East Kent CCGs Protocol for the Management of Long Term Mental Health Conditions in Primary Care

Introduction

The purpose of this protocol is to ensure safe, effective, recovery-focused treatment and support of people with chronic, stable, long term mental health conditions in primary care. It is also intended to reduce gaps and prevent duplication of services by a clear definition of the roles and responsibilities of primary and secondary care and to improve the signposting and transfer of care to IAPT and community mental health services as appropriate.

Primary care mental health specialist (PCMHS) service is to support a positive and successful planned transfer of care from secondary care services by providing time limited community support for those patients. It is expected that this support will be time limited for most patients, whilst acknowledging that some patients will need longer term support.

PCMHS will also work with GPs in primary care by providing mental health support for those who may not meet the thresholds of secondary mental health care. This could involve an assessment and short term interventions or advice and guidance to the patient's GP.

By primary, secondary and community-based services working together, this will deliver safer, more personalised, evidence-based care with better outcomes for individuals.

Benefits of the Primary Care Mental Health Specialist (PCMHS) role

The service will:

- increase the competence and capacity in primary care enabling people to be supported in the least restrictive setting and the most appropriate resource
- improve communication between primary and secondary care
- promote quicker access to secondary care for those who require it and timely transfer of care for those who do not. In this way, secondary care will be able to focus on those people most in need of their services
- reduce stigma as more people using services will receive the support they need in community settings
- ensure that physical health needs are properly assessed and addressed by all services
- promote a personalised recovery approach supported by appropriate workforce
- ensure those who do not require secondary care receive the support they need from the service that can deliver it best
- ensure onward 'transfer' of care to IAPT providers as appropriate
- ensure collaboration with primary care community link worker posts (Live Well Kent), so that the practical issues of the person and their carers are addressed

Target population for patients discharged from secondary care

For the purposes of this protocol, people with a long term stable mental health condition are identified as:

- those who fall into clusters 7, 11 and 12 of the national Cluster framework (see Appendix 1 for more details about the clusters. As the service increases in capacity across the four East Kent CCGs it would be expected that clusters 4 and 8 will access the service as appropriate).
- currently in receipt of secondary care mental health services
- those who have a likely diagnosis (ICD-10) of schizophrenia, bipolar disorder, recurrent depression or chronic neurotic, stress-related and somatoform disorders.

There are important parallels between this group and those with long term physical health conditions where primary care already holds a central role.

1 Eligibility criteria for transfer of care to primary care

1.1 Inclusion criteria:

- A stable mental state for at least six months, supported by a multidisciplinary clinical decision
- CPA review completed
- Functional independence skills i.e. able to attend GP practice or other community venue, does not routinely require home visits on mental state grounds
- Self-management of medication regime
- Transfer of care will not disrupt established social support systems
- Service user/carer willingness to discuss transfer of care
- Ideally completed, or near completion of, a recovery programme
- Agreed information sharing and point of referral (patient requested to consent if information can be shared to improve patient care)
- Confirmation of patients with a Section 117 status and transfer of care plans

Acceptance of referrals from GP practices

- GPs will often be confident in offering initial treatment and signposting to patients within cluster 1, 2 and 3 and referring patients in cluster 4 and above to secondary care ('step up' referrals of cluster 7, 11 and 12 can also go to the PCMHS service). However, where GPs/primary care clinicians are unsure on either the cluster of the patient, what intervention to offer, or if the patient meets the threshold for secondary care, then it is appropriate for them to seek advice of the Primary Care Mental Health Service. GPs can telephone the PCMHS service for advice or more formally send a referral letter or referral form. The PCMHS service will offer the GP or primary care clinician advice or assessment.
- Patients who may not meet the threshold for secondary care
- Where the patient may have been known to secondary care mental health services previously and may require a brief intervention to prevent readmission to secondary care
- Where initial intervention with IAPT has either not proved successful or is considered unlikely to be successful.

THE CARE PATHWAY

2 Primary Care Mental Health Specialist (transfer of care from secondary to primary care services)

2.1 Identify suitable individuals through regular discussions with the local secondary care mental health team. Individuals with long term stable mental health conditions are identified by the CMHT, GP and the PCMHS Team; those who fall into clusters 7, 11 and 12 and have an indicative diagnosis of these clusters such as schizophrenia, bipolar affective disorder, recurrent depression or chronic neurotic stress related and somatoform disorders for potential transfer.

2.2 Ensure there is a reasonably predictable clinical situation. Clinical responsibility should be considered for transfer to primary care only where it is agreed that the patient's clinical condition is stable or predictable.

2.3 Determine if safe and effective care can be provided in primary care to meet the needs of any given individual, based on agreed risk assessments.

2.4 Ensure eligibility criteria are met (see Eligibility Criteria for transfer of care to Primary Care, page 2 above).

2.5 A clear definition of responsibility between PCMHS and PC will be in place (**See Appendix 2**). Arrangements identify the areas of care for which the PCMHS has responsibility and where the GP or other primary care clinician is responsible.

2.6 A communication network. Agree communication arrangements between the practice and the PCMHS. This should include a telephone contact number for use when problems arise, and secure email address (NHS.net). Progress updates should be produced to an agreed time-scale with regular review and entered into the GP record.

2.7 Emergency support. A primary care crisis response plan, including relapse indicators, with in-hours for secondary care services and out of hours contact number for urgent/crisis service, as appropriate. (see Section 4.3 if a patient is at risk of destabilising)

2.8 Safety. The issue of patient safety must always remain paramount.

2.9 Ensure an Advance Directive is recorded where appropriate as this will detail the patient's wishes and preferred treatment interventions.

3 Exclusion criteria:

- Instability in mental state with identifiable social stressors and/or recent medication changes still currently under review
- Significant or current safeguarding concerns (child or adult) as an indicator of levels of risk with primary and secondary care. (Where possible open safeguarding cases should be concluded, however a safeguarding case should preclude a patient's transfer of care)
- Recent admission or CRHT intervention (within the last six months)
- History of Community Treatment Order (CTO) or has recently undergone transfer of care from this. (People with a history of CTO cannot be completely excluded; secondary care would need to demonstrate that adherence to treatment was no longer a significant concern)
- Predominant drugs or alcohol issues
- Is currently or very recently under probation/MAPPA. (Some people under MAPPA or

probation can be under MAPPA/probation for reasons other than mental health)
- Risk assessment indicates that lone working is not recommended

- Where the GP has concerns a GP can disagree with the patient's transfer of care. In these cases transitional care arrangements should be considered
- In receipt of a comprehensive multi-disciplinary/multi-agency care package

4 The PCMHS will provide:

4.1 Review. In consultation with the GP (and Consultant Psychiatrist as appropriate) undertake regular reviews of the patient's mental state and their medication, including identification of any untoward side-effects and communicate this to the practice.

4.2 If an individual is at risk of destabilising (or changes in risk profile) a more intensive follow up is initially provided in Primary Care, however if they are in need of management from the CMHT and in keeping with NICE guidelines then the Primary Care Mental Health Specialist Team will need to urgently refer the individual back to Secondary Mental Health Services with the PCMHS making the referral (see Section 5 for Single Point of Access)

4.3 Recovery focused support to the individual as a step down from the CMHT. The PCMHS meets with people in the community (where necessary in their homes) and focuses on relapse management and prevention as well as support with their functional recovery and accessing vocational and wider community opportunities.

4.4 Maintain and update Care Planning for the patient as appropriate that is shared with the patient's GP when updates are entered.

4.5 Training. Provide advice and guidance for Primary Care as required by GPs and the staff to better support the client group.

4.6 Ensure the patient has an annual health check in primary care that reviews their current physical and mental health status.

4.7 When patients are ready for transfer of care from the PCMHS they will be discharged to Primary Care with appropriate written information to access community based MH services (i.e. IAPT, Live Well Kent).

4.8 If a patient no longer needs treatment or social care support and is discharged back to GP care only, ensure the patient is discharged from Section 117 prior to the patient's transfer of care from the CMHT.

4.9 *Check and note in the patient's record where a power of attorney exists, or Section 117 applies,* as appropriate

5 Single Point of Access (SPoA)

5.1 If it is identified by the service that input from a consultant is required the service can attend client discussion meetings in secondary where there is multi-disciplinary representation present.

5.2 If there was a need for urgent secondary input a referral would be made to SPoA. The SPoA would recognise triage and prioritise the referral. The referral would be headed "urgent referral from PCMHS".

5.3 It is expected that patients will be transferred back directly to the local CMHT (based on deterioration in mental state and increase in risk profile)

5.4 If any patient who has been re-referred and requires a medication review with a Psychiatrist to prevent deterioration in their mental state and contain an increase in risk to self or others, this will be arranged. The team will offer the urgent slots (within 24 hours) available to SPoA to offer such a review and then return to the PCMHS team for ongoing monitoring.

5.5 SPoA will provide feedback by letter through the use of email regarding the referral made and the outcome of the patient's screening and assessment.

6 Responsibilities of GP and primary care staff

6.1 Ensure the PCMHS has lead responsibility for making transfer of care arrangements with secondary care for this group. This includes not accepting patients back without the prior involvement of the PCMHS (particularly for those on depot medication). The GP must agree to the particular circumstances of each person identified for transfer of care with the PCMHS and the consultant's recommendations before transfer can commence.

6.2 Support safe and effective care in primary care to meet the needs of any given individual.

6.3 A clear definition of responsibility between PC and PCMHS. **See Appendix 2.** Arrangements identify the areas of care for which the PCMHS has responsibility and where the GP or other primary care clinician is responsible.

6.4 Ensure processes are in place for administration of medication and repeat prescribing as appropriate. **See Appendix 2 for SKC process (Ashford, Canterbury and Thanet CCGs will agree process)**

6.5 GP to assume overall clinical responsibility for the on-going care of the patient in primary care following the patient's transfer of care from secondary care, and supported by the PCMHS for a defined period of time prior to the patient being transferred to primary care.

6.6 A communication network. Agreed communication arrangements between the practice and the PCMHS. This should include a telephone contact number for use when problems arise, and secure email address (NHS.net) as appropriate.

6.7 Review. Primary care clinician/s to undertake an annual physical health check (as per QoF). The physical and mental health checks may be done jointly between the primary care clinician and the PCMHS where indicated. This will need to be done jointly if subject to Section 117.

7 Responsibilities of secondary care

7.1 Identify suitable individuals through regular discussions with the PCMHS.

7.2 Work with PCMHS and PC as to whether safe and effective care can be provided in primary care to meet the needs of any given individual.

7.3 Only transfer of care via the PCMHS, not directly to the GP for this group.

7.4 Provide a clinical summary. This should include a brief overview of the condition and more detailed information on the treatment being transferred. As a minimum, it should identify a product's licensed indications, therapeutic classification, dose, route of administration and duration of treatment, adverse effects (their identification, management, importance and incidence), monitoring requirements and

responsibilities, clinically relevant drug interactions and their management, storage and reconstitution of product, peer-reviewed references for product use, and contacts for more detailed information.

7.5 Secondary care to provide up to date information on physical health checks completed via the CMHT prior to transfer.

7.6 Provide an up to date care plan where appropriate

7.7 Ensure discharged individuals are closed on the RiO system in a timely manner.

8 Additional considerations

8.1 Section 117 after care arrangements:

8.1.1 It has been determined locally that Section 117 responsibilities may equally be discharged through primary or secondary care.

8.1.2 At the time of transfer of care, the PCMHS must ensure that the individual's Section 117 status is recorded in the person's electronic notes.

8.1.3 KCC must be advised by the secondary care provider so that they may record the status of SWIFT.

8.2 Depot prescribing in Primary Care:

8.2.1 **See Appendix 2** for the administration of depot medication in primary care.

8.3 Social Care Package Funding may be provided following a joint health and social care review.

8.3.1 Social Care will support access to mental health social care needs assessment for people with mental health problems in clusters 1, 2, 3, 4, 7, 11, 12. Within the statutory functions in assessing the needs of vulnerable people as outlined in the S75 KCC will ensure that effective social care provision remains available for those service users with long term conditions who can safely leave secondary care services.

Appendix 1 – Clusters 1 – 12

Cluster	Name of Cluster	Description of need	Likely diagnoses	Provider
1	**Common Mental Health conditions (mild)** **Common Mental Health Problems (Low**	Definite but *minor problems* of depressed mood, anxiety or other disorder. No psychotic symptoms. *No disruption* to wider functioning (activities of daily living, work, socializing, etc). Unlikely to be an issue with risk. Indicative duration of care: 8-12 weeks.		GP
2	**Common Mental Health conditions (moderate)** Common Mental Health Problems (Low Severity with greater need)	Definite but *minor problems* of depressed mood, anxiety or other disorder. No psychotic symptoms. *Minor problems* with everyday functioning. Risk unlikely to be an issue. May have already received care associated with cluster 1 and require more specific intervention or previously been successfully treated at a higher level but are re-presenting with low level symptoms. Indicative duration of care: 12-15 weeks	Depressive episode, phobic anxiety disorders, other anxiety disorders, obsessive compulsive disorder, stress reaction/adjustment disorder, eating disorder.	Primary Care Psychological Therapies
3	**Complex mental health conditions (severe)** Non-Psychotic (Moderate Severity)	*Moderate problems* involving depressed mood, anxiety or other disorder. No psychotic symptoms. *Moderate problems* with everyday functioning. Risk unlikely to be a serious issue. Indicative duration of cared: 4-6 months.		
4	**Complex mood and anxiety conditions** Non-psychotic (severe)	Severe depression and/or anxiety *with increased complexity* of needs. *Significant disruption* in everyday functioning. Moderate risk to self through self-harm or suicidal thoughts or behaviours (for some). Individual is unlikely to improve without treatment and may deteriorate with longer term impact or functioning. Indicative duration of care: 6-12 months (with 6 month review)		KMPT (planned care)
5	**Acute mood or anxiety conditions Non-psychotic Disorders (Very Sever)**	*Severe* depression and/or anxiety and/or other. No distressing hallucinations or delusions. May have some *unreasonable beliefs.* May present safeguarding issues. *Severe disruption* to everyday living. Moderate or severe problems with relationships. Various problems in other areas of role functioning. *High risk* for non- accidental self-injury, other risks or safeguarding issues if responsible for young children or dependent adults. Indicative duration of care: 1-3 years (6 monthly review) (locally agreed that a daily tariff will apply)	As above plus: dissociative disorder, somatoform disorder, other neurotic disorders. (Locally to include bipolar disorder where mood disturbance is the main presenting feature)	
6	**Enduring mood or anxiety conditions**	*Moderate to very severe* disorders. *Limited treatment response* to date. Everyday activities and role functioning are *seriously affected* in many ways. Risk is unlikely to be a major feature. Safeguarding may be an issue.	Enduring depression, treatment resistant	KMPT (planned care)

Appendix 1 – Clusters 1 – 12

Cluster	Name of Cluster	Description of need	Likely diagnoses	Provider Lead:
7	**Stable mood or anxiety conditions (high disability)** Enduring Non-psychotic Disorders (High disability)	*Moderate to severe* disorders. Received treatment over a number of years. Improvement in positive symptoms but considerable *disability in daily activity* and role functioning. Risk unlikely to be a major feature. Safeguarding may be an issue if any responsibility for young children or vulnerable dependant adults. Indicative duration of care: 3 years+ (annual review) Annual tariff will apply.	Eating disorder, OCD etc, where extreme beliefs are strongly held. Also some personality disorders.	**PCMHS**
8	**Complex Personality Disorders Non-Psychotic Chaotic and Challenging Disorders**	Wide range of symptoms with *chaotic and challenging lifestyles*. Moderate to very sever repeat *deliberate self-harm* and/or other impulsive behaviours. Chaotic, over-dependent engagement accompanied by hostility towards services. Poor role functioning. Severe problems in relationships. Suicide *risk* likely to be present. Safeguarding may be an issue. Indicative duration of care: 3 years+ (annual review) Annual tariff will apply	Personality Disorders	KMPT (planned care)
9	(was 'drug abuse' in early versions but later removed. Separate clusters developed for substance misuse)			
10	**First episode psychosis**	*First presentation with mild to severe psychotic symptoms*. May also have depressed mood and/or anxiety or other behaviours. Drinking or drug taking may be present but *will not* be the only problem. *Mild to moderate* problems with activities of daily living and relationships. Poor role functioning. Indicative duration of care: 3 years (with minimum annual review). Annual tariff will apply.	Schizophrenia, schizotypal and delusional disorders (locally agreed to include bipolar disorder only where psychosis is the main presenting feature.	KMPT (planned care)
11	**Stable psychotic conditions** Ongoing recurrent Psychosis (low Symptoms)	History of psychotic symptoms that are currently controlled and causing minor problems. If any at all. Currently experiencing a period or recovery. Capable of full or near functioning. May be impairment in self-esteem and vulnerability. Risk of relapse. Indicative duration of care: 2 years (with minimum annual review). Annual tariff will apply.	Schizophrenia, schizotypal and delusional disorders, manic episodes, bipolar disorder.	**PCMHS**
12	**Stable psychotic conditions (high disability)** Ongoing or recurrent Psychosis (High Disability)	History of psychotic symptoms. Significant disability and major impact on role functioning possible cognitive and physical problems linked with long-term illness and medication. Limited survival skills and lacking basic life skills. Poor role functioning in all areas. Likely to be vulnerable to abuse or exploitation. Indicative duration of care: 3 years+ (with minimum annual review). Annual tariff will apply.		

Appendix 2

East Kent* CCGs Protocol for the Management of Long Term Mental Health Conditions in Primary Care – Arrangements for the management of Depot antipsychotic prescribing

Patients will only be discharged if they are stabilised on their medication and there is agreement with a patient's GP.

1 Responsibility of the Primary Care Mental Health Specialist (PCMHS) – CPNs only

1.1 To ensure that the patient is stable on their depot antipsychotic and to agree their transfer into primary care with the GP.

1.2 Currently the PCMHS service does not take on patients on the following medications:
- Clozapine
- Paliperidone
- Risperdone consta
- Olanzapine (depot)
- Aripiprazole (depot)

1.3 To ensure the GP is provided written information from the Consultant Psychiatrist in Secondary care regarding the patient's medication and frequency of injection prior to transfer.

1.4 To arrange the initial appointment for the administration of the antipsychotic depot.

1.5 To manage and resolve any issues the patient has with regard to compliance with their medication regime e.g. regular ordering, collection and attendance at administration appointments.

1.6 To deal with any concerns a GP may raise in relation to the patient's medication and seek advice from a consultant as needed.

1.7 PCMHS home visits will only be made in circumstances where there are complex physical health needs and the patient would be regarded as housebound in relation to the delivery of care. These patients will be assessed by the Primary Care Mental Health Specialist who will co-ordinate the administration of the depot where appropriate with the community services.

1.8 Monitoring of side effects and ensuring annual physical reviews of patients are undertaken.

* Currently in use in SKC CCG only

2 Responsibility of the GP

2.1 To prescribe the depot antipsychotic as instructed by the consultant as part of the usual repeat prescription process.

2.2 To refer to the PCMHSW any clinical concerns they may have regarding the patient's antipsychotic depot

2.3 To review the patient six monthly that may include the primary care physical health check (as per QoF).

3 Responsibility of the Practice nurse

3.1 To administer the depot antipsychotic as prescribed by the GP. To liaise with the PCMHSW regarding any issues in relation to administration.

3.2 To arrange subsequent appointments for antipsychotic administration with the patient.

3.3 To refer to the PCMHSW any problems the patient has regarding compliance with their medication regime e.g. regular ordering, collection and attendance at administration appointments. The Practice Nurse is not responsible for resolving the issues.

Appendix 3

Changes to the Reimbursement Arrangements for the Administration of Depot Antipsychotics for patients under the agreed coordinated care of the Primary Care Mental Health Specialist PCMHS and the GP

Background

- The CCG has agreed that it is appropriate for patients to be administered depot in Primary Care for those patients where the GP, Consultant and PCMS are in agreement and for a care plan to be developed to support those patients in the Community (most practices are already doing this and this is to formalize and recognise Primary Care for the input).

- Shared guidelines have been agreed and specify the responsibilities of the consultant, GP and PCMHS and are available on the CCG Website: http://www.southkentcoastccg.nhs.uk/about-us/prescribing-recommendations/

- The patient requires that their depot be administered every 28 days or 14 days, this may be done by the PCMHS in the community and/or in the practice and where necessary by a practice nurse and that the GP Monitors the patient at least annually and if required six monthly.

Reimbursement

1. The CCG has agreed a reimbursement per patient per year of:

- £229.42 for patients that are administered their depot injection every 14 days or
- £129.71 for patients that are administered their depot every

28 days This includes payment for:

- either the PCMHS administering the depot and/or the practice nurse
- for the GP to review the prescription and consult with the consultant where necessary
- review the patient at least annually, this may be done alongside any other reviewthe patient requires in routine primary care

2. Practices can now claim reimbursement for this work through the GP Supplementary Services claims process.

3. Practices should provide the following details as an attachment to the invoice:
    a. NHS number of the patient.
    b. Date of administration

- Shared care guidelines have been agreed that specify the responsibilities of the consultant and GP. These should be sent to the GP when the patient is transferred to primary care. They are also available on the CCG website; http://www.southkentcoastccg.nhs.uk/about-us/prescribing-recommendations/

Please contact: Heather Lucas, Head of Medicines Management (heatherlucas@nhs.net) or Jeanette Dean-Kimili, Commissioning Manager