

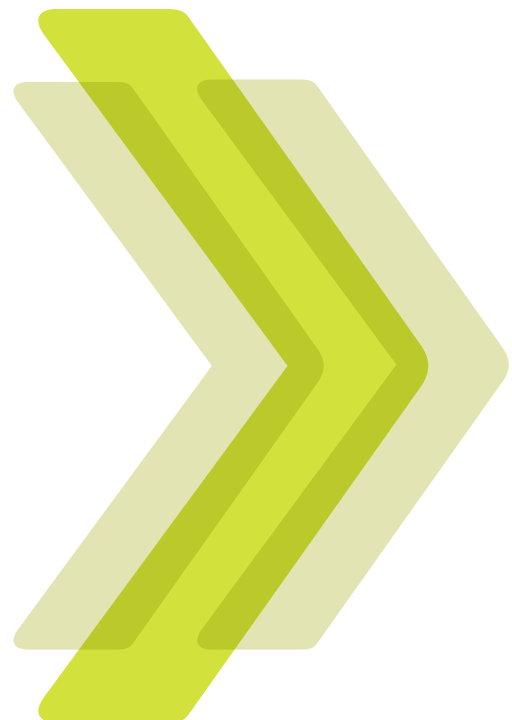


Mental health and primary care networks

Understanding the opportunities

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July 2020



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Key messages

- Primary care supports people with a wide range of mental health conditions, including people with high levels of need and complexity. There is a striking degree of consensus that the current arrangements for mental health in primary care do not serve the interests of patients or professionals.
- The provision of mental health support in primary care does not meet the range of needs of that exist, with significant gaps in services. Children and adolescents and older people are among those who are often poorly served.
- The Covid 19 pandemic means the case for change is stronger than ever, with intense workload pressures being experienced in both primary care and mental health services, and with potential increases in mental health needs in the population.
- Psychological therapy services developed through the Improving Access to Psychological Therapies (IAPT) programme provide valuable support and treatment for many people but do not present a complete solution to the range of challenges that exist in primary care.
- Significant numbers of people assessed as too complex for IAPT services have their referral to specialist mental health services rejected. This often leaves general practitioners (GPs) to pick up the pieces by supporting people with needs they may not have been trained to manage.
- There has not been a clear national plan for improving mental health support in primary care for many years. NHS England's new Community Mental Health Framework is a notable step forward but there remains a need for greater clarity about what primary mental health care should look like in future.
- The primary care networks established across England since 2019 potentially create an important opportunity to develop more comprehensive approaches to primary mental health care, with new forms of provision shared across groups of neighbouring practices. Current plans are that from April 2021 this will include the option of using new funding to pay for mental health practitioners based in general practices.
- Where primary care networks choose to use the new funding in this way, it is important that the creation of new mental health roles in primary care forms

part of a comprehensive strategy to meet the full range of needs in the local population. This will involve rethinking how the system works as a whole, as well as putting extra resources into general practices.

- As sustainability and transformation partnerships and integrated care systems across England develop plans to implement NHS England's Community Mental Health Framework, they need to ensure that their plans reach into primary care and address the significant gaps and challenges that exist. Working closely with mental health trusts and primary care network leaders offers a way to better understand what changes are needed from a primary care perspective.
- Making progress on this issue will require joined-up policy-making at the national level. Close alignment is needed between primary care policy and mental health policy to ensure that each supports the other and that gaps are avoided.

1 Introduction

The establishment of primary care networks (PCNs) is one of the most important reforms to primary care in England in recent years. This report explores what opportunities the emergence of these new networks creates for improving the support and treatment provided to people with mental health needs in primary care.

As part of the *NHS long term plan*, which NHS England published in 2019, local areas are being asked to realign community mental health services with primary care networks, creating 'new and integrated models of primary and community mental health care' by 2023/24 ([NHS England 2019c](#), p 69). NHS England has since published a Community Mental Health Framework, giving further detail on what these models of care might look like, with a range of models currently being tested in 12 early implementer sites across England ([NHS England 2019b](#)).¹ Improvements to primary mental health care need to be part of these wider reforms to community mental health provision, creating a coherent, flexible system of care and support.

We start this report by describing why improvement to primary mental health care is badly needed, before examining what this might look like in practice, and the role primary care networks could play in bringing about change.

¹ The King's Fund is currently working with NHS England to provide implementation support to the 12 early implementer sites and to identify learning for other areas.

2 Why do we need a new approach?

A diverse range of mental health needs is seen in primary care, much broader than is often assumed. In England the focus in recent years has been on providing access to appropriate treatment for people with anxiety or depression in primary care. However, in reality, general practices support people with a wide range of diagnoses and complexities, including people with psychosis, bipolar disorder, personality disorders and other needs.

Demand for mental health support in primary care is increasing as a result of greater awareness and help-seeking, as well as changes in the prevalence of some conditions (McManus *et al* 2016). Referrals from primary care to community mental health teams increased by 19 per cent between 2010/11 and 2014/15 in England, and prescriptions for antidepressants doubled between 2005 and 2015 (British Medical Association 2017). In a survey of 1,000 GPs published in 2018, 66 per cent reported that the proportion of patients needing help with their mental health had increased over the previous 12 months (Mind 2018). The survey also indicated that around 40 per cent of GP appointments now involve mental health.

The Covid 19 pandemic may add to these pressures. Our research was conducted before the pandemic began, but there are concerns that the changes to everyday life that followed in the wake of the pandemic, the experience of isolation, anxiety and bereavement, the effect on people's ability to access health care and other services, and the direct effects of the virus itself may together lead to increased mental health needs in the population. General practice will often be the place where these needs are felt first.

In this section we map out the diversity of needs presenting to primary care and discuss how existing policy and practice are not currently addressing the full range of needs. The result is a fragmented system, which provides good care for some people, while others fall into the gaps between services or find themselves excluded from specialist support by inflexible referral criteria and thresholds.

People with complex needs that do not fulfil criteria for specialist mental health services

One of the biggest gaps reported by GPs is the increasing number of people who do not fit a clear referral pathway because of the complexity of their needs. In this context, complexity refers to people who have multiple interacting issues that need consideration. Increasing complexity is one of the major factors responsible for the rising workload in general practice (Baird *et al* 2016). Part of this relates to growing levels of multimorbidity (having two or more health conditions), of which mental health is a key component (Barnett *et al* 2012), as well as increasing polypharmacy (being on multiple medications). There is also a wide variety of social factors – such as poverty, social isolation and trauma – that can add to the complexity of a person’s needs.

The key problem arising from this is that significant numbers of people in England are falling into a gap between Improving Access to Psychological Therapies (IAPT) services and specialist mental health services. People may present with anxiety or depression alongside other issues – such as inadequate housing, drug or alcohol misuse, debt problems or a history of traumatic experiences in childhood – and find that local IAPT services are unable to offer an appropriate service due to the level of need and complexity involved. But they may also have their referral to secondary care rejected as their conditions are not ‘severe’ or high-risk enough to meet the rising thresholds of these stretched specialist services. NHS England’s Community Mental Health Framework indicates that closing this gap – being too complex for IAPT services but not severely ill or high-risk enough for secondary care – should be a high priority for providers and commissioners as they redesign local services (NHS England 2019b).

The current gap leaves GPs supporting people with complex needs that they do not always feel well trained to deal with, with less than 50 per cent of GPs having had formal training on the assessment of suicide risk, and many having no previous training experience in psychiatric services (Bajaj *et al* 2008).

Example

A 35-year-old man has a history of trauma in childhood. He has recently lost his job and is struggling to meet rent payments. He goes to his GP with significant symptoms of anxiety and depression and is referred for psychological therapy provided by local IAPT services. However, when his case is assessed it is rejected by IAPT services due to his history of complex trauma likely requiring longer-term psychological therapy. At the same time, his symptoms are not considered severe enough or appropriate for secondary care services.

Child and adolescent mental health needs that do not fulfil criteria for secondary care services

A similar gap is seen with child and adolescent mental health needs, with many children and teenagers who are struggling with mental health concerns receiving no specialist support. A recent analysis based on freedom of information requests indicated that more than a quarter (26 per cent) of referrals to child and adolescent mental health services (CAMHS) were not accepted in 2018/19, involving approximately 133,000 children and young people (Crenna-Jennings and Hutchinson 2020). Recent statistics have also highlighted a concerning rise in teenage suicide rates, which increased by 67 per cent between 2010 and 2017 (YoungMinds 2018).

Part of the issue here is simply a lack of capacity in specialist services. Recognising this, the NHS long-term plan commits to an expansion of CAMHS and also to the creation of mental health support teams in schools (NHS England 2019c). This expansion will go some way towards meeting needs that are currently poorly met. But it is unlikely that this growth will ever meet the full range of needs encountered in primary care unless it is accompanied by steps to ensure that GP practices are better equipped to work with schools and other agencies to support children and young people's mental health needs appropriately – particularly for those who are unlikely to be accepted for treatment by CAMHS.

Example

An 11-year-old boy has increasing levels of anxiety and low mood, is sleeping poorly and is not engaging with his lessons at school. He has started to restrict his eating and exercises several times a day, although he has not yet lost a significant amount of weight. After waiting for two increasingly stressful months for an assessment by CAMHS, he is discharged back to his GP as his needs did not meet the threshold for secondary care treatment.

Mental health needs among older people

There is also a rising number of older people presenting to general practice with mental health needs, often alongside physical health and social care needs that add to the complexity of their situation. Mental health needs in older people can present a challenge to primary care professionals because they often tend to manifest in different ways, such as tiredness or weight loss, and can be dismissed as an expected part of ageing (Rodda et al 2011). Symptoms of cognitive impairment, anxiety and depression can overlap considerably, which can result in delayed diagnosis or inappropriate treatment. Mental health needs among older people are under-recognised for a number of reasons (Ismail et al 2017), including the tendency to focus on physical symptoms during GP appointments (Wiese 2011). Poor mental health can be overshadowed or taken for granted, meaning that an estimated 85 per cent of older people with depression receive no help from the NHS (Stapleton 2020). Older people are more likely than younger people to experience bereavement but there is wide variability in the support available for this across England, with many places having very limited services (Wilkinson et al 2018). Substance misuse among older people is also widely underdiagnosed (including misuse of prescribed medications), in part because the symptoms are often masked by other conditions (McGrath et al 2005).

Example

An 80-year-old man has recently had difficulty sleeping and has experienced a loss of motivation to go out of the house for a walk or to play bridge, which he used to enjoy. His wife passed away a year ago and he only sees a carer once a week who comes to the house with his shopping. He has started to notice he is more forgetful and has difficulty concentrating at times and goes to see his GP.

People with long-term mental health conditions discharged from secondary care

There is a perception that people with severe mental illnesses such as psychosis or bipolar disorder are supported primarily by specialist mental health services rather than primary care. This is often not the case – our discussions with local commissioners suggest that around 30–50 per cent of people with these conditions are supported exclusively by primary care without ongoing specialist input. This includes people who have previously been supported by specialist services but who have been ‘stepped down’ to primary care as their acute mental health needs have stabilised and they are responding well to medication. While this may, in principle, be an appropriate way of providing long-term support, discharge back to primary care can nonetheless be worrying for patients and their families and a challenging area for primary health care professionals. GPs do not always have expertise in psychiatric medications and may lack confidence in making alterations to an established treatment programme, often with no easy access to specialist advice from mental health teams. As a result, the support that people receive may not be sensitive to their specific needs or adaptive to changes in their lives. There may also be cases where a person needs rapid access back to secondary care if their condition worsens or they experience a relapse of symptoms. Processes for this are often unclear, likely resulting in a worsening of the person’s mental health, and possibly their later outcomes, before specialist services can reassess them.

Example

A young woman has a history of a psychotic illness and has been stable on an antipsychotic medication for several years. She becomes pregnant and wants to discuss the risks and benefits of continuing the medication. She may struggle to get clear advice from a GP on whether the risk of relapse outweighs the potential risk of the medicine to her baby, but she no longer has access to specialist psychiatric input.

People with persistent physical symptoms

People often present to GPs with persistent physical symptoms that can be associated with mental health problems that may or may not be identified. These range from chronic headaches to unexplained joint pain for which no physical cause has been found on investigation. Such symptoms are present in 15–30 per cent of all consultations in general practice (Kirmayer *et al* 2004) as well as a quarter to two-thirds of all outpatient appointments (O’Shea 2019). The symptoms can be extremely debilitating and are not easily managed with conventional treatments.

People experiencing these kinds of symptoms often undergo multiple investigations that can do more harm than good, and attend frequent appointments in both primary and secondary care without any improvement in their symptoms or functioning. More than 40 per cent of these people may have an associated mental health condition, such as anxiety or depression, which further adds to their distress and can exacerbate their medical symptoms (Nimnuan *et al* 2001).

While it can be challenging for both the patient and their doctor to understand what may benefit them, there are options, including psychological therapies that can improve people's experiences of their symptoms and their overall resilience and functioning. However, as this is an area few GPs receive specific training on or feel confident managing (Salmon *et al* 2007), people with these conditions often have poor outcomes and continue to require intensive, yet often ineffective, primary care input.

Example

A young woman has persistent symptoms of indigestion and has also recently experienced a bereavement. Her symptoms are investigated using camera tests but no signs of abnormality are discovered. In spite of this, her symptoms do not respond to typical treatments such as antacids, and she continues to have recurrent troublesome symptoms that disrupt her daily routine and ability to work. As a result, she suffers from low mood but does not identify as having mental health needs.

Psychological needs of people with long-term physical health conditions

One area that is rightly receiving growing interest is the psychological health of people with long-term physical health conditions, such as diabetes or heart disease. People with long-term conditions are two to three times more likely to suffer from a mental health condition, particularly depression or anxiety, and can end up receiving poorer-quality care as a result, for both their mental and physical health (Naylor *et al* 2012). Lack of identification and management of these mental health needs can lead to poor quality of life for the person and significantly impair their functioning, as well as causing deterioration in their physical health condition (de Ridder *et al* 2008). Worsening of their physical health can result in escalation of treatment and require further monitoring and review, resulting in higher costs for health services (estimated at 12–18 per cent of all NHS expenditure on long-term conditions) (Naylor *et al* 2012). Previous research has estimated that 4.5 million people in England experience this form of 'co-morbidity', demonstrating

the significance of the issue (Naylor *et al* 2012). Psychological approaches can be hugely beneficial for people with long-term conditions struggling to manage their condition, regardless of whether or not they also have a mental health problem.

As a result of national policy requirements introduced in 2016, IAPT services in many parts of England are currently being extended to increase their ability to support people with long-term conditions. While this is a welcome development, this expansion is aimed primarily at those with 'uncomplicated' anxiety and depression and is not designed to support the full range of mental health needs that those with physical health problems may experience (Sachar 2020).

Example

A 45-year-old man, recently diagnosed with diabetes, is struggling to process all the information he has been given about his condition and to adapt his 'lifestyle' to improve his health. He presents to the GP with symptoms of low mood, poor sleep and increasing anxiety levels.

Managing the physical health of people with severe mental illness

An important issue in primary care is the management of physical health in people with severe mental health conditions, such as psychosis, including those receiving ongoing care from secondary mental health services. Evidence consistently shows that people with a long-term mental illness have a greater risk of poor physical health and resulting premature mortality, with a 15–20-year reduction in life expectancy (Chesney *et al* 2014). An estimated two out of three deaths of people with severe mental illness are attributable to physical illnesses that could be prevented, such as cardiovascular disease and diabetes (Public Health England 2018). Multiple factors contribute to this, including the side effects of antipsychotic medications, a lack of support with diet, smoking and physical activity, and barriers to accessing health care when it is needed.

It can be difficult for primary health care professionals to manage these health risks for patients who are also seen in secondary care mental health services, with a lack of clarity over who is responsible for what. Secondary mental health services may arrange some physical health checks, such as an electrocardiogram (ECG) (heart tracing) on starting antipsychotic medication, but general practices are also required to arrange annual monitoring of these patients' physical health, including blood tests, and to encourage participation in cancer screening programmes. While

the Quality and Outcomes Framework (QOF) provides general practices with an incentive payment to cover the cost of providing annual health checks for people with psychosis or bipolar disorder, the same is not true for people with other long-term mental health conditions such as personality disorders, which are associated with similarly high levels of physical health problems. There may also be variable ongoing support to treat any ill health picked up on these annual checks.

Example

A man has a history of schizophrenia, is taking an antipsychotic medication and is getting support from a community mental health team. He has gained weight rapidly and developed high blood pressure, but he does not want to take blood pressure tablets as he does not feel physically unwell. He struggles to lose weight despite regular exercise, and this challenge is exacerbated by the weight-gain effect of the antipsychotic medication.

People at risk of suicide, but not in contact with specialist mental health services

Less than a third of people who lose their lives to suicide are in contact with mental health services at the time of their death, but many more have visited their GP in the months preceding it (Pearson *et al* 2009). While a range of services is available for people in crisis, there is little support for people with suicidal feelings who are not at immediate risk (Bear *et al* 2019). Suicide remains a major public health concern, and a key area of focus in national mental health policy in England, with someone dying by suicide every 90 minutes in the UK and the Republic of Ireland (Samaritans 2019). It is a challenging area in general practice, with short appointments often making it difficult to identify and protect people at risk, and with many primary health care professionals receiving only limited education and training in suicide. Another factor may be the lack of continuity some people experience when seen in general practice, meaning they may not feel comfortable disclosing serious concerns to a doctor or nurse they are meeting for the first time.

Example

A 28-year-old woman describes low self-esteem, stress from her work as a trainee lawyer and occasional abstract thoughts of suicide. She reports no active plans to carry this out and has a good support network. She does not have a clear mental health diagnosis and is assessed to be at low risk of suicide. She continues to be seen in primary care, but despite a course of cognitive-behavioural therapy, she continues to experience suicidal thoughts.

As demonstrated in this section, general practices support people with a very broad range of mental health needs, often with high levels of complexity and with limited or variable input from other services. Although these needs are presented here as separate categories, in reality there is significant overlap between the groups described, and in many cases there are common factors that underlie them. For example, the experience of traumatic events in childhood can make it more likely that a person will have multiple needs later in life, with a mixture of physical and mental health problems, potentially including substance misuse, long-term conditions and persistent physical symptoms.

The system is currently failing to meet the needs of the large numbers of people who fall into the groups described. Services are highly stretched, with both GPs and specialist mental health professionals struggling to provide appropriate and effective care. Existing policy responses – notably the psychological therapy services developed across England through the IAPT programme – provide valuable support and treatment for many people but do not present a complete solution to the range of challenges that exist in primary care.

3 What would a better approach look like?

The Community Mental Health Framework produced by NHS England (2019b) describes a broad direction of travel for community mental health services in England. As the framework is developed further and put into practice, greater clarity will be needed about how the full range of needs in primary care will be met in future.

Over recent years, local areas have responded to the clear and growing gaps in service provision by embarking on a wide range of initiatives in primary care, taking various different approaches to meeting people's needs (Newbigging *et al* 2018). While no single model has emerged, some key principles are becoming apparent, as described below. In many cases, these complement and build on the ideas outlined in the Community Mental Health Framework.

Nine principles for primary care mental health services

- **Meeting people's needs in the right setting for them.** For many people, GP surgeries are accessible, close to home and non-stigmatising places to get emotional or psychological support. Most of the primary care mental health services described by recent research (for example, in Newbigging *et al* 2018) are located within GP surgeries, some of them providing open access without a GP referral. However, this environment will not be right for everyone – for example, some young people may prefer to meet in other community settings. Flexibility is therefore needed.
- **Bridging the gap between primary and secondary care.** Many of the emerging primary care mental health services have been developed in order to bridge gaps in support. As discussed in the previous section, this includes the significant gap between Improving Access to Psychological Therapies (IAPT) services and secondary care. The Community Mental Health Framework requires that the development of primary and community mental health services addresses this gap, including for people with persistent physical symptoms, personality disorder diagnoses and complex traumas.
- **Two-way communication rather than rigid referral processes.** Often the only way for a GP to get advice from a mental health professional is to make a

formal referral to specialist services and wait for an assessment to take place. However, many newer primary care mental health services are moving towards a more flexible system in which it is easier and quicker for GPs to obtain expert input. For example, the 'PRiSM' primary care mental health service in Cambridgeshire and Peterborough (see below) is designed not to be a separate service for GPs to refer people into, but rather a shared resource based in primary care that GPs can access by making a 'request for service'.

- **Taking responsibility for the whole population.** General practice is unique in that it serves the whole registered population rather than specific individuals meeting agreed clinical thresholds. Mental health provision in primary care therefore needs to involve specialists and generalists sharing responsibility for managing the mental health needs of the entire local population. This might involve specialists working with GPs and practice nurses to oversee the quality of care provided to all patients with mental health needs, of whom only a proportion would need direct face-to-face intervention from a specialist. Shared prioritisation of resources is an important feature of this approach, with this being based on individual needs rather than diagnosis.
- **Supporting shared learning between professionals.** A major benefit of having mental health professionals working closely with GPs and other primary care staff is that it allows both groups to learn from each other. Joint consultations, case discussions, formal training and informal advice all provide opportunities for mutual learning, helping professionals to improve the support they offer. This could include some form of expert supervision for GPs with a special interest in mental health. Shared learning opportunities can also incorporate others involved in supporting people in primary care, such as link workers or benefits advisers (Newbigging *et al* 2018).
- **Maintaining expert skills.** Mental health professionals working in general practices need to be unambiguously part of the primary care team. However, to ensure they maintain their specialist skills, care needs to be taken to help them to also preserve their connections with other specialists, including making sure there are appropriate arrangements for professional supervision and development. This is needed to ensure that mental health workers embedded in primary care do not become isolated from their peers.
- **Connecting with local resources and community assets.** For many people with mental health difficulties, poor health is related to wider economic and social disadvantage and exclusion. For example, there is a strong connection between poverty and antidepressant prescribing levels (Thomas *et al* 2019). Providing advice and support for wider social needs such as money, housing and safety may be just as important as clinical care: even very brief advice

about money in primary care can prevent later costly crises ([Bond and Clarke 2019](#)). It can sometimes be helpful for these wider services to be located in the same premises as GP services, although space can be a limiting factor in many practices. Social prescribing approaches and community link workers also have an important role to play, helping people to access wider support and allowing their needs to be met more holistically ([Newbigging et al 2018](#)). For some people, it is important that 'signposting' is accompanied by practical support and help with confidence to enable them to take up these wider opportunities.

- **Valuing prevention and early intervention.** Some of the emerging models of primary mental health care include a range of preventive approaches and all seek to intervene early to prevent later crises. Prevention can also take the form of supporting the physical health of people with a mental health condition, for example help with smoking cessation or securing access to physical activity opportunities.
- **Rapid access back to secondary care when necessary.** As described in section 2, some people with long-term mental health conditions are discharged from secondary care if their symptoms are assessed as being stable. However, when a person's circumstances change they may need rapid access to specialist advice or support to prevent their condition from deteriorating. Having clear processes in place for this often helps GPs to feel more confident in taking on further responsibilities in relation to mental health.

Examples of innovative approaches in England

The principles described above are based largely on examples of existing good practice. In recent years, a number of areas of England have developed innovative approaches to mental health in primary care in an attempt to meet some of the needs described in section 2. For example, a review of service developments in London found that a wide range of approaches has been developed in this region alone ([Healthy London Partnership 2017](#)).

Some of the recent initiatives work on a large scale, for example across multiple GP surgeries with populations of up to 200,000 people. Others work with a single GP surgery or a cluster of surgeries in a local area. Similarly, some services have very specific areas of focus (for example, supporting people with persistent physical symptoms or helping people discharged from secondary mental health services), while others offer help for a much broader range of needs and have few exclusion criteria.

A wide range of approaches has also been developed internationally. The

'collaborative care' model has been a focus for research in the United States in particular, and also in the UK (Coventry *et al* 2015). This is an evidence-based approach with the aim of improving the care provided to people with mental health problems (most often depression or anxiety) in primary care, typically involving a case manager working closely with primary care staff and with supervision from a mental health specialist (Baird *et al* 2018). Integrated health systems in other countries, such as Intermountain Healthcare, have developed other approaches for embedding mental health support in primary care (Naylor *et al* 2016).

None of the existing primary care mental health services in England are comprehensive in their scope, and there is no single recommended model to replicate. However, the following provides illustrative examples of services that are attempting to put into practice some of the principles for primary care mental health services described above. For fuller descriptions of these services, please see the summaries provided in the report *Filling the chasm* (Newbigging *et al* 2018) and the other references cited below.

Large-scale primary care services: Cambridgeshire and Peterborough, and Swindon

The PRISM service in Cambridgeshire and Peterborough and the LIFT service in Swindon involve the creation of a significantly enhanced service working at a large scale, each supporting people from numerous GP surgeries (Newbigging *et al* 2018). Both offer a wide range of services. In the case of LIFT, it brings together the existing IAPT offer with a wider range of psychological therapies, psychoeducation classes (for example in mindfulness) and physical exercise groups. It sees about 650 people a month, does not require a GP referral, and waiting times are typically between two and four weeks. In common with many other primary care mental health services, LIFT also sees people before a non-urgent referral to secondary mental health care (Newbigging *et al* 2018).

Meeting complex needs: Nottingham and Bradford

In some local areas, services that work with people who have specific forms of complex needs have been developed. The Primary Care Psychological Medicine (PCPM) service in Rushcliffe, Nottingham (O'Shea 2019), and the Primary Care Wellbeing Service (PCWBS) in Bradford (Durcan forthcoming), provide psychological treatment to people with persistent physical symptoms. An economic evaluation of the PCPM found that, in its first year alone, the service helped to reduce the use of acute hospital, primary care and ambulance services by £153,000, in excess of its own staff costs (£129,000 a year) (O'Shea 2019).

Psychology in the GP surgery: Catterick and Shropshire

In some local areas, smaller-scale services have been piloted, working within one or two GP surgeries. In Catterick, North Yorkshire, and Telford and Ludlow, Shropshire, psychologists have been embedded in GP surgeries, offering one or more 15- or 30-minute appointments to people who either self-refer or are referred by their GP. The service in Catterick provides an all-age psychology service and has seen people from infancy to later life (Durcan forthcoming). These services have not been formally evaluated but show considerable promise – for example in reducing the number of referrals to IAPT and secondary care services and increasing the proportion that are accepted.

A whole-community approach to mental health and wellbeing: Healthier Fleetwood

GP practices in Fleetwood, Lancashire, have worked together with other providers and local residents to improve the wellbeing of the community. They have invested in mental health practitioners based in primary care who see around 2,000 patients a year, providing both tailored treatment and links to wider community services. They work particularly closely with the local substance misuse team, sharing the care of people with co-morbid mental health and substance misuse problems. Multidisciplinary teams – which include social workers, GPs and mental health workers from secondary and primary care – have designed pathways better suited to the needs of their patients. A ‘child and adolescent support and help enhanced response’ team was created to support young people who have worries about their mental health, and the service is open in the evenings and at weekends. A critical enabler of these changes has been that GP practices across Fleetwood have worked together in a networked way, using the ‘primary care home’ model developed by the National Association of Primary Care to collaborate over and co-ordinate services (NAPC 2019). As discussed in the next section, primary care networks provide a new vehicle for developing approaches such as this across networks of neighbouring GP practices.

4 How can primary care networks help?

What are primary care networks?

Primary care networks (PCNs) signal a new way of working in primary care based on deeper co-operation between neighbouring GP practices. While collaboration between practices is not wholly new – GP practices have been finding different ways of working together over many years – the NHS long-term plan ([NHS England 2019c](#)) and the new five-year framework for the GP contract, published in January 2019 ([NHS England 2019a](#)), put a more formal structure around this way of working. By creating an extension to the contract, known as a ‘directed enhanced service’ (or DES), with additional funding attached to it, GP practices across England have come together in around 1,300 geographical networks, each covering populations of approximately 30–50,000 patients.

NHS England has significant ambitions for PCNs, with the expectation that they will be one of the main channels for delivering many of the commitments in the long-term plan and providing a wider range of services to patients. PCNs will eventually be required to deliver a set of seven national service specifications:

- structured medication reviews
- enhanced health in care homes
- anticipatory care
- personalised care
- supporting early cancer diagnosis
- cardiovascular disease case-finding
- locally agreed action to tackle inequalities.

To deliver against these specifications PCNs will be expected to provide a wider range of primary care services to patients. The majority of the additional funding available to networks is to fund, or part-fund, designated new roles, including clinical pharmacists, social prescribing link workers, physiotherapists, physician

associates, paramedics, health coaches, dietitians, podiatrists, occupational therapists and, in future, mental health practitioners – including Improving Access to Psychological Therapies (IAPT) practitioners.

Mental health in the PCN contract

The inclusion of mental health practitioners in the additional roles reimbursement scheme creates a much-needed way of funding new forms of mental health provision in primary care. The detail about exactly what kinds of mental health practitioners will be covered – and what requirements will be attached – is still to be established and will be informed by the work of the 12 early implementer sites that are testing new service models as part of the implementation of the Community Mental Health Framework (NHS England 2019b).

It will be important for mental health practitioners based in general practices to be part of a comprehensive offer, bringing together primary care mental health provision with local community mental health provision, to ensure that practice-based practitioners retain strong links with other mental health services. The February 2020 update to the GP contract indicates that there will be requirements on primary care mental health practitioners ‘to work in collaboration with community mental health providers and/or IAPT providers’, to prevent them from becoming isolated from the wider system (NHS England and BMA 2020).

Making sure these new roles are aligned with broader service redesign plans may also help to mitigate one of the main concerns about expanding primary care mental health provision – namely that specialist services could be weakened or destabilised if primary and secondary care are forced to compete for a scarce supply of mental health professionals. It will be important to take a whole-system approach, thinking through how the available workforce can be used to best meet the mental health needs of the entire local population, and what new ways of working may be needed to support this (Durcan *et al* 2017).

In addition to the option of using network funding to pay for mental health practitioners, the PCN contract creates some further opportunities, which may help to improve mental health provision in primary care. In particular, funding for community link workers and pharmacists in each network could play an important role in better supporting people with a range of mental health needs. Designating one pharmacist in each network to act as the local lead for mental health pharmacy could be a helpful first step for PCNs to take.

The introduction of PCNs may make it easier for GP practices to work together to develop new approaches to mental health. Neighbouring practices will be expected to work more collaboratively than ever before and it may therefore be easier for practices to come together and share resources to change the way they support people with mental health needs. Examples from the 'primary care home' approach developed by the National Association of Primary Care (such as the Fleetwood example included in section 3), and other models of general practice 'at scale' that have been working for longer, show the potential (Baird *et al* 2018).

Some of the new service specifications can be expected to have a bearing on the care that people with mental health needs receive. For example, plans to develop more robust arrangements for reviewing medications include psychiatric medications, and the inequalities specification – which is still in development – may offer the chance to focus on people with mental health problems who experience some of the worst health outcomes.

Partnership working between PCNs and mental health providers

It is clear that there needs to be closer dialogue between primary care and specialist mental health providers to explore how the challenges we have highlighted in section 2 can be met in future. In the past, it has often been hard for mental health providers to engage with primary care, given the large areas covered by mental health trusts and the large number of GP practices present within these areas. PCNs create an important opportunity here. They will be the footprint around which integrated community-based teams will develop, and the NHS long-term plan states that community and mental health services will be expected to move towards a new place-based, multidisciplinary service across health and social care, aligned with PCNs (NHS England 2019c). This should create structures that support dialogue between GP practices and mental health providers, and the development of new services and approaches (although large mental health providers will still face the challenge of engaging with multiple PCNs in the area they serve).

Working collaboratively across primary and secondary care requires careful implementation, relationship-building and trust, which will take time to develop. PCNs will receive funds to support their development and may wish to use some of this funding to focus on collaboration with other system partners, including mental health providers.

PCNs, mental health providers and other partners will need to ensure that new services are developed in a way that is sustainable and allows small-scale initiatives to be scaled up when they have been demonstrated to be successful.

It is regrettable that many of the most innovative services to date have also been short-lived. This may be due to short-term funding settlements, a lack of evidence or limited national policy backing for primary mental health care outside of the IAPT programme.

A significant opportunity created by the primary care network contract and the NHS long-term plan is the focus on collaboration between providers at a neighbourhood level. Primary care networks are configured around local populations and may therefore offer the opportunity to realise the population health-focused approach that will need to underpin primary care mental health services. The data and intelligence they can gather about local mental health needs and inequalities will provide vital insights and will need to feed into more strategic thinking at a wider system level.

Seizing the opportunity

Both general practice and mental health services are under significant pressure, with demand increasingly outstripping capacity (Gilbert 2018; Baird *et al* 2016). Primary care networks cannot be expected to solve all of the issues we highlighted in section 2, but they do create important new opportunities for local focus and collaboration that could bring about real improvements in primary care mental health provision.

5 What needs to happen now?

There is a striking degree of consensus that the current arrangements for mental health in primary care do not serve the interests of either patients or professionals. People whose needs do not fit into the available service structures are left without the care and support they need and GPs feel under immense pressure to help people with highly complex problems, sometimes with minimal support from other professionals, while mental health specialists struggle with unsustainable caseloads. All parties recognise that something needs to change, and yet there is not a sufficiently shared understanding of what the gaps are and how they should best be closed. One of the greatest risks is that the solutions developed by mental health providers and commissioners do not address the problems that primary care professionals identify, and vice versa.

At the heart of the problem is an over-simplification in how mental health needs are often understood. There is a false dichotomy between what are sometimes known as ‘common mental disorders’ – to be supported by primary care and/or Improving Access to Psychological Therapies (IAPT) services – and ‘severe mental illnesses’ – requiring referral to secondary care. Services designed around this dichotomy struggle to deal with the fact that large numbers of people do not sit easily in either category.

The disconnect between primary and secondary care needs to be overcome at two levels.

First, in local systems there needs to be closer working between primary care leaders and mental health organisations. Sustainability and transformation partnerships and integrated care systems across England are currently developing plans to implement NHS England’s Community Mental Health Framework ([NHS England 2019b](#)) backed by new long-term plan funding from 2021/22–2023/24, and in doing so they need to work closely with mental health trusts and PCN leaders to understand what changes are needed from a primary care perspective. This is required to ensure that new models of primary and community mental health care address the full range of mental health issues that are encountered in primary care, as described in section 2 of this report.

Clinical commissioning groups and integrated care systems can support this local partnership working by establishing multi-agency working groups – with PCNs at their heart – tasked with strengthening primary care mental health provision. Integrated care systems can also play an important enabling role by working at the system level to remove commonly encountered barriers, including in relation to the workforce, estates and information technology (IT) infrastructure.

Second, there also needs to be joined-up thinking in policy-making at the national level. There are currently two policy levers that create opportunities to improve the provision of primary mental health care: the Community Mental Health Framework and the emergence of PCNs. Close alignment is needed on an ongoing basis to ensure that each of these initiatives supports the other.

More broadly, national leadership is also needed to address the acute shortages of mental health workers in many parts of England. Until this wider issue is solved there will continue to be a risk of both primary and secondary mental health services struggling and competing to recruit the workforce they both need to function effectively.

Primary care and mental health policy and practice cannot sit in isolation from one another. PCNs could provide a new start for mental health in primary care by acknowledging that they cannot fulfil their core roles without mental health being integral to their work. And mental health services can reach out to primary care colleagues to help to build a truly ‘whole-population approach’ that leaves no one out and that draws on the strengths and abilities of both. The result could be significant improvements both for people with mental health needs and for those providing services.

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