National primary care mental health collaborative

The Improvement Foundation launched the initial first wave of the National Primary Care Mental Health Collaborative in 2006 to improve the care of adults of working age with common mental health disorders, such as anxiety and depression, in primary care. The goal of the programme is to help primary care providers develop sustainable improvements in care through:
Identifying evidence-based practice that leads to better clinical outcomes, service-user satisfaction and use of resourcesInvolving patients as partners so services are built around their needsCreating care pathways for common mental health disorders between service providersProactive case management and better self-careCreating an opportunity for providers to share learningSpreading the knowledge and capability to other practices
 Given the tremendous results achieved by the participants and the impact on patients, the Improvement Foundation is very keen to spread this work and is in discussion with a number of PCTs around the country about starting a second wave. For further information, please see the New Developments section. The national policy and guidance on mental health is set out in the mental health section on the Department of Health's website. If you are interested in working with the Improvement Foundation please go to How we can help or click here to contact us. Who is involved Sixteen PCTs have taken part in the first wave of the improvement programme and each has set up a team including GPs, practice staff, secondary care, social services, voluntary sector organisations, service users and carers. A total of 97 practices participated in the first wave of the collaborative covering 726,225 people. What we are doing Teams attend an orientation event followed by a series of three learning workshops spread over nine months. The first step towards improvement is to identify those people with common mental health disorders, compile an electronic list and decide which severity assessment tool to use. Many practices have now developed templates for the coding of patients, as they have done for the management of other chronic diseases. Using the learning gained at the events, practices then make improvements and measure progress in an ongoing cycle. All progress is tracked through reporting of results. There are four global collaborative measures:
Rates of consultation with GPs Rates of consultation with other practice staff Rates of referral to community mental health teams/consultant psychiatrists Percentage of people issued with sick notes totalling 13 weeks or longer.
 Key results First wave: CHANGE PRINCIPLES MEASURES RESULTS POPULATION COVERAGE PARTICIPANTS   Create and validate an electronic list for pro-active care Create alternative care management arrangements Implement directed self care Rate of consultations with GPs for people on the common mental health disorders electronic list Rate of consultations with other practice staff for people on the common mental health disorders electronic list Rate of referral to community mental health teams and/or consultant psychiatrists for people on the list % of people on the list issued with sick notes for a continuous period of sickness absence totalling 13 weeks or more 44% reduction in patients receiving sick notes of over 13 weeks (getting people back to work) 20% reduction in referrals to specialist services Up to 21% reduction in GP consultations across sites 726,225 100 general practices Minimum of 100 GPs 300 primary care team members 30 lay/patient representatives as part of improvement team   Ten top themes of best practice that have emerged from the programme:
Work with key stakeholders across health and social care to ensure people who can make a difference are involved and all services form part of the redesigned patient care pathway Process-map the patient journey from a patient perspective and use this to see where services can be streamlined or improvedAdopt the collaborative methodology and use the Plan-Do-Study-Act cycle as a way of making long-term sustainable changesInvolve service users and carers as partners to ensure that the needs of individuals are metImplement the stepped care approach as well as, or instead of, prescribing anti-depressants. A stepped care approach suggests that many service users should have access to simple interventions (such as self-help and talking therapies) before they have access to more complex services. The sites on the programme were encouraged

to implement stepped care as a care pathway rather than separate silos of care optionsMake self-help literature widely available to service users, including setting up a 'books on prescription' schemeSet up an 'exercise on prescription' scheme and other social prescribing schemes (art, drama etc)Offer cognitive behavioural therapy (CBT), including computerised CBTWork with Job Centre Plus and other organisations to help keep people in workEncourage service users to attend the Expert Patient Programme's courses