Wandsworth Primary Care Plus (PCP) Service

South West London and St George's NHS
Mental Health NHS Trust

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Service Description

The Primary Care Plus Service (PCP) aims to:

* Improve the outcomes and experiences for people with mental health conditions and co-morbid physical illnesses.
* Integrate mental health expertise into primary care teams.
* Improve pathways between primary and secondary care.

Partnership Working

Involves:

* Wandsworth CCGs
* South West London & St George's Mental Health NHS Trust
* Local GP services
* Family Action (Wandsworth)
* Local Service User Groups
* Wandsworth Carers' Centre

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Aims of the PCP Service

The PCP service provides:

* A recovery-focused model of care.
* Low intensity interventions to support self-management.
* Liaison with other agencies (community, housing, etc.)
* Depot treatment reviews (3-monthly).
* Support with the annual mental health review.
* Assistance with physical health monitoring (weight & diabetes management, smoking cessation etc.)

Inclusion Criteria

* **Over** the age of **18 years**.

* Registered with a GP practice **in the Wandle catchment area** AND who are under the **SMI register/MH QOF** for the practice.

Exclusion Criteria

Patients…

* Who are **not registered** with an identified GP practice in the Wandle catchment area.
* Who have not been discharged from secondary care.
* Who at high risk of harm to themselves or others.
* Who need to be under the care of a Consultant Psychiatrist.
* Whose mental health needs require a CPA.
* With a primary diagnosis of dementia.
* In receipt of Clozapine therapy.

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Team Composition

Clinical Team Manager

Mental Health Practitioner

3 Recovery Support Workers

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Step-Up Referrals

The Single Point Access (SPA) team is notified of the referral.

Both the individual, their family member and/or carer are made aware of the referral to secondary care services.

GP and Primary Care Plus service identifies an individual for referral.

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Step-Down Referrals

Individuals will be identified for discharge by the CMHT/RST; a discharge plan will be established and the individual as well as their identified carer/family member will be informed.

The GP/Consultant Psychiatrist will be notified of the discharge plan and decide if the individual is suitable for the PCP service (e.g. on the SMI register, Clustering).

If the individual is suitable, and they agree to having the PCP service, they will be invited to attend an appointment with the GP and PCP team member within two weeks of their discharge. Their Care Co-ordinator and identified carer/family member will also be invited to attend.

During the first appointment the individual will be offered support to develop their Wellness Recovery Plan. This will involve discussions around goal-setting, hope and recovery, symptom management (inclusive of risk), annual health check and medication monitoring, and healthy living.

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Questions?

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Thank You! ☺

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