

# Item-of-service payments for general practitioner care of severely mentally ill persons: does the money matter?

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## SUMMARY

*A pilot of item-of-service payments (£85 per annum per patient) to general practitioners for monitoring long-term mentally ill individuals was successful in recruiting practices and ensuring assessments. It did not, however, demonstrate an improvement in health care.*

*Keywords: mental health; item-of-service payments; general practitioners.*

## Introduction

Up to a quarter of schizophrenia patients rely entirely on their general practitioners (GPs) for medical care,<sup>1,2,3</sup> though few practices have specific policies.<sup>4</sup> Teaching GPs to use structured assessments of long-term mentally ill (LTMI) patients significantly increased the changes in treatment with neuroleptic drugs and referrals to community psychiatric nurses (CPNs).<sup>5</sup> The intervention increased the involvement of GPs but seemed impracticable in routine surgeries. We decided to test whether item-of-service payments would improve care.

Merton, Sutton and Wandsworth FHSAs (subsequently MSWHA) funded this pilot scheme of item-of-service payments at £85 per patient per year of intervention (maximum 12 per practice). Ethics committee approval was obtained. We compared case notes of patients for the study year and the preceding year to determine impact.

## Method

### The practices

All 124 MSWHA practices were written to; 54 expressed an interest and 22 refused. Of the 21 practices successfully recruited, two submitted no claims, and records were unobtainable for three. Five were both training (postgraduate) and teaching (undergraduate) practices, four were teaching practices, and seven were neither. Six practices were single-handed and 10 were fundholders. All received the top level health promotion banding. Six GPs had previous psychiatric experience.

Eligible patients were aged 18–65 years, suffering from a psychotic illness (ICD9 295, 296 or 299) or from severe neurosis requiring psychotropic medication for a minimum of two years.

### Training and induction

The authors explained the proposal, discussed its rationale, and clarified the mechanisms of the proposed register and reviews. Implementation was reviewed and separate half-day training sessions were provided for the practice nurses. The intervention

comprised the construction of a disease register, a care plan for each patient, and three-monthly structured reviews.

It was anticipated that the practice nurse would complete the structured assessment (modified from the GP study encompassing psychological, physical, and social well-being).<sup>5</sup> The care plan (recording identified needs, how and by whom they would be met) was to be reviewed at six months.

### Evaluation

Patients' notes, structured assessments, and care plans were transcribed onto pre-coded sheets on completion of the study. Data were analysed using chi-squared tests for categorical variables and Willcoxon's signed rank test for continuous variables using SPSS for Windows 6.1.

## Results

One hundred and sixty-eight patients (90 male, 78 female) were recruited. Over 80% suffered from psychotic illnesses (schizophrenia 107, Bipolar Affective Disorder 29). The mean age was 49 years and the mean duration of illness 18.6 years. Fifty-eight (35.6%) had had no contact with the secondary services in the preceding year, but 136 (86.1%) had been hospitalized at least once in their lifetime, and 69 (41.3%) were currently receiving depot antipsychotics.

All but three patients received at least one structured assessment. There was a slight falling off of the assessments over the year (Table 1) but almost two-thirds (74.4%) received all four. Only two patients refused. Anxiety, depression, physical symptoms, and medication side effects were the commonest problems identified. At least one problem was noted in over 50% of all assessments.

Care-plan cards were found for 136 study patients and were completed for 134 (79%), but only 75 (44%) had two. They consistently recorded name, age, sex, address, diagnosis, and psychotropic medication, but recorded secondary care data less frequently. One in 10 patients recorded no 'needs', most had one (usually for medication), and a sprinkling had up to four.

The process of care was examined for key variables, including seven health promotion and seven mental health items, for the 12 months preceding and during the study. The only significant changes were the number of GP consultations (mean 13.3 increased to 14.1) and the lines of text in the notes (mean 48.7 increased to 54.9). For the 659 assessments claimed, 561 (85%) were completed (two practices only conducted 55% of those claimed).

## Discussion

Recruitment to this study was noticeably easier than with GPs<sup>5</sup> or practice nurses.<sup>6</sup> Payments were important — whether as commercial good sense ('I'm doing it anyway, I might as well get paid for it') or a matter of principle (recognition of difficult work currently undertaken). The rate of assessments also significantly exceeded that achieved by the GPs (62.9% vs 15.8% for all four, 2.4% vs 23.9% for no completions,  $P < 0.001$ ). Care plans completion was high at 80%, but reflected little real appreciation of their purpose. The most disappointing finding in this study is the

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**Table 1.** Completion of structured assessments.

Completed	Assessment 1 Frequency (%)	Assessment 2 Frequency (%)	Assessment 3 Frequency (%)	Assessment 4 Frequency (%)
At right time	131 (78.4)	109 (65.7)	113 (68.9)	77 (48.1)
At wrong time	25 (15.0)	38 (22.9)	27 (16.5)	42 (26.3)
Uncompleted	11 (6.6)	19 (11.5)	24 (14.6)	41 (25.6)
Total	156 (93.4)	147 (88.6)	140 (85.5)	119 (74.4)

absence of significant changes in the process of care. But why is this the case?

First, there may be insufficient feedback to GPs from practice nurses. Nurses were diligent and detected problems but there is little evidence that they communicated these to the GPs. In the GP study<sup>5</sup> the rate of completion of structured reviews was substantially lower but resulted in significantly raised referral rates and medication changes. Secondly, the GPs in the first study were self-selected with an interest in mental health. Thirdly, the GP study lasted two years.

These explanations cannot account for the failure to increase health-promotion exercises. The overall performance was disappointing, with levels substantially below that for band 3 health promotion payments (which includes all practices in this study). This may reflect inaccuracy in assessing health promotion levels generally, or that the LTMI receive significantly fewer checks than the general population. The latter would be worrying given this group's increased standardized mortality.<sup>7</sup>

The overwhelming impression from this pilot study is the extent of GP involvement with the LTMI, the feasibility of a structured assessment, and the GPs' recognition of the needs of this group. Translating effective monitoring into therapeutic activity will, however, require improved training for both practice nurses and GPs.

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