A commissioner’s guide to primary care mental health

Strengthening mental health commissioning in primary care: Learning from experience
The London Mental Health Strategic Clinical Network would like to thank all stakeholders and partners for their time and commitment in assembling the primary care mental health guide.

A special thank you goes to all case study contacts for their contributions to the directory. The case study directory is a rich resource for commissioners and others, which would not have been possible without the many submissions – some at short notice!

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In setting up London’s Mental Health Strategic Clinical Network it was clear that something different was needed; something that represented more directly the different narratives that exist around mental health and illness. Primary care is one of the most important of these and I think that this publication goes a long way to showing why that is. Mental health and wellbeing are central to the work of GPs, and high quality primary care is critically important for the health of local communities.

Indeed we are, in many ways, at a moment of real possibility in relation to mental health. Increasingly, a body of ideas is being shared that together represent a coherent direction of travel. Care and support moving further out of hospital towards home; moving from prescription to partnership in working with empowered citizens and patients; seeing the development of resilience and health promoting communities as key ingredients for real population health; working towards holistic approaches that bridge the mind-body divide that we have artificially created.

In these pages we see not only just how much work has already been done but how much there is to be done. Primary care is most people’s first point of call in times of healthcare need, and this is no less the case when the problem is emotional or psychological rather than physical.

I am overwhelmed by the volume of good practice we have been able to collect and impressed by the quality of experience it shows. An important part of spreading quality innovation in the NHS is our ability to share and inspire others, not to reinvent the wheel when others have a solution to the issues we face. I hope that this paper leaves readers feeling energised and inspired to take this challenge on – for the benefit of the people we serve.

Dr Matthew Patrick
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Chief Executive, South London and the Maudsley NHS Trust

Preface

Mental health’s time has come.

No longer is it good enough for mental health to be the poor relative of physical health. No longer is it acceptable for there to be no parity of esteem.

Many courageous people are starting to speak out about their lived experience of mental health problems. That is really good news and commissioners need to respond by transforming the nature of the services delivered for mental health to settings that help to destigmatise and enhance access for the millions of ordinary people and their carers who have a mental health condition.

It is time to stop the short term approach of simply treating the problem when it presents and become more proactive about prevention and early intervention. That means working with schools, colleges and universities, employers, transport, police, local authorities and community organisations to raise the profile and priority of good mental health and early action if there are signs of difficulties in any individual.

It is time to stop accepting second best in mental health services and work with those who have lived experience to design better services together.

It is time to shift care into the communities where people live by increasing primary care mental health services and supporting specialist care - absolutely essential for many who have episodic crises or enduring severe mental illness - in moving to community environments with close links to primary care. We all need specialists to be freer to respond when there is need.

It is time to act and do what the evidence shows. This guide will hopefully support and provoke us all to do just that.

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EXECUTIVE SUMMARY: Lessons for Commissioners

There are pockets of good practice being performed regionally, nationally and internationally. It has however been difficult to capture this exemplar work in one place for all. This ambitious guide attempts to start this process.

Case studies have been collected including initiatives and projects demonstrating various different approaches to service redesign, partnerships and methods – not to immediately benchmark quality or set standards but to highlight and share advice on approaches that have worked, ones that have failed and to crucially start conversations which will lead to transformational change.

Ten lessons have been derived from 64 international, national and regional case studies. Lessons which cover community based care, proactive wellbeing, accessible services and coordinated mental healthcare.

A resource of approximately 60 case studies have been compiled into a directory and expanded further into detailed one page accounts explaining the aims, development and outcomes of the initiatives, challenges faced, top tips for commissioners and named contacts. This will assist readers to make positive changes in primary care mental health, benefiting their local population mental health care needs.

Community based mental health care
Delivering proactive care: Supporting health and wellness, self care, staying healthy

1.) Local champions drive forward implementation
   - Proactive approach to developing GPs and others as mental health leaders
   - Role for them in influencing local authorities and voluntary sector, working with people who use services
   - A consistent figure around for the long haul

2.) Effective Health and Wellbeing Boards can be enormously helpful
   - Can help to provoke change and plan for delivery
   - Oversight of health, social care and public health budgets
   - Requires time to build an effective relationship

3.) Primary care education and training will enable change
   - Upskilling of primary care key to success
   - Base and build on existing GP and practice nurse skills
   - Build into workplace and practical experience

4.) Money needs to move with the patient
   - Enable money to follow the patient, as part of a system change
   - Use the Better Care Fund proactively
   - Identify savings from reducing use of acute services

5.) Co-production will deliver ownership by people who use services and carers as well as better services
   - People who use services are best placed to determine what works best
   - Harness families and friends and social networks
   - Harness the experience of the voluntary sector
   - Cover the whole pathway – from design to monitoring

Accessible mental health services
Delivering accessible care: Responsive, timely and accessible service responding to care needs

6.) Services need to cover all ages
   - Ensure smooth transition between services – young to adult, and adult to older people.

7.) A mosaic of services needs to be provided to wrap around individuals and carers
   - Support individuals, carers and professionals to navigate through statutory and voluntary sector provision
   - Support effective co-produced care planning
   - Build and maintain relationships to be aware of the variety of services available locally

Coordinated care integrating primary, community and secondary care
Delivering coordinated care: Patient centred care, coordinated care, GP continuity

8.) Specialists’ time should be freed to look after those with complex needs and to be available for rapid advice and help for primary care
   - Focus specialist resource on people with more complex and immediate needs by enabling people with stable conditions to be supported by primary care,
   - Ensure simple process to enable patients to move between primary and specialist care
   - Use collaborative relationships for shared learning and care

9.) IT-enabled communications between primary care and mental health is vital for a fully functioning service
   - Vital to ensure good communication between primary and secondary care for patient safety, service quality and patient experience
   - Work-arounds exist that can be used before a fully integrated IT system is developed
   - Improved IT system aids collecting data about activity, quality, and outcomes

10.) Managing long term conditions
    - All services share the responsibility of improving physical health of people with mental illness
    - Care plans that are co-produced, holistic, first person singular and recovery focused, and include social care
    - People seen as part of their social system or network and not in isolation
Mental health’s time has come.

There is a growing passionate army of GPs, specialists, other professionals in health and social care, voluntary organisations, patients and carers working hard to improve mental health and transform mental health services.

Mental health is a current ‘high visibility’ topic in the news and in the NHS. The government’s 25 priorities for change in mental health set out a comprehensive programme of relatively short-term transformation. NHS England’s work on parity of esteem focuses on valuing mental health equally with physical health, echoed by a Royal College of Psychiatrists’ paper. The Royal College of GPs has published resources and tools on mental health to support practitioners. Resources include reports, audit papers, frameworks, useful websites, fact sheets, patient information, e-learning links and references to relevant NICE guidance. Celebrities and MPs are increasingly being open about their lived experience of mental health issues and how they have coped with accessing support. Many equally courageous service users are speaking out on TV and radio about their conditions calling for earlier and better treatment so that they can remain productive citizens.

This guide is intended to provoke and support clinical commissioners to champion effective primary care mental health services. The guide is written specifically for mental health commissioners and practitioners and could be a useful resource for other commissioners and providers too.

Where should mental health care take place?

The National Service Framework for Mental Health discusses the configuration and relationships of mental health services. The paper states that ‘mental health services represent a continuum from primary care to highly specialised services’. That continuum however has often been disjointed and ‘clunky’ which has resulted in discontinuous care for patients and carers. GPs and other professionals have found access to services difficult and management across interfaces and boundaries at times impossible. Mental health providers have found their case loads full and have had to decline further referrals. Seventeen years on and these issues remain.

The use and allocation of resources is also disjointed. Across the country there is major variation but in the main, the majority of the mental health spend is on inpatient and specialised care. One south west London CCG’s expenditure figures for 2013/14 reveal 73 per cent of the total mental health expenditure was spent on secondary care services and 20 per cent was spent on specialist tertiary care services compared to 7 per cent spent on primary care services. In London, 90 per cent of people with a common mental disorder are cared for entirely within the primary care sector. These figures seem to be fairly typical across the country. Whilst specialist services care for people with more complex conditions and is therefore understandably higher cost, the figures are stark enough to cause us to reflect.

There are confounding effects on the figures. Exclusion rates for the general practice Quality Outcome Framework (QOF) serious mental illness register vary widely. There is wide variation in who does the physical health checks for people with serious mental illness from mainly mental health trusts to mainly general practice. Clearly high levels of QOF exclusions do not help to ensure the reduction in the excess burden of long term physical illnesses.

The national context is that access to effective care for people with mental illnesses is only available to approximately 30 per cent of those that need it, and standards of care across the country vary greatly. Fifty per cent of all mental ill health has started before age 14 and yet investment in prevention and early identification and children and young people’s services is limited.

Mental health problems form a large and growing proportion of primary care presentations: one in three GP appointments involve significant mental health issues. Common mental health problems include depression and other affective disorders, some people with learning difficulties, eating disorder, perinatal conditions, substance misuse (particularly alcohol misuse), dementia and severe mental illness. The general view is that there needs to be a shift from bedded care towards community based care where there is support from multi-disciplinary and multi agency teams. The extent to which this shift has occurred varies widely across the country.

As a sector, mental health has led the move away from hospital care to home based treatment by intensive community teams, usually multi disciplinary, but increasingly multi agency, to drive recovery.
What is primary care mental health?

Primary care is the first point of contact with a patient, delivered by general practitioners and other health professionals. After families and friends, it is most people's first point of call in times of healthcare need. One in four of the population will need treatment for mental health problems at some time in their lifetime and the majority of these will be managed in primary care. The GP and practice nurse are at the centre of providing whole person care which meets the health related needs of the patient. Increasingly this includes promoting health and engaging with social care and the wider determinants of health.

Primary mental health care is a relatively recent concept in health care. It is defined by the World Health Organisation as:

- First line interventions that are provided as an integral part of general health care, and
- Mental health care that is provided by primary care workers who are skilled, able and supported to provide mental health services.

Prevention and early intervention in primary care

To successfully address the issues and challenges of parity of esteem and improving patient outcomes, the focus must be around prevention and early intervention. Early diagnosis and efficient and effective management of mental health issues have been linked to high quality outcomes and value for commissioners. This will play a central role in primary care settings. Restating some of the priorities from this and other papers suggests that action should include:

- Preventing illness from occurring in the first place (tackling the causes through local mental Health and Wellbeing Board programmes, identification of high risk groups, self referral routes, and preventative interventions)
- Early identification and treatment (integrated perinatal care, evidenced based treatments and choice of intervention)
- Promotion of recovery and management of long term conditions whether physical or mental (people with mental health problems have higher rates of physical illness and lower life expectancy. For mild to moderate mental health conditions this can be up to 19 years lower than the general population). The government strategy aims to empower individuals and their families, looking to communities to promote independence and choice. It suggests that people with mental health problems have higher rates of physical illness and lower life expectancy. For mild to moderate mental health conditions this can be up to 19 years lower than the general population. The government strategy aims to empower individuals and their families, looking to communities to promote independence and choice. It suggests that people with mental health problems have higher rates of physical illness and lower life expectancy. For mild to moderate mental health conditions this can be up to 19 years lower than the general population. The government strategy aims to empower individuals and their families, looking to communities to promote independence and choice. It suggests that people with mental health problems have higher rates of physical illness and lower life expectancy. For mild to moderate mental health conditions this can be up to 19 years lower than the general population. The government strategy aims to empower individuals and their families, looking to communities to promote independence and choice. It suggests that people with mental health problems have higher rates of physical illness and lower life expectancy.

- Medically unexplained symptoms

Patients and carers should be empowered to lead independent lives and take control of their health, to learn and be able to work in safe and resilient communities. Good mental health and resilience are fundamental to physical health outcomes, relationships, work, education and achieving our potential. No Health Without Mental Health clearly sets out that preventing illness, promoting good health and intervening early if a difficulty develops will improve both patient and carer well-being and reduce costs associated with mental health. Approximately £7.5 billion is spent each year to address mental ill health in London. This includes spending on health and social care to treat illness, benefits to support people living with mental ill health, and costs to education services and the criminal justice system.

Managing physical and long term conditions in primary care

Managing people with long term conditions remains a priority for clinicians. Research suggests that, for mild to moderate mental health conditions such as depression, there are considerable improvements to be made within general practices. Many GPs with their practice teams have the right skills but lack the support, confidence and time to use them. They are also unclear as to what their role is in managing the care for people with depression. This report on managing people with long term conditions states the need for clinical education and training around long term conditions, as well as building collaborative care models with specialists and tackling social attitudes and stigma.

It may be time to look at enabling longer consultation times as the care of more people with mental ill health shifts to a primary care setting. It may even be that elements could be achieved through the co-commissioning of primary care by CCGs and NHS England.

More than four million people in England with long term physical health conditions also have a mental health problem. A recent King’s Fund paper sets out that healthcare for people living with co-morbid conditions could be improved by:

- Integrating mental health support with primary care and disease management programmes.
Improving liaison psychiatry provision in acute hospital ward and clinic settings
» Providing basic mental health skills and knowledge training for health professionals
» Removing barriers to integration through redesign of payment and incentive systems to ensure they are aligned across secondary, community and primary care

Data systems need to become more sophisticated and equipped to integrate data sets and give commissioners an overall understanding of the individual’s health. CCGs should work closely with local providers to integrate mental health and physical health strategies to improve the productivity and quality of mental health services. The new technology revolution now provides greater opportunities for patients to learn about and engage in their own care through the increased use of apps, guided learning and self-healing tools.

Primary care mental health commissioning

In 1984, a survey examined the extent to which mental health professionals had moved to work in primary care26. This found that almost a quarter of all consultant psychiatrists were spending at least one session a week with primary care colleagues. Three models of these shared care services were then common:
» Shifted outpatient model
» Consultation liaison model
» Shared treatment model

There is no standardised model for commissioning or the provision of primary mental health care services. Now that robust local information on levels of need is becoming available, matching that with local and, cultural contexts and commitment to a shared vision between partners will reap benefits.

Evidence shows however that general primary care systems in the UK perform highly when compared with other international systems22. London in particular has many examples of best practice in general practice24. These examples will be referred to later in this guide.

Recent policy imperatives make provision of good quality mental health care services a priority for CCGs including an emphasis on providing care as close to patient’s home as possible and incorporating patients views into their care plans. Taking into consideration patient and carers preference for treatment within primary care where the environment is less stigmatising, physical and mental health care can be more easily delivered together. A report by the Mental Health Foundation in 200727 raised a number of concerns about the availability and quality of mental health care. Often this came down to a lack of parity between physical and mental health. There is also insufficient education and training for primary care staff to deliver best quality mental health care. The lack of a national tariff for mental health services made it hard to identify cost savings by moving services from hospitals into primary care. Some of the same themes were picked up by the King’s Fund report this year28.

One of our opportunities is that we have extremely diverse communities and boroughs across London. This means that across the CCGs, many models and configurations of services will emerge in response to the challenges general practice faces.

Removing the barriers between primary and secondary care will be key. Primary care has a leading role to play in the development and delivery of integrated care systems across London. Well-commissioned primary care services should be valued based, age inclusive, integrated (secondary, tertiary, social and spiritual care), holistic, preventative, linked with community, voluntary and faith sectors, focused on recovery and anticipatory29.

A report from the Nuffield Trust30 examined a number of configurations such as: accountable care organisations, community health organisations with patient facilities, regional and national multi-practice organisations, marginalised groups, networks of federations, professional chambers, specialist primary care, super partnerships, super partnerships with inpatient facilities and vertically integrated systems. They concluded that whilst scope and scale was important, the choice of different models, no single model for delivery should be advocated outside of the local context.

In the US, innovative delivery models have been developed in line with the patient centred medical home model which is defined as ‘an approach to provide comprehensive primary care which facilitates partnerships between patients and providers and the patients’ families31’. Models in development have been based on:
» Patients having an ongoing relationship with doctors trained to provide primary contact, that is continuous and comprehensive
» Doctor led practice team approach, a whole person orientation
» Coordinated and/or integrated care across specialist, hospital and community agencies
» Quality and safety assurance by a care planning process, clinical decision support tools, information technology, quality improvement activities

NHS England London Clinical Board for Primary Care Transformation has drafted primary care standards in 2014 including:
» Proactive care: supporting health and wellness, self care, staying healthy
» Accessible care: responsive, timely and accessible service responding to care needs
» Coordinated care: patient centred care, coordinated care, GP continuity

These themes will clearly be seen running through this guide and will be an important part of recommendations made and lessons learned.
LEARNING FROM PRACTICE

Developing the lessons

From each case study where a new, innovative or redesigned service has been set up or piloted, valuable lessons are captured. The lessons in this paper have been derived from 64 international, national and regional case studies. These lessons and examples can be modeled as good practice, as examples of an attempted approach, a method to avoid or as general tips and advice on how to make a service enhanced. The report is designed to be used as a trigger to start conversations or begin the process of enabling change or service improvement locally.

The lessons are grouped under headings which are closely aligned to the primary care standards developed by the NHS England London Clinical Board for Primary Care Transformation.

Headings include:
- Community based mental health care (delivering proactive care)
- Accessible mental health services
- Coordinated mental health care

Each lesson provides:
- A brief summary of the lessons learned
- Ideas on how to minimise the problems
- Examples of where this has come out of projects
- Cross referenced to case studies

There are approximately 60 case studies within the ‘directory’ (located at the end of the guide) which have been expanded into consistent detailed accounts explaining the aims, development and outcomes of the initiatives, challenges faced, top tips for commissioners and contacts. Named contacts have been identified for readers to speak to directly to follow up.

This is designed to be a useful resource to assist and enable readers to make positive changes in primary care mental health, benefiting their local population mental health care needs.

COMMUNITY BASED MENTAL HEALTH CARE

More secondary mental health services need to be community based with reduced reliance on bedded care and on-going secondary care which should release resources to achieve it. This must include improved management of long term conditions (including dementia, and mental health conditions as well as physical conditions) and an ongoing review of the quality of the outcomes. While less reliance on secondary care is needed, continued community access to specialist expertise is essential and one of the aims of redesigning care delivery.

A fundamental shift in focus is required which will have an impact on the infrastructure including workforce, IT systems and estate and therefore this requires some medium term planning. However, as evidenced by the case studies, there is every reason to make a start.

Alongside this shift, there is a need to improve the prevention of mental health problems through education, work with employers and community groups, effective early intervention and the reduction of stigma that often is a barrier to seeking help.

Lesson 1: Local champions drive forward implementation

What has worked well

Those projects that have been most effective in delivering a sustainable change in service delivery have been marked by having a local champion. The most common model is a GP commissioning champion who has the drive and energy to pick up and run with primary care mental health in and across CCGs. Often such a GP carries long standing local historical knowledge.

Many such GP champions have started out with little more than their passion and enthusiasm and have learned their leadership skills as they go. For the future we need to be proactive about developing GPs and others in mental health leadership. The London mental health leadership development programme, now being rolled out elsewhere in England, will play a vital role in achieving this.

GP mental health champions also need to be adept at influencing the local authority and voluntary sector as well as working with people with mental illness, carers and the local population. A common theme is that local people tend to respond to their passion and persistence as much as the details of the plans they bring.

Persistence is key. In many cases, the build up to implementation will suffer set backs, delays and opposition. This is where a consistent figure that is around for the long haul seems to have proved so essential. From the case studies it is clear that any local leader needs to be backed up by a ‘tenacious steering group’. They can also act as an enabler for staff at all levels in commissioning and provider organisations to be involved in redesigning services.

If synergy can be created with leaders and people with lived experience of mental health within the local authority, be they councilors or officers, through HealthWatch and in practices and the local community, change becomes much easier to achieve. Others, such as practice nurses, are effective at championing the cause of improved mental health.

The mental health challenge asked local authorities to nominate a councilor as a ‘member champion’ for mental health in return for which they get information, advice and a network of other champions from the Centre of Mental Health and the other national charities. There are currently approximately 26 councils involved and numbers are growing.

Another area that requires champions is the mental health needs of armed service veterans. A great deal of work is going on through the armed forces networks and should not be forgotten when we consider GP champions.

What to avoid

There is a danger of GPs having management tasks loaded onto them for which they are not necessarily best equipped. This can be avoided if there is a close relationship built between the clinical commissioner and their manager colleagues. The alignment of tasks with skills will enable change to occur more rapidly.

"Dedicated GP leadership is crucial.”

– Croydon QIPP project
Many GPs learn most effectively when the training is aligned with the function they are carrying out. Trying to train in advance is often frustrating and ineffective. Work-based learning backed up by education packages where GPs learn by getting on with projects seems to be acquiring evidence of effectiveness.

There are some areas where there is either no GP mental health leader or a GP with time too thinly spread to be effective. There are many excellent examples of GPs who have made serious strides and it is worth contacting them (see case studies) to learn from them.

### Tower Hamlets mental health in integrated care
(Case study 19)

This initiative aimed to develop a recovery orientated primary care mental health service to support the discharge from secondary care. GP leadership and engagement with other clinicians were essential in succeeding this.

### Lesson 2: Effective Health and Wellbeing Boards can be enormously helpful

**What has worked well**

GPs are not always clear on the role of Health and Wellbeing Boards and struggle to engage with them. Those with good experience find they can help provoke change and planning to help delivery, and report that the development of robust relationships is key to their achievement.

Health and Wellbeing Boards can be really helpful when they have a shared vision for primary care based mental health and support the implementation of transformational change. This involves taking a wider perspective of budgets for mental health across CCGs, local authorities and public health. The most effective areas manage this in a joint way, often using joint commissioners. Ultimately pooled budgets are the destination but fewer places have achieved this to date.

Of particular concern is to ensure public health engagement since their transfer to local authorities. The benefits of winning good relationships and their support for transformation as fully engaged partners are worthwhile.

**What to avoid**

The expectation that an effective Health and Wellbeing Board can be affected quickly is likely to lead to significant disappointment. All the examples where this is working well indicate that considerable effort and time is required to build effective and working relationships and it is worth bringing them along with you in your planned changes where you can.

In addition, health staff (clinicians and managers) need to seek to understand some of the different culture and language of local authorities in order to become a useful partner and contribute to debates and priorities. Understanding the different pressures on officers and members is useful in making a Health and Wellbeing Board truly joint.

The shared vision of transformed mental health services helped achieve extensive engagement of GPs, health and social care professionals, people with lived experience and carers. The joint impetus this provided enabled more rapid change in mental health services.

### References to case studies

- Croydon primary care mental health support QIPP project 2013-14 (Case study 1)
- The Esteem Team (Case study 5)
- Starfish: Health and wellbeing | Stafford and Cannock deliver this approach IAPT plus (Case study 59)
- Tower Hamlets mental health in integrated care (Case study 19)
- Newham primary care psychological services (Case study 57)
- Greenwich and Oxleas Outreach Educational Model (Future case study submission to be added)
- The Mental Health Challenge (Future case study submission to be added)

### Kingston Health and Wellbeing Board
(Case study 4)

In Kingston several years of relationship building and working together on the ‘knotty issues’ enabled early establishment of the board and the formulation of shared priorities, one of which was mental health.

The shared vision of transformed mental health services helped achieve extensive engagement of GPs, health and social care professionals, people with lived experience and carers. The joint impetus this provided enabled more rapid change in mental health services.

**“Alignment with Health and Wellbeing Boards enabled commissioners to deliver change.”**

- Kingston CCG

### References to case studies

- Kingston Health and Wellbeing Board (Case study 4)
- Lambeth and Southwark wellbeing programme (Case study 43)
Lesson 3: Primary care education and training will enable change

What has worked well

People with mental ill health and their carers tend to complain of the lack of consistency in primary care when it comes to mental health clinical expertise and knowledge of services. Those who have implemented primary care mental health all identify the upskilling of primary care as a key to the success. This relates to the capacity, competence and confidence of primary care practitioners. GPs will have existing skills as a base upon which to build the education and training. Experience also suggests that learning needs to be embedded in the multidisciplinary teams, especially practice nurses who often undertake the routine checks for both physical and mental health. There may also be opportunities to add training for community pharmacists to help them identify when there is a need to encourage people to engage with their GP.

Specialists also need reassurance that their primary care colleagues are competent to manage patients they return to primary care.

“The right training, development and support could be the major factor in improving emotional health.”

– Sandwell IAPT Lead

They return to primary care.

That their primary care colleagues identify when there is a need to encourage people to engage.

Finally, creativity is needed to provide good education and training, using opportunities to base it in the normal work place based experience of practitioners.

The Joint Commissioning Panel for Mental Health suggests that the primary care team needs to work proactively with sub-populations and vulnerable groups at risk of mental ill health, including those unemployed, low income families, elderly, those with long term conditions, people with protected characteristics, as well as with carers and patients’ relatives. They recommend the multi-disciplinary teams should comprise of:

» GPs, practice nurses and health visitors
» Primary mental health clinicians (psychological wellbeing practitioners and high intensity therapists)
» Improved Access to Psychological Therapies workers (mental health GP advisors with links with housing, welfare benefits, addiction services)
» Integrated specialists (primary care liaison psychiatrists and community practice nurses)
» Local authority workers - includes social workers and mental health workers but extends to housing, leisure, education and training, employment, etc.
» Third sector providers/social enterprises including faith groups
» Other community based non-specialist practitioners- school nurses

They go on to propose that teams will need support and the capacity to deliver:

» Case management
» Peer mentorship, social prescribing, health training
» Cognitive Behaviour Therapy
» Low intensity interventions
» High intensity interventions
» Collaborative care with psychiatric/acute liaison services

What to avoid

There is no substitute for a structured and comprehensive approach to the training and education of primary care - avoid just doing it once without regular updates, or in a vacuum. It is much better achieved by educating clinicians as they get on with the job.

Creating the competence and confidence without providing the capacity is likely to lead to a group of well trained but frustrated clinicians. Ensure the funding of their time runs alongside the education or build into existing programmes that allow this.

Service user and carer experts
» Managerial support

The Sandwell lead GP worked with Primhe (Primary Care Mental Health and Education) to set up accredited training in mental health for GPs (and others) to diploma level. The course delivered competencies for a GP with a special interest in mental health as well as training in wellbeing and prevention. Following the initial training, regular updates are provided. It has been found that once a GP from a practice is trained confidence improves in the practice resulting in a reduction of around 50 per cent of referrals into secondary care. The comprehensive nature of the training has empowered the GPs.

References to case studies

» Education and training for frontline staff in Camden (Case study 23)
» Bespoke mental health and wellbeing training package for practice nurses (Case study 39)
» Primhe RCGP and uUniversity accredited diploma in primary care mental health (Case study 7)

The Sandwell integrated primary care mental health and wellbeing service (Case study 6)

» Peer to peer education through youth radio broadcasting (Case study 58)
» Mental Health CCG Leadership Programme (Case study 37)

Primhe RCGP and university accredited diploma in primary care mental health (Case study 7)

» Ongoing programme of education in diabetes for care coordinators (Case study 29)
» Mental Health First Aid Lite (MHFA Lite) (Case study 52)
» Developing a mental health triage service in primary care (Case study 10)
» Sandwell integrated primary care mental health and wellbeing service (Case study 6)
» Parental mental health (Case study 42)

» Oxted NHS Foundation Trust GP master classes held in Bexley, Bromley and Greenwich (Future case study submission to be added)
Lesson 4: Money needs to move with the patient

What has worked well

The challenge for commissioners is how to ensure funding is available to enable the movement of care from specialist to primary care. There is a growing body of opinion that this is best achieved as part of a system change whereby more of the specialist mental health services are transferred to a community setting, freeing some resource for use in the transfer to primary care.

A national DES for the national management of anxiety and depression and possibly serious mental illness is also being proposed in order to assist in the delivery of good primary care mental health care.

In some areas the Better Care Fund is being seen as a potential source of savings to help make the case for moving funds.

What to avoid

The experience of pilots is that trying to create primary care mental health without appropriate funding of the service is unlikely to be successful, much less sustainable. The issue of funding therefore needs to be addressed at the stage of project planning and dealt with in a transparent and robust manner.

It has also been found that a trial of a service that does not succeed, for example due to lack of resources, makes the next attempt more difficult.

Lesson 5: Co-production will deliver ownership by people with mental illness and carers as well as better services

What has worked well

All areas that have been early adopters of primary care mental health services report that the involvement of people with mental illness, carers and others in the design and delivery of services has been a key factor in success. Harnessing families and friends and social networks will add to the comprehensive view of service design.

Achieving co-production requires a great deal of effort and, sometimes, there is a perception that it slows down delivery due to the considerable effort required to fully engage individuals and carers. But the time taken is repaid in the quality of the product, and ownership of people with mental illness and their carers through the influence they have had in shaping it.

Voluntary sector organisations have considerable experience in facilitating co-production and can be engaged to achieve this. The Centre for Mental Health is training local HealthWatch champions. GPs are often very experienced at talking to groups of people to ensure their views are taken on board. Some relate very effective experience of engagement that can be very challenging too. However, without understanding the narrative of people’s experiences, change will be less effective.

If procurement is needed, users and carers should be fully engaged in all aspects of the process from the specification to the tenders, interviews and decision making. Experience from many sectors sees the value of this.

This engagement needs to continue through to operation. Data on performance of a service is important and it needs to be aligned with patient and carer narrative if it is to be fully rounded.

What to avoid

» Involving users and carers too late
» Assuming you can involve them without considering the cost to them
» Involve will often require some training in aspects of the task
» Ensuring ownership from a wide spectrum of mental health users rather than a ‘chosen few’

References to case studies

» Croydon primary care mental health support QIPP project 2013-14 (Case study 1)
» Severe mental illness local enhanced service (Case study 11)
» Development of a local enhanced service for serious mental illness in Brighton and Hove (Case study 25)

Service user involvement in mental health commissioning (Case study 22)

In east London a service user group, hosted by a voluntary sector organisation, were commissioned to develop a training package. The group contributed to an excellent prescribing project posing very good challenges for the mental health provider to respond to. In addition the group was involved in developing CQUIN proposals this year (2014) and has been instrumental in designing a new set of inpatient standards.

Applying value based commissioning to mental health in Camden (Case study 24)

North central London engaged in a developmental programme of value based commissioning that involved the co-production of outcomes that matter to people with mental health problems.

References to case studies

» The Esteem Team (Case study 5)
» Service user involvement in mental health commissioning (Case study 22)
» Applying value based commissioning to mental health in Camden (Case study 24)
» Primary care mental health forum (Case study 33)
Primary Care Mental Health

Accessible Mental Health Services

Lesson 6: Services need to cover all ages

What has worked well

Many practitioners identify a concern that there is fragmentation of services on the basis of age. Already there is national progress toward a fuzzy edge between children and adolescent mental health services (CAMHS) and adult services so that between 16 and 25 years appropriate transition is arranged. Equally, care of older people has been defined by age rather than condition. In primary care, the age will be of little consequence and appropriate and timely intervention is what counts.

It has not been possible to find a case study where a truly all-age service is being implemented. Many aspire to this. There is real progress in areas to produce an adult service that does not identify age as a criterion but manages people on the basis of their conditions and needs. Others are keen to extend this approach to children and young people and avoid some of the transition problems that exist. However, there is variation about who commissions children’s services. In some areas it is done by children’s commissioners and in others by mental health commissioners. The challenge is how the service is prevented from being fragmented and provides excellence quality for all ages with smooth transition through all phases of need.

The aspiration extends beyond services to outreach (eg to schools and the workplace) and the development of prevention to create resilient mental wellbeing. Some progress is being made across the board and much more remains to be achieved.

“‘The Big White Wall aims to increase access to mental health services, particularly for groups who have lower levels of service use and high unmet need.”

– Southwark CCG

What to avoid

There is the ever present danger of silo working when it comes to creating services that cover all age groups. Division between commissioners and providers working with defined age groups may overshadow the need to work with the individual’s conditions and needs.

Nevertheless, the solution may not be to try to bring everything under one commissioner or provider but to place the effort into ensuring the smooth transition between services with the individual and carer at the centre.

Wheel of Wellbeing (WoW) (Case study 30)

In South London, the Wheel of Wellbeing is a simple framework designed to translate well-being theory into positive practice to help build more flourishing communities using actions, activities and practices to improve mood, reduce the risk of depression, strengthen relationships and keep people healthy. Being web based it is designed to appeal to a very wide range of age groups.

Primary Care Mental Health

References to case studies

» Wheel of Wellbeing (WoW) (Case study 30)
» IAPT – Greenwich Time to Talk (Case study 48)
» Wandsworth Child and Adolescent Mental Health Service redesign (Case study 2)
» Western Cheshire Primary Care Mental Health IAPT Service (Case study 3)
» Sunderland and South of Tyne Initial Response Team – single point of access (Case study 8)
» Northumberland, Tyne and Wear, Initial Response Service (Case study 9)
» North West London Mental Health Urgent Care Pathway redesign (Case study 11)
» WebGP telehealth (Case study 26)
» Use of a digital mental health Service (Big White Wall) for treatment of common mental illness (Case study 27)
» Big White Wall – Digital Mental Health Support in Wandsworth CCG (Case study 44)
» Integration of CAMHS into a single point of access for children (Case study 41)
» Developing a Mental Health Triage Service in Primary Care (Case study 10)
» York’s Primary Care Depression Case Managers (Future Case Study Submission to be added)
» Surrey Primary Care Older Adults Liaison Service (Future Case Study Submission to be added)
» Primary Care Based Service for Elders – based on Wayne Katon’s Seattle Primary Care Mental Health Model (Future Case Study Submission to be added)
» Stockport Prevention and Personalisation Service – Redesigning Access to Mental Health Services (Future Case Study Submission to be added)
Lesson 7: A mosaic of services needs to be provided to wrap around individuals and carers

What has worked well

Well-developed community based systems describe a plethora of services provided by statutory and voluntary sectors, by health and social care, and advice, by community and faith groups that wrap around the individual and carer. Social prescribing – the prescribing of exercise, weight control, diet, and other lifestyle issues – is also identified as a key facet of these services. A clear view emerges that these need to be based in primary care.

They also describe how these need to have connectivity and navigation to assist the individual and carer in selecting, often sequentially, the kind of support that is best suited to them as a person and to their situation. In some cases this is provided through a hub which supports the professionals, individual and carer.

Examples of the advice services people might need include debt advice, relationship support, benefits advice - the list could go on and on. There is real value in practical advice and problem-solving services.

A challenge is to ensure that these services deliver to agreed quality standards.

A model that seems to work effectively is a ‘hub’ into which risk-assessed GP referrals are sent where they are managed by experienced staff who match appropriate services to the needs of the individual. This can be an iterative process as the individual’s condition changes. Much more effective use is made of the huge variety of services available and the individual is better maintained in the community.

Some areas have used navigators or community health workers to achieve much the same outcome. Such community health workers can be trained in bridging the gap and working with a health trainer methodology to deliver on parity of esteem through support and motivational work on lifestyle and physical health as well as supporting the vulnerable.

Support of effective co-produced care planning is an added enhancement when the plan is able to embrace the variety of supports that are available for the individual.

The role of CCGs as community leaders could help in identifying and preventing the causes of mental ill health (e.g. tackling or incentivising employers’ practice, schools that promote resilience and tackle bullying, community safety, churches that promote community cohesion).

What to avoid

GP referrals are faced with a multitude of potential services that can be mobilised for individuals across a wide variety of conditions. There is little chance they can maintain awareness of what service may be ideally suited for any individual. As a result many good services may be underused. In this period of the explosion of primary care mental health innovation, it is vital that evaluation is embedded in services and outcomes are clearly commissioned and transparent. It is as important to be willing to say when the evaluation shows less benefit so that commissioners can be sure of value.

Keep building the relationships – with a huge variety of services it can be daunting but there is no substitute.

Retain an overview of the patient while in the services to avoid them getting lost and simply bouncing from one service to another – there is a role for a ‘navigator’, whoever may be the most appropriate person needs to be determined with each individual.

References to case studies

» Sandwell integrated primary care mental health and wellbeing service (Case study 6)
» Ways to wellness: Social prescribing for people with long term conditions in Newcastle West CCG (Case study 14)
» The Sandwell Esteem Team (Case study 5)
» The Managed Care Network for Mental Health (Case study 38)
» Lambeth mental health community incentive scheme (CIS) (Case study 20)
» Bromley multidisciplinary and multi agency outreach team (Future case study submission to be added)

The Sandwell Esteem Team (Case study 5)

The team receives referrals from secondary, primary and community care organisations as well as social care and probation services. Patients can also self-refer. Link workers are navigators, typically having a social worker background and/or experience with mental health conditions. Link workers form close relationships with patients, visiting them at home and accompanying them to appointments. The team’s work is not time-limited: patients will be discharged from the service only if the link worker and the clinical coordinator agree.

Ways to wellness: Social prescribing for people with long term conditions in Newcastle West CCG (Case study 14)

This initiative was to improve the quality of life of people with long term conditions through access to social prescribing and reducing costs to commissioners. Link workers provide focused support to help patients identify and access community activities and where necessary specialist advice to help improve their wellbeing. The outcomes of the initiative reduced secondary care usage leading to net savings, decreased the number of GP visits and reduced the reliance on prescription drugs.

Integrated primary care mental health and wellbeing service (Case study 6)

The service is engaged with voluntary sector and non-traditional partners to improve co-ordination via a hub. GPs are asked to assess risk and refer. There is open access to the hub, 10 percent of referrals are self referrals, others from social services etc. The staff at the hub contacts the patient and explains to them the services on offer. The hub takes 930 referrals a month. The excellent hub customer services, together with the variety of services which meet the community’s needs are the reason for a low DNA rate of 4 percent.
CO-ORDINATED MENTAL HEALTH CARE

Truly integrated care will benefit both people with mental illness and professionals. It will require improved links and communication with effective IT linkages and sharing accurate up-to-date data and information. The sharing of information between specialists and primary care will inform the strategy for training and education.

Clarity about who does what and how there is an agreed transfer of responsibility based on the needs of the individual will enable decisions about the transfer of funding to be made.

The use of the terms admission and discharge is reported by individuals and carers to be unhelpful as it often seems to imply that someone has ‘finished’ with them. It can also feel a very clunky system where repetitive questions tend to be asked and the process is often so onerous as to deter appropriate transfer of responsibility.

A system of shared responsibility where services recognise they have a cohort of patients with long term conditions who will need to access various services at different times over the course of their lives, will enable people to access elements of the service based on their needs.

Lesson 8: Specialists’ time should be freed to look after people with complex needs and to be available for rapid advice and help for primary care

What has worked well

The complaint is often made that specialist services are ‘full’ with people with stable conditions so that there is no capacity to respond to difficulties primary care practitioners encounter. More seriously, there have been reports from some GPs that even seriously unwell people cannot be seen because of lack of capacity in specialist services.

Some areas report a widening gap between secondary and primary care as secondary services raise eligibility levels. This creates challenges for primary care and links to the need to keep in touch with people as they go into secondary care so their physical health needs are met.

The vision driving primary care mental health services is for specialist advice to be readily available to primary care patients so that both primary care practitioners and specialists have confidence in the system. Increasing the services delivered by primary care mental health is a means of achieving this.

People with stable serious mental illness can be actively managed with the support of primary care if there is instant access back to specialist services when and as this may be required. This return for specialist advice may be available to self referral by the individual based on an agreed care plan. This can only be achieved if specialists’ time is freed up from managing those who are stable.

If specialists’ time is made more available, there is additional energy that can be invested into mutual learning. The use of collaborative relationships for shared learning and care is an enhancement to the general principle of freed up specialist time and the added value gained in a truly shared system cannot be overestimated.

What to avoid

Transformation projects of this size and complexity need particular care in planning to avoid patients falling through ‘cracks’ in services. Awareness of the nature of the service is also a vital component that can easily be missed.

A fully functioning shared care service needs to address the nature of the admission and discharge process (which can be clunky and repetitive) and allow patients to move according to their needs between primary and specialist services.

References to case studies

» Sandwell integrated primary care mental health and wellbeing service (Case study 6)
» Sunderland and South of Tyne Initial Response Team – single point of access (Case study 8)
» Tower Hamlets mental health in integrated care (Case study 19)
» Severe mental illness local enhanced service (Case study 21)
» Development of a local enhanced service for serious mental illness in Brighton and Hove (Case study 25)

The Initial Response Team offers an efficient 24 hour response, through a single point of access, to urgent telephone requests for help from people of all ages and conditions, and to offer triage and routing or signposting to appropriate services around Northumberland, Tyne and Wear.

The team reduces clinician administrative time in the crisis response and home treatment teams, freeing time to care for service users with the greatest need, while also improving personal and clinical outcomes for people in crisis with mental ill health by reducing harm and premature mortality, improving safety and experience.

Service users receive a timely response to urgent requests for help and are now being seen and routed to the most appropriate service.
Lesson 9: IT enabled communications between primary care and mental health is vital for a fully functioning service

What has worked well

Adequate communication between specialist and primary care services are vital if primary care mental health is to be fully implemented.

The ideal solution would be a fully integrated IT system and work is under way for a London solution. In the meantime, people are finding helpful workarounds. These make for effective communication that enables patient safety, service quality and good patient and carer experience. But while workarounds fill a gap to allow services to progress they can only be stop gaps until a longer term solution is designed or commissioned.

What to avoid

Avoid making the assumptions that somehow communication will just ‘work’ without considerable effort and definition invested.

Patient held records can be useful— for people with all levels for need — as an adjunct to the record systems held by providers.

Patients constantly complain about the same information being collected recurrently. We need to find effective ways to ensure that this does not happen and that time can be given to patient care instead. There are projects seeking to address this but are still in the early phases.

IT is also essential to allow full collection of the data required to adequately commission services in the future. We are in desperate need of more timely, adequate and comprehensive mental health data. Without it, the process of commissioning real transformation in services is much more difficult.

References to case studies

» Tower Hamlets mental health in integrated care (Case study 19)
» UCLPartners mental health informatics platform (Case study 40)
» WebGP telehealth (Case study 26)
» Digital mental health service (Big White Wall) for treatment of common mental illness (Case study 27)
» Big White Wall – digital mental health support in Wandsworth CCG (Case study 4d)
» Youth wellbeing directory (YWD) with ACE-V quality standards (Case study 60)
» Developing a shared care EMIS web based template (Case study 34)
Lesson 10: Managing long term conditions

What has worked well

This lesson considers the added complexity regarding the interface between mental health and other specialties, for example, neurology and dementia, various medical specialties and physical long term conditions with mental illness, social services and the process of reintegration onto communities. There are many other examples.

The investigation and care of people with dementia can be better coordinated between neurology, mental health and primary care services. People living with dementia and their carers need something less than a multitude of appointments with a variety of professionals. Too often professionals underestimate the complexities of attendance for those with dementia.

The London Mental Health Strategic Clinical Network is specifically addressing physical health care alongside mental health illnesses in a separate work stream. Diabetes has been used as a model as there is a considerable body of work addressing this particular condition. Once again, the complexities of attending differing appointments for those with mental health issues, particularly the more severe end of the spectrum, makes the provision of these services challenging.

Nevertheless, the 20 years reduction in life expectancy for those with severe mental illness must not be ignored. Whilst the buck stops with primary care as the holder of the overview and holistic care of the person, the solution can only lie in all services sharing the responsibility of improving the physical health of people with serious mental illness.

There are some models of encouraging mental health professionals to pay attention to physical health and CQUns have been designed for this purpose. Schemes where navigators assist users in attending appointments have also been proposed. The eventual ambition is for care plans which are co-produced, holistic, including both mental and physical health needs and recovery focused. Social care needs should be met as part of a coordinated package of care if people are to be safely transferred from specialist to primary care. Support plans need to include how the person uses their time to remain engaged and active (education, training, employment, voluntary work etc.) including their accommodation (supported housing and similar schemes) with the necessary resources. People should be seen as part of their social system or network and not in isolation.

As the numbers of individuals under primary care increase, access to social workers needs to match. The following options could be considered:

- Primary care patients accessing mental health social workers in specialist services such as community mental health teams
- Access to generic adult social workers
- Reduction in the numbers of mental health social workers in specialist services as they are moved to the primary care mental health service
- A more shared care community based approach is achieved that allows mental health social workers to work across specialist and primary services

“Approximately 8,500 people with diabetes in Lambeth and Southwark have psychological and/or social problems.”

– 3DFD

What to avoid

It is very easy to confuse individuals and carers with multiple appointments with a variety of providers. Integration of their care still seems to be a rarity.

Do not assume that providers and specialties will automatically coordinate - provide clarity on your expectations of them for joining up the way they deliver care.

Do not consider your job done if appointments have been arranged but not attended - provide clarity and reminders for users to assist them in achieving the best health outcomes.

“A space to think,” the diabetes wellbeing programme (Case study 47)

This initiative recognises that psychological and social factors interfere with the individual’s ability to prioritise their diabetes self-care in both Type 1 and Type 2 diabetes.

Evidence suggests that combining psychological and psychiatric treatments for conditions such as depression in people with diabetes leads to improvements in health-related outcomes, psychological wellbeing and reduces healthcare costs.

References to case studies

- Newham primary care psychological services (Case study 57)
- Hedgie Pricks Diabetes (Case study 56)
- Development of a long term conditions site (Case study 55)
- Long terms conditions within IAPT (Case study 53)
- IAPT – Greenwich Time to Talk (Case study 48)
- 3 Dimensions for Diabetes (3DFD) (Case study 46)
- “A space to think” diabetes wellbeing programme (Case study 47)
- Ways to wellness: Social prescribing for people with long term conditions in Newcastle West CCG (Case study 14)
- Kingston Housing and Liaison Worker support Initiative (Future case study submission to be added)

Three Dimensions for Diabetes (3DFD) (Case study 46)

3DFD integrates medical, psychological and social care for patients with persistent suboptimal glycaemic control and aims to improve glycaemic control, reduce psychological distress, improve quality of care and patient-reported outcomes and to reduce short and long term health service use costs.

The interventions delivered include a medical review of diabetes status, brief focused psychological treatments, optimising psychotropic medication and interventions targeting social problems (such as poor housing, debt management, literacy, occupational rehabilitation). It integrates psychosocial care with diabetes care by patient-led case conferences, addressing barriers to diabetes self-care, risk assessments and patient safety.
## PRIMARY CARE MENTAL HEALTH: CASE STUDY DIRECTORY

### LONDON-WIDE AND NATIONAL CASE STUDIES - Compiled by the London Mental Health Strategic Clinical Network

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<td><a href="mailto:ianwalton@btinternet.com">ianwalton@btinternet.com</a></td>
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### Health and wellbeing boards, integration, engagement

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<td>Kingston Health and Wellbeing Board</td>
<td>The establishment of an effective Health and Wellbeing Board where by health commissioning is closely integrated with public health and community engagement.</td>
<td>Kingston and办好 Board</td>
<td>Phil Moore, Lead Governance Manager, Kingston CCG</td>
<td><a href="mailto:phil@jimmoore.org">phil@jimmoore.org</a></td>
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4. Single point of access, standards of care, co-production, whole health, referrals.

5. Triage, signposting, pathways, community, older people, CCGs.

9. Single point of access, co-production, holistic, voluntary sector, training needs of staff and alignment of service provision as complementary to traditional medical prescription. Promotion of non traditional Befriending and befriending supports, then people to take up activities instead or alongside medical support. GPs are encouraged to refer people to a range of long term conditions and mental health pathways in a single telephone number 24/7.

17. User led support, volunteer, spirituality, community, holistic, education.

35. User led support, volunteer, spirituality, community, holistic, education.

43. CRISIS service, emergency support, self harm, suicide, alternative care.

98. CRISIS service, emergency support, self harm, suicide, alternative care.

Primary Care Mental Health: Case Study Directory

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<td><a href="mailto:Denise.pickstock@nhs.net">Denise.pickstock@nhs.net</a></td>
<td><a href="mailto:Ian.Hollyday@nhs.net">Ian.Hollyday@nhs.net</a></td>
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<td>Gloucestershire</td>
<td>Simon Sawyer, Senior Mental Health Nurse, Gloucestershire NHS Foundation Trust</td>
<td><a href="mailto:Simon.sawyer@glos.nhs.uk">Simon.sawyer@glos.nhs.uk</a></td>
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<td>Clare Monks, North West London Mental Health Programme Director</td>
<td><a href="mailto:Clare.montok@ucant.org">Clare.montok@ucant.org</a></td>
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<td>Sandra King, Project Director</td>
<td><a href="mailto:Sandra.king@vonne.nhs.uk">Sandra.king@vonne.nhs.uk</a></td>
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17 Community access, Community care interface, navigators, signposting, holistic
Ear’s Court Health and Wellbeing Centre
A service designed to offer community access to a range of primary care healthcare services co-located under one roof. The building houses a GP health centre, community sexual health services and NHS dentistry as well as offering space for community groups. Services are provided at the interface of primary and community services. Reception is staffed by wellbeing navigators who do administrative duties as well as answering health questions, making links with community hubs locally and signpost to support resources.

Contact name(s): Richard Fradgley, Northamptonshire
Contact details: richard.fradgley@noh.org.uk

18 SAPT, NICE, stepped care, peer support, self-help
Changings Minds Education Centre
The service is a practice based initiative with an early intervention and recovery focus. Initially centred on primary care medication but expanded to look at new ways of working and new roles such as graduate workers and community nurses trained in mental health. Service includes peer support and parent support service.

Contact name(s): Richard Fradgley, Tower Hamlets CCG
Contact details: richard.fradgley@noh.org.uk

19 Integration, care planning, co-morbidities, coordination, contracting, CQI, GP led, service user engagement
Tower Hamlets Integrated Care
The development of a coherent mental health strategy requires the identification of mental health problems in patients with multiple co-morbidities, improving care planning, improving patient experience; reducing emergency admissions to hospital, reducing length of stay and reducing readmissions to care homes. Developing recovery orientated primary care mental health services to support discharge from secondary care.

Tower Hamlets CCG
Contact details: richard.fradgley@noh.org.uk

20 CIS, social support, co-production, community, complex life problems, QIPP, access
Lambeth Mental Health CCG, Community Initiative Scheme (CIS)
CIS provides resources and incentive payments to General Practitioners to develop an integrated pathway and outcome based service offer promoting recovery, wellbeing and social inclusion. The aims of CIS are to improve management and outcomes for adults with complex life problems, severe mental illness and enduring mental health problems. It will support GPs to deliver high quality care, reduce variation of mental healthcare offered by GPs, support CCG and local authorities to achieve QIPP and reduce secondary care admission.

Contact name(s): Lambeth CCG
Contact details: info@lambethccg.gov.uk

21 Severe and enduring mental illness, LES, stepped down care, recovery care support, plans, physical health checks, integration
Severe mental health services local and funded service
To develop a local enhanced service for severe and enduring mental illness. The project aims to discharge stable patients (clusters 1-3 and 11) into a stepped down care pathway increased role of mental health workers and GPs in primary care.

City and Hackney CCG, Tower Hamlets CCG, Newham CCG
Contact details: dr.rhian.england@nhs.net

22 Service user involvement, user voice, leadership, voluntary sector, LACCG commissioning
Service user involvement in mental health commissioning
A jointly commissioned (LA/CCG) service user group, hosted by the voluntary sector was commissioned to develop a training package. Objectives were to embed user voice into commissioning processes identifying power and influence to service users, developing confidence and leadership, building social capital amongst service users, promoting opportunities for social value service commissioning.

City and Hackney CCG
Contact details: dr.rhian.england@nhs.net
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<tbody>
<tr>
<td>23</td>
<td>Education, early indica- tors, risks, common mental health, personality disorders, MUS, PTSD, alcohol problems, stigma, suicide, signposting</td>
<td>To provide specific and targeted education, awareness and skills training across primary and secondary care among health professionals. Aimed to help early recognition of indicators and risk factors for common mental health disorders, personality disorders, PTSD and medically unexplained symptoms. Includes the development of awareness and skills training for frontline staff, local communities and others to improve engagement, reduce stigma, and support earlier recognition of mental health problems and suicide risk and signposting to effective support. Also improves support for GPs in identifying and treating people with alcohol problems within primary care.</td>
<td>Camden CCG</td>
<td>Alex Warner, Mental Health GP Lead, Camden CCG</td>
<td><a href="mailto:awarner@nhs.net">awarner@nhs.net</a></td>
</tr>
<tr>
<td>24</td>
<td>Value based commissioning, psychosis, outcomes, outcome measures, depression, IPR, tariff</td>
<td>Applying value based commissioning to mental health in Camden</td>
<td>Camden CCG, Greenwich CCG, South London and Maudsley NHS Foundation Trust</td>
<td>Alex Warner, Mental Health GP Lead, Camden CCG</td>
<td><a href="mailto:awarner@nhs.net">awarner@nhs.net</a></td>
</tr>
<tr>
<td>25</td>
<td>BIN EIS, choice, personalised, physical health, integration, primary care, discharge, step-down</td>
<td>Development of a local enhanced service for serious mental illness in Brighton and Hove</td>
<td>Brighton and Hove CCG</td>
<td>Zo Payne, Named Nurse</td>
<td><a href="mailto:Zo.Payne@sussexpartners.nhs.uk">Zo.Payne@sussexpartners.nhs.uk</a></td>
</tr>
<tr>
<td>26</td>
<td>Telehealth. Self management, remote access, online tool, capacity, digital disinhibition</td>
<td>WebGP Using GP practice websites to allow patients to consult their own GP remotely for common general practice issues (including anxiety, depression, panic attacks). Developed service to improve patient access to self help information from GP practice websites. Signposting patients to locally commissioned services appropriate to their condition e.g. Big White Wall, online CBT. Allows patients to check symptoms, access 24/7 nurses and submissions of webforms. Increases response from GPs in urgent situations. Better access, health outcomes and practice/commissioner efficiency.</td>
<td>Hurley Group</td>
<td>Dr Arvind Madan, GP Partner, CEO Hurley Group</td>
<td><a href="mailto:Arvind.madan@nhs.net">Arvind.madan@nhs.net</a> 07956217974</td>
</tr>
<tr>
<td>27</td>
<td>Education, early indicators, risks, common mental health, personality disorders, MUS, PTSD, alcohol problems, stigma, suicide, signposting</td>
<td>Education and training for frontline staff in Camden</td>
<td>Camden CCG</td>
<td>Alex Warner, Mental Health GP Lead, Camden CCG</td>
<td><a href="mailto:awarner@nhs.net">awarner@nhs.net</a></td>
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<td>28</td>
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<td>Southwark CCG</td>
<td>Care-Ann Murray, senior mental health commissioner, Southwark CCG</td>
<td><a href="mailto:care-ann.murray@phs.net.Kuchemann">care-ann.murray@phs.net.Kuchemann</a>@phs.net</td>
</tr>
<tr>
<td>78</td>
<td>Navigator, discharge, recovery, transition, supported employment, accommodation</td>
<td>Evolve, The Mental Health Long Term Conditions Project, is part of CREST Waltham Forest, a local voluntary sector charity, commissioned to provide four navigators and a team leader in April 2012. The aim of the scheme is to support adult service users with a severe mental illness in their discharge from secondary to primary care, and ensure service users attend appointments with GPs/practice nurses to monitor mental and physical health and ensure social isolation is addressed. The programme also addresses proportion of people with schizophrenia and diabetes who attend for annual review of their diabetes, have a care plan and access the nine care processes of diabetes care.</td>
<td>Waltham Forest CCG</td>
<td>Chris O Sullivan, Team Leader, Waltham Forest CCG</td>
<td><a href="mailto:chris.osullivan@crestwf.org.uk">chris.osullivan@crestwf.org.uk</a></td>
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<td>Dr Nancy Kuchemann, Mental Health GP Lead, Southwark CCG</td>
<td><a href="mailto:nancy.kuchemann@phs.net">nancy.kuchemann@phs.net</a></td>
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<tbody>
<tr>
<td>32</td>
<td>Mental health well-being, control, choice, resilience, toolkit</td>
<td>Mental Wellbeing Impact Assessment (MWIA)</td>
<td>Is an evidenced-based toolkit for well-being that enables a wide range of organisations and programmes to identify, demonstrate and improve impact on mental well-being. It has been extensively tested with over 750 programmes and services ranging from major regeneration through to small physical activity projects.</td>
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<tr>
<td>33</td>
<td>Service user involvement, primary care, consultation, feedback, peer support</td>
<td>Primary Care Mental Health Forum</td>
<td>The Primary Care Mental Health Forum is a platform for mental health service users to feedback on their experience of accessing primary care services. Each forum is attended by a local GP and a primary care mental health worker who are able to answer questions on the spot or take away for further action.</td>
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<tr>
<td>34</td>
<td>EMIS web, shared care, information</td>
<td>Developing a shared care EMIS web based template (in progress)</td>
<td>Developing a shared care EMIS web based template for vulnerable adults. An attempt to standardise the care plan across social services, secondary care, matters and GPs. Working with community providers to buy into EMIS web community so they can access the SCR part of the records and the most recent attendances are visible. An integrated system that communicates between local resident, community providers to buy into EMIS web community so they can access the SCR part of the records and the most recent attendances are visible. An integrated system that communicates between Royal Borough of Greenwich Public Health, Norfolk and Suffolk and Norfolk Constabulary. The programme was identified as aiming to provide support and opportunities for local residents to access services, evidenced to promote and maintain mental well-being and to evaluate the impact of uptake of these services via Feel Good Greenwich.</td>
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<tr>
<td>35</td>
<td>Police, crisis prevention, partnership, community, online navigation, care</td>
<td>Integrated mental health team</td>
<td>Integrated mental health team based within the control room at police headquarters. To improve safeguarding for those suffering from mental ill health, introduce and provide early access to services for those with mental health issues before they reach crisis point, provide an improved response to repeat callers with mental health issues and thereby reduce demand on the police services, improved joint working between trust and ambulance service and co-producing physical and mental health issues, sharing of expertise.</td>
<td></td>
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</tr>
<tr>
<td>36</td>
<td>Mental health well-being, access, wellbeing, health, resilience, self-management, goal setting, online navigation</td>
<td>Feel Good Greenwich</td>
<td>Programme born out of a partnership forged between Royal Borough of Greenwich Public Health (originally NHS Greenwich and Greenwich Mind). The primary purpose of the programme was identified as aiming to provide support and opportunities for local residents to access services, evidenced to promote and maintain mental well-being and to evaluate the impact of uptake of these services via Feel Good Greenwich.</td>
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<tr>
<td>37</td>
<td>Leadership training, health, community, commissioning, primary care, outcomes</td>
<td>Mental Health CCG Leadership Programme</td>
<td>Programme was developed by NHS England and Norfolk and Suffolk Foundation Trust (NFT) in partnership with Norfolk and Suffolk NHS Foundation Trust (NFT) and Norfolk and Suffolk Health Care NHS Trust.</td>
<td>Norfolk NHS Alliance, Lead Mental Health Nurse, Norfolk and Suffolk Foundation Trust (NFT)</td>
<td>Amanda Elia - Chief Inspector, Norfolk Police</td>
<td></td>
</tr>
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**Details**

- Mental Health Wellbeing Impact Assessment (MWIA) is an evidenced-based toolkit for well-being that enables a wide range of organisations and programmes to identify, demonstrate and improve impact on mental well-being. It has been extensively tested with over 750 programmes and services ranging from major regeneration through to small physical activity projects.

- The Primary Care Mental Health Forum is a platform for mental health service users to feedback on their experience of accessing primary care services. Each forum is attended by a local GP and a primary care mental health worker who are able to answer questions on the spot or take away for further action.

- Developing a shared care EMIS web based template for vulnerable adults. An attempt to standardise the care plan across social services, secondary care, matters and GPs. Working with community providers to buy into EMIS web community so they can access the SCR part of the records and the most recent attendances are visible. An integrated system that communicates between Royal Borough of Greenwich Public Health, Norfolk and Suffolk and Norfolk Constabulary.

- Integrated mental health team based within the control room at police headquarters. To improve safeguarding for those suffering from mental ill health, introduce and provide early access to services for those with mental health issues, to answer questions on the spot or take away for further action.

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<td>Prevention, discharge, managed care networks, self-management, mental wellbeing, recovery, outcomes,</td>
<td>The Managed Care Network for Mental Health (MHNCS) is a network that provides access to mental health services for people across Lincolnshire. It supports people with mental health needs to access the services they need.</td>
<td>Lincolnshire Partnership NHS Foundation Trust</td>
<td>Paul Jackson, Associate Director</td>
<td><a href="mailto:paul.jackson@lphi.nhs.uk">paul.jackson@lphi.nhs.uk</a>, 01522 222427</td>
</tr>
<tr>
<td>29</td>
<td>Practice nurse training, integration, education, action learning, primary care</td>
<td>The Managed Care Network for Mental Health (MHNCS) is a network that provides access to mental health services for people across Lincolnshire. It supports people with mental health needs to access the services they need.</td>
<td>Richmond CCG</td>
<td>Brian Parsonbyvan, Children’s Clinical Lead, Richmond CCG</td>
<td><a href="mailto:brian.parsonbyvan@richmondccg.nhs.net">brian.parsonbyvan@richmondccg.nhs.net</a></td>
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<td>30</td>
<td>Information, needs assessment, feedback, costs, savings, outcomes, benchmarking, OF</td>
<td>The aim is to provide a comprehensive local mental health needs assessment feedback for primary care to support improved population mental health. Developed a mental health information platform, including national data covering treatment of mental disorder (in both primary and secondary care) as well as risk factors for mental disorder, groups at higher risk of mental disorder and protective factors for wellbeing. Performed analysis and presentation of information including local estimated numbers, numbers and costs of different mental disorder, proportion receiving treatment for different mental disorder in primary and secondary care, local spend on treatment in primary and secondary care and savings among care intervention.</td>
<td>UCLPartners, Partnership Mental Health (PMMH)</td>
<td>Jonathan Campion, Director of Population Mental Health (UCLPartners)</td>
<td><a href="mailto:j.campion@uclpartners.com">j.campion@uclpartners.com</a></td>
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<tr>
<td>31</td>
<td>CAMHS single point of access, assessment, triage, integration, children</td>
<td>Designing a single point of access to children’s services. This currently already accessible to Tier 2 (primary mental health workers) as well as to a range of other tier 1 services. This is also the route for children’s safeguarding concerns, however still working towards incorporating an element of Tier 3 at the early triage stage to prevent patient bouncing across services and that the best, most appropriate service is offered from day 1. The hope is that some simple interventions can also take place at this stage, reducing onward referral to Tier 3.</td>
<td>Lambeth and Southwark Parental Mental Health Service</td>
<td>George Howarth, Lead of Mental Health and Continuing Care, Lambeth CCG</td>
<td><a href="mailto:george.howarth@lambethbc.nhs.uk">george.howarth@lambethbc.nhs.uk</a></td>
</tr>
<tr>
<td>32</td>
<td>Parental mental health, assessment, families, outcomes, partnership working, parents, social care, personality disorder</td>
<td>Development of a service which applies a psychologically informed case management model to support mental health needs of parents with mental health problems. This involves ongoing support and interventions to families with multiple needs affected by parental mental illness. They receive a timely service that meets their needs and delivers improved outcomes to the whole family. This includes the knowledge and skills of staff to deliver assessments, interventions and the early identification of mental health issues and partnership working at case management level.</td>
<td>UCLPartners, Partnership Mental Health (PMMH)</td>
<td>Jonathan Campion, Director of Population Mental Health (UCLPartners)</td>
<td><a href="mailto:j.campion@uclpartners.com">j.campion@uclpartners.com</a></td>
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<td>Mental health wellbeing, assessment, training, schools, policy shops, workplace, voluntary sector, mental health (ie primary mental health workers)</td>
<td>To build the capacity for more people and organisations in Lambeth and Southwark to promote mental wellbeing. Programme works at individual, community and strategic levels. Some of the elements include: mental wellbeing impact assessment, mental health/suicide awareness training, a wellbeing network and e-bulletin, small grants scheme, promotion of ‘five ways to wellbeing’ messaging, outreach projects with DBE, development of wellbeing profiles for local organisations, self-developing self-study programme in schools, wellbeing policy advice.</td>
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<td>31</td>
<td>CAMHS single point of access, assessment, triage, integration, children</td>
<td>Designing a single point of access to children’s services. This currently already accessible to Tier 2 (primary mental health workers) as well as to a range of other tier 1 services. This is also the route for children’s safeguarding concerns, however still working towards incorporating an element of Tier 3 at the early triage stage to prevent patient bouncing across services and that the best, most appropriate service is offered from day 1. The hope is that some simple interventions can also take place at this stage, reducing onward referral to Tier 3.</td>
<td>Lambeth and Southwark Parental Mental Health Service</td>
<td>George Howarth, Lead of Mental Health and Continuing Care, Lambeth CCG</td>
<td><a href="mailto:george.howarth@lambethbc.nhs.uk">george.howarth@lambethbc.nhs.uk</a></td>
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<td>32</td>
<td>Parental mental health, assessment, families, outcomes, partnership working, parents, social care, personality disorder</td>
<td>Development of a service which applies a psychologically informed case management model to support mental health needs of parents with mental health problems. This involves ongoing support and interventions to families with multiple needs affected by parental mental illness. They receive a timely service that meets their needs and delivers improved outcomes to the whole family. This includes the knowledge and skills of staff to deliver assessments, interventions and the early identification of mental health issues and partnership working at case management level.</td>
<td>UCLPartners, Partnership Mental Health (PMMH)</td>
<td>Jonathan Campion, Director of Population Mental Health (UCLPartners)</td>
<td><a href="mailto:j.campion@uclpartners.com">j.campion@uclpartners.com</a></td>
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<tr>
<td>33</td>
<td>Mental health wellbeing, assessment, training, schools, policy shops, workplace, voluntary sector, mental health (ie primary mental health workers)</td>
<td>To build the capacity for more people and organisations in Lambeth and Southwark to promote mental wellbeing. Programme works at individual, community and strategic levels. Some of the elements include: mental wellbeing impact assessment, mental health/suicide awareness training, a wellbeing network and e-bulletin, small grants scheme, promotion of ‘five ways to wellbeing’ messaging, outreach projects with DBE, development of wellbeing profiles for local organisations, self-developing self-study programme in schools, wellbeing policy advice.</td>
<td>UCLPartners, Partnership Mental Health (PMMH)</td>
<td>Jonathan Campion, Director of Population Mental Health (UCLPartners)</td>
<td><a href="mailto:j.campion@uclpartners.com">j.campion@uclpartners.com</a></td>
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<td>44</td>
<td>BWW, parity of esteem, illness, stigma, access online resource, self-management, well-being, physical health, crisis prevention</td>
<td>Big White Wall (BWW) was commissioned to increase access to mental health support for people in Wandsworth, especially for those not accessing current services and to support parity of esteem between mental and physical health care. BWW reduces barriers to access. It is available 24/7, can be accessed easily online or via an app for smartphone and is anonymous, reducing stigma. It supports the local IAPT to improve waiting times and manage patients who do not meet IAPT caseness, or who need the opportunity for round the clock support whilst waiting for tier 3 high intensity sessions.</td>
<td>Wandsworth CCG</td>
<td>Emma de Balsis, Head of Business Development, Big White Wall</td>
<td><a href="mailto:mark.robertson@wandsworthccg.nhs.uk">mark.robertson@wandsworthccg.nhs.uk</a></td>
</tr>
<tr>
<td>45</td>
<td>Wellbeing, self-management, community, holistic, salutogenesis, community wellbeing practices, community wellbeing enterprises, CIC</td>
<td>The CWP model aligns general practice more closely with voluntary, community and social enterprise sector agencies so that healthcare practitioners not only help patients with the treat-</td>
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<td>46</td>
<td>Long term conditions, well-being, self-management</td>
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<td>47</td>
<td>Long term conditions, diabetes, self-management, outcomes, psychological care</td>
<td>Diabetes wellbeing service was established in the borough of Greenwich with common concerns such as anxiety or depression. Treatment is based on cognitive behavioural psychotherapy (CBT) and counselling. Involves guided self-help and talking therapy. This service does not prescribe medication. Specialist support is provided over the phone along with stress control classes and online computer programmes to help develop skills needed to make positive changes. GP referral is not needed, can self refer.</td>
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**PRIMARY CARE MENTAL HEALTH: CASE STUDY DIRECTORY**

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<tr>
<td>48</td>
<td>Long term conditions, diabetes, self-management, outcomes</td>
<td>A space in which patients can receive diabetes, psychological and social care. The model for 3DFD came from the difficulties experienced in trying to work across these sectors on behalf of patients. The model of intensive case management with the involvement of multidisciplinary teams including the patient as a member of the team, has been successful and cost effective. The cross-fertilisation of skills sets within the team has been a key part of the success.</td>
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### PRIMARY CARE MENTAL HEALTH: CASE STUDY DIRECTORY

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<tr>
<td>49</td>
<td>Long term conditions, comorbidity, resilience, early intervention, self-management, crisis prevention</td>
<td><strong>Mind – service transformation programme</strong>&lt;br&gt;Three year programme ending March 2016 and funded by Dorf. Set up early intervention wellbeing sessions to support people with long-term physical conditions to become resilient and therefore less likely to develop mental health problems. An additional outcome of this work will be that people are better able to manage their LTC and will use crisis care less frequently.</td>
<td>Local Minds in Birmingham and Manchester</td>
<td>Mar Harasoglu, Service Development Manager, local mind</td>
<td><a href="mailto:m.harasoglu@mind.org.uk">m.harasoglu@mind.org.uk</a></td>
</tr>
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<td>50</td>
<td>Long term conditions</td>
<td><strong>Primary Care Psychology</strong>&lt;br&gt;have a specific care pathway for anyone either referred from a medical specialism - diabetes, cardiac, sickle cell, gastro etc. If a GP or self-referral is identified as having a significant health concern they would go through the pathway. Care is reviewed by senior health psychologist -slim or adapted telephone screen takes place - usually they would then be treated by either clinical health psychologist, CBT therapist with additional support and training, or more rarely as WP. Also support education groups in diabetes, cardiac rehabilitation and pulmonary rehabilitation. There is a number of senior psychologists with backgrounds in clinical health psychology.</td>
<td>Homerton University Hospital NHS Foundation Trust</td>
<td>James Grey, Consultant Clinical Psychologist for Long term conditions</td>
<td><a href="mailto:James.Grey@homerton.nhs.uk">James.Grey@homerton.nhs.uk</a></td>
</tr>
<tr>
<td>51</td>
<td>PPI, carers</td>
<td><strong>Working Together for better mental health in Hackney</strong>&lt;br&gt;The specific aim of this partnership is to ‘hard wire’ the people with mental health experience and carer voice and experience into the planning, delivery and evaluation of health and care services. The project aims to share good practice, centralise resources, strengthen existing networks and build an infrastructure that connects and coordinates involvement.</td>
<td>NHS and City and Hackney CCG</td>
<td>Naomi James, Region Manager, NSUN DH/PHE/NHS England, GP mental health lead, Hackney CCG</td>
<td><a href="mailto:naomij@nhs.uk">naomij@nhs.uk</a></td>
</tr>
<tr>
<td>52</td>
<td>Education, fist aid, self-assessment/self management</td>
<td><strong>Mental Health First Aid (MHFA) Lite</strong>&lt;br&gt;Presentation of mental health first aid training to GP receptionists across Hackney. Three hour session aiming to enable participants to gain a wider understanding of some of the issues surrounding mental health, work more effectively with people living with mental health problems, identify the discrimination surrounding mental health problems, define mental health and some mental health problems, relate to others’ experiences, help support people with mental health problems to look after their own mental health.</td>
<td>City and Hackney CCG</td>
<td>Teresa McInerney, General Manager, City and Hackney CCG</td>
<td><a href="mailto:teresa.mcinerney@nhs.net">teresa.mcinerney@nhs.net</a></td>
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55 | Long term conditions, COPD, diabetes, CHD, pain, chronic fatigue, self management, stepped care | Development of a long term conditions site | Barking and Dagenham IAPT, Church Elm Lane Health Centre | Julie Wilson, IAPT Lead, Church Elm Lane Health Centre | julie.wilson@nclf.nhs.uk
56 | User-led support, diabetes, self management | Hedge Pricks Diabetes | Essex | Zoe Scott, Founder, Hedge Pricks Diabetes | hedgepricksdiabetes@gmail.com
57 | Service, diabetes, COPD, psychological interventions | We are a Pathfinder site and currently focusing on two LTCs: diabetes and COPD. Looking at the effectiveness of group and individual high intensity psychological interventions. The Pathfinder 1 project focuses on the effectiveness of LI and HI interventions for the treatment of LTCs and MUS. The service integrates LI and HI interventions. It offers a package of care that is case managed by an F1 staff member (usually a clinical psychologist) who proposes a programme of intervention based on clinical presentation, client choice, language factors etc. It also offers a variety of interventions which have been designed for people with diabetes, although non-diabetics also access this intervention. Additionally, there is a stepped care pain intervention, graded exercise therapy, memory and wellbeing, coping with chemotherapy, breathlessness and COPD and a specific intervention for people wi | East London Foundation NHS Trust | Sarah Garell, Associate Director of Development, East London Foundation NHS Trust | sarah.garell@eastlondon.nhs.uk
58 | Youth radio, stigma, young people, self management, eating disorders, bullying, teenage depression, substance misuse | Hedgie Pricks Diabetes was set up to highlight the life of people living with diabetes. Aim to gain greater awareness of the psychological, emotional and social issues of living with diabetes, especially depression, diabetes-related and anxiety problems. Longer term the aim is to spread the work about the emotional psychological impact of living with diabetes, to create a well-informed, knowledgeable and empathetic team of health professionals and counsellors who specialise in diabetes, to create diabetes centres that really help millions of people with diabetes to care for their diabetes and take control. | Essex | Zoe Scott, Founder, Hedgie Pricks Diabetes | hedgiepricksdiabetes@gmail.com
No | Title | Description | Location | Contact name(s) | Contact details
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62 Depression, suicide, primary care, GPs

The role of general practitioners in prevention of depression related suicides, 2012

Use of a depression-management educational program for GPs to prevent suicides, included as evaluation of a 5-year suicide prevention educational program for GPs and their nurses in a rural region with a very high suicide rate. The study supported the role of the programme in enabling GPs and nurses to help reduce the number of suicides.

Hungary Rihmer, Z., Dome, P. and Gonda, Z.

63 eCHAT – integrated electronic lifestyle and mental health self-assessment tool in primary care

Study aimed to assess the feasibility and acceptability of the systematic use of a Web-based eCHAT (electronic case finding and help assessment tool) screening patients for problematic drinking, smoking, and other drug use, gambling, exposure to abuse, anxiety, depression, anger control, and physical inactivity, and whether they want help with these issues. Outcome: eCHAT is an acceptable and feasible means of systemic screening patients for unhealthy behaviors and negative mood states and is easily integrated into the primary care electronic health record.

New Zealand Goodyear-Smith F, Warren J, Bojic M, Chong A
fg.goodyear-smith@auckland.ac.nz jim@cs.auckland.ac.nz
http://bit.ly/1mKbzHV

64 Building a system of perfect depression care in behavioral health, 2007

In 2001, the Division of Behavioral Health Services of the Henry Ford Health System (Detroit) launched an initiative to completely redesign depression care delivery. The goal of the “Perfect Depression Care” was the elimination of suicide. The sustained reduction in suicide rate suggests that the process improvements implemented as part of the Perfect Depression Care initiative substantially improved the care of persons with depression. The initiative is the prototype for a comprehensive redesign of behavioral health care. Work is under way to “perfect” the care of persons with anxiety or psychotic disorders, and similar care systems are being developed for violence prevention and medication safety, with a particular focus on perfecting communication between providers.

Detroit, USA Coffey DE.
mseyrig1@hfhs.org
http://1.usa.gov/1jzvTah

The IMPACT intervention. Collaborative care management of late life depression in primary care setting (RCT), 2002

To determine the effectiveness of the Improving Mood–Promoting Access to Collaborative Treatment (IMPACT) collaborative care management program for late-life depression. Outcome: The IMPACT care model appears to be feasible and significantly more effective than usual care for depression in a wide range of primary care prac-

USA Underhill J, Karon W, Carehan CM, et al
underhill@uc.edu
http://bit.ly/5zZ6f

The development of an online directory ACE-V quality standards is aimed to improve the emotional wellbeing and mental health of children, young people (CYP) and their families and care-

Evidence Based Practice Unit
Dr. Debbie Jones
EBPU Improvement Programme Lead
ace-v@annafreud.org

INTERNATIONAL STUDIES
1. CROYDON PRIMARY CARE MENTAL HEALTH SUPPORT

Aims
» Support GP practices, overtime, to deliver the medical mental health care of patients with stable, low risk serious mental illness (SMI) who are currently receiving a community and secondary specialist mental health service.
» Inform future commissioning and service development in primary care and at the primary-secondary care interface.

Rationale
Models of collaborative-integrated working between secondary and primary care for this group of people is varied, has a limited evidence base and is often poorly understood. There is increasing interest in enhancing mental health care provision in primary care for people with SMI.

Development
Funding was enabled by a disinvestment and de-commissioning of the South London and Maudsley NHS Foundation Trust’s (SLaM) Psychosis CAG Low Intensity Treatment Team, and a QIPP investment in the commissioning, from SLaM, of the Primary Care Mental Health Support Service (PCMHSS). This also included investment in a GP Local Enhanced Service (LES) incentive arrangement to support the implementation and project manager time. The gross QIPP 2013-14 saving was £150,000.

Challenges
The early stage, focussed on informing and influencing commissioning planning and decision activity. Most of the barriers preventing flows to primary care require significant and or whole system redesign / change: well beyond the scope of this project. As a natural consequence the service delivery aspect of the project has and will remain limited until these issues are resolved. At month 12, nine patients had been fully discharged to GP care, 30 patients were in the support-transition-working towards discharge stage and possibly up to 500 patients, receiving community secondary care, identified for screening for service eligibility.

Outcomes
The project has demonstrated that a QIPP approach can deliver enhanced quality and effectiveness whilst releasing financial efficiencies. This has been largely achieved by the pioneering of minimum standards (designed and agreed between primary and secondary care) relating to the application of transfer-discharge criteria, GP patient information sets and GP practice support. These standards have been well received in primary care and secondary care and are now either influencing or being adopted into mainstream practice.

Top tips for commissioners
» Dedicated GP leadership is crucial
» Commissioning working arrangements and capacity. Greater impact and sustainability appear to be provided with CCG federated approaches. Also, how joined up, strategic, holistic, effective and efficient are CCG commissioning processes?
» Whole system issues- any change development impacts on the system and requires whole system redesign. See notes in Appendix A (page 97).

Contact
Susan Gurney, Mental Health Project Coordinator, Croydon CCG
Susan.gurney@croydonpct.nhs.uk

Further reading
Kelly et al. (2011) Shared care in mental illness: A rapid review to inform implementation: www.jmhs.com/content/5/1/31

2. WANDSWORTH CHILD AND ADOLESCENT MENTAL HEALTH SERVICE REDESIGN

Aims
» Redesign Wandsworth Child and Adolescent Mental Health Service to provide timely access to services for children young people and their families.

Rationale
The CAMHS Commissioning Partnership was requested in July 2012 by Ofsted to produce an action plan that addressed a number of criticisms the service had received:
» Stakeholders were unclear as to the thresholds re eligibility to the Specialist CAMHS team
» The thresholds for the specialist service were seen as too high and it was not clear as to where those children with mild to moderate emotional well-being issues could be referred because there was not a stepped model of care in operation.
» Lack of clarity and communication about the therapeutic services provided for children suffering from sexual abuse.

The service was also deemed non compliant with NICE guidance in relation to people with suspected Autism. The service redesign was supported by local GPs.

Development
Wandsworth CCG and South West London and St Georges (SWL and STG) working in collaboration with Local Authority Partners, developed a multi-disciplinary and multi-agency assessment service. The model can include a range of Tier 2 professionals (for example: paediatric liaison, educational psychologists, youth offending, youth support and social care team members) reinforced by elements of Specialist CAMHS (Psychiatrist and Clinical Psychologist resource).

The Clinical Component of the service includes:
» Elements of Specialist CAMHS (Tier 3): A consultant psychiatrist, Family Therapist, consultant clinical psychologist, and clinical psychologists. Paediatric liaison staff would link to the Assessment Service.
» Staff from the Local Authority Schools and Community Psychology Service falling under the umbrella of Targeted Mental Health in Schools workers (TAMHS).

Outcomes
» The Home office Review of Wandsworth in Relation to Gangs and Violence February 2014, commended the new access Service in their summary report as an example of best practice in London
» The Access Service has been presented with the South West London and St George’s Mental Health Trust Award for Integrated Service Delivery in April 2014.
» New Access service has reduced waiting times and the majority of referrals are seen within 2 to 6 weeks.
» Feedback from the Wandsworth GP and other key stakeholders given in the Home Office Review has been positive. The single point of Access has removed the issue of thresholds proving a barrier to getting a service within comprehensive CAMHS
» CAMHS service is now NICE compliant in regard to both the Autistic Spectrum and ADHD conditions

Contact
John Beckles, Children’s services commissioning manager, Wandsworth CCG
John.beckles@wandsworthccg.nhs.uk
3. **Western Cheshire Primary Care Mental Health Service**

**Aims**
- To deliver an accessible, high quality, local based primary care service. It is a single point of access model for all mental health referrals, providing psychological interventions via the stepped down model to improve patient outcomes and satisfaction.

**Rationale**
The service was established as a Nurse led initiative in 1997 by GPs to deliver an accessible locally based service. In 2008 the service became a first wave IAPT site which enabled the service to enhance mental health provision with low and high intensity workers. The philosophy behind the development of the service over the years has always been shared ownership with the locality GPs which has been underpinned by the Local Enhanced Service for Mental Health and the identification of Mental Health Lead GPs in each practice. Historically Western Cheshire has had a high percentage of local GPs with an interest in the development of innovative mental health services that have been designed to meet the needs of the local population.

**Development**
The service is an amalgamation of the Primary Care Mental Health Team and IAPT High Intensity and Psychological Wellbeing Practitioner teams. It is a single point of access for adults (over 16 years) serving a population of approximately 250,000. It receives approx. 12,000 referrals per year, with no exclusion criteria. Psychological interventions are delivered within a stepped care model which includes complex presentations. The team includes Specialist Mental Health Nurses, Social Care practitioners, Support workers, Graduate Mental Health Worker, Psychological Well Being Practitioners, CBT Therapist, Counsellors and Clinical and Counseling Psychologists. There is provision for a sessional Psychiatrist to provide medication reviews and advise regarding complex cases. Individuals with more complex problems are case managed where appropriate, rather than handed on the secondary services.

**Recent service developments include:**
- Management of ASD and ADHD pathways through primary care, including initial screening and case management following specialist diagnosis
- Creation of a Specialist Nurse Practitioner role to enhance the physical and mental health interface.
- Provision of a link CPN to homeless services.
- Development of specialist psychological services for Military Veterans.
- Development of a joint referral pathway with police to fast track individuals with mental health problems into Primary Care and street triage (staffed by police and a mental health professional).
- Input to LTC teams and Community Matrons.

Future development includes integrating Physical and mental health single point of access.

**Challenges**
There is a constant mismatch in demand and capacity leading to creative and flexible use of budgets and staff. Accommodation also provides a huge challenge as the service develops.

**Outcomes**
The service has been identified as one of the best in the country in terms of targets.

From these contacts it became clear that mental health and mental health services were a concern shared by all the participants. The Joint Strategic Assessment identified health as a priority and this was adopted by the Health and Wellbeing Board and written into the Joint Health and wellbeing Strategy. Following this a Mental Health Commissioning Mandate was developed to hold the mental health commissioners to account.

In parallel there were efforts to engage with GPs (similar concerns about the services) and the users and carers (still more of the same concerns). This alignment with the Health and Wellbeing Board enabled the commissioners to push very hard to deliver change.

The appointment of a Joint Commissioner for Mental Health with access to the budgets of the CCG, Local Authority and Public Health helped to commission a much more integrated service for mental health in all its aspects.

**Contact**
- Janet Foster, Clinical Lead Primary Care Step 3 / IAPT Clinical Lead, Cheshire and Wirral Partnership NHS Foundation Trust
  Janet.Foster@cwp.nhs.uk
- Jane Palombella, Clinical Service Manager, Cheshire and Wirral Partnership NHS Foundation Trust
  Jane.Palombella2@cwp.nhs.uk

4. **Kingston Health and Wellbeing Board**

**Aims**
- Kingston recognised the need for a fully functional Health and Wellbeing Board (though not by that name) long before CCGs were commenced. Over a period of some 6 to 8 years there were concerted efforts to engage with the officers in the local authority.

**Rationale**
It was well recognised that sustainable solutions could only be found if the health commissioners worked closely with the local authority, public health (already the Director of Public Health was an appointment shared with the local authority) and their existing networks with the local population. We recognised that dealing with the wider determinants of health was essential to making real progress.

**Development**
Regular meetings, away days and even away 2 days were held involving clinicians and senior managers. These meetings were relationship building and also focussed on seeking to solve some of the really knotty issues that were known in the area. These related to finance, services, health and wellbeing.

From these contacts it became clear that mental health and mental health services were a concern shared by all the participants. The Joint Strategic Assessment identified health as a priority and this was adopted by the Health and Wellbeing Board and written into the Joint Health and Wellbeing Strategy. Following this a Mental Health Commissioning Mandate was developed to hold the mental health commissioners to account.

Top tips for commissioners
- There is no short-cut to building relationship and trust with the local authority. Starting with officers will help open the door to working with members (councillors). The change of councillors at elections can be mitigated by strong relationships with officers.

**Contact**
Phil Moore, Lead Clinical Commissioner for Mental Health, Kingston CCG
phil@philmoore.org
5. The Sandwell Esteem Team

Aims

» The aim of the Esteem Team is to support people with mild–moderate mental health conditions and complex social needs at an early stage to prevent deterioration and admission to secondary care services. It aims to empower patients to take control of their own lives by offering guided therapies and tools for self-help.

Rationale

Patients can feel left unsupported: if a care intervention is not successful. Complex referral pathways can mean that patients get ‘lost’. In standard practice patients can access a certain number of therapy sessions and have to seek a new referral from their GP once these end or if their condition has not improved.

Development

The hub is mainly funded by the Sandwell and West Birmingham CCG. The cost for the Esteem Team in 2012/13 was £490,349. In 2013/14, the budget was £569,674. The team is part of the Sandwell Integrated Primary Care Mental Health and Wellbeing Service (the Sandwell Esteem Hub). It is a holistic primary and community care-based approach to improving social, mental and physical health and wellbeing. The team receives referrals from secondary, primary and community care organisations as well as social care and probation services. Patients can also self-refer. Link workers are navigators, typically having a social worker background and/or experience with mental health conditions. Link workers form close relationships with patients, visiting patients at home and accompanying them to appointments. The team's work is not time-limited: patients will be discharged from the service only if the link worker and the clinical co-ordinator agree.

Challenges

In the absence of formal referral criteria many services (probation, social services, alcohol and substance abuse counselling services) would refer inappropriate cases to the team. This led to duplication and increased the team’s workload. The team would also receive referrals of people with acute suicide risks. The team helps in these cases by alerting the appropriate services, but at the same time they can also apply for the additional work. There was also a lack of differentiation between the roles of gateway worker and link workers.

They were too similar and risked duplication and delay of assessment. In combination with the capacity problems due to inappropriate referrals, this hampered the efficient delivery of care. To overcome this, the team’s brief has been reviewed and since June 2013 the team is operating under a new structure.

Outcomes

A statistical analysis carried out showed significant levels of improvement on a clinical and a wellbeing scoring tool (the Core 10 and Warwick-Edinburgh Mental Wellbeing Scale -WEMWS). There was also a reduction in the percentage of patients with a diagnosis of clinical depression.

Top tips for commissioners

» Review processes and interventions on an ongoing basis. Early intervention and reaction to problems ensured continuity of service for patients during the restructure of the team

» Co-production and involving patients and service users in service design. This facilitates buy-in and trust, while harnessing patients’ expertise ensures the service is patient-centred and responsive.

» Skill mix and staff roles

» Staff has experience of mental health conditions; therefore understand the patients issues.

» Awareness-raising and relationship-building

» The team relies strongly on relationships with other services, particularly those in the voluntary sector, to offer patients access to a range of services and support groups.

» Holistic care tailored to patients needs using a stepped care approach

» The team tailors care packages to the specific need of patients. Upon referral by link workers, they remain embedded in the hub, therefore retain an overview of their care, picking them up if necessary.

Contact

Ian Walton, IAPT lead, Sandwell and Birmingham CCG
ianwalton@btinternet.com

6. Sandwell Integrated Primary Care Mental Health and Wellbeing

Aims

» To develop a Primary Care and Wellbeing Service that offers help to patients at any stage of the stepped care pathway to improve the health of patients and save money, as less people would need costly in-patient care.

Rationale

To get help from mental health services one has to reach a level of illness that is debilitating, when prevention and early intervention works. Primary care and community mental health and wellbeing services are under-developed or none-existent outside IAPT (Improving Access to Psychological Therapies), as we spend most mental health funding on the minority that do reach the level of illness which allows them to enter services.

Development

Developed and commissioned a model of integrated primary care mental health and wellbeing linked to local needs assessment and national policy drivers. Although supporters of IAPT, it was believed that it works better if social problems (housing, debt, criminal justice, families etc) are solved first, so the model integrates with benefits advice, housing services, advocacy, family centres and probation.

The model:

» Developed GP leaders. GPs attended the Primmh (Primary Care Mental Health and Education) Masters course in Primary Care Mental Health with the lead commissioner for Primary Care Mental Health Development. The course delivered competencies for a GP with a special interest in mental health.

» Started a “books on prescription” scheme, supported by all libraries. Our original scheme had books which tended to focus more on health than those advocated on the recent list, as “books on prescription” is now a national policy, where mental illness is more the theme.

» Recruited Community Development Workers and consulted with Black and Minority Ethnic, deaf and LGBT communities including Voluntary and Community Services to sustain involvement. Placed ‘chaplain’ services in a walk in centre near A&E, so patients could have an accessible listening service.

» Developed low intensity interventions consisting of psycho educational courses, wellbeing and self care approaches alongside higher intensity talking therapies, social navigation and support. Interventions which are offered at a whole population (horizontal) and targeted level (vertical).

» Trained Primary Care Mental Health workforce. One third of the local GPs have taken the RCGP and university validated diploma in primary care mental health or attended the modules on a CPD basis. If one GP from a practice attends the course then referrals into secondary care mental health services go down by about half for the whole practice due to increased confidence in managing cases in primary care. Local nurses and primary care mental health workers attend a course.

» Offer interventions and choice of services at each level. Invested in a computer program that measures patients psychological and wellbeing scale, ensuring improvement and effective services.

» Engaged with voluntary sector and non-traditional partners to improve co-ordination via a hub. GPs asked to assess risk and refer. Open access to the hub, 10 per cent of referrals is self referrals, others from social services etc. The hub contacts the patient and explains to them the services on offer. (Hub takes 930 referrals a month). The excellent hub customer services, together with the variety of services which meet the communities’ needs are the reason for a low DNA rate of 4 per cent.

» Have the Esteem Team, link workers dealing with complex cases (See Case Study 5)

Outcomes

Outcomes showed reliable and clinical change and that the integrated model meets the diverse needs of the target group. There is reduced bed usage and length of stay in secondary care mental health services. Wellbeing has positive outcomes at all levels of the stepped pathway, reflecting recovery built into each step.

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Further reading

Lester H, Glasby J and Tylee A 2003 The Prevalence of Mental Health Problems in Primary Care British Journal of General Practice.
7. PRIMHE RCGP AND UNIVERSITY ACCREDITED DIPLOMA IN PRIMARY CARE MENTAL HEALTH

Aims
To run validated education in primary care mental health that is relevant to the needs of GPs and the primary care workforce, giving the workforce an understanding of and the skills required to improve emotional health and wellbeing outcomes for themselves and their patients.

Rationale
GPs and the primary care workforce in the UK are generally good at dealing with mental health problems in primary care, but they have a lack of confidence in their abilities. One reason for this is because mental health in primary care is poorly defined and scarcely resourced. Training to deal with the issues surrounding mental health care that we meet every day in our work is generally woeful, and the resources and time put aside for it do not reflect that at least one-third of our work in primary care relates to mental health issues. Our confidence in our abilities is not helped by a lack of understanding by non-generalists in particular of what mental health in primary care is, and the skills required to manage it.

In order to improve poor recovery rates from mental illness and decrease prevalence, primary care needs to be seen as a valuable resource, that with the right training, development and support could be the major factor in improving the emotional health of so many people.

Development
In 2007 Primhe (Primary Care Mental Health and Education) worked alongside the RCGP to develop the competencies to meet the criteria for GPs with a special interest in mental health, and ran four successful Masters courses at Stafford University developing GP leaders. From this we were able to develop an Advanced Diploma and generalist training aimed at developing skills in Primary Care Mental Health for GPs generally and also have run successful day trainings for GP registrars in the local Deanery. The training is underpinned by values and case based it identifies the social determinants of mental health and why a bio-psychosocial approach is most effective for patient outcomes.

Recognising that only 1 to 2 per cent of general nurses working in acute and primary care have training in mental health a further program has been developed with another university to teach nurses, allied health professionals and primary care teams including primary care mental health workers so that a workforce can be trained to support GPs and their patients in primary care. The courses include well-being and prevention as it is recognised that there is a need for patients to self care alongside their health professionals.

Outcomes
We can demonstrate that once a GP from a practice is trained confidence improves in the practice resulting in a reduction of around 50 per cent of referrals into secondary care. Course feedback and results from the viva confirm that students gain a lot of confidence in managing risk and psychosis within primary care. Rapid psychotherapeutic listening techniques such as the BATHE technique help patients progress, even in a short consultation. By getting interested in the patient’s stories doctors, nurses and primary care workers understand how the patient has reached the point they are currently at, how only the patient can discover their road to recovery, but with the help of an empathic clinician, they may be guided to set themselves goals and milestones along that road. In primary care every patient is a work in progress.

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8. SUnderland and South of Tyne Initial Response Team

Aims
The primary aims of the Initial Response Team (IRT) are to offer an efficient 24/7 response, through a single point of access, to urgent telephone requests for help from people of all ages and conditions, and to offer triage and routing or signposting to appropriate services within and without Northumberland, Tyne and Wear (NTW).

Rationale
NTW is one of the largest mental health and disability trusts in England serving a population of approximately 1.4 million and providing services across an area totalling 2,200 square miles. Sunderland was chosen for the development of a new access model following discussions with service users, carers, GPs and commissioners.

Development
Working collaboratively with commissioners and other partners the transformation of access to NTW for urgent referrals was implemented and tested, developing telephone triage and a rapid response function as a first point of access for the public, service users, carers and referrers, supported in its first year through the imaginative use of the CQUIN attached to the contract.

Challenges
Lessons learned were primarily in relation to stakeholder communication. GP feedback suggested a lack of awareness of IRT and suggested that more PR work would be beneficial. Operationally, there were initial issues with data collection which made activity monitoring challenging. Also some of the training offered to staff needed to cover a broader spectrum of topics or be delivered in greater depth to realise the intended benefits.

Outcomes
IRT reduces clinician administration burden in the crisis response and home treatment teams, freeing time to care for service users with the greatest need, while also improving personal and clinical outcomes for people in crisis with mental ill health by reducing harm and premature mortality, improving safety and experience.

Service users receive a timely response to urgent requests for help and are now being seen and routed to the most appropriate service. Feedback from service users has been very positive, clearly indicating that IRT staff are polite, show kindness and empathy, and behave in a professional manner. Remarkably feedback from service users has shown that 100 per cent would recommend the service to a friend in need of similar help.

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9. NORTHUMBERLAND, TYNE AND WEAR INITIAL RESPONSE SERVICE

Aims
- The Initial Response Service (IRS), providing a single point of access to Northumberland, Tyne and Wear NHS Foundation Trust, will ensure service users are referred to the right service and placed on the right pathway without any delay, keeping them fully informed of this process. If service user needs cannot be met by one of our services they and their referrer are signposted to the most appropriate service elsewhere, with an explanation as to why this is happening.

Rationale
Northumberland, Tyne and Wear NHS Foundation Trust (NTW) is one of the largest mental health and disability Trusts in England serving a population of approximately 1.4 million and providing services across an area totalling 2,200 square miles. IRS is a key development within our Principal Community Pathways (PCP) programme. PCP will design and implement new, evidence-based community pathways for adults and older people. The implementation will commence in June 2014 with the Sunderland CCG.

Development
NTW’s strategic direction is one of transforming services in order to ensure a sustainable future of higher quality services and clinical effectiveness, reducing overall costs of delivery by 20 per cent. We are working collaboratively with our partners to deliver this through the PCP programme, funded through transition reserves and incentivised through CQUIN.

Challenges
The volume and complex design of existing teams made accurate baseline measurements difficult. Adapting the wider organisation’s culture to embrace the lean approach will take time, and we envisage a delay in fully realising benefits while the new ways of working are embedded. Public sector financial pressures will continue. This must be considered when developing a new model which must be sustainable in the medium to long term.

Outcomes
Services will be easier to access. This new “front door” to NTW will be available 24/7 and receive requests for help both urgent and non-urgent referrals as well as providing advice and information. This new front end will be more integrated with partners organisations to ensure that residents receive the help and support they need. Where appropriate, previous patients needing to re-engage with services are quickly and easily put back in touch with the support team they are familiar with.

Top tips for commissioners
- Acknowledge that every system has inefficiencies and that your support is needed to identify and address these. Form relationships in which providers can be honest about difficulties around these challenges. Make imaginative use of CQUIN to incentivise innovative developments attached to the contract.

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10. DEVELOPING A MENTAL HEALTH TRIAGE SERVICE IN PRIMARY CARE

Aims
The service has evolved over 10 years experiencing at least three major re-configurations of community mental health services. During this time the service has had the following aims and objectives:
- Improving access to an initial mental health screening service for patients with mild to moderate mental health issues, working within a stepped-care model.
- After screening to give appropriate and timely advice, to signpost to suitable non-statutory organisations or to refer directly to specific local NHS mental health services.
- Offer and deliver the most appropriate treatment, since 2010 service users have been referred to the local IAPT service for CBT etc.
- Reducing inappropriate referrals from Primary Care to Secondary Care.
- Providing a service that satisfies the needs of GPs and the purchasers of the service.
- Improving/maintaining good working relationships with GP surgeries.

Rationale
As a result of changes to the roles of CMHTs, there was a large group of clients with mild to moderate mental health problems e.g. anxiety and depression who were finding it difficult to receive an assessment of their needs or an indication of where they could receive help. The service has undergone a number of changes over the last 7 years. Currently the service is undergoing a merger with the IAPT team.

Development
The first group of three triage nurses joined in some of the training programme for the graduate mental health workers. This was important in forging a bond between each nurse and their identified Graduate mental health worker. An audit was carried out to establish a profile of all existing services that was available. These included counselling organisations, housing associations, benefits and advice centres and many others. Public health data used to provide timely but time-limited interventions.

Extrapolating from my own activity levels 50 to 60 thousand referrals to PMHS/MHICT have been made in the past 10 years.
- Secondary care teams have been better able to focus on their target population of severely mentally ill patients.
- GPs feel much better supported and enjoy having a weekly visit from a clinician to run a clinic or provide advice.

Outcomes
- To improve access to an initial mental health screening service for patients with mild to moderate mental health problems.
- To give appropriate and timely advice, to signpost to suitable non-statutory organisations or to refer directly to specific local NHS mental health services.
- To offer and deliver the most appropriate treatment.
- To improve/maintain good working relationships with GP surgeries.

Challenges
Initial distrust by:
- GPs who had previously having increasing issues/problems in making referrals to Secondary Care.
- Secondary care mental health teams. Having a presence at CMHT meetings in order to communicate aims, objectives, etc. were important. As the number of referrals to CMHTs dropped they were able to see the benefits.

Top tips for commissioners
- Face to face time with patients is important.
- Primary Mental Health is very different from Secondary Care. Having experienced primary care mental health nurses and managers who are committed to the development of a primary mental health model is essential to the development/improvement of the service.
- A PMH service needs to be ‘light on its feet’, doing face to face time with patients as appropriate.
- Be clear and defined about the remit, scope and limitations of what the service can offer.
- Developing good relationships with secondary care.

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11. URGENT CARE ASSESSMENT AND CARE PATHWAY REDESIGN

Aims

» To create a single, consistently responsive and high quality, secondary care mental health assessment and treatment pathway for all professionals, users and carers to use across North West London (NWL).

Rationale

As a key enabler of the NWL strategic commitment to move care increasingly closer to people’s homes, into primary and community settings, referrees, service users and carers need to be confident that they access specialist secondary services when they are needed in a timely fashion and appropriate setting. Increased pressure on A&E departments, Police and GP Out of Hours services indicated that crisis services in particular would benefit from review and re-specification, with clear standards setting for access and all key stages of the assessment and treatment response. To do this, a ‘whole pathway’ view had to be established, with demand mapping across the system, and definition of the roles that services throughout need to contribute to successful delivery. Such an approach led to development of a Mental Health Crisis Concordat Delivery Plan ahead of its publication, February 2014.

Development

In two phases, Co-Production, involving clinicians, managers, CEOs of mental health Trusts, GPs, service users and carers, Police, Third Sector, Acute Urgent Care Boards, and local authorities:

» Phase 1 (April to June 2013) to produce and roll out NWL-wide Access Policy and Standards, Common Referral and Shared Care Paperwork, Assurance Dashboard and Toolkits to support Engagement, Communications and Workforce Skills Mix/Training roll out at local level.

» Phase 2 (January 2014 – March 2015) via a diverse membership Expert Reference Group, jointly Chaired by GP Urgent Care Lead and Metropolitan Police Lead, to define a model whole system pathway (pre-referral to discharge and ‘staying well’), populate with data/flow, co-produce care pathway service specifications covering Pre-Referral/Staying Well; Referral/Assessment; Treatment and Transfer/Staying Well, including ‘we-defined’ outcome statements, supporting providers to deliver robust transformation delivery plans to secure prevention and recovery focussed/social integration services to help better prevent crises and a 24/7/365 crisis advice, support, assessment and treatment, where and when its needed.

Resources required included;

» Phase 1: 28 days of senior level external consultancy, delivered over 14 weeks, including forward action plan for Phase 2. Participation of stakeholders in 2 large scale co-production events, plus venue costs, and smaller ‘task and finish’ working groups of c6 people each, to deliver paperwork, finalise standards, develop dashboard and both Toolkits.

» Phase 2: Two days per week Head of Urgent Care Programme (8D), Leadership/Supervision by Programme Director (1 day a week), administrative support for Expert Group, Chairing and attendance by Group members, Co-production workshops, Programme Delivery Leads within provider Trusts supporting delivery, allocation of CQUIN and Transformation funding within NHS contracts 2014-15.

Top tips for commissioners

» Invest in partnership and process – it’s all about people. Know your champions for change.

» Data and evidence should underpin the decision-making, but it’s people who make changes.

» Co-production is essential. Co-design is easy, co-delivery more of a challenge.

» Plan and map the whole pathway in one – vital to see the sum of the parts to learn more.

» The best-handled crisis episode is a prevented one. Believe in the agency of people with mental health issues. Invest in self-management, resilience and staying well services.

» Write a project Gantt in draft and double the timescales. Change is a process not an event.

Contact

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Contact

Sandra King, Project Director Ways to Wellness

1 Thanks for the Petunias, A guide to developing and commissioning non traditional providers to support the self management of people with long term conditions, NHS, 2011, http://www.diabetes.org.uk/upload/Professionals/Year%20of%20Care/thanks-for-the-petunias.pdf

2 http://www.nesta.org.uk/project/people-powered-health

3 Social Prescribing for Mental Health - and Integrated Approach (Draft report) http://movingforwardnewcastle.co.uk/
15. PRIMARY CARE PSYCHOTHERAPY CONSULTATION SERVICE (PCPCS)

Aims
- Support and advise GPs and other practice staff managing complex patients.
- Provide a service for referred patients—mainly medically unexplained symptoms/complex personality disorder.
- Perform joint consultations and practice meetings and raise the level of understanding of medically unexplained symptoms locally.

Rationale
People with medically unexplained symptoms, people with personality disorders and complex mental health problems frequently get bounced around the NHS. A group of GPs in City of London and Hackney decided to tackle this by setting up a new service in 2009. The PCT had an underspend and GPs lobbied to have this service commissioned. Mental health providers were not engaging with patients with complex conditions, and the patients did not believe they should see mental health professionals. The patients did not meet Community Mental Health Team thresholds and often were frequent attenders/multiple OPD etc. therefore costly to the system.

Development
PCPCS was implemented and run by Tavistock and Portman Foundation Trust offering help for a range of needs close to the patient’s home. This includes psychotherapies, joint consultation with GPs, and training for primary care staff to enhance their capacity to help. Approximately £800,000 was available to address this and the service was commissioned to serve 50 per cent of practices in Hackney—they are now in 95 per cent of practices. Estimated cost of 1 session of PCPCS treatment is £109 (full cost). Typical treatment lasts for 12–13 sessions therefore £1348 for average cost of PCPCS treatment per person. Based on cost effectiveness framework by PCPSC has a cost per quality adjusted life year of £10,900 (well below NICE thresholds of £20,000–£30,000) and therefore good value for money.

Challenges
This was unknown territory—GPs wanted a service, but the kind of patients we wanted to refer would not want to use it. We knew we wanted a service that totally committed itself to primary care values, engaging GPs, training, seeing patients in primary care. The interest and skills in mental health are variable between practices and we thought GPs may not be able to see the value of this service as identifying MUS can be difficult.

Outcomes
PCPCS improves health outcomes and leads to a reduction in health service in both primary and secondary care settings. There is good patient satisfaction and excellent GP satisfaction. There is more recognition of medically unexplained symptoms and need for a different approach. The Centre for Mental Health report states that the service is good value for money and an excellent service. The financial savings from the reduced service are equivalent to about a third of PCPCS treatment costs.

Top tips for commissioners
Use the CFMH report to challenge CCG boards as to why they do not have this service or similar. Prepare GPs by education sessions about personality disorders. Persuade GPs to give rooms. Persuade GPs to audit medically unexplained symptoms in their practices as this raises the issue and builds a momentum to get the service. Link this service into a primary care mental health model and pathways to other services.

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Further reading
For information on PCPCS including a full evaluation, service description, cost effectiveness and outcomes refer to the CFMH report entitled: The Evaluation of the City of London and Hackney Psychotherapy Consultation Service: http://bit.ly/1rSH2Jr

19. TOWER HAMLETS MENTAL HEALTH IN INTEGRATED CARE

Aims
- To improve health and social care outcomes through a coherent mental health offer as part of our integrated care system; improving identification of, and care planning for, mental health problems in patients with multiple co-morbidities; improving patient experience; reducing emergency admissions to hospital and length of stay for patients with a mental health problem who are admitted and reducing admissions to care homes. Developing recovery orientated primary care mental health services to support discharge from secondary care.

Rationale
Twentieth to 18 per cent of all spend on long term conditions is linked to poor mental health: 28 per cent of patients in acute setting have diagnosable mental disorder; 41 per cent have sub-clinical symptoms; 37 per cent of sample “integrated care” cohort known or previously known to secondary care; second highest proportion of patients known to secondary mental health care in London in Tower Hamlets.

Development
A whole system GP led approach across health and social care. Clinical and service user engagement was extensive, bringing together GPs and secondary care clinicians to identify opportunities, with finance and analytics support. A multi-agency Integrated Care Board reviewed the service model which included:

Care coordination: Risk profiling/avoiding unplanned admissions Direct Enhanced Service incentivises GPs to risk stratify population to determine integrated care cohort. Coordinated Care Network Incentive Scheme was used to incentivise GPs to coordinate care for patients at risk, including all patients with dementia. CHS incorporating an integrated CHT (including CHS, social care, palliative specialist nurse and community geriatrician) considering options for full integration reconfigured to link into paired GP networks. Mental health offer to include case-finding, consultation/training and CHS staff, assessment and treatment for patients.

Primary care mental health services: Network incentive scheme with GPs to support people with stable severe mental illness (focus on care, recovery planning, with incentives to promote smoking cessation and weight management); improved secondary care mental health support to primary care (all practices have regular MDT’s with a consultant in attendance, single point of access); Primary care mental health liaison nurse service, including social care; targeted voluntary sector support.

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Dept of psychological medicine: 24/7 RAID style liaison service: Single point of access for referral for all ages, mental health and drug and alcohol, all areas of the hospital and associated sites; Well resourced for senior clinical leadership, 4.5WTE consultant psychiatrists, Nurse consultant linked with University to develop and support training and education; Team retains specialisms in adults of working age, old age, and drugs and alcohol, but developing generic competencies for all staff; Records all activity on acute EPR, metrics to be reported via CSU to CCG; UCLP leading two year evaluation.

Contracting: Integrator specification developed with non-competitive assurance process with provider developed collaborative: Integrated care CQUIN for acute and mental health, 14/15 approach building relationships; 15/16 focus on outcomes and performance related reimbursement; 16/17 weighted capitation.

Challenges
Working across primary and secondary care to develop a single coherent vision is complex and needs time.

Outcomes
Under development, but range of metrics for liaison in place; range of metrics for primary care MH service in place; metrics for care coordination to be developed, but partially incentivised by CQUIN in 14/15. Financial impact: Significant 14/15 investment to deliver system savings in 15/16 and beyond.

Top tips for commissioners
- Ensure clinical buy-in from the very beginning across primary and secondary care
- GP leadership with early engagement of key local clinicians including LMC
- Use data to inform the model

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20. LAMBETH MENTAL HEALTH COMMUNITY INCENTIVE SCHEME (CIS)

**Aims**
- Improve the management and outcomes for adults (usually) with complex life problems; social, financial, housing, family etc. mental health problems (severe mental illness and other enduring mental disorders e.g. depression). Difficulties with coping with life circumstances; personality problems, lack of other support etc. Also those who would benefit from and accept the support of the Living Well Hub.
- Support GP practices to deliver high quality care to people with mental health problems that is evidenced based, person-centred and equitable.
- Reduce variation of mental healthcare offered by General Practice and improve the overall standard
- Support CCG and Local Authority to achieve QIPP saving target for 2014/15, and for the next 3 years
- Reduce activity in secondary care especially admissions and unscheduled and emergency care episodes. Specifically, the South London and Maudsley NHS Mental Health Foundation Trust (SLAM) is redesigning its services so as to align them with Living Well Collaborative principles and to achieve required efficiencies. A central component of the redesign is to reduce the caseload by 400 people.

**Rationale**
Reasons for a primary care mental health CIS:
- Dependence on secondary and unplanned care
- Address inequalities in physical health and long term unemployment experienced by people with SMI
- Improve access to social support in the community
- Improve the consistency of the primary care offer
- High relapse rates leading to use of A&E, acute admission and Mental Health Act assessments
- Implement co-production – leading to cost efficiencies

**Development**
SLAm and the Lambeth Living Well Network (LWN) have identified people who would benefit from moving on from secondary care but who require more input than primary care can offer. The CIS sets out the approach to support people in the community and the tasks that general practice needs to undertake to deliver an enhanced level of care. The CIS provides resources and incentive payments to GP practices to develop an integrated, person-centred and outcome based service offer in the community that promotes recovery, wellbeing and social inclusion. The CIS provides resource in the form of the LWN Mental Health Hub. The hub is a new front door to mental health services which is a collaboration between secondary care Lambeth Council, Clapham SPMS (manages nurses within the Primary Care Support Service), Thamesreach, (providing social support) and Missing Link (a peer support group managing staff). The hub allocates leads to each GP locality and will encompass the clinical, social and peer support elements of the offer. Hub staff will regularly hold their surgeries within GP practices where they can work with service users and staff.

NB. CIS is one element of a wider GP Delivery Framework. The GP Delivery wraps up all previous Local Enhanced Service into one scheme. To ensure full population coverage and equity of access, from April 2014, practices will sign up to the Delivery Framework and all its constituent parts rather than to individual LESs. In some instances, some practices will not be able to commit to delivering all the components. In such circumstances, the practice will work with practices in its locality to make alternative arrangements for their patients to access services.

**Challenges**
The hub operates in the north of the borough and a bid has been made to Guy’s and St Thomas’s Charity for resources to roll-out to the south. The CIS requires practices to establish effective administrative and organisational procedures which practices in the south can put in place.

**Outcomes**
The Lambeth Living Well Collaborative has identified three overarching outcomes called the ‘Big 3’:
- Recover and stay well
- To make their own choices and achieve their personal goals
- To participate on an equal footing in daily life

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21. SEVERE MENTAL ILLNESS LOCAL ENHANCED SERVICE

**Aims**
- To develop a local enhanced service for severe and enduring mental illness. The initiative aims to discharge stable patients- clusters 1-3 and 11 into a stepped down service supported by support from mental health workers and GPs in primary care.

**Rationale**
Three CCG Mental Health Leads in East London (City of London and Hackney, Newham and Tower Hamlets) joined together to develop a recovery based service following data which revealed that there were many patients remaining as out patients who were not receiving a supportive service.

**Development**
The service took one year to develop and implement. To get the service off the ground there were some financial issues to be addressed. Initially patient data was collected under community mental health teams, guidelines were developed to determine eligibility for stepping down and communication channels were established between primary and secondary care clinicians for permissions/contacts to be agreed. Clear guidance was derived for GPs and patients to understand processes to follow (appointments, recovery care plans, physical health checks etc.). Easy, fast access back into secondary care was also identified if necessary.

**Challenges**
The main challenges were:
- Persuading the provider and primary care that this was a safe and stable option for patients.
- Obtaining data
- Skilling up general practice staff
- Establishing effective pathways for step down and step up

**Outcomes**
As a result, more than 1400 patients in the past two years have been successfully discharged through to enhance primary care service across the CCGs. Patients state that it felt good to be talking about recovery, they felt they were improving and it was nice to have a named contact worker and set appointments.

**Top tips for commissioners**
- Recommend recruiting a project manager for additional support. Need project manager support.
- To run education sessions and workshops with providers and service users
- Careful data analysis.
- Sufficient mental health workers with a primary care leaning.
- Support for GPs

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22. SERVICE USER INVOLVEMENT IN MENTAL HEALTH COMMISSIONING

Aims
» To embed user voice at the top of commissioning decisions.
» To allow genuine power and influence for service users- not tokenism.
» To develop confidence and leadership within the service user group to become an autonomous and independently functioning group with skilled users.
» To build social capital amongst service users and exploit the opportunities for increased social value across commissioning and provision.
» To develop a system of governance for mental health services, which are executive and user led.

Rationale
The initiative came about as a jointly commissioned (LA/CCG) service user group (hosted by a voluntary sector organisation) were commissioned to develop a training package for group members. An advisory group would regularly feed into the commissioning process. £50,000 was provided for a two year development programme.

Challenges
» It is difficult to maintain momentum to form a group and ensure that it is fully representative. Initially most of the members had severe and enduring mental illness. It is hoped that patients with less severe illness will join and that the whole age range and ethnic mix of the community will be represented.
» It is important that the group see the results of their input and that they are helped to develop responses to questions asked of them.
» The ambition is for the group to have executive power over commissioning decisions. This will take time, focus and energy.

Top tips for commissioners
» Training and support is vital- so aligning with a voluntary sector organisation for support is encouraged.
» Have some practical problems to address rather than concepts.
» Have some projects which will show results e.g. CQUINs and show that user views have directly affected commissioning.
» Allow service users to identify some priorities and ways they want them addressed- even when these are not CCG priorities but be honest and realistic about what can be changed.

Outcomes
The initiative has had really positive feedback to date. The group has contributed to an excellent prescribing project posing very good challenges to our mental health provider to respond to. In addition the group was involved in CQUIN proposals this year (2014) and have been instrumental in designing a new set of inpatient standards.

23. EDUCATION AND TRAINING FOR FRONTLINE STAFF IN CAMDEN

Aims
» To provide specific and targeted education, awareness and skills training across primary and secondary care. This is aimed at helping health professionals to recognise early indications and risk factors for common mental health disorders, personality disorders, PTSD and medically unexplained symptoms.
» To develop a programme of awareness and skills training for frontline staff, local communities and others to improve engagement, reduce stigma, support earlier recognition of mental health problems and suicide risk and signposting to effective support.
» Improve support to GPs in identifying and treating people with alcohol problems within primary care, including training for the RCGP certificate in the management of alcohol problems.

Rationale
In 2013 Camden CCG conducted a wide ranging review of how mental health needs were being addressed. This process involved focus groups and one to one interviews with service users amongst other methods. One of the most frequent messages heard was the need for improved mental health awareness and training for frontline staff across the local health and social care services. There was also a strong theme of promoting earlier recognition of mental health problems in all health services, and particularly recognising and treating alcohol problems in primary care.

Development
Wandsworth CCG and South West London and St Vincent NHS Foundation Trust (LA/CCG) group was involved in CQUIN proposals this year (2014) and have been instrumental in designing a new set of inpatient standards. £50,000 was provided for a two year development programme.

Challenges
It is difficult to maintain momentum to form a group and ensure that it is fully representative. Initially most of the members had severe and enduring mental illness. It is hoped that patients with less severe illness will join and that the whole age range and ethnic mix of the community will be represented.

Outcomes
An outcome framework has been developed for the mental health programme as a whole. For this particular component, measures of awareness of best practice and of available services will be monitored. As a result of increasing awareness and earlier recognition, more people with mental health problems should have these recognised at an earlier stage. This will take time to establish; symptom severity and use of interventions will be monitored, along with primary and secondary care data on mental health and alcohol diagnoses.

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Wandsworth CCG and South West London and St Vincent NHS Foundation Trust (LA/CCG) group was involved in CQUIN proposals this year (2014) and have been instrumental in designing a new set of inpatient standards. £50,000 was provided for a two year development programme.

Challenges
It is difficult to maintain momentum to form a group and ensure that it is fully representative. Initially most of the members had severe and enduring mental illness. It is hoped that patients with less severe illness will join and that the whole age range and ethnic mix of the community will be represented.

Outcomes
An outcome framework has been developed for the mental health programme as a whole. For this particular component, measures of awareness of best practice and of available services will be monitored. As a result of increasing awareness and earlier recognition, more people with mental health problems should have these recognised at an earlier stage. This will take time to establish; symptom severity and use of interventions will be monitored, along with primary and secondary care data on mental health and alcohol diagnoses.

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24. APPLYING VALUE BASED COMMISSIONING TO MENTAL HEALTH IN CAMDEN

Aims
- To use the value based commissioning model to drive better outcomes for people with mental health problems, and to improve the experience of service users.
- To provide a mechanism for acute, community, primary care and mental health providers to work together to improve outcomes for people with psychosis, providing truly integrated care.

Rationale
CCGs in North Central London are engaged in a developmental programme of Value Based Commissioning (VBC). This is being applied to frail and older people, people with diabetes, and Camden and Islington CCGs are developing this approach for people with mental health problems. The process has been facilitated by consultants with experience in VBC.

Development
Phase 1 of the programme involved the co-production of outcomes that matter to people with mental health problems. A day-long workshop was held in November 2013 where a long-list of outcomes was generated from patients, providers, commissioners, clinicians and managers. This concentrated on outcomes that mattered for patients with depression and patients with psychosis. Similar outcomes were then grouped together, including groups such as ‘Recovery / Improvement in Symptoms’, ‘Experience of Care’ and ‘Social Outcomes’. The outcomes were then prioritised for each CCG in consultation with an expert reference group.

Phase 2 of the programme involves the agreement of a shortlist of outcomes and accurate methods of measurement for these outcomes. This has required identification of suitable measures and potential data sources, as well as design of new measures where needed. Once these are then agreed, the intention is to use these outcome measures within contracts with providers of ‘Integrated Practice Units’ (IPUs). IPUs are organised around a set of closely related conditions, where a multidisciplinary clinical team delivers patient care throughout the full cycle of care.

Challenges
This work has coincided with considerable reorganisation in the commissioning of mental health services, a major review of mental health provision in Camden, and the implementation of Mental health tariff. It became apparent that the VBC work would need to be closely aligned with the development of mental health tariff, and was an opportunity to add value to this.

The initial planned scope included both people with depression and anxiety, and also people with psychosis. However it was recognised that the needs and outcomes for these two groups may differ considerably, making the development of a coherent Integrated Practice Unit difficult. There were also concerns from commissioners and from providers about the potential destabilising risk of applying this approach too broadly at the same time. The intention is therefore to initially pilot this approach to people with psychosis.

Contact
Dr Alex Warner, Clinical Lead for Mental Health, Camden CCG
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25. DEVELOPMENT OF A LOCAL ENHANCED SERVICE FOR SERIOUS MENTAL ILLNESS

Aims
- Provide step-down support to patients discharged from Specialist Mental Health teams in Brighton and Hove into primary care
- Increase patient choice of service delivery
- Improve integration of physical and mental healthcare and personalised care planning
- Improve relations across primary and secondary care and
- Enhance the quality of physical health screening for SMI patients.

Rationale
The initiative has been running since 2011, it took approximately three years to draft to specification, largely due to changes to commissioners, commissioning structures, the government and busy schedules. The project was developed to support the recovery and wellbeing agenda which recognised that not all patients required treatment and support in secondary care. This also coincided with a number of changes nationally to commissioning structures and mental health services.

Development
The project recruited two liaison nurses who were linked to a group of surgeries and managed a maximum case load of fifty patients. The nurses were provided with laptops and travel passes. Provision of psychiatry tele-consultation, completion of training and audit was costed (however no training/audit costs were incurred).

A specification was developed based on clinical priorities identified by GPs

A review of the demographics of service users in depot clinics was performed

GP attitudes to current service provisions was captured in an evaluation as well as potential barriers to developing primary care based services for this population

National models and successful local enhanced services in other areas were made available

Challenges
- Cross matching patients to surgeries to ensure we targeted the right practice
- Culture change in discharging patients earlier form MH teams
- Encouraging GPs to view the benefits of the scheme
- Getting the right amount and type of training in place
- Getting everyone on board that need to be to get the project started

Outcomes
The project has not been formally evaluated as audit and QOF results are not available at present. There have been individual case reports of reduced A&E presentations/non urgent GP appointments/calls to mental health duty desk, and there appears to be a good user satisfaction from feedback to the nurses – this focuses on accessibility, support, and being able to be discharged from mental health services whilst still being able to access them quickly if necessary.

Top tips for commissioners
- Identify larger practices with large mental health user population
- Scope suitable clients with practices
- Encourage good relationships in shared care pathway working
- Get both parties around the table to develop ideas about what is workable
- Cluster 11 pathway interventions can cost less resourced and managed in primary care
- You need a tenacious steering group

Contact
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z.pan妮@sussexpartnership.nhs.uk

Linda Harrington, Lead Commissioner Mental Health, Brighton and Hove
Linda.harrington@nhs.net

Dr Rebecca Jarvis, CCG Mental Heath GP Lead, Brighton & Hove CCG
Rebecca.jarvis@nhs.net
26. **WebGP**

**Aims**
WebGP uses GP practice websites to allow patients to consult their own GP remotely for common general practice issues (including anxiety, depression and panic attacks). The aim of WebGP is to allow patients to access the following from their GP practice website:
- Find self-help information and signpost them to locally commissioned services appropriate to their condition e.g. Big White Wall, online CBT
- Use symptom checkers to ensure they approach the right service for their symptom severity
- Access a 24/7 nurse call back (within an hour)
- Submit a webform from their practice website for their GP to consider and respond to within 1 working day

**Rationale**
The service was developed to:
- Improve patient access (83 per cent friends and family recommendation)
- Help ease pressures on practices (300 hours of appointment time saved in six month pilot)
- Improve use of urgent care (14 per cent of users polled said they would have attended urgent care had the service not been available).

**Development**
Initial funding came from NHS London, Tower Hamlets CCG and the Hurley Group. The plan going forward is to create a sustainable business model to make the service available to all CCGs and GP practices on a commercial basis.

**Challenges**
Challenges include future funding for on-going development as well as scaling up. This means the speed with which we can disseminate the offer is constrained. Also, GPs fears over supply-led demand were a barrier to growth, but this has diminished as we have built an evidence base around improved GP capacity.

**Outcomes**
WebGP has been mobilized for 25 London practices to date (covering about 175,000 patients) with many more keen to join. A total of 33,000 patients have used the website in 6 months with large numbers using the various online tools. It is the Hurley Groups intention to make WebGP available to all practices. WebGP has led to increased access, improved health outcomes, better practice and commissioner efficiency. Mental health presentations figures show WebGP to be the most popular online consultation. This may be because patients may feel more able to divulge this information online (digital disinhibition). This allows patients to present sooner and for GPs to intervene earlier, from which we can infer better outcomes.

**Top tips for commissioners**
Commissioning WebGP in practices can improve general practice productivity by helping GPs manage more minor conditions remotely (60 per cent in pilot). This frees up capacity to cope with more complex patients face-to-face. It also permits the presentation of mental health issues at an earlier stage.

**Contact**
Dr Arvind Madan, GP Partner, CEO Hurley Group
Arvind.madan@nhs.net, 07956217974

27. **Digital mental health service (Big White Wall)**

**Aims**
It is hoped that Big White Wall, the digital mental health service for treatment of common mental illness will:
- Increase access to mental health services, particularly for groups who have lower levels of current service use and high unmet need.
- Increase self-referral and provide a service which is accessible 24 hours per day.
- Provide early intervention for individuals who are experiencing poor emotional/mental wellbeing and thus to reduce the need for avoidable, expensive interventions.

**Rationale**
There is significant mental illness within the local population and importantly a need to provide services for people who do not meet the criteria for higher steps (Steps 2 and 3) in the stepped care model. Southwark currently does not provide digital mental health and well-being services in primary care.

**Development (to be implemented)**
Southwark CCG was successful in an application to the Regional Innovation Fund (RIF) in March 2014. We hope to implement the service in July 2014 and are currently at the start of a local publicity campaign. Southwark CCG has been awarded a budget of £50,000 plus evaluation costs.

**Desired outcomes**
Southwark CCG is re-commissioning the entire pathway for primary care psychological therapies and it is hoped that feedback from this pilot will inform the scope for a future digital mental health services.

**Top tips for commissioners**
Although this is a new type of service for Southwark, it has been developed in a context which values health promotion, evidence based practice, partnership working and integration. It has also come at a pertinent time and will provide valuable data to inform future commissioning decisions. Practical demonstration of this new service was vital to simulate the interest of the team and ensure endorsement by clinicians.

**Contact**
Carol-Ann Murray, senior mental health commissioner, Southwark CCG
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Dr Nancy Kuchemann, Mental Health GP Lead, Southwark CCG
nancy.kuchemann@nhs.net
28. “Evolve” – Mental Health Long Term Conditions Navigator Service

Aims
- Support adult service users with a serious mental illness in their discharge from secondary to primary care
- Ensure service users attend appointment - GPs/practice nurses to monitor mental and physical health
- Using a person-centred recovery focus, to support clients to reduce any social isolation they may be experiencing by an increased access to a variety of local opportunities/services.

Rationale
The Mental Health Long Term Conditions Project ‘Evolve’, part of CREST Waltham Forest a local voluntary sector charity, was commissioned to provide four navigators and a team leader in April 2012 by Waltham Forest CCG for the annual sum of £187,000.

Development
Working with a designated Navigator for a period of 12-18 months, clients attended 3 to 4 20-minute appointments where GPs and practice nurses monitored their mental and physical health. Where any health issue was discovered at these meetings, the Navigator worked with the client to ensure they attended out-patient assessments at hospital alongside any pre-requisite health assessments (blood tests, scans, x-rays). Navigators kept regular contact and offered reassurance along with a practical approach. During the 12-to-18-month period, Navigators used a person-centred recovery focus to support clients to reduce any social isolation by increased access to a variety of local opportunities/services. With Navigators support, GPs and Practice Nurses from 13 surgeries have managed the discharge of approx. 200 patients from secondary care. All discharge meetings held by secondary care have been attended by a Navigator to ensure a clear/easy transition back to primary care. A redesigned Discharge Care Plan has been completed to ensure the accepting GP receives full details on managing the mental illness and any medication to minimise relapse. Navigators also encouraged clients to complete a Wellness Recovery Action Plan (WRAP) as part of their recovery. Navigators have supported primary care staff to complete a comprehensive template installed at the surgery to capture data that measures the progress of patient’s mental and physical health. The one-to-one Navigator sessions were recorded on the social inclusion/recovery template at the Evolve office.

Challenges
The primary challenge has been limiting the number of clients/GP practices as, with an increased awareness of the Navigators, more clients along with secondary care practitioners wanted to be able to access it.

Outcomes
Initial outcomes of the pilot have shown that the expertise of the Evolve team has contributed to:
- Reduction in acute hospital admissions
- Reduction of clients at A&E in favour of seeing their GP first
- Reduction by GPs in re-referring clients back to the Access and Assessment Team
- Reduction in time spent back in secondary care if a client has required inpatient/referral
- Reduction in stigma associated with receiving a depot injection at a mental health venue through clients accessing a practice nurse alongside other patients with no mental illness

Top tips for commissioners
It is essential to establish regular dialogue between primary and secondary care practitioners to ensure effective management of these clients in their local community.

Contact
Chris O’Sullivan, Evolve Team Leader, CREST Waltham Forest, chris.osullivan@crestwf.org.uk

29. Programme of Education in Diabetes for Care Coordinators

Aims
The initiative is to achieve the nine care processes for people with diabetes and serious mental illness comorbidity. The programme will determine whether a brief educational intervention for mental health care coordinators can provide better uptake of care processes and improved outcomes for those with schizophrenia and Type 2 diabetes in terms of glycaemic control, blood pressure management and lipid management as well as improved quality of life. Objectives include:
- Develop an education intervention, underpinned by adult learning theory, to provide mental health care coordinators with applied knowledge of the history, treatment and required care processes to effectively manage Type 2 diabetes as well as basic motivational interventions to facilitate concordance with self-care behaviours.
- Deliver an educational intervention for mental health care coordinators in a community based setting.
- Optimise the proportion of people with schizophrenia and Type 2 diabetes who attend for annual review of their diabetes, have a care plan and access the nine care processes of diabetes care.
- Measure the uptake of the 9 care processes for diabetes care for those with existing Type 2 diabetes before and 6 to 9 months after the educational intervention.
- Measure the proportion of people meeting outcome for targets for blood pressure ≤140/80, HbA1c ≤64mmol/mol and cholesterol ≤5.0mmol/l before and 12 months after the intervention.
- Measure quality of life before and 6 to 9 months after educational intervention.

Rationale
The rationale for this programme was due to poor diabetes control and difficulty in engagement of people with severe mental illness and diabetes identified by consultant diabetologist, confirmed by GPs.

Development
The one year programme started in November 2013. It is funded by a successful bid to the South London Innovations Awards- aimed at promoting the design, implementation and diffusion of innovation in health care education and training in South London: http://bit.ly/1iqWbD5

The judging panel included South London Member- ship Council, Health Education South London and South London Academic Health Science Network board members. The financial breakdown is below.

<table>
<thead>
<tr>
<th>Resources</th>
<th>Cost</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational materials, etc</td>
<td>£5,000.00</td>
<td>£5,000.00</td>
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<td>£11,540.00</td>
<td>£13,463.45</td>
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<td></td>
</tr>
<tr>
<td>£20,327.52</td>
<td>£22,783.59</td>
<td></td>
</tr>
</tbody>
</table>

Challenges
Engagement of the mental health trust to release staff for training (the consultant was also undergoing reorganisation within the trust).

Outcomes
There has been a positive response from care coordinators to the training package. Expect improvements in the uptake of the nine care processes in these patients and improvement in outcomes – HbA1c and BP control.

Top tips for commissioners
Pilot not yet completed therefore will advise when complete.

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Dr Charles Gostling, GP, Lewisham & Greenwich NHS Foundation Trust Charles.gostling@nhs.net
30. Wheel of Wellbeing (WoW)

Aims
- The Wheel of Wellbeing is a simple framework designed to translate well-being theory into positive practice to help build more flourishing communities.

Rationale
More is showing how certain actions, activities and practices can improve mood, reduce the risk of depression, strengthen relationships, keep us healthy and even add seven years to our lives. At the heart of the Wheel of well-being is the WoW website (www.wheelofwellbeing.org). It’s a practical collection of free tips, tools, activities and ideas, all designed to inspire people to develop new ways to improve well-being, whether from an individual, group or strategic perspective.

Development
Over the last six years the South London and Maudsley NHS Foundation Trust, in partnership with UsCreates, a strategic design company, worked with a diverse range of communities to develop, design and test a range of open access web-based resources and materials to spread the word about positive mental health and well-being.

Challenges
- Allowing enough time to develop, test and improve staff again.
- Funding

Outcomes
The WoW website and resources will officially be launched on 11 July 2014 but as part of testing it has already been used in nine London boroughs through the Well London Programme and is being rolled out by Kent County Council as part of a major programme to promote mental well-being of residents. The WoW is also being used to integrate well-being into mental health services in south London.

Top tips for commissioners
- Design and creativity are key aspects of mental health promotion
- Consistent messages, images and branding are important
- Spreading messages peer to peer can be very effective
- Make it easy for others to use and adapt your messages and materials

Contact
Sherry Clark, Research and Development Manager, South London and Maudsley NHS Foundation Trust sherry.clark@slam.nhs.uk

31. Happier@work

Aims
The aims of the initiative are to increase staff well-being, increase productivity, reduce staff stress, reduce sickness absence and increase recognition of mental health problems.

Rationale
We spend one third of our lives, and half of our waking hours, at work. Creating optimal conditions for happier working lives seems a worthwhile aspiration – for individuals, teams and organisations. Since November 2011, King’s Health Partners has been running the happier@work programme to improve staff well-being.

Development
A range of King’s Health Partners’ staff including clinical services, HR, occupational health and mental health promotion, worked with seven teams to discover what it’s like to work at King’s Health Partners and to create a realistic picture of what might help to improve staff well-being. Each of the seven teams was involved in exploring the factors that have an impact on employee well-being. They participated in a group process called a mental well-being impact assessment (MWIA) and each team was ‘job-shadowed’ to record their daily experience – in a clinic or for a specialist health service. As a result, a range of new pilot initiatives were provided for King’s Health Partner staff under the banner ‘Lights’ seminars. Approximately 500 staff benefited from the programme in the first year.

Challenges
Challenges include engaging busy staff teams, staff being released to attend interventions and the completion of baselines and follow up questionnaires.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Follow up</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-being</td>
<td>60% lower than average well-being</td>
<td>53% lower than average well-being</td>
<td>7% increase in well-being</td>
</tr>
<tr>
<td>Psychological health</td>
<td>35% threshold for minor psychiatric disorder</td>
<td>16% threshold for minor psychiatric disorder</td>
<td>19% reduction in minor psychiatric disorder</td>
</tr>
<tr>
<td>Sickness absence (burnout)</td>
<td>21.8% average time limited performance</td>
<td>14.7% average time limited performance</td>
<td>Reduction in time taken off in last 2 weeks but no significant difference</td>
</tr>
<tr>
<td>Productivity</td>
<td>7.1% reduction in average time limited performance</td>
<td></td>
<td>15% increase in those who would recommend their trust as a place to work</td>
</tr>
<tr>
<td>Employee satisfaction</td>
<td></td>
<td></td>
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</tbody>
</table>

Outcomes
London Southbank University (LSBU) performed an evaluation. Whilst the indicators of well-being improved and mental ill health decreased the sample size is too small to be conclusive. LSBU concluded that, “despite the methodological difficulties of this evaluation, the results would suggest that well-designed employee well-being interventions that are integrated into the workplace could help increase the well-being of employees”.

Further funding has been secured therefore an additional 150 staff have benefitted from the programme. In 2014/15 the interventions are being funded by individual KHP training departments. Kent County Council has also commissioned happier@work for their staff, which commenced in January 2014.

Top tips for commissioners
- Senior level support is crucial
- Understanding the well-being context of the organisation and tailoring the interventions accordingly
- Ensure regular feedback loops to influence organisational understanding of staff well-being
- Strong branding and cross promotion of well-being interventions

Contact
Tony Coggins, Head of Mental Health Promotion, South London and Maudsley NHS Foundation Trust, tony.coggins@slam.nhs.uk
32. Mental well-being impact assessment (MWIA)

Aims
» Maximise wellbeing potential and add value to programmes, projects, services, workplaces, policies
» Develop local measures of mental well-being
» Integrate mental well-being in policies programme and services
» Inform commissioning of services and programme
» Increase understanding of mental well-being

Rationale
Virtually all areas of policy making, commissioning and provision of goods and services are capable of producing mental wellbeing to at least some extent, yet when considering mental health the focus remains in mental illness. The Mental Wellbeing Impact Assessment (MWIA) is a systematic approach to assessing how proposals, programmes, services, employers and projects can capitalise on opportunities to promote mental wellbeing, minimise risks to wellbeing and identify ways to measure success in achieving wellbeing. MWIA uses Health Impact Assessment methods but focuses on the factors that are known to promote and protect mental wellbeing:
» A sense of control over one’s life including having choices and skills
» Communities that are capable and resilient
» Opportunities to participate e.g. in making decisions, through work
» Being included: having friends, family, work colleagues

Development
MWIA was developed in the UK but is in use globally. It was developed through a national collaborative leading to the publication of a final online version in 2011.

Challenges
» Identifying funding for longer-term evaluation of the toolkit

Outcomes
» Evaluation: ‘compelling qualitative evidence that MWIA has helped initiatives increase positive impact on mental well-being’ (Tavistock 2014)
» Highlighted in UK mental health outcomes strategy (HMG 2011)
» Over 750 MWIAs have been undertaken, 20,800 MWIA Toolkit downloads in the last 24 months
» MWIA training now accredited by the Royal Society of Public Health, over 250 people trained
» Integration with Equality, and Health Inequality Impact Assessments

Top tips for commissioners
» Ensuring that decision makers are involved in the initial scoping of the MWIA and are in a position to take forward recommendations.
» Ensuring a good spread of stakeholders in the process improves the quality of the data

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Further reading
The MWIA toolkit, guidance and MWIA reports are available on the Health Impact Assessment Gateway: http://bit.ly/V2mvGo

33. Primary care mental health forum

Aims
» The aim is to provide a platform for feedback on the service which mental health users receive in primary care. This develops effective service user involvement and co-production in primary care services. It also improves the experience of people with mental health problems in primary care.

Rationale
The project came about in the planning of Shifting Setting Of Care (SSoC) to support the process of service users being transferred from hospitals and secondary care to primary care (clusters 3-6 & 11) where a more preventative approach can be addressed. The first forum was in February 2013.

Development
The project was developed alongside a user involvement project. With no additional funding, GPs and Primary Care workers gave up their time to attend. It was heavily reliant on relationships and informal partnership working. The forum has a quarterly action based feedback cycle.

Challenges
» Development: Difficult to target SSoC group of service users however a need to provide the platform for all mental health service users was recognised and therefore client group was widened. The starting point was people being discharged under the SSoC including people accessing their GP to manage their mental health (clusters 1-2) and people still accessing secondary care.
» Feedback cycle – getting relevant feedback to relevant practice (32 GP practices) further development needed.
» Keeping forum members on topic and not trying to resolve individual health problems within the forum. Request suggested agenda items at point of invitation/meeting reminder – strong group facilitation skills
» Attendance: getting people to engage and insuring the group are representative of the borough. Utilise networks to promote & reach wider group of people. Ensure there is something of interest at meetings outside of the feedback cycle, for example, people like that the group is attended by a GP.

Outcomes
» Identifying gaps in training needs; for example, GP administration staff needing basic mental health awareness training which we are currently in the process of rolling out across the borough.
» Service users having a better understanding of the service they are entitled to receive and what to do if they are not receiving that service.
» Being able to link service users in with other H&F Mind projects when they are being discharged back and are feeling isolated and without support.
» Peer support and being able to compare the service they receive with others.

We would like to see improvements in the service mental health secondary care users receive from primary care. Currently developing how to evidence this.

Top tips for commissioners
It is essential to get buy in and support from primary care providers. It worth thinking about resources which are available to action change based on feed-back. A watertight feedback cycle and actions must be in place; members will disengaged if they don’t see change and improvements.

Contact
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35. INTEGRATED MENTAL HEALTH TEAM BASED WITHIN POLICE HEADQUARTERS

Aims
The aim of the project is to have an Integrated Mental Health Team based within the Control Room at Police Headquarters in Norfolk. The objectives of the project are to:

- Improve safeguarding for those suffering from mental ill health
- Introduce and provide early access to services for those with mental health issues before they reach crisis point
- Provide an improved police response to those in mental health crisis by identifying appropriate intervention and referral pathways
- Provide an improved response to repeat callers with mental health issues and thereby reduce demand on the police services
- Improve joint working between Norfolk Constabulary and Norfolk and Suffolk Foundation Trust (NSFT), East of England Ambulance Service and Norfolk County council when responding to mental health issues due to co-location and sharing of expertise
- Reduce demand across NSFT and Norfolk constabulary. This will be evaluated by randomised controlled trials and the University of East Anglia are doing a full academic evaluation.

Rationale
As Norfolk is a large rural county it was felt that Street Triage would not have as much of an impact as having a mental health team based within the control room. A funding request was sent to the Police Innovation Fund who approved funding for a trial period to scope the project and its value.

Development
The project is a joint partnership between NSFT. The NSFT seconded a Senior Nurse to scope the project, which provided many benefits and efficiencies (see ‘outcomes’). Following the success of the scoping bid a full bid has been submitted to the Police Innovation Fund for one Band 7 Clinical Team Leader and three Band 6 Mental Health Practitioners. The bid has requested funds of £170,000 to enable the project to be implemented. The outcome of the bid will not be known until June 2014. Due to the success of the pilot, the Chief Constable has agreed to release money from the constabulary ahead of the bid results to enable the project to be implemented. We are currently about to interview for the Band 6 positions, a Band 8a Nurse has continued to be seconded to the project with the funding coming from the NSFT and the Constabulary. Year 2 funding has been applied for and we are engaging with Commissioners about the longer term funding.

Challenges
The development phase has been very successful. There have not been any pitfalls or significant challenges. Norfolk is the only Police force to have an initiative such as this and it has forged strong partnership links with NSFT and other agencies.

Outcomes
The scoping project has shown many benefits such as cost reductions for the Constabulary and the NSFT as a result for example a reduction in S136 detentions. The welfare of Service Users was enhanced by them being able to obtain a more appropriate and timely service with early referrals made to more suitable agencies. There has been improved confidence and skills of staff when responding as first contact within the Control Room. Other police forces are showing interest in this project as we have demonstrated real time benefits. Police officers have direct access to a mental health professional whilst at the scene of incidents enabling an improved response by the Police, a reduction in harm, threat and risk in the most vulnerable communities, improving professional understanding across the Police and the NSFT leading to an enhanced working relationship and finally increased confidence and knowledge of mental health by police officers and staff.

Contact
Terri Cooper-Barnes, Lead Mental Health Nurse, Norfolk and Suffolk Foundation Trust
terri.cooper-barnes@nsft.nhs.uk
Amanda Ellis, Chief Inspector, Norfolk Police
ellisam@norfolk.pnn.police.uk

36. FEEL GOOD GREENWICH

Aims
» The programme aims to provide support and opportunities for local residents to access services, evidenced to promote and maintain mental well-being and to evaluate the impact of uptake of these services via Feel Good Greenwich. The project aims to evaluate the impact Feel Good Greenwich has in the uptake of the five ways to wellbeing by providing support and opportunities to access services, evidenced to promote and maintain wellbeing. The overarching call to action is that we want people to recognise that ‘life can always get better’ by accessing activities and interventions offered via Feel Good Greenwich.

Rationale
The programme was officially launched on World Mental Health Day in October 2012 after a 12 month period of scoping, social marketing research and partner and resource development. After 2.5 years, the project has just completed its pilot phase and is currently being reviewed for future delivery. The recognition of a gap in addressing the variation in the mental wellbeing needs of The Royal Borough of Greenwich led to Feel Good Greenwich being considered as an umbrella service that could potentially reach those on the spectrum of mental health need but also to increase the recognition of the benefits of a mental wellbeing focus for all.

Development
The programme is committed to building mental capital through addressing the languishing population and targeting specific groups who are recognised as being at ‘risk’ of developing mental ill health. One specific target focus has been to consider the needs of the 16-24 years group although in the main, the activities are aimed at 18+. The programme is fairly broad in providing access to services that are evidenced to promote and maintain mental wellbeing. Grounded in the five ways of wellbeing, the programme includes partner services that resonate with the five ways messages, commissioned services where gaps were identified, has created a range of resources to promote focussed conversations and goal planning including a bespoke ‘Top Tips’ well being wheel and user guide as well as training for front line staff, offers an online navigation service and a phone line for additional support. The extent of the programme offer includes Pop Up Villages and piggy backing other events to promote and engage the population in awareness of the service, direct conversation around wellbeing and to sign post to activities. The project is currently funded at £50,000 per year.

Challenges
The main challenge has been to evaluate the depth and breadth of the service impact given the extensive nature of the offer and in many cases the indirect effects of feel good as a permeating presence in the wider population. Establishing strong links with GPs in the delivery of signposting to FGG has been a slow process and yet remains integral to the project success.

Outcomes
We have collated a number of case studies which are accessible via Feel Good Greenwich website on the Top Tips webpage (www.feelgoodgreenwich.co.uk). Recent analysis shows that we can evidence 3,500 to 4000 people having engaged with Feel Good in the past 18 months. There is more specific data from wemwebs* indicating positively the distance travelled within specific interventions.

*Warwickshire Edinburgh mental wellbeing scale - a self report subjective well being measure used broadly to assess population well being. Refer to http://bit.ly/1mdCexU

Top tips for commissioners
Do not be too broad in scoping if others want to do something similar

Contact
Carole Stagg, Creative Consultant and Coach, Royal Borough of Greenwich
Carole.stagg@greenwichmind.co.uk
38. MANAGED CARE NETWORK FOR MENTAL HEALTH

Aims
The Managed Care Network for Mental Health was created to strengthen what is available to people once they are well enough to be discharged from Lincolnshire Partnership NHS Foundation Trust (LPFT) services, and to prevent the need for specialist mental health services in the first place. It helps people who have already experienced mental health problems, or who are having their first experience of mental illness. Unlike Personal Budgets, people will not need to be eligible under Social Care Eligibility Criteria.

Rationale
Since 2011, LPFT has been working with key partners to implement a Mental Illness Prevention Strategy. The focus of this work has been the establishment of a “Managed Care Network” of groups and organisations to offer support to people with mental health issues in Lincolnshire.

Development
Lincolnshire County Council commissions LPFT to provide:

» A range of support and services (through partner providers) for adults of all ages, through the Mental Health Promotion Fund,

» Projects that promote good mental health across all ages aiming to influence people’s knowledge and attitudes about mental health, encouraging them to help others and to learn about how they can look after their own mental health.

The Managed Care Network is a federation of organisations that provide a range of services (e.g. wellbeing services or activities) to give people support and structure in their lives. These organisations have close operational and developmental links with each other to help people prevent, manage and improve their quality of life as they possibly can.

Approximately £850,000 has been invested by the County Council so far in three phases of development of the network. The next wave of investment is currently being progressed, with the County Council agreeing to continue funding for a third year, with an additional investment of £420,000.

When the Network was first established 32 groups and organisations provided a total of 32 projects. Currently there are 67 member organisations providing 72 projects across the county. 29 different types of activity have been identified, giving people more choice in finding the type of help that is right for them.

Outcomes
Up to 2,500 local people have benefitted from the help and support provided by Managed Care Network members, and the outcomes that have been reported include better self-esteem and greater confidence, and improved mental and physical health which has enabled people to enjoy more social contacts, learn new skills and, in some cases, return to work and other meaningful activities. Lincolnshire’s mental health support networks won the prestigious Local Government Chronicle Award 2014 for Health & Social Care.

Contact
Paul Jackman, Associate Director, Lincolnshire Partnership NHS Foundation Trust
paul.jackman@lpft.nhs.uk, 01529 222247

39. BESPOKE MENTAL HEALTH AND WELLBEING TRAINING PACKAGE - PRACTICE NURSES

Aims
» For patients seen in primary care to be treated by a health care professional who understands their mental, physical, emotional, spiritual and social needs and can respond appropriately and effectively.

» To create a sustainable model of capacity building through the creation of a community of nurse educators engaged with improving the capability for mental health in primary care.

» To improve integration between primary and secondary care for mental health patients.

Rationale
To understand the training requirements of practice nurses regarding mental health and wellbeing, a national needs assessment was undertaken in the format of a survey. Responses were attained from 390 nurses. The key findings were that 82 per cent of practice nurses have responsibilities for aspects of mental health and wellbeing in which they have not had training with 88 per cent of these nurses stating they would like to undertake at least one aspect of training in mental health and wellbeing.

Development
The project was funded by the Health Education North Central East London (HENCEL); £250,000 was secured to establish a sustainable network of nurse educators, develop a 10 module training and train the trainer programme and educate practice nurses in the region. A steering and expert reference group (ERG) were set up with representatives from all participating partners (HENCEL; the Academic Health Science Network, UCLPartners; the Mental Health Trusts, Barnet, Enfield and Haringey Mental Health NHS Trust, Camden and Islington NHS Foundation Trust, East London NHS Foundation Trust, North East London NHS Foundation Trust; and GP practice) to develop the programme. The key findings from the survey have been used to help shape the programme of learning (consisting of 10 RCGP accredited modules, five of which are available as eLearning through the BMJ), developed by Dr Sheila Hardy, with the support of the ERG. Mental health nurses from the four trusts were trained to become Nurse Educators and they delivered the programme. These Nurse Educators have been supported by UCLPartners to develop a network, which has initially been achieved through creation of action learning sets. In doing so, they have created a system of support and ongoing learning. To create a sustainable solution to capability and capacity building for mental health in primary care, this network is being supported to form a community of practice (COP) to help practice nurses and nurse trainers to continue their development in mental health.

Outcomes
We have achieved our aims in that:

» 199 practice nurses completed module 1 and 282 have gone through modules 2 to 5. The evaluation shows that 98 per cent will apply the learning to practice.

» 23 mental health nurses have been trained in North Central and East London to become Nurse Educators.

» 17 per cent of practice nurses are now contacting mental health nurses regarding patients with mental health problems.

» The project has been shortlisted for the Patient Safety Care Awards 2014.

Top tips for commissioners
Use of the adoption tool kit enables creation of a highly cost effective, sustainable approach to building capacity for mental health in primary care, while improving integration, through building relationships between primary and mental health trusts nurses.

Contact
Dr Sheila Hardy, Education Fellow, UCLPartners
Sheila.hardy@uclpartners.com
40. **UCLPartners Mental Health Informatics Platform**

**Aims**
- Provide a comprehensive local mental health needs assessment including for primary care to support improved population mental health

**Rationale**
- Effective interventions exist to treat mental disorder, associated health risk behaviour and physical illness, as well as preventing mental disorder and promoting wellbeing.
- However, only a minority of people with mental disorder except psychosis receive any intervention!
- Primary care is an ideal opportunity to detect and treat mental disorder and if necessary refer to secondary care.
- Mental health is poorly covered in needs assessments which contribute to this intervention gap.
- Public mental health commissioning guidance has been implemented in several local authorities to improve information about the size of the mental health intervention gap in order to facilitate better coverage and outcomes.

**Development**
- Informatics is a priority area of UCLPartners.
- Inclusion of all relevant nationally collected data covering treatment of mental disorder (in both primary and secondary care) as well as risk factors for mental disorder, groups at higher risk of mental disorder and protective factors for wellbeing.
- Partnership with Concentra to load onto a mental health informatics platform.
- Additional data not available in national datasets provided by localities.
- Analysis and presentation of information including:
  - Local estimated levels, numbers and costs of different mental disorder.
  - Proportion receiving treatment for different mental disorder in primary and secondary care.
  - Local spend on inpatient and outpatient care.
  - Savings arising from intervention including timeframes and where such savings accrue.
- Resources: Director of Population Mental Health and IT support.

**Challenges**
- The time and resources to develop the platform was much greater than anticipated. However, UCLP investment means that this does not have to be repeated.
- Outcomes you have seen/hope to see (or any evidence based outcomes/measures) impact on patients.
- Benchmarking against other local authorities and deprivation levels.
- Treatment rates in primary and secondary care.
- Mental health associated QOF measures including exception rates outlined at local authority and individual practice deprivation level.
- Opportunity to highlight within locality variation.
- Highlights primary care, secondary care, social care and public health areas to facilitate coordination and a whole system approach.
- Areas which has received this work have prioritised mental health.

**Top tips for commissioners**
- UCLPartners have invested in this to support organisations across England.

**Contact**
Dr Jonathan Campion, Director of Population Mental Health at UCLPartners, Visiting Professor of Population Mental Health at UCL, and Director for Public Mental Health and Consultant Psychiatrist at South London and Maudsley NHS Foundation Trust.
j.campion@ucl.ac.uk

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41. **Integration of CAMHS into a Single Point of Access for Children**

**Aims**
- To develop the existing single point of access (a council led initiative) to improve assessment and triage so that appropriate referral is made to Tier 2 Primary Mental Health Services, Tier 3 services or redirected to Tier 1 services.

**Rationale**
- The background is one of dissatisfaction of current services, long waits, bounce back of referrals to GPs or bouncing of patients from one service to another.
- The aim was that no child should fall through the net and that the child is directed to the correct service first time around.

**Development (in progress)**
- The development is a joint collaboration between the CCGs and local authority of two boroughs (Richmond and Kingston) and SWL St George’s (the provider).
- We are still at the negotiation and implementation stage— we have agreed the principles of the service and all participants are supportive and excited.
- A number of ‘Emotional Wellbeing Forums’ were organised for consultation, with attendees from a wide range of backgrounds and services.
- We reviewed the proposals from the provider and after discussion agreed a way forward. We have also looked at similar local models to inform us on likely numbers going through the service, costing and possible pitfalls.

**Challenges**
- The main pitfall so far has been through lack of communication and a failure to clearly define at the outset what we wanted from the provider. This meant that the provider drew up proposals to provide a ‘gold standard’ service which was unaffordable and impractical.
- The availability of data from existing services has enabled us to agree a more appropriate level of service.

**Outcomes**
- The new service has not been implemented yet but we hope that there will be a single access point for all children’s emotional and behavioural services.
- The referral will be assessed by a psychologist from Tier 2 with input from a Tier 3 psychologist and a plan made as to the best management of that child.
- We hope that the child will therefore reach the most appropriate service first time around reducing waiting time and bounce around. The GP would have the knowledge that their referral has been accepted and the child will be seen by the correct service—there will be feedback to the GP to this effect so that all parties are kept fully informed.

**Top tips for commissioners**
- Communication and honesty are key. What is it you want and what can you afford? Look at your own data and look at other local services to see what their experience has been.

**Contact**
Dr Brinda Paramothayan, GP Lead for Children’s Health and CAMHS, Richmond CCG.
brinda.paramothayan@nhs.net
42. Parental Mental Health Service

Aims
To support assessments and interventions to families with multiple needs affected by parental mental illness to ensure they receive a timely service that meets their needs and delivers improved outcomes to the whole family. Objectives include:

» Delivering direct assessment and intervention to parents presenting with mental health needs and challenging and complex behaviours using an outreach approach.

» Improving knowledge/skills base of Children’s Services staff so that their assessment, planning and interventions are psychologically informed and can bring about improved outcomes for families.

» Improving knowledge/skills of staff in identification of mental health issues and gain access to the services.

» Increase partnership working at case management level across Children’s and Adult’s Services.

Development
The service has been operational since November 2013. Funding was agreed in June 2013. The idea was developed by commissioning and the Personalisation Board and then developed fully with Children’s Social Care managers. Implementation followed a period of development where AMH psychologists and children’s social care managers jointly produced operating policy. This required time commitment to ensure they receive a timely service that meets their needs and delivers improved outcomes to the whole family. Objectives include:

» Delivering direct assessment and intervention to parents presenting with mental health needs and challenging and complex behaviours using an outreach approach.

» Improving knowledge/skills base of Children’s Services staff so that their assessment, planning and interventions are psychologically informed and can bring about improved outcomes for families.

» Improving knowledge/skills of staff in identification of mental health issues and gain access to the services.

» Increase partnership working at case management level across Children’s and Adult’s Services.

Top tips for commissioners
Commissioners to act as enabler for front line managers to jointly define problem and design solution.

Contact
George Howard, Head of Mental Health and Continuing Care, Islington CCG
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43. Lambeth and Southwark Wellbeing Programme

Aims
The aim of the programme is to build capacity for more people and organisations in Lambeth and Southwark to promote mental wellbeing.

Rationale
Feeling good and doing well in life are related. People are more productive and healthier when they feel good about themselves and others. They are also more resilient to life’s difficulties such as family problems, unemployment and ill health. There is good evidence that improving wellbeing, including mental wellbeing, has a range of health, social and economic benefits. Programme works at individual, community and strategic levels. Some of the elements include: mental wellbeing impact assessment, mental health/suicide awareness training, a wellbeing network and e-bulletin, small grants scheme, promotion of ‘five ways to wellbeing’ messaging, outreach projects with BME communities, development of wellbeing profiles for JSNA, measuring wellbeing, health and wellbeing programme in schools, wellbeing ‘policy shops’.

Development
The programme has run from 2005 onwards (in Lambeth) and a joint programme with Southwark from 2012. It is led by Public Health, resourced by Public Health staff and has a small CCG budget (including commissioning SLAM mental health promotion unit).

Challenges
There are challenges around getting people to understand that the programme is about promotion of good mental health for all not about treating illness. Other challenges include:

» Translating research and evidence into changes in commissioning decision making

» Making the business case when return on investment is longer term

» Evidence base is stronger on primary prevention than promotion

» Finding the local/organisational policy levers to effect change

» Engagement with businesses on workplace health

» Translating policy rhetoric into practical ideas to change commissioning decision making, ensuring groups at risk of poor mental wellbeing have an opportunity to contribute

Contact
Lucy Smith, Public Health Manager, London Borough of Southwark
lucy.smith@southwark.gov.uk, 020 7525 7530

Top tips for commissioners
Grass roots committed to work but difficult to align activity with senior leaders.

Needs a mandate through Health and Wellbeing strategy and senior level buy-in.

To use organisational levers e.g. procurement, workforce health and wellbeing, understand and use the evidence to inform policy and commissioning

Good strategic oversight of the work, making wellbeing core business

Further reading
44. Big White Wall – Digital Mental Health Support in Wandsworth

Aims
» Big White Wall (BWW) was commissioned to increase access to mental health support for people in Wandsworth, especially for those not accessing current services, and to support parity of esteem between mental and physical health care.

Rationale
In 2010, the CCG identified a gap in mental health provision for people who were currently not accessing services. This was partly due to stigma and a reluctance to discuss issues face to face, and also because some people found it hard to access services due to work and personal commitments. Big White Wall addresses these issues by reducing barriers to access. It is available 24/7, can be accessed easily online or via an app for smartphone (iOS and Android), and is anonymous, which reduces stigma. Big White Wall also supports the local IAPT to improve waiting times, and manage patients who do not meet IAPT caseness, or who need the opportunity for round the clock support whilst waiting for tier 3 high intensity sessions.

Development
Big White Wall was founded in 2007 in response to a lack of safe spaces where people could discuss mental health issues. Today it provides 24/7 peer support and self-management, a range of safe therapeutic services, and is moderated and facilitated by specially trained counsellors at all times. Big White Wall currently has contracts with organisations that serve 27 per cent of the UK adult population. In Wandsworth, Big White Wall is accessible to all adults (16 and over) by self-referral. Since 2012, LiveTherapy (online and/or via video, webcam and/or instant messaging) has also been available with a referral from a GP or the local IAPT. Residents can also access GuidedSupport – online therapeutic groups for common mental health conditions.

Challenges
The key challenge for the adoption of Big White Wall has been raising awareness of the service. Initial pilots targeting very small groups (e.g. young people in care) were comparatively unsuccessful, with wider promotion working much better. Direct contact with GPs has been challenging to arrange but very important – 58 per cent of members hear about the service this way.

Outcomes
» Service reach is high, with 686 people using the service during 2013/14
» In a survey, 86 per cent of members in Wandsworth reported improved wellbeing as a result of using the service, and 64 per cent of members said they had shared an issue not shared elsewhere
» 92 per cent of LiveTherapy users were satisfied with their treatment, and recovery rates (using IAPT standard measures) were 58 per cent

Top tips for commissioners
» Develop detailed plans for service promotion within and beyond healthcare, drawing on the experience of promoting services like this in similar areas
» Make sure your plans include regular, low level reminders of the service for GPs and others
» In promotion, use wellbeing language (“feeling stressed or low?” rather than “are you depressed?”) to help messages resonate with a broader audience

Contact
James de Bathe, Head of Business Development, Big White Wall, james.debathe@bigwhitewall.com
Mark Robertson, Mental Health Commissioning Manager, Wandsworth CCG mark.robertson@wandsworthccg.nhs.uk

45. Community Wellbeing Practices (CWP)

Aims
» The CWP model aligns general practice more closely with voluntary, community and social enterprise sector (VCSE) agencies so that Healthcare practitioners not only help patients with the treatment and management of illness, but also take action on social determinants of health by connecting patients to community-based services and support. This approach enables us to support patients who are experiencing common mental health problems by assisting them to acquire the skills, knowledge and resources they need to make meaningful improvements in their own health and wellbeing.

Rationale
Senior leaders in NHS Halton Clinical Commissioning Group and Halton Borough Council recognised that a new and innovative way of working was required to take account of the social issues affecting a person’s wellbeing. A more holistic, community-centred approach to healthcare resonated strongly with Halton GPs to tackle an increasing number of ‘frequent attendees’, relieving the pressures on Urgent Care services and the spiralling costs associated with a rise in anti-depressant prescriptions.

Development
In 2012, Wellbeing Enterprises were commissioned to design and deliver the CWP initiative, initially funded to work with eight pilot GP Practices in the borough. Using the approaches around salutogenesis and the findings from the Marmot Review, Wellbeing Enterprises designed an iterative model that responded to the local needs of patients, clinicians and GP Practices. Each Community Wellbeing Practice has a dedicated Community Wellbeing Officer, who works closely with Clinicians and practice staff to provide a clear picture of the support services available in the community. Clinicians can refer patients directly to the Community Wellbeing Officers for a structured one-to-one Wellbeing Review session to develop a personal action plan and techniques for managing problems that address the route causes of the patient’s social problems. The Community Wellbeing Officers also provide community based psychosocial support such as social prescribing programmes, volunteering opportunities and life-skills courses for patients with mild to moderate mental health problems. The Community Wellbeing Officers are also linked in the practice risk-profiling meetings to help support patients who are at risk of a hospital admission by providing a range of social interventions.

Challenges
We recognised that each GP Practice has different kinds of support available in their respective area of the borough, therefore there was work to be done to develop an approach that aligned all of the assets and resources in the local area around each GP Practice; this involved developing relationships with the plethora of local VCSE providers (e.g. charitable organisations, peer support groups).

Outcomes
» Over 7,000 interventions have been delivered within two years of the initiative
» 63 per cent of participants engaging in a full intervention have shown an improvement in their wellbeing levels post-intervention (SWEMWBS subjective wellbeing levels)
» Participants attending life-skills courses have reduced their depression symptoms by 50 per cent at the end of the intervention (PHQ20 health metric).
» Based on the success of the pilot phase of the project, the Community Wellbeing Practice initiative has now been scaled up to work with all 17 GP practices in the borough

Top tips for commissioners
Critical to the success of the CWP initiative was developing a relationship with the Commissioners to work collaboratively to identify local needs. This involved using local intelligence sources (eg Joint Strategic Needs Assessments) and tapping into the knowledge of the Commissioners to identify critical pathways which the CWP model could align with (eg aligning the CWP social model of health with the hospital discharge teams and local housing trusts).

Contact
Mark Swift, Chief Executive Officer, Wellbeing Enterprises info@wellbeingenterprises.org.uk, 07872 690687
58. **Peer to Peer Education through Youth Radio Broadcasting**

**Aims**
- To challenge the stigma around mental health by getting young people to discuss it more openly; to make young people more aware of symptoms they, their friends or family may be suffering; to increase awareness of support services they can access or promote to friends/family, and increase uptake in the borough.

**Rationale**
During Mental Health Awareness Week, NHS Newham CCG wanted to find an effective way to engage young people. As a borough with one of the youngest populations in the country, under 25s are a significant stakeholder group and crucial to the success of the CCG’s long term health ambitions of improving the health of Newham residents and changing the behaviours that lead to poor health outcomes. Supporting children and young people to get a good start in life and helping people take responsibility for their own health are two big priorities in Newham. Young people do not engage in traditional communications channels and engagement activities, so we needed to employ audience relevant channels and harness the power of peer-to-peer education. That’s why we chose radio. To help young people to feel more confident in asking for help and to publicise local services, the Newham CCG developed a series of radio programmes with Reprezent 107.3FM – the only radio station in the UK that is presented entirely by young people under 25. Our rationale was that young people presenting and discussing the issues on air would be a more effective tool for engaging your young residents.

**Development**
The project was developed and fully delivered in five weeks, at a cost of £12,500. Programmes were researched, written and delivered by young people, covering topics from their own perspectives and experiences such as: eating disorders; bullying; teenage depression; drugs and alcohol; depression, young people and the music industry. To make the programmes even more attractive to the audience, celebrity interviews were sprinkled through the week (Rudimental, UK artist Bashy and conscious rapper Akala). In addition to the 120,000 FM youth audience, the station used social media, posted articles on other youth media channels and secured a feature on ITV’s ‘Good Morning Britain’ breakfast show to increase interaction and reach.

**Challenges**
There’s a stigma with young people around discussing mental health. Many feel isolated with their symptoms or uncomfortable with those displayed by friends and family, mainly through a lack of awareness of the issues and how they can be supported. One challenge was to support the young presenters to create content that was engaging, listenable and informed, without dictating what they should say. Another challenge was to ensure that young people from our borough benefited, as the station has a London-wide reach. Presenters chose a mental health issue from a designated list, created the show concept, broadcast the feature then engaged with the audience responses. The result was a series of features presented by young people with interest and passion. Newham young people were recruited to get involved with the programming, as well as participate in listening and focus groups.

**Outcomes**
- A measurable increase in service uptake; thousands of young people actively learning from the broadcasts; requests from colleges and universities to use the content to inform their students. For full evaluation report: http://bit.ly/1j1JPJ

**Top tips for commissioners**
- Know your audience and ensure you engage them in ways that interest and enthuse them
- Sometimes you need to take some risks – outcomes can be surprising and unexpectedly positive
- Include partners and service providers in programme development and communicating about the project to their networks – added benefit of building your corporate reputation

**Contact**
Sarah Garner, Newham CCG
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Satbinder.Sanghera, Director of Engagement, Newham CCG
Satbinder.Sanghera@newhamccg.nhs.uk

59. **Starfish: Health and Wellbeing Stafford and Cannock: IAPT Plus**

**Aims**
To improve access to psychological therapies by providing additional choice of psychological therapies and interventions and improve effectiveness
- Objectives of the initiative include:
  - Develop Client directed outcome informed approach to IAPT NICE guidelines approved therapies
  - Reduce emotional distress
  - Support ongoing recovery and relapse prevention
  - Increase engagement from patients from areas with high deprivation

**Rationale**
- Four years ago to deliver a more effective model of IAPT provision
- Reduce waiting lists
- Improve Recovery rates
- Reduce DNAs
- Improve access and patient experience

**Development**
The service was developed by a clinical development team that also work with other IAPT providers. No additional funding required. The knowledge and skills of the clinical development team are key. The service had to build on the experience of professionals. The service was set up to demonstrate the importance of a menu of treatments and the importance of the community interventions provided by community workers and peer mentors.

**Challenges**
- Pitfalls and challenges include:
  - Training staff to be client directed and recovery focused.
  - NICE guidelines versus the reality of client’s needs.

**Outcomes**
- Improved IAPT recovery rates
- Reduce DNAs
- Cost effective

**Top tips for commissioners**
- Look at practice based research for the flaws in psychological therapy delivery.
- Realise the difference between practitioners in relation to outcomes (practice based research) have an integrated social and health care approach.
- Experts by experience are an important aspect of the service.

**Contact**
Iain Caldwell, CEO Hartlepool & East Durham Mind
iaincaldwell@starfishhealthandwellbeing.co.uk
60. **Youth Wellbeing Directory (YWD) with ACE-V quality standards**

**Aims**

The ACE-V Quality Standards aim to improve the emotional wellbeing and mental health of children, young people, and their families and carers by clarifying how to recognise and consider quality. The Youth Wellbeing Directory aims to create online shared learning community expertise around quality and to enhance the accessibility of the services who commit to continual improvement of quality. Specific objectives include:

- Helping commissioners, referrers, service providers and service users find high-quality, accessible and suitable services by providing a comprehensive map and directory of UK providers
- Levelling the playing field between and improving the quality, accessibility and availability of all providers by asking them to commit to the same ACE-V Quality Standards
- Promoting/supporting the building of a shared strategy for CYP mental and emotional health
- Providing a transparent space that encourages learning, communication, collaboration/integration, and the use of shared language between cross-sector professionals
- Facilitating, guiding, and informing referral and commissioning for all involved by sharing information about the processes and supporting the building of local community consortia

**Development**

YWD is a free online directory of UK services who are committed to improving the emotional wellbeing and mental health of children, young people, their families and caregivers. YWD is being developed and funded by the Evidence Based Practice Unit (EBPU) at the Anna Freud Centre (AFC). The ACE-V Steering Group includes members leading in the field of CYP mental health and emotional wellbeing, including YouthAccess, Child Outcomes Research Consortium (CORC), Cernis, and Lisa Williams consulting. As part of striving to maintain and improve upon these outcomes, the ACE-V Steering Group will be consulting a range of experts in the field of CYP mental and emotional health to annually review the ACE-V Quality Standards and ensure they remain relevant to all sectors and in line with the most recent government developments and initiatives. Providers put themselves on the “quality map” and provide information around the ACE-V Quality Standards, the UK’s first cross-sector indicators of best practice.

The ACE-V Quality Standards include:

- Accountability – to offer quality services and review impact on those they seek to support
- Compliance – a commitment to safe practice, clear confidentiality policies and supervision procedures
- Empowerment – a commitment to collaborative practice with service users
- Value – a commitment to offer high value services and a chance to highlight unique features

The resource can help commissioners identify good practice, effectiveness, value and innovation in providers. An advanced filterable search enables commissioners, referrers and service users to discover and compare services to find those that best meet their needs.

**Outcomes**

- Over 110 services have already registered onto the directory and provided information to demonstrate compliance with the ACE-V Quality Standards
- The ACE-V Quality Standards are recognised by the CYP IAPT Accreditation Group as one of the main vehicles for providers to demonstrate compliance with CYP IAPT Service Values & Standards
- The resource is being supported online and at events by the Royal College of General Practitioners
- Surveys have shown that the majority of providers find that the registration process and learning about ACE-V Quality Standards increased their understanding of the areas of development necessary to achieve commission readiness
- Other benefits reported by providers who are using the directory and standards include:
  - having a better understanding of commissioner’s needs,
  - being able to take an active role in the commissioning processes,
  - encouraging a focus on what is expected by commissioners and supporting reflective practice,
  - and understanding the language used by commissioners and the importance of service user participation and feedback

**Contact**

Dr. Melanie Jones, EBPU Improvement Programme Lead, ace-v@annafreud.org

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**APPENDIX A**

2013/14 South West CCG Expenditure Split by Primary, Secondary and Specialist Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total expenditure (2013/14)</th>
<th>As % of total expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Care Services</strong></td>
<td>£9,860,370</td>
<td>7%</td>
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<tr>
<td><strong>Secondary Care Services</strong></td>
<td>£95,832,631</td>
<td>73%</td>
</tr>
<tr>
<td><strong>Specialist Services</strong></td>
<td>£95,832,631</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£131,606,233</td>
<td>100%</td>
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**Specialist Services** £25,915,232

<table>
<thead>
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<th>CCG</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Kingston*</td>
<td>£1,346,748</td>
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<tr>
<td>Merton</td>
<td>£1,206,480</td>
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<tr>
<td>Richmond</td>
<td>£2,526,000</td>
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<tr>
<td>Sutton</td>
<td>£1,193,520</td>
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<tr>
<td>Wandsworth</td>
<td>£3,587,622</td>
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<tr>
<td><strong>Total</strong></td>
<td>£9,860,370</td>
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**Secondary Care Services**

<table>
<thead>
<tr>
<th>CCG</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kingston*</td>
<td>£14,302,493</td>
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<tr>
<td>Merton</td>
<td>£14,267,279</td>
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<tr>
<td>Richmond</td>
<td>£14,073,736</td>
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<td>Sutton</td>
<td>£14,114,020</td>
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<tr>
<td>Wandsworth</td>
<td>£39,075,104</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>£95,832,631</td>
</tr>
</tbody>
</table>

* This figure is the reported figure for 2013/14 which takes into account £250k carried forward from 2012/13 by Royal Borough of Kingston on behalf of Kingston CCG.
About the Strategic Clinical Networks

The London Strategic Clinical Networks bring stakeholders -- providers, commissioners and patients -- together to create alignment around programmes of transformational work that will improve care.

The networks play a key role in the new commissioning system by providing clinical advice and leadership to support local decision making. Working across the boundaries of commissioning and provision, they provide a vehicle for improvement where a single organisation, team or solution could not.

Established in 2013, the networks serve in key areas of major healthcare challenge where a whole system, integrated approach is required: Cardiovascular (including cardiac, stroke, renal and diabetes); Maternity and Children’s Services; and Mental Health, Dementia and Neuroscience.