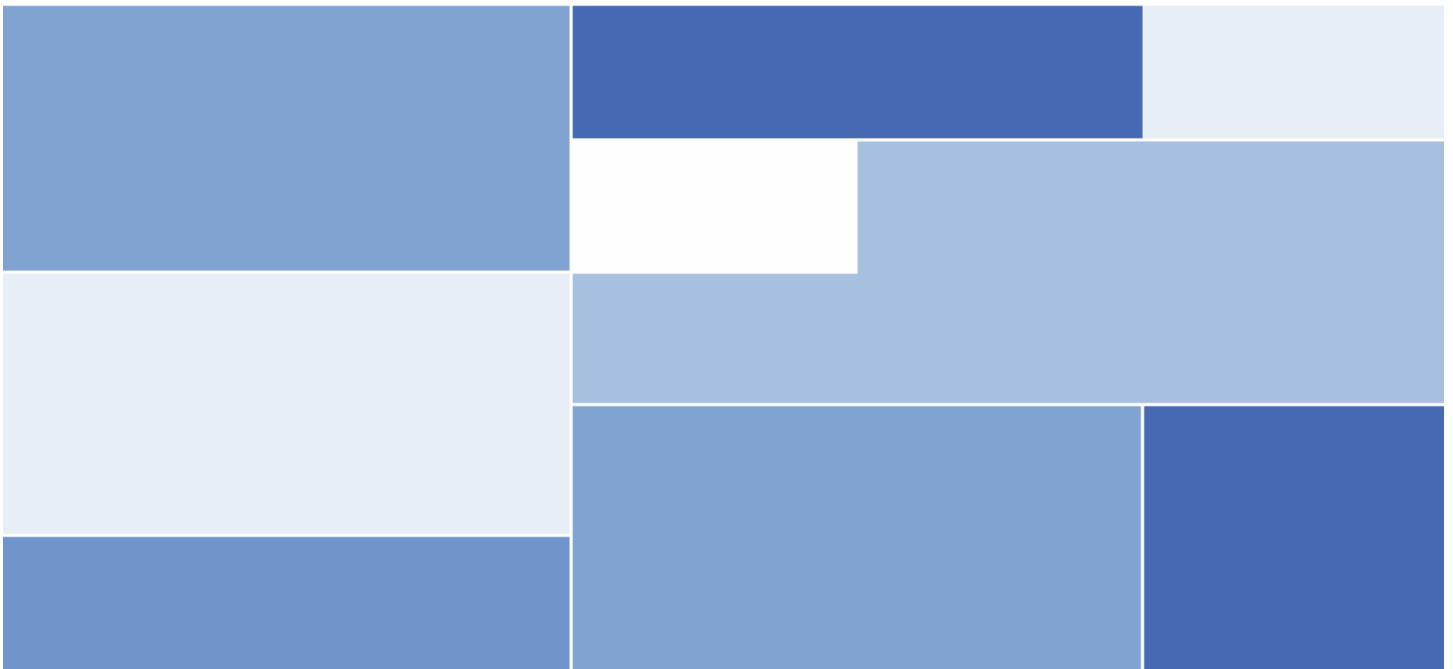


# New Ways of Working for primary care mental health: a briefing document



# Contents

<b>Introduction</b>	<b>3</b>
<b>A Five key practice and operational changes that would make a real difference to the primary care mental health workforce</b>	<b>5</b>
<b>B The scope of mental health problems in primary care</b>	<b>7</b>
<b>C The essential characteristics of primary care and general practice</b>	<b>9</b>
<b>D Values for primary care mental health</b>	<b>10</b>
<b>E Three themes to underpin New Ways of Working for the primary care mental health workforce</b>	<b>14</b>
<b>F New roles for health and social care workers in primary care</b>	<b>20</b>
<b>G Practical guide for interface and responsibility issues</b>	<b>40</b>
<b>H Practical hints for achieving change</b>	<b>43</b>
<b>Conclusion</b>	<b>51</b>
<b>Membership of the New Ways of Working group primary care subgroup</b>	<b>52</b>

# Introduction

This document is part of the New Ways of Working programme, and has been produced by the primary care subgroup of the New Ways of Working national steering group for mental health. It was developed in collaboration with and endorsed by the Royal College of General Practitioners, as well as having representation from other key Primary Care Stakeholders. This document is intended as a briefing document to assist PCTs, GPs and other Primary Care Practitioners to review the way they work and for staff in other sectors to review how they work, link and practice in a Primary Care Setting

This document aims to assist commissioners and providers in the redesign of primary care mental health services and roles, in the context of an NHS in transformation. The ongoing change provides opportunities for primary care mental health to develop roles and to change practice, two elements that are critical to the success of the whole 'primary care led commissioning' and 'care closer to home' agendas.

Lord Darzi's Next Stage Review (2008) describes the importance of an NHS that is "locally led, patient-centred and clinically driven". Published in July 2008, the document *NHS Next Stage Review: Our vision for primary and community care* set out the Department of Health's vision for primary and community care services, and launched a strategy to support patients, the public, clinicians and the local NHS to achieve continuous improvements in the quality of services.

*"Primary care services should be shaped around individuals and listen to and respond to their needs. The system should feel connected and work for them. They should have convenient access to a growing range of health services in GP surgeries, in a range of other community settings and in their own homes. They can make more choices, including choosing their GP practice. People can take greater control over how they manage their care, particularly those with long-term conditions."*

The work described in this report, although predating the Next Stage Review, anticipates and supports the implementation of this vision. Supporting clinical staff to be "practitioners, partners and leaders" and acknowledging that "healthcare is delivered by a team... clinicians, managerial staff and those in supporting roles. All members of the team are valued", has been the key focus of the work that has collectively been called New Ways of Working (NWW) since 2003.

The New Ways of Working for Primary Care Mental Health subgroup was part of the New Ways of Working for Everyone programme, launched in 2007, and included practitioners and managers from primary and secondary care, and from diverse professional groups. It considered evidence from generalists and specialists with expertise across the age range to develop examples of innovative practice. It also complemented other initiatives – the introduction of the Quality and Outcomes Framework indicators for mental health, the Improving Access to Psychological Therapies (IAPT) programme and guidance from the primary care mental health programme of the National Institute for Mental Health in England (NIMHE)/Care Services Improvement Partnership (CSIP).

**In this document a range of real examples that typify the values, characteristics and themes of primary care mental health are offered.**

This report first re-examines the clinical typologies of people presenting to primary care practitioners, then looks at the critical values for PCMH. It outlines three themes, with examples of how excellent primary care mental health can be delivered through new roles and the changing of practice in the workforce.

The main substance of this document includes suggestions about how practitioners' roles might change, and includes practical guidance on how practitioners from primary and specialist care can effectively and safely work together towards improved outcomes for service users and carers.

# A Five key practice and operational changes that would make a real difference to the primary care mental health workforce

## Five practice changes

- 1. Increase confidence in mental health issues for primary care team members.**  
Brief education and practical training in mental health issues can increase the likelihood of staff recognising people with mental health problems, and should improve their confidence in working to support them.
- 2. Develop more flexible use of mental health specialists.** Specialists can provide brief mental health assessments and treatment in primary care settings, as well as consultation and supervision to core primary healthcare team members.
- 3. Increase use of low-intensity interventions.** Train core primary healthcare members in the use of simple low-intensity interventions based on counselling, social prescribing, solution-focused and cognitive behavioural approaches.
- 4. Adopt a single patient record for specialists and generalists working together in primary care.** Develop common information systems between specialist and generalist services to support shared communication between teams caring for the patient.
- 5. Develop referral pathways from primary care for people with long-term mental health problems** to services that promote recovery and inclusion in educational and vocational activities.

## Five operational changes

- 1. Develop career pathways for primary care mental health workers, including those delivering the IAPT programme** (see [www.skillsforhealth.org.uk/page/career-frameworks](http://www.skillsforhealth.org.uk/page/career-frameworks)).
- 2. Support the development of networks to promote self-management and recovery for those with enduring mental or physical health problems**, including developing new approaches to bringing professionals together to promote physical and mental wellbeing and recovery in primary care.
- 3. Encourage partnership working between voluntary and statutory services along care pathways, including health and social care.**

4. **Develop an implementation strategy for commissioning guidance for the material within this document.** Enable the commissioning of flexible mental health services based on local need by practices (practice-based commissioning) and on individuals (individual budgets).
5. **Develop a mental health and personal wellbeing component of education within the core curriculum for professionals who may go on to work in primary care.**

# B The scope of mental health problems in primary care

Primary care mental health is often characterised as the realm of common mental health problems. It lies at three critical interfaces:

- between the lay and medical worlds;
- between primary care and specialists; and
- between physical and mental healthcare.

Problems presenting a challenge to the workforce in primary care range in their severity, complexity, co-morbidity and chronicity; and across the lifespan of patients. With this in mind, we propose that the workforce needs the skills, knowledge, attitudes and competences that reflect the following range of clinical presentations:

- 1. People with common mental health problems:** short-lived distress related to life situation, low-grade ongoing mood and anxiety symptoms, through to diagnosable episodes of depression, anxiety or other psychiatric problems.
- 2. People with mental health problems associated with physical health,** including health anxiety; distress related to recent physical investigation or diagnosis; medically unexplained physical symptoms; and mental health problems resulting from long-term physical health problems.
- 3. Those with long-standing, complex, non-psychotic mental health problems,** such as recurrent depression, chronic anxiety, post-traumatic stress disorder and obsessive compulsive disorder. There is often associated psychiatric and physical co-morbidity, recurrent self-harm, substance misuse, homelessness and unemployment. This heterogeneous group has often fallen in the gap between primary care and specialist services.
- 4. People with psychosis:** new and recurrent episodes, often with ongoing disability, social exclusion and physical illness. They may or may not be looked after by a specialist mental health team. Primary care can be involved in early recognition and in ongoing physical and mental healthcare.
- 5. Those with cognitive impairment:** dementia, learning difficulties or developmental and organic disorders. These problems are also associated with physical and mental co-morbidity and social exclusion.

# **C The essential characteristics of primary care and general practice**

The following characteristics are important to understand when considering NWW, as they provide the building blocks on which new systems of care, new roles and new skills are developed.

**1. High-volume throughput and rapid point of access to healthcare**

Access that is timely, acceptable and available 24 hours

Access that engages, sorts, holds, treats and signposts large numbers of patients

**2. Undifferentiated symptoms and tolerance of diagnostic uncertainty**

Ensure that there is an early stage of presentation when a diagnosis is uncertain

Maintain awareness that the problems of the mind and body are intertwined

Recognise that levels of distress or symptoms are an understandable response to life events

**3. Continuing care over time**

Provide proactive health promotion through the life course

Provide chronic disease management for long-term conditions at home and at health centres

Care for whole families over time.

# D Values for primary care mental health

Primary care and mental health services each have sets of values underpinning care. The following is an amalgam – a set of values embodied in the examples of good practice from around the country, which has been used to develop this guidance:

1. **Recovery and social inclusion**
2. **Choice of treatment**
3. **Care closest to home**
4. **Working and learning together**
5. **Self-care**

## 1. Recovery and social inclusion

While promoting recovery and working towards inclusion in mainstream society (e.g. having meaningful work and relationships, and participating in creative activities) are now accepted values and objectives for mental health, they are relatively new in terms of being explicit aims for primary care practitioners. However, they build on the related values of holistic and patient-centred practice held by primary care practitioners, and can complement the more medically orientated functions of diagnosis and treatment allocation.

The ‘personalisation’ agenda, which is dominating social care, will be extended selectively in the NHS through the Next Stage Review. This is entirely congruent with the values and attitudes of recovery and social inclusion.

Generalists in primary care can help people to understand that distress may be normal and does not imply pathology. They can orientate consultations around individuals’ strengths and social aspirations. They can also work with community-based teams to ensure that marginalised groups – such as those in residential homes, the homeless and offenders – receive good healthcare and have meaningful lives.

The National Social Inclusion Programme maintains a database of models and interventions – these illustrate practical approaches to developing services that promote social inclusion and help to achieve positive outcomes for those who use them.

**Further information can be found at [www.socialinclusion.org.uk/](http://www.socialinclusion.org.uk/).**

## 2. Choice of treatment

The last ten years have seen an expansion in the range of psychological, social and educational options advocated in primary care for people with mental health problems. As these modalities become mainstream for people of all ages, then working with individuals as partners to choose the most appropriate, accessible and desirable management option will need to be embedded in new systems of care in primary care.

### Northumberland, Tyne and Wear NHS Trust – adult mental health delivery for primary care

A model of adult mental health self-help delivery, available to primary care and the community:

GP practices are offered a supply of self-help booklets to help those suffering with common mental health problems and, via the trust's website, they are provided with familiarisation sessions.

Practice nurses are offered a number of detailed sessions based on the materials, which include information associated with diagnosis and clinical interviewing techniques.

Local psychologists provide GP training on ongoing supervision associated with the cognitive behavioural approach.

Self-help clinics are run by mental health facilitators, GPs or counsellors, and psychotherapy practices deliver approaches based on the workbooks.

**Further information can be found at [www.ntw.nhs.uk/pic/?p=selfhelp](http://www.ntw.nhs.uk/pic/?p=selfhelp).**

## 3. Care closest to home

GPs and community nurses have long had a philosophy of caring for people at home. Practice-based commissioning provides incentives for increased involvement of primary care for those with complex mental health needs within the community. Care closest to home also suggests the critical importance of working with families and other partners in care, as well as with the resources of the individual patient.

## Plymouth primary care link working

The function of Plymouth's primary care liaison teams has been redesigned to include all community mental health workers (i.e. mental health nurses, occupational therapists and social workers) providing advice and linking with specific clinics in general practice, to carry out brief assessment and signposting under primary care, providing reviews and sharing care with GPs for those with less complex needs and at a lower level of risk.

Records are entered directly into GP systems and discussions about care development take place in liaison with patients, carers and primary care team members.

**Contact Dr Richard Byng, University of Plymouth**  
**[richard.byng@pms.ac.uk](mailto:richard.byng@pms.ac.uk)**

## 4. Working and learning together

By working together we will have something to learn from each other – patients and practitioners, specialists and generalists. By welcoming specialists into primary care, generalist practitioners will become more skilled, willing and able to support people with mental health problems to become independent. Conversely, primary care skills can be utilised within a specialist setting. In all cases, appropriate supervision should be made available. As practitioners we also need to value working with patients and be aware of their roles as self-carers and as experts by experience.

**Lewisham Primary Care Trust (PCT)** has implemented a multifaceted programme to develop primary care healthcare workers' skills, knowledge and resources to improve their provision of services to patients with depression. A facilitator arranges to visit each team to ensure that they: are aware of current thinking regarding depression management; engage in appropriate provision of education and support; receive resources developed by the programme to aid the management of depression; and know how to access high-quality local and web-based resources.

**Further information can be found at [www.mdpclew.org.uk](http://www.mdpclew.org.uk).**

## 5. Self-care

Self-care was highlighted in *The NHS Plan* as one of the key building blocks for a patient-centred health service. Support for self-care involves increasing the capacity, confidence and effectiveness of the individual for self-care by providing a range of options, including:

- appropriate and accessible advice and information, including multimedia and multilingual NHS Choices website;
- computerised and online therapy, e.g. Living Life to the Full, MoodGYM and Mood Manager;
- materials, campaigns and training on lifestyle issues to change behaviours, promote good health and prevent ill health, such as by lay self-care trainers or health trainers;
- individual care plans;
- self-diagnostic tools, self-monitoring devices and self-care equipment;
- self-care skills training, for example through the Expert Patients Programme.

# E Three themes to underpin New Ways of Working for the primary care mental health workforce

By considering different individuals' needs, best practice guidance and values, and by building on the essential characteristics of primary care, we have developed three themes underpinning the development of new roles:

- Ensuring high volume and rapid access to the most appropriate level of care.
- Breaking down the mind/body divide.
- Developing proactive care for long-term mental health conditions in primary care.

## Ensuring high volume and rapid access to the most appropriate level of care

Timely access to psychosocial interventions should be made available via the primary healthcare team for a range of conditions, and at all ages. These may include:

- signposting to services, e.g. self-help groups, user-led organisations etc;
- group cognitive behavioural therapy (CBT) psycho-educational courses;
- computerised cognitive behavioural therapy (CCBT);
- guided self-help, delivered face-to-face or by telephone;
- book referral/prescription scheme;
- exercise referral schemes/green exercise; and
- specific support for returning to and staying in work, e.g. Pathways to Work and the Conditions Management Programme.

Interventions of varying intensity should be available in a framework of stepped care, following two principles:

1. Interventions offered should always have the best chance of delivering positive outcomes, while burdening the patient as little as possible.
2. A system of scheduled reviews to detect and act on non-improvement must be in place – to enable stepping up to more intensive treatments, stepping down to less intensive treatments

when appropriate, and stepping out altogether when an alternative treatment or no treatment becomes appropriate.

Providing access to these interventions requires both excellent consultation skills and adaptable, resourced care pathways. Generalists require skills to engage with the emotional presentation of helping people understand or accept distress, or discuss possible onward referral. Although a diagnosis of, for example, depression is valuable to some individuals, others may be set on the path to recovery through acknowledgement of distress and prompt access to non-stigmatising care.

As well as needing investment in a range of services, stepped care requires new skills, and systems of supervision for both generalist and specialist practitioners in primary care. For example, ensuring that GPs are aware of psychosocial interventions as alternatives and adjuncts to medication. This is particularly important if generalists and specialists are to work together providing the range of psychosocial interventions required for those with complex and recurrent non-psychotic conditions (one of the current gaps in provision).

The Department of Health's **IAPT programme** provides significant investment to PCTs for a programme of service redesign, staff recruitment and training to implement the National Institute for Health and Clinical Excellence (NICE) guidelines for depression and anxiety, which include a range of evidence-based psychological approaches managed via a process of stepped care.

**Further information can be found at [www.iapt.nhs.uk](http://www.iapt.nhs.uk).**

## Breaking down the mind/body divide

There is an increasing importance being given to the **mental health of people with long-term physical problems**. Whether understanding the psychological needs of those with **medically unexplained symptoms** or ensuring high-quality **physical care for those with severe and enduring mental health problems**, primary care remains in an excellent position to promote integrated physical and psychological healthcare.

## Long-term conditions

Practice-based commissioning and the new GP contract provide incentives for **improving psychosocial care for people with long-term physical conditions**. Such initiatives, by improving mental wellbeing, may improve people's ability to self-manage illnesses such as diabetes, and may help to prevent unscheduled admissions. Practice and district nurses will also need to acquire new mental health roles and skills. There may be opportunities for occupational therapists, with their dual training, to become core members of primary healthcare teams, supporting the recovery of people with long-term mental health and physical health problems. It is well recognised that community matrons, who focus on those most at risk of re-admission, require mental health skills.

The IAPT programme has supported special interest groups, including Pathfinder sites in the East Riding of Yorkshire, North Tees, Dorset, Hertfordshire, Stoke and Salford. A positive practice commissioning guide, published in October 2008, details the benefits of improving access to psychological therapies for people with long-term conditions, including physical health outcomes, recognition and treatment strategies, and economic costs.

**Further information can be found at [www.iapt.nhs.uk/special-interests/long-term-conditions/](http://www.iapt.nhs.uk/special-interests/long-term-conditions/).**

## Physical care for those with mental illness

**Improving physical care for those with psychosis and other mental health problems** has been tackled head-on by the Disability Rights Commission (now part of the Equality and Human Rights Commission (EHRC)) and their 'Do your duty' campaign (for more information visit the EHRC website:

[www.equalityhumanrights.com](http://www.equalityhumanrights.com)). PCTs have a duty to actively prevent 'diagnostic overshadowing' and ensure that those affected by mental health problems and learning disabilities have their physical health needs met. This will require closer co-operation and better communication between generalist and specialist teams, particularly around the Quality Outcomes Framework and Care Programme Approach systems.

As well as the need to ensure that significant diagnoses are not missed, practitioners should engage patients experiencing psychosis in health promotion activities. This may require specific support from primary care teams to, for example, help people stop smoking and improve their diet, but also referral and encouragement to engage in a wide range of physical activities.

It is particularly urgent that we improve the physical care and promotion of health for those people with dementia in residential and nursing homes.

Everybody's Business (2005) was launched to improve health and social care practice for older people. Older people's mental health is relevant across health and social care, physical and mental health services, and mainstream and specialist services. Further information can be found at [www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business/](http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business/).

*Transforming the quality of dementia care: consultation on a National Dementia Strategy* (2008) will have a key impact on improving awareness, early diagnosis and intervention in primary care. CSIP Communities of Interest: Dementia Practice Development and Positive Practice is building a useful resource of practice development and positive practice examples in dementia care, through the sharing of work being undertaken across the country. Further information can be found at [www.olderpeoplesmentalhealth.csip.org.uk/positive-practice-/dementia-practice-development-and-postive-practice.html](http://www.olderpeoplesmentalhealth.csip.org.uk/positive-practice-/dementia-practice-development-and-postive-practice.html).

Working on behalf of Shift, the Government initiative to tackle stigma surrounding mental health, Mentality has developed a set of resources for people with mental health problems, and for those

working in health and social care to address physical health issues. The resources, called *Healthy Body – Healthy Mind*, are developed for people who use services and for staff working on inpatient wards, in community roles and in primary care.

**Further information can be found at <http://kc.csip.org.uk/viewresource.php?grp=581>.**

## Medically unexplained symptoms

**People with medically unexplained symptoms are over represented in outpatient clinics and on investigation waiting lists.** General practice has a key role in the management of this clinical problem, as at least 20–30% of primary care patients have medically unexplained symptoms. This heterogeneous group includes those with health anxiety resulting from physical symptoms, those with as yet undiagnosed serious physical illness, as well as those with somatoform disorder and a range of conditions such as irritable bowel syndrome and atypical chest pain, which may or may not have underlying emotional causes.

Best practice requires GPs and specialist physicians to attend to people's concerns, beliefs and expectations, to act and communicate consistently, and to support individuals to make links with the psychosocial if they wish. While formal 're-attribution' work is not usually recommended, mental health specialists can help the most difficult cases, both by treating co-morbid mental health problems and by helping people to cope with ongoing symptoms and work towards realistic life goals. Current evidence indicates that care of medically unexplained symptoms should include improvements in three interrelated elements – diagnosis, specific treatment strategies and communication.

Practitioners must have theoretical knowledge about medically unexplained symptoms to be able to appropriately diagnose and manage patients presenting such symptoms. Diagnosis is not merely the exclusion of serious physical diseases but also the simultaneous consideration of the role of the psychosocial. Practitioners should listen to the concerns and ideas of the patient, broaden the agenda and discuss a new understanding of the symptoms, including the possibility of psychosocial factors.

Medically unexplained symptoms are commonly presented in primary care and result in a considerable use of health resources. There is randomised controlled-trial evidence that improving access to psychological therapies for people with such symptoms may improve function and reduce health expenditure.

Along with the Pathfinder site Stoke PCT, the Improving Access to Psychological Therapies Medically Unexplained Symptoms Special Interest Group has been exploring the benefits, recognition and treatment strategies relating to delivering psychological therapies to people with medically unexplained symptoms. Their findings can be found in a positive practice guide published in October 2008.

**Further information can be found at [www.iapt.nhs.uk/special-interests/medically-unexplained-symptoms/](http://www.iapt.nhs.uk/special-interests/medically-unexplained-symptoms/).**

## Developing proactive care for long-term mental health conditions in primary care

While general practice has a long tradition of providing ongoing care, the approach has often been reactive rather than proactive in nature. Practice-based commissioning may provide the incentives for bringing care closer to home for people with dementia, long-term physical conditions, psychosis and learning difficulties, and also for the heterogeneous group of people with severe and enduring mental health problems caused by recurrent depression, ongoing anxiety and other co-morbidities.

The Quality and Outcomes Framework in general practice provides a foundation of incentives for most of these groups. However, there is relatively little specificity within the mental health domains of the new contract; the emphasis is primarily on medical care, and values such as recovery and promoting social inclusion are not addressed.

Practice-based commissioning could encourage practices to extend systems of chronic disease management in the following ways:

- Specialist liaison: community-based specialists such as community psychiatric nurses, occupational therapists, physiotherapists and psychologists will be working in, and sharing care with, general practice.
- The systems of review and recall will be extended beyond the requirements of the Quality Outcomes Framework to ensure the 'whole person care' for all those disabled by, or requiring proactive care for, physical and mental health problems.
- Self-care and information for patients at the practice level will integrate national resources, e.g. websites with local information signposting and user groups.
- Models of care such as Wellness Recovery Action Plan (WRAP), which build on strengths and promote recovery, will need to be promoted locally through service-user influence, local contracting strategies and professional pride in best practice. It is this last area of proactive care where specialists and generalists will have to start working together most effectively.

*Mental health: New ways of working for everyone* (2007) outlined a series of mechanisms for joint working, many of which involved working and learning together through discussing cases and designing the detail of local services alongside user experts. Further information can be found at [www.newwaysofworking.org.uk/](http://www.newwaysofworking.org.uk/).

## Wellness Recovery Action Planning (WRAP)

Self-management is one of the ways in which people build up a range of personal resources that work for them and give them more control over their lives. WRAP, developed by Mary Ellen Copeland with others who had experienced serious mental health problems, found that a self-management plan could be effective in avoiding or moderating the negative effects of their mental health problems. The programme includes wellness tools, a daily maintenance plan, identifying triggers and action plans, identifying early warning signs, crisis planning and post-crisis planning.

**Further information can be found at [www.mentalhealthrecovery.com/](http://www.mentalhealthrecovery.com/).**

# F New roles for health and social care workers in primary care

This section provides a detailed description of how each professional can develop their role. This is followed by a brief outline of the capabilities and competences relevant to primary care mental health, which are explored in more detail in Key Skills.

## Roles for workers in primary care

1. **General practice teams**
2. **Practitioners based in primary care and other community settings**
3. **Primary-care-based mental health workers**
4. **Mental health liaison in primary care**

Around the country roles are changing in primary care, but often in a piecemeal way. Here we provide a comprehensive guide to how roles can shift. As primary care mental health is redesigned, clinicians and supporting staff will take on additional roles and develop their competences. We recognise that many teams and professionals are already engaged in this transformation.

## 1. General practice teams

General practices are usually independent partnerships within the NHS family employing their own staff.

### GPs

#### *Common roles*

- Usually acting as the first point of contact for people accessing primary care.
- Recognising and engaging with patients who have mental health problems.
- Treating with medication and referring for counselling or secondary care.
- Providing ongoing support for people with common mental health problems.
- Providing reactive physical care for people with mental health problems.

### *New Ways of Working in primary care*

- Developing more specific psychological skills such as cognitive behavioural and solution-focused approaches.
- Directing people with common mental health problems to a wide range of social and psychological interventions, including IAPT services.
- Recognising and managing medically unexplained symptoms.
- Providing proactive physical care of those with long-term mental health problems.
- Leading and sharing care for those with long-term mental health problems.
- Providing proactive mental healthcare for those with long-term physical health problems.

### **Practice nurses**

Although the role of the practice nurse has changed significantly over recent years, the focus has remained on physical conditions.

### *Common roles*

- Informally supporting those experiencing emotional distress.
- Managing the care of people with chronic diseases such as diabetes.
- Providing physical health checks for individuals on the severe and enduring mental illness registers.

### *New Ways of Working in primary care*

- Screening and identifying depression and anxiety among those in at-risk groups.
- Discussing therapeutic options.
- Signposting and referring to interventions within the stepped care model.
- Providing ongoing psychological support for those with long-term conditions.
- Providing follow-up and support in medication management.

## Practice receptionists and managers

### *Common roles*

- Facilitating access to appointments with professionals.
- Responding empathetically to those experiencing distress.

### *New Ways of Working in primary care*

- Noticing potential mental health problems and communicating concerns to clinicians.
- Responding to distress and finding out how the practice can help.
- Involving GPs in proactive reviews of services and primary care spending.
- Organising proactive reviews of progress to recovery for people with mental health problems.
- Supporting the work of practice-based psychological therapists and other mental health specialists.
- Distributing pre-appointment or post-appointment questionnaires including patient experience, some of which may have a mental health component.
- Facilitating access to CCBT.

## General practitioners and practitioners with a special interest (GPwSIs and PwSIs)

These roles were highlighted in the review *The National Service Framework for Mental Health – Five Years On* (2004). The Royal College of General Practitioners and other professional bodies are keen to support the development of this new role, where established practitioners are identified and undertake training and regular supervision to:

- provide an intermediate specialist level of skills and knowledge in primary care;
- work in a specialist team (e.g. IAPT) to provide generalist skills and understanding; and
- support service redesign and training.

Under the Pathfinder programme, IAPT services were also asked to nominate a GPwSI or PwSI to attend a Master's degree course developed by the charity primhe ([www.primhe.org](http://www.primhe.org)) covering the implementation of therapies in primary care, commissioning and leadership. Participants noted that clarifying the role of primary care in IAPT had been beneficial, as had the opportunities to develop operational and strategic thinking.

## 2. Practitioners based in primary care and other community settings

Many professionals such as district nurses and health visitors are attached to general practice teams. They may be part of a professional team (e.g. district nurses) or a functional team (e.g. occupational therapists as part of enablement teams) with looser links to general practices.

### Health visitors

Health visitors are specially trained to assess the health needs of individuals, families and the wider community. Their work may include tackling the impact of social inequality on health or working closely with at-risk or deprived groups.

### *Common roles*

- Using the Edinburgh Post Natal Depression Scale (EPNDS) to carry out postnatal depression screening at 6 weeks, 12 weeks and 8 months.
- Supporting cases of postnatal depression with listening and increased contact.
- Referring women with postnatal depression to GPs and/or a postnatal depression group.

### *New Ways of Working in primary care*

- Collaborating with midwives in the antenatal period to identify women with a pre-existing mental health disorder.
- Working within an integrated care pathway for antenatal and postnatal, infant and family, and parental mental health.
- Having a clear referral pathway into specialist perinatal services.
- Assessing attachment difficulties.
- Recognising and managing a parent's mental distress in the postnatal period, identified with screening tools.
- Managing the mental health and wellbeing of parents using a stepped care approach involving social prescribing, cognitive approaches, supported medication management and guided self-help.
- Referring patients with mental health problems directly to specialist mental health services, including IAPT teams.

- Working collaboratively with or within agencies involved with children's and families' mental health, e.g. Sure Start Children's Centres and nursery nurses.
- Working to support extended families with multiple indicators of social exclusion.

## Midwives

Midwives have been identified as key professionals in predicting women at risk of perinatal mental health disorders.

### *Common roles*

- Monitoring individuals in their care for previous or present history of mental ill health.
- Running antenatal groups.

### *New Ways of Working in primary care*

- Supporting individuals within their care who have a previous or present history of mental ill health, through active listening and behavioural interventions.
- Liaising with specialist mental health professionals or parental mental health teams to share care of the individual.
- Including psychosocial interventions into prenatal groups.

Robust, clinically focused training has enabled established workers (e.g. health visitors, community workers and midwives) to develop the skills, competence and confidence to deliver a stepped care approach to perinatal mental health.

The approach includes the detection and prediction of mental health problems within prenatal and postnatal care, and to deliver low-intensity psychological treatments for common mental health problems.

In the stepped care approach, the more moderate to severe cases are referred on to secondary care, which functions as a specialised service for more complex cases as well as offering support, training and advice to primary care workers.

**Contact Helen Adams, Perinatal Mental Health, Northampton PCT**  
**Helen.Adams@northamptonpct.nhs.uk**

## District nurses

District nurses provide nursing at home and support to those with long-term physical health needs; teams are linked to general practices.

### *Common roles*

- Providing nursing care on discharge from hospital.
- Providing palliative care.
- Providing emotional support for those in distress.

### *New Ways of Working in primary care*

- Screening for and diagnosing mental health problems such as dementia and depression.
- Integrating basic mental healthcare into care for physical health conditions.
- Providing specific cognitive behavioural and solution-focused support for those with long-term conditions.

## Care assistants

Working in district nursing teams, home care teams and residential and nursing homes, care assistants provide essential help with personal care, mobility and supporting access to recreation.

### *Common roles*

- Listening and providing support – but they are not seen as having a role in mental healthcare.

### *New Ways of Working in primary care*

- Identifying and referring those with suspected mental health problems to clinical staff or IAPT services.
- Using behavioural techniques to help ensure social inclusion.
- Supporting medication concordance.

## Occupational therapists

Occupational therapists work across the health and local authority divide, in acute trusts, community

mental health teams (CMHTs) and community rehabilitation teams.

### *Common roles*

- Assessing and treating of physical and psychiatric conditions using specific, purposeful activity to prevent disability and promote independent functioning in all aspects of daily life.
- Assessing need for aids to support independent living.

### *New Ways of Working in primary care*

- Working with general practice teams to support recovery and rehabilitation for those with physical and mental health problems.
- Developing links between primary care and local mainstream resources (leisure, education, volunteering, self-help) to support recovery.
- Delivering psycho-educational courses in stress management, focusing on the interaction between physical and psychological needs.
- Working as part of the Conditions Management Programme attached to Jobcentre Plus, supporting Pathways to Work programmes and the Fit for Work programme to be piloted next year (2009) following Dame Carol Black's report *Working for a healthier tomorrow* (2008) and the NHS Next Stage Review by Lord Darzi.

### **Community matrons**

This is a new type of post, designed to enhance the health and social care of people with long-term conditions. In their 'hands-on' case management role, community nurses will identify those at greatest risk of re-admission and:

- work as members of the primary healthcare team to ensure a team approach to care, evaluating outcomes in partnership with GPs and hospital colleagues;
- collaborate with health professionals, social services, carers and relatives to understand all aspects of patients' physical, social and environmental condition; and
- assess and monitor the psychological wellbeing of clients and provide support or referral for mental health.

## Cornwall CBT training for the management of long-term conditions by community matrons

Cornwall PCT has been offering training to a cohort of non mental health professionals (including community matrons and practice nurses, who specialise in offering care close to home and self-care) working with people with long-term conditions. Two days of core CBT training is supplemented by three days on enduring mental health problems, including background psychological issues, problem level formulation and skills development based on cognitive behavioural techniques.

**Contact Dr Paul Farrand, University of Exeter**  
**p.farrand@exeter.ac.uk**

### School nurses

School nurses can play a vital role in recognising and assessing mental health problems, referring young people for help, and managing children's mental health themselves.

#### *Common roles*

- Screening children and adolescents for physical health problems.
- Signposting children with mental health problems for referral via their GP.

#### *New Ways of Working in primary care*

- Working in an integrated school health team.
- Screening for and recognising mental health problems using validated instruments.
- Utilising self-help materials and problem-solving approaches to assist mental health problems.
- Providing ongoing mental healthcare in liaison with general practice and specialist mental health teams.
- Providing access and referral to advice from Child and Adolescent Mental Health Services (CAMHS).

## QUEST project

The Quality Improvement Evaluation for School Nurses and Teachers (QUEST) project, led by the Institute of Psychiatry at King's College London and the mental health charity Rethink, is developing training for school nurses so that they can better recognise early signs of mental health problems in young people and understand when and how to refer them for more help and support to improve their quality of life, their attainment at school, their health and their emotional wellbeing.

**Contact Mark Haddad, Institute of Psychiatry, King's College London**  
[www.iop.kcl.ac.uk/staff/profile/default.aspx?go=10141](http://www.iop.kcl.ac.uk/staff/profile/default.aspx?go=10141)

## Employment advisors and Conditions Management Programme workers

These posts are funded by the Department for Work and Pensions, which is also to pilot **employment advice workers** within some new IAPT services; these workers will provide guidance on remaining in or returning to work for people who are experiencing common mental health problems but are not eligible for Incapacity Benefit.

## Conditions management teams

Conditions management teams provide a work-focused interview with a specially trained advisor for all new Incapacity Benefit claimants within six weeks of the start of their claim. Individuals presenting with long-term health conditions will have the option of attending a Conditions Management Programme delivered using the biopsychosocial model by a multidisciplinary team including physiotherapists, psychologists, mental health nurses and occupational therapists. The programme has helped people to understand and manage their health conditions, and to recognise the benefits that work can have on their health.

## Community pharmacists

The introduction of a new contract in 2004 encouraged pharmacists to expand their role in chronic disease management.

### *Common roles*

- Offering advice on medication interaction.
- Directing patients to their GP for further discussion on medication.

### *New Ways of Working in primary care*

- Supervising repeat prescriptions and medicines.

- Reviewing the promotion of healthy lifestyles (including smoking cessation).
- Supporting patient involvement in medicine management via the delivery of medicines use reviews (MURs) in partnership with GP colleagues.
- Supporting self-care.

The Pharmacist Independent Prescriber (PIP) role allows qualified PIPs to prescribe any licensed medicine for any medical condition within their competence.

### Wandsworth Enhanced Pharmacy Project

As part of the local mental health promotion strategy to broaden the scope of primary care to address issues of mental health, this project in south London aimed to ensure that people presenting with depression for the first time obtained maximum benefits from their prescribed medication (antidepressants).

Every patient who presented with depression and was prescribed a new course of antidepressants received a 'Mood Manager' DVD, a booklet and advice from local pharmacies.

**Contact Dr Chris Gilleard, South West London and St George's Mental Health NHS Trust**  
**Chris.gilleard@swlstg-tr.nhs.uk**

## 3. Primary-care-based mental health workers

Commonly, general practices have had attached counsellors and in some cases psychologists; the development of primary care mental health teams has led to the creation of new roles.

### Primary care counsellors

Many counsellors, particularly those integrated as part of a primary care mental health team, have taken on New Ways of Working. There is an increasing recognition of the need for tighter governance arrangements. Commissioners share responsibility for ensuring that all counsellors receive supervision and are accredited.

Primary care or practice-based counsellors are often located within general practice and receive referrals from the GP. While the majority are trained in non-directive 'Rogerian' approaches, there are many theoretical counselling models.

### Common roles

- Providing person-centred counselling to people with common mental health problems.
- Assisting people with life-adjustment problems rather than mental health 'disorders'.

## *New Ways of Working in primary care*

- Becoming integrated within the stepped care system for the delivery of psychological therapies.
- Providing direct access to patients for assessment in primary care settings.
- Embedding routine outcome monitoring within clinical practice.
- Sharing relevant patient information with other primary care staff.

## **IAPT practitioners**

### *Low intensity therapy workers*

Qualified low intensity therapy workers provide high-volume, low-intensity cognitive behaviourally based interventions at Step 2, including guided self-help. They have nationally defined training to postgraduate certificate level.

One of the underlying principles of this role is that there should be a diversity of backgrounds to match local communities, and there is a non-graduate route to training.

### *High intensity psychological therapists*

Qualified high intensity psychological therapists provide CBT sessions. There is a national curriculum with accreditation being undertaken by the British Association for Behavioural and Cognitive Psychotherapies (BABCP) and the IAPT programme. These workers are likely to be staff drawn from a mix of professions, including CBT therapists, clinical psychologists, counsellors, nurses, occupational therapists and psychotherapists, as well as experienced graduate workers.

IAPT practitioners need access to staff with expertise in employment support, benefits and housing, who can offer sound advice and information to the people accessing IAPT services and those supporting them.

Further information on these services and roles can be found at [www.iapt.nhs.uk/services/workforce/](http://www.iapt.nhs.uk/services/workforce/)

## **Primary care mental health workers (PCMHWs)**

When reviewing roles of service personnel nationally there is wide variation in titles. PCMHWs are clinicians from a variety of professional backgrounds, whose role is to provide specialist mental healthcare in primary care settings to individuals of all ages.

These titles include:

- mental health practitioners;
- primary mental health workers (CAMHS);
- link workers;
- gateway workers; and
- associate practitioners.

Despite their very different titles, these workers have similar roles and are expected to have a recognised professional qualification, with several years' experience in the mental health field. With skills including a variety of therapeutic interventions, many have a nursing, occupational therapy or social work professional background. They may be associated with a variety of community based teams; in the future some may find roles within IAPT services.

### *Common roles*

- Providing brief therapy for those with more complex problems.
- Providing assessment in a primary care setting in collaboration with GPs or school nurses.
- Sharing with GPs, school nurses or community matrons the ongoing care of those with moderately complex but low-risk problems.

### **Primary care graduate mental health workers**

In the year 2000, the NHS Plan proposed to recruit 1,000 new graduate mental health workers in order to treat 300,000 new patients in primary care. Specific postgraduate courses were commissioned nationally to provide them with education targeted at patient care and primary care liaison.

With appropriate supervision, graduate workers function as a first contact point for stepped care services, carrying out:

- assessment and signposting;
- delivery of low-intensity interventions, e.g. guided self-help, supporting CCBT;
- patient education; and
- medication management.

Many have additional skills and experiences, and have taken on other roles such as running groups, providing assessment for more complex cases and delivering brief CBT and solution-focused therapy.

## 4. Mental health liaison in primary care

### Support, time and recovery (STR) workers

An STR worker is part of a team that provides mental health services and focuses directly on the needs of the people who use the service. Often working across traditional boundaries of care, organisation and role, STR workers provide support, give time to the service user and help promote their recovery. Recovery values are based on the individual defining their recovery in their own terms and as far as possible self-managing their recovery process. The worker is there to help the individual define and achieve their recovery objectives. They pay attention to the wishes and aspirations of individuals to recover or discover the life they wish to lead.

#### *New Ways of Working in primary care*

- Sharing care with GPs for low-risk clients with psychosis who are in recovery and requiring support and short-term input.
- Supporting brief therapy on social interventions, e.g. to support cognitive behavioural work or attendance at mainstream vocational education or leisure activities.

Further information about the new post of STR worker may be found in *The Mental Health Policy Implementation Guide* (2003); *Support, Time and Recovery (STR) Workers: Learning from the national implementation programme – Final Handbook* (2008); and *Support, Time and Recovery (STR) Workers: A competence framework* (2008).

### Community psychiatric nurses (CPNs)

These are key members of community-based mental health teams (CMHTs, primary care liaison teams, assertive outreach teams, crisis and home treatment teams and early intervention teams).

#### *Common roles*

- Carrying out full mental health assessments, using the Care Programme Approach (CPA), of people referred from primary care to CMHTs.
- Liaising with GPs about the continuing care for those with severe mental illness through CMHTs.

#### *New Ways of Working in primary care*

- Providing assessments within primary care.
- Providing psychological treatments and support to people within primary care settings.
- Sharing care with primary healthcare team members.

- Providing liaison functions for complex cases.
- Utilising primary care systems for record keeping.
- Providing independent/supplementary prescribing.

## **Clinical and counselling psychologists**

Clinical and counselling psychologists provide therapeutic services within CMHTs, or direct psychological therapy services in either mental health trusts or PCTs. In the former case (i.e. when they are located in secondary care services), access can be via GP referral but may require a generic team assessment and a wait before seeing a psychologist.

### *New Ways of Working in primary care*

Most applied psychologists already working in primary care with CBT training can provide longer-term intensive psychological therapy to those with more complex problems in primary care; additionally they can be IAPT high intensity workers and undertake supervision of high intensity and low intensity staff.

Other roles will also be possible for other psychology grades:

- delivering psychological services and therapies directly to clients (graduate psychologists);  
and
- delivering group-based psycho-educational programmes for people with common mental health problems.

For more information see [www.newwaysofworking.org.uk/psychology.aspx](http://www.newwaysofworking.org.uk/psychology.aspx) and [www.mhchoice.csip.org.uk/psychological-therapies/workforce.html](http://www.mhchoice.csip.org.uk/psychological-therapies/workforce.html).

## **Community psychiatrists**

Community psychiatrists are core members not only of CMHTs but also of assertive outreach, crisis and home treatment and early intervention teams,

### *Common roles*

- Receiving referrals from primary care (normally via CMHT referral meetings) for work with individuals experiencing severe mental illness.
- Delivering care according to the Care Programme Approach in outpatient settings.
- Using expertise in prescribing psychotropic medication.

- Undertaking the Responsible Medical Officer role for the current Mental Health Act.
- Diagnosing complex and rare psychiatric conditions.

### *New Ways of Working in primary care*

- Providing liaison, consultation, advice and supervision for primary care and CMHTs via telephone, email and face-to-face contact.
- Providing emergency appointments for brief reviews or assessments.
- Considering co-location within general practices providing specialist liaison.
- Providing sub-specialty advice and liaison for medically unexplained symptoms.

For more information see *New Ways of Working for Psychiatrists* (2005), available at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4122342](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4122342).

### **Social workers**

Social workers often work in local authority adult and children's teams and in 'mental health teams' under various partnership arrangements.

### *Common roles*

- Acting as generic members of community-based mental health teams.
- Assessing for 'social care packages' including housing and direct payments.
- Carrying out Mental Health Act assessments as 'Approved' Social Workers – this will be changed under the new Mental Health Act to a role of Approved Mental Health Professional.

### *New Ways of Working in primary care*

- Taking on a link worker role (assessment and shared care).
- Developing a recovery and social inclusion function in primary care.
- Supporting reviews of social care packages for those with primary-care-based mental health input, e.g. those with stable psychosis.
- Supporting the implementation of personalisation, individual budgets and direct payments.
- Becoming members of IAPT services.

## Competences and capabilities for primary care mental health

This guidance provides a comprehensive overview of the key knowledge and skills recommended to assist individuals within primary care in developing essential mental health competences, linked National Occupational Standards and the Ten Essential Shared Capabilities (see below).

### Key skills for key staff: the six areas of the 'HEALTH' approach

Health promotion, emotional wellbeing, social inclusion

Evidence, best practice, data

Assessment, consultation, interview techniques

Lifestyle

Therapeutic interventions, improving access and choice

Holistic approach

Full details of this approach, including self-assessment methodologies, are available at [www.nimhe.csip.org.uk/silo/files/nimhe-key-skills-bropdf.pdf](http://www.nimhe.csip.org.uk/silo/files/nimhe-key-skills-bropdf.pdf)

**National Occupational Standards** have been developed to help raise the standard of practice in a given sector, such as mental health services, by providing a benchmark against which performance at both individual and organisational level may be assessed and measured. A number of tools are available on the Skills for Health website to help you find competences, create and save lists of relevant competences and undertake assessments relating to competence-based role and team profiles and clusters.

The tools are available at [www.skillsforhealth.org.uk/page/competence-application-tools](http://www.skillsforhealth.org.uk/page/competence-application-tools)

**The Ten Essential Shared Capabilities Framework**, developed in consultation with service users and carers together with practitioners, provides the essential shared capabilities required to achieve best practice for all staff who work in mental health services. Evaluated learning materials are available on the website of the University of Lincoln's Centre for Clinical and Academic Workforce Innovation at [www.lincoln.ac.uk/ccawi/](http://www.lincoln.ac.uk/ccawi/)

Full details of the Framework can be found at [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4087169](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4087169)

### Therapeutic competences for delivering psychological interventions

In 2007 the Department of Health published *The Competences Required to Deliver Effective Cognitive and Behavioural Therapy for People with Depression and with Anxiety Disorders*. This

document describes a model of CBT competences and indicates the various areas of activity that, taken together, represent good clinical practice.

The model describes:

- generic competences – used in all psychological interventions;
- basic cognitive and behavioural therapy competences;
- specific cognitive and behavioural therapy techniques – the core technical interventions employed in most forms of CBT;
- problem-specific competences – the packages of CBT interventions for specific low and high intensity interventions; and
- metacompetences – overarching, higher-order competences which practitioners need to use to guide the implementation of any intervention.

The report also describes and comments on the types of competence found in each domain, and presents a 'map' showing how all the competences fit together and interrelate. Finally, the report comments on issues that are relevant to the implementation of the competence framework, and considers some of the organisational issues around implementation. These competences have been used as the basis for the high intensity curriculum and for the accreditation audit tool that is being used for all courses, led by the BABCP.

Full details of the competences framework are available at [www.ucl.ac.uk/clinical-health-psychology/CORE/CBT\\_Framework.htm#Background](http://www.ucl.ac.uk/clinical-health-psychology/CORE/CBT_Framework.htm#Background)

The work of the above report needs to be seen in the context of the development of National Occupational Standards, which apply to all staff working in health and social care. Skills for Health is developing National Occupational Standards for psychological therapies, which will make a timely and significant contribution to a number of UK initiatives in this area.

A project is under way to look at a wider range of psychological therapy modalities. I project should be completed in summer 2009.

- CBT;
- psychodynamic psychotherapy;
- systemic and family therapy; and
- humanistic and integrative therapy.

Details of this project are at [www.skillsforhealth.org.uk/page/competences/competences-in-development/list/psychological-therapies-nos-development-project](http://www.skillsforhealth.org.uk/page/competences/competences-in-development/list/psychological-therapies-nos-development-project)

# G Practical guide for interface and responsibility issues

This section provides a summary of the guidance to support the professionals who are being asked to carry out new roles, to enable them to carry out the roles in a high-quality, safe and defensible way. The subgroup responsible for this piece of work included representation from different professions, unions, defence bodies, the Department of Health and Royal Colleges. As traditional boundaries between professionals and between primary and specialist care are broken down, the notion of medical responsibility is transformed into shared responsibilities between practitioners and the people who use services.

## Providing advice about a patient or service user you have not seen

This occurs frequently when primary care clinicians ask for advice from specialists, and occasionally in reverse. The following principles should be adhered to:

- The person giving advice should ask for sufficient information about the clinical case, and record this.
- A record should be kept of the problem and the advice given, including the date and a patient identifier as an absolute minimum for good practice.
- Records should be secure and accessible but do not need to form part of the employing Trust's system.
- Best practice would indicate that for telephone contact, the advice should be subsequently provided in writing so that it can be incorporated into primary care or other records.
- Email advice provides a useful audit trail but needs to be incorporated into primary care records.

## Advice for clinicians working within another team

Increasingly as part of NWW, team clinicians are asked to work alongside other teams in order to provide co-ordinated and multidisciplinary care. For example CPNs, social workers and occupational therapists may be asked to take on the role of a link worker and provide advice and shared care for people with long-term problems. The following principles and guidance arose:

- It is good practice for clinicians working for other organisations to provide care within a primary care setting.
- Responsibilities for the roles should be documented in an agreement between the two teams.

- It is considered good practice for linked workers, who are doing assessments or engaged in shared care, to make the principal logging of records into the notes of the team they are working with, rather than into the notes of their own team. Some may wish to keep supplementary records or copies of records for their own or for their organisation's use. This is not considered essential practice.
- Agreements for the retrieval of records made by practitioners outside of the organisation they are working in should not cause a problem, as medical records are NHS property rather than belonging to primary care or the specialist trust.

## Chronic disease management and shared care

The co-ordinating function for chronic disease management may well be located in primary care, and might be the joint responsibility of administrators and clinicians.

- It is essential to record the responsibilities for components of care in terms of which team and which professional are responsible for carrying these out. This is particularly critical for the various sub-components of care with respect to lithium, depot injections and clozapine treatment.
- Joint working within the Care Programme Approach (CPA) and other care navigator functions (e.g. the Quality Outcomes Framework) should ensure proportionate engagement of all those involved in the care of individuals with complex needs.
- Invitations to attend lengthy CPA meetings or case conferences may not be the most appropriate way of engaging others. Alternative mechanisms, such as requesting key information to be sent to care co-ordinators or having verbal discussions prior to CPA meetings, are considered best practice when liaising with those unlikely to attend.

## Medication risks at the interface

It is vitally important that anyone prescribing for patients with mental health problems has a complete record of any medication the patient is taking, the reason why drugs have been started, changed or stopped, plus details of future monitoring and planned reviews. It is therefore essential that:

- it is recorded who is responsible for prescribing, monitoring and reviewing any medication;
- in shared care, both primary and secondary care records should include all oral and parenteral medication (not just psychotropics) and significant diagnoses, in order to anticipate interactions and prevent prescribing against contraindications; and
- information on changes in medication, along with related issues, be forwarded to other teams involved, in a timely manner and usually before the service user is likely to see the other teams.

# H Practical hints for achieving change

The guidance offers a potentially daunting agenda for the redesign of roles and services in primary care mental health. It also demonstrates how, around the country, determined individuals and brave organisations have achieved substantial change. This final section considers how we might achieve this across the whole system. It complements the detailed guidance for implementing NWW for everyone, aimed primarily at mental health trusts.

To achieve beneficial and lasting service improvement in primary care mental health we need to align key elements of the change process:

- Local service user and clinician opinion leaders
- Local initiatives and pilots
- Effective commissioning
- Evaluation and governance arrangements
- Research, learning and educational initiatives
- Local and national policy.

Top-down and bottom-up, commissioning organisations can provide a supportive framework for change, which embraces the initiatives of educators, managers, clinicians and service users.

## Developing a case for change

Those involved in promoting and developing NWW for primary care mental health may be service users, clinicians or commissioners. The changes envisaged may be within a single team or across the whole system. Although primary care mental health is achieving increased recognition, it is still often seen as marginal business to those in both mental health services and primary care. The following questions and approaches might be useful for developing a case for change:

- Clarify the problem. This might be described in terms of poor access, low levels of recognition, little investment in active treatment or recovery-focused activity, poor outcomes, gaps in provision or wasted resources. We need to understand the 'experience' by systematically collecting stories from service users and clinicians.
- Use comparative epidemiological approaches – what is the expected need in your population? What are the expected inequalities? Look at desired social inclusion outcomes as well as diagnoses. How do they relate to the problem you have identified?

- How does current service configuration address this need or these inequalities? Does the care pathway need redefining? Which functions and roles are critical and which are missing?
- How have others solved the problem? Case studies and narratives are useful, in addition to random controlled trials, which are in short supply. Learn from others' successes and failures.
- What are the policy or best practice guidance levers to support change, both locally and nationally, through NWW approaches? (With an emphasis on primary care espoused in many policy documents, e.g. the Darzi Next Stage Review, the CPA review and the National Service Framework review.)
- How would change or investment have a positive effect on other parts of the NHS?
- Develop a redesign plan involving commissioners, service users and clinicians (specify the new functions and outcomes required before deciding on role or team redesign).
- Recruit service-user, clinician and management champions to support the case for change – encourage brave conversations, promoting ideas but also listening attentively to valid concerns, so that your model can be improved.
- Draw up a financial model that will deliver your intended outcomes – you will need to convince both commissioning and provider finance teams.
- Draft specifications for new roles, measures of success and training requirements.
- Consider a piloting approach to improve on the new redesigned model. Perceive failures as 'learning opportunities' and develop a 'learning organisation' culture.
- Do not be put off by the inevitable objections and blocks from those whose interest is in maintaining the status quo – ensure that you have identified those in authority who have credibility and who support the ideas and plans. Detailed pathways, governance arrangements or training can be developed later.

## Making change happen

The impetus for change may originate at different levels and in different parts of the system. For beneficial change to be sustained and spread, the seeds of both innovation and best practice implementation need to be fostered by senior managers, clinicians and commissioners – and supported by educators until alignment is achieved between all the points at which change may have been initiated:

## Policy/best practice/proven innovation

- Service and pathway redesign
  - Service Level Agreement/contract
    - Role redesign
      - New job descriptions to articulate roles
        - Governance to support new roles
          - Competences developed
            - Change practitioner behaviour

There is also a requirement for a continuous cycle of monitoring to ensure that the intended outcomes are met by the new roles.

There is a need to improve the capabilities of the whole workforce with an 'integrated approach', so that new roles are not split off from the existing workforce and vice versa.

### *Key change management lessons*

Broadly speaking, initiatives can arise from either clinical leaders (bottom-up) or managers (top-down). Learning from the initiatives described in this document that have inspired this guidance provides some pointers as to how we can achieve lasting beneficial change.

For bottom-up initiatives to survive, the following criteria are likely to be required:

- a culture where innovation is fostered and applauded;
- clinical champions and knowledge brokers are identified;
- small changes are supported – not smothered by bureaucracy or risk aversion; and
- support is provided to evaluate initiatives – and to learn from those that are not successful.

For most initiatives to spread, the following criteria are required:

- partnership between practitioners, patients and managers;
- a clearly agreed, articulated rationale for new roles, with pathways linking to better outcomes;
- formalised clinical and service user leadership that promotes change and asks difficult questions;
- excellent in-house work-based learning;
- governance arrangements for clinical decision making, supervision or mentorship, sharing responsibility, record keeping and practicalities to support new roles, in order to support reluctant or less confident practitioners; and
- an evaluation of inputs, key processes and outcomes in order to demonstrate value.

### *Achieving change across the primary-specialist interface*

The organisational cultures of general practice and mental health services are very different. Community-based mental health teams are made up of diverse professional groups, and sit within a wider NHS corporate structure – as an NHS trust, with or without foundation status. Trust and team culture have a great impact on the pace and nature of change.

In contrast, GPs run small businesses as well as being ‘coalface’ practitioners. Practices vary greatly in size, culture and business acumen. Behavioural change is generated by both financial incentives and professional pride. GPs with an interest in mental health need support, as most of their peers have other priorities.

Trailblazers is a programme that has been running for ten years, designed to bring practitioners together from diverse backgrounds to develop both personal qualities and local services across the interface. Meeting with, and learning from, clinicians and managers (among others) from across the interface has been critical to Trailblazers’ success in developing both primary care mental health champions and examples of service innovation.

**Further information can be found at**  
**[www.iop.kcl.ac.uk/departments/?locator=367&context=790](http://www.iop.kcl.ac.uk/departments/?locator=367&context=790)**.

### *Team- and practice-based change*

The Creating Capable Teams Approach has been designed for mental health teams to work with service users in order to develop new roles and ways of working for practitioners. This approach may be particularly useful for developing primary care mental health teams, especially with increased IAPT

funding.

The framework may also be useful when considering the development of the 'virtual teams' working across organisations to provide primary care mental health including general practices and the voluntary sector. The approach would need to be streamlined to allow for the participation of generic workers, for whom mental health is not their core business.

Changing the behaviour of general practices can be enhanced by:

- providing opportunities for clinical skills and knowledge development;
- providing financial incentives;
- identifying a lead GP or other primary health care team member who is keen, interested and motivated to drive change through;
- working with practice managers;
- adapting practices' own systems to achieve new outcomes;
- providing training for practice nurses and receptionists;
- supporting reluctant practitioners; and
- commissioning opportunities.

Further information can be found at [www.newwaysofworking.org.uk](http://www.newwaysofworking.org.uk).

### *Mental health of the workforce*

The good mental health of practitioners and managers is critical to the success of any change programme. The NHS and local authorities have some excellent examples of programmes that improve wellbeing and reduce stress among employees, but there are still high rates of sickness absence and burnout. Programmes to identify and support struggling employees, as well as boost wellbeing through positive activities, should be supported.

Change itself can be stimulating and fulfilling, but it is also often cited as a cause of stress. There are a number of ways to make change a positive experience, including:

- providing genuine consultation;
- encouraging involvement in decision making;
- encouraging individual reflection and associated behaviour change;
- providing support to help reluctant practitioners to feel confident;
- devolving planning of detailed changes to clinical leaders within teams;
- developing a learning culture, so that mistakes are seen primarily as opportunities to improve rather than to blame;
- offering support through supervision, mentoring, and action learning sets to involved personnel as needed;

- offering training to those with developmental needs;
- devolving authority and decision-making to the requisite level; and
- investing in and resourcing change.

Leeds Mental Health Teaching NHS Trust has developed a 'code of personal responsibility', in which all employees share responsibility for reporting the understanding and learning gained from incidents, errors and disagreements. Disputes are generally settled in the team in which they occur and formal disciplinary proceedings have been reduced by 90%. This has been associated with improved staff and patient satisfaction results, and achieved while undergoing considerable service change.

**Further information can be found at**

**[www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH\\_5918705](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_5918705)**.

### *Stakeholders in primary care mental health commissioning*

Commissioners developing primary care mental health services need to justify service investment and redesign time to those responsible for commissioning mental health services and for the wider healthcare system. It is often unclear how decisions are made and which bodies hold the power.

Furthermore, investment and commissioning of the primary care mental health workforce, including counsellors as well as non-specialist workers such as community nurses and GPs, are the responsibilities of a range of commissioners who do not see mental health as their core business.

There are therefore a number of decision-making bodies and stakeholders in primary care mental health commissioning:

- Local implementation team (LIT) – representing all/most stakeholders in the partnership
- Joint mental health commissioning teams – sometimes with executive responsibility devolved from the LIT or advisory to the LIT
- Commissioning directorates responsible for primary care, children's services, long-term conditions, health promotion and offender healthcare
- Practice-based commissioning groups/practices
- PCT executive
- Professional executive committee
- Service-user commissioning groups
- The new local involvement networks (LINKs).

It is helpful if PCTs and local authorities clarify responsibilities to promote collaborative and timely

decision making. Those commissioning primary care mental health will often need to align a number of different commissioning managers or groups, as well as the budgets they control.

### *Where does the money come from?*

Remodelling of the financial pathway to those areas that are evidence-based and evaluated as effective. For example:

- Saving on out of area placements, developing a positive risk management culture using crisis teams to gatekeep admissions to acute beds.
- Investing in psychological care for patients with medically unexplained symptoms (MUS) and long-term conditions from within physical healthcare budgets – by shifting generic roles and by providing additional specialist mental health support, e.g. reductions in unnecessary investigation of people with medically unexplained symptoms.
- Investing practice-based commissioning savings (including results of MUS investment) for wellbeing and psycho-social community-based services.

# Conclusion

This document provides guidance for practitioners and commissioners as to how primary care mental health services can and should provide a strong, reliable and essential component of community-based health and social care. It has outlined how, through adapting traditional roles and developing new roles, generic primary care and specialist mental health workers can nurture three important links:

- between primary and secondary care;
- between mental and physical healthcare; and
- between the lay and medical worlds.

Promoting self-care, bringing in specialist support, providing access to psychological therapies and focusing on recovery, will complement the traditional primary care strengths of rapid access, family orientation and ability to cope with uncertainty. The development of high-quality services for all ages and conditions across the country will demand exceptional leadership, local innovation and a high level of involvement from practitioners.

# Membership of the NWW Primary Care Subgroup

Richard Byng	GP, and GP with Special Interest in Mental Health , NHS Plymouth . Senior Clinical Research Fellow Peninsula Medical School
Barry Foley	Senior Workforce Consultant/CSIP/NIMHE, Joint Chair
Mike Cooper	Psychiatrist, Plymouth Teaching PCT
Dave Tomson	GP, Newcastle
Les Ashton	GP RCGP Mental Health Task Force member, Curriculum Lead for PRIMHE
Jane Shears	Joint Chair, New Ways of Working for Social Workers
Helen Adams	Health Visitor, Specialist Interest in maternal care
Tania Tulloch	Occupational Therapist North Yorkshire and York PCT
Dave Ekers	Mental Health Nursing, National Nursing Networks/nominated DoH Lead Nurse
Chris Gilleard	Clinical Psychologist representing Division of CP at BPS
Mark Haddad	Clinical Research Fellow (Nurse), Institute of Psychiatry
Dave Tombs	Service User Representative
Lu Duhig	Carer Representative
Maureen Casey	Service Redesign in Primary Care
Ray Lyons	Chief Pharmacist, Sussex Partnership NHS Foundation Trust
Roslyn Hope	Director, National Workforce Programme Mental Health, CSIP/NIMHE
Tom Dodd	National CSIP Primary Care Programme Lead, Joint National Dual Diagnosis Programme Lead

## **Minutes for information**

Ian Hulatt            Mental Health Advisor, Royal College of Nursing

Neil  
Brindlecombe        Director of Nursing, Research and Development, South Staffordshire and  
Shropshire NHS

Elaine Weston        Chief Pharmacist, Leeds Partnerships Foundation NHS Teaching Trust