Improving general practice – A call to action
November 2013

Rethink Mental Illness – who are we?

Rethink Mental Illness is a charity that believes a better life is possible for millions of people affected by mental illness. For 40 years we have brought people together to support each other. We run services and support groups that change people's lives and challenge attitudes about mental illness. We directly support almost 60,000 people every year across England to get through crises, to live independently and to realise they are not alone. We give information and advice to 500,000 more and we change policy and attitudes for millions.

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Note about QOF Changes

We are grateful to NHS England for granting us an extension on the original deadline for submission. However, during this time, we learned of the changes to the Quality Outcomes Framework, and the removal of several indicators for severe mental illness. We recognise that QOF was not as effective as it could have been, however we had been hopeful that measures could become more meaningful. We believe that removal of mental health indicators, particularly regarding the physical health care of people with schizophrenia and bipolar disorder, is contrary to the Government commitment to parity of esteem for mental health.

Early mortality (on average 20 years shorter life span) is one of our most significant health inequalities, largely due to preventable diabetes, heart disease, respiratory disease and stroke, among others. We know that fewer than 50% of people with schizophrenia get the physical health checks in primary care which are NICE recommended. General Practice currently demonstrates a lack of understanding and accessibility with regards to the physical healthcare of people with mental illness, and the new GP Contract does nothing to ensure adequate prioritisation.

Please note therefore that a caveat regarding our disappointment and concern applies to the comments made about QOF throughout this response.

Information, Choice and Control

How do we go further in publishing – and getting practices to publish – an increasing range of comparative public information?
It is currently difficult for the public to access information on GP's in their area to see how they compare. Quality Outcomes Framework data is not necessarily presented with the public in mind, particularly information about exemption rates. Exemption rates vary significantly on mental health measures, which is an indicator for how accessible primary care services are.

How do we stimulate new forms of patient involvement and insight, including introducing the Friends and Family test in general practice?
A main concern is that GPs need more training and knowledge around mental health. An example of effective patient involvement is a Carers group and service forum in Lancashire, that have been trying to increase local patient involvement to influence care in their local surgery. The group was concerned that GP's do not know enough about mental health or understand the referral process. Often GPs can end up referring patients to the wrong service, causing delays to them receiving the correct treatment. Both the forum and Carers group have successfully engaged with local commissioners and invited them along to meetings to emphasis the need for improved GP training for mental health. Talking with local commissioners has had more of an effect on influencing changes to be made at GP level.

Clinical leadership and innovation

How can we best stimulate and create space for clinically led innovation?
An up-to-date and more detailed picture of mental health data nationally and in each area is essential to deliver service improvements through evidence-based commissioning. We welcome the introduction of a Mental Health Intelligence Network, which should also be used to reveal gaps in data, particularly on co-morbidities.

Most importantly, the experience of communities accessing services must be captured through good quality Joint Strategic Needs Assessments. Local communities know best what is, and is not working, and should be involved at every level of strategic thinking and service design. There is a great deal of potential for primary care to offer much more in terms of support and management of severe and enduring (typically fluctuating) mental health conditions. Creativity comes from open conversations between with the local community and decision makers. For some examples of this approach, see here: http://www.rethink.org/get-involved/campaigns/local-involvement

How can we challenge and support local health communities, including CCG's and health wellbeing boards, to develop more stretching ambitions for primary care?

We would like to see an increase in training primary health care professionals to work with people with mental illness, to improve care provision and local leadership. We are keen to see roll out of the Primary Care Mental Health Leaders programme developed in London, across the country.

People with schizophrenia and psychosis are currently underserved by primary care. Responsibility for the physical health of people with these diagnoses tends to be ambiguous, and support for mental health itself is extremely variable. Many people fear being discharged from secondary mental health services because it can seem like a 'cliff edge'.

Addressing the accessibility of primary care for people with mental illness is an important starting place. Examples of this would be making adjustments in surgeries and having leaflets and posters available for patients about mental health. GPs can also access tools such as the Integrated Physical Health Pathway:
http://www.rethink.org/about-us/health-professionals/physical-health-resources

CCG's and Health & Wellbeing Boards should be supported with information about mental health and wellbeing, with an insight into how mental health needs vary with age and in different parts of the country and what the most pressing needs are in each area. It would also help to gather information about the services being provided – and how effective they are. This will help local Health and Wellbeing Boards and CCGs to decide what types of services are needed in their area, and how they can improve the mix of services available. One source of support is the Local Authority Champions Programme, through which councillors can be supported by the mental health sector to champion local mental health:
http://www.mentalhealthchallenge.org.uk/champions/

How do we best support integration pioneers in testing new ways of commissioning and contracting for integrated primary care and community services for people with physical and mental health conditions?

Integrated service provision should be developed from the point of view of people using services. We know in particular, that people with mental illness experience a lack of join up with regard to their physical health needs. It is also common for people to have difficulties accessing specialist services as and when required, when under primary care. Rethink Mental Illness has worked in many parts of the country to hear from people with mental illness how services should be provided, particularly on physical healthcare:
http://www.rethink.org/media/511826/20_Years_Too_Soon_FINAL.pdf

Commissioners must be supported to develop knowledge of what is effective in helping people recover. There is a wealth of evidence for treating mental illness, reflect by NICE guidelines. Yet these recommended treatments are nowhere near

universally available. We wish to see much great use of strategic joint commissioning and provision to deliver what we already know works.

Freeing up time and resources

How might we develop QOF so that we preserve its essential features but create more flexibility for practices and reduce the feel of a tick-box culture?
The QOF could perhaps focus on outcomes for more meaningful incentivisation. Exception reporting for mental health is particularly high compared with other health conditions. This suggests that QOF measures are not currently as meaningful as they could be. An outcomes focus could allow for greater flexibility in ensuring provision of care (i.e. physical health support for people with mental illness). Ideally exemptions would not be permitted, since this undermines the need to prioritise certain groups and interventions. GP practices would also need to make more reasonable adjustments to work with populations that are harder to reach and engage.

How can we help ensure that practices are making most effective use of all practice staff, including practice nurses and practice managers?
By providing staff with effective learning tools and training programmes so that staff have a greater awareness of the physical and mental health problems patients may have. Mental health nurses should be trained to carry out simple physical health checks to release pressure on GP's.

An example of good practice and effective training is:

The Northampton Physical Health and Wellbeing Project

People with severe mental illness have a reduced life expectancy due to cardiovascular disease. Sheila Hardy, Nurse Consultant and Visiting Fellow at the University of Northamptonshire, has developed training for practice nurses and carried out research (seven separate studies) to address these health needs. Her main findings are that, contrary to popular belief, patients with severe mental illness will attend for a health check, and training practice nurses increases the level of screening and lifestyle advice received.

The necessary guidance and tools (including a best practice manual - the HIP-PC) required for setting up a nurse led clinic and carrying out a health check for people with SMI are available from the website ***http://physicalsmi.webeden.co.uk/*** This allows nurses to follow best practice guidance even if they have no access to formal training in this area. A ***programme of training*** (RCN accredited) for practices nurses in the East Midlands has just commenced using funding from the Health Innovation Education Cluster.

Defining practice accountabilities for high quality

How can we put general practice at the heart of more integrated out of hospital services and give GPs and practices greater responsibility for coordinating care for patients?
There is a great deal of potential for general practice to play a much more active role in supporting people with schizophrenia and psychosis. This is an underdeveloped area and requires some particular attention, since there is no clear model of provision.
There needs to be more clarification over responsibility for coordinating care so that people's physical healthcare is not overlooked. Tools like the Integrated Physical Health Pathway could support professionals to agree processes locally so health checks are not missed. http://www.rethink.org/about-us/health-professionals/physical-health-resources
Communication between partners needs to be more holistic and there need to be more robust communication channels put in place.

How do we create synergy with the new system of CQC ratings and inspections to create a clearer sense of what patients can expect from good general practice?
People should expect general practice to be accessible and to provide NICE recommended treatment and care. The CQC ratings and inspection system should be closely aligned with NICE guidelines and quality standards. General Practice must also be able to demonstrate registration and accessibility for all communities, including people affected by severe mental illness, who may need reasonable adjustments to engage with primary healthcare. Any particular measures should be focused on the outcome delivered by primary care.

GP contract: incentives for outcomes

How far should we create stronger incentives for both inter-practice collaboration and collaboration with other primary care providers, acute, community and social care services?
We would encourage greater use of financial incentivisation to improve integration. At present, secondary mental health services can respond to CQUIN incentives, however these can only include the scope of secondary provision. Ideally incentives would be used to reward integrated service provision, between different system parts.
We also suggest developing a closer link between the various national Outcomes Frameworks (NHS, Social and Public Health). Whilst there are some shared

measures, there is little clarity as to the shared accountability at local and national levels.

How can we better stimulate and recognise/reward quality of care for people with co-morbidities and complex health and care problems?
Groups with complex health and care needs should be identified and be a priority in influencing service delivery. Good practice in services should be acknowledged – for example financial incentives from local commissioners to reward providers for addressing complex health needs.
One area that needs more robust measures is premature mortality rates. There is extensive evidence that people with SMI are at risk of dying on average 20 years prematurely. This is due to poor medical care that fails to monitor risk actors such as obesity that are avoidable. There needs to be a better provision in annual health checks.

How far should we seek to reward practices for wider outcomes, such as enhancing quality of care for long term conditions and reducing avoidable emergency admissions, or reducing incidence of strokes and heart attacks, or improving patient experience of integrated care?
There needs to be more preventative measures in place to enhance the quality of care. As an example of a model which impacts on wide ranging outcomes, Early intervention for Psychosis (EIP) services have a very strong evidence base, including cost effectiveness. We would like to see access EIP services prioritised for local commissioning through the Commissioning Outcomes Indicator Set.
A&E usage is currently twice as likely in people who use mental health services, we would suggest that this is partly due to people experiencing acute symptoms are unable to access help any other way and is a last resort. Alternatives to hospital admission, such 'recovery houses' (previously commonly known as crisis houses) demonstrate better recovery outcomes than standard care, plus significant cost savings over the subsequent 12 month period.

Ongoing, appropriate support to manage mental health for people with mental illness of all types would arguably help prevent serious relapse. So often, triggers for relapse can be of a very practical nature (i.e. problems accessing housing, benefits or employment), which models of care offering an alternative to admission are well placed to help with.
One challenge to commissioning recovery focused, preventative care, is the ongoing pressure to find immediate savings – regardless of longer term costs incurred through disinvestment. NHS England must establish a way to ensure longer term approaches to finding savings are encouraged and rewarded.

Safe, controlled investment

How can CCGs, local authorities and NHS England best collaborate to develop integrated commissioning plans for out of hospital services?
The starting point for strategic collaboration must be a good quality Joint Strategic Needs Assessment, which relies on quality data from providers, alongside meaningful community engagement. We recommend involving local communities at the outset, in describing what sort of support and services would be effective. This should start creative thinking around options for pooling resources for new approaches.

As aforementioned, we also recommend extending existing reward levers such as CQUIN to reward integrated provision.

Workforce Development

How can we and our national and local partners best support improvements in recruitment, retention and return to practice?
We recommend involving people who use services in the recruitment of clinical and support staff, and in co-designing and co-delivering training. This is particularly important in mental healthcare, as mental illness is highly stigmatised. These approaches can reinforce the understanding of working in partnership with people using services, for the provision of recovery focused services and better outcomes greater staff morale.
There is a relationship between good quality care and staff retention (including reduced sickness absence). Rethink Mental Illness is working with a number of mental health service provider through our Innovation Network to learn from existing god practice, and to evaluate approaches against retention and absence related outcomes. We look forward to sharing evidence from this work, and will also work to collate and share best practice outside the Innovation Network. We hope NHS England will also support good practice sharing.

What are the strategic priorities for improvements in education and training to reflect the evolving role of general practice, the changing profile of the general practice workforce and the challenges facing the health service in the next ten years?
We know that general practice is the first port of call for people with mental health and related physical health conditions. A main priority is to increase knowledge of mental health through medical training, including the relationship between mental and physical healthcare. We support recent calls for an additional year or medical

training, incorporating this mental health focus. There needs to be a greater opportunity for personal development through continuing professional development to develop an enhanced career pathway.
Nurses should be given more of a strategic role as they can become specialist providers in certain care e.g. providing physical health monitoring to people with mental illness, relieving pressure on GP's.

Specific Issues and Questions

How do we ensure that people with more complex health and care needs have a named clinician with responsibility for coordinating their care? Should people with more complex needs have a named GP with responsibility for overseeing their care?
We want to ensure that the right services are commissioned in local areas to address a patient's need. It is helpful for clinicians to develop a good understanding of local need by building relationships with people in their care. Assigning a GP is one approach to coordinating ongoing care. This requires development around mental health so that GPs can recognise treatment needs, help them access treatments quickly and liaise with secondary mental health services. It may be beneficial to introduce a complex needs and/or mental health team into general practice to support GPs with this.

How can we strengthen general practice accountability for the quality of out-of-hours services provided to patients and ensure that OOH services are more integrated both with daytime general practice and with wider urgent care services?
There need to be more out-of-hours services particularly for those with complex health needs. This can be strengthened by practices working with nurses and social workers to help provide out of hours care to people.
Out of hours services need to be adequately funded and quality controlled to ensure they are offering the best service and using resources effectively. It would be useful for patient's records to be available when patients need to use out of hours services and Accident and Emergency Departments. Additional information can be added to the record following discussion between the patient and GP, and can include information regarding a person's mental illness and any other conditions they may have.

How do we stimulate more convenient routine access to general practice services, including ease of making appointments, speed of contact for urgent problems (whether telephone or face-to-face) ability to book less urgent appointments in advance, ability to communicate electronically (e.g. online consultations) and, particularly for working age adults, availability of evening/weekend slots?

Inequalities around service usage need to tackled as well as access to services particularly for those with complex health needs. People with mental illness often have problems with understanding and communicating health needs, lack of support to access services, discriminatory attitudes among health care staff and failure to make 'reasonable adjustments' to services so that they can be used easily and effectively by people with complex mental health needs. There needs to be improvement on introducing access standards and maximum waiting times for mental health services.
Medication can often make it very difficult for people to get up early in the morning to book an appointment and other issues include inappropriate waiting areas if they are distressed. These issues need to be recognised.
Adjustments such as removing physical barriers to access, making necessary alterations to policies, procedures, staff training and service delivery need to be made. Families and carers should also be involved in the provision and treatment of care.

How far should there be a shift of resources from acute to out-of-hospital care? How far should this flow into general practice and how far into wider community services?
There are significant cost/outcomes benefits to alternatives to hospital admission for acute mental illness. Many people know when their symptoms are becoming acute and would like to seek support outside the home to prevent full relapse. This is because inpatient care typically focuses on containment of acute symptoms rather than recovery and prevention on further relapse. Alternatives to admission, such as 'recovery houses' (previously commonly known as crisis houses) demonstrate better recovery outcomes than standard care, plus significant cost savings over the subsequent 12 month period.
As aforementioned, there is great potential for the primary care to provide ongoing care and treatment for mental illness. This is an underdeveloped area and we would welcome the chance to work with NHS England to explore the possibilities.