New models of mental health care- MCPs and beyond

Dr Liz England, RCGP Mental health and whole person care lead, SWB CCG Mental health and Commissioning Lead, GP modality

Dr Will Murdoch, Executive Partner Modality Birmingham
• LE has chaired, presented and attended meetings sponsored by Janssen
• LE is a representative and advises the RCGP on mental health and while person care
• LE is a clinical commissioning lead in Sandwell and West Birmingham CCG
• LE is a salaried GP in Modality
• WM is a partner in Modality
• Modality has received ‘vanguard funding’ from NHSE
• WM has presented at an event sponsored by MSD
• WM is a non-executive director for Birmingham Women’s and Children’s Hospital
Our MCP Vision

Based on our registered population, our collective vision is to develop a true population health model that provides the right services by the right team at the right time and place based on individual needs and acuity

Together, we will:

- Increase access to our services and ensure the right care and support at the right time and place by the right professional team, delivered in the way people want according to their needs

- Make the best use of available resources and work together to provide integrated and seamless care closer to home

- Harness our collective skills, capabilities and expertise to deliver excellent quality and experience and value across the system and improve long-term outcomes of our population

Working Together

Birmingham Community Healthcare NHS Trust

Sandwell and West Birmingham Clinical Commissioning Group

Sandwell and West Birmingham Hospitals NHS Trust

Birmingham and Solihull Mental Health NHS Foundation Trust

Birmingham City Council
About Modality Partnership

At a Glance

• Approaching 150K patients in four regions: Sandwell, Birmingham, Walsall and Hull
• NHS Ethos / Single Partnership
• 1° and 2° care contracts
• 400+ staff
• 25 primary care sites
• 59 Partners
• Executive Boards to oversee each region

Registered Population

- 2010
- 2011
- 2012
- 2013
- 2014
- 2015
- 2016
- 2017

- 10,000
- 20,000
- 30,000
- 40,000
- 50,000
- 60,000
- 70,000
- 80,000
- 90,000
- 100,000
- 110,000
- 120,000
- 130,000
- 140,000
- 150,000
- 160,000
EPC and MDT Teams

**EPC Team 1**
- Core EPC Care Team
  - GP
  - APN/PA
  - Practice Nurse
  - HCA
- EPC Care Management Team
  - Moderate-risk patient
  - Care Coordinator*
  - Frail patient
  - Wellbeing Coordinator
  - Advanced illness patient
  - Care Coordinator*
- Extended EPC Team
  - 3,500 Patients

**EPC Team 2**
- Core EPC Care Team
  - GP
  - APN/PA
  - Practice Nurse
  - HCA
- EPC Care Management Team
  - Moderate-risk patient
  - Care Coordinator*
  - Frail patient
  - Wellbeing Coordinator
  - Advanced illness patient
  - Care Coordinator*
- Extended EPC Team
  - 3,500 Patients

**EPC Team 3**
- Core EPC Care Team
  - GP
  - APN/PA
  - Practice Nurse
  - HCA
- EPC Care Management Team
  - Moderate-risk patient
  - Care Coordinator*
  - Frail patient
  - Wellbeing Coordinator
  - Advanced illness patient
  - Care Coordinator*
- Extended EPC Team
  - 3,500 Patients

**Complex Case Management MDT**
- Care Management Oversight
  - Most complex patients
  - Care Coordinator*
  - Care Manager
  - Wellbeing Coordinator
- Care Management Team
  - District Nursing
  - Senior Social Worker
  - Therapies e.g. Physio
  - Mental Health ANP
- Community-based Team
- 10,500 Patients

*Care Coordinator*
Embedding ANPs

- Focus on key referral sites
- Referral facilitation (previously high diversion)
- EPC facilitation
- First clinic appointment (previously high DNA rate)
- Discharged patient support
- Complex care management

And then........
Shared records
Physical health
AND BEYOND......
West Midlands Combined Authority
by Local Enterprise Partnership Area

MAP KEY
- Black Country LEP
- Constituent members
- Coventry & Warwickshire LEP
  - Constituent members
  - Non-constituent members
  - Part of the LEP but not the WMCA
- Greater Birmingham & Solihull LEP
  - Constituent members
  - Non-constituent members
  - Part of the LEP but not the WMCA
- The Marches LEP

[Map showing regions within the West Midlands Combined Authority]
Thrive West Midlands

• Mental illness in Birmingham
• Co-production- work based on citizen’s jury
• The cost to the Birmingham economy is estimated to be around £12 billion annually
• Lack of Parity of Esteem
• Improving Access to Psychological Therapies
• Waiting standards for mental health
• Investment in in-patient care to prevent OOA admissions
• Case management models and early intervention
Work themes

• **THEME 1** Supporting people into and while in work
• **THEME 2** Providing safe and stable places to live
• **THEME 3** Mental health and criminal justice
• **THEME 4** Developing approaches to health and care
• **THEME 5** Getting the community involved
For primary care

- IPS in primary care
- Zero Suicide Ambition approach
- Regional primary mental health care model
- Ensure region meets national access and waiting time standards for EIS for FEP
- Establish how the principle of early intervention should be applied
- Establish a group to ensure access to specialist ‘perinatal’ mental health services
STPs

- There are three main aims:
  1. Bring services together on a place basis (in each CCG area)
  2. Bring secondary care services together at scale
  3. To tackle the wider determinants of health e.g. housing, jobs

- Place based Commissioning - practice register based, CCGs, whole budgets
- Geography – West Birmingham (Wards) Sandwell Towns?
- Standardisation of Primary Care
- 365 day access
- Prevention
- Early detection
- Evidence based interventions/best practice
- Empowered patients who can self care
- Integration of services/agencies around complex patients
What tools are available to help us?

Positive Cardiometabolic Health Resource

**Smoking**
- Current smoker
- Poor diet AND/OR Sedentary lifestyle

**Lifestyle and Life Skills**
- BMI ≥ 25 kg/m² (≥ 23 kg/m² if South Asian or Chinese) AND/OR Weight gain > 5 kg over 3 month period

**Body Mass Index (BMI)**
- Poor diet AND/OR Sedentary lifestyle

**Blood Pressure**
- > 140 mm Hg systolic AND/OR > 90 mm Hg diastolic

**Glucose Regulation**
- HbA1c > 42 mmol/mol (> 6.5%)
- AND/OR FPG > 5.5 mmol/l
- OR RGP > 11.1 mmol/l

**Blood Lipids**
- Total chol/HDL ratio to detect high (> 10%) risk of CVD based on QRISK2 tool
- http://qrisk.org/
- Note: CVD risk scores can underestimate risk in those with psychosis

**INTEVENTIONS**

**Brief intervention**
- Combined NRT and/or varenicline
- Individual/group behavioral support or specialist support if high dependency
- Referral to Smoking Cessation service

**Follow NICE guidelines for obesity**
- http://www.nice.org.uk/Cg43

**Consider anti-hypertensive therapy**
- Limit salt intake in diet

**At High Risk of Diabetes**
- HbA1C > 48 mmol/mol (> 6.5%)
- FPG > 7.0 mmol/l
- RGP > 11.1 mmol/l

**Endocrine review**
- Follow NICE diabetes guidelines
- http://www.nice.org.uk/Cg87

**Follow NICE guidelines for lipid modification**
- AND
- Refer to specialist if total cholesterol > 9, non-HDL chol > 7.5 or TG > 20 (mmol/l)
- AND
- Consider lipid modification for those with CVD or Diabetes

**TARGET**
- BMI 18.5-24.9 kg/m² (18.5-22.9 kg/m² if South Asian or Chinese)
- < 140/90 mm Hg (< 130/80 mm Hg for those with CVD or diabetes)
- Prevent or delay onset of diabetes
- HbA1c < 42 mmol/mol (< 6%)
- FPG < 5.5 mmol/l
- HbA1C, 47-58 mmol/mol (6.3-7.5%)

**Primary Prevention: consider Statin treatment if ≥ 10% risk based on QRISK2**
- OR
- Secondary Prevention: aim to reduce non-HDL chol by 40% and review in 3 months

FPG = Fasting Plasma Glucose  | RGP = Random Plasma Glucose  | BMI = Body Mass Index  | Total Chol = Total Cholesterol  | HDL = High Density Lipoprotein  | TRIG = Triglycerides
Place Based Care

People only go to hospital when they need treatment or care that can’t be provided in their community.

Care is centred around communities and people, and is focussed on wellbeing, self-care and prevention.

Non-statutory services and volunteers working with doctors, therapists, social workers and specialist teams.
# Community resources

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www.common-unity.org  
www.the-waitingroom.org
Crisis care

• New understanding of different types of crisis
• Different types of responses
• Times of response
• Home based
• Hospital avoidance
• Early intervention
• Care planning
• Home treatment and crisis care
• Respite – cafés, beds
• Role of primary care in this
• Zero suicide goal
The Challenges?

- Working with (against) the system
- Multi-partner working
- Funding & in-year savings
- Understanding system pressures and pathways
- Geography
- Bio-psycho-social nature of mental health
- Workforce capacity
- Workforce knowledge and skills
- Implementation factors- how do you achieve change?