Healthy London Partnership

NHS London Clinical Networks

Commissioning Guidance: Development of Primary Care Mental Health Models

September 2018

Healthy London Partnership /NHS England

Vincent Kirchner, Clinical Director, London Mental Health Transformation Team

Healthy London Partnership established a steering group during 2017 to look at how mental health care needs of individuals can be better supported within a primary care (community-based) setting. Through a review of international and national evidence and models currently used in London the group through its Darzi Fellow, Dr Dori Newton, have produced this commissioning guidance for primary care mental health models.

There is no consensus of a single service model of primary care mental health so this guidance document identifies and promotes the service components that are essential to delivering effective PCMH services. It will support the development of integrated health and care systems (ICSs) and be an aid for providers and commissioners in the planning and development of their primary care mental health services. The inclusion of an assessment tool allows services to compare their service against the recommendations made by the guidance document.

The steering group can be proud of their work in producing this welcome contribution to improving the mental health care and wellbeing of Londoners.

Royal College of Psychiatrists

Dr Adrian James, Registrar, Royal College of Psychiatrists

Professor Safi Afghan, Primary Care Lead, Royal College of Psychiatrists

The Royal College of Psychiatrists is pleased to support the Primary Care Mental Health (PCMH) guidance document produced by Healthy London Partnership in collaboration with the Clinical Network for Mental Health (London Region). The guidance proposes a comprehensive approach to PCMH service development across London, promoting more integrated and co-produced mental health services, with individuals with lived experience at the centre of new service formation. Increasing capacity, confidence and capability of primary care mental health service providers is central to achieving the vision of care closer to home, closer to friends, family and sources of community-based support. The guidance outlines core 'gold-standard' components for future PCMH services, formed through wide ranging engagement, including the valuable input of Londoners, who use the services, and their carers. In line with The Five Year Forward View, the guidance details ways to achieve this vision, with examples of new approaches to delivering more joined-up mental health care.

This document/resource has been formally endorsed by The Royal College of General Practitioners.

The King's Fund

Dr Chris Naylor, Senior Fellow in Health Policy, The King's Fund

Primary care is a vital part of the mental health system, and one that is changing fast. While there is a lot of innovation, with new models of primary care mental health being developed in many parts of England, there is currently little consensus about what the future should look like. This guidance document helps fill that gap by providing a framework for high-quality primary care mental health, accompanied by illustrative case studies from London. It will serve as a useful resource for GPs and commissioners in London and beyond.

Mind

Vicki Nash, Head of Policy and Campaigns, Mind

One in four people experience a mental health problem in any given year and the majority of those who get treatment receive it within primary care. Everyone with a mental health problem deserves timely, accessible and high quality primary care support and services. It's also vital that our primary care staff receive relevant, sufficient and on-going mental health training in order to ensure they are well placed to provide that care. This commissioning guidance is a welcome addition to help in the task of transforming our primary care services for Londoners.

NHS Clinical Commissioners

Julie Wood, Chief Executive, NHS Clinical Commissioners

The majority of people with mental health problems are treated in primary rather than secondary care settings. However, most of the spending on mental health care is on specialist services. Commissioners are always looking for innovative models to strengthen the provision of mental health support in primary care, especially due to the pressures on our secondary care colleagues. Many patients with complex mental health conditions are cared for in primary care with all the challenges this can create under current arrangements. This guidance provides welcome support to both commissioners and providers of mental health services to identify good practice provide case studies and a benchmarking tool that will help greater understanding of primary care mental health models and informed decision making.

Foreword

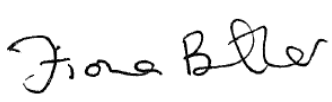
We are delighted to introduce the London Primary Care Mental Health (PCMH) guidance. This has been written to support providers and commissioners in the development of PCMH services across London. It promotes more integrated and co-produced mental health services, with individuals who have lived experience at the heart of new service development.

A health and care system that allows people experiencing mental illness to deteriorate until they are 'bad' enough to meet 'local' access criteria for specialist treatment is costly and inequitable. Londoners rightly expect the NHS to provide the right mental health treatment and support at the right time, and in the right place.

Over 50% of people with severe and long term mental health needs and over 90% of people with common mental health needs are treated and supported by their GP practice. Some primary care services do not have the capacity and confidence to treat people struggling with mental ill-health. It is rewarding to know that, in line with the Five Year Forward View[1] and Better Health for London[2], new PCMH services are providing more Londoners with timely mental health treatment and support in their local GP practice, close to their sources of community support and family and friends.

London's Mental Health Transformation Programme has produced several documents that draw attention to PCMH, and promote its inclusion as an essential building block for integrated health and care systems. This PCMH guidance document aims to surface, spread and celebrate best practice for key stakeholders. It adds to a suite of documents that aim to support commissioners and providers. These documents include a review of the scientific literature[3], a scoping[4] of PCMH services across London and a commissioner's fidelity scale for PCMH service development. An economic evaluation of Primary Care Mental Health models of Care was also commissioned to consider the financial efficiencies brought by PCMH and the value produced in the health system. We hope that together these will be a real support to the mental health system in London as we push ahead to develop innovative ways to treat and support those experiencing mental ill-health.

This guidance proposes a comprehensive approach to developing PCMH services. It was shaped through wide ranging engagement, including the invaluable input of Londoners, who use the services, and their carers. The guidance also emphasises the need to support those working within primary care (from GPs to reception staff), the importance of quick and easy access to specialist clinical advice and clear agreements in place to share care with other responsible community services.



Dr Fiona Butler
General Practitioner
Chair of NHS West London Clinical Commissioning Group
Chair of the London Primary Care Mental Health Steering Group

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Acknowledgements

Working in partnership

This guide has been produced by Healthy London Partnership (HLP) Mental Health Transformation Programme. Healthy London Partnership was formed in May 2015 and is a collaboration between London's 32 Clinical Commissioning Groups (CCGs) and NHS England (London Region) to deliver the Five Year Forward View[1] and Better Health for London[2].

We aim to work with a growing community of people and organisations to make London the healthiest global city in the world by 2020. The NHS England (London Region) Mental Health Clinical Network provides clinical expertise and leadership to the programme.

Special thanks

With special thanks to Dr Fiona Butler, GP, who chaired the steering group, and to Dr Dorothy Newton, who undertook the extensive background research and coordinated the production of the guidance. Also, huge thanks to the many others who worked tirelessly to write and produce this guidance.

Considerations

Please note that all data provided within this document was correct at the time of printing. Throughout this guidance, individuals using mental health services are referred to as 'service users'. We appreciate this term lacks individualism. It has been used as the most relevant description for a group of people using health and care services, to provide referencing consistency.

Introduction

Londoners have benefited from the recent emergence of primary care mental health (PCMH) services. The London developments reflect new models of PCMH treatment and support that can be seen internationally.

Integrated Care Systems (ICS) in London will take collective responsibility for NHS financial and operational performance. They present an opportunity to take a systemic approach to improving outcomes and realising system-wide efficiencies.. The evidence for integrating physical and mental health services is compelling. NHS planning guidance is clear that areas with the ambition to be Integrated Care Systems will have to have robust plans to integrate services, including primary care and mental health. London's PCMH services are well placed to make a significant contribution to ensure new Integrated Health and Care Systems become a reality across the capital.

The moral argument for PCMH services is clear. It is recognised that mental health problems are best managed in primary care wherever possible[5]. There is a greater emphasis on care closer to home, encompassing friends, family and sources of community-based support. There is also emphasis on closer links between mental health specialists and primary care staff, and care provided in the familiar and relatively less-stigmatised setting of the general practitioner's (GP) surgery.

This guidance document confirms how PCMH models improve communication and joint working between primary care and specialist mental health providers. Their focus is on improving outcomes for Londoners, who experience long-term mental ill-health, (severe and common mental illnesses). Access to more integrated physical and mental health care is also improved via the development of primary-care based mental health services. This more holistic, joined-up approach to care may support the reduction of premature mortality in those with serious mental illness, allowing for more timely and effective care through the development of shared care records.

The guidance was produced with oversight by the Primary Care Mental Health Service Development Group. This was convened by Healthy London Partnership (HLP) to include a broad range of senior system expertise (see appendix 1). Fundamental to the work of this group was the contribution of service users and carers.

Purpose of the guidance document

The purpose of this guidance is to support the development of integrated health and care systems (ICSs). It is primarily, but not exclusively, for commissioners, and aims to aid in the planning and development of PCMH services and to help integrate treatment and support in a localised setting for Londoners.

There is no consensus of a single service model of PCMH, and so the guidance does not propose one specific model of PCMH service. Instead, it identifies and promotes the service components that are essential to delivering effective PCMH services. These components are described as steps which commissioners and providers of mental health services can collaboratively take to produce integrated treatment and support for Londoners recovering from mental illness.

The guidance isn't directly applicable to Improving Access to Psychological Therapies (IAPT) services however it is recognised that a number of PCMH services incorporate IAPT. The document also does not directly relate to Community Mental Health Teams (CMHTs). Child and Adolescent Mental Health Services (CAMHS) are not covered in the scope of this guidance.

The guidance has been produced with a self-assessment tool to enable areas for improvement to be identified (see appendix 2). The scope of the guidance includes the full range of London PCMH services, from the 'Enhanced Primary Care Service in City and Hackney' to 'Community Living Well' in West London[4] and the Bexley Primary Care Mental Health Service which is third sector led.

Preparatory work for this guidance included scoping PCMH services across the capital[4] and was informed by published scientific evidence, which is collated in a complementary literature review[3]. In addition, two half-day workshops were held in London with key stakeholders (see appendix 3).

The emergence of PCMH services in London is relatively recent. As such, the data that describes the impact of PCMH on patient activity across treatment and support settings and associated costs is limited. Following publication of this guidance, Healthy London Partnership evaluated PCMH services across London to inform the financial case for change.

Guidance document structure

The guidance identifies and promotes the components that are essential to delivering effective PCMH services. These components are broken down into the following areas and sub-areas:

Case for change - unmet need and primary care.

Elements of Service Delivery - including scope, access, system flow and capacity, new care roles, social prescribing and recovery and co-production.

Enablers - including structure, communication, workforce and medicines management.

Measuring Success - including patient outcome measures and performance monitoring to ensure continuous service improvement.

Checklist for development and Service Assessment Outcome Sheet – enabling services to self-assess against the guidance.

The case for change

Unmet mental health need

At any one time, more than a sixth (15.7%) of the adult population is living with a common mental health problem such as depression or anxiety[6]. Despite this, only 39.4% of those with a common mental disorder receive any type of mental health treatment[6]. Furthermore, between 1% and 2% of the population live with severe and enduring mental illnesses[6]; bipolar disorder affects 2% of the population and 0.4% are affected by psychotic disorder[6]. In addition, 13.7% of people aged 16 and over screened positive for a personality disorder[6].

People with established severe mental illness have significantly worse physical health than the general population[6]. More than a third of people (37.6%) with severe common mental health conditioners also live with a chronic physical condition[6]. For example, people with severe symptoms or common mental conditions are twice as likely to have asthma as people with no or few symptoms. Having a chronic physical condition is also associated with a lower level of mental wellbeing[7]. Further, smokers have consistently been found to be more likely to suffer from a common mental illness than non-smokers: 31.3% of those who smoke more than 15 cigarettes a day suffer from a common mental illness. Research based on the last Adult Psychiatric Morbidity Survey[8] determined that 42% of all cigarettes smoked in England are consumed by people living with mental illness[9].

Those with serious mental illness are at risk of dying on average 16-20 years earlier than the general population[7]. Mortality rates for people with serious mental illness (aged under 75) are over three times higher than the rest of the population[10]. People with mental ill health use more emergency care than people without mental ill health. In 2013/14, they had 3.2 times more Accident and Emergency (A&E) attendances and 4.9 times more emergency inpatient admissions than the general population, yet they had fewer planned inpatient care episodes[11]. Deprivation exacerbates this trend with deprived people with mental ill health visiting A&E 1.8 times more than the least deprived and having 1.5 times more emergency inpatient admissions[11]. There is an established relationship between social and economic inequalities and health. People on low incomes are at higher risk of developing mental health problems[6].

Impact of unmet mental health need in primary care

Local GP practices are often the first point of contact for people seeking help with a common mental illness. This accounts for nearly a quarter of general practice consultations. There has been an increase in access to mental health treatment over the past 10 years, with the expanded access to psychological treatment through the IAPT programme, as well as an increase in prescribing psychotropic medication[12].

Mental health problems present in primary care in a number of different ways. In addition to the diagnosable psychiatric conditions mentioned above, many people attending primary care have emotional and social needs affecting their wellbeing. These can include relationship difficulties, housing issues, debt problems and family dysfunction. All of these cause distress and have huge impacts on work, sickness and family function. Whilst these are not classified as ‘mental illness’, they require an emotionally literate response from the primary care practitioner and assistance from other professionals, as well as links to the community and voluntary sectors to prevent a more entrenched problem such as anxiety or depression from developing. It is essential for primary care to have the workforce to address these needs[13].

Other people present with highly complex needs including high levels of social adversity and emotional and psychological distress, which can sometimes present in the form of physical symptoms. It has been estimated that persistent physical symptoms of this kind are present in between 15% and 30% of GP appointments[7]. Whilst GPs are well versed in managing less severe cases where physical symptoms are expressed instead of emotional distress, for example tension headaches and gastrological symptoms, complex presentations can cause anxiety in the professional and a cycle of over-investigation and referral. This is then compounded by a very medical secondary care response and limited availability of psychological pathways within outpatient systems. It is vital to facilitate management of these patients within primary care where health records can be accessed, notes summarised and over-investigation and repeated tests identified.

Primary mental health care is not limited to general practice but for many individuals the relationship with their GP is the focus of their care provision. Primary care is 'most people's first port of call in times of health care need' and the patient-GP relationship is 'central to continuity of care'[6]. Primary Care Mental Health (PCMH) services present opportunities for the early identification of mental illness, intervention and improved management of long-term illness. The Joint Commissioning Panel for Mental Health suggests, 'mental health problems should be managed mainly in primary care by the primary health care team working collaboratively with other services'[5]. The Kings Fund similarly asserts, 'care for large numbers of people with long-term conditions could be improved by better integrating mental health support with primary care'[14].

The development of more integrated PCMH services provides a valuable opportunity to increase mental health confidence, capacity and capability in primary care. Closer integration of primary and specialist services, and additionally with the wide range of community-based support organisations, promotes knowledge-sharing and collaborative working. As PCMH services become more established, individuals with more complex and long-term mental health conditions may be supported via primary care rather than specialist services; providing them with care closer to home, friends, family and sources of community-based support.

London Context

In London, mental illness continues to be under-diagnosed and under-treated. Around two million Londoners will experience some form of mental ill health each year[15], yet only a quarter of those experiencing difficulties will receive treatment.[16] Often, the physical health of people with mental illness is also poor and individuals are more likely to have a long-term physical health condition.[17] Life expectancy of those with serious mental illness is shortened by 10-20 years.[18] Compounding these issues, nearly 90% of those with mental ill health across England reported stigma and discrimination having a negative impact on their lives.[19]

What do we know about current primary care mental health services in London?

Londoners have benefited from the recent emergence of PCMH services. Evidence gathered via a review of the scientific literature[3], and through a pan-London scoping exercise examining PCMH services[4], has demonstrated there is no standardised model for the commissioning and provision of PCMH services. The current patterns of service provision in London vary greatly and in many areas are likely to result from historical factors. The recent scoping of PCMH services across London demonstrated that care provision is starting to transform in the direction of more integrated mental health care provision between providers.[4]

There are examples of excellent and innovative practice across London. However, many services remain fragmented with limited communication between the agencies involved in an individual's care.

In addition, response to people with common mental health problems is variable. Some, but not all, are diagnosed and receive evidence-based treatments, however there is no systematic process for allocating patients to appropriate care pathways (with no emphasis on primary-based mental health care being the mainstay of treatment). There is inconsistent assessment of the impact of mental distress and symptoms of common mental illness on a person's capacity to work or on their family life and relationships. There are often no clear systems in place for early intervention to help people recover and return to work more rapidly.

There is a lack of understanding of how collaborative care works; the roles and responsibilities of specialists operating in primary care settings and the importance of the interface between psychiatrists and General Practitioners (GPs). GPs may lack confidence in their ability to provide appropriate services, particularly for individuals with psychosis or severe and complex needs.

Strategic fit

Integrated Care Systems (ICS) in London will take collective responsibility for financial and operational performance in the NHS. Planning guidance is clear that areas with the ambition to be Integrated Care Systems will have to have compelling plans to integrate services, including primary care and mental health.

The Five Year Forward View[1] Mental Health Taskforce report[20], and subsequent implementation guidance[21], emphasise the importance of increased capacity within primary care; the value of integrating physical and mental health provision and the imperative to address the health and wellbeing gap.

> *"By 2020/21, community mental health services for adults of all ages will be better supported to balance demand and capacity, deliver timely access to evidence-based*

interventions, integrate with primary care, social care and other local services, and contribute to the delivery of efficiencies across the adult mental health system"[21]

The Mental Health Taskforce considered it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. It sets out eight principles to underpin reform:

- Decisions must be locally led.
- Care must be based on the best available evidence.
- Services must be designed in partnership with people who have mental health problems and with carers.
- Inequalities must be reduced to ensure all needs are met, across all ages.
- Care must be integrated – spanning people's physical, mental and social needs.
- Prevention and early intervention must be prioritised.
- Care must be safe, effective and personal, and delivered in the least restrictive setting.
- The right data must be collected and used to drive and evaluate progress.

The Primary Care Workforce Commission[22] made recommendations to address these challenges. The Commission suggested 'practices, or groups of practices, should have access to a named consultant psychiatrist and to a named mental health worker such as a primary care mental health worker or community psychiatric nurse'…'these links might include availability for telephone advice, face-to-face case reviews and on-site clinics'. This model is already functioning in parts of London as evidenced in the pan-London scoping of PCMH services[4].

This guidance document aligns with the service specifications outlined in '*Transforming Primary Care in London: A Strategic Commissioning Framework*'; and '*Next Steps for General Practice*' which builds on the Framework, with a clear focus on collaboration and at-scale working between practices.[23] The focus includes partnerships to provide more, more efficiently. The benefits of scale, system partnerships, a developed workforce, better access will be significant enablers for developing and improving Primary Care Mental Health.

The Framework details a specification for general practice that sets out 'a new patient offer;

- *Proactive care* – supporting and improving the health and wellbeing of the population, self-care, health literacy, and keeping people healthy.
- *Accessible care* – providing a personalised, responsive, timely and accessible service.
- *Coordinated care* – providing patient-centred, coordinated care and GP/patient continuity.

Next Steps for General Practice sets out here how London must:

- Restore Joy – by supporting primary care teams and improving their working lives.
- Offer More – by broadening the skills and roles in the primary care workforce.
- Boost collaboration – between isolated individuals and local health and care organisations.

Primary Care Mental Health has a significant contribution to make to Londoners in the development of Primary Care. Integrated Care Systems will provide for the care needs of whole populations. The PCMH guidance draws on the principles of 'Care Closer to Home' delivered through integrated care. The emphasis is on personalised care based on the best clinical evidence. It supports the London vision for Primary Care by describing an approach to collaboratively building integrated mental health capability at a local scale that aligns to Primary Care Networks and Larger Scale General Practice Organisations (LGPOs).

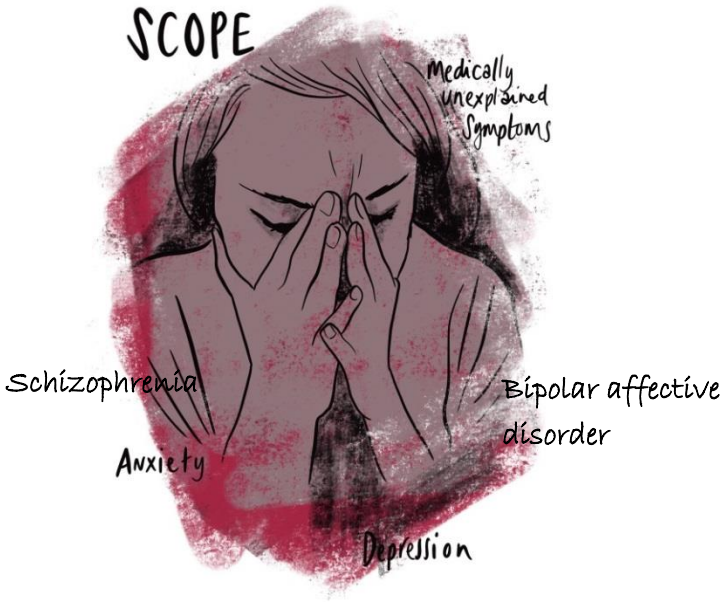
Guidance

The following guidance identifies and promotes the service components that are essential to delivering effective PCMH services. These components are broken down into the following areas and sub-areas:

1. **Elements of Service Delivery** - including scope, access, system flow and capacity, new care roles, social prescribing and recovery and co-production
2. **Enablers** - including structure, communication, workforce and medicines management
3. **Measuring Success** - including patient outcome measures and performance monitoring to ensure continuous service improvement.

1. Elements of Service Delivery

Scope



Ninety percent of patients with any mental health condition are managed solely in primary care and at least one in four consultations have mental health content. Primary care is accessible, local and family based, has a broad team approach and provides truly integrated health care with an emphasis on early intervention and prevention using a biopsychosocial model. Primary care has developed relationships with local voluntary sector providers, which can help to address social issues causing mental ill-health such as debt and housing.

A PCMH model needs to address all levels of need from less serious wellbeing issues to complex, severe and enduring mental illness. Thus a gold standard PCMH model should include provision to step down stable patients from secondary care; step up patients who need extra psychological help and maintain good mental health in a primary care setting for patients needing regular reviews for all mental health issues.

Using a long term conditions model for mental health is a useful way of looking at possible models for better primary care management of mental illness. Diabetes and hypertension are now almost solely managed in primary care. This demonstrates that care delivered locally in this

way can potentially dramatically help improve the health outcomes for patients living with long term conditions. Condition management requires reliable data, information dashboards, call and recall systems and regular reviews targeting specific interventions.

A gold standard PCMH model could encompass the following actions:

I. **Provide systematic identification via disease registers for call, recall, physical health checks and screening for all long term mental health conditions.** This includes; depression, anxiety, obsessive compulsive disorder, psychosis, personality disorder, bipolar and dementia. This facilitates patient reviews and analysis of data around prescribing, referrals to therapies, social prescribing, substance misuse services and other help available. This approach starts to embed a consistent management approach to mental ill-health that, for some people, is a long term condition.

II. **Provide full support teams around the patient**; practice nurses, health care assistants and receptionists, community psychiatric nurses, practice pharmacists, primary care psychologists, psychiatrists and counsellors, wellbeing workers, social prescribing, benefits advice and housing (all available in primary care bases). Primary care mental health requires a multidisciplinary team.

III. **Understand the particular physical health care issues and providing appropriate care and services to address them**. For example high rates of smoking and medication that affect cardiovascular risk in patients with severe and enduring mental illness, the side effects of medication and low uptake of health screening such as smear tests.

IV. **Introduce new models of recovery and return patients to primary care from secondary care.** This allows for fast access for diagnostic assessments/crisis and relapse in an unclogged system. Understanding what community support is available particularly via the third sector is vital to ensuring that patients receive this help.

V. **Collect mental health data**; leading to emphasis on outcomes, dashboards and targets, as found in other long term condition management in primary care. These enable good performance monitoring and management to ensure continuous improvement of the service. Primary care thus becomes responsible for its population's health, and mental health is on a par with other medical conditions.

VI. **Address other ways that patients present with emotional distress.** For example looking at:
    - Poorly controlled long term conditions and identifying possible mental health issues which may be affecting medication compliance and healthy lifestyle choices.
    - Markers indicating medically unexplained symptoms, such as frequent referral and investigation.
    - Engaging with sources of community support, through social prescribing, to enable a more holistic approach to recovery and relapse prevention. This includes support for housing, debt management, employment, education and training.

VII. **Consider the competency, culture, capacity and confidence of the surrounding system.** Any attempt to introduce a new service model for mental health care within primary care provision needs to:
    - Examine the potential impact on capacity and whether this has been addressed.
    - Explore whether primary care has the level of competence needed locally.
    - Identify whether a culture of mutual confidence has been established between professionals and services to ensure successful transitions of patients between different parts of the health system.

- Explore whether primary care staff have the confidence to know what to agree to and what is not appropriate in terms of these transitions.

VIII. **Ease the flow between primary care staff and specialists**. Ensure access to prompt advice from specialists that does not involve traditional referral and discharge processes, but a shared care approach. Increasing the confidence of primary care staff to aid the support and management of more complex mental health presentations is important. This will help reassure service users who may be anxious about their mental health care being re-centred within the primary care setting and have concerns about it being difficult to access secondary care again. As the changes start to develop within primary care, the current model of Community Mental Health Teams (CMHTs) may need to be redesigned to fit with the new PCMH models and shifting patient flow pathways.

Ways to effect change and timescales to realise the benefits

It is possible to achieve change and move along the pathway towards a gold standard PCMH model from wherever one is on the continuum. Many areas in London have models working already and can add or develop these further where capacity and finances allow. The key development areas of capacity, culture, competence and capability can be used as a framework to support the creation of a complete PCMH service model. Such frameworks can also potentially demonstrate how the introduction of changes to PCMH services can impact positively on competence and confidence, which will in turn affect culture. However, assessing the potential impact of service development on competence, confidence and culture within PCMH requires capacity to be clearly and honestly addressed.

Below are some ideas for developing PCMH provision. Many of these models are already in use London wide. Even in areas where much work has already been done, it is clear that benchmarking against another long term condition, such as diabetes, would expose the deficiencies in excellent care and outcomes for mental health versus physical health conditions. In times of austerity it is unlikely that funds will be sufficiently forthcoming to provide gold standard care across London using staff-heavy dedicated primary care services. Until funds do emerge, it is vital to prepare the ground by addressing some of the particular needs in local areas.

Low cost models:

I. **Establish regular mental health training for all primary care staff using providers including the voluntary sector and experts by experience.** Make this free, local and relevant for primary care consultations. Use contractual mechanisms such as GP Confederation and Clinical Commissioning Group (CCG) contracts to make training more mandatory or just ensure that topics are popular and keep attendance voluntary. *(Building Confidence and Competence)*

II. **Move depot medication administration into primary care.** Pilot in a few good practices to start and offer a small financial reward to cover nurse appointment time. Debunk myths around risks by inviting speakers from areas already offering depot medication. Secondary care providers may offer free practice nurse training and links to provide help and support if needed. Learn from and adopt what is working well in other areas. *(Addressing Cultural Change and Building Capacity)*

III. **Ensure that all practices have an allocated link psychiatrist and offer email and mobile contact.** Make this a contractual requirement. This ensures ownership of patients within an area by both primary and secondary care. Organise mental health care

provision to be aligned with practices such as Improving Access to Psychological Therapies (IAPT) links and Child & Adolescent Mental Health Service (CAMHS) links. *(Addressing Cultural change)*

IV. **Establish regular multidisciplinary meetings within practices**. Include IAPT, secondary care, and the voluntary sector if possible. Offer a standardised meeting template to focus discussions. *(Building Capacity, Confidence, Competence and Addressing Cultural change)*

V. **Pilot paying the voluntary sector to work in a few practices** with a specific remit such as social prescribing for mental health patients and trained peer support workers. *(Building Capacity)*

VI. **Establish mental health templates for data collection**. Duplicate Education Management Information System (EMIS) and SystmOne templates already being completed for severe mental illness, depression and anxiety, frequent attenders and dementia. Gradually introduce template use and outcome measurement via a GP contract. *(Building Confidence and Competence)*

VII. **Incentivise mental health audits within practices**. Start small and use areas of interest or concern for GPs, such as antidepressant use in the under 25s. *(Building Competence and Addressing Cultural change)*

VIII. **Ask for a public health trainee to scope some primary care mental health work.** *(Building Capacity)*

IX. **Choose one area to concentrate on.** For example, focus on anxiety or depression and build on existing dementia requirements. *(Building Capacity)*

Moving on to larger models:

I. **Address medically unexplained symptoms, frequent attenders and over-investigation through training and service provision in practices.** This can start small and grow. *(Building Competence and Confidence)*

II. **Step down models.** Transfer care back to primary care for stable patients with support, so PCMH workers are seeing patients regularly and are linking with GPs for physical health checks. *(Building Confidence, Capacity, Competence and Addressing Cultural change)*

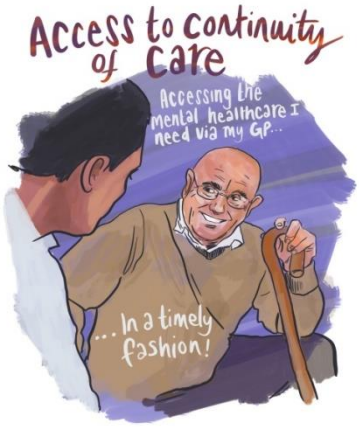
III. **Step up models.** Manage crisis urgently in primary care, avoiding A&E with good community support provision e.g. crisis house/café and service user groups. Also prevent crises by assessing and agreeing care plans with patients whose needs are beyond the scope of routine primary care but are not eligible for secondary care services. This may involve triage of routine mental health referrals from a variety of professionals.*(Building Confidence, Capacity, Competence and Addressing Cultural change)*

IV. **Provide all talking therapies in the community**. Introduce all the staff involved so that practices know the therapists seeing their patients. *(Building Capacity and Confidence)*

V. **Construct mental health registers for all conditions.** This allows for assessment of need, potential for mental health reviews via formal clinics or ad hoc consultations and greater data collection on physical health parameters. It also allows for the inclusion of conditions previously omitted from the Quality and Outcomes Framework (QoF), such as personality disorder, post-traumatic stress disorder and obsessive compulsive disorder. *(Building Competence and Addressing Cultural change)*

Many services perform a variety of these functions. The detail of the provision must be based on the agreed population needs in that area which may adapt with time and the interrelationships that develop between services within the health system.

Access



Evidence shows that people prefer to be seen locally, in a non-stigmatising setting and by professionals with whom they already have a relationship. Good access to PCMH services relies on adequate capacity within the primary care system and shared workload between all members of the primary care team.

Placing mental health care predominantly in the community setting does not necessarily mean the main care setting is within GP surgeries. With challenges including workforce resource and estate availability, it may be necessary to think creatively about the use of other locally-based facilities, such as libraries, community centres and pharmacies. Positive feedback has been received from service users of PCMH services across London, for example in City and Hackney's Enhanced Primary Care Service (see case study 1).

CASE STUDY 1

ENHANCED PRIMARY CARE SERVICE (EPC), LONDON BOROUGH OF CITY AND HACKNEY

City and Hackney have an enhanced primary care service that sees patients discharged from secondary care provision with a "step-down" service. Patients' response to this service has been very positive:

"I like being seen at my GP surgery"

"I like flexibility of approach and that I can contact in-between appointments and that appointments can be brought forward as necessary"

"I benefit from the reviewing of shared Recovery Care Plan and goals"

"I appreciate the information I'm given e.g. support services/crisis services"

"I appreciate the support from EPC to get appointments to see my GP and have blood tests"

"I like having depot medication administered at the GP surgery rather than in a hospital setting"

"The meetings are useful as the focus is wider than just medication"

IAPT services are being delivered in the community, some from primary care. Many GP surgeries offer access to social prescribing and wellbeing activities, thus widening the emotional wellbeing offer.

One other way in which PCMH services can be more accessible is by adopting a primary care style 'case list' approach rather than a secondary care 'caseload' approach. This views the patients as a potential list of clients who can access the service as needed as occurs in the Hounslow PCMH service. In that way it is accessible to the patients as and when they need it rather than there being strict eligibility criteria that may exclude some needs.

The extension of primary care opening hours also provides another significant opportunity for improved mental health care access. The ambition for improved and extended access to primary care services in London includes pre-bookable appointments to be available from 8am – 8pm, 7 days per week. Accessible care is one of three service specifications for the vision of future primary care services outlined in 'Transforming Primary Care in London: A Strategic Commissioning Framework'.[23]

The strategy for service improvement outlined in this document focuses on providing a personalised, responsive, timely and accessible primary care service. Seven specifications for good access in London are detailed as follows:

- Patient choice
- Contacting the practice
- Routine opening hours
- Extended opening hours
- Same day access
- Urgent and emergency care
- Continuity of care

The General Practice Forward View[24] also sets out specific, practical and funded steps on investment, workforce, workload, infrastructure and care redesign.

"On care redesign: support for individual practices and for federations and super-partnerships; direct funding for improved in hours and out of hours access, including clinical hubs and reformed urgent care; and a new voluntary contract supporting integrated primary and community health services."[24]

Deliverables from the General Practice Forward View[24] relating to access includes:

- Commissioning and funding of services to provide extra primary care capacity across every part of England backed by over £500 million of recurrent funding by 2020/21.
- Integration of extended access with out of hours and urgent care services, including reformed 111 and local clinical hubs.
- Achievement of full interoperability across Information Technology (IT) systems.

All London Clinical Commissioning Groups (CCGs) planned to achieve the vision of extended access by March 2018. There are further requirements in the delivery of extended and improved access, including the reduction of inequalities in accessing primary care; availability of services to all members of the registered population in an area; ability of patients to access these

services via multiple routes including via the practice itself, online or via NHS 111 services; and ability of services to access patients' medical records across sites. These improvements in access to primary care will be significant contributory factors to achieving accessible, joined up and holistic care; paramount for patients with mental health needs.

System flow and capacity

Shifting resources and flow from secondary care

A key aim of PCMH service development is to shift patient flow and resources from specialist care towards primary care. In this way, individuals can receive care closer to home, in a normalised setting skilled at integrating physical health care with mental health. As evidenced in the pan-London scoping exercise[4], the focus of many developed and developing PCMH services is the care of individuals who are in a non-acute phase of their illness, with many stepping down from secondary care into PCMH services or transitioning from community mental health teams (CMHTs). PCMH services can therefore, as a minimum, relieve pressure on CMHTs, freeing them up to be able to be more responsive to patients with more acute needs who may be presenting in primary care.

There is evidence that more extensive PCMH expansion programmes, such as the Enhanced Primary Care (EPC) service in City and Hackney[4], may lead to a reduction in the demand for CMHT-based care, with re-deployment of staff from CMHTs into PCMH services. Freeing up of CMHT resources requires careful modelling of patient step-down flows and their impact on CMHT capacity. If clear patient flow baselines are not established and monitored prior to and following PCMH service development, there is a risk that freed up capacity in CMHTs, related to PCMH activity, will be lost or overlooked or duplication of provision to occur.

In North West London (NWL), for example, the movement of resource to follow shifted activity (with creation of new PCMH services as part of the Shifting Settings of Care programme), has not been as straightforward as initial modelling (undertaken in 2012) suggested. It was seen that if 20% of activity was transferred, only 5% of associated resource could be shifted with it (too low to be meaningful). It is felt this may be due to initial transfer of individuals with the lowest levels of mental health needs within CMHT's and followed by those who have slightly higher, but still relatively low levels of need and generally fewer CMHT contacts. The NWL Collaborative has been trying to increase the number of contacts per caseload in CMHTs, but this acts as a confounding factor when seeking to shift resource.

The service user view

The potential benefits of care being transferred to PCMH services (care closer to home and in a more familiar setting) have been discussed earlier in this document. In the NWL collaboration, service user views have been sought regarding the possible challenges associated with transfer of care from specialist mental health services to PCMH. Here, service users have consistently expressed concern that moving to primary care can feel like a withdrawal of mental health care and can lead to a sense of increased risk (increased potential for deterioration in mental health and wellbeing). However, service users' involvement in the NWL PCMH service model development has helped to allay such fears. The role of the peer support worker/care navigator in PCMH services has proved significant in ensuring people feel effectively supported by their GP and the wider primary care team. In the Bexley model it was noted that 'once referred into the service, there is greater flexibility in signposting to the most relevant type of support' which service users found very helpful.

There are also concerns expressed by service users that key non-clinical wellbeing supports may be limited if their care is not based in specialist services. For example, if care is transferred to PCMH services, they feel it may potentially impact on the eligibility of access to support from social care services, such as housing and welfare benefits. It should be noted that social care thresholds should apply wherever the patient is, whether in primary or secondary care, and entitlement is based on individual circumstances, not place of care. The only exception to this is aftercare for patients on Section 117 of the Mental Health Act (1983)[25] following admission on section 3 of the Mental Health Act (1983).[25] In this situation, it is again of note that access to aftercare is the same whether treatment focus is within either the primary or secondary care-setting. It will be important for health care professionals to clearly consider the range of needs their service is designed to provide when requested to provide medical information to support an individual's claims.

Ensuring continuity of wider forms of support is crucial to holistic care provision. Excellent communicative links between social care and primary care staff are necessary to ensure service users stepping down from specialist services continue to receive appropriate holistic wellbeing support. New care roles, such as trained peer support workers, are seen as being crucial to facilitating access to essential social care support mechanisms (see case study 2).

CASE STUDY 2

PEER SUPPORT WORKER[26]

A peer worker is a role specifically for people who have lived experience of mental ill health.

"Through sharing their own experiences they will inspire hope and optimism, empathy, mutuality, and friendship"

The Peer Worker is an integral and highly valued member of the multi-disciplinary team; they will provide formalised peer support and practical assistance to people who have received services in order for them to regain control over their lives and their own unique recovery process.

Arizona-based Recovery Innovations Services follow this model and describe the key elements as follows:

- Mutuality: Giving and receiving help and support with respect based on a shared experience.
- Empathy: Understanding through the personal experience of having "been there".
- Engagement: Sharing personal recovery experiences. "If she/he can do it, so can I."
- Wellness: Focusing on each person's strengths and wellness.
- Friendship: Promoting recovery through relationship and friendship.

Through sharing the wisdom from their own lived experience, they inspire hope and belief that recovery is possible in others. Within a relationship of mutuality, facilitate and support information sharing to promote choice, self-determination and opportunities for the fulfilment of socially valued roles and connection to local communities.

Increasing capacity in primary care

Freeing up resources in secondary care is only one side of the coin: capacity also needs to be added into primary care to cope with the increased patient flow. Primary Care Mental Health services are usually a partnership between secondary care resources (such as psychiatric liaison nurses, psychiatric support and advice), and primary care resources (such as GPs, practice nurses and health care assistants).

Matching increased patient flow by increasing secondary care inputs into primary care has been demonstrated in some London boroughs as relatively straight forward (for example City and Hackney EPC Service[4]). This has been seen to rely on staff being willing to transfer from community mental health teams (CMHTs) into PCMH services though this can be an attractive option for mature staff who enjoy the autonomy of primary care working. .

Time-efficient input from secondary care input into PCMH can also be effectively given through telephone or email consultations with specialist staff, or via regular practice-based multi-disciplinary team meetings.

Examples of coping with and increasing patient flow can be seen in the North West London Collaborative (see case study 3 and 4).

CASE STUDY 3

NORTH WEST LONDON (NWL) COLLABORATIVE:

To help embed a PCMH focus and facilitate patient flow back towards PCMH services, the NWL Collaborative has identified two facilitating factors:

- A 24/7 crisis line, which GPs can use to obtain specialist advice, or to refer individuals back into specialist services in a timely fashion. Before this service was launched in its totality, there was often concern that if primary care was 'holding' a patient and their needs escalated; they then were left holding the problem unsupported by specialists.
- A clear communication approach where transfers of care between secondary and primary care are formally agreed in writing – providing the opportunity for discussion and challenge. Whilst this approach may increase paperwork volume, it means there is a managed process to communicate with the service user and between GP and psychiatrist at point of transfer.

Meeting the needs of service users transitioning back from specialist to PCMH services may require increased capacity within GP services and other areas of primary care. During the pan-London PCMH scoping exercise, key challenges relating to increasing primary care capacity were identified. These included:

- Very low levels of spare capacity within the GP system.
- Recruitment of more primary care staff, in particular GP's, is likely to be over a longer term than that required by the development of PCMH services.
- GP consultation time is limited, with typical consultations being 10-15 minutes long. Many GPs find this time frame too short to do justice to the complexity of mental problems, which are often combined with physical health problems.
- GP's act as the responsible clinician in many PCMH services and this role cannot be undertaken by other members of primary care staff.

One solution to the lack of GP capacity is to use other practice staff such as nurses or health care assistants (HCA) to help deliver primary mental health care, including, for example, recovery goal-setting and care navigation. Appropriate training for non-GP primary care staff could lead to increased capacity for effective primary mental health care, building on the skill sets of a broader range of primary care staff.

Because GPs are, in many PCMH models, the responsible clinician, it may be necessary to ring-fence a proportion of GP capacity as part of PCMH contracts. For, example, GPs could be required to undertake a number of face-to-face patient reviews per annum. Such reviews may need to be longer than an average GP consultation. Increased GP consultation duration (and requirement for GP time) would need to be reflected in PCMH contracts, in addition to the basis on which payments are made such as activity, patient cohort coverage, outcomes or a combination of these.

CASE STUDY 4

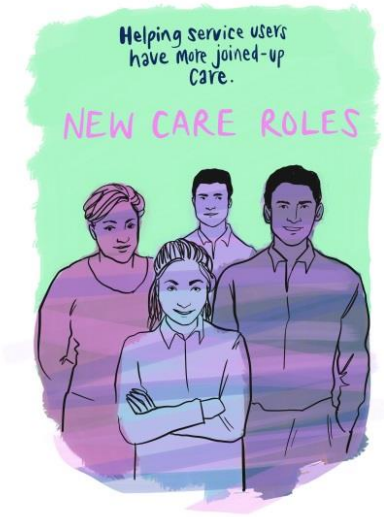
NORTH WEST LONDON (NWL) COLLABORATIVE

NWL Collaborative has looked at increasing capacity, confidence and capability across their wider primary care teams. Through working with service users and carers, NWL have identified the need for, and supported, considerable training with GP reception staff. They wanted to ensure that the first contact with services was more service-user aware and supportive. Of note, feedback on the initial 'GP reception interaction' was always more vehement than any criticism of the level support provided to service users by GP's. In addition to staff training, NWL Collaborative also addressed increasing capacity via:

- Extending GP time to undertake more regular appointments (undertaken in 5/8 CCGs).
- Supporting 2 cohorts of GPs through a mental health diploma, in order to act as local trainers, provide coaching to peers and act as a point of escalation of problems with transfers and transitions. Developing this wider pool of clinical leads has been identified by NWL as a critical factor in helping embed PCMH services.
- Dedicated PCMH teams support GP practices and help enable GPs to remain the accountable clinician for individuals with more complex mental health presentations.

With the development of North West London (NWL) PCMH services, data relating to transitioning of service users from secondary to primary care is now being gathered. Comparatively less data is available relating to individuals who continue to be managed in primary care for their mental health needs.

New care roles



What are they and why are they needed?

By 2021, one million extra people will be provided with support for their mental health and everyone facing a mental health crisis should have 24/7 access to mental health care, in the right place, at the right time.[20] It is anticipated that 11,000 extra qualified staff will be required in order to support and deliver these changes. It is clear that the scale of this growth cannot be met via traditional training routes alone given the short timescale. There is a need to create and recruit for the new care roles and also to invest in the development and reskilling of existing staff.

Some of the extra staff will be drawn from traditional pools of professionally regulated staff, including nurses, doctors, psychologists, occupational therapists and social workers, but these will need to be combined with new and enhanced roles. These new care roles will include peer support workers, personal wellbeing practitioners, nursing associates, assistant practitioners, assistant psychologists, physician associates and call handlers. The growing proportion of support staff is due to a broadening of the talent pool as new roles are developed. This will help create more flexible teams and increase capacity as clinical staff can spend more face to face time with patients and support staff can take on the non-clinical and administrative work.

When considering PCMH service development, it is worth considering the development of roles such as care navigator and mental health link worker. Evidence gathered in the pan-London scoping exercise demonstrated a range of roles such as these, which were centred on care liaison (particularly between primary and specialist care providers) and care navigation (e.g. to sources of community-based support), made an important contribution[4]. Individuals in these roles within London were sourced from a variety of backgrounds within both primary and specialist care services, based at a range of settings in the community, including community centres and general practices.

Examples of new care roles can be seen in box 1, case study 5 and case study 6 on the next page.

BOX 1

CARE NAVIGATORS

Care navigators are just one of the new workforce roles suggested by the Primary Care Workforce Commission in its report; 'the future of primary care: creating teams for tomorrow'[22] to support GPs to manage their workload.

The role of care navigators is to navigate patients and carers to the source of help they need, be it medical, social or housing guidance. They can work across a range of different care settings and can have a range of different titles, including patient navigator, primary care navigator, care coordinator, health navigator or life navigator. Care navigators are considered to be one of the truly innovative roles in a review of the new roles crossing boundaries in health and social care.

CASE STUDY 5

GREENWICH CO-ORDINATED CARE[27]

The care navigator role is a core part of delivering the Greenwich Co-ordinated Care vision of 'right care, right time, right place;' targeting adults at high risk of ill-health and hospitalisation.

The role sits within a dedicated team aiming to co-ordinate resources to build a 'team around the person'. Other members of the team include GPs, the community assessment and rehabilitation service, the community mental health team, representatives of community organisations and carer support.

Greenwich Coordinated Care is an approach underpinned by intensive work of the core team involving the care navigators who then draw on a wider array of services specific to the needs of the individual person's care. Examples include district nursing, community matrons, continence, podiatry, IAPT, memory services, social care, housing, telecare/telehealth, domiciliary care, physiotherapists, occupational therapists, community psychiatric nurses and voluntary sector.

In addition, the core team has named links with the patient's established specialist services for example diabetes, chronic obstructive pulmonary disease or mental health. They also work closely with a range of well-established integrated health and social care teams focusing on rapid response in the community for clinical deterioration; community assessment and rehabilitation; hospital discharge; support for learning difficulties and reablement services.

The care navigator is the first point of contact for the person and their family, and helps the person to say what they want from services and what is most important to them. Using the 'I statements' approach developed by National Voices, the care navigator ensures that the care plan and delivery of care remains person-centred.

CASE STUDY 6

BRADFORD[28]

In Bradford, Band 4 associate practitioners were employed and trained to carry out physical health checks on mental health patients prescribed antipsychotic medication for the first time, those on a high dose of antipsychotic medication, and on any patient referred from the community mental health team caseload.

There was not sufficient capacity in the existing workforce to have qualified nurses do the physical health checks and hence these alternative arrangements were made. Four associate practitioners worked in the Midlands community mental health teams which were based across five community sites and a physical health/wellbeing clinic was set up on each one. The practitioners carry out the checks on a full-time basis and the information is electronically sent to the patients' GPs.

As a result, more patients with serious mental illness are receiving physical health checks, a number of which have had physical health needs identified.

New care roles will be funded in part by NHS England as the government has committed to an extra £1.3 billion investment for mental health services by 2021. Sustainability and transformation plans will also feature plans to improve mental health and to integrate mental health into new models of care.

The roles planned by NHS England will be predominantly based in the community and are likely to work across a number of venues in order to provide integrated mental and physical health care. This may, for example, consist of a mental health therapist being co-located in a GP practice and assessing the mental health needs of patients with chronic physical health conditions. It is important that the post holders have the space to innovate and to work to their full scope of practice and receive appropriate training to increase skills, knowledge and competencies in order to help them deliver care differently.

What is the relationship of PCMH with IAPT services, including the new role of the mental health therapist?

By 2020/21 access to evidence based psychological therapies will be increased so that at least 25% of people with anxiety and depression can access care each year; 75% within 6 weeks and 95% within 18 weeks. This will require the training of an additional 4,500 therapists between 2016 and 2020. The service follows the principle that the treatment offered should be the least intensive treatment that is appropriate and involves two groups of clinicians; psychological wellbeing practitioners (PWPs) and high intensity therapists.

Psychological Wellbeing Practitioners support people with common mental health problems in the self-management of their recovery without extensive training. High intensity therapists deliver specialised services (such as cognitive behavioural therapy), which need more formal qualifications and training.

As part of the planned expansion described above, at least 3,000 new mental health therapists will be co-located in primary care, as set out in the general practice forward view.[24] The new mental health therapist role will likely be an enabler for delivering integrated IAPT services which provides both mental and physical health services.

Further new care role formation resulting from the General Practice Forward View: Clinical Pharmacists[24] can be found at the guidance point ‘medicines management’.

Social prescribing

Kings Fund[29]

Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It (social prescribing) also aims to support individuals to take greater control of their own health.

Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses, social workers and other care professionals to refer people to a range of local, non-clinical services. It is designed to support people with a wide range of social, emotional or practical needs and many schemes are focused on improving mental health and physical wellbeing.

There is growing awareness of the importance of social prescribing schemes to help individuals experiencing mental health difficulties move successfully along the recovery pathway. In response to the NHS Five Year Forward View[1], multiple prevention programmes have commenced to help prevent illness and support health.[30] This includes work to promote healthy communities and support those with long term conditions to manage their own health, wellbeing and care.

NHS England is working collaboratively with the voluntary sector and primary care to design a common approach to self-care and social prescribing.[30] MIND's 'Mental Health in Primary Care report'[31] also identifies the importance of community-based referrals in helping support those with mental illness. It highlights that many best practice examples of PCMH services have 'strong links with community support and social care in order to address the wider social needs which may be impacting on someone's mental health'.[31]

Social prescribing and primary care mental health services

Social prescribing offers primary care professionals a wide range of support options that can be offered to individuals to form a personalised mental health recovery plan. It places further emphasis on care and recovery being focused in the locality in which an individual lives, helping them remain near to friends and family and receive support in a setting with potentially less associated stigma than a traditional hospital setting. The range of forms of social prescribing available to 'prescribe' by primary care workers depends on what is present in a particular locality.

There are many different social prescribing models currently operating in England, all using slightly different referral mechanisms, funding arrangements and ways of working. Many PCMH

services being developed have involved the formation of new care roles such as 'care navigator' or 'link worker.' These primary care-based workers provide a key function in connecting individuals to appropriate community-based services. They gather and hold information relating to local community and social care organisations, which can then be shared with other primary care workers and with service users to help develop recovery care plans. One important element of this role is not just signposting patients to these services but being available to walk alongside patients to enable them to begin utilising them.

Some areas employ health and care professionals in these new care roles, while others recruit non-clinical individuals from the local area who, being based in the community, have excellent knowledge of local support networks and organisations. The majority of this workforce is based in the voluntary sector, not the NHS.

Potential benefits of social prescribing

Social prescribing recognises that people's health is determined primarily by a range of social, economic and environmental factors and seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health. A wide range of potential benefits associated with social prescribing have been cited, including:

- Improvements in mental health and wellbeing, including an increased ability to manage long-term conditions and care and support needs.
- Better social and clinical outcomes for people with long-term health conditions.
- Reduced social isolation.
- Reduction in unnecessary attendance at health services.
- Reduction in demand for social and health care services.
- Reduction in burden for police, fire and ambulance services.

The characteristics of a successful social prescribing service have not yet been fully researched or defined. However, there are good early examples such as Bexley PCMH service and guidance on best practice in social prescribing is currently being developed through the Healthy London Partnership's 'Social Prescribing and Self-Care Wiki'.[32]

In June 2016, NHS England appointed a national clinical champion to advocate for social prescribing schemes and share lessons from successful projects.

Challenges presented by social prescribing

Currently, systematic evidence on the effectiveness of social prescribing is limited. Much of the evidence available is qualitative and relies on self-reported outcomes. Bexley PCMHS has shown good patient reported outcomes using the Recovery Star at twelve to fifteen week intervals covering a range of domains (see evaluation of the cost effectiveness of primary care mental health models). Their model appeared to be very cost effective as patients were highly satisfied with the service and the costs were relatively low through use of MIND's volunteer workers. They were also noted to be managing step down patients with a similar range of serious mental illnesses in clusters 4-21 with high levels of disability to the other more medically based teams studied. Further work is needed to determine the quality, cost, resource and risk implications of this interesting approach in the longer term.

Variability exists in the extent and nature of support forms available in different areas, and lack of availability may limit community prescribing via some PCMH services.

In addition to the need for ensuring prescription quality, there is also the need to ensure appropriate feedback to primary care professions. When an individual has completed a community-based support option, the primary care team needs to be made aware of whether the individual engaged and whether the support was deemed to be beneficial. In this way, GP's in particular can ensure that they are able to appropriately address any remaining mental health difficulties being experienced and help individuals explore further support options.

Examples of social prescribing

There is a wide range of social prescribing initiatives across London and developing PCMH services in many areas involves recognizing the value of social prescribing referrals. Examples in London focusing on health and wellbeing include Southwark Safe and Independent Living (SAIL) [33] and the Bromley-By-Bow Centre[34] (see case study 7 and 8).

CASE STUDY 7

SOUTHWARK SAFE & INDEPENDENT LIVING (SAIL)

SAIL is a service that has been operating since December 2013. It provides a quick and simple way to access a wide range of local services to support older people (50+) to maintain their independence, safety and wellbeing. Age UK Lewisham and Southwark work in partnership with local SAIL agencies to coordinate and monitor the response. A web-based checklist enables access to a wide range of support services which improve:

- Health and wellbeing.
- Mental resilience.
- Isolation and social exclusion.
- Financial inclusion.
- Fire safety and wider home security issues.
- Safeguarding concerns.
- Personal safety and security.

SAIL are also able to give advice around areas such as: claiming benefits, managing debt, obtaining health support, finding accessible holidays, solving housing problems, accessing support and activities, gaining support to remain in your home, and paying utility bills.

CASE STUDY 8

BROMLEY-BY-BOW CENTRE[34]

The Bromley-by-Bow Centre is an internationally renowned charity which has earned a reputation as a dynamic and pioneering organisation that has transformed its community over 30 years. Their focus is on supporting vulnerable young people, adults and families who can be hard to reach through conventional statutory service support. Each month, the centre supports over 2,000 people to improve their health and wellbeing, learn new skills, find employment and develop the confidence to achieve their goals. The centre's approach is based on three key principles:

Accessibility

- Making it easy for people to access support by bringing services together and delivering a friendly and sensitive service in high quality buildings.

Integrated Services

- Offering a broad holistic range of services so people can find help for both their most immediate problems and longer term deep-seated issues.

Long Journeys

- Encouraging people to gradually build up the skills and confidence they need to progress in life and build a positive future for their families.

The Bromley-by-Bow Centre runs a huge range of projects across a range of different sites, both individually and in partnership with others. It provides an integrated range of services, locally where people need them and can access them. People are supported across a range of projects and services in four main ways:

- Supporting people to overcome chronic illness and unhealthy lifestyles.
- Enabling people to learn new skills.
- Supporting people to take control of their lives, for example; improving their capabilities, financial advice and employment support.
- Providing tools to create an enterprising community.

Social prescribing through the voluntary and community sector has multiple benefits for both the GP and the Voluntary and Community Organisations (VCOs) involved. VCOs can play a lead role in setting up and administering social prescribing services and monitoring their impact, and are well placed as they are often familiar with the full range of services available locally. The impact for the GP is a more effective use of their time in being able to refer directly to a non-traditional provider who will have the time to assess the patients' needs and suggest a suitable pathway for them.

Recovery and co-production

> NESTA
>
> '…delivering public services in an equal and reciprocal relationship between professionals, people using services, their families and their neighbours. Where activities are co-produced in this way, both services and neighbourhoods become far more effective agents of change.' [35]

The recovery approach as applied to mental health may be seen as part of a movement away from symptoms-based thinking towards a focus on life quality. A sense of agency (having control over one's life), building a life beyond illness through social networks and the installation of hope are often seen as key elements of this approach. The concept of recovery has particular relevance for people with a serious long term mental illness, who may never recover fully in a medical sense but may, with appropriate support, experience a better quality of life.

For primary care providers, adopting a recovery approach to mental health care may require a cultural shift away from traditional approaches to service development. Embedding a co-produced approach to care planning and delivery harnesses the expertise of service users and their carers and cements them at the centre of service delivery. They become confident, active agents in the care of themselves rather than passive recipients of services. The role of co-production is arguably of greater significance in primary compared to specialist services, with increased emphasis on self-care and management as individuals move along the recovery pathway, transitioning away from specialist care towards primary and community-based services.

In order to help fully embrace a recovery-based approach to care, it is essential that PCMH care plans reflect recovery goals which are identified by the service user. Historically, the steps and ultimate goals of treatment were encompassed in care plans. These tended to be clinician-produced documents with limited service user input. Increasingly, care plans are being replaced by recovery plans; co-produced documents detailing the steps towards wellbeing as identified by the service user and clinician in equal partnership. In the Bexley PCMH service run by Bexley MIND the focus is on co-creating with patients a' life' rather than a 'care' plan. This encapsulates this thinking

The development of recovery plans requires close communication between service users and all those involved in their care. Input may include non-clinical services such as social care and community-based voluntary sector organisations.

In PCMH services, recovery may be supported through navigation to local community resources and by helping build the service user's support network. Examples of this form of support and

care navigation have been seen developing in PCMH services around London, for example, the mental health link worker initiative in Barnet Clinical CCG[2] and the co-produced 'Like Minded' strategy in the North West London Collaboration (see case study 9).

Recovery care plans need to be reviewed at regular points to check progress against goals and make any necessary adjustments to these. Reviews provide opportunities for a multi-disciplinary care approach, with the possibility for face-to-face meetings with professionals from a range of different services meeting with the service user and PCMH team.

'Progress through Partnership'[36] a report published by Rethink in 2017, conducted research to evaluate current practice in the involvement of experts-by-experience in mental health commissioning in England. The report aimed to establish how best to support CCGs to embrace co-production, evaluating the findings of the research to 'establish key recommendations for CCG's and the wider health system to ensure co-production becomes common place within mental health commissioning'.

Despite a recommendation in the Five Year Forward View for Mental Health[4] calling for a culture change in mental health commissioning and recommending commissioners actively involve experts-by-experience in all stages of commissioning cycles, it was found few CCG's were genuinely embracing co-produced approaches. The research showed that only 15% of CCGs who responded had used a co-production approach at least once in mental health commissioning, and only 1% of CCGs explicitly stated a commitment that, in the future, co-production will be a standard approach to commissioning.

Rethink's report[36] recommendations are detailed in Box 2.

BOX 2

PROGRESS THROUGH PARTNERSHIP[36]

Rethink recommendations:

Recommendation 1

NHS England and NHS Improvement should demonstrate leadership through:

- Delivering on the FYFVMH commitment to develop evidence based approach to coproduction in commissioning by April 2018.
- Embedding co-production in all national policy work.
- Supporting local areas to embed coproduction via regional teams.

Recommendation 2

NHS England should establish mechanisms to hold CCGs to account and encourage CCGs to develop co-produced approaches and measure progress, for example, incorporating measures of co-production in the 'CCG Improvement and Assessment Framework' by 2019/20.

Recommendation 3

CCGs should use the Rethink Mental Illness Commissioners Co-production Grid, as well as the National Survivor User Network's (NSUN) 4PI National Standards, to consider their existing involvement approaches and the steps they could take to develop more meaningful and embedded co-production with experts-by-experience.

CASE STUDY 9

LIKE-MINDED – NORTH WEST LONDON COLLABORATION:

To improve mental health and wellbeing across North West London a new strategy was established called 'Like-Minded' which was co-produced with patients, carers, doctors, voluntary organisations, charities and other experts. The aim of the strategy is to establish joined up care that leads to excellent mental health and wellbeing outcomes for people in North West London.

Engagement with service users has been key in developing a co-produced strategy, allowing the focus to concentrate on the needs of individuals rather than the diagnosis. Inviting members from their service user forum the Making a Difference Alliance allowed conversations to flow from real local experiences and concentrate on how to better meet the needs within the community, including the social needs of individuals and carers.

Ethos and values driving our service design and delivery

- Co-production – our way of working.
- A service which gives people a sense of value and worth.
- People seen as a person not a 'service user'.
- A service focussing on people's strengths, building up their confidence.
- Service delivery is based on equal and reciprocal relationships.
- There is a proactive approach to care and support.
- An understanding of what recovery means to each individual person.

Co-production opportunities

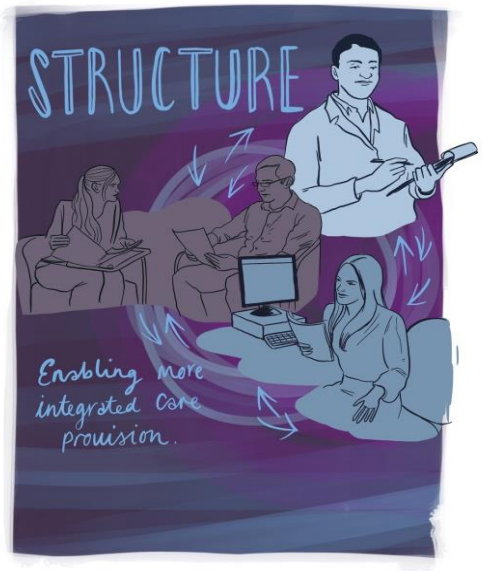
- Staff recruitment.
- Evaluation.
- Stakeholder workshops.
- Steering groups.
- Communications and marketing.
- Health and wellbeing plans.
- Commissioning panels.
- Clinical/social hub design.

Co-production challenges

- Balance between professionals and lived experience.
- Training.
- Resilience, commitment, reliability.
- Managing expectations.
- Time.
- Geographical boundaries.

Enablers

Structure



Because primary care mental health services act as a bridge between secondary care, social care and psychological and wellbeing interventions, they usually involve services being provided by more than one organisation. For example, GPs, practice nurses and healthcare assistants are employed by GP practices, whilst liaison workers, link workers and psychiatrists may be employed by a secondary care trust. In addition, elements of social care advice and navigation may be provided by the local authority, and local resources that support wellbeing may be provided by the third sector. In view of this, finding the right structure for the service is an important means of ensuring that the activities of various organisations are coordinated, integrated and effectively governed in the interests of service users.

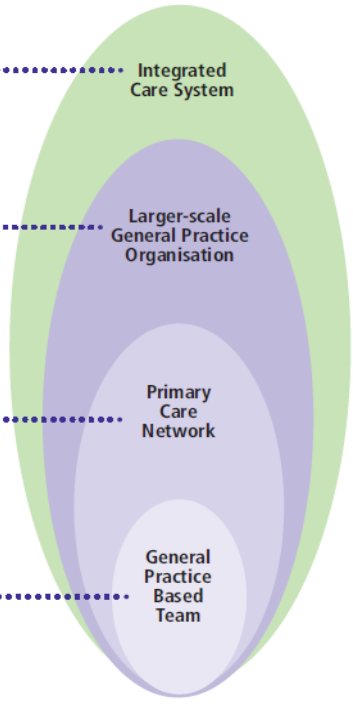
Illustrative model of care

General Practice as the foundation of a wider Integrated Care System – working in partnership with other health and care providers to collaboratively manage and provide integrated services to a defined population within a shared budget

Usually at a borough level and often a single formal organisation e.g. federation or multi-site practice organisation – this is the platform to provide the scale to develop and train a broad workforce, create shared operational systems and quality improvement approaches including use of locally owned data, support the delivery of collective back office functions to reduce waste and enhance efficiency, develop integrated unscheduled and elective care services for the whole population, and provide professional leadership and the "voice" for general practice in the local health economy.

Serving populations of 30-50 thousand, bringing together groups of practices and other community providers around a natural geography. Support multidisciplinary working to deliver joined up, local and holistic care for patients. Key scale to integrate community based services around patients' needs to provide care for people with enduring, complex health and care needs, who require close collaboration between service providers and long-term care condition.

Small enough for the benefits of continuity of care and personalised service. Big enough to safely cover rotas and ensure a balanced skill mix. Providing care to patients with on-going illnesses and flare-ups of established conditions, undifferentiated or medically unexplained symptoms or health anxieties, who may benefit from an episode of continuity pending diagnosis and effective treatment, or long-term continuity of care with single clinician or a clinical team for an enduring condition.



Collaborating to strengthen general practice

- A strong general practice voice in the provider landscape
- Strengthened practice resilience
- Effective system partnerships
- On-going quality improvement
- Economies of scale
- Workforce development
- New population based approaches to care
- Innovative approaches to care provision
- Adopting new technology

Primary Care Networks (as set out in 'Next Steps for General Practice') will produce the scale to integrate community based services and has the potential to significantly improve access and outcomes not just for mental health conditions, but also for co-occurring health physical and mental health conditions. Additionally ***Larger Scale General Practice Organisations*** will have the capacity to develop and train a broad workforce that can treat and care for the whole person effectively.

There are a number of possible structures that can be used to support provider integration. Examples of these are discussed in detail in the Kings Fund report: 'mental health and new models of care: lessons from the vanguards'[37] and are summarised as the following:

Provider integration models:

- **Primary and Acute Care Systems and Multi-Specialty Community Provider (MCP) models**

  The new care models set out in the 2016 NHS England guidance may also be an appropriate means of ensuring primary care mental health services are integrated across providers. Primary Acute Care Systems and MCP models can take a variety of forms; from alliance arrangements to single contract models with a prime contractor.

Contractual mechanisms promoting integration:

- **Aligned contracts**

  Having aligned contracts is a minimum means of ensuring a degree of integration between organisations. One way of aligning contracts is to ensure they cover the whole of the service, not just a part. For example, a contract with a secondary care mental health trust for primary care mental health services could also cover what is expected of primary care practices, social care and third sector providers. It could also set out the role each organisation has within the service and how they should work together such as; joint meetings and how information will be shared. Furthermore, as contracts cover the whole service, all providers can receive similar contracts which are aligned.

- **Alliances**

  After contractual alignment, an alliance is often a useful next step in cementing joint working. An alliance is a formal agreement setting out how organisations will work together to achieve shared aims for a defined population. The alliance agreement sits on top of individual contractual agreements and binds the organisations more closely together. Typically, an alliance will have an alliance board, which should include the primary care mental health providers and may also include commissioners.

  The advantage of an alliance is that it brings organisations together to think strategically about how best to deliver primary care mental health. Integrated working can be further incentivised in an alliance through shared performance metrics and rewards. Budgets can also be pooled or aligned so that money can flow more flexibly between organisations via a central fund holder. An alliance model has been used to deliver primary care mental health in City and Hackney. Other areas are looking to work together under a joint venture (see box 4) where, similar to an alliance, organisations work in partnership by pooling

resources to achieve the best outcome for their particular venture and share in the risks and rewards.

BOX 4

What is a Joint Venture?

A joint venture is a business arrangement in which two or more parties agree to pool their resources for the purpose of accomplishing a specific task. This task can be a new project or any other business activity. In a joint venture each of the participants is responsible for any associated profits, losses and costs. However, the venture is its own entity, separate and apart from the participants other business interests.[38]

- **Prime contractor**

In an alliance all partners usually have equal contractual status. This can make both contracting and decision making complex. An alternative is that one organisation becomes the prime contractor, meaning they have a single contract with a commissioner and then sub-contract to other organisations. For example, a GP Confederation or individual GP practice could sub-contract to a secondary care mental health trust for inputs into a primary care mental health service such as practice aligned psychiatry or psychiatric nursing.

Communication

At the centre of any PCMH service development is the need for clear and effective lines of communication between all those involved in care provision, as well as service users and carers. Strong communication links are required for safe and timely mental health care and are key to raising awareness of PCMH services and knowledge-sharing between health care professionals.

The potential benefits of enhanced communication links in any developed or developing PCMH service are summarised in box 5, along with an outline of the different approaches to communication which could be considered in box 6. In addition, feedback from stakeholders on improving communication can be found in box 7.

BOX 5

POTENTIAL BENEFITS - Enhanced Communication in PCMH Services

- Linked-up, timely care between different mental health providers.
- Avoiding care and recovery planning duplication.
- Facilitating service user and carer involvement in care planning and in accessing appropriate sources of support in a timely manner.
- Engendering a more holistic approach to care via enhanced communication links between mental health service providers and other relevant agencies such as social care, community-based third sector organisations.
- Teaching and mental health knowledge-sharing.

BOX 6

POSSIBLE APPROACHES - Building Strong Communication Links in PCMH Services

- Shared electronic clinical records systems.
- On-call telephone advice from specialists for PCMH teams and primary care staff.
- Single care/recovery plan shared between providers.
- New care roles (e.g. care navigator, link workers) allowing effective liaison between service users, carers and all those involved in mental health care provision of an individual. This could include feedback to GPs on service user recovery following social prescribing, helping to inform onward care pathways and effectiveness of different treatment approaches.
- Multi-disciplinary team working e.g. joint assessment and review sessions.
- Informal conversations between professionals e.g. in staff rooms, which allow for increased knowledge-sharing of mental health care approaches. This may be particularly appropriate when specialists are present working within primary care settings.
- Joint mental health teaching and training sessions between general practice staff (all surgery staff at individual practice level through to GP Federation level) and specialists, also potentially with staff from allied services, such as social care.
- Consideration of a wider range of communication forms e.g. text messaging, email, telephone, letters, online booking systems for appointments/repeat prescriptions, access to wellbeing information and sources of community-based support available online.

Feedback from service users, carers, mental health service providers and those working in allied professions highlighted a range of key considerations in the area of communication (appendix 3). Emphasis was placed on the use of clear, non-clinical language, general practice-centred mental health care provision (with its associated lower level of perceived stigma) and the need for a range of communication forms to be employed.

Of particular note, feedback emphasised the need for shared IT systems and electronic patient records. Current IT systems are frequently unable to communicate with each other, which can lead to duplication of information across different areas of mental health services, and less time-efficient access to the latest care and recovery records. As evidenced in the recent pan-London PCMH service scoping exercise[4] some areas of London, such as the North West London Collaborative, are beginning to use shared IT systems between GP services and specialist mental health providers.

BOX 7

ADVICE TO IMPROVE COMMUNICATION FOR NEW AND DEVELOPED PCMH SERVICES

Collated feedback from service users, carers and health care professionals

(Appendix 3)

- Use simple, non-clinical language.
- Develop shared care records using integrated IT systems.
- General Practitioner to be the 'first port of call' for mental health care.
- General Practice to act as the 'information hub' for mental health support and service information.
- Use a variety of different mediums to communicate with individuals e.g. email, text, apps, letters and online information.
- Continuity of care provider staff supporting service users – reducing need for service users to repeat their mental health history.
- Increased awareness of local mental health support services (e.g. social care, voluntary organisations) including a resource pack available to primary care staff with access details of community-based support available.
- Anti-stigma promotion for mental health issues via a wide range of communication formats.

Workforce

PCMH services are multi-disciplinary in nature, covering a wide range of clinical and non-clinical roles. These roles include GPs, nurses, liaison services, other clinicians (e.g. dentists, pharmacists), staff working in out-of-hours services, commissioners, practice managers, practice reception and administration staff. Strong and sustainable PCMH services need to support the training, development and wellbeing of this wide range of staff in order to respond positively and at pace to transformation taking place across the NHS.

What needs to happen?

PCMH services need staff that are competent, confident, and have the capacity and values needed to drive forward the very necessary changes in culture required to manage PCMH services. It is important that the right skill mix of staff is in place to allow the PCMH team to be responsive to and flexible in responding to the needs of the patients. Services can become overly bureaucratic which puts an unnecessary burden on the staff and does not allow for development of the service as required for the local area. This responsiveness and flexibility is highly valued by patients and GPs alike and will help to ensure everyone who needs support from the service is able to access it, taking into account an individual's culture and the community they belong to. The work then also becomes more rewarding for the staff employed in it, improving staff morale. Monitoring of staff vacancy and sickness absence rates is a useful means to gage success in this area.

At the moment there are variable levels of confidence and competence within primary care staff across London regarding mental health care provision. There are many ways to provide primary care practitioners with the right tools to deliver high quality and best practice interventions. These include education, training, mentoring, and supervision.

Whilst there needs to be a greater focus on mental health in initial training for the primary care workforce, it is also hugely important that those already working in primary care receive regular training on mental health. One way to achieve this is for CCGs to fund protected learning time for GPs and other primary care staff in order to receive regular mental health training relevant to their positions.

Training of all primary care staff needs to be reviewed to help achieve consistency across primary care, together with further clarity given around the roles and responsibilities within collaborative care teams. Primary care practitioners need to build their confidence with appropriate support from their specialist colleagues, particularly around people with complex and multiple needs.

All primary care staff should be trained in mental health and wellbeing, not just GPs. General Practice reception staff, for example, may benefit from mental health first aid training, increasing their confidence and competence as first-point of contact for those accessing PCMH services. Secondary care colleagues need confidence in the service provided in primary care to allow patients to remain in, or return to, primary care. Most importantly, people using services and their carers need to be confident in the safety and quality of care they will receive from primary care. It is essential that primary care is not overloaded and is supported with the necessary workforce.

The London Clinical Network report, 'Tooling Up and Gearing Up Mental Health in Primary Care in 2016',[39] details a framework for primary care mental health education and training. This sets out training needs against roles; from training components relevant to everyone who may come into contact with an individual with mental health illness as part of their day-to-day work, to clinical staff who are a first point of contact for people with mental ill-heath. The report suggests, for example, that suicide prevention training is part of the training curriculum for workers at all tiers of contact with service users, essentially forming a key part of training, equivalent to mandatory annual basic life support training.

The mental health of the workforce

It is critical that everyone working in primary care gets the right support for their own mental health and wellbeing. When primary care professionals and support staff are well supported, they can provide the best care for their patients. Too much pressure and other demands in the workplace cause stress, which can lead to some people becoming unwell, both physically and mentally. Almost 90% of primary care staff experience workplace stress, compared with 56% of the general workforce. Half of GPs have been found to be at high risk of burnout[40], with 16% experiencing a significant and unmanageable amount of work-related stress.[41]

It is therefore crucial that all of the primary care workforce have access to mental health support and that primary care services are commissioned to consider workplace wellbeing. Alongside the new national occupational health services for GPs, CCGs should also address the mental health needs of the wider primary care workforce. For example, there should be consideration of the supervision and support arrangements for reception staff who are usually the first point of contact within PCMH services.

As PCMH teams develop, it is likely that they will support people with increasingly complex and chronic mental health presentations. Training in, for example, mental health first aid[42], could equip staff with the necessary skills to help manage any distress encountered and start recovery and support for individuals at the point of entry into PCMH services. In turn, the provision of supervision for all staff interfacing with individuals who may potentially be experiencing high levels of distress is vital. This ensures staff are adequately supported in the workplace and the sustainability of primary care services is considered. The need to ensure the wellbeing of the primary care workforce was highlighted in MIND's report 'Mental Health in Primary Care 2016'[29], which recommended that, 'all of the primary care workforce have access to mental health support and primary care services are commissioned to support workplace wellbeing'.

Support for PCMH service workforce development

There are many sources of information available to help develop training and support programmes for the primary care mental health workforce, regardless of the starting point and stage of training development so far. These include:

- 'Tooling up and gearing up mental health in primary care: transforming and strengthening the role of mental health in primary care'.[39]
- 'Mental health in primary care: a briefing for Clinical Commissioning Groups'.[31]

There is also a wealth of practical experience on the ground across London and beyond. Areas are tackling this challenge in their own way, with over 40% of London boroughs having regular mental health training established. Examples of training schemes already up and running include:

- *Central London (Westminster):* staff within the PCMH service are seconded from Central and North West London Mental Health Trust, with the trust also providing mandatory and other training as required, in addition to supervision and human resource processes. Internal mental health training also occurs within the team.
- *Camden:* The Together Around the Practice (TAP) service offers tailored mental health training and support to family physicians and other general practice staff.
- *Ealing and Hounslow:* training is provided by the consultant psychiatrist and mental health nurses, to GPs and practice nurses.
- *Barnet:* an initial package of mental health training was delivered across four days and a buddy system is also in place to provide further peer support.
- *City and Hackney:* 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 practice nurses can attend the training and both are reimbursed for time spent. Practices are also being reimbursed for undertaking free locally provided training in mental health over and above the mandatory 4 hours per annum.

Health Education England (HEE) has recently published two reports relating to mental health workforce[43]:

- 'Stepping forward to 2020/21: The mental health workforce plan for England' (July 2017)
- 'Action plan for mental health promotion and prevention courses 2016-2020' (August 2017)

Both reports highlight the need for increased capacity, confidence and capability within the mental health workforce, including within the primary care setting, and the need for services to be delivered in a more integrated way. There is a focus on utilising the wider workforce to promote mental health and prevent mental illness and suicide.

The increased use of digital technologies to aid increased competence and capability in mental health care is highlighted, for example through e-learning programmes. Additionally, there is a focus on mental health care sustainability through the creation of networks of practice, resources and training. These aims align closely with the aims of PCMH services being developed across London.

Medicines management

Shared care prescribing

Approaches to prescribing and monitoring psychotropic medication need to be considered when developing new PCMH services. Service users transitioning from secondary care to PCMH services, and individuals with more complex mental health presentations being cared for by PCMH, may require treatment with, for example, depot antipsychotic medicines.

The confidence of GP's in treating individuals with less-commonly prescribed psychotropic medications, and medicines administered as depot formulation, is likely to be lower than their confidence in treating with medications prescribed more frequently, such as certain forms of antidepressants.

Timely access for GP's to specialist advice on medicines management has been identified as crucial in allowing service users with more complex and chronic mental health presentations to be safely managed within the primary care setting (for example, through feedback from stakeholders at two PCMH workshop events (appendix 3)). This is an essential and more medical aspect of PCMH services in addition to the social prescribing aspects already discussed. Initiatives, such as having dedicated telephone support lines for GP's to access secondary care consultant advice, have been developed in response to these concerns. Formal agreements may also be necessary to clarify roles and responsibilities between providers around medicines management where service user care is shared.

A number of PCMH services developed in London have developed shared care prescribing arrangements. Here, GP's and other primary care staff work with secondary care staff to manage more complex prescribing requirements of individuals being cared for by PCMH services.

North West London Collaborative has a nominal shared care prescribing agreement in place with mental health trusts. This has been an important basis for out of hospital mental health GP services. The principle of the agreement has helped ensure GPs are willing to take over the prescribing of psychotropic medications whilst service users remain open to secondary care services. Details of their shared care prescribing agreement are outlined in case study 11 below.

CASE STUDY 10

NORTH WEST LONDON COLLABORATIVE SHARE CARE PRESCRIBING

This element of the service is designed to cover the enhanced aspects of providing general practice based care in the transfer of prescribing responsibilities of some or all mental health medications from consultant psychiatrists to General Practitioners (GP) through a Shared Care Agreement (SCA).

Under this service, prescribed mental health medications includes antipsychotics, mood stabilisers, lithium, antidepressants and any other mental health medication including drugs used for side effects of these medications. This does not include clozapine. The service provider is expected to accept patients on depot medication that secondary care deem suitable to have administered in primary care.

The shared care prescribing responsibilities of the primary care service provider includes:

- Writing the prescription.
- Proactively following up if the prescription is not requested.
- Monitoring clinical response and side effects.
- Monitoring any necessary drug levels.
- Other blood tests and physical health checks.
- Liaising with professional colleagues e.g. over abnormal results and DNAs.

Shared Care Prescribing Request Process

The request for the registered GP to prescribe under shared care is made by the secondary care psychiatrist in writing via the agreed transfer form or letter to the GP. The form/letter will include a summary of baseline investigations from secondary care, as a minimum requirement.

The registered GP is expected to accept the transfer of prescribing responsibility. GP agreement is voluntarily, with the right to decline to share care if for any reason the GP does not feel confident in accepting clinical responsibility. Any objection to the transfer request should be made proactively within 14 working days of receipt.

The patient will be advised by the secondary care psychiatrist to make an appointment with their registered GP in order to obtain the first prescription and to discuss necessary monitoring from primary care.

However, medicines management roles within the primary care setting are held not only by the GP, but also by other primary care staff. For example, administration of depot psychotropic medication is likely to be via practice nurses who will require appropriate training (potentially provided by secondary care staff working as part of integrated PCMH teams). In addition, a structured and safe approach to medication non-compliance also needs to be developed in PCMH services.

In some London boroughs, the new PCMH roles developed (such as care liaison worker) include functions such as supporting patients in medication concordance, in particular acting to follow-up non-attendance (such as depot medication administration). This aspect of new care role function may be crucial to ensuring that the care of service users can remain within the primary care setting.

PCMH services in North West London have developed flow management diagrams and information leaflets relating to the administration of neuroleptic medication by injection, the possible side effects and how to manage these. The leaflets have been created for primary care staff, in particular, practice nurses. They are examples of positive initiatives that help promote the care of individuals within the primary care setting, who historically have been unable to transition back from secondary care due to their need for depot-administered antipsychotic therapy (see appendix 4 and 5 for further information).

New role development relevant to medicines management within PCMH services

Clinical pharmacists

Other primary care roles, such as clinical pharmacists, are also developing which can help support service users with mental health difficulties to remain in the primary care setting. Pharmacists play a key role in supporting those facing mental health challenges.

A report by the Royal Pharmaceutical Society[44] highlights the importance of pharmacy for mental health, not only for medicines management but also as a key and recurring point of contact for those with mental illness. Those on medication may encounter a pharmacist more frequently than any other primary care clinician and this therefore presents a key opportunity for providing advice and care in a setting which for many, is more comfortable and less intimidating than a GP surgery. Such advice might include managing side effects or encouragement to persevere with medication.

The General Practice Forward View[24] has set out ambitious targets to expand and develop the primary care workforce by 2020 in order to meet the growing needs and expectations of patients, including direct commitment for investment in clinical pharmacists in primary care. The role of the clinical pharmacist is to work alongside GPs and other primary care clinicians to provide expert advice on medicines, including those for mental health conditions.

> *'Current investment of £31 million to pilot 470 clinical pharmacists in over 700 practices to be supplemented by new central investment of £112 million to extend the programme by a pharmacist per 30,000 population for all practices not in the initial pilot – leading to a further 1,500 pharmacists in general practice by 2020.'*[24]

As of April 2017, there are 29 CCGs in London with a clear plan or commitment to roll out clinical pharmacists in general practice. The role is being well supported across London, including through the 'Clinical Pharmacists in General Practice' scheme.

NHS England has invited applications from GP practices and other providers for funding to help support recruitment, training and development of clinical pharmacists. London has been set a national allocation of 84 whole time equivalent clinical pharmacists per annum for 3 years from 2015, and pilots have commenced across all London STPs.

Measuring Success

Outcome measures

Determining service outcomes

Historically, the way that mental health services within the NHS have been organised and funded has focused on activities undertaken and associated costs, which contrasts with acute trusts. However, following the publication of the Five Year Forward View for Mental Health (FYFVMH) there is now an increased focus on quality and effectiveness of care. Additionally, the economic value derived from spending in the NHS and through wider public spending, has led to increased focus on measuring the success of initiatives based on the outcomes achieved.

The FYFVMH sets out the vision for evidence-based treatment pathways, with clear transparency around quality and outcomes. When considering outcome measures there is a recommendation that a mixture of clinically and practically appropriate national and local measures is implemented. The FYFVMH recommends a framework approach which includes outcomes that are:

- Clinically relevant and adds value for clinicians.
- Reflect what people and carers who use the service want.
- Culturally appropriate, reliable and aligned to the system wide objectives.
- Established and are known to be reliable and valid.

It is expected that clinical services will implement collection of mental health outcomes measures into routine day-to-day practice with the aim of achieving a range of benefits, including:

- Supporting clinicians working with people with mental illnesses to achieve their recovery goals and improve their wellbeing by using these quality indicators.
- Providing valuable feedback to clinicians on patients' recovery and progress within the team at a patient and service level.
- Supporting team and individual clinician development using systematic feedback of these quality and outcome measures, therefore promoting reflective practice for the clinicians within their team.

- Providing leadership roles for service users who can co-develop services by being empowered to self-monitor and ensure services use their feedback and outcomes to quality improve.
- Support mental health services to improve using quality improvement methods; being transparent about their outcomes and quality measures, thus enabling services to benchmark themselves against other similar services.

There are many different outcomes measures which are focused on the individual level, population level and care pathway.

Individual/personalised outcomes

In London, the Mental Health in Integrated Care Systems Partnership Board have agreed person-specific outcome measures (CROM, PROM and PREM) for all secondary care mental health trusts. These are identified in the final column of Table 1 below.

Table 1.

Domain	Type of outcome	Outcome tool	Pan London mental health trusts outcome measures
Clinical effectiveness	Clinician reported outcome measure (CROM)	• Health of Nation Outcome Scale (HoNOS)	HoNOS
	Patient reported outcome measure (PROM)	• DIALOG • Short Warwick and Edinburgh Mental Wellbeing scale (SWEMWBS) • Recovering quality of life (ReQoL)	DIALOG
Patient experience	Patient reported experience measure (PREM)	• Friends and Family Test (FFT)	FFT

In order to support transparency and benchmarking, it is recommended that PCMH services use the same outcome measures as secondary care mental health services for CROM, PROM and PREMs. This allows for alignment with the aims of the Five Year Forward View[1] by providing clear, validated measures of success against service offer.

In addition to person-specific outcome measures there are population and process measures, as detailed in Table 2 below. It is important to consider wider population and process measures which focus on broader aspects of an individual's wellbeing, and which could be considered wider determinates of health[45]. Such wider scope measures could include accommodation, education, employment and training, smoking and other aspects of day to day functioning.

Table 2.

Domain	Type of outcome	Outcome Tool	Being used by
Clinical effectiveness	Wellbeing, recovery and quality of life	• GAD / PHQ9 / recovery rates • Mortality rate/suicide rate • DREEM / recovery star, global quality of life • Disease specific outcomes e.g. OCD (YBOS), Eating disorder (EDEQ) • Emergency re-admission within 30 days	IAPT Minimum data set Oxfordshire CCG Richmond CCG
	Physical Health	• Diabetes/smoking/alcohol/ respiratory • Smoking rates, cancer rates • Heart disease/stroke • Reduced mortality • Cardiometabolic risk factors (Lester)	Camden and Islington IPU Oxfordshire CCG
	Wider determents of Health	• WSAS - Work and Social Adjustment Scale • Housing status/activities (as above) • % of persons in mainstream or supported housing • % of persons who are employed and training	IAPT C&I IPU Oxfordshire CCG
Patient experience		• Friends and family • Service recommended by staff • Carers signposted to local community support services • Delayed Transfer of Care (DToC)	
Domain	**Type of outcome**	**Outcome Tool**	**Being used by**
Access	System	• Number of people referred for care that receive care - including access/waiting • Number of people in contact with GP • New referrals and assessments in secondary care • Duration of treatment in secondary care • Discharges from secondary care • Black, Asian and Minority Ethnic (BAME) population - % of population who identify their ethnicity as BAME access services	IAPT / EIP Services
Efficiency Reduced life disruption - reduced reliance on secondary care, crisis and	System	• Use of A&E for people with mental illnesses • Use of primary care • People in contact with mental health services per 100,000 population • Help out of hours	Oxfordshire CCG Economic modelling from Managing Patients with Complex Needs

emergency department services			(MPCN) (City and Hackney) – reduced GP visits[46]
Capacity Increased capacity, capability and confidence in Primary Care workforce to care, support and provide treatment for people with mental health needs	System	• Patient and carer satisfaction (friends and family test and national GP patient survey  GPPS 2017 - Questionnaire.pdf • GP satisfaction with mental health services (survey of GPs) • Effectiveness of communication and relationships between primary care and mental health professional (survey of health care professionals) • Number of primary care staff prescribing psychotropic medicine	

How often outcome measures should be collected will depend on the disease group and duration of the separate illness groups, with some illnesses being more likely to be episodic (depression/anxiety), and others being long term and enduring (such as personality disorders, bipolar affective disorder). Consideration should be given to the healthcare setting of the collection, such as primary care where patients may have shorter treatment durations than in secondary care settings.

It is recommended that both PCMH and IAPT services collect outcome measures at the same time in order to obtain a holistic view of common and serious mental health conditions (see table 3).

Table 3.

Severe & Enduring Conditions Assessments and Outcomes Measured by IAPT												
	Psychosis			PD Primary Care			PD Secondary Care			Bipolar Disorder		
Measure	To be Taken	Frequency	Completed by	To be Taken	Frequency	Completed by	To be Taken	Frequency	Completed by	To be Taken	Frequency	Completed by
PYSRATS	Yes	Beginning / Middle / End	Patient									
CHOICE shortened	Yes	Session by Session	Patient									
WEMHWBS	Yes	Beginning / Middle / End	Patient	Yes	Beginning / Middle / End	Patient	Yes	Beginning / Middle / End	Patient			
WASAS	Yes	Beginning / Middle / End	Patient	Yes	Session by Session	Patient	Yes	Beginning / Middle / End	Patient	Yes	Session by Session for 6	Patient
SAPAS				Yes	Beginning / Middle / End	Patient	Yes	Beginning / Middle / End	Patient			
PHQ				Yes	Session by Session	Patient	Yes	Beginning / Middle / End	Patient	Yes	Session by Session for 6	Patient
GAD7				Yes	Session by Session	Patient	Yes	Beginning / Middle / End	Patient	Yes	Session by Session for 7	Patient
Health Utilisation				Yes	Session by Session	Patient		Monthly				
PEQ	7 item incl F&F	Middle & End	Patient	8 item incl F&F	Middle & End	Patient	8 item incl F&F	Middle & End	Patient	Yes	Monthly	Patient
QAS												
Internal States Scale										Yes	Session by Session for 6	Patient
Bipolar Recovery Scale										Yes	Session by Session for 6	Patient
Bipolar Quality of Life Scale										Yes	Session by Session for 7	Patient
EQ-5D	EQ-5D-3L	Beginning / Middle / End	Patient	EQ-5D-5L	Session by Session	Patient	EQ-5D-5L	Beginning / Middle / End	Patient	Yes	Montly	Patient

Supporting and enabling recording of outcome measures in routine clinical care

The NHS FYFV[1] sets the aim to make the NHS paperless. There is clear guidance that outcome measures could be collected in real time using digital technology. The Mental Health FYFV[21] provides clear guidance on collecting outcomes measures digitally via text message, app or by embedding it into electronic patient records (EPR). This would support the reduction of time between collection, outcomes analysis and availability to clinicians on the ground to monitor treatment progress.

The advantages of use of digital enablement are clear however there are factors to consider in delivering the NHS digital vision.[47] These include the various IT systems used by primary care and mental health services, whether these IT systems talk to each other and how outcome measures recorded in one IT system can be transferred and extracted in other IT systems.

Different trusts have developed different systems to ensure digital recording of outcomes. Central and North West London Foundation Trust (CNWL), in collaboration with their local CCGs and GP practices, have changed their EPR system to SystmOne to match what was being used in primary care to promote sharing of outcomes and other clinically meaningful patient data. This was enabled by developing Commissioning for Quality and Innovation (CQUIN) to promote the use of outcome measures.

Another trust, Northumberland, Tyne and Wear Foundation Trust, have used digital enablement to develop a clinical dashboard where outcomes are recorded in order to improve their quality of data and sharing of clinically meaningful data to improve quality of care. In addition, digital

enablers would support increased time to care with patients and reduce the burden for clinicians by 20-30%.[48]

Additional studies have shown electronic screening tools are an acceptable and feasible means of systemic screening of patients within GP surgeries and easily integrating them into the primary care electronic health record. The eCHAT for Lifestyle and Mental Health Screening in Primary Care in New Zealand asked patients to self-administer eCHAT on an iPad in the waiting room.[49] Patients would answer questions on life-style issues such as problematic drinking, smoking, and other drug use, anxiety, depression, anger control, and physical inactivity and whether they wanted help with these issues. The patients received summarised results via the electronic health record (EHR) at the point of care. 91% of patients completed the questionnaires. Patients found the iPad easy and acceptable to use with the questions appropriate and easy to understand.[49]

There are differing views on pan-system interoperability of the current EPRs used in primary care and secondary care. Some EPRs are more suited for mental health (RiO) and other systems are more suited for primary/community care (SystmOne). Some organisations have thus considered developing IT portals to incorporate the different EPRs rather than adopting one EPR system across healthcare organisations.

The London dashboard is a useful strategic planning tool that enables local areas to benchmark themselves against other areas (see box 8).

BOX 8

LONDON DASHBOARD – ONE STOP SHOP FOR MENTAL HEALTH INTELLIGENCE ACROSS LONDON

The London mental health dashboard has been designed as an electronic system that holds important information about London's mental health. The dashboard acts as a single, agreed point of reference and source of record for London. It is also a place where progress against key strategic targets can be measured. The dashboard does not focus on performance management and is not an exhaustive list of indicators. The dashboard is founded on common data owned within London's mental health system and populated with commissioner level data using content available from existing public domain sources including; NHS Digital, Public Health England, and Care Quality Commission. Provider level data has been sourced almost exclusively from content held by the NHS Benchmarking Network.

The data describes the progress that has been made in London's mental health system over the previous year, with many key indicators for London showing improvements. Current functionality of the dashboard for CCG and Trust level metrics include prevalence/context, primary care Quality Outcomes Framework (QoF) and IAPT, CAMHS, psychosis, perinatal and dementia. Registered and weighted populations, STP profiling, time series analysis, tabular data and chart export can also be used.

Since its inception and launch in 2016 it has already had further developments. The inclusion of additional feeds and further functionalities are currently in discussion, such as finance information to allow discussion of baseline investment levels and variation between Trusts and CCGs.

In order to ensure that services can be sustained beyond the initial period, intended outcomes should be agreed at the outset so that the value and efficacy of services can be demonstrated to funders. This will allow us to know whether scarce NHS resources are being used most effectively and can enable informed service development.

As described by the Health Foundation[50], moving from an activity based approach to outcomes based approach will present some challenges for everyone working within and using local healthcare services. The expected timescale for achieving outcomes should also be considered, and where there is an expected lag in achieving outcomes, process measures may be identified as a proxy or short-term approach. Whilst some areas will wish to formally commission based on outcomes, and/or engage in a full co-production approach to agreeing desired outcomes for their local area, other areas may wish to adopt outcomes defined and agreed elsewhere.

The contracts and specifications used within the NHS usually include references to the NHS Outcomes Framework[51] as well as locally defined outcomes. There are also a number of other National Outcome Frameworks that could provide a useful source, such as 'I' statements for coordinated care and support in mental health[52], public health outcomes framework[53], and the adult social care outcomes framework.[47] During this transition, it is important to check whether the activities currently being undertaken, or new activities you have planned, align with the desired outcomes. If they do not, there is a need to consider whether the outcomes have been correctly defined and/or whether the activities are adding value. Driver Diagrams[54] can be a useful tool to test this.

Appendix 1 Steering group membership

Dr Fiona Butler	Chair of PCMH Steering Group, Chair of NHS West London Clinical Commissioning Group
Dr Smitha Addala	Clinical Lead for Proactive Care, Healthy London Partnership
Dr Andy Bell	Deputy Chief Executive, Centre for Mental Health
Dr Asif Bachlani	Consultant Psychiatrist, South West London & St. George's NHS Mental Health Trust
Sophie Corlett	Director of External Relations, Mind
Dan Burningham	Head of Mental Health Service Development, NHS City & Hackney Clinical Commissioning Group
Dr Chris Curtis	Consultant Psychiatrist and Clinical Lead, NHS Camden & Islington Mental Health Assessment & Advice Team
Temo Donovan	Project Manager, Healthy London Partnership, NHS England
Dr Rhiannon England	GP Mental Health Lead, NHS City & Hackney Clinical Commissioning Group
Dr Lise Hertel	GP/Clinical Associate, NHS England
Jane Lindo	Primary Care Lead, Healthy London Partnership, NHS England
Glen Monks	Associate Director, Mental Health, NHS North West London Collaboration of Clinical Commissioning Groups
Vicky Nash	Head of Policy and Campaigns, Mind
Dr Chris Naylor	Senior Fellow in Health Policy, The King's Fund
Dr Dorothy Newton	Darzi Fellow, Healthy London Partnership, NHS England
Michael Oates	Project Manager, Healthy London Partnership, NHS England
Holly Paulsen	Policy Research Fellow, The Royal College of Psychiatrists
Dr Rosalind Ramsay	Consultant Psychiatrist, South London & Maudsley NHS Mental Health Trust
Simon Rayner	Assistant Director, Adult Social Care, London Borough of Southwark
Colette Roach	Project Manager, Healthy London Partnership, NHS England
Jennifer Speller	Senior Joint Commissioning Manager, NHS Islington Clinical Commissioning Group
Emily Waller	Senior Policy and Campaigns Officer, Mind
Jane Wheeler	Programme Director, Mental Health & Wellbeing, NHS North West London Collaboration of Clinical Commissioning Groups

Appendix 2 Checklist for development of Primary Care Mental Health Services

Service Domain	Key Questions	Early Development Phase	Intermediate Phase	Advanced Phase
1.Service Maturity	• Is there a planned/piloted or developed PCMH service in/associated with the practice? • Is there co-location or named links of primary/specialist staff caring for individuals with MH needs or evidence of extensive MDT working across sites/provider tiers?	• PCMH services in planning stage with MH care provided via standard primary care service and referral to secondary care services • Primary care and specialist staff not co-located or secondary care staff not practice linked and low levels of MDT working evident	• Piloted or early phase of PCMH service development • Increasing communication evident between MH care providers involved in patient MH care, including primary, specialist and community-based services, possibly with joint assessment processes, named links or MDT case meetings	• Dedicated PCMH service with identified staff members from within both specialist and primary care settings • Shared clinical environment for primary/specialist staff working in PCMH or evidence of highly developed well-integrated multi-disciplinary team working
2.Scope	• Is there a diagnostic range determined for patients under PCMH (e.g. age range, SMI, CMI, diagnostic codes)? • Is there a clear distinction between individuals supported by PCMH versus specialist services?	• Clear criteria to define those individuals being cared for within primary care for MH needs e.g. age, diagnostic cluster • Clear criteria defined for threshold for referral to specialist services and back from specialist care to primary care	• On-going active scrutiny of specialist care patient caseloads e.g. at CMHT's, to identify individuals who could transition back to PCMH services (e.g. stable psychotic illness, patients not actually being seen more than twice a year, patients, patients seen only for prescriptions)	• PCMH service aware of any changes to demographic of individuals being cared for by primary care for MH needs e.g. more complex MH presentations as PCMH services become established

Service Domain	Key Questions	Early Development Phase	Intermediate Phase	Advanced Phase
3.Care Roles including Medicines Management	• Is there a shared care plan? • Are there clearly defined roles/responsibilities between different care providers, including medication prescribing/monitoring?	• Mental health care provided by primary care or specialist MH staff with no shared care responsibilities	• Formalised agreement of clinical responsibility for an individual's care within PCMH service, including prescribing functions e.g. who is responsible for psychotropic medication prescribing and monitoring • Evidence of developing liaison working between primary care and specialist staff • Psychotropic medication including depot prescribing /administration/monitoring being established in primary care setting • Team mix appropriate for PCMH service aims – e.g. team comprises primary and secondary care staff from a range of backgrounds such as nursing, pharmacy, care liaison worker, mental health therapist, doctor • Development towards clearly defined care role areas within PCMH team e.g. responsible clinician role, nursing staff overseeing depot medication administration, link workers facilitating social prescribing	• PCMH services providing MH care for appropriate individuals in place of specialist services • PCMH service holds clinical responsibility for care of patients, including those with more complex MH presentations e.g. those with stable psychotic illness • Shared care plan between primary/specialist providers • Possible new care role development in PCMH services e.g. Care Navigator, Link Worker • Primary care staff training in depot medication established • Primary care staff training in lithium medication established • Clear care plan established for management of medication (including depot) DNA's • Evidence of GP-based pharmacists diverting patient flow away from medical and nursing staff • Shared care guidelines for medication prescribing and screening in primary care e.g. anti-psychotics follow up, Aricept, ADHD drugs etc.

Service Domain	Key Questions	Early Development Phase	Intermediate Phase	Advanced Phase
4.Access	• Is there a clear referrals process in place? • Is there good local awareness of PCMH service?	• Standard referrals process from primary care to specialist services	• Good local awareness of PCMH services • Timely access to specialist advice for primary care providers to help prevent re-referral of individuals • Timely re-referral to specialist services is available if required	• Single point of access to services for those experiencing mental health difficulties • Extended opening hours for PCMH services • Timely and full discharge summaries between primary and secondary care with full ongoing management plans
5.Communication	• Is there a shared IT system? • Is there clear, timely access to specialist advice for primary care staff? • Is there evidence of liaison links between primary, specialist and community-based care s • Services?	• Evidence of case discussion and referrals discussion between primary care and specialist services	• MDT working evident between primary/specialist staff, e.g. weekly meetings to discuss referrals and more complex presentations • Duty system in place, or clear substantive arrangements evident, for primary care staff to access timely specialist support for patient care • Established named link for practice s from secondary care • PCMH service becoming firmly embedded within primary care e.g. care navigators linked to named practices, PCMH workers seeing patients in GP surgeries	• Shared electronic data record system which primary care staff and specialists can access in a timely manner • Shared care plan between primary/specialist services • Shared physical health care data, shared approach to ensuring complete screening

6.Co-produced Care	• Are Service Users Involved in service development?	• Limited evidence of service user involvement e.g. through service feedback questionnaires	• Evidence of more service user involvement in planning of services e.g. via questionnaires during service development rather than simple service feedback	• Service users and carers involved in service development as equal partners • Use of PROMs and outcome measures
Service Domain	**Key Questions**	**Early Development Phase**	**Intermediate Phase**	**Advanced Phase**
7.Social Prescribing	• Is there evidence of effective social prescribing?	• No or limited referral to sources of community-based support	• Central resource list of local community-based support options available to primary care staff	• Feedback loop completed following primary care referral to community-based services • Primary care services considering quality of community-based support available and co-ordinating referrals around this and individual SU need
8.System Flow & Capacity	• Are individuals of all ages with stable MH conditions able to transition back to primary care services? • How many service users are being enabled to transfer to primary care from secondary care mental health services? Is this process facilitated by liaison with secondary care?	• Caseloads held separately between primary and specialist MH providers	• Individuals with chronic but stable MH presentation being actively identified for possible transition into primary care services • More complex MH caseload being held within primary care setting supported by specialist in-reach/liaison	• PCMH services providing support to a range of individuals with more complex MH presentations • Active in-reach support to PCMH teams by MH specialists • Consider all age step down- i.e. CAMHS and older adults • Facilitation of service user step-down through joint appointments prior to transfer of care to primary care setting
9.Training	• Is there dedicated training in mental health for all primary care staff (i.e. not	• Mental health training present via existing mandatory primary care	• Evidence of knowledge-sharing between practices, e.g. at GP	• Tailored training packages to upskill primary care staff in mental health care,

	just clinicians)? • What level of support and supervision is available for primary care staff around mental health & wellbeing?	sessions (e.g. annual half-day training) • Monitoring of mental health training compliance at practice level • Evidence of knowledge-sharing between staff at practice-level	federation level • Evidence of upskilled primary care staff via increased confidence & capability (e.g. via appropriate feedback mechanisms, staff and patient experience questionnaires, attendance of staff at MH training) • Supervision & support for all primary care staff who interface directly with service users	preferably delivered by specialists involved in the PCMH service • Increased episodes of knowledge-sharing between primary care settings and more widely e.g. at national MH conferences
Service Domain	**Key Questions**	**Early Development Phase**	**Intermediate Phase**	**Advanced Phase**
10.Outcome Measures & Service Funding	• How is the PCMH service funded? • Is recurrent funding secured? • Are there outcome measures in place to measure performance and inform service development?	• Mental health services funded in bloc as part of primary care package	• Proposed benefits of PCMH service development monitored against specified outcome measures, including cost efficiency, service user satisfaction and service provider satisfaction & clinical outcome measures e.g. RCADS	• Economic evaluation of PCMH service completed • Recurrent funding secured/ economic sustainability of PCMH service deemed as likely • Benefits of PCMH service established and monitored against specified outcome measures across the wider system (i.e. cost efficiency, reduced unplanned care via A&E attendance, reduced input from liaison and home treatment teams, improved patient and clinician satisfaction with services)

Service Assessment Outcome Sheet

Service Domain	Identified Service Strengths	Barriers to Progress	Possible Solutions	Resources Needed
1.Service maturity				
2.Scope				
3.Care roles including medicines management				
4.Access				
5.Communication				
6.Co-produced care				
7.Social Prescribing				
8.System flow & capacity				
9.Training				

Appendix 3 Stakeholder Event

Primary care mental health - new models of care workshop 15th June 2017

Introduction

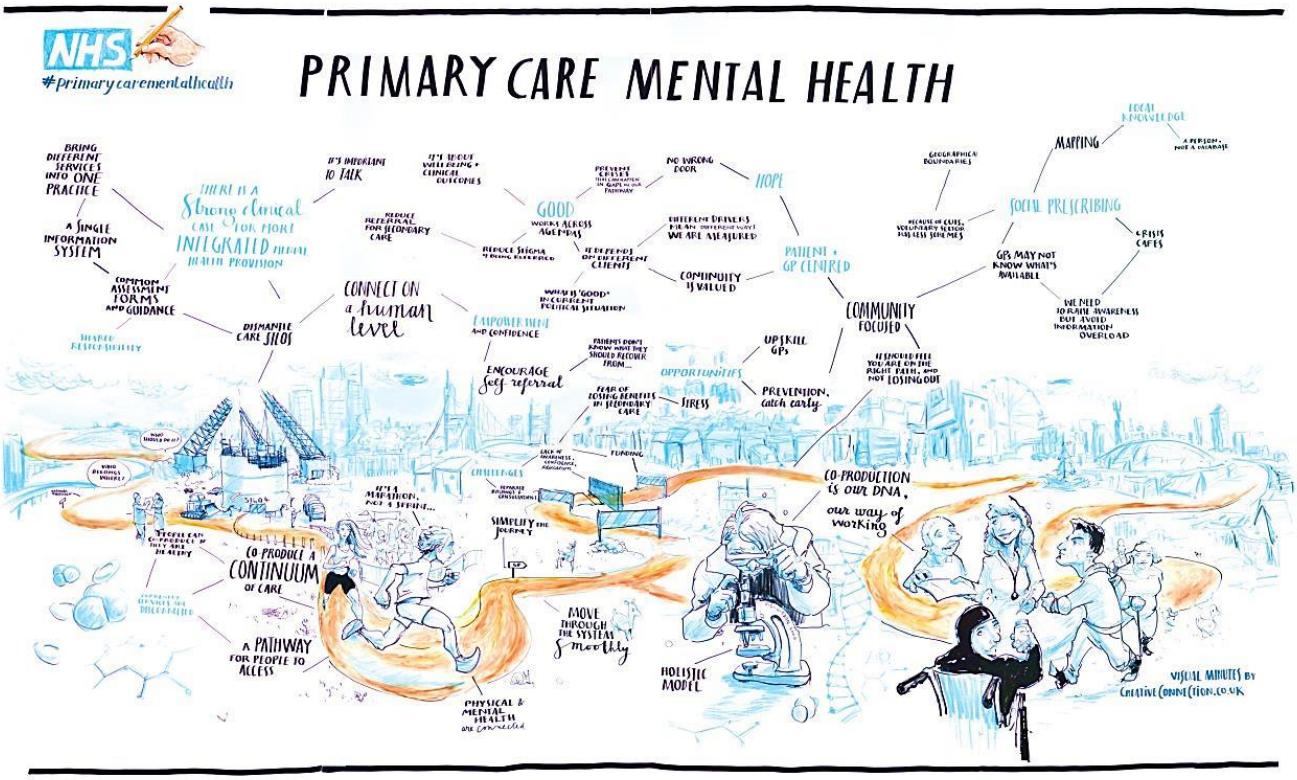
Primary care mental health (PCMH) models of care which have been developed or currently being developed in London vary significantly between boroughs in their structure, scope and level of financial/other investment. Healthy London Partnerships are aiming to identify a set of core components of service development models. These are based on those described within a recent scientific literature review and through the examination of current scoping of PCMH services across London. Guidelines will be set against these core components, which have been identified as crucial to the future success of PCMH service development.

This workshop aimed to capture stakeholder opinion and insight on the development of the guidance document.

Invitations were sent out to a wide group of stakeholders:

GPs, Providers, Commissioners, Psychologists, Psychiatrists, Pharmacists, Education leads, IAPT staff, Voluntary sector staff, Service users including carers, GP practice staff, Community mental health teams.

Visual minutes were also captured on the day and represented comments and discussions heard throughout the day from the stakeholders present.



Analysis

The event was split into two sessions with an almost identical format for both the morning and afternoon, with a different chair overseeing each session. The programmed outlined an overview of the work done to date including a statement on case for change - current approach, challenges and areas for improvement; this was supported by case studies and lived experience presentations. The workshop provided group discussions on questions relating to the components that will frame the guidance document.

The emerging information and themes from these discussions have been collated into the following spreadsheet:

PCMH event table notes - themed.xlsx

Approximately 85 delegates registered for the event, with lived experience delegates attending for both the morning and afternoon sessions.

An evaluation form was provided for delegates and these were completed by 30 delegates. Overall the response from the evaluation was extremely positive providing evidence that delegates found the event informative, inspiring and beneficial to their work. The following provides an analysis of this information.

The first four questions related to the event as a whole:

Overall event

Excellent	Good	Average	Poor
66.7%	33.33%	0	0

Information provided from the presentations

Excellent	Good	Average	Poor
43.33%	50.00%	6.67%	0

Table discussion session

Excellent	Good	Average	Poor
70.00%	30.00%	0	0

World café session

Excellent	Good	Average	Poor
36.67%	56.67%	6.67%	0

The next three questions related to delegates own reflections on what they had heard throughout the sessions and what they would consider to be the next steps.

What are your key reflections from this workshop?

"I thought the discussion was really helpful for me, great opportunity to learn about different models"

"It is a good idea to set up such a forum for professionals and service users to share expertise"

"It is complex. Good examples of good practice. More work needed on outcome measures, sharing data, common incentives, system saving and defining fidelity"

Double click on the icon to see all the responses:


Q5.pdf

Please explain if there is anything new you learnt today?

"How to start the conversation of bringing together all stakeholders, co-location / would be key"

"New incentives taking place that I'd not heard from before"

"Issues from GP perspective"

Double click on the icon to see all the responses:


Q6.pdf

Do you have any specific suggestions for next steps after the publication of the guidance?

"Really good to pull together an outcomes framework e.g. across CCGs in STP area"

"Need to consider STP need and evaluation to support commissioning"

"Shout about all the good work from the rooftops! These activities really need to be publicised to all 'partners'"

Double click on the icon to see all the responses:


Q7.pdf

Missed doses

In most cases the patient will have a reservoir of drug in the body; as the blood level drops, the drug will be mobilized from its storage in fat tissue and some will go to the brain so that rarely do the symptoms reappear. Only when the reserves are empty will the symptoms return. If the illness reappears in a severe form the patient usually ends up needing a higher dose of medication than he was receiving before he stopped the injections. This is not true of the new atypical drug Risperidone Long Acting Injection. Risperidone LAI can only be given as a 2 weekly injection. Over the first 2 to 3 weeks there is little absorption of the active drug into the body but the drug begins to reach peak plasma levels by week 4-5. It is essential the patient receives alternative antipsychotic cover for the first three weeks after the first injection. A 2 week regimen needs to be maintained in order for plasma levels to remain stable.

If the patient does not attend/misses their depot

1. Telephone the patient and ask them to rebook appointment.
2. If no contact with patient or patient refuses to attend, inform the GP and Primary Care Liaison Nurse.
3. If patient still unavailable or DNA, GP or Primary Care Liaison Nurse (PCLN) to contact last known secondary care service, if still known to them.
4. PCLN to arrange a visit to patient.

Step Down Patients from Secondary to Primary Care

Patients recently stepped down from secondary care will be reviewed by the PCLN on transfer, 3 months and 6 months and after that as required.

Patients consenting to discharge from the Secondary Care will attend their primary care practice for their injection to be given by the Practice Nurse.

The Practice nurse will give the patient their next due depot after step down to primary care and continue to manage depot.

If on a depot, the depot to be booked in for next due date by adding to medication screen and order first dose.

Practice Nurse to ensure that:

1. The Depot appointment is given to the patient
2. Add the depot to the medication screen.
3. Ensure that the depot has been ordered.

If in need of specialist help the GP can refer to secondary care via ABT who will ensure to fast track the patient to the relevant sector team.

Further information can be found at http://www.ukppg.org.uk/long-acting-injections-guidelines-sops.pdf

Primary Care Plus
Mental Health Service
Central London Healthcare

Primary Care Plus Mental Health Service

Guidance for administering a neuroleptic injection

Primary Care Plus (PCP) Mental Health Service

020 7535 8330

pcp.mentalhealthservice@nhs.net

09.00 to 17.00 Monday - Friday

Introduction

Antipsychotic medications are used in the treatment of schizophrenia and other psychotic disorders. Depot neuroleptics work best for hallucinations, delusions, bizarre behaviour and thought disorder. Injections may be preferred over tablets for a variety of reasons. It is easier to have one injection a month than to have to remember to take pills every day. If someone has difficulty absorbing medication from his or her intestinal system, an injection may provide for increased absorption. With a scheduled injection it can be certain that the patient is receiving the exact amount of medication prescribed.

It is currently believed that the positive symptoms of psychosis (e.g. hallucinations) are produced by a surplus of the neurotransmitter dopamine in the synapses between brain cells in the limbic area of the brain (the emotions). Cognitive symptoms and negative symptoms (e.g poor motivation) are thought to be related to too little dopamine in the synapses of the cerebral cortex. Dopamine is responsible for maintaining normal thoughts and behaviour and emotions. The neuroleptic drugs work by decreasing the activity of the dopamine.

Depending on which drug is being used the duration of action from a single injection varies between one and eight weeks. Each injection overlaps in effect with previous ones so that at any point in time, 3 or 4 recent injections will be contributing to the patient staying well.

Current Depot IM Injections

Trade Name	Proper Name	Dose/Amount	How Often
Modecate	Fluphenazine decanoate	Up to 100 Milligrams	Once every 2 to 5 weeks according to response and severity of condition
Haldol	Haloperidol decanoate	Up to 300 milligrams	Once every 2 to 4 weeks according to response and severity of condition
Piportil	Pipothiazine palimate	Up to 200 milligrams	Once every 4 weeks
Clopixol	Zuclopenthixol decanoate	Up to 600 milligrams	Once every 1 to 4 weeks
Risperdal Consta	Risperidone	Up to 50 milligrams	Once every 2 weeks.
Xepilon	Paliperidone	Up to 150 milligrams	Once every 4 weeks (in the deltoid)

Side Effects

Common Side Effects

Include:

Drowsiness, hyperactivity or insomnia, dry mouth, blurred vision, constipation, weight changes, loss of appetite, stiffness, restlessness or inner anxiety. Patients suffering from any new symptoms of the above should be advised to make a routine appointment with their GP to discuss.

Check if the patient is on procyclidine and their compliance with this.

Side effects, which should be reported IMMEDIATELY to the GP

Muscle spasm, severe rigidity, shaking or restlessness, unusual headache, dizziness, nausea and vomiting, difficulty urinating, soreness of the mouth, gums or throat, flu-like symptoms, skin rash or itchiness, dark-coloured urine, yellow tinge in the eyes or to the skin, elevation in body temperature and local skin reaction to the injection.

Muscle effects that can occur with the use of depot neuroleptics include: spasms, rigidity, shaking or tremor as well as restlessness. Antiparkinsonian drugs are used to help alleviate muscle side effects (examples include procyclidine, benztropine, orphenadrine).

Care pathway of responding to severe side effect

Delay depot
Discuss with psychiatrist/psychiatric teams
Discuss with CNWL pharmacy help line 02082067270. Opening hours are Monday to Friday 9am-5:15pm. You can also send an e-mail to medinfo.cnwl@nhs.net.
Refer to A&E if no other causes for symptoms identified.
If Neuroleptic malignancy syndrome is suspected refer directly to A&E.

Key points

The practice nurse should follow the manufactures instructions provided with each particular injection.
The dose should be given as prescribed in the patient's psychiatric care plan, in the patients' record. If there is any doubt, discuss with GP.
Record in consultation notes and medicine page.
The patient should be advised when the next injection is due.
Any deterioration or concern in the patient's mental state should be reported to the GP and the PCLN.
The practice nurse should make sure there is an injection available for the next appointment by following the usual ordering system. The medication page should show last date of issue and the last injection date.
Side effects should be rated 3 monthly by using SESCAM. This has 14 items in the clinician assessment and 13 items in the patient's self-report.
Check patient has had his/her physical health check. Arrange if necessary and discuss benefits with patient.
Add read code for depot neuroleptics to problem page.
Where possible, the Practice Nurse to give depots when the Primary Care Nurse is in surgery.

Appendix 5 Depot antipsychotic medications flow chart

Neuroleptic Side Effects

Common Mild Side Effects

Drowsiness

Hyperactivity or insomnia, dry mouth

Blurred vision

Constipation

Weight change

Loss of appetite

Stiffness

Restlessness or inner anxiety.

Patients suffering from any new symptoms of the above should be advised to make a routine appointment with their GP to discuss.

Side Effects which need Immediate Action

Muscle spasm

Severe rigidity

Shaking or restlessness

Unusual headache

Dizziness

Nausea and vomiting,

Difficulty urinating,

Soreness of the mouth, gums or throat,

Flu-like symptoms,

Skin rash or itchiness,

Dark-coloured urine,

Yellow tinge in the eyes or to the skin,

Elevation in body temperature and local skin reaction to the injection.

Muscle effects that can occur with the use of depot neuroleptics include: spasms, rigidity, shaking or tremor as well as restlessness. Antiparkinsonian drugs are used to help alleviate muscle side effects (examples include procyclidine, benztropine, orphenadrine).

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