Red Kite
HEALTHCARE SOLUTIONS CIC
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# Urgent Care Innovation Mental Health Assessment Evaluation
# April 2022

## Executive Summary

Due to the increasing and ongoing challenges of the COVID-19 pandemic and the impact this will have on maintaining access to timely health care, the South Powys Cluster proposed to implement strategies for patients accessing urgent primary care in relation to low level tier 0-2 mental health issues over the winter period of 2021/22

Concerns regarding mental health during the pandemic have grown rapidly during the COVID-19 pandemic. Increases in the number of primary care contacts relating to low level mental health issues has been seen across the cluster and continues to rise. Historically, patients who have required support with their mental health have reached out to their GP as a first point of contact and under the existing system would be given the telephone number of community services with the expectation that the patient would then contact the service. This results in a patient often having to relay their needs up to 3 times before accessing the correct service should they chose to contact community services. It has also not been possible to record whether patients did follow up on the advice or evaluate outcomes for these patients with their GP as there has not been a mechanism to facilitate this.

The South Powys cluster proposes to employ the services of a first contact mental health practitioner to triage patients presenting to primary care with low level mental health issues across the winter period. Enabling this early intervention will mean patients can be signposted to the most appropriate service in the MH pathway, e.g. community services, GP, and avoid delays resulting from GP appointment waits or second stage triage referral. It will also facilitate a closer working relationship between existing mental health services with a mechanism for reporting outcomes to the patients GP. At the present time MIND the mental health charity would be able to supply practitioners to supply this service remotely to the cluster practices based in primary care, creating a change in pathway referral for these patients.

## Scope

The service will be provided to the South Powys Cluster, consisting of four practices covering a rural population of 46,320 across;

- Brecon Medical Group Practice
- Ystradgynlais Group Practice
- Crickhowell Group Practice
- Haygarth Doctors

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The aim of the project is to provide first contact telephone support service for any patient registered within the cluster presenting to primary care with low level mental health issues. A Mental Health Needs Assessment will be provided my MH link workers at Brecon & District MIND and Ystradgynlais MIND.

Patients who are identified as suitable via care coordination, will be referred to the MH link worker for a telephone assessment of their mental health needs and advised of the options and services available to support them. The benefit of this increased capacity will be the improved access to timely mental health needs intervention by trained practitioners who are able to provide an immediate response to patients. This decreases the number of patient contacts required under the current system of triage and/or clinical consultation in primary care, therefore enabling clinicians to provide more time to patients presenting with medical issues. Evaluation of contacts and outcomes will capture the benefits of early intervention and any reductions in the number of triage/GP appointments.

## Considerations

- Capacity of staff in primary care due to the current issues with COVID-19 and low practice numbers may limit the service across different practices
- Capacity of staff within MIND due to the current issues with COVID-19 and levels of demand
- Ensure staff are educated and skilled in care coordination to identify patients
- Red flags – Ensure there is a robust protocol to cover concerns over patients and appropriate pathways for urgent issues

## Method and preparatory work

A large amount of preparatory work was undertaken during January, including;

- Identification of staff and uplift of current services MIND/Practices
- Creation of clinical IT templates in the practice systems for data capture (EMIS web)
- Creation of clinical IT system searches in the practice systems (EMIS web)
- Creation of a MH needs assessment standard operational procedure and safety netting
- 4 sessions training for staff
- 2 Cluster meetings

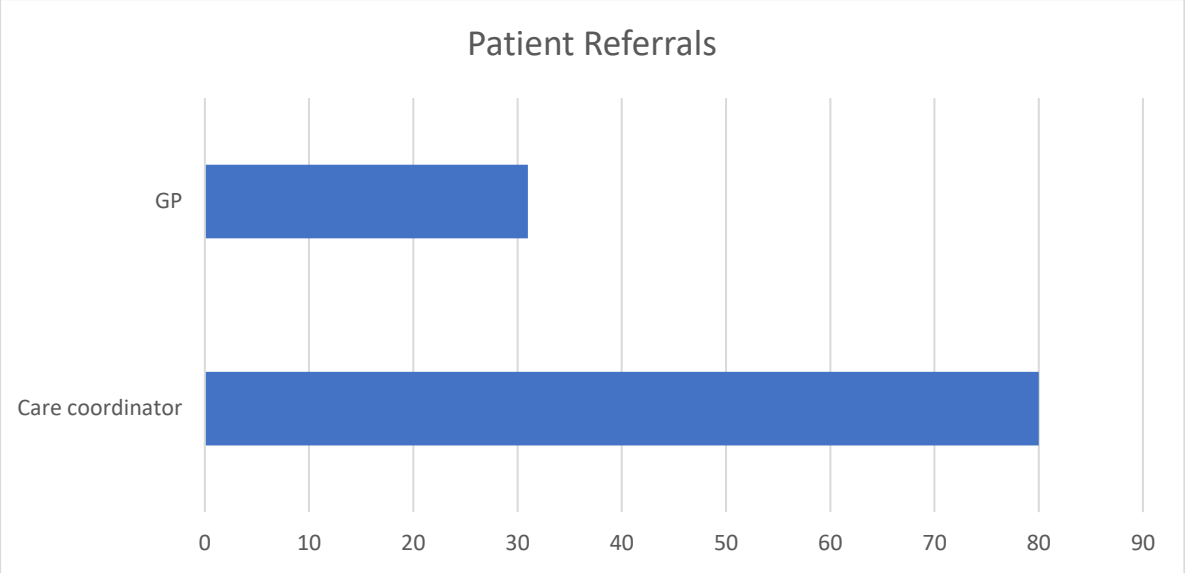
- 2 meetings with Primary and Community Mental Health Services at Powys Teaching Health Board
- Creation of telephonist protocol including obtaining patient consent
- Check of IT and recording availability
- Secure file sharing system set-up and DPIA completed
- Direct communication lines checked and signed off
- Telephone triage protocol completed, clinically agreed and disseminated to staff
- Mechanism for reporting patient outcomes to practices completed
- Live service in first practice 24/01/2022
- Weekly review meetings
- Collation of data
- Production of evaluation reports

## Outcomes

During January 2022, a large amount of administration time was spent ensuring a safe and robust system was in place, with the service going live on the 24th January 2022 in one practice. Two further cluster practices were able to go live in February, with one practice unable to currently provide care coordination due to major COVID-19 related staffing issues.

As the service is a new concept for care-coordinators within the practices, we were aware that it would take some time to increase the confidence of the staff who are in a position to facilitate the referral of patients presenting with low-level mental health issues. To support this, systems were set up to enable patients who were added to triage to be deemed suitable for referral and passed back to administration to coordinate, as well as robust safety netting procedures. In addition, all practices have engaged as a cluster to provide staff with further care-coordination and signposting training from February 2022, which will further enhance the confidence of direct signposting.

Referrals to date show that 72% of patients have been signposted directly from the care-coordinators. The remaining patients were passed back from Triage as appropriate for referral.




From the 24th January 2022 – April 2022, a total of 111patients have been referred to the service from 3 practices. The following outcomes were recorded across the cluster

| | |
|---|---|
| **Total No. patients referred for a MH needs assessment** | **111** |
| **No. of patients referred back to GP** | **2** |
| **Total No. of patients referred into Community wellbeing Services** | **71** |
| **Total No. of patients re-contacting GP after assessment** | **0** |

**NB: Two patients were not able to be contacted and passed back to GP practice for follow up but on checking were already enrolled in MIND services.**

Of the 109 patients who completed a MH needs assessment, each patient has been linked to a different community service and/or given information and advice to support their needs.

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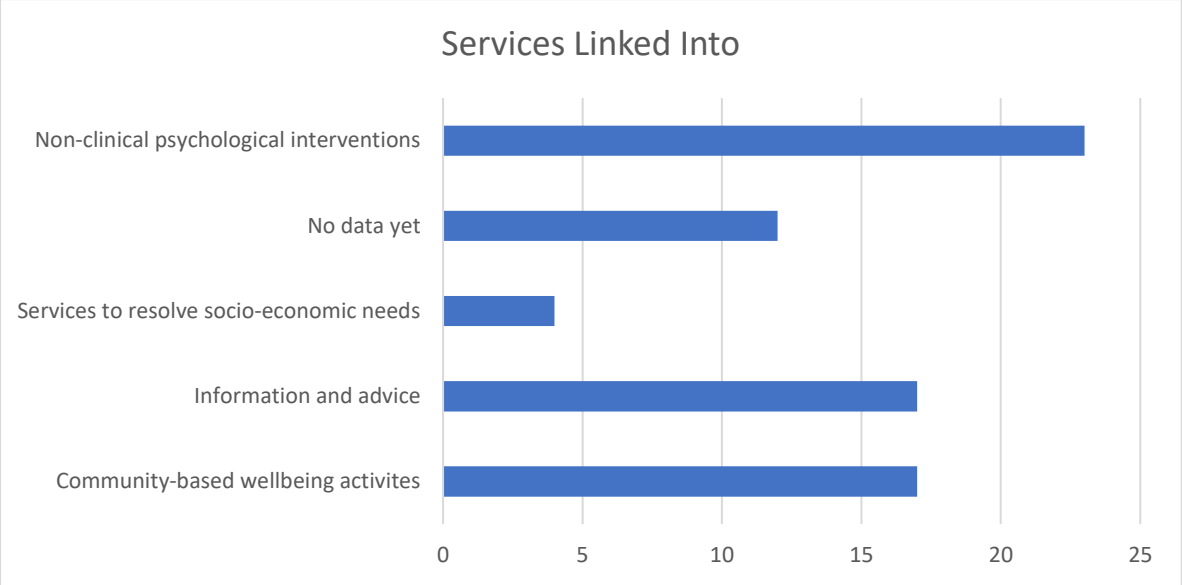


- 32% of patients were linked into Non-Clinical Psychological Interventions and a further 19% to, Community Based Wellbeing Activities.
- 25% of patients have received information and advice on management
- All the referrals received were appropriate for the service.
- On average the introduction of the service has resulted in a reduction of the number of contacts a patient has to make from up to 3 times to 1 contact when referred directly from care coordination.
- Potentially, this saved an extra 218 contacts being made by the patients in order to receive the appropriate referral and/or care pathway.
- This reduction in the number of contacts to Triage equates to 5.45 (109 pts) Triage/GP sessions saved if the patient is referred directly to MIND via care coordinators (based on 20 patients per session).

This early intervention has resulted in a direct contact from the MH link worker within 2-24 hours and subsequent direct referral in to community-based services. This has shown an improvement in the pathway for patients by reducing the number of contacts made by patients, improving their access to timely and appropriate care and increasing the capacity of Triage in practices.

In addition to the implementation of the service, meetings with Primary and Secondary Care Mental Health Services have resulted in positive discussions to improve the pathway for patients who require further or advanced mental health support. Under the current system, patients that attend community services have to book a GP appointment for a referral to these services if they are identified as having more severe mental health needs. Our discussions have yielded agreement to look to build a framework for patients identified in the community as requiring specialist

mental health input to be referred directly from community services under an enhanced pathway.

## Discussion and Considerations

The introduction of this service has required a large amount of preparatory work that has already seen an improved pathway for patients who are contacting their GP with tier 0-2 mental health issues, by reducing the number of contacts made and ensuring these patients have accessed timely and appropriate care. It has the potential to reduce demand upon Triage and GP services, increasing access for more complex health needs. It has highlighted the ability of Third Sector organisations to demonstrate strong leadership and be reactive to population needs with MIND services being able to uplift their current provision to support the cluster with implementation. In addition this work has increased collaborative working between community, primary and secondary care services with a view to further improving the pathways for mental health, and refining direct pathways between all mental health services.

We will continue to monitor and build upon the effectiveness of care-coordination referrals in the practices. There are some ongoing issues with staffing levels in some practices and there were some practice concerns around the pilot in the initial stages. These concerns related to the appropriateness of care-coordination staff in relation to making referrals and the capacity of administration staff to refer patients. A large amount of work has gone in to ensuring a clinically robust operational procedure and safety netting is in place, which has alleviated some of those concerns and there have been no inappropriate referrals made. All practices are investing in further care-coordination training for staff to improve confidence from February 2022. The pilot also has the support of both primary and secondary care services who continue to work with the cluster and MIND.

Staff undertaking the service in both MIND and the practices have been supportive of the concept and have put a large amount of work into ensuring the implementation of the pilot was facilitated. Some initial staff feedback has included;

*'I think this is a wonderful service for the patients and it will mean they can speak to somebody a lot quicker'*

*'I think this is the way forward. I am seeing increasing numbers of patients who could benefit and I never know if they will reach out to MIND themselves on my advice alone'*

*'I think the concept is great but we may have a lot of work to in in relation to care-coordination'*

*'Our GPs like the service but are apprehensive about care coordination and the capacity of our staff having the time to send referrals to MIND, it would be easier if they were in the practice I think'*

## Feedback from Brecon MIND Link Workers

*'Benefits of Social Prescribing: recognises well-being relates to body, mind and spirit and that these are interconnected. The service moves away from the more traditional medical model of health car and supports people holistically'*

*'Some individuals just require validation, reassurance and advice from the link worker, mainly as a one-off. The vast majority though were supported over a 6 week period, with the link worker providing advice and guidance along with referrals either inside Mind or to other agencies/organisations'*

*'We consider the ease of access, speed of response and simplicity of delivery as invaluable elements of the service'*

*'As link workers we are aware that face to face delivery would considerably reduce the patient contact time. Main delivery of the service is by telephone, text and email. This has not been a barrier in service-delivery to-date'*

## Service User Feedback

SP FEEDBACK snapshot end Jan-end

Patient Feedback to end of March 22.docx

## Future Plans

The service will continue to focus on the continuation and expansion of the pilot and the confidence of care-coordination staff. Additionally, discussions will continue with Primary and Secondary Care Mental Health Services at Powys Teaching Health Board to build on the initial work in refining referral pathways between all services. This will improve access to timely care for patients and support the increasing demands on primary care colleagues.

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## Demand and Capacity

The initial funding available for this pilot was to cover Jan-Mar 2022, with most of the preparatory work being undertaken in month 1. The pilot has now been extended to June 2022. The number of referrals increased considerably in month 2, and we expect demand to continue growing as the fourth, and largest cluster practice begins referrals from April 2022. On initiation, the demand was an unknown, however, it has become apparent that there is significant need. To that end, extending the pilot and increasing the MH needs assessment hours by a further 15 hours a week will allow for an uninterrupted service Mon-Fri and a further detailed evaluation of the impact.

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