

# NEW WAYS OF MANAGING MILD TO MODERATE SUFFERERS

## A 12 MONTH PILOT STUDY

### THE TASK

The National Institute for Mental Health in England wanted to explore whether lean production had any application in mental health, an area already recognised for making limited resources stretch a long way.

In consultation with the NIMHE programme director for West Midlands, Saigei agreed to run a pilot to investigate the application of lean production techniques to the provision of care for mild to moderate mental health patients.

### ORGANISING WITH PURPOSE

The team began by going directly to the front-line to consult with GPs, nurse practitioners and psychiatrists.

The process began with an audit of mild to moderate patient care. Although there were many clinical diagnoses, over six meetings, the group were able to sort them into nine pathways (types).

Type	Diagnosis and clinical need	Cases reviewed
A	Reactive depression Adjustment Disorders Depression Recurrent depressive disorder, unspecified Anxiety with depression Cannot sleep – insomnia Neurotic (reactive) depression Stress related problem	11
B	Endogenous depression Low mood Post natal depression	3
C	Anxiousness - symptom	2
D	Depression Mixed anxiety / depressive disorder Severe depressive episode with psychotic symptoms Anxiety with depression c/o feeling depressed Dizziness symptom	6
E	Depressed	1
F	Reactive depression Depression Anxiousness Depressive disorder Endogenous depression – recurrent	6
G	Feeling depressed	1
H	Reactive depression	1
I	Agitated depression Moderate suicide risk	2

For each type they identified a preferred course of action ranging through:

- life advice;
- monitoring;
- convince they have a condition;
- general psychological counselling;
- specialist counselling;
- clinical management;
- degrees of acute care

The strong insight was that the current provision resulted in many patients not being identified as mild to moderate mental healthcare sufferers; a very high instance of prescribing; and inappropriate referrals to secondary care.

### SERVING NEEDS

The new pathways were documented in a communication pack and three GP practices selected to take the pilot forward.

A measurement framework was agreed and current performance base-lined by manually auditing a stratified random sample of cases from each practice. The measurement framework included:

Aim	Measure
Better Care	Instance of prescribing Instance of GP consultation Instance of referral to secondary care
Better Point of Care	Instance of recognition Use of voluntary resources
Better outcome	Patient Satisfaction HAD Score over time

To enable the exercise to progress it was necessary to adapt the read codes on the practice administration systems so that each patient's type could be recorded.

Changes were also made to the working practices of graduate workers and psychiatric nurses so that they were present at the practices to support screening, risk assessment;

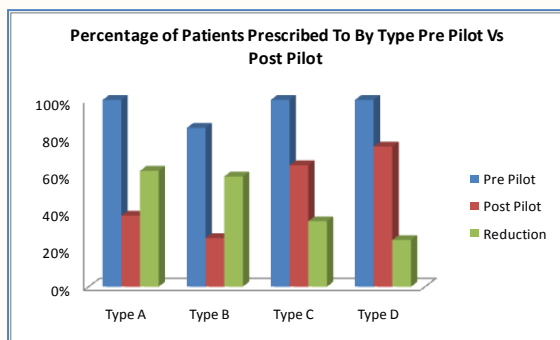
signposting; structured counselling; case review and management of patients.

## MEASURING OUTCOMES

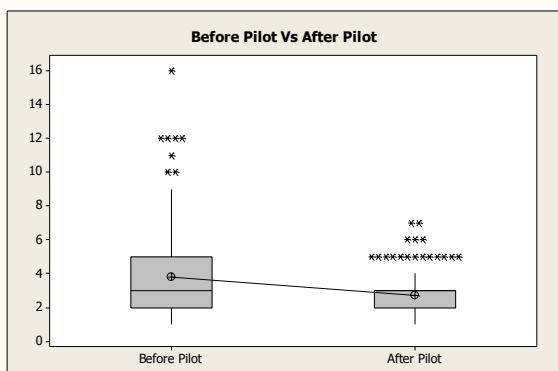
The study was coordinated and managed throughout the twelve months, after which a second baseline was established by auditing another stratified random sample of cases from each practice.

The first result was that recognition and recording of mild to moderate mental health patients was up from an average 13% to 72% across the practices.

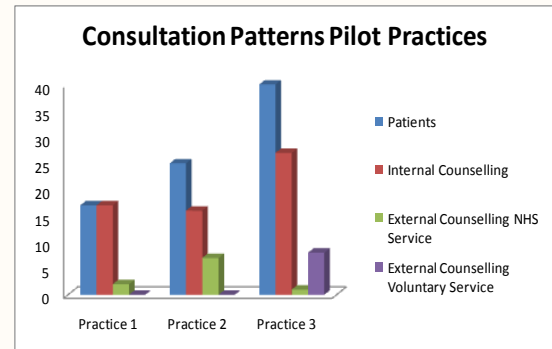
The next result was a 60% reduction in prescribing for types A & B, and a 30% reduction for type D & E.



The third result was a clear reduction in the instance of referrals to secondary care both in terms of mean and variability of experience.



Before the pilot, the instance of counselling type care was negligible. Although the results varied between practices, all showed marked increases in the instance of counselling and some use of voluntary services.



Patient feedback (gathered using quantitative survey techniques and depth interviews) showed notable increases in satisfaction with both the GP and psychiatric nurse services.

The case for quality of care is robust. An estimate of the financial value of the improvement is less compelling, showing a modest opportunity for the economy of the order of £200,000. This is largely because drugs like Citalopram cost pennies per month.

## WHY IT WORKED

The initiative was constructed around the delivery of improved care and the use of lean helped navigate the difficult diagnostic space. As a result it was easy to engage clinical professionals, practice administrators and patients in designing and seeing through the programme.

Ends...

For further information contact:

James Heffron  
 +44 (0)7779 702159  
[james.heffron@saigei.com](mailto:james.heffron@saigei.com)

Saigei Limited  
 41 Ormond Avenue  
 Hampton  
 Middlesex TW12 2RY

[www.saigei.com](http://www.saigei.com)