NHS
West Hampshire
Clinical Commissioning Group

Wellbeing Implementation Network (WIN) Co-Production Event

Developing Mental Health Support in Primary Care – Eastleigh Leisure Centre 21 March 2018

Time	Item	Lead
1pm	Arrivals, Tea Coffee	
1:20pm	Welcome, Introductions	Dr Katrina Webster
1:30pm	Introduction to Primary Care Mental Health	Jason Hope
2:00pm	Cambridge Model	Dr Katrina Webster
2:10pm	Nottingham Model	Jason Hope
2:25pm	Tea and Coffee	
2:35pm	Introduction to discussions, sharing local intelligence	Dr Katrina Webster
2:45pm	Discussion Group: Who will a primary care mental health service support	All
3:10pm	Discussion Group: What does a good primary care mental health service look like	All
3:45pm	Co-producing a Primary Care Mental Health Service: Next Steps	Jason Hope
3:55pm	Final Comments and Close	Dr Katrina Webster

Presentations

The workshop was introduced by a short presentation to give participants a clear idea of the scale of the service and where NHS funding for mental health services was allocated proportionately.

A short exercise was held to identify people's initial hopes for improved mental health support in primary care. These were as follows:

Hopes for a Primary Care Mental Health Service

- Seamless service with access to all other specialties to instantly support individuals adapted to their 'needs' at the time.
- Easily accessible services with minimal barriers to access (ie no long waiting times).
- Mental Health Practitioner available in every GP Practice.
- Primary care providing front door access to seamless services wrapped around the patient.
- Information / guidance on how I can help myself and what local support groups and community facilities are available which could help support my mental health.
- Primary care actually owns and gets resourced so that patients get local integrated personal support rather than fragmented, signposted care.
- To listen empathetically.
- Has closer connections with secondary care teams.
- Support for people who are repeatedly referred to secondary services but do not engage
- Outward looking – where individuals with substance misuse issues also get support
- More low level mental health support for GP's delivered in Primary care.
- Consistency of practitioner.
- Responsive and well informed
- Individual getting what they need from the right place in a timely way.
- A service that supports all areas of mental health.
- Compassion
- Service that addresses health inequalities and the socio-economic deprivation factors that might determine illness prevalence and health outcomes.
- Timely and appropriate support to allow me to become / feel well.
- Facilitate access to the right level of care that the individual needs.
- Very local groups easily access by primary care team.
- Inclusive
- A smoother link between GP and therapy.
- Increased joint working with third sector providers.
- To offer solutions to my problems
- Improved communication
- More time to talk things through.
- Accessible
- Has a subtle and sophisticated response that is flexible to the need of the individuals
- A service where age is not a barrier, neither is the ability to represent oneself.

- For care to be aimed and targeted to those most at risk eg identifying calls for help. This may mean services sharing information.
- Respect and continuality of care are most important. Allow patients to build a rapport. Follow through on actions.
- Timely, accessible, flexible, holistic, service based in GP Practice.
- That patients have the confidence to ask for what they need because they know what's available.

Workshop discussions

Two workshop sessions ran with 5 groups looking at two broad questions and key points emerged from the discussion as follows:

<u>What does Primary Care Mental Health look like?</u>

- In house evening and weekend support – extended hours hub – accurately signposting to services and increasing access.
- Having a service within allows more holistic care.
- Preventative – helps prevent escalation of patient towards acute intervention and assist the individual to self manage.
- MH care navigators? – bridge the gap if needed to access other roles. Would need to be senior enough to refer and have authority.
- MH café? – drop in?
- MH Nurses in every GP Surgery? – 1 day a week into surgeries / 20 min appointments – signpost or escalate referrals.

- Extended primary care team – assessor / coordinator to assist patient to help step-up / step-down within services.
- Primary care space / buildings / rooms – managed and funded by primary care as an extension.
- Short term support for those who need support when needed to signpost or assist with referral.
- Long term support if / when needed.
- Support to prepare for other services.
- Interface with secondary care where “immediate” action is required.
- Triage – supporting the ‘gap’ as a ‘wait’ on referrals – flexibly needs lead for individual and utilize third sector and other specialist / local services (ie dementia, DASH, neighbourhood care, wellbeing centres).
- Would need to be supported by good quality knowledge of non-clinical provision / other support.
- Good communication / overlap between primary and secondary care.
- Receptionist / nurses/ HC assistants have skills to identify MH problems
- Self and formal referrals.
- Accessible / flexible / affordable and understandable – option to not re-visit for a few weeks.
- Clearly promoted – people should know it is an option when speaking to the receptionist.
- Option of telephone assessments / online assessments.
- Technology enabled care.
- Reduce emergency admissions / attendance of A + E / early deaths – accessible in a crisis.
- Reduced or more appropriate GP time (similar to that of the physio pathway)
- Access to GP notes / part of GP team.
- Good relationships with local services – navigators.
- Peer support – informal support / formal advocacy / hand holding (go with them to group and to access services).
- Not bounced around between services.
- Pharmacy expertise
- Physical health
- Life skills
- Dietary and drug advice.
- Support for the staff.
- Champions within a surgery – GP’s, nurses, receptionists’ transformation teams – trouble shooters, know the services available, prevent admin post admissions.
- Managing expectations.
- Mindful of impact on other services – if an increase in signposting to somewhere else.
- Chaplaincy teams.
- Somewhere for a GP to refer to – not necessarily CMHT / AMHT – eg WBC + - in practice a local MH worker.
- Alternatives to a WBC for those who want to access something different.
- Counselling that is free at the point of delivery.
- Employment support – stigma reduction – build on the existing WBC capacity.
- Dual diagnosis.
- PTSD – EMDR

- One stop shop.
- Falling between gaps, not meeting eligibility criteria, maybe tried iTalk not worked, long waiting lists. Wellbeing is time limited.
- Consistent – 1 (service user) get completely different experiences from different GPs in same service – one 15 minutes and holistic, another just symptoms.
- Less intensive support, not under CMHT or service engaged in presentation – people who need small amounts of psychological support.
- People who need ongoing support for step down – ongoing support for a long term MH.
- People who need to help problem solving – identifying the problem and solving.
- People with long term conditions who are more prone to MH needs (training for practice nurses).
- Train and skill up the primary care workforce.
- End to the issue from the moment you get in touch with 'services'
- Appointments booked immediately (choose and book).
- Rough idea of what the plan will be for you.
- Service will be able to build trust with partners and individuals.
- Needs formal route for progression – a service.
- Development of skills in MH sector and other organisations.

Who will a Primary care Mental Health Service Support?

- People appear to be either too well or not well enough to get services they need.
- People who want to seek support as opposed to people who don't.
- Stable service users for ongoing management (stepping down).

- People with ‘less severe’ MH services.
- People with ‘more severe’ MH problems who need advocating for – can’t assume family could do this.
- First assessment primary MH service (starting point)
- Those with barriers to other services ie iTalk
- Those who do not engage with secondary MH care ?SMI ?dual diagnosis
- Co-morbidity physical health.
- Geographically isolated.
- Rough sleepers.
- Poor literacy.
- ESOL.
- Carers of both Physical and Mental Health.
- Transition – CAMHS, Younger Older, Older Younger / leaving home / uni
- Post prison
- Ageless
- Veterans
- LGBT
- BME, Travelers, Nepalese.
- Commuters / working people
- Post natal
- Personality disorder
- Self harming (MH resilience building)
- Leaving care
- Hoarders
- Supporting troubled families cohort
- People identified y other services.
- Everyone – excluding people in residential care / high cost placements.
- Need to look at those at risk – self referrals (such as iTalk) can be distressing so could have a ‘down the corridor’ service.
- People who have a mental illness but are challenged by housing, finance etc and not a mental health issue.
- 90% not in secondary care – people who have the challenges with housing, finance etc but have no support.
- Emotional needs but not unwell enough for CMHT.
- Discharged but needing ongoing psychological support but not iTalk
- People who are being held by GP’s whilst they are waiting for a specific service.
- People who need brief interventions but don’t need a secondary care service (Worcestershire Model – Senior triage nurse).

The Broad Discussion also raised other key points outside the questions

- Can be starting point, step down or ongoing.
- Really exciting thing to develop primary care and link with other services.
- What about the money – a day a week overwhelmed will be no good, no good to wait 6 weeks.
- About filling the gap and getting the right support, there a loads of gaps, difficult to focus. Is this a way of addressing.
- Could help to normalise mental health as a health issue – not just I'm unhappy, it's a health issue
- Communication important in lots of different ways.
- Signposting has to have up to date information.
- Managed and ongoing not just stopped or forgotten about because you've been discharged.
- Someone down the corridor could spend 20 minutes not 10 minutes – stop GP having to refer to service they don't know timeframe etc.
- If you don't engage with secondary care you will fall out of it.

Next Steps

The development of a primary care mental health service is a system transformation project.

- A project steering group including people with lived experience will be established to guide this work.
- A further event in September was proposed to consider options for a service model

Key actions and milestones will include: