentially diverted from the recovery teams.
- The majority of patients accepted by PCMHs are ultimately discharged back to the GP with only a minority requiring referral into secondary mental health services.



**Funding:** N/S

**Contact:** Dr Annabel Crowe, GP Clinical Lead for Mental Health, Hounslow CCG,  
[Annabel.crowe@nhs.net](mailto:Annabel.crowe@nhs.net)

Dr Blake Pritchard, Consultant Psychiatrist, Hounslow Primary Care Mental Health Service  
[Blake.pritchard@wlmht.nhs.uk](mailto:Blake.pritchard@wlmht.nhs.uk) [blakepritchard@nhs.net](mailto:blakepritchard@nhs.net)

## **WEST LONDON (covering KENSINGTON & CHELSEA + QUEENS PARK AND PADDINGTON IN NORTH WESTMINSTER)**

**Current Situation:** West London CCG's core Primary Care Mental Health service has been established for several years. It comprises Primary Care Liaison Nurses and Consultant Psychiatrists input, together with talking therapies (IAPT and Step 4 psychology, and a voluntary sector provided Mother Tongue service for Arabic and Farsi speakers) and facilitated social events, also provided by the voluntary sector.

In 2014 West London was one of two CCGs in North West London selected by the Department of Health as a pioneer site for *Whole Systems Integrated Care*. Our proposal, submitted on behalf of the North West London Mental Health Programme Board, was for West London CCG and Hounslow CCG to develop models of care and become early adopters of models of care that best support people with long-term serious mental health conditions to 'live well' in the community, increasing their resilience and decreasing their reliance on secondary care services.

Co-production commenced in 2014 and has been at the heart of the subsequent development of the Model of Care, resulting in a Business Case for 'Community Living Well' being successfully approved by the CCG's Governing Body in June 2016. This brings together the elements of existing primary care mental health services into a single integrated operating model with a range of well-being services, in a formal partnership between the NHS, Local Authorities and Third Sector.

**Model:** Collaborative, wrap-around, stepped-care model.

**Aims:** The planned Community Living Well service will be:

- Population-based, pro-active, preventative and vigilant, based on membership rather than a traditional referral/acceptance model of service provision.
- Offers hope, secures enduring recovery, resilience and wellbeing.
- Has GP's, as accountable clinicians, at its heart.
- Brings together a robust, vibrant menu of services to wrap around the individual and improve the mental, physical and social resilience of those with long term mental health needs whose are being supported in a primary rather than secondary care setting.

The Community Living Well service will integrate existing providers in the current primary care mental health service model with a wider range of wellbeing services, including:

- An employment support service providing support to find paid or unpaid employment, undertake training and to retain existing employment.
- Health and social care navigators to provide practical support around areas such as housing and to help individuals access the support they need.
- A wider peer support offer providing a range of peer support activities, including one-to-one and group work.



The clinical and wellbeing services will be underpinned by a Partnership Agreement and will be aligned to a wider range of allied services.

The new service model has been developed through extensive co-production with people with serious long term mental health needs, carers, local authorities, voluntary sector, GP's, secondary care clinicians and managers.

**Scope:** The service is aimed at people aged 16 years and above who are registered with a GP in West London CCG (Kensington & Chelsea and Queens Park & Paddington) with stable mental health needs which are, or can be, supported in a primary care setting i.e. individuals on a GP QOF for serious or common mental illness, as well as individuals with mental health needs such as personality disorders.

Exclusion criteria include:

- Individuals with personality disorder, where the primary aim of treatment is to treat long-term maladaptive behaviour patterns and persistent interpersonal disorder – referral to more appropriate services is required
- Individuals under the care of secondary services, except in ensuring the safe transition step-down for case-management to primary care services
- Individuals with a significant forensic history
- Individuals with severe ADHD
- Individuals with a severe eating disorder
- Individuals with substance misuse as their only diagnosis

**Working Style:** The services will operate as one service, wrapped around GP practices and providing integrated support to people using the services. Services will be centred at two main hubs, with a number of community-based 'spokes.'

**Care Roles:** The service will be brought together by a Head of Community Living Service Network, responsible for bringing partners together to ensure an integrated service is provided. Clinical and Wellbeing services are each supported by a service manager. Staffing is as follows:

- Primary Care Liaison Nurses 12.0 WTE + 1.0 Team Manager
- Consultant Psychiatrist 1.4 WTE
- Step 2 and Step 3 Talking Therapist approximately 45 WTE
- Step 4 Psychologist 6.5 WTE
- Employment Advisers 5 WTE incl. manager
- Health & Social Care Navigators 5 WTE (plus 2 WTE trainee posts)
- Peer Support Workers 4 WTE incl. team leader (this will be expanded to include a bank of peer support workers)

**Mental Health Training:** TBC. A cross-organisational development plan is currently being finalised.

**Electronic Record Keeping:** TBC. The need for an IT system which can deliver an integrated care record is identified by West London CCG as of particular importance, and will be built within the local GP patient record, SystmOne.

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** Validated measures are to be used across a number of key elements of the CLW service. SWEMWBS has been introduced for all GP-registered patients in receipt of the out of hospital service, with effect from 17/18, with a target for two such measures to be completed each year. Talking Therapy services use a range of diagnosis-specific and well-being measures.

During co-production, high level outcomes were discussed and proposed, which will be captured in an overarching 'CLW Impact and Benefits Realisation Dashboard'. These can be summarised as follows:

### System

- Reduced incidence of crisis/reliance on secondary care and ED
- Improved well-being/reduced social isolation
- More people in stable accommodation and meaningful occupation
- Improved physical health, notably in management of LTCs

### Service

- Face to face assessments in 5 working days; 15 day access to talking therapies
- Reduced DNA rates
- Increased productivity (clinical face to face time)
- Positive impact on health and well-being (as demonstrated by validated measures, e.g. SWEMWBS)
- Achievement of employment outcomes (retain or gain work or meaningful occupation)
- Increased GP and user/carer satisfaction

### Individual

- Is aware of and able to access CLW services of their choice, flexibly, matched to their needs.
- Has an in date Recovery & Stay Well Plan that reflects their personal goals.
- Achievement of personal goals is demonstrable through validated service user measure.
- Would recommend the service to others.

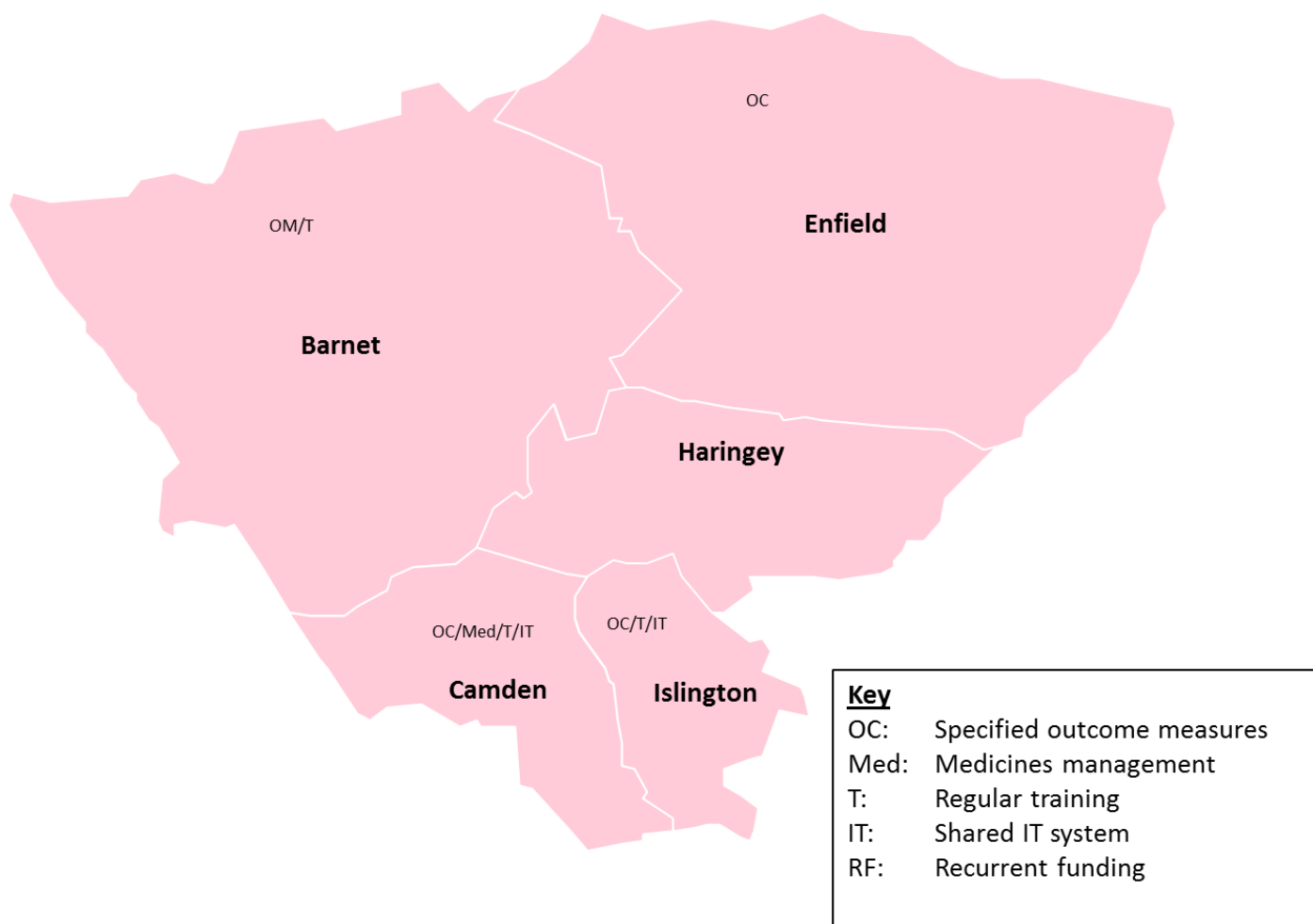
**Funding:** In addition to existing current funding for PCMH service, West London CCG has provided three-year funding for the new wellbeing services, on the basis that over that period, savings can be made from productivity and the transformational impact of the new service.

**Contact:** Dr Will Squier, GP Clinical Lead for CLW, West London CCG [wsquier@nhs.net](mailto:wsquier@nhs.net)

Glen Monks, Associate Director Mental Health, West London CCG [glen.monks1@nhs.net](mailto:glen.monks1@nhs.net)

Fiona Sutcliffe, Head of the Community Living Well Service Network, West London CCG [fionasutcliffe@nhs.net](mailto:fionasutcliffe@nhs.net)

## NORTH CENTRAL LONDON SERVICES



- ✓ BARNET: Primary Care Link Working Team
- ✓ CAMDEN: Together Around the Practice (TAP) Team
- ✓ ENFIELD: (Currently under development)
- ✓ HARINGEY: (Currently under development)
- ✓ ISLINGTON: Practice-Based Mental Health Service

### BARNET

**Current Situation:** Barnet have established the Primary Care Link Working Team (PCLWT) which works across all GP practices within the borough. 'Re-Imagining Mental Health' is the over-arching CCG initiative which has run in Barnet for two years. Representation has come from Barnet, Enfield & Haringey Mental Health Trust, the Local Authority, Barnet CCG, voluntary services and service user and carer organisations and individual service user representation.

**Model:** In-reach model of service provision – the Primary Care Link Working Team work across all Barnet GP practices. The team also has embedded links with Mind Matters (formerly IAPT services), the Local Authority Network Service and the newly-developed Wellbeing Hub (a collaboration of Barnet's voluntary sector services), with alignment and a clear pathway across all three services. The Wellbeing Hub was launched in November 2016 and one of the Link workers is based at the hub one day each week.

Psychiatric assessment and review continues to be offered by Barnet Assessment Service (BAS) and formal social care intervention is also provided via BAS. Psychological and psychiatric support is offered weekly to the Link Working team to discuss more complex cases.

**Aims:** The aim of the Barnet primary care mental health model (and that of the 'Re-Imagining Mental Health' initiative), is to develop a service which supports patients 'at the right time, in the right place and for the right period of time.' The initiative aims to develop a more cohesive relationship with primary care, a clearer knowledge of voluntary services and what they can deliver to support patients, and enablement of meaningful relationships between different care providers. The service aims to provide clarity in its referrals process and also in referring on of individuals to other sources of support.

**Scope:** SMI+. The service is open to all service users with an address in the borough who present with a 'wellbeing need' in relation to their mental health. This varies from low/moderate needs to those who are facing a very challenging time due to their mental health. Future service development is planned to also encompass supporting secondary care providers to step service users back into primary care, and helping primary care providers feel enabled to manage more complex mental health presentations within the primary care setting (with emphasis on the smooth and timely re-accessing of specialist services as required).

Those who live outside of Barnet but who have a GP in the borough are excluded as such individuals would be at a disadvantage given the PCLWT is not familiar with resources in other boroughs.

**Working Style:** The main referral route is via GP's, although referrals are also accepted from the MASH, social care direct, other statutory services and the voluntary sector. The Primary Care Link Working Team is based in GP practices, in the local community and in mental health team offices in the North and West of the Borough.

**Care Roles:** In the first year, the staffing was as follows (adjusted slightly in 2017/18):

- Transformation Lead (1.0)
- Psychiatrist (as required basis)
- Senior Psychologist (2 hours per week in an advisory capacity)\*
- Occupational Therapist, Band 7 (1.0)
- Community Psychiatric Nurses, Band 6 (6.4)
- 2 Graduate Mental Health Workers (2 WTE)
- Administrator, Band 4 (1 WTE)

\*Psychology support is accessed through Mind Matters, or via secondary mental health services if needs are particularly complex.

From January 2017 four additional members of staff from Barnet Assessment Service (BAS) have merged with the Link Working team. Psychiatric review continues to be accessed from psychiatrists from BAS. Medical and Social Care members of the BAS also join the Link Working weekly team meeting.

The Link Working team members spend time visiting a variety of third sector organisations and updating a Link team database of local and national resources. This work is identified as key to ensuring good working relationships with different services, promoting an ethos of enablement and recovery in mental health.

**Mental Health Training:** An initial package of training was delivered to the link working team across four days. This was positively received. A refresher day is now planned for existing and new team members, which is aimed at providing an overview of solution-focused work and further opportunity to support newer members of staff. The Link working team have also implemented a buddy system to provide further peer support.

**Electronic Record Keeping:** The link workers use Rio as the recording system for patient related data. The link workers also access the EMIS primary care system and Swift as the local authority system. Consent for data recording from the patient is obtained at point of referral.

**Psychotropic Medication Prescribing:** During 2016/17 link workers directly accessed psychiatry assessment and review from colleagues in the assessment service. This has been slightly amended for 2017/18.

A small number of GP practices currently administer psychotropic depot medication.

**Outcome Measures:** The main outcome measures used are as follows-

- Service User surveys
- GP surveys
- 24 Hour - acknowledgement of referral
- 5 Day - information gathering complete & contact made with referrer and individual referred
- 15 Day – outcome letter received by Service User and referrer
- 1 Month – review with individual that their goals have been met
- (Pre-31<sup>st</sup> January 2017) – collating all external contacts and professional discussions
- (From 31<sup>st</sup> January 2017) – collating the number of discussions which negate the need for formal referral
- (From 31<sup>st</sup> January 2017) – collating volume of referrals specifically to the Wellbeing Hub
- Analysis of referral rates to secondary care services
- Analysis of psychiatric liaison presentations
- Analysis of referral rates to the CRHTT

Data against outcomes continues to be collected and is awaiting evaluation. However, early analysis has identified reductions in secondary service referrals since the Link working team was implemented, in addition to reductions in presentations to psychiatric liaison services and shorter length of stay rates at CRHTT.

Since 1<sup>st</sup> August 2016, a total of 504 referrals have been received which have been directly supported by the Link Working Team.

Reduction in referrals to secondary care team

	Barnet Assessment Service	South Locality	South/West locality
	May-July 2016	Aug-Oct 2016	Nov-Dec 2016
Referrals to secondary teams	173	57	81
Total referrals received	275	225	276
% of referrals to secondary teams	62.91	25.33	29.35

## Reductions in presentations to psychiatric liaison services

	Psychiatric liaison presentations			
Number of presentations by	May-July 2016	Aug-Oct 2016	Nov 2016	Dec 2016
South locality	37	23	5	3
Monthly average	12.33	7.67	5	3
% Reduction		37.84	34.78	40.00
West locality		59	14	7
Monthly average		19.67	14	7
% Reduction			28.81	50.00

## Reduced length of stay with Crisis Resolution Home Treatment Team and inpatient wards as the PCLWT was rolled out into two GP localities

	CRHTT				
	April 2015-March 2016 (South locality)	April 2015-March 2016 (West locality)	Aug-Oct 2016 (South locality)	Nov 2016-Dec 2016 (South & West localities)	
Number of referrals	519	542	154	212	
Monthly locality average	43.25	45.17	51.33	53	
Average length of stay	14.63	13.63	8.84	7.47	
				South	West
			Number of referrals	118	94
			Average length of stay	7.74	7.13

**Funding:** The service was set up with transformation funding from Barnet CCG April 2016-2017 and a bid has been successful for a further one year of funding for continuation of the service.

The service has to date been funded via the Transformation funding stream as follows:

- 2016/17      £500 000
- 2017/18      £400 000

**Contact:** Sharon Thompson, Community Services Manager, Barnet CCG  
[Sharon.Thompson@beh-mht.nhs.uk](mailto:Sharon.Thompson@beh-mht.nhs.uk)

## CAMDEN

**Current situation:** The Camden enhanced model is called 'Together Around the Practice' ('TAP'), and builds upon the Primary Care Psychotherapy Consultation Service (PCPCS), established in Hackney. The service is commissioned by Camden CCG and delivered by the Tavistock and Portman NHS Foundation Trust, alongside Mind in Camden. It is a flexible mental health service based in GP practices. The TAP service aims to be inclusive and sees individuals with a range of mental health difficulties as well as SMI, but does not aim to be limited to a psychiatric team. However, the team does liaise closely with secondary care clinicians. The TAP does not offer therapeutic help to those either waiting to be referred or waiting to receive help

from other psychological services. The service is 'GP centric' in that it works alongside GPs with complex cases where diagnostic categories and co-morbidities often leave patients falling between traditional gaps in MH services due to exclusion criteria

**Model:** Wrap-around & In-reach model of enhanced mental health primary care working closely with IAPT and secondary care services for smoother care pathways. The TAP team offers assessment to individuals within Camden referred by their GP. This may consist of one or more assessment sessions and a care plan is identified during this process. Extended consultations may be offered (typically over 4-6 sessions), working on a specific issue identified during assessment. Brief packages of psychological treatment can be offered by the team (from 6 sessions up to a maximum of 16 sessions), including Cognitive Analytic Therapy, Dynamic Interpersonal Therapy and Mentalisation-Based Therapy. Group psychological treatment is also available currently utilising the local City Farm as a base for Horticultural therapy groups, a model successfully piloted in Hackney. The TAP also provides case management and an important linking with collaborating GPs (face to face/telephone/service liaison). TAP aims to engage a small number of patients through family and couple work. There are 3 teams – one for each locality in the borough. The TAP also provides signposting and social prescribing via Link Workers from Mind (up to 6 sessions of social prescribing can be provided per individual)., this service often reaches people who have found mental health services too stigmatising or need something more occupational /activity based to aim for.

TAP has an active Service User Advisory group made up of patients and members of the public with lived experience. Some members have experience of MIND and Tavistock services. The group plays an active role in assessing, recommending and commenting on Tap work and new initiatives.

**Aims:** The model aims to provide a range of services to both GP's and patients.

GP's are offered

- Professional consultation with TAP staff – to help understand presenting patterns.
- Case Based discussions with GP's and other practice staff
- Joint consultations with GP's and patients
- Tailored training & support to GP's and other practice staff
- Careful Liaison with other services and agencies (e.g. IAPT, Secondary Care & Voluntary sector services)
- Sign-posting to other services where appropriate but not rejecting or referring back to GP without very good reason or advice as to next steps.

Patients are offered (as appropriate to need):

- Assessment, identifying an on-going care plan
- Crisis plans for more vulnerable and higher risk people.
- Extended consultation
- Brief psychological treatment
- Group psychological treatment
- Case management
- Family therapy and couple therapy

**Scope:** SMI + (including, for example, MUS, somatisation, personality difficulties, personality disorder, frequent attenders at A&E/Primary Care, long-term chronic mental health difficulties such as co-morbid anxiety disorders and depression, those struggling with the psychological

impact of long-term health conditions). The TAP service can be accessed by anyone aged 18 years or over who is registered with a Camden GP.

**Working Style:** TAP workers and Link workers from Mind are all based in GP surgeries when seeing patients.

**Care Roles:** The Camden TAP staffing structure consists of:

- Service Lead / Consultant Clinician (0.6 WTE)
- Assistant Psychologist ( 1 WTE)
- Consultant Psychiatrist (0.5 WTE)
- Locality Lead for two localities (2.0 WTE)
- Clinical Operations Manager, also leads for one locality ( 1.0 WTE)
- Senior Administrator (1.0 WTE)
- Administrator (1.0 WTE)
- MIND in Camden Senior Mental Health Link Worker ( @ 0.9 WTE)
- MIND in Camden Mental Health Link Worker. 2 @ 0.8 WTE)

TAP clinical and support staff, other than those from Mind, are employed by The Tavistock and Portman NHS Foundation Trust.

**Mental Health Training & Support:** The TAP offered tailored training in mental health to GP's and other practice staff. A typical application might take the form of a reflective practice supervision group which could include clinical and reception staff or either group distinctly.

**Electronic Record Keeping:** TAP use the surgery based EMIS Web system in order to provide an important link between the EPRS used by GPs for mainly Physical Health records and the patients Mental Health record and care plan. EMIS was not designed as a Mental Health electronic record system however Camden CCG and The Tavistock has overcome obstacles to make the system work in the interests of parity of esteem.

**Psychotropic Medication Prescribing:** As part of the holistic assessment, review and consultation service to GPs and patients The TAP Psychiatrist (jointly trained in Adult Psychiatry and Psychotherapeutic approaches) offers medication review and advice to GPs , TAP also refers to secondary care Psychiatry for more complex SMI and Polypharmacy review. NB. Camden CCG is currently reviewing and developing their existing services to align with STP and Five Year Forward View objectives.

**Outcome Measures:** Referrals are being received from 34 of 36 GP surgeries in Camden and between 20-30 referrals are received each week. Approximately 75% of referrals received are accepted for assessment. TAP currently uses GAD7, PHQ9 and WASA but recognises the need to develop non IAPT based measures for the increasing numbers of patients in primary care with multi-morbidity, 'MUS' and co-morbid mental as well as physical Long Term Conditions.

**Funding:** N/S

**Contact:** Mr Tim Kent, Tavistock Primary Care Service Lead – PCPCS (Hackney), TAP (Camden) and External consultation / development work.

TAP Service Lead, Consultant Psychotherapist & Social Worker

[TKent@tavi-port.nhs.uk](mailto:TKent@tavi-port.nhs.uk)

## ENFIELD



**Current Situation:** There is currently little specific mental health care provision within primary care settings in Enfield outside of IAPT services. In response to this, Enfield CCG are currently finalising plans for a new primary care mental health service model in the borough. As part of the STP CHINs model, the proposal is to embed mental health multidisciplinary teams within primary care, ensuring linked up patient care, better communication and shared care between professional groups. Enfield, as a pilot site, are looking to test the STP CHINs model.

Enfield's voluntary and community sector mental health and wellbeing network is also recognised as requiring further development and it is planned that this will be addressed through a council-led procurement framework that is due to commence in September 2017.

**Model & Working Style:** Enfield are planning a consultation-liaison model of care which will embed mental health multidisciplinary teams within primary care, ensuring linked up patient care, better communication and shared care between professional groups. The comprehensive care model envisaged will bring together key elements of the Link Worker model in Barnet and the MDT model in Islington.

**Aims:** The key aims of the proposed Enfield PCMH model are:

- Reduction in referrals to secondary care mental health services
- Increased discharge of stable patients from secondary care mental health into primary care
- Support the CHIN model to deliver whole person care, closer to home, reducing the pressure on secondary care services

**Scope:** SMI+. The patient cohort to be seen by the PCMH MDT will be of a lower threshold to those supported by secondary care in the short term. Once established, the team will seek to be as inclusive as possible. The Link Workers will focus activity on supporting people with common mental health issues and pre-crisis populations where they may be referred to secondary care inappropriately.

**Care Roles:**

- Consultant psychiatrist (1WTE)
- Nurse Band 6 (1WTE)
- Psychologist Band 7 (1WTE)
- Pharmacist Band 7 (1WTE)
- Social Worker Band 6 (1WTE)
- Team manager Band 6 (1WTE)
- Link Worker Band 6 (2.5WTE)
- Administrator Band 4 (1WTE)

**Mental Health Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** Success will be measured as a set of measurable outcomes aligned with NCL's STP aims. It is anticipated that the full benefits and savings will not be realised in the first year due to the time taken to establish and embed the model.

Outcomes	Key Performance Indicators/Metrics
Reduction in referrals to secondary care	30% reduction in number of referrals to

mental health	secondary care mental health services
More individuals discharged from secondary care mental health into primary care	% discharged into primary care, broken down by cluster.
Reduction in GP appointments for frequent attenders	Number of GP appointments
Increased IAPT referrals	IAPT referrals from service
Improved patient experience	PREMS, PROMS
Improved GP experience and confidence in supporting people with mental ill health	GP survey
Community mental health teams increase in treatments offered	CRHTT's treatment numbers
Increased access for groups falling into crisis in the community	Access metrics Diagnosis rates versus prevalence
Holistic care delivered within primary care	Physical health checks for SMI Depression assessments Medication review
Improvement in DNA rates	DNA rates
Reduction in A&E presentations by frequent attenders	A&E presentations Mental Health liaison team capacity

Anticipated economic outcomes:

- £360 000 savings to secondary care mental health with wider systems savings anticipated

**Funding:** Proposed investment costs are as below

- Set up costs (non-recurrent)                   £31 680
- Staffing model costs (recurrent)           £500 000

Anticipated gross savings (30% reduction in referrals to secondary care mental health)

£360 000

Net savings

£140 000

**Contact:** Pippa Wady, NCL Mental Health Programme Manager

[Pippa.wady@camdenccg.nhs.uk](mailto:Pippa.wady@camdenccg.nhs.uk)

## HARINGEY

**Current Situation:** Haringey are currently looking to commission Community Psychiatric Nurse input into primary care to provide assessment and brief interventions (for those in Haringey with mental health difficulties).

**Model:** In-reach care model (CPN working as part of primary care teams), with additional planned transfer of medication clinics into primary care (currently held in specialist services). 'Network' model being developed as a high-level pathway of care, with planned shared service provision between primary, specialist, voluntary services and through peer support mechanisms being established. The development of the network model is being co-produced with an 'Enablement Champions' – a group of individuals with lived experience and carers who have been commissioned to support the programme.

**Aims:** To improve mental health treatment and access for individuals experiencing difficulties in the Haringey area. To build mental health treatment capacity within primary care and to provide guidance in mental health treatment to those working in primary care services. Aiming for full-borough coverage by 2018/19. Commissioners have the intention of funding the enhanced primary care service from funds already existing within the Trust- and Voluntary Care Sector-

commissioned budgets. However, further resourcing is likely to be needed. Funding is currently identified as a 'blocker' to the project becoming live. A lack of capacity and facilities within the primary care estate is also identified as a potential issue to the service starting.

**Scope:** SMI+. Exact scope to be confirmed. However, aiming the enhanced service to provide support to those who are stable on depot medication, individuals transitioning to primary care services following an episode of secondary mental health care and individuals in care clusters 1-7 who may be at risk of a secondary care referral.

**Working Style:** The enhanced primary care service will operate as part of a 'network' with voluntary sector advice and advocacy services, plus peer support. Primary care 'collaboratives' are being established (originally 4 in the borough, now merged into 2). The proposed enhanced primary care model may provide a short assessment and transfer function as part of a pathway into other services, rather than case-holding everyone. However, the service is intended to be 'needs-led' and there will not be arbitrary time restrictions following discharge from secondary services.

**Care Roles:** Mental health workers (base within the primary care setting), voluntary sector workers and peer-support workers. Consultant specialist input will be required for the depot and clozapine clinics, but this level of input is not envisaged as being necessary for the 'prevention aspects' of the model.

**Mental Health Training:** N/S

**Electronic Record Keeping:** The Mental Health Nurse activity is intended to be recorded on EMIS.

**Psychotropic Medication Prescribing:** BEHMHT are working with Haringey GP mental health leads and commissioners to transfer the depot and clozapine clinics into primary care services. The details of this model are yet to be confirmed.

**Outcome Measures:** Evaluation is planned (no details provided).

**Funding:** N/S

**Contact:** Dr. Muhammed Akunjee, GP Clinical Lead for Mental Health, Haringey CCG  
[makunjee@nhs.net](mailto:makunjee@nhs.net)

## ISLINGTON

**Current Situation:** Islington has designed and is implementing a Practice Based Mental Health (PBMH) Service. The borough now also has a practice-based service user network and regular co-produced 'evolution' type events within the trust. Islington is also hoping to set up a peer support network in the near future (details TBC).

**Model:** In-reach primary care-based mental health liaison service. The Practice Based Mental Health Service (PBMHS) model consists of (planned total of four, currently three) locality based multi-disciplinary teams operating at practice level with the primary aim of developing a holistic approach to the management of the mental (and physical) health of patients outside of specialist care pathways.

**Aims:**

- To provide expert support to primary care including direct assessment and short term interventions so that more people with complex mental health problems (including those with co-morbidities such as physical ill-health and/or substance misuse) can be managed in primary care, rather than being seen in specialist mental health services
- To increase Primary Care's capacity and confidence in managing mental health need
- To provide an accessible service that reduces stigma for many patients who prefer to receive care from their GP
- To increase the access of mental health clients to physical health care assessment, specialist physical health support and relevant non statutory organisations
- To support recovery and enable patients to take ownership of their treatment
- To support integrated care within Islington
- To reduce acute activity (Admissions, A&E attendances) through effective management of need within primary care

In order to achieve these aims the service provides:

- Triage of referrals from primary care and other sources (e.g. social care, housing)
- Timely high quality and proportionate risk and needs assessment
- Direct clinical care: advice, assessment and treatment: (time-limited nursing, psychiatric and psychological interventions)
- Social Care Functions including needs assessments as required under the Care Act including carers assessments and Safeguarding processes
- Short-term social interventions/advice/signposting including practical support and advice around daytime structure, education, finances, employment and occupational needs.
- Joint consultations with GPs and other relevant services across primary/secondary care
- Onward referrals and signposting where appropriate
- Where indicated, liaison between primary care and secondary care mental health services. Provide a seamless interface between primary and secondary mental health care so that GPs receive the appropriate support to meet the needs of their patients with mental health problems.
- Prescribing advice, medication reviews and optimisation, including agreeing on-going treatment plans and time limited side effect monitoring.
- Dual Diagnosis treatment as part of an integrated offer with PCADS (future plan)
- Outreach services for hard to reach patients i.e. patients that are isolated and lonely and BME communities
- Education and training to Primary Care so as to increase partners' capacity and confidence confident in their ability to manage stable mental health clients.
- Work collaboratively with other statutory and non-statutory agencies and support patients to access available resources and services.
- Communicate effectively with referrers which will be supported by the team maintaining a regular presence within the GP practice and through a shared record system

**Scope & Underpinning principles:** SMI+. Individuals aged 17.5 years and over. Collaborative, Holistic, Inclusive, Integrated, Co-located.

**Working Style & Interventions:** Flexible, Adaptive, Tailored, Focused, Learning, Creative.

These principles are applied through:

- Joint/shared responsibility with GPs for patients with mental health needs.

- Accessible and flexible service, adaptive to individual GP practice needs.
- An inclusive approach to referrals.
- An easy in and easy out fluidity to service users who may require support at multiple times.
- A strong emphasis on building relationships between mental health staff and GPs; to facilitate this each practice is allocated 1-3 Practice-Based Workers with whom they have primary relationships.
- Focused interventions are provided as guided by clinical need, and for no longer than is necessary.
- Service is embedded within a Primary Care Network and can facilitate internal referral/provision of care via other primary care services, such as iCope, when appropriate.
- Seamless links with specialist mental health pathways and facilitation of patients into these pathways when appropriate.
- Good links with other community resources and physical health care providers.
- There is an emphasis on reflexivity and learning so as to continually develop and improve the offer for service users, GPs and other partners

PBMH team members undertake direct consultation with GP's and/or direct clinical assessment of patients. Joint consultations which include patient, GP and PBMH team may also occur.

*Interventions:* The teams offer time limited interventions and follow-up appointments according to clinical need. These will broadly fall under the following categories:

- General: Diagnosis and formulation, psycho education, care and crisis planning, liaison with other services including liaison with voluntary sector as well as primary and secondary care partners, joint consultation with GPs.
- Biological: Medication advice and management, prescribing support, facilitation of physical health monitoring, dual diagnosis, training and education. Prescribing responsibility remains with the GP.
- Psychological: 1:1 brief psychological intervention, treatment preparation, relapse prevention planning, psychological support for long-term conditions
- Social: Community linking and enhancing engagement with local 3rd sector organisations, employment support and benefits advice, needs assessment under the Care Act, participation in safeguarding procedures when appropriate

#### **Care Roles:**

- Team Consultant Psychiatrist – Clinical lead of the team providing specialist assessment for health diagnosis and formulation purposes, specialist medical advice & support to GP's, onward referrals for appropriate patients into secondary care, triage activities.
- Practice Based Mental Health Workers – Screening, assessment, treatment, advice and signposting for referred service users, triage activities, time-limited support for service users presenting with a range of mental health problems who are under the care of the GP.

Profession specific roles include:

- Psychology: 1:1 brief psychological intervention, treatment preparation, re-lapse prevention planning, psychological support for long-term conditions.
- Nursing: Medication advice and management, facilitation of physical health monitoring, community linking and enhancing engagement with local 3rd sector organisations, carers

assessment, participation in safeguarding procedures when appropriate, relapse prevention

- Practice Based Mental Health Pharmacist – Comprehensive medication reviews, support for GP's, other primary care staff and patients around medication issues, support to improve prescribing safety, education & training support, joint consultations with other members of PBMH, GP's or other practice staff, one-to-one sessions to follow up medication changes.
- Administrative support.

**Mental Health Training:** PBMH staff training is provided by

- Supporting staff to attend relevant courses and conferences.
- Individual appraisal of staff and producing a Personal Development Plan to identify individual training needs.
- Regular case presentation by staff members to colleagues to learn from the intervention but also to reflect and share different ideas, which are underpinned by evidence based practice.
- Local GP practice CPD events (delivered by PBMH teams in collaboration with practice staff)

**Electronic Record Keeping:** EMIS - sharing the same electronic patient record as GP colleagues lends itself to effective communication leading to joined up patient care. Record keeping currently takes the form of a detailed entry. Structured assessment forms are being developed. When the clinician and/or administrative staff are off-site from GP practices, the assessment and discharge summary information is communicated via Docman EDT when necessary.

**Psychotropic Medication Prescribing:** Not currently but plan to use practice FP10s once governance agreed

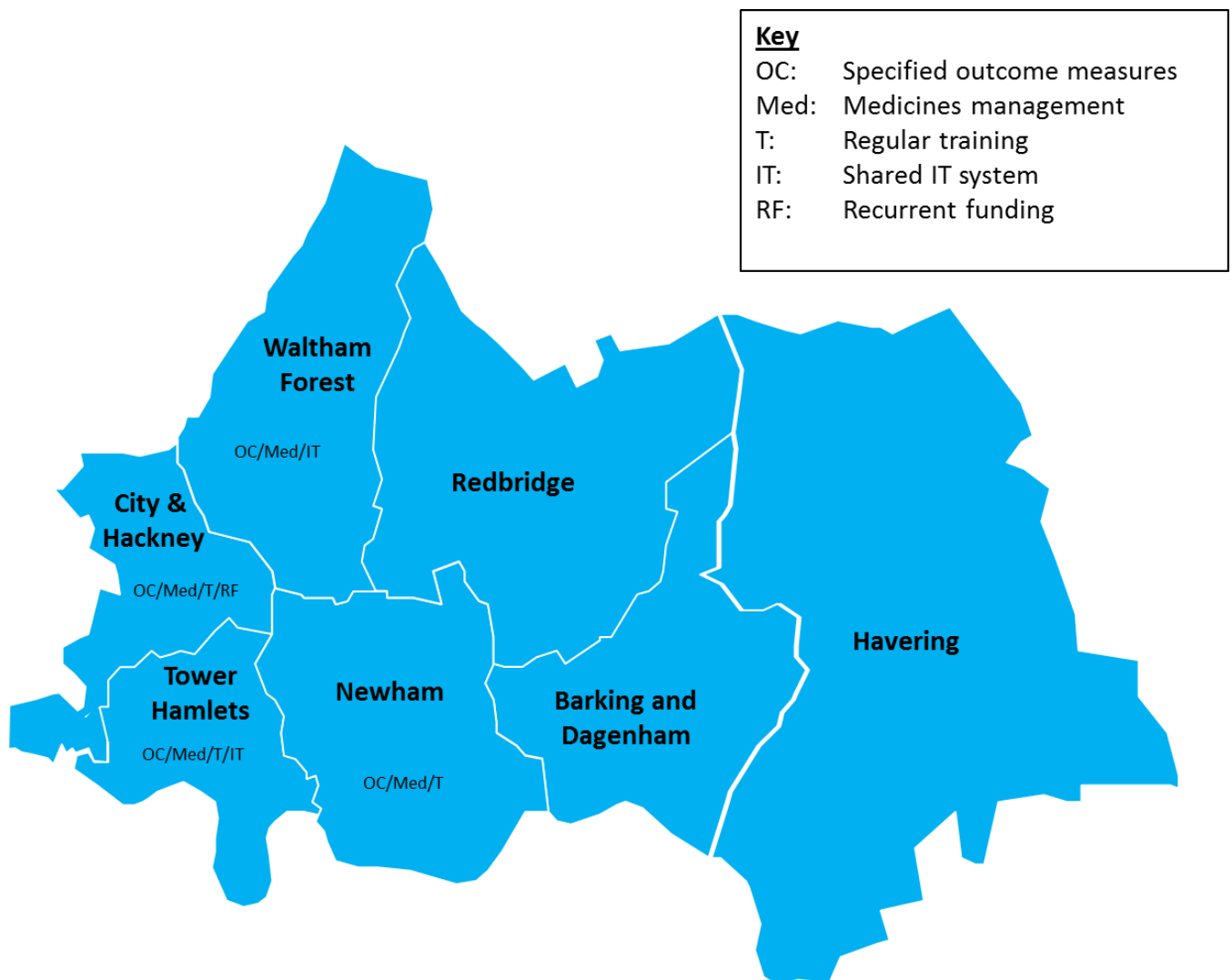
**Outcome Measures:** Feedback can be provided to the service via a Service User Satisfaction Questionnaire, which is offered to each patient at the end of their period of contact with PBMH. GP's are also regularly asked for their feedback on the service. It is anticipated that other clinical outcome measures will be used once the service has been fully embedded. (Other Trust PBMH teams have used PHQ9, GAD7, WSAS, CORE 10).

**Funding:** N/S

**Contact:** Dr. Chris Curtis, Clinical Director, Community Mental Health Services  
Consultant Psychiatrist, Camden + Islington Mental Health Assessment + Advice Team  
Trust Clinical Lead, Practice Based Mental Health Services (Islington, South Barnet, Camden and Kingston) [Chris.curtis@candi.nhs.uk](mailto:Chris.curtis@candi.nhs.uk)

Emily Van de Pol, Divisional Director, Community Mental Health Services, Camden & Islington NHS Foundation Trust [Emily.vandepol@candi.nhs.uk](mailto:Emily.vandepol@candi.nhs.uk)

## NORTH EAST LONDON



- ✓ BARKING & DAGENHAM: (Currently under development)
- ✓ CITY & HACKNEY: Mental Health Enhanced Primary Care Service
- ✓ HAVERING: (Currently under development)
- ✓ NEWHAM: Enhanced Primary Care Service
- ✓ REDBRIDGE: (Currently under development)
- ✓ TOWER HAMLETS: The Tower Hamlets Primary Care Mental Health Service
- ✓ WALTHAM FOREST: Wellness Service (Pilot)

### BARKING & DAGENHAM, HAVERING, REDBRIDGE

**Combined Approach Model:** Barking, Dagenham, Havering and Redbridge CCGs do not currently commission enhanced models of primary care for mental health.

The mental health transformation programme has a primary care work stream which includes work on developing the primary care offer, including developing Integrated IAPT for people with co-morbid chronic conditions and common mental health problems, implementing a primary care depression pathway and on improving the primary/secondary care interface, for example the development and implementation of a primary care psychosis pathway as well as ongoing work

in primary care on dementia. We are consolidating the pathway developments through individual and collective work with practices, led by our GP clinical lead for mental health, Dr. Raj Kumar.

**Contact:** Dr. Raj Kumar, GP Clinical Lead for Mental Health, Barking & Dagenham (& Interim Lead for Redbridge) [raj.kumar2@nhs.net](mailto:raj.kumar2@nhs.net)

Gemma Hughes, Deputy Chief Operating Officer – Mental Health Transformation Programme Lead, NHS Barking and Dagenham Clinical Commissioning Group [gemma.hughes6@nhs.net](mailto:gemma.hughes6@nhs.net)

## CITY & HACKNEY

**Current situation:** In City and Hackney have a four pronged approach to primary care mental health provision. City and Hackney CCG commissions a Primary Care Psychotherapy Consultation Service for complex patients, frequent attenders and patients with medically unexplained symptoms and a Primary Care Liaison service providing linked psychiatry input into practices. Both these services are well established.

They also commission enhanced mental health services from primary care directly via a GP Confederation contract which incentivises GPs to do depression reviews, frequent attender reviews and some physical health care and lifestyle outcomes for patients with mental illness.

Information on any of these three strands can be obtained from the named CCG contact.

Fourthly, they commission an Enhanced Primary Care Service (EPC) across 100% of general practices in City and Hackney which is described below.

**Model:** City & Hackney CCG commission a Mental Health Enhanced Primary Care (EPC) Service. The service is jointly provided between primary care practices within the City & Hackney Confederation and East London NHS Foundation Trust (ELFT). The model is a 'Step-up/Step-down' approach: patients step up who are not currently in secondary care but who have needs that require an enhanced level of support. Patients step down who, after a period of treatment in secondary care, have become stable enough to be transferred to primary care but require support to make the transition.

**Aims:** To treat mental health problems in the normalised setting of the GP surgery, closer to home, where a long-term care relationship has often been established. The service aims are as follows-

- To support service users to achieve their recovery goals through a process of joint planning that places the service users at the centre.
- To empower people to self-manage their own recovery journey and reach a position where they can reduce their contact with mental health services.
- To mark the recovery journey by recognising achievements whilst in EPC and at the point of discharge from EPC.
- To improve service user experience and outcomes through enhanced multi-disciplinary team working that addresses mental health, physical health and social care need as part of an integrated approach.
- To improve service user experience and outcomes through the provision of care in a normalised setting, close to home.
- To assist the navigation of service users towards community resources that support their recovery journey.



- To enable the development of capacity, confidence and competence in relation to mental health treatment and care in the primary care workforce through the sharing of knowledge and expertise.
- Ensure the best clinical processes are followed in the discharge for patients from secondary to primary care.

**Scope:** SMI+. Originally set up to focus on people with stable psychosis, in practice, a much wider cohort of patients has been seen, including individuals with anxiety, depression and personality disorders. Patients are aged 18 years or older and must be a resident of City & Hackney and registered with a City & Hackney GP.

**Working Style & Responsibilities:** The EPC service is a primary care based service in which the GP is responsible clinician. All those receiving help from EPC must have been discharged from secondary care services. Consequently, EPC is not for people who are high risk or require intensive, acute or specialist treatment. The service is currently focussed on people with severe and/or enduring mental health conditions including anxiety, depression, psychotic disorders and personality disorders. EPC is not aimed at individuals with milder or common mental health problems, whose needs are met sufficiently within a primary care setting under general medical services, IAPT or other primary care-based services.

- Upon transfer into EPC services, the GP assumes the role of Responsible Clinician.
- GPs will be supported in this role by a named psychiatrist for each practice who will provide advice in MDT meetings and the GP will update the Recovery Care Plan for each patient.
- Mental Health Liaison Workers (MHLW) will complete a Recovery Care Plan when a patient enters the EPC service. This is checked and approved by the GP.
- The GP will complete a Mental Health Review Meeting twice a year for each patient: A first review to complete and approve the recovery care plan and a second meeting (at least 90 days apart), to review progress. [N.B. For patients on the QOF, one of these reviews can count as a QOF review].
- The GP will ensure that the physical health section of the recovery plan is completed and that, where indicated, lifestyle interventions are offered to patients as part of the mental health review. Interventions may include, for example, social prescribing, referral on to another service, provision of patient education literature.
- All DNA's will be recorded on the EMIS system by either the EPC team or the GP practice. Practices will notify liaison workers of a DNA and the liaison worker will follow up with a telephone call to the patient.
- If a patient in EPC is deteriorating they have rapid access back into secondary care services.

**Care Roles:** In addition to the GP role –

- Mental Health Liaison Workers – act as a key point of contact for the patient and are responsible for leading joint creation of the patient's recovery care plan, care navigation and liaison with GP's and with other EPC ELFT staff including peer-support workers and support workers. MHLW's provide a minimum of quarterly 1-1 contact with patients in EPC.
- Psychiatrists – chair practice-based MDT meetings in which EPC patients and referrals can be discussed. These occur at least quarterly. In addition, for each patient in EPC there is access to a named psychiatrist who can be consulted for advice.

- Peer support workers and support workers – provide assistance in care navigation and engagement in community services if needed. Peer support workers also offer service users the benefit of lived experience of a mental health recovery journey.

**Mental Health Training:** All general practices must complete 4 hours of mandatory training per practice per annum covering agreed topics in mental health. Mandatory training is locally-provided and free of charge. GP's and/or practice nurses can attend the training and both are reimbursed for time spent. Practices are also be reimbursed for undertaking free locally provided training in mental health over and above the mandatory 4 hours p.a. All mental health workers are EMIS trained and enter directly onto the health record.

Psychotropic medication prescribing: All general practices are expected to administer and monitor medication for patients in EPC (including depot medication).

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:**

- Improvements in psychological wellbeing measured using a Patient Reported Outcome Measure (PROM) every 6 months and at discharge.
- Achievements of recovery goals as set out in the patient's Recovery Care Plan.
- A Patient Reported Experience Measure (PREM) – The Friends and Families Test.
- Delivery of lifestyle interventions in response to identified physical health problems.

EPC Service City & Hackney	At 31/07/2015	At 29/02/2016	At 30/10/2016
<b>Active Caseload</b>	510	547	633
<b>Received EPC Service</b>	955	1317	1635
<b>EPC Transfer to Primary Care</b>	384	675	939
<b>Transfer back to Secondary Care</b>	65	95	117

**Funding:** N/S

**Contact:** Dr. Rhiannon England, GP Clinical Lead for Mental Health, City & Hackney CCG  
[Rhiannon.england@nhs.net](mailto:Rhiannon.england@nhs.net)

## NEWHAM

**Current Situation:** In 2014, an Enhanced Primary Care service (EPC) was developed in East London, with a partnership formed between Newham, City & Hackney and Tower Hamlets. Its aim is to facilitate and provide high quality mental health treatment and care in primary care settings. The function is intended to support and facilitate flow through the mental health care system, focussed on step-down from secondary care services towards general medical services within GP practices. The emphasis of the EPC service is one of Recovery.

**Model:** In-reach liaison service to support primary care mental health service provision for those stepping-down from secondary care.

**Aims:** The objectives of the Enhanced Primary Care service are varied and include consultative, educational and advisory roles, support transfer between different levels of primary care provision and support functions for patients in primary care. Functions include (but are not limited to):

- Facilitate effective referral from primary care to secondary care.
- Ensure the best clinical processes in discharge of patients from secondary care to primary care.
- Gather and provide information on the range of services available for people with mental health problems in the local community and facilitate referral to the appropriate services based on need.
- Facilitate the engagement of secondary care with the primary care workforce responsible for mental health, in particular ensuring the involvement of consultant psychiatrists in shared care.
- Facilitate engagement of partners in treatment and care from parties such as the service user, carers, social care, voluntary sector providers and universal services.
- Establish and maintain a model for each (GP) practice to have access to, as a minimum, quarterly clinical consultation sessions for primary care staff led by a consultant psychiatrist from secondary care.
- Assess patients who have been referred to secondary care with mild to moderate mental health problems and provide a diversionary function back to primary care.
- Review patients diverted to the LES/NIS every three months.
- Undertake assessments to ensure that patients meet agreed criteria for discharge from secondary care and acceptance in primary care.
- Create a database of community, psychological, self-help and social care provision that will aid recovery and ensure its availability to primary care.
- Organise quarterly face-to-face consultant psychiatrist-led clinical review meetings for primary care staff.

**Scope:** SMI+.

Acceptance criteria include:

- Patients in PbR clusters 1, 2 & 18 discharged from secondary care to general medical services.
- Patients in clusters 3 & 11 discharged into Local Enhanced Services/ network improvements service.
- Patients on the SMI register of adults of working age.
- Older adults.

Exclusion criteria include:

- Children & adolescents.
- Patients experiencing a crisis.
- Patients with severe mental health problems and complex needs.
- Patients admitted to psychiatric hospital in the last 6 months.

**Working Style:** The primary care mental health liaison function operates at a number of interfaces. Nurse roles within the primary care mental health liaison function are based at GP practices, with GP networks making decisions about the practices in which these roles are located. In the EPC, patients are seen every 3 months by Psychiatry Liaison and their GP in joint

multi-disciplinary clinics. There is reciprocal urgent email and telephone access between GPs and the psychiatry team.

The following ELFT clinical governance standards apply to the liaison function:

- Response time by the liaison nurses for urgent assessments for a patient on LES/NIS who is relapsing and requiring urgent interventions is 24 hours.
- Response time for assessments for acceptance from secondary care services is 5 working days.
- Reviews of mental health patients in primary care is every 3 months.
- Reviews of breaches on interface protocols is within 72 hours.

**Care Roles:** Mental Health liaison care roles are determined by East London Foundation Trust (details to be confirmed).

**Mental Health Training:** The Liaison function delivers components of a Development Curriculum to upskill primary care staff about managing mental health conditions, risk (including positive risk taking) and medications (including side effects). They will also provide training on administration of depot medication.

**Electronic Record Keeping:** All liaison consultations are recorded on GP IT systems (EMIS LV/ PCS/ INPS). The SMI-DEPOT LES template is used to record physical and mental health checks and interventions for all patients on practice SMI registers and for all patients discharged to primary care from ELFT.

**Psychotropic Medication Prescribing:** Aim is for depot prescribing responsibility to be held with GP.

#### Outcomes:

EPC Service Newham	At 31/07/2015	At 29/02/2016	At 30/10/2016
<b>Active Caseload</b>	485	557	610
<b>Received EPC Service</b>	787	1186	1448
<b>EPC Transfer to Primary Care</b>	184	465	705
<b>Transfer back to Secondary Care</b>	120	164	227

**Funding:** N/S

**Contact:** Dr Muhammad Naqvi, Newham Clinical Commissioning Group [M.naqvi@nhs.net](mailto:M.naqvi@nhs.net)

## TOWER HAMLETS

**Current Situation:** Tower Hamlets Together (THT) are a Multi-Community Provider Vanguard site and have a mental health offering consisting of a variety of service provision. The Tower Hamlets Together Vanguard mental health offering has recently been examined in detail by The Kings Fund (Mental Health and New Models of Care: Lessons from the Vanguard. The Kings Fund, May 2017). Readers are encouraged to refer to their report for details of the complete THT mental health offer. For the purposes of this scoping exercise, focus is placed upon the

primary care mental health service aspect of care provision (part of THT approach to addressing Vanguard Priority 1 – Integrated care for adults with complex needs). The Tower Hamlets Primary Care Mental Health Service commenced in 2014 and was developed working with partners from City & Hackney and Newham. It comprises three main elements:

- GP practice delivered recovery-oriented care which includes medical management, care planning, depot administration and support with healthy lifestyles. This is secured via a contract between the CCG and general practices, where responsibility for delivery sits with 8 networks of four or five practices (Network Incentive Scheme payments for the practices).
- A team of nurses who provide recovery-oriented psychosocial support, access to mainstream services and care planning. The nursing staff are employed by ELFT but work within the general practices, but are linked to each of the 8 Gp networks. The nursing team generally offers three-monthly appointments to patients in general practices and carry caseloads of approximately seventy individuals. The nurses work with peer support mental health workers linked to each GP network.
- An enhanced primary/secondary care interface, including a regular practice-based MDT meeting in which a consultant psychiatrist, liaison nurse, GP and practice staff attend to agree patients for transfer into the service and for case discussion.

**Model:** Wrap-around care model, with step-up/step-down care to/from secondary care to primary care and from specialist GP care to general medical services, appropriate to individual patient needs.

**Aims:** The Primary Care Mental Health Service provides a supportive interface between secondary care services and general medical services with/without enhanced mental health input. It aims to treat those with a diagnosis of serious mental illness, who are stable in secondary care services and can be discharged back towards general medical services. After being with the PCMHS for 1-2 years there is a review of the possibility of discharge to general medical services. PCMHS also aims to provide an enhanced primary care mental health service (including adequate physical health input) to individuals with a diagnosis of SMI who do not currently receive secondary care services and who would benefit from support (including those with SMI diagnoses who currently receive regular depot medication in primary care). A key focus of the PCMHS model is to improve communication between primary and secondary care providers, through regular practice-based multi-disciplinary teams attended by secondary care consultant psychiatrists.

**Scope:** SMI (serious mental illness with a stable risk and a level of ongoing symptoms that does not require the need for ongoing Care Programme Approach). The service is for individuals aged 18+ years, a resident of Tower Hamlets and permanently registered with a GP practice in Tower Hamlets.

#### **Working Style:**

- General Practice Responsibilities
  - Maintain a record of all patients receiving support via the PCMHS.
  - Hold regular MDT meetings with the lead consultant psychiatrist for the practice and discuss patients under CMHT or PCMHS care.
  - See also below for joint GP/primary care mental health liaison worker responsibilities.
- East London NHS Foundation Trust Responsibilities:

- The PCMH has a lead consultant psychiatrist (0.2wte).
  - Ensure that each practice has a lead CMHT consultant psychiatrist identified to act as the main link to secondary care mental health services for practices and to attend multi-disciplinary meetings. Each practice had at least a month MDT meeting.
  - Employ and manage primary care mental health liaison workers.
  - Ensure that any patient identified for discharge from ELFT to PCMH (or into GMS) has a recovery plan in place prior to discharge.
  - Participate in training to networks and practices, informally through network meetings and practice MDT meetings, and formally through protected time learning. E.g. Depot, suicide assessment, training.
- Primary Care Mental Health Service Responsibilities:
    - Agree with practices the patients who are eligible for discharge from ELFT.
    - Develop a recovery plan for patients.
    - Provide proactive follow-up with PCMH patients should they not attend an appointment, either within the practice, or with the mental health liaison worker, or for depot injection.
    - Facilitate rapid access to secondary care assessment should a PCMH patient show signs of relapse.
    - Provide a mental health assessment, and develop a recovery plan, for patients moving into PCMH from the primary care SMI register.
    - Report on patient outcomes (DIALOG measure).
    - Provide training to practice nurses on depot medication.

All patients who are managed by PCMH have in place a recovery plan, developed by a primary care mental health liaison worker in partnership with the patient's GP in the following areas:

- Mental health
- Physical health
- Medication
- Healthy lifestyles
- Access to employment
- Relationships & social support (linking to Social Prescribing)
- Cultural needs

**Care Roles:** Creation of the role of Primary Care Mental Health Liaison Worker. The key responsibilities for this role are outlined above.

**Mental Health Training:** General practice staff participate in training opportunities including an annual programme of training delivered as part of protected learning time. The consultant psychiatrist provides training to the PCMH team members as required e.g. on psychotropic medication administration and monitoring.

**Electronic Record Keeping:** Records are stored electronically on the general practice system, EMIS.

**Psychotropic Medication Prescribing:** GP practices take on the responsibility for prescribing anti-psychotic, mood stabilising and anti-depressant medication for individuals transitioning from secondary care into the PCMH. They also, take on responsibility for prescribing and

administering depot anti-psychotic medication. Depot medication can be administered by the practice nurse or by the primary care mental health liaison worker where the practice feel they do not have the requisite skills and knowledge.

**Outcome Measures:** DIALOG, number of referrals to secondary care services.

Since its inception in 2013, more than 5000 individuals have received support from the PCMH service. This includes more than 1500 patients in Tower Hamlets, with more than 90% stepped down from CMHTs. Approximately 10% of PCMHs patient have been referred to secondary care/ CMHTs.

**Funding:** N/S

**Contact:** Edwin Ndlovu, Borough Director, East London NHS Foundation Trust

[Edwin.ndlovu@elft.nhs.uk](mailto:Edwin.ndlovu@elft.nhs.uk)

Karl Marlowe, Clinical Director, East London NHS Foundation Trust

[Karl.marlowe@elft.nhs.uk](mailto:Karl.marlowe@elft.nhs.uk)

## WALTHAM FOREST

**Current Situation:** The Waltham Forest Wellness Service Pilot is currently being trialled (1<sup>st</sup> September 2015-31<sup>st</sup> March 2017). The Wellness Service Model is a new intermediate level enhanced service positioned between Primary Care (Level 1) and Specialist Secondary Care (Level 3). Development of a full business case/full service rollout for the Level 2 Wellness Service is planned during this 18-month pilot period. The purpose of the new model is to provide the following:

- A base for a holistic care service bringing together mental, physical and social care models
- Led by GP's with support from specialist clinicians and Wellness Manager
- A clearly defined wellness care pathway with clear referral and accountability frameworks
- Clinical governance and supervision provided by a Specialist Consultant
- Management support provided by a Wellness Manager
- Navigation of services provided via a Wellness Worker

**Model:** New Level 2 Service Provision, working alongside (but not based within) GP practices and secondary care services. The service is based on the following models of care – Wellness Model, Person Centred Approach, Rehabilitative Models, and Psychological Approach.

**Service User Involvement:** Ongoing engagement and feedback from patients as part of the pilot, this is informing the shaping of the project. We also include customer feedback/satisfaction surveys.

**Aims:** The aim of the pilot is to validate both the clinical model and the impact on secondary care services. The basic premise is that selected individuals with mild to moderate enduring mental health issues can be provided with information, advice, support for prevention and early intervention and that they can be managed within a new integrated model of service. GP's hold clinical responsibility. For complex patients they will receive support and advice from a Mental Health GP with Special Interest in the community. Patients are also supported by a Specialist Clinician and Wellness Workers. The Wellness Service proactively reviews service users quarterly for the first three quarters following discharge from North East London Foundation

Trust. Review frequency may then be decreased to six-monthly should it be deemed clinically appropriate.

**Scope:** SMI-registered individuals only.

Categories of patients accepted for referral include:

- Mild to Moderate common mental health problems (clusters 1, 2, 3)
- Stable psychotic conditions (clusters 11, 12)
- Mild cognitive conditions (cluster 18)

Acceptance Criteria are as follows:

- Aged 18 years and over
- Registered with a GP practice covered by the pilot sites
- Are not on a CPA pathway
- Are identified in PBR clusters as shown above
- Are on the practice SMI register
- The patient has needs over and above those that would ordinarily be provided under normal GMS care

The Wellness Service is based in a single location and provides services across three localities working within a group of fifteen GP practices. The Wellness Service provides assessment and treatment for service users as defined in the categories above. Referrals to the service are either directly from existing GP's, via the existing mental health assessment service or through other agreed referral sources.

**Working Style:** Patients are treated and supported in primary care for their mental health and physical health checks (reducing the referrals to secondary services). The model moves individuals from a secondary care setting into a community and primary care 'Wellness' setting, supported by professionals in a new service setting.

Timescales for providing assessment appointments are – Urgent, within 72 hours. Routine – within 4 weeks Same-day telephone response is provided within working hours (Mon-Fri 9am-5pm) for non-crisis queries and enquiries. The existing assessment service from NELFT responds to all urgent calls and also to any call outside of Wellness Service hours.

**Care Roles:** The Wellness Team consists of the following roles:

- *GP with special interest (GPwSI)* – role includes initial assessments of patients, review and initiation of medications, review of risk and mental state, physical health screening and co-morbidity condition management. The Wellness Service GP takes medical responsibility for patients in the Wellness service, supervised by a mental health consultant.
- *Mental Health Consultant* – consultant psychiatrist who provides professional supervision to the Wellness Service and assumes the role of clinical governance lead.
- *Wellness Manager/Specialist Clinician* – senior specialist nurse who functions as a Wellness service manager. The role includes managing the Wellness team, regular meetings with NELFT access service to support appropriate triage of patients, leading the development of wellness plans for patients (in conjunction with GPwSI), delivery of clinical components of the Wellness treatment package, including depot administration for cluster 11 & 12 patients.



- *Wellness Workers* – the role includes supporting selected patients in accessing key resources such as housing & accommodation, home support and signposting to key community resources. Wellness workers may also be involved in therapy delivery and undertake training to evaluate service performance (e.g. HoNOS).
- *Administrative role* – provides administrative support to the Wellness team.

**Mental Health Training:** N/S

**Electronic Record Keeping:** The Wellness service uses existing GP electronic information management systems. A service user Wellness registration and tracking system is also maintained for the liaison function to ensure data is available to support functions such as reviews.

**Psychotropic Medication Prescribing:** Prescribing and medicines management is the responsibility of the GP practice, including administration of depot medication

**Outcome Measures:** Clinical efficacy will be evidenced and reported by:

- Percentage significant improvement (cluster discharge to primary care)
- Percentage improvement/decline within the service caseload
- Percentage significant decline (cluster transfer to specialist services)
- Percentage moved out of area/deceased (neutral measure to be deducted)
- Number of A&E attendances by services and by patient

Service performance will be evidenced and reported by:

- Number of active cases within the service
- Percentage assessed by Wellness service and refused
- Percentage greater than referral to treatment target
- Average contacts by cluster by pathway manager
- Waiting times – initial referral to health assessment, waiting times, initial referral to social work, employment and housing

**Funding:** N/S

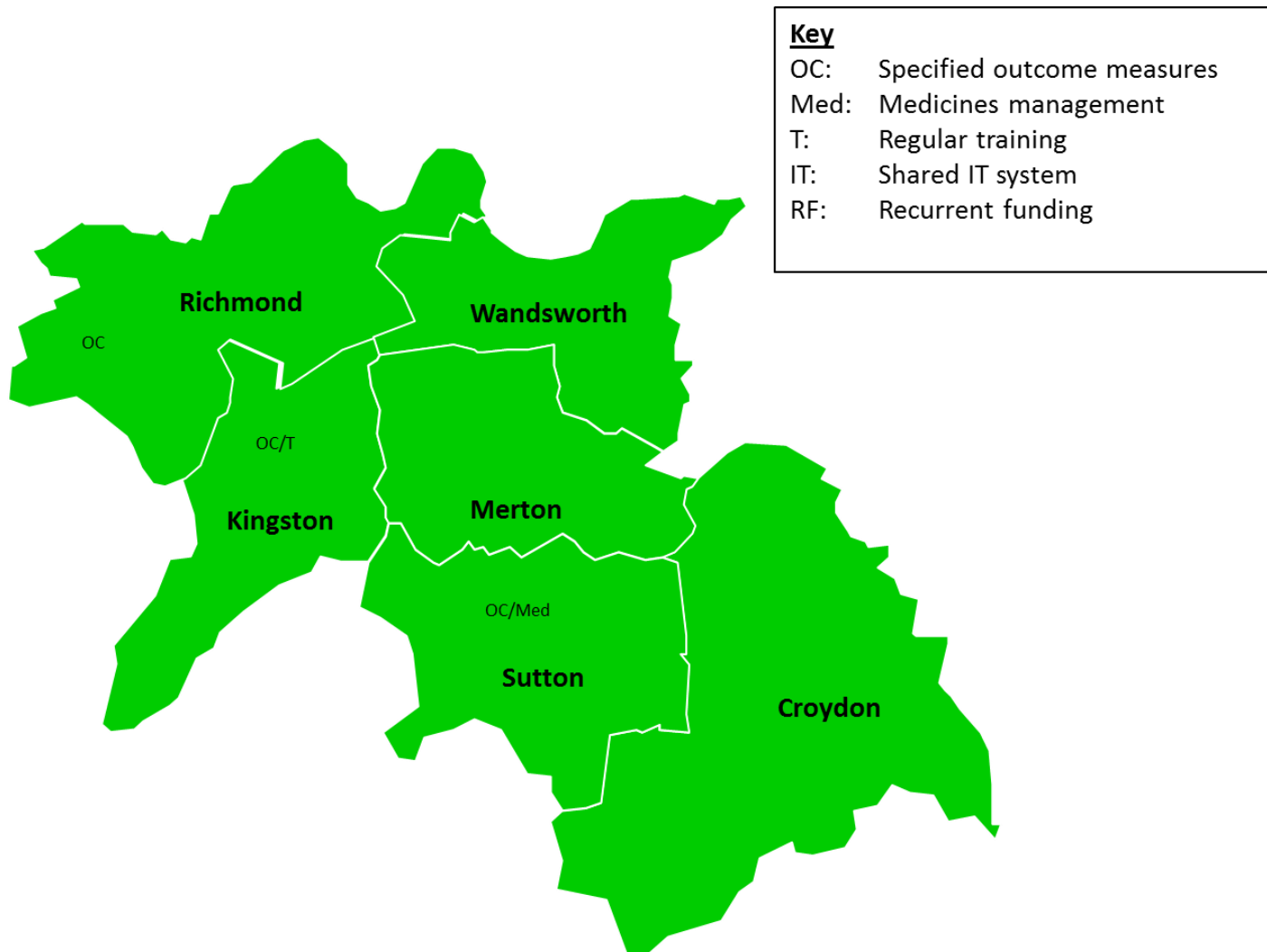
**Contact:** Nuzhat Anjum, Associate Director Strategic Commissioning

[Nuzhat.anjum@walthamforestccg.nhs.uk](mailto:Nuzhat.anjum@walthamforestccg.nhs.uk)

Deborah White, Mental Health Commissioning Manager

[Deborah.white@walthamforestccg.nhs.uk](mailto:Deborah.white@walthamforestccg.nhs.uk)

## SOUTH WEST LONDON



- ✓ CROYDON: Primary Care Mental Health Support Service
- ✓ KINGSTON: Primary Care Mental Health Service
- ✓ MERTON: (Currently under development)
- ✓ RICHMOND: Primary Care Liaison Service
- ✓ SUTTON: Primary Care Mental Health Service (part of Sutton Uplift)
- ✓ WANDSWORTH: Primary Care Plus Service

### CROYDON

**Current Situation:** Primary Mental Health Support Service.

**Model:** In-reach model of mental health care within a primary care setting.

**Aims:** To increase successful transitioning of stable patients with a diagnosis of SMI back into primary care.

**Scope:** SMI only. Supports the management and discharge of stable SMI patients back to primary care services. i.e. Patients who are transitioning from an episode of secondary mental health care. Funding for the service is within block contact.

**Working Style:** This is a psychiatrist-led team.

**Care Roles:** N/S

**Mental Health Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** Data has been collected and evaluated (not available at time of report preparation). The service has not had a major impact so far in its development. There has been difficulty engaging with practices due to increasing demands on primary care. The service is considering ways to increase its level of self-promotion.

**Funding:** N/S

**Contact:** Dr D Malhotra, Mental Health GP Clinical Lead, Croydon CCG  
[drdevmalhotra@hotmail.com](mailto:drdevmalhotra@hotmail.com)

## KINGSTON

**Current Situation:** In October 2015, Camden and Kingston Foundation Trust commenced the Kingston Primary Care Mental Health (PCMH) service. This was commissioned to provide initial assessments and short term interventions with the overarching aim of preventing service users needing to access secondary services and to support the management sub-acute threshold successfully in primary care. The enhanced primary care service was resourced alongside a Primary Care offer to improve management, experience and outcomes for people with Personality Disorder. The model was informed by the South Barnet Primary Care Service delivered by Camden and Islington NHS Foundation Trust. A key difference with the Kingston model is that it is not intended to be a single point of access for all mental health referrals (and this is reflected in the level of resource into the service).

**Model:** In-reach from secondary care services (Consultant Psychiatrist), in addition to upskilling of GP's in mental health care. Meetings and staff are based within GP practices. There is a single referral form for enhanced primary care mental health/IAPT/substance misuse services. Telephone consultations available between primary and secondary care staff for advice and support for re-referral back to secondary care if required. Ad hoc MDT meetings also occur between primary

Kingston aims to extend the service to include perinatal and Long Term Conditions for mental health. We are also developing plans to support GPs with Physical Health checks for SMI and depot prescribing to stable patients who wish to be transferred back to primary care services.

**Scope:** SMI + service. Individuals aged 18 years and over.

**Care Roles:** The service consists of a Consultant Psychiatrist, a Mental Health Nursing and psychology. The service is Consultant Psychiatrist led and short-term psychological therapies and nursing interventions available for patients.

**Mental Health Training:** 19 GP's have been trained in mental health skill, attaining a Post Graduate Diploma in Mental Health. They are now acting as a resource for training and dissemination of mental health skills within the borough. The trained GP's also act as a support network for other GP's in Kingston.

**Electronic Record Keeping:** EMIS.

**Psychotropic Medication Prescribing:** It is planned that depot medication will in due course be administered and overseen for patients within the enhanced primary care services.

**Outcome Measures:** Positive patient experience. Improved GP satisfaction. Reduced referral rates to secondary mental health services - reduction of caseload in secondary care has been very rapid to date.

**Funding:** N/S

**Contact:** Sylvie Ford, Joint Mental Health Commissioning Lead, Kingston CCG  
[Sylvie.ford@nhs.net](mailto:Sylvie.ford@nhs.net)

## MERTON

**Current Situation:** Merton CCG are currently developing plans for a new model of primary care mental health service provision in the borough. Service users are engaged in the consultation and planning process.

**Model & Working Style:** A multi-disciplinary care team based within the primary care setting is envisaged.

**Scope:** SMI+. All individuals with a mental disorder registered with a GP in the borough aged 18 years and above.

**Care Roles:** N/S

**Mental Health Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** N/S

**Funding:** N/S

**Contact:** Dr Andrew Otley, GP Mental Health Lead, Merton CCG [Andrew.otley@nhs.net](mailto:Andrew.otley@nhs.net)

## RICHMOND

**Current Situation:** A Primary Care Liaison Service (PL) for mental health was established in Richmond CCG approximately 3 years ago in response to concerns regarding high levels of referrals to secondary care mental health services and also to the need for primary care clinicians to access timely advice and support when caring for patients with mental health difficulties. The principles behind the Richmond model include moving towards a more highly integrated mental health care model (that is based on 'hospital' and 'community' care rather than primary/secondary). The overarching aim is to establish an alliance of organisations, including

social care, health care and others, to provide care and support services to those with mental health difficulties, with associated outcomes-based commissioning.

In addition to the formation of the PCL service, Richmond has plans to transform into four primary care homes, each of around 50 000 people, with an initial rapid test site in Twickenham and Whitton localities. The formation of the primary care homes brings together health and social care professionals from primary as well as community care to work together, and with other health and social care providers in the borough, to deliver integrated and timely health and social care solutions. The project aims create the opportunity for multi-speciality providers to work together to develop innovative ways of delivering more care to patients out of hospital in a community setting or at home.

**Model:** The Richmond model is essentially an 'In-reach' model of care with Primary Care Liaison workers being based in GP surgeries. These are newly-established roles and are in addition to previous staff roles within the primary care setting. The PCL is a rapid-access service. GP's are able to telephone PCL staff for timely advice and support of patients in their care. The PCL is not designed to replicate or replace current Community Mental Health Teams.

**Aims:** To support GP's in Richmond with easy access to specialist mental health advice and expertise. Providing GP's with a facility for rapid assessment and review of patients with known or suspected mental health difficulties within a primary-care based service, thus also reducing the need for secondary care referrals.

**Scope:** SMI + but the PCL service is not appropriate for very high risk or very high complexity patients.

**Working Style:** The PCL staff work alongside GP's and there is scope for MDT meetings if required. However, the majority of patients are seen independent of a GP. Referral of patients to PCL is by letter. On formation of the PCL service, care was taken to avoid establishing a 'parallel caseload' to that of GP's. The aim of the service is to see patients for whom GP's require an input of specialist mental health advice and expertise. When referred to PCL, patients co-produce their care plan following PCL review and assessment.

**Care Roles:** The PCL comprises liaison mental health workers (4-5 FTE's) and 2 consultant psychiatrists (part time in GP surgeries and easily accessible by telephone/email at other times Mon-Fri standard working hours).

**Mental Health Training:** Training - no specific additional formalized training session although ELFT delivered two mental health training sessions in the past 12-month period to primary care staff.

**Electronic Record Keeping:** ELFT PCL staff have access to Rio which they use to check whether a patient is under secondary care. PCL staff are unable to access current primary care EMIS notes.

**Psychotropic Medication Prescribing:** PCL do not currently prescribe or administer depot medication – this remains within secondary care services.

**Outcome Measures:** An outcomes framework has been formalised and is being used to gather data at the present time. Patient referral numbers are recorded (referrals to PCL service and also to IAPT and secondary mental health services). Patient Satisfaction surveys are also being completed for the PCL with reported high levels of user satisfaction to date. There has been an

approximate 70% reduction in referrals to secondary care since the PCL service was established: Referrals to PCL are continuing to increase.

**Funding:** N/S

**Contact:** Dr Stavroula Lees, GP Clinical Lead for Mental Health, Richmond CCG  
[Stavroula.lees@nhs.net](mailto:Stavroula.lees@nhs.net)

## SUTTON

**Current Situation:** Sutton launched its Primary Care Mental Health (PCMH) service on 1st July 2015. The service is provided by South West London and St George's Mental health NHS Trust and voluntary sector partners; Imagine, Age UK, Off the Record, and the Sutton Carers Centre. It is called 'Sutton Uplift' and is based on the values of empowerment and preventing ill health, through intervening early to support and educate individuals to better manage their mental health and wellbeing. By recognising people's own strengths and capabilities, the service aims to support people to reconnect with their communities and networks, with the ultimate aim of building resilience within the community.

**Model:** Collaborative stepped-care model.

**Aims:** The service aims to operate in the heart of the community and offer a holistic approach to promoting positive mental health and wellbeing focusing on early intervention in line with national guidelines. This mental health care model offers Sutton residents more treatment choices; mental health care in a less stigmatised environment, improved knowledge on how to manage mental well-being, a holistic model of care addressing physical, social and mental health needs. It generally supports the 'keeping people in their lives' approach to mental health care and build emotional resilience among Sutton's communities.

Co-production is central to the Service's design and delivery. It has a well-established Service User Development Group, chaired by a service user and good carer and service user feedback systems.

**Scope:** SMI+. Professional and self-referral access for adults (18+) who have a mental health problem who live in Sutton or have a Sutton GP.

**Working Style:** Sutton Uplift comprises four service elements (of which the primary care recovery team is one). The services work collaboratively to ensure the most appropriate support is offered to individuals requiring mental health support in primary care. The service has a central base but also operates from a range of community venues to ensure borough-wide coverage and increased access. Uplift is a single point of access (SPOA) service. There is professional and self-referral access for adults (18+) who have a mental health problem who live in Sutton or have a Sutton GP. Multiple modes of referral are available including telephone, online and postal.

The 4 service elements

- **Assessment**  
The assessment team are based within the referral centre and coordinate all referrals into the service. From Monday to Friday, two multi-disciplinary teams meetings are held (12 noon & 4pm), involving community psychiatric nurses, a consultant psychiatrist, a psychologist and a wellbeing navigator, to identify the most suitable pathways for referrals.

the assessment team offer telephone triages in addition to face-to-face psychiatric assessments and will lead on assessments where urgent risks are associated.

The assessment team are the gateway and interface with secondary care services, monitoring and managing flow in and out of the more specialist mental health services. The assessment team aim to provide a seamless approach and interface with other providers and specialist mental health services. Following assessment, a holistic and appropriate package of support is offered.

- **Primary Care Recovery Team (PCRT)**  
The primary care recovery team has been set up to support those who have a severe and enduring mental health problem whose condition is stable and will benefit from a recovery approach to care.

The PCRT aims to 'bridge the gap' for individuals who historically were discharged from specialist services back into the care of their GP. The PCRT aims to provide some stability during a period of transition towards more independence. The PCRT also plays a role in offering early intervention to prevent deterioration of those already care for within GP practices. By supporting people early, the PCRT aim to prevent service users needing more intensive interventions.

The PCRT approach to care is aimed at being holistic, integrating physical, social and mental health support. The central purpose of interventions is to prevent relapse, maximise role functioning, maintain current social role functioning, reduce risk of self-harm and promote better adjustment to their daily living and situation. A service user's holistic package of care is considered, in collaboration with the service user and any carers, to ensure all needs are met throughout their recovery journey.

- **Well-being Service**  
The Wellbeing element of Sutton Uplift is led by the voluntary sector organisation Imagine Independence and includes other voluntary sector organisations such as Off the Record, Age UK and Sutton Carers Centre.

The Wellbeing component offers a range of functions which includes the provision of:

- Information
- Signposting
- Practical support
- Employment support
- Well-being clinics
- Workshops
- Drop-ins
- Local forums/events

The service includes Wellbeing Navigators who work in partnership with service users in goal oriented ways to:

- Access community and vocational opportunities (leisure, social and education).
- Develop strategies for managing wellbeing.
- Offering practical support and signposting (benefits, housing, finance)

Outreaching in the community and partnerships with other organisations is also a fundamental role for the Wellbeing team. A strong partnership with other organisations

has allowed the Wellbeing service to be able to bridge gaps in provisions within the community. Such examples include mind & body and long term conditions at Sutton Mental Health Foundation, confidence and assertiveness at the Women’s Centre and developing a conversation group for parents with English as a second language with the Refugee and Migrant Centre.

The Well-being Navigators facilitate a range of well-being work-shops; run drop-in sessions at various local venues this has enabled engagement with those who may not readily access support and those who have greatest need via housing support groups, food banks, children’s centres, colleges, voluntary sector organisations, religious groups, job centres.

- Psychological Therapies

Psychological therapies are offered via Sutton IAPT service, with a range of low and high intensity psychological interventions available. Appointments are offered across the borough at various GP surgeries and the Sutton Carer’s Centre, in addition to those at Jubilee Health Centre base, to improve ease of access, as well as provide therapy in non-stigmatised settings.

As part of the psychological therapies offer, Sutton Uplift provides guided self-help courses for service users via an online service called Silver Cloud. Silver Cloud users can, in addition to guided self-help, also access a clinician throughout their treatment. Courses can be tailored around the service user, who can select the modules most relevant to them at any given time with the guidance and support of the clinician. Service users are able to access Silver Cloud 24 hours a day and continue to access them for one year after appointments with their clinician have ended, to maintain wellbeing.

Sutton Uplift also has an Employment Support Service – assessment of support for employment is carried out during initial triage. This service recognises research findings that employment improves psychological wellbeing, as it provides structure and opportunities for growth leading to increased self-esteem. If the service user is not work ready but has employment needs, they are allocated a Wellbeing Navigator. If the service user is work ready, they are referred to Imagine for employment support. Imagine are the main voluntary partner within Uplift, so there is a seamless referral pathway across organisations.

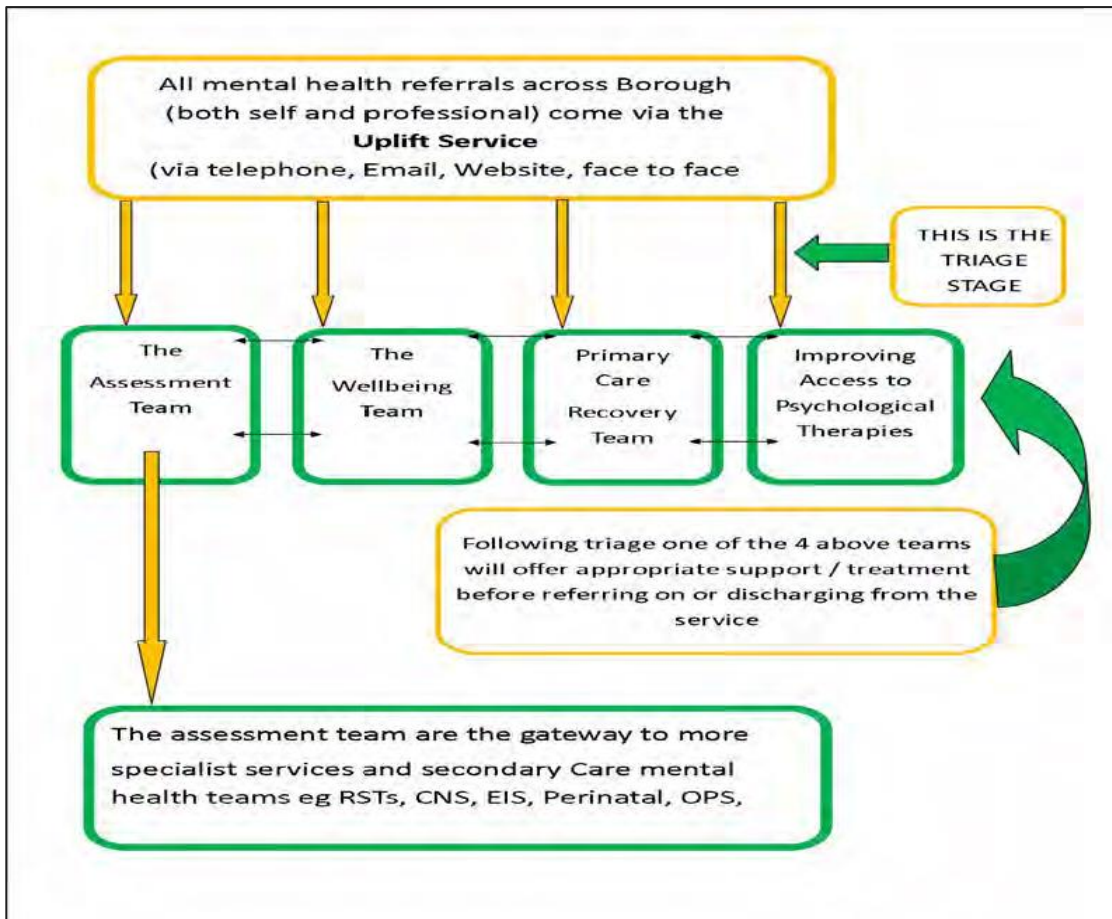




This service model is unique and offers a range of benefits:

- Easy access for GP and patients
- A broader level and range of support & increased patient choice
- A holistic package of care & support
- Support to those who don't meet criteria for current mental health provision
- Facilitated access to range of support for those needing this
- Psychological support and recovery support for those with stable but enduring mental health concerns
- Mental health pharmacy support
- Manages patients' journeys in and out of specialist mental health services
- Builds community resilience

The model promotes a holistic approach to mental health & well-being, enabling people to receive support across the service components when clinically appropriate. For example, people can receive support from the Well-being Team prior, during and/or post receiving an IAPT intervention and people held by the Recovery Team can access psychological therapies from the IAPT team.



**Care Roles:** There is a new role within the PCMH service of Wellbeing Navigator (see above), in addition to existing expertise.

The Sutton Uplift service includes the following roles - Consultant Psychiatrists, Mental Health Nurses, Pharmacist, Occupational Therapists, Clinical Psychologists, High and Low intensity IAPT workers, Well-being Navigators, Peer Trainers, Course Facilitators and Administrators.

**Mental Health Training:** In-house training for IAPT workforce and Wellbeing Navigators.

**Electronic Record Keeping:** The electronic databases Rio and IAPTus are used.

**Psychotropic Medication Prescribing:** The recovery component of the PCMH Service includes a prescribing service, medication and physical health reviews.

**Outcomes:** The service has progressively improved upon its IAPT performance over the 21 months since its inception.

The service received 7649 referrals during its first year and approximately 86% of these were considered appropriate for the Sutton Uplift 'treatment' arms.

The service contract includes seven quality indicators, two of which are the National IAPT 'access' & 'recovery' performance indicators. The table below highlights the improvement in performance comparing IAPT performance the year prior to the new model and the new model's first year.

Key National IAPT performance indicators by year

KPIs	1 <sup>st</sup> July 14 – 30 Jun 15	1 July 15 – 30 June 16	National Target
Access	13.3%	16.1%	15%
Recovery	40.0%	44.1%	50%

This service has not reach the end of its second year yet for further comparison, but for year 2016-17 (Apr 2016 -March 2017) the service met a 16.2% Access rate and 48.2% Recovery rate across the year.

Key to the success of this new model has been the well-being component and its close working with the IAPT team. This team has been able to carry out an outreach and engagement functions, which not only has enabled the IAPT workforce to focus on their clinical functions but has engaged more local people to access mental health support.

Another change has been in equity of access. The Uplift model is demonstrating improved access by ethnicity and a slight improvement in access by older people (65+) than the previous IAPT only service reported.

	Q4 15/16	Q4 16/17	Pop
BAME Comm Grps	16%	23%	21%
Older People (65+)	4%	6%	14%

**Patient Satisfaction Outcomes:** Currently the service is collecting Patient Experience Questionnaires for IAPT and WBS following assessment and following end of treatment with a view to embed this across the whole service.

Patient satisfaction and experience outcomes were measured using the Patient Experience Questionnaire (PEQ). Key outcomes across the service's first year (1<sup>st</sup> July 2015-31<sup>st</sup> June 2016) are:

- 94% reported that they were completely or mostly satisfied with the assessment process
- 98% reported the service has helped them better understand and address their difficulties
- 92% reported that on reflection they got the help that mattered to them.

The Assessment Team and Primary Care Recovery Team currently use Real Time Feedback devices (RTF), which enables the service to respond to comments and queries on a day-to-day basis (in real time). Service users are also encouraged to use Patient Opinion.

A pilot evaluation project was also conducted during the first year to gain a deeper understanding of people's experiences through each stage of the care pathway.

This pilot highlighted service users' positive first impressions of the service, with the majority reporting they got the help they wanted and were able to better deal with life as a result of the support they received.

Service users also reported that the professional approach, the opportunity to learn about managing their mental health and the support they received were the best aspects of the service. The groups and workshops were also highly valued.

The evaluation questionnaire continues to be rolled out to ensure the service user voice continues to grow and support the strengthening of the service.

Additional service user feedback:

*One man who received talking therapies and well-being support reported that the service was "gold-standard" and added:*

*"Can I just say I am amazed, this is what I get for my NI contributions – this service is incredible and is exactly meeting my needs, thank you so much"*

Another:

*"I never properly got to thank the service at Jubilee Health Centre in Wallington but they really did change my life. I referred myself for CBT which helped me with my negative thoughts. To think at one time I found it difficult to answer the door and speak to people, now I have a job. It's amazing what they are doing"*

**Funding:** The service is funded via block contract with the local mental health trust.

**Contact:** Corinna White, Mental Health Programme Manager, Sutton NHS Clinical Commissioning Group [Corinna.white1@nhs.net](mailto:Corinna.white1@nhs.net) [www.suttonuplift.co.uk](http://www.suttonuplift.co.uk)

## WANDSWORTH

**Current Situation:** Primary Care Plus service being launched early November 2016.

**Model:** In-reach stepped-care model.

**Aims:** To integrate mental health expertise into primary care, with initial over-arching list of objectives which will be tailored within each GP practice. A key objective is to allow CMHTs to be able to discharge patients earlier back to primary care, allowing improved flow through the system.

**Scope:** SMI+.

**Working Style:** Aims to forge strong relationships between psychiatrists, Care Navigators, Mental Health Liaison Workers and GP's. Facilitates face-to-face clinical contact with patients.

MDT meetings with GP involvement are planned, with new mental health caring roles being highly integrated into GP practices.

**Care Roles:** New care roles are being formed including Clinical Team Manager, Mental Health Liaison Worker (1 Whole Time Equivalent), Care Navigators (Band 4, 3 WTE's), Consultant Psychiatrist (1 session).

Input level: Average planned 1 clinical contact per patient/month (clinical staff providing total 21 hours direct clinical contact/week). Care Navigators and Mental Health Liaison Workers are being sourced via third sector organisations (Mind).

**Mental Health Training:** Currently considering similar training as in Kingston, with named GP's undertaking a diploma in mental health and streaming their knowledge to other GP's in their practice area.

**Electronic Record Keeping:** The exact form this will take is not yet confirmed. The borough is currently exploring using the EMIS system for the Primary Care Plus service.

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** N/S

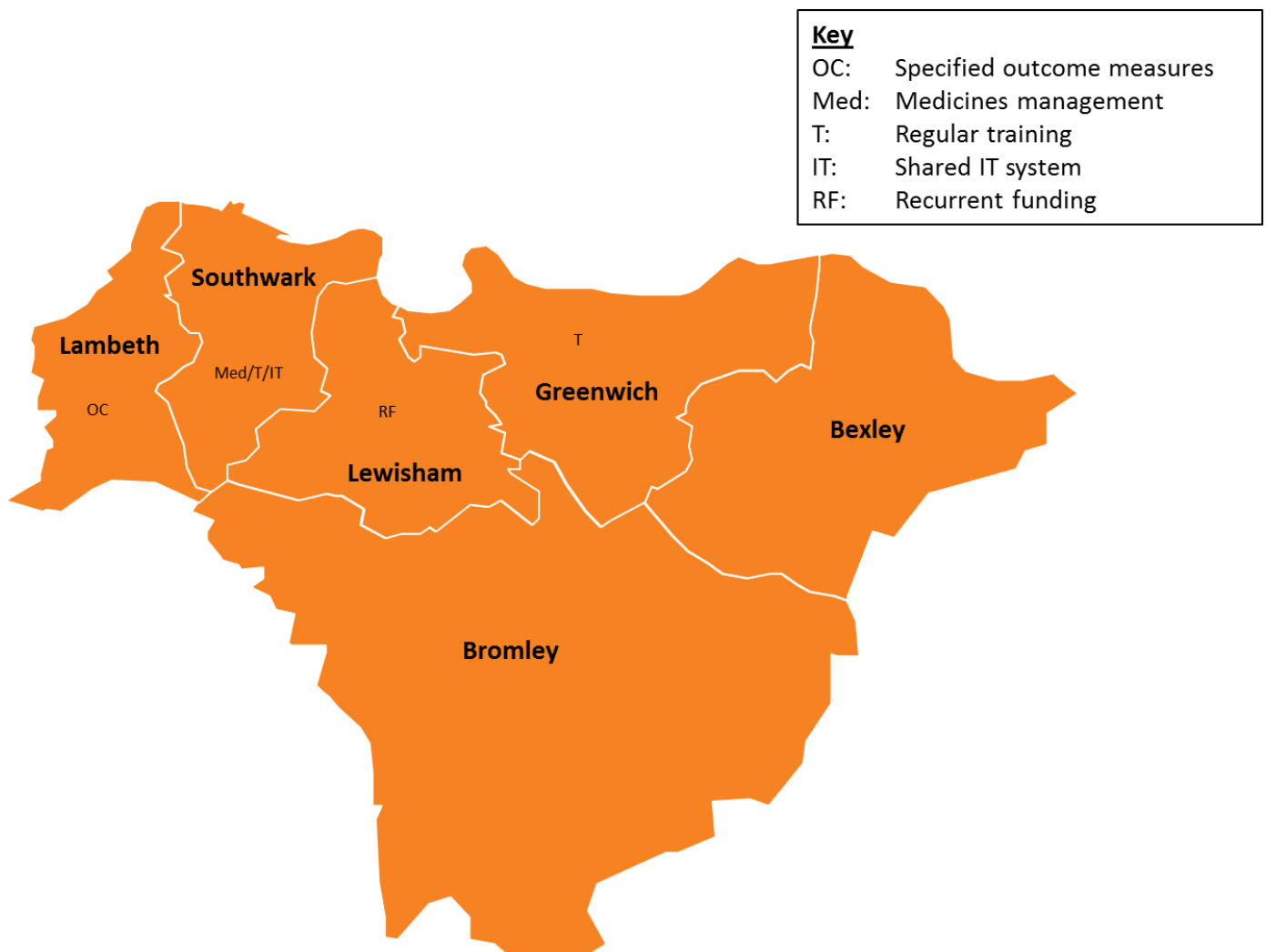
**Funding:** N/S

**Contact:** Dr Tom Coffey, GP Clinical Lead for Mental Health, Wandsworth CCG

[Tom.coffey@nhs.net](mailto:Tom.coffey@nhs.net)

Mark Robertson, Commissioning Manager & Mental Health CCG Lead, Joint Commissioning Unit, Wandsworth CCG & Borough Council [Mark.robertson@nhs.net](mailto:Mark.robertson@nhs.net)

## SOUTH EAST LONDON



- ✓ BEXLEY: (Mental health service offer via Bexley Mental Health Recovery College)
- ✓ BROMLEY: (Currently under development)
- ✓ GREENWICH: Primary Care Plus Service
- ✓ LAMBETH: Living Well Collaborative
- ✓ LEWISHAM: (Enhanced Primary Care Mental Health Service currently under development)
- ✓ SOUTHWARK: Enhanced care being commissioned via the Severe Mental Illness Commissioning Development Group

### BEXLEY

**Current Situation & Model Overview:** Bexley has an Adult Mental Health Recovery College, an IAPT service and supports personal health budgets. Access to these services is dependent upon each person's individual presentation and clinical background. The Recovery College and IAPT service are commissioned through the Integrated Commissioning Team on behalf of NHS Bexley CCG and London Borough of Bexley. Other mental health services are commissioned

from a range of sectors and include within the workforce clinical staff, allied health professionals as well as individuals working within third sector organisations.

Additional data as per information provided on the Bexley MIND website, accessed May 2017 ([www.mindinbexley.org.uk](http://www.mindinbexley.org.uk)).

**Aims:** The Bexley Recovery College was set up in June 2014 with the aim of ‘empowering people with mental health problems to become experts in their own recovery.’ The college courses and workshops help individuals develop their skills, understand their own mental health, identify personal goals and ‘support access to opportunities.’

**Scope & Working Style:** SMI+. The college runs workshops and courses to achieve these goals and ‘offers a learning approach that complements the existing preventative services provided by MIND in Bexley.’ Most workshops are free of charge, with some charging a small fee to cover costs of running the course.

MIND runs courses that are, wherever possible, co-produced and co-delivered by those with lived experience of mental illness and mental health practitioners. ‘The Recovery College provides a joint learning environment where people with lived experience, those who provide their support and MIND staff can learn together and from each other.’

Courses take place at MIND in Bexley premises and at a range of community based venues across Bexley. Courses run throughout the day and there are also some evening courses available. The college is open to:

- Individuals who are currently or have received mental health services from Oxleas NHS Foundation Trust.
- People referred by the MIND in Bexley Improving Access to Psychological Therapies (IAPT) programme.
- Supporters of people using these services (family, friends and carers).
- Staff.
- Individuals referred by their GP.

Referral is via completion of a specifically-designed referral form (which can be accessed online via the Bexley MIND website).

**Electronic Record Keeping:** Fully meets requirements and information governance requirements.

**Outcome Measures:** The service is commissioned and reviewed by the Integrated Commissioning Team in Bexley on behalf of NHS Bexley CCG and London Borough of Bexley.

**Funding:** N/S

**Contact:** MIND in Bexley, Recovery College, Mind in Bexley [info@mindinbexley.org.uk](mailto:info@mindinbexley.org.uk)

## BROMLEY

**Current Situation & Model:** Bromley CCG are currently developing a Mental Health Shared Care pathway between primary and secondary care. Bromley partnership is developing its 5-year strategy for mental health which will inform commissioning and planning priorities. This is being planned via partnership-wide activities that will include strategic partners and service users and their carers to be part of developing the new strategy. Bromley CCG has recently used both Appreciative Enquiry and Asset Based Community Development approaches to

engage service users in both Young Person's and Adult services. This has provided valuable insight and understanding of the resources available on a personal, organisational and community level beyond any formally commissioned services.

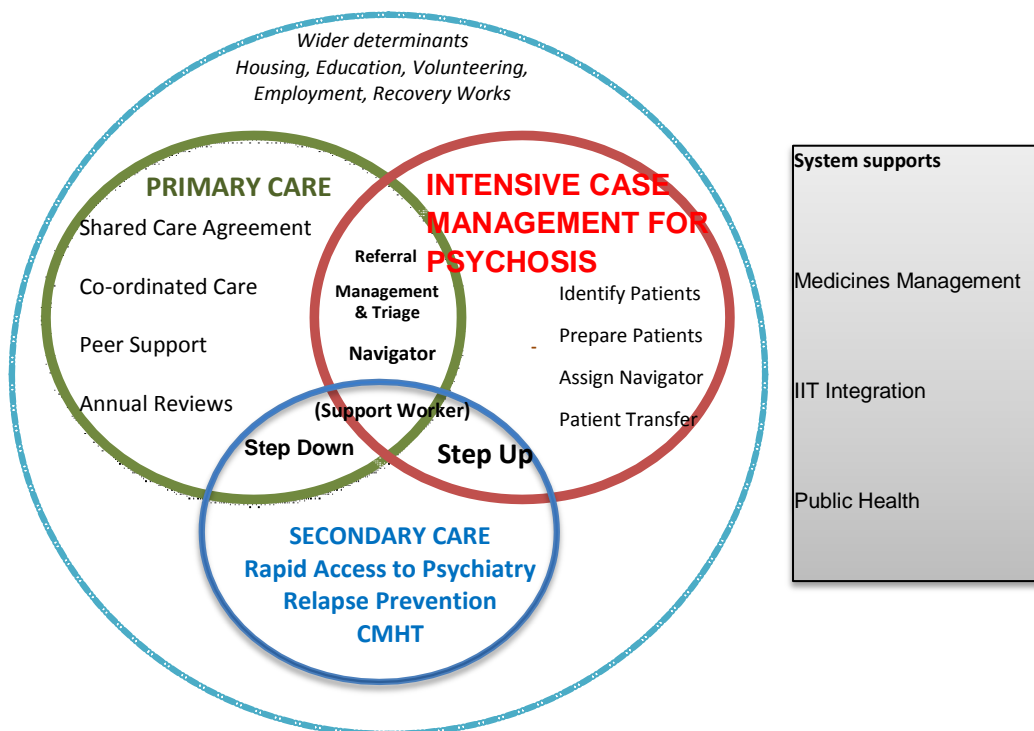
**Locality Teams Shared Care Pilot - Intensive Case Management for Psychosis Teams:** It is proposed that a 6-month pilot is conducted with a small group of stable patients from the east and west of the borough. Oxleas NHS Foundation Trust have identified 20 patients in these areas who are stable on depot medication and suitable to be moved into shared care arrangements with their local GP (care cluster 10 or 11). The pilot will run with Intensive Case Management for Psychosis (ICM-P) Teams intensive case management, with a new role of Care Navigator (support worker), who will provide day-to-day follow-up and engagement with patients, working closely with them to resolve any social care issues that, if not dealt with, may result in a deterioration of mental health (e.g. housing, benefits, relationships). The Care Navigator role also seeks to support patients in accessing services or activities which promote independence and recovery in the community. They will follow up non-attendance of appointments on behalf of the GP and facilitate continuation within primary care or begin the process of transfer back to specialist services, as appropriate.

The ICM-P teams will work closely with GP surgeries and each GP practice participating in the pilot will be contacted by Oxleas to set up initial meetings to discuss the patients to be transferred. ICM-P will provide follow-up and outreach to patients when non-attendance occurs. Regular reviews will take place between all parties involved in the shared care of the patient. In the event that a patient becomes unwell during the shared care arrangement, they will have rapid access to psychiatry and specialist interventions within both the GP and community settings and will be stepped back up to secondary care if required.

A shared-care agreement will be completed by GP's and Oxleas clinicians outlining the roles and responsibilities of each. The respective community mental health locality team (Bromley east/west), retains responsibility for care coordination unless an alternative agreement is reached between the locality team and the receiving GP surgery. The patient will always be made aware of the lead clinician who is co-ordinating their care. The shared care agreement cannot be terminated without both services being in agreement.

In the event of the pilot being successful, the proposed model of shared care for stable mental health patients will be rolled out across the borough with the aim of incrementally improving the flow of patients from secondary care back into primary care. It is envisaged that this will result in around 350 people moving back to their local GP's for the continuation of their treatment and support in the community.

The diagram below outlines the key functions and interactions that will take place within any shared care arrangement. ICM-P Intensive Case Management for Psychosis will identify those patients within cluster 11 or 10 who are stable and work with them to prepare their transfer preparation.



**Recovery Works:** In conjunction with this, Bromley have just commissioned a Recovery Works service which works with service users, coproducing peer, mentor and mutual support in the community, as an alternative to formal mental health treatment services. The Recovery Works service is delivered by Bromley & Lewisham Mind, working in collaboration with Oxleas NHS Foundation Trust. Recovery Works began operating on 1<sup>st</sup> September 2016. Bromley CCG has undertaken the Bromley Healthwatch detailed consultation with local service users to inform their commissioning of Recovery Works and the newly-commissioned IAPT service.

Individuals with mental health difficulties can self-refer to Recovery Works or be referred by a health professional.

**Scope:** *Locality Teams Shared Care Pilot - Intensive Case Management for Psychosis Teams:* The patients who are suitable for the pilot and subsequent shared care arrangements will be from cluster 11 (i.e. patients with a diagnosis of psychosis or bipolar affective disorder) who will be stable and do not need MDT input by secondary care. These patients will be on small doses of medication and will not need active titration. The patients would have already have had a number of psychological interventions in the past, and be adhering to their medication. Some of these patients will be receiving social care packages, and some may be accessing third sector services such as Bromley and Lewisham Mind.

**Recovery Works service:** SMI+. Services are available to people aged 18 years and over and who are registered with a Bromley GP.

**Care Roles:** A new care role of care navigator is being established within the shared care pilot model. This role will provide the day to day follow up and engagement with patients to work closely with them to resolve any social care issues that if not dealt with may result in the patient’s mental health deteriorating (e.g. housing, benefits, relationships). In addition to this, care navigators will seek to support patients in accessing those services and or activities that promote independence and recovery in the community. They will follow up non-attendance of appointments on behalf of GP’s and facilitate continuation within primary care or where necessary begin the process of accessing secondary care support.



**Mental Health Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** Specific drug shared care agreements will be followed.

Prescribing responsibility will only be transferred when the consultant psychiatrist and the patient's GP consider the patient's condition to be stable or predictable. Transferred care will be documented on care programme and crisis planning documentation.

GP practices will be expected to provide medicine management, including anti-psychotic depot and lithium medication where the patient's needs warrant sole primary care management.

**Outcome Measures:** N/S

**Funding:** GP practices will receive a payment of £150 for each patient received back into primary care as part of the shared care pilot scheme.

**Contact:** Stuart Thompson, (Interim) Mental Health Commissioning Manager, Bromley CCG  
[Stuart.thompson3@nhs.net](mailto:Stuart.thompson3@nhs.net)

Dr Atul Arora, Mental Health GP Clinical Lead, Bromley CCG [atularora@nhs.net](mailto:atularora@nhs.net)

## GREENWICH

**Current Situation:** The Greenwich Primary Care Plus service was introduced in September 2015, providing a specialist mental health liaison service to primary care providers in the borough.

Greenwich Primary Care Plus has two teams – West (covering Eltham and Blackheath & Charlton GP syndicates) and East (covering Excell and Network GP syndicates).

**Model:** In-reach specialist liaison service.

**Aims:** To increase successful discharge of patients with mental illness from specialist care back to primary care services. The four core aims of the PCP Service are:

- Assessments and referrals management
- Relapse prevention and shared care provision
  - For individuals who have previously been under Oxleas' services, PCP aims to support primary care to maintain people in remission or with stable optimally-controlled symptoms and develop good self-management skills.
  - PCP helps prevent relapses by quickly re-engaging people who drop out of treatment.
  - PCP psychiatrists support GP's to manage complex medication regimens, and provide advice and oversight for issues such as off-license prescribing, monitoring and input into the updating of shared care prescribing guidelines.
  - PCP psychologists are able to offer systematic consultations for people who are not willing or able to access treatment pathways (for example for personality disorder), and help formulate a care plan for that person.
- Health promotion
  - PCP promotes functional recovery and mental wellbeing by offering occupational therapy-led social inclusion work, to help link people to opportunities available

- within the borough e.g. Greenwich Recovery College, MIND, local further education colleges.
- PCP supports the development and dissemination of directories of third sector resources.
- PCP runs expert patient groups for some specific disorders.
- PCP promotes physical health by offering a range of interventions and linking-in with other services, supporting integrated care and access to physical health services e.g. supporting individuals with severe mental illness who may neglect their physical health needs.
- Education, training and consultation
  - In addition to providing a range of training options (see 'Training' below), the PCP can, in conjunction with psychological therapists, provide a consultation/joint meeting service for particularly complex service users and their significant others, with GP's.

**Scope:** SMI +

**Working Style:** The Primary Care Plus service aims to map onto GP opening hours of 9am to 8pm. It provides a single point of access for all referrals to Oxleas Mental Health Services (specialist care services) from primary care. Urgent referrals are telephone triaged within 24 hours, and if needed, individuals receive a same day face to face assessment from the crisis service. Routine referrals to PCP are triaged within 2 weeks. New referrals are directed to the appropriate treatment pathway (psychosis, ADAPT [anxiety, depression, personality disorder and trauma], early intervention, older adults or memory service) for full assessment or treatment.

**Care Roles:** Each team (East/West) will have a full time consultant (link) psychiatrist, together with a multidisciplinary team comprising a team manager, community psychiatric nurses, occupational therapists, psychologists and social workers.

**Mental Health Training:**

- PCP provides regular teaching at borough-wide GP training events.
- PCP psychiatric nurses deliver training to general practice nurses.
- PCP provides training opportunities for medical foundation trainees and GPVTS trainees.
- PCP can provide bespoke training for particular needs identified by primary care e.g. master classes for mental health leads, or link to particular courses e.g. mental health first aid for reception staff.

**Electronic Record Keeping:** No dedicated electronic data system. The PCP service is currently using EMIS for record-keeping.

**Outcome Measures:** N/S

**Funding:** N/S

**Contact:** Dr Vivienne Chai, GP, Greenwich CCG Clinical Project Lead for Mental Health  
[Vivienne.chai@nhs.net](mailto:Vivienne.chai@nhs.net)

West PCP Team: Dr Joshua Maduwuba, Consultant Psychiatrist, West PCP Service, Greenwich CCG  
[Joshua.maduwuba@oxleas.nhs.uk](mailto:Joshua.maduwuba@oxleas.nhs.uk)

East PCP Team: Dr Matheesha Gunathilake, Consultant Psychiatrist, East PCP Service, Greenwich CCG  
[Matheesha.gunathilake@oxleas.nhs.uk](mailto:Matheesha.gunathilake@oxleas.nhs.uk)

## LAMBETH

**Current Situation:** In 2010, Lambeth established the Lambeth Living Well Collaborative (LLWC), which is a group of commissioners, providers of health and social care services, service users and carers who have come together to improve outcomes for people with mental health issues. Central to the Collaborative's way of working is the use of the principles of co-production in developing and commissioning services. This approach aims to recognise people as assets, promote mutuality and reciprocity, break down barriers between professionals and focus on facilitating rather than delivering care provision. The LLWC supports the Living Well Network Alliance, an alliance contract aligning providers of mental health care and support on a shared set of outcomes and the method by which to achieve them. The Living Well Network Alliance Project is operating within the context of the Mental Health Integrated Programme (MHIP) which is the main mental health programme covering all adults of working age in Lambeth.

Lambeth also has a Talking Therapies Service which is part of the Improving Access to Psychological Therapies service (IAPT). This service is available to anyone 18 years and older registered with a Lambeth GP. Lambeth Talking Therapies Service offers talking therapies for people experiencing mild to moderate depression, general anxiety and worry, panic attacks, social anxiety, traumatic memories and obsessive compulsive disorder. They also offer help with other problems including anger, eating, and relationship or sexual difficulties. The service offers appointments at many GP surgeries and clinics across the borough of Lambeth.

**Model:** Enhanced primary care provision for mental health is just one aspect of a large-scale programme of planned service-reconfiguration in Lambeth - The Mental Health Integrated Programme. The MHIP is Lambeth's overarching mental health programme and covers all adults of working age. It comprises three key, interconnected elements of structural change:

- Living Well Network Alliance with creation of a Recovery Hub (operational since Nov 2013, borough-wide since June 2015).
- SLaM Adult Mental Health Model.
- Integrated Personalised Support Alliance – this is the 3<sup>rd</sup> element of system change within the programme. This initiative is a partnership between 5 organisations (SLaM, Lambeth CCG, Lambeth Council, and 2 charities – Thames Reach and Certitude).

**Aims:** To improve care quality and service user experience through creation of better interfaces via a reduction in duplication and also by closer alignment of service priorities. Additionally, to reduce the burden on secondary mental health services by enabling transitioning of patients back into the primary care setting where appropriate based on individuals' mental health needs.

**Scope:** SMI+.

**Working Style:** Six key design principles determine working style-

- i. Improved access to all mental health services focussed on supporting recovery and independence.
- ii. Easier access to secondary care assessment & treatment, support for primary care including link workers, easier access back to secondary care if required, improved discharge arrangements.
- iii. More and better information – a new virtual and physical resource information service.
- iv. Better guidance – personal guide/community recovery workers within the voluntary sector.

- v. Capacity improved for primary care and GP's to support and manage mental health patients including easier access to social and community support options and peer support services led by service users.
- vi. Ensuring social inclusion through a variety of means including time banking.

**Care Roles:** The Living Well Network is the 'front door' to mental health services in Lambeth. It provides help and support to people experiencing mental health issues in a personalised and co-productive manner via integrated MDT's. As part of this, The Hub provides support via self-referral and via referral from health care professionals. This removes eligibility criteria and allows the network to provide support to people when they feel they need it. It is thought that this offer of earlier intervention will prevent more serious mental health problems developing and mental health crises occurring (thereby reducing the burden on secondary care services).

**Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** The Living Well Collaborative has jointly agreed three 'big outcomes' which direct and frame all of its work. These are for people with mental health issues to:

- Recover and stay well, experiencing improved quality of life, physical & mental health.
- Make their own choices and achieve personal goals, experiencing increased self-determination and autonomy.
- Participate on an equal footing in daily life, specifically to include connecting with family/friends, to be 'included' in relation to education, housing, employment, adequate income, to 'participate' on an equal footing with others with reduced stigma and discrimination, to 'give' to the community such as volunteering, peer support.

Over the first 6 months of borough-wide operation, The Hub's work resulted in:

- 80% Average reduction in referrals to secondary care.
- An average of 400 people supported a month – many of whom may not have been accepted by secondary care services in the past.
- 25% Reduction in secondary care caseloads since 2013.
- Reduced waiting times for support – on average 1 month pre-Hub formation; on average 1 week post-borough-wide service provision.

**Funding:** N/S

**Contact:** Dr Paul Heenan, Mental Health GP Clinical Lead, Lambeth CCG  
[paulheenan@nhs.net](mailto:paulheenan@nhs.net)

## LEWISHAM

**Current Situation:** Lewisham CCG are currently consulting on a draft service specification for an Enhanced Primary Care Mental Health service with GP's. There is planned collaboration with service users in the formation of the PCMH service. The service is planned to commence in autumn 2017.

**Model:** Collaborative, in-reach stepped care model.

**Aims & Working Style:** The planned service will work in partnership with GP's to develop care plans for patients and provide professional liaison for prescribing and for psycho-social support.

**Scope:** SMI. The service is intended to be available to individuals with an SMI stepping down from secondary care or stepping up from primary care services. Its planned scope is for individuals who have serious mental illness and are stable with low risk of relapse or hospital admission. Individuals registered with a GP in the borough of Lewisham.

Exclusion criteria include individuals whose needs are sufficiently met in primary care General Medical Services and/or IAPT services, patients who need high intensity care or treatment likely to average more than one contact per month, patients with a common and mild mental health problem (clusters 1-3), patients with a primary diagnosis of dementia or other organic problem, patients at high risk of harm to self or others, the patient needs to be under the care of a psychiatrist due to care or medication complexities.

**Care Roles:** The PCMH team will be comprised of a consultant psychiatrist, mental health practitioners (social workers, occupational therapists, and nurses), support workers, peer supporters and a team administrator.

**Mental Health Training:** N/S

**Electronic Record Keeping:** N/S

**Psychotropic Medication Prescribing:** N/S

**Outcome Measures:** CROMs, PREMs, PROMs – details of outcome measures currently being planned.

**Funding:** A specific budget for the service has been identified within the bi-lateral contract held with the local mental health service provider (South London and Maudsley Mental Health NHS Trust) – i.e. within the Mental Health Block Contract envelope.

**Contact:** Kenneth Gregory, Joint Commissioning Lead, Adult Mental Health, Lewisham Clinical Commissioning Group [Kennethgregory@nhs.net](mailto:Kennethgregory@nhs.net)

## **SOUTHWARK**

**Current Situation & Aims:** Southwark has established a Severe Mental Illness Commissioning Development Group incorporating the Council and CCG. A partnership commissioning team between Council and CCG is currently being established which will include pooling of budgets. This will focus on services for children, people with mental illness, older adults and people with complex needs. Southwark are also in the process of producing a joint mental health strategy.

**Model:** Collaborative care model with emphasis on care service interface enhancement. Expansion of mental health skills set within GP population. Increased interface with local authority mental health services and secondary care clinicians. Southwark sensed they did not want to develop a separate service to facilitate transfer of care from secondary to primary care, but instead to enhance the interface already existing between services. Progressing ideas redefining a subset of those with mental illness and commissioning for outcomes using an alliance model. There are opportunities to incentivise and enable primary care through the PMS review in Southwark. The CCG is also leading on community-based Multi-Disciplinary Team work to improve care coordination of people with 3+ LTCs and complex needs.

**Co-production:** Engagement with people with lived experience has been a priority for the development of the mental health strategy. There is a Healthwatch representative on the SMI Clinical Decision Group and co-production will be an essential aspect of any alliance commissioning model.

**Scope:** SMI+. Individuals aged 18 years and over. Southwark are hoping to define a core cohort for the SMI population in order to address areas of high spend and poor outcomes for both health and social care services in the borough. There is a strong argument to include people with personality disorders and substance misuse as well as SMI.

A number of general practices in Southwark undertake alcohol/substance misuse detox work (collaboration between a third sector organisation, SLaM Foundation Trust clinicians and GP practice) and are members of a network of practices offering shared care drugs misuse clinics.

**Working Style:** Up-skilling of existing GP population and collaborative working with secondary care clinicians, local authority and third sector organisations.

**Care Roles:** Up-skilling in mental health care of existing GP roles within the borough. No new role formation currently.

**Mental Health Training:** Mental health training for GPs is within the CCG-led mandatory teaching afternoons and is currently at the level of one afternoon per annum.

**Electronic Record Keeping:** All local practices use EMIS and have access to a local shared record (development of which was funded by a charitable organisation). The record system is accessible at both primary and secondary care 'ends'.

**Psychotropic Medication Prescribing:** Prescribing and monitoring of oral medication remains the responsibility of the patient's GP for the majority of patients but administration of depot psychotropic medication is still mostly provided by secondary care.

**Outcome Measures:** N/S

**Funding:** N/S

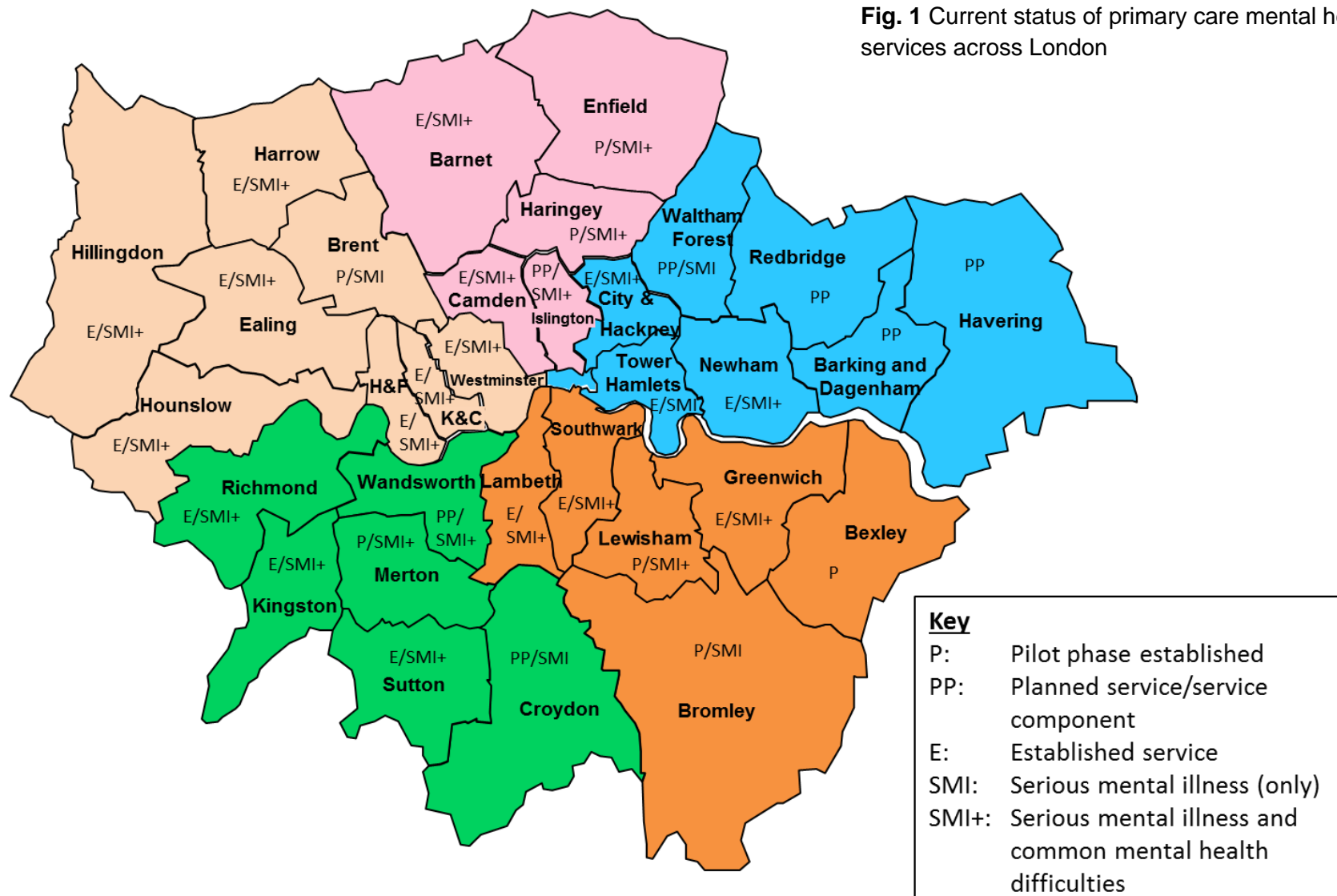
**Contact:** Dr. Nancy Kuchemann, Mental Health GP Clinical Lead, Southwark CCG.

[Nancy.kuchemann@nhs.net](mailto:Nancy.kuchemann@nhs.net)

# APPENDIX

## Map of current status of services across London

**Fig. 1** Current status of primary care mental health services across London



**Table of current status of services across London (grouped within STP footprint)**

<b>North West London STP</b>									
<b>Borough/Clinical Commissioning Group</b>	<b>Page Number</b>	<b>Service Status</b>	<b>Service Form (Model Type)</b>	<b>Scope (age 18-65 unless stated differently)</b>	<b>Shared IT System</b>	<b>Outcome Measures Described</b>	<b>Regular mental health training established</b>	<b>Medicines Management in Primary Care</b>	<b>Recurrent funding</b>
Brent		Pilot phase	Step down Collaborative care approach	Stable SMI: Support for transitioning from secondary to primary care	No	Planned - Currently under development	No	Not stated	No
Central London CCG		Established	Step up/down Collaborative, wrap-around care approach	SMI+	Yes	Yes	Yes	Yes	Yes
Ealing		Established	Step up/down, collaborative care approach	SMI+	Yes	Yes	Yes	Yes	Yes
Hammersmith & Fulham		Established	Collaborative in-reach model, step up/down care	SMI+	Yes SystemOne	Yes	Yes	Yes (consultant psychiatrist advice telephone line for primary care staff)	Not stated
Harrow		Established	Collaborative in-reach model, step up/down care	SMI+	No	Planned - Currently being developed	Not stated	Not stated	Yes - funding secured 2017/2018
Hillingdon		Established	Collaborative in-reach model, step up/down care	SMI+	No	Yes	Not stated	Yes	Not stated
Hounslow		Established	Collaborative in-reach model, step up/down care	SMI+	Yes	Yes	Yes	Yes	Yes
West London CCG		Established (currently being re-designed)	Collaborative wrap-around model, step up/down care	SMI+ 16yrs+	No	Not stated	Not stated	Not stated	Yes – 3-Year funding secured



<b>North Central London STP</b>									
<b>Borough/Clinical Commissioning Group</b>	<b>Page Number</b>	<b>Service Status</b>	<b>Service Form (Model Type)</b>	<b>Scope (age 18-65 unless stated differently)</b>	<b>Shared IT System</b>	<b>Outcome Measures Described</b>	<b>Regular mental health training established</b>	<b>Medicines Management in Primary Care</b>	<b>Recurrent funding</b>
Barnet		Established	Collaborative in-reach care model	SMI+	No	Yes	Yes	No (Some GP practices administering antipsychotic depot)	No
Camden		Established	Collaborative care in-reach model	SMI+	Yes (EMIS)	Yes	Yes	Yes (medicines advice available from specialists for GP's)	Not stated
Enfield		Pilot phase	Collaborative step up/down model	SMI+	Not stated	Yes	Not stated	Not stated	No
Haringey		Pilot phase	In-reach, attached professional (CPN in primary care setting)	SMI+	No	Not stated	Not stated	Planned - Planning clozapine and lithium clinics in primary care	Not stated
Islington		Planned service/service component	Collaborative in-reach care model, Step up	SMI+ 17.5yrs+	Yes - Team shares EMIS with GP's	Yes	Yes	No - but planned primary care-based mental health team pharmacist	Not stated

<b>East London STP</b>									
<b>Borough/Clinical Commissioning Group</b>	<b>Page Number</b>	<b>Service Status</b>	<b>Service Form (Model Type)</b>	<b>Scope (age 18-65 unless stated differently)</b>	<b>Shared IT System</b>	<b>Outcome Measures Described</b>	<b>Regular mental health training established</b>	<b>Medicines Management in Primary Care</b>	<b>Recurrent funding</b>
Barking & Dagenham		Planned - all service aspects currently in early planning stage	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component
Havering		Planned - all service aspects currently in early planning stage	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component
Redbridge		Planned - all service aspects currently in early planning stage	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/service component
Waltham Forest		Planned service/service component	Allied health team, collaborative care, Step down	SMI	Yes (team will share GP system)	Yes	Not stated	Yes	Not stated
City & Hackney		Established	Collaborative care model, Step up/down	SMI+	No	Yes	Yes	Yes	Yes
Newham		Established	Collaborative care model, Step up/down	SMI+	No	Yes	Yes	Yes	Not stated
Tower Hamlets		Established	Collaborative care, wrap-around model	SMI	Yes (Share EMIS with GP's)	Yes	Yes	Yes	Not stated

<b>South West London STP</b>									
<b>Borough/Clinical Commissioning Group</b>	<b>Page Number</b>	<b>Service Status</b>	<b>Service Form (Model Type)</b>	<b>Scope (age 18-65 unless stated differently)</b>	<b>Shared IT System</b>	<b>Outcome Measures Described</b>	<b>Regular mental health training established</b>	<b>Medicines Management in Primary Care</b>	<b>Recurrent funding</b>
Croydon		Planned service/service component	In-reach collaborative care , Step down model	SMI	Not stated	Not stated	Not stated	Not stated	Not stated
Kingston		Established	Collaborative care, in-reach, Step up/down	SMI+	No	Yes	Yes	No (planning antipsychotic depot via primary care team)	No (in pilot phase)
Merton		Pilot phase	All service aspects currently being planned/ initiated	SMI+	Planned service/ service component	Planned service/service component	Planned service/service component	Planned service/service component	Planned service/ service component
Richmond		Established	In-reach collaborative, Step up model	SMI+	No	Yes	No (but some mental health training provided via trust specialists)	No	Not stated
Sutton		Established	Collaborative care, Step up/down model	SMI+	Not stated	Yes	Not stated	Yes	Not stated
Wandsworth		Planned service/service component	In-reach collaborative care, Step down/up	SMI+	No	Not stated	No (planning mental health diploma for PCMH team staff)	Not stated	No (planning phase)

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Bexley		N/A*	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Bromley		Pilot phase	Collaborative care model, step down	SMI	Planning phase	-	-	Plans include primary care prescribing/ monitoring antipsychotic depot & lithium	No (planning phase)
Greenwich		Established	In-reach collaborative, Step up/down	SMI+	No	Not stated	Yes	Not stated	Not stated
Lambeth		Established	Collaborative wrap-around, Step up/down	SMI+	Not stated	Yes	Not stated	Not stated	Not stated
Lewisham		Pilot phase	Collaborative in-reach, Step up/down model	SMI+	Not stated	Not stated	Not stated	Not stated	Yes (planned to sit within block contract)
Southwark		Established	Collaborative care model	SMI+	Yes (EMIS available to primary care and PCMH team)	Not stated	Yes	Yes	Not stated

**Key: N/A = not applicable, SMI = serious mental illness (only), SMI+ = serious mental illness and common mental health difficulties**

**\*Bexley currently offers a Mental Health Recovery College, an IAPT service and personal health budgets on a case by case basis**