Evolving a model for integrating physical health, mental health and social care to include closer collaboration with primary care

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• Integration and the Triple Aim
• (Not) re-inventing the wheel
• ICP – Integrated care planning - quality
• Familiar faces – Integrated care planning - efficiency
• Intermediate intermediate care – partnership working
Finance and efficiency

£1.3 billion funding gap by 2021
Care and quality

A third of patients in our acute hospitals could be better cared for in the community or at home.

Four in five of us would prefer to die at home but only one in five are able to do so.

Waiting times for many outpatient services and operations are increasing.

Care is often fragmented.
Health and wellbeing

36% increase

in people living with one or more long term condition

One in five children aged 4-5 are overweight
Mental health and wellbeing

> 5% A&E presentations are for a mental health problem

Self harm consistently ‘Top 5’ reason for emergency admission (170 000 pa)

¼ people with physical illness develop psychological reaction

42% of cigarettes are smoked by people with MH problems

26% of adults receive MH care vs 92% pts diabetes

65% amputees get back to employment vs 7% patients SEMI
**Current system:** Reactive care often responding to crises, under resource and capacity pressures

**Future system:** Pro-active care focusing on self-care, wellbeing and community interventions
Partners Healthcare, Boston MA

- Fully integrated mental health will enrich the ‘medical neighborhood’ with an opportunity for physician to psychiatrist ‘curbsides’ (patient discussions without referral), and multidisciplinary care based upon ‘huddles’ and ‘warm handoffs’ (face to face referrals, rather than ‘cold handoffs’ ie delayed written referrals).

“if you are able to embed mental health into the model from the beginning, you should go for it”.
Integrated behavioral health input aimed at:

- improving mental health outcomes
- LTC treatment adherence
- self management
- quality of life
- reduced substance misuse
- reduced costs

Use of:

- Screening
- Brief Intervention
- Referral to Treatment (SBIRT)
- IMPACT model
Incentivise GPs to work with secondary care, social services and mental health to care plan patients

Supported by monthly multidisciplinary group case discussion (MDGs)

Initially diabetes and frail elderly pathways in Inner NW London

Now a variety of complex cases and LTCs across Outer and Inner NW London

First 34 case conferences, discussed 205 cases. 167 (81%) had relevant mental health issues.

Benefit to:

- Professionals’ skills and confidence
- Patient wellbeing (?)
- Formal screening
- Funding pilot service

Primary care interfaces

- Broadmoor Hospital and West London Forensic Service – **Liaison Physician**
- Primary care mental health – **shifting settings of care**
- Cognitive impairment and dementia – **link workers and third sector partnership**
- **Community Independence Service** Partnership with CNWL, LCWUCC, Central London and West London GP Federations – and provision in H&F of Virtual Ward model proactive **case management**
- Actively exploring how secondary care partnership and corporate functions can support development of **primary care at scale** without loss of GP independent contractor identity
Every WSI integrated care team should include a mental health professional
  • Core team member (not referral)
  • Identify undiagnosed MH needs
  • Reduce need for referrals to specialist services

All members of the integrated care team should be trained and supported to identify mental health needs and support mental and social wellbeing
  • Awareness
  • Identification
  • Interventions
  • Onward referral if required

(1) NWL Whole Systems Integration Model of Care group recommendations:
(2) Familiar faces – NW London

2013/14 - 105 patients identified across NW London

96 patients mapped into four themes

- Primary substance misuse related presentations \( [n=33 \ (34\%)] \)
- Long term medical conditions +/- mental health comorbidity \( [n=26 \ (27\%)] \)
- Elderly frail with globally deteriorating physical health \( [n=14 \ (15\%)] \)
- Other including complex psychiatric morbidity \( [n=23 \ (24\%)] \)

105 patients
3199 attendances pre-intervention
2617 per year

Reduced rate of attendance post-intervention
Saving of 1075 attendances per year
32 clients identified using mixed methodology

20 identified as frequent attenders / complex clients using the ED Symphony Data
11 were referred to the project by the Liaison Psychiatry Team and 2 by ED staff.

Case reviews were conducted in all cases, with joint working with GP in 31 cases.
Face to face contacts with the patients were undertaken in 14 cases.

The identified patients had attended Ealing ED **304 times** in the three months prior to the project.
A comparison 3m attendance rate following our intervention was **60 attendances**
(reduction of **244 attendances per 3m**).

Patient: “It’s just good… very helpful… it’s been helpful talking about my problems”
GP: “Thank you for your ongoing input and the invaluable work you are doing with [this patient]. This is very helpful for me”.
Objective: to test the principles of the partnership in practice

- Identified 71 patients who had visited A&E ≥ 10 times in 10 months, of whom 13 had visited > 20 times.
- Local GPs obtained special consent from 19 patients to share their clinical records between all partners.
- Brought together senior clinicians from across the partnership to review specially consented cases.
- Clinicians also individually reviewed the other case records.
- Identified key themes to inform potential care pathway improvements.
Achievements and learning so far

- Building trust and knowledge between clinicians across the partner organisations.

- Important to bring together all clinicians involved in an individual’s care to achieve insights BUT it is time-intensive.

- Different information systems and information sharing rules are acting as a significant barrier to better care.

- We have a better understanding of this vulnerable patient group – characterised by complex health and mental health conditions, in contact with GP but also often requiring out-of-hours urgent or emergency care.

- GP and social care need to be involved in care planning and multi-disciplinary team planning.
Next steps

• Working with some of the specially consented patients to see how we can improve the design of urgent and emergency care pathways.

• Looking at how we could improve outcomes and experience for patients who stay in hospital for a long time.
Baseline evaluation (13-14 pilot)

- AHPs: “not confident in identifying MH needs”
- “Not aware of referral processes”
- 40% MH training was “poor”
- Symptomatic mental health diagnosis exclusion criteria

Activity (13-14 CQUIN / 14-15 Winter resilience)

- 596 referrals to ICE – single LPS nurse inputted into care of 96 (22%) with face to face assessments for a third of these.
- 912 referrals to ICE – 7 days service inputted into care of 351 (38%) with face to face assessments for 18%.
Acute hospital / inpatient care

Intermediate care

Care coordination / joint care team
Community services

General Practitioner
Carers and Community Support
Care Navigation / Primary care MDT
82% patients said care had improved as a result of healthcare professionals enquiring about emotional wellbeing (13-14)

“They took time to talk about my life… they were interested in me as a person”

“The team made my mum feel at ease”

Referrers

“They were at every MDT”

“Clients benefited from psychiatric nurse contacting them”

“It was helpful to have them to talk to and to arrange visits”.
Ealing Home Ward
Integrated intermediate care service
There’s no ward like home
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<td>• Care planning</td>
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<td>• Care coordination</td>
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<td>• Care closer to home</td>
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<td>• Patient-centred care</td>
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<td><strong>1950 – 2016 in MH</strong></td>
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<td>• Care Programme Approach</td>
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<td>• Care coordination</td>
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<td>• Care in the community / shifting settings of care</td>
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<td>• “New ways of working”</td>
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