The *GPimhs journey: Developing primary mental health care in the Surrey Heartlands Integrated Care System

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*General Practice Integrated Mental Health Service
Why do we need to change the way mental health care is delivered?

• There is growing support for integrated physical/mental health care models

• Mental health needs of people not being met because they don’t meet criteria for services, or have complex health and social care needs

• Lack of knowledge in primary care about the availability of community & social care services
  • Under utilised

• Historical underfunding of mental health care across Surrey Heartlands
Why do we need to change the way mental health care is delivered?

- People with serious mental illness are dying young
  - FYFVMH Key Performance Indicator:
    - to increase physical health checks & access to interventions in primary care for people with SMI by 60%
- There is a gap between primary and secondary care:
  - There has been an increase in referrals not taken up by secondary care
  - people with SMI who are stable but remain under care of CMHT
- IAPT (talking therapies) access targets in Surrey are under performing – and there is capacity
- Right Care Prescribing data suggests that Surrey Heartlands ICS spend on anti-depressants is high
Co-designing the new model of care in the ICS:

• Summer 2018:
  • a series of multi-stakeholder workshops to co-design the new model of care
• September 2018:
  • successful Business Case awarded appox £1m
  • ICS Transformation funding
  • one year non-recurring
What did we do?

- Set-up a GP integrated mental health service (GPimhs) in 3 PCNs
  - one in each ICP across Surrey Heartlands
  - North west Surrey
  - Guildford and Waverley
  - Surrey Downs
- Established a GPimhs service that includes existing providers and new roles
- Currently referred into service by GP but looking to broaden to self-referral
The core GPimhs team

Fully recruited:
- Clinical Psychologist/Team Lead
- Administrator
- MH Practitioner
- Voluntary sector primary care link worker
- Psychiatrist: advice & guidance
- MH Pharmacist: advice & guidance, medicines reviews & optimisation
- Sessional IAPT LTC (co-location based on room availability)

In discussion:
- Interface with Social Prescribing
- Interface with Dementia Care Navigators
- Working with social care
- Peer support
New GPimhs Service to target Four cohorts

COHORT 1

People with unmet mental health needs that:

• Do not meet IAPT or CMHRS thresholds
• Use health and care services in a potentially chaotic pattern
• Find it difficult to access right services to meet their needs
• May have medication dependence, or co-morbid physical long term
• conditions that contribute to their poor mental health status
• Are ‘held’ by GPs presenting as frequent attenders, and who provide excessive proportions of non-medical short term prop-up interventions.
Cohorts Continued

COHORT 2
• People who are in recovery and “stable” in secondary care mental health services
• seamless step-up and step-down as required

COHORT 3
• People diagnosed for Dementia who have been transferred back to GPs
• May need more community and carer support

COHORT 4
• Supporting the delivery of physical health checks of SMI patients in primary care (a key MHFYFV deliverable).
Initial Focus on referrals for Cohort 1

- An extended assessment by a mental health practitioner with planned follow-up
- Access to psychology, psychiatry, voluntary sector, pharmacy
- Identification of appropriate services and support to access these.
- For example:
  - substance misuse interventions, Citizens Advice Bureau, benefits claimant processes, housing, DWP support, Social Care Assessment, Carers Prescription, etc
- Active case find people with an LTC and potential mental health concerns
- Identification of patients frequently attending GP-practices and A&E services
### Rational: Mental Health transformation as a national priority is an embedded component of transformation and investment plans in Surrey Heartlands. SHP is one of ten health and social care systems nationally to move towards integrated care systems status. Mental Health is described as a national priority within the national CQC HQI 2019/20 with expected delivery targets aligned to the STP. The Surrey Heartlands join is a process of transforming services to ensure better integration with primary care and locally to improve the quality of experience for people who use services and increase efficiency. There is currently not an integrated Primary Mental Health Care service in Surrey Heartlands and there is a need to provide better co-ordination and connection across mental health providers.

### Inputs
- What resources are needed?
  - New Investment to test & evaluate model in 3 PCNs
    - £977,700 (non-recurrent)
    - Recurring TDC
  - New Partnerships:
    - GPs
    - PCNs
  - Community Connections
    - Social Prescribing
  - Workforce per Primary Care Network
    - 9.30 Clinical Licenced Practitioner
    - 1.0 VTE Service Administrator
    - 1.0 VTE Mental Health Practitioner
    - 1.0 VTE Primary Care Link Worker (Community Connections)
    - 9.10 sessional Psychiatrist
    - 9.10 sessional Mental Health Pharmacists
    - Lead PCN sessional GP
    - Peer support
  - Cross ICT functions
    - 0.80 VTE LTC Access Coordinator
    - Project Management
    - Programme Leadership
    - Digital & Data expertise

### Activities
- What activities need to be undertaken?
  - Co-design a new & transformational model of integrated primary mental health in Primary Care Networks
  - Prioritize & segmentate MH patient population
  - Report new workforce to deliver X 35 Field Work Tests
  - Secure space in PCNs/GP Practices to deliver service
  - Establish & Information Sharing processes
  - Provide biopsychosocial assessment, needs and brief interventions with a focus on prevention & self-management
  - Provide practical advice, guidance & signposting to community, social prescribing & Care Act assessments
  - Joint planning and preparation of step-down for appropriate patients
  - Develop a peer support model
  - Create & test new approaches to improve access to IAPT for people with Long Term Conditions in the 3 PCNs
  - Case finding using algorithms, and collaboratively through CIC (regional and local prescription data)
  - Capture sufficient evidence to inform scaling & sustainable funding for the model
  - Develop communications materials & approaches

### Outputs
- What is produced through the activities?
  - A new model of integrated primary care mental health care that will provide lessons learnt on mobilization and modal outcomes, to inform the refinement of service offer and resources planning for scaling up the remain, PCNs in Surrey Heartlands
  - Improved relationships between primary and secondary care & IAPT care & better use of resources
  - Tacking the integration of existing services and streamlining Community Connections to improve co-ordination, flow and efficiency in the pathway for people with mental health needs in primary care
  - Improved patient flow between primary and secondary care – mobilization of patients easier
  - Improved knowledge and awareness of mental health needs among primary care professionals will ensure the models are embedded and scalable

### Outcomes
- What is the effect of the activities?
  - Reduced number of services & referrals for people with SHM
  - Reduced number of people with SHM who are discharged from hospital
  - Improved access to and integration of community services
  - Improved care pathways between hospital and primary care
  - Improved quality of life
  - Improved knowledge and awareness of mental health needs among primary care professionals will ensure the models are embedded and scalable
  - Improved quality of life

### Impacts
- What are we trying to achieve?
  - Improve efficient utilisation of resources through a prevention and early intervention approach that impacts on long term reduction in deterioration of mental health thus preventing higher cost of specialist interventions.
  - Improve outcomes for patients and carers.
  - Long term reduction in system costs due to integrated physical and mental health service impact on LTCs.
  - Workforce and an integrated model and experience improved working practices.
  - Embedding mental health into a physical healthcare environment in GP practices.
Key Challenges

• Data sharing:
  • Different IT systems
  • Significant lost months chasing an information sharing solution
  • highly mobile service working across several GP practice sites
Key challenges continued

• Workforce:
  • most roles have a 2 and 3 month notice period
  • workforce availability:
    • impact of developing a new service on the rest of the mental health system.

• PCN maturity:
  • very early days in developing collaboration and relationships between GP practices

• Premises:
  • Room availability
External evaluation process established:

• R- Outcomes and NAPC
• Improve access to physical health checks & interventions for people with SMI.
• Increase number of people with SMI who could be stepped down from CMHRS
• Increased access to IAPT for people with LTCs (e.g. Diabetes & COPD)
• Reduce avoidable presentations to A&E
Outcomes Continued

- Increase in medication reviews to reduce polypharmacy
- Improve access to community resources
- Reduce overall burden on GPs:
  - Reduce frequent attendances to GPs.
  - Reduced time GPs spend on non-clinical patient support
More Outcomes

• Improve workforce wellbeing, confidence and experience:

• Improve health status and wellbeing of people using the service.

• Provide a positive service experience for patients

• Increase the number of carers having their needs identified and being offered access to carer support.

• Increase carer wellbeing and confidence.

• Provide a positive service experience for carers

• Provide a positive experience of workforce integration in primary care.
### Patient Reported Outcome Measures

<table>
<thead>
<tr>
<th>How are we doing?</th>
<th>Excellent</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treat you kindly</td>
<td>3-5</td>
<td>1-2</td>
<td>0-1</td>
<td>0</td>
</tr>
<tr>
<td>Listen and explain</td>
<td>3-5</td>
<td>1-2</td>
<td>0-1</td>
<td>0</td>
</tr>
<tr>
<td>See you promptly</td>
<td>3-5</td>
<td>1-2</td>
<td>0-1</td>
<td>0</td>
</tr>
<tr>
<td>Well organised</td>
<td>3-5</td>
<td>1-2</td>
<td>0-1</td>
<td>0</td>
</tr>
</tbody>
</table>

### Carer-Reported Outcome Measures

#### Carer Confidence

<table>
<thead>
<tr>
<th>How do you feel about being a carer?</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I know enough about caring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I can cope well</td>
<td></td>
<td></td>
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<tr>
<td>I can get help if I need it</td>
<td></td>
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<td></td>
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<tr>
<td>I am involved in decisions</td>
<td></td>
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</tbody>
</table>

### Staff Reported Outcome Measures

#### Service Integration (staff view)

<table>
<thead>
<tr>
<th>How do you work with other services?</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services talk to each other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>We all know what other services do</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think about other services when planning care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel part of the overall care team</td>
<td></td>
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<td></td>
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</tbody>
</table>
The Model:

Integrated PCH-MH Service/Team

- Recognition, support & facilitate access
- MH Practitioners and others in service:
  - Case finding e.g. frequent attenders
  - Assessment & Formulation of needs
  - Brief Interventions & motivational approaches
  - Post Dementia diagnosis mental health support
  - Care navigation
  - IAPT LTC case finding

Community Connections Support Workers:
- Support & help e.g. benefits, housing, debt
- Help to access community resources
- Peer support approaches to be developed
- Catalyst drugs & alcohol support worker

Practice nurse/HCA
- SMI Physical Health checks
- Stable SMI patient LAI's/Depots

Medicines optimization
- Joint consultant/GP/MHP clinics

Other Services
- Integrated Primary Care and Mental Health
- Dementia Care Navigators
- P/Care Liaison PLD
- IAPT
- IAPT supported employment
- IAPT LTC
- Request for P/Care MH service, Allocate task, GP, Self, Carer

Secondary Care
- Single Point of Access to Secondary Care SPA
- Step Up Rapid Access to SABP

Social Prescribing
- Health promotion
- Recovery College
- IPS Employment

Surrey County Council
NHS

Surrey Heartlands
Health and Care Partnership
COHORT 1
Unmet MH needs in primary care. Not eligible for CMHRSS, not engaging or deemed too complex for IAPT. May include frequent or chaotic attenders, MUS etc.
Identified by GPs

COHORT 2
Step down Adult mental health
Long term stable patients. May require depots etc
Identified by CMHRSS
Model TBA with CMHRSS + GPs (with LCS?)

COHORT 3
Post diagnostic support for Dementia.
Early onset? MCI? Pop unclear.
Identified by older adults memory clinics.
(many services & pathways)
Mainly already catered for by dementia navigators

COHORT 4
Physical health of Adult Mental Health Patients
Leicester Screening tool
Identified by GP SMI registers
(already in place?)
MHP’s leading SMI audit and supporting HCAs

Key word is integration - aim of ease of access and light admin load – enabling GPs and primary care patients to benefit from input from the team at short notice.

- 1 Mental Health Practitioner - MHP (who has access to primary care & AMH systems) & 1 Community Connections worker per PCN.
- Access to service making full use of Emis Web for GPs to book their patients into 30 min consultation slots (admin light – can be face to face or phone – ideally 1 day pw per GP surgery) or for GP to access advice and guidance. Flexibility for MHP/CC to offer additional appointments if decided clinically needed (i.e. higher complexity / co-morbidity, complex dynamics, needing more time due to dementia / learning needs etc).
- GPMHs also provide training to GPs to support working with difficult dynamics in their consultations and part of clinical practice meetings.

Service able to support with
- Engagement & biopsychosocial formulation (time for the patient to feel heard and believed and understood, support to provide best understanding of their difficulty (moving away from diagnosis), how to support them get their needs best met). May include carers in this process.
- Bridging to other services such as IAPT / Social Prescribing / Carers support etc (more than signposting aiding their engagement and supporting patients self-efficacy).
- Employing brief interventions around Psycho-education / Solution focused / Motivational interviewing / CBT / relapse prevention.
- Supporting the GP-Patient relationship, potentially include joint 20 minutes consultation with GP and patient.

Joint consult with patient and GP/ indirect consult with GP
Support engagement with IAPT (not triage for AMH – use SPA)
Connections linking to 3rd sector organisation Inc carer support
Link to team pharmacist – advice & guidance + reducing polypharmacy
Link to team Psychiatrist – Advice & guidance Meds + Risk
Link to team Clinical Psychologist for extended assessment / support
Link to groups (e.g. STEPPS / Recovery college / Peer support)
Offer brief intervention (2-6 sessions max)
Offer follow up session (using recall as a safety net approach)
Joan – 35 years old

• Co-habiting and has young children. Some adverse early life experiences but enough protective factors.

• Low mood and anxiety in 20’s – treated by antidepressants. Becomes more socially isolated. Increasing frequency of GP visits – antidepressants increased, referred to IAPT.

• Additional life stressors – loss of protective factors (relationship break up / unemployment) – more socially isolated, increase in maladaptive coping (e.g. self harm, reliance on alcohol). Referred to CMHT – turned down as not meeting their criteria.

• Increasing medication, perhaps chronic pain presentation emerging. Referred to IAPT again, not felt helpful. Frequent appointments with GP. Joan start attends A&E at times of crisis.

• GP feeling overwhelmed, Joan losing protective factors and decompensating, future risks around harm to self and safeguarding for child.
Case Finding

- Frequently attending GP
- Frequently attending A&E
- Not meeting criteria for adult mental health services in secondary care
- Stepping down from adult mental health services.
Taking the cultural differences between primary and secondary care seriously

• Decades of history needs to be acknowledged
• Venting – frustrations in the system.
• Temptation to engage in splitting – jointly finding solutions
• Differing views on what constitutes high risk
• Challenge of how to bring people together under one roof
  • Being in GP practices
  • Shadowing GPs and Practice Nurses
  • Understanding the importance of the Practice Manager
  • Valuing difference
  • Joint consultations
  • Coffee club and Christmas parties
Easily accessible and light admin load

- Able to access specialist mental health support without a diagnosis or high risk.
- “No wrong door”
- Being in the GP practice and liaising frequently with other practice staff.
- Making full use of Emis Web to aid communication with record sharing with GPs.
- Not relying on a referral and discharge plan, long assessment reports and risk assessments that are not read.
Not duplicating other services or recreating a CMHT in Primary Care.

• Move away from a diagnostic / deficit model towards strengths based approach.

• Not ‘signposting’ – Bridging → understanding and containment.

• Core model of motivational interviewing & positive risk taking – together with psychoeducation and coping skills.

• Be Helpful!
Building good risk management into systems

• All requests for service are reviewed by a Mental health practitioner (Band 7).

• Team has access to both adult mental health and primary care records.

• MDT and peer support are key.

• Cultivate a relationship with local CMHT, A&E and Crisis services.
• “it has been helpful to know there are alternative help at the GP surgery”

• “I’ve been understood in ways that I haven’t before. I’ve been able to express myself in ways that I never thought I could due to my feeling being understood quite well. I feel comfortable being able to expose stuff that means quite a lot to me. I genuinely feel happy talking about my feelings today”.

• “I think this service is a very program to extend a helping hand to those who are having a hard time with emotional or mental health but are stable enough to take care of themselves.”

• “The service is brilliant!”

• “Worked together on a holistic approach with many options that I’m hopeful for an pleased with. Really value the engagement and hearing that my needs are being listened to. Thanks.”
‘Peter’ is a man in his 40’s who had been presenting regularly to his GP with various physical symptoms related to low mood and anxiety. He had been diagnosed with Autistic Spectrum Disorder several years beforehand, but reported that he hadn’t had any support or treatment beyond having been given the diagnosis. He had also lost both of his parents within a short space of time after his diagnosis, since when his functioning had reduced to the point that he no longer felt able to work. His job as a decorator had previously been valuable to him, particularly as his colleagues constituted his only consistent source of social contact.

During his initial appointment under GPimhs, Peter identified returning to work, increasing his social contact and managing and understanding his anger as recovery goals. Over the course of four sessions the Mental Health Practitioner (MHP) worked with Peter on grounding techniques to support him to manage his anxiety and anger during difficult moments as well as identifying the most appropriate external organisations to provide Peter with longer-term support and expert guidance. By the end of his contact with GPimhs (GP integrated mental health service), Peter had progressed to having been able to return to work with his old company for one day per week, with the intention of gradually increasing his hours, and having support in place from both IAPT and ASPIRE, a service provided by the National Autistic Society offering one-to-one support to help individuals with ASD understand how their condition affects them and build on their strengths in order to reach identified targets. Peter expressed feeling that he would not have been able to take the first steps in order to engage with these organisations, or to return to work, without the enhanced support offered by GPimhs, saying that: “It feels as though I’ve got someone on my side to help me on my feet a bit.”
What is the GP integrated mental health service?
GPimhs brings expert advice and guidance for emotional wellbeing and mental health issues into your GP practice, and can connect you with services to provide the support you need in the community.
We all experience difficulties in life. Sometimes we need more help in understanding and coping with these difficulties, especially when they begin to affect our general wellbeing, level of everyday activity, and personal relationships.

What can the service offer you?
- An extended consultation time with a member of our team so you have more time to discuss your concerns
- Quick, easy access to practical advice and guidance from our team
- Telephone contact or face-to-face meetings in a local GP practice

Who can use this service?
GPimhs is for anyone over 18 who is registered with a GP in the Banstead area. Difficulties people may be experiencing include depression, anxiety, stress, social isolation, problems in relationships, and physical health difficulties. We also seek to ensure that people’s wellbeing and independence are maximised by involving their family, friends and anybody who supports a person in keeping them well.
If it is felt that another service might better meet your needs, or if you are already getting support from elsewhere, it may mean that GPimhs is not the right option for you. However, we will work with you to think about this and find the best solution to meet your needs.

Where will your appointment take place?
You may be offered a telephone session or meet one-to-one for an appointment at the Banstead Clinic, The Horsehoe, 15 Bolters Lane, Banstead, SM7 2SQ. Please note parking for the clinic is in the car park opposite, and not in the on-site staff car park.

What can you expect?
Appointments will generally last for around 30 minutes, and we may offer you more than one. Each meeting is an opportunity for you to explore and make sense of the difficulties you are experiencing, and how they may relate to your physical and emotional wellbeing.

Who works with us?
GPimhs consists of a team of practitioners from different NHS and community backgrounds who are experienced in helping people with their mental health and emotional wellbeing.
You may have contact with our team administrator and be invited to meet with a member from the team, such as a mental health practitioner or community connections link worker. They will work closely with you so that you are supported with your difficulties in a way that feels best for you.
We can provide support in the following areas, which will be agreed in discussion with you when you meet us:
- Information and guidance around emotional and physical wellbeing
- More time to help make sense of difficulties
- Practical support to access community resources
- Brief interventions around ways of coping with stress and anxiety
- Access to mental health pharmacist
- Links to other mental health services and providers of therapy
- An ongoing plan that is shared with your GP