Wandsworth Primary Care Plus (PCP) Service
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 CCG
* South West London & St George’s Mental Health NHS Trust
* Local GP services
* Family Action (Wandsworth)
* Local Service User Groups
* Wandsworth Carers’ Centre
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 (annually).
* Support with the annual mental health review.
* Assistance with physical health monitoring (weight & diabetes management, hypertension, smoking cessation etc.)
Inclusion Criteria

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

* Registered with a GP practice **in the Wandsworth & Battersea locality area AND** who are under the **SMI register/MH Quality Outcome Framework (QoF)** for the practice.
Patients…

* Who are **not registered** with an identified GP practice in the Wandsworth & Battersea locality.
* Who have not been discharged from secondary care.
* Who are 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.
* Currently receiving Clozaril treatment.
Team Composition

Clinical Team Manager

Mental Health Practitioners

Recovery Support Workers
Step-Up Referrals

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

- Both the individual, their family members and/or carers are made aware of the referral to secondary care services.

- The Single Point Access (SPA) team is notified of the referral.
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 Coordinator and identified carer/family member may 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, medication monitoring, and healthy living.
Thank You! 😊