Integrated Care Team – Mental Health (Leicester City)

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Integrated Care Team Mental Health Team – historical context

- Funded since 2013/14 – started with one Band 7 RMN
- Aim to improve the access to mental health services for people (over 65) with frailty and/or long term physical health conditions and patients aged 18-64 with long term physical health conditions that are directly impacting on their mental health
- To promote mental health with the team being based in primary care
- Expansion of the service due to success – year on year increase in funding (Currently 19 Practices/ 24 Surgeries). There have been some challenges with recruiting to posts
- Use of a single Electronic Patient Record (S1) enabling direct communication with GP’s, Community Nurses and other community based health services
Who are the team?

We are a team of:

- 4 Mental Health Nurses
- 1 Occupational Therapist
- 1 Health Care Support Worker

Who refers to the team?

- All GPs/Practice Nurses from practices covered by the service refer through PRISM.
- Heart failure and respiratory health care professions based within acute care.
- Senior nurses for complex care based in primary care
- Care Navigators
- LOROS Specialist Nurses
- Re-referrals are accepted direct from patients or carers (GP made aware and agreement in place.)
Benefits of the Service

- Move away from disease focussed approach to more holistic care
- Enables early referral for a wide range of mental health conditions
- Comprehensive assessment and follow up
- Ease of referral/short waiting times (15 working days)
- Use of one IT system improves referral and communication
- Supporting carers
Benefits of the Service

• Improves MDT working-with community nursing and Care Navigators
• Appropriate signposting
• ‘Safety net’ on occasion until secondary mental health get involved
• Increased number of patients with previously undiagnosed dementia discovered.
• Patients with depression have had trial of at least two antidepressants prior to referral on for psych opinion
• Improved link with secondary care – referring appropriate patients
Team outcomes

The team receives approximately 30 referrals each month. In 2018/19 they assessed and discharged 310. There is an intensity of intervention for up to 12 weeks.

The following are the discharge outcomes:

- 67% were treated and returned back to the care of their GP without the need for secondary care
- 15% were referred onto memory services highlighting a potential early diagnosis of Dementia.
- 18% of discharge outcomes were due to various other reasons e.g. patient refused/CMHT referral/patient died/Psychiatrist opinion required

Additional outcome measures:

- Patient/carer feedback: FFT/ CQC contact with patients
- GP feedback
- Just starting to use: PHQ9 and GAD7 for patients with depression and anxiety
Team integration – onward referrals

- Social Services
- Care Navigators
- Breast Care Moving forward group
- Physiotherapy
- LOROS - specialist nurse
- Local lunch club
- Wheelchair referral - GP
- CLASP (Carers assoc.)
- DWP

- Day Centre
- Care Navigators
- Alzheimer’s Society
- Housing
- Podiatry
- Wheelchair Service
- Active Lifestyle
- Planned Therapy
- Stroke Association
- Cardiac Support Group
Case Example 1

Background
• 74 year old lady living with her husband
• History of Depression and Anxiety – Taking Citalopram 20mg
• Type 2 diabetic-poorly controlled on oral 3 agents
• Multiple admissions for non-specific abdominal pain-when metformin was stopped
• Poorly controlled diabetes and need to consider insulin
• GP referred to Integrated Care Mental Health.

Assessment
• Clinically Depressed – Poor appetite, disturbed sleep
• Low energy and motivation (stopped leaving the house)
• Negative view of the future – A sense of hopelessness
• Ideas that life not worth living but NOT suicidal. (Protective Factors)
Case Example 1 continued

Interventions

- Psychological Support – Counselling Skills
- Anxiety Management – Breathing exercises / Relaxation / Challenging Negative Thoughts
- Antidepressant Therapy – Switched from Citalopram to Mirtazapine –
- Referred to Care Navigator – Social inclusion
Case Example 1 - continued

Outcome

• Mood lifted – Patient no longer depressed.
• Anxiety reduced - More able to cope
• Started to go out – doing own shopping - joined local social group
• Blood sugars stabilised
• Insulin not required.
• Discharged back to the GP - saved referral to CMHT
Case example 2:

Background

• 87 year old lady living at home, caring for elderly husband who had a diagnosis of Alzheimer's, which has been identified by ICT-mental health and referred onto memory service for diagnosis.
• She had recently been diagnosed with Heart Failure – Struggled with symptoms and diagnosis.
• Reported increased problems with Memory.
• GP referred to Integrated Care Mental Health.

Assessment

• Evidence of Carer Strain
• Evidence of low mood
• Cognitive difficulties felt to be related to the low mood - not felt to be a Dementia.
Case example 2 cont’d:

Intervention

- Psychological support  Counselling Skills / Anxiety Management
- (Patient wanted to avoid antidepressants)
- Liaise with Heart Failure Nurse regarding support and education
- Referral to Alzheimer's Society (Carer Support)
- Referral to Clasp (Carers Association)
- Referral to Care Navigator: Sitting Services organised/Emergency Respite plan in place
Case example 2 cont’d:

Outcome

• Mood lifted – Patient felt supported and more able to cope with caring role.
• Memory improved – Saved referral to Memory Clinic
• Improved understanding of her physical health condition and future management.
• Discharged back to care of GP.
Any Questions.........

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