

Evaluation of the Primary Care Mental Health Specialist role: Final Report

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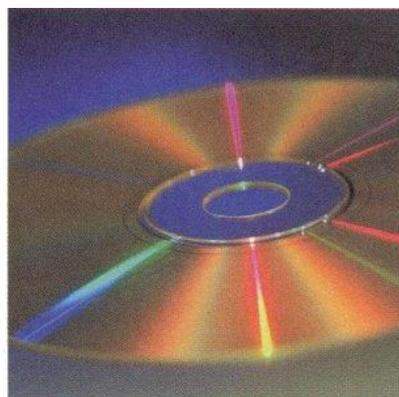
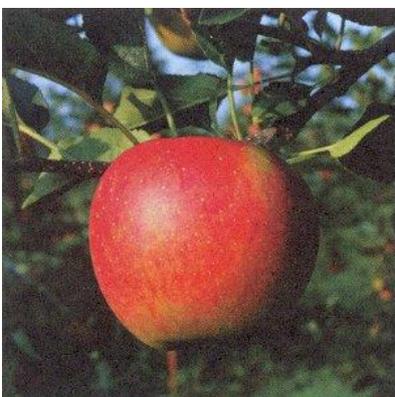
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1. Introduction

Aims of the evaluation

This report details an evaluation to assess the impact of the new primary care mental health specialist (PCMHS) role in Kent and Medway. The evaluation was undertaken by the Centre for Health Services Studies (CHSS) at the University of Kent and was conducted June 2013 to December 2014. The evaluation was commissioned by NHS Kent and Medway and supported by Kent and Medway Commissioning Support.

The evaluation encompasses six CCG areas across Kent and Medway, with 13 PCMHS employed in these areas (see Table 1-1 for breakdown). The number of posts per CCG is dependent on the amount CCGs invest (roughly equating to population size), rather than prevalence of illness. The PCMHS have been seconded from Kent and Medway NHS and Social Care Partnership Trust (KMPT) for the duration of the pilot, and are either community psychiatric nurses (CPN) or occupational therapists (OT) by profession. The majority of PCMHS are hosted by a voluntary organisation (mcch); three are hosted by GP practices and two by a community Interest Company, Invicta CIC.

Table 1-1: PCMHS, CCG and hosting organisation

CCG	Hosting organisation	Number of PCMHS
Canterbury & Coastal	Invicta CIC	2
Dartford Gravesham & Swanley	MCCH (Gravesend)	1
	The Oaks Surgery (Swanley)	1
Medway	MCCH	3
South Kent Coastal	MCCH	2
Swale	MCCH	2
Thanet	Westgate Surgery	2
Total		13

The main objectives of the evaluation are:

1. To assess the impact on patients by capturing their experience of the service;
2. To assess the impact by capturing experiences of those delivering the service (i.e., PCMHS);
3. To assess the impact by capturing experiences of other professions who work alongside the service (i.e., mental health professionals in secondary care, GPs);
4. To assess the economic cost of the new service via a unit cost analysis.

To meet these aims, the evaluation team collected data under five different work packages that form the basis of this report. These work packages are:

1. **Patient interviews:** Semi-structured interviews (either face-to-face or by telephone) were conducted with a sample of patients from clusters 7, 11 and 12 to gain in depth insight into their experiences of the new service;

2. **PCMHS interviews:** Semi-structured (face-to-face) interviews were conducted with all the PCMHS to gain an insight into the implementation of the new service;
3. **Other professionals:** Collection of views from GPs and other health professionals (secondary services) in the pilot sites to capture their experiences of the service. A short online survey was circulated to CCGs, host organisations, PCMHS, and secondary care services for them to complete and/or cascade to relevant colleagues and organisations;
4. **Activity data:** Collection of activity data via a form, developed specifically for the pilot and evaluation, completed monthly by the PCMHS for each CCG area;
5. **Economic analysis:** Provide a unit cost in regard to the service.

The structure of the report will reflect the different work packages, with key conclusions from each package highlighted and discussed.

National Background/ NHS context

Before reporting on the evaluation, it is important to provide some context to understand why this service was developed.

The role of the primary care mental health specialist (PCMHS) is part of a two year pilot provided by QIPP 'invest to save' programme to improve primary care mental health services. The Quality, Innovation, Productivity and Prevention (QIPP) programme is a national Department of Health strategy which aims to improve the quality and delivery of NHS care, while reducing costs to make £20bn efficiency savings by 2014/15.

The main aim of the new specialist role is to increase mental health capacity and expertise in primary care, alongside increasing the provision of primary care mental health services, based on local population need.

The rationale for the creation of this role, and the pilot programme, is twofold:

1. 'No health without Mental Health' (2011) outlined the coalition Government strategy to improve the mental health and wellbeing of the population. In line with the Health and Social Care Bill it sees a shift away from Department of Health control towards local decision making. This supports local commissioning of services designed to best meet the needs of local people by the use of tools such as Payment by Results (PbR). In 2012-13 there was a shift in bringing mental health services for working age adults and older people within the scope of the payment by results framework. Use of the mental health clusters was mandated to start in April 2012 and are 'currencies' for most mental health services, forming the basis of the contracting arrangements between commissioners and providers. The mental health care clusters are based primarily on the characteristics of a service user and their diagnosis during a period of care (up to 12 months). It was identified that the care of services users who fall within

certain care clusters, (long term, stable, mental health needs) could be managed by primary care.

2. Current service provision has centred on secondary care providers such as mental health trust access teams, recovery teams, and community psychiatry. Traditionally, service users considered to be stable long term tend to stay within secondary care rather than being discharged to primary care. If discharged from secondary care, these service users would be supported by GP alone care. Consequently there is reluctance for health professionals in secondary care to discharge, while GPs may feel they are not equipped with appropriate resource or skills in primary care.

However, considering new policy initiatives emphasising the need to provide more healthcare in a primary care setting, rebalancing the provision of mental health care from secondary to primary care needs to be addressed. Therefore the primary care mental health specialist role was proposed to help facilitate the navigation of patients between these two service providers.

Taking in to consideration this context, the role of the newly appointed PCMHS was to identify mental health service users in secondary care who can be discharged and receive long term support in primary care. Additionally, the role was created to support general practices' capacity and capability to support these service users, as well as to support patients accessing mental health services for the first time. The pilot programme introducing the new role into practice was rolled out across Kent and Medway in March 2013 and is due to end in March 2015.

2. Analysis of patient responses

To meet the objectives of evaluation, within the resources available, interviews were conducted with patients in three CCG areas: Canterbury & Coastal (C&C) CCG, Medway CCG, and Thanet CCG. The three CCGs also represent different hosting organisations- one being hosted by a GP practice, one by a voluntary organisation, and one by a community interest company. Thanet and Medway recruited patients from the start of the evaluation, while C&C started in August 2014.

Recruitment procedure and participants

Potential interviewees were identified by the PCMHS in each CCG. These patients were provided with an information sheet about the evaluation. Interested patients were asked to send their contact details in the provided SAE to the lead researcher at CHSS, who would subsequently contact them to arrange a convenient time for the interview to take place – either by phone or face-to-face.

This process produced an initial sample of 20 patients who expressed an interest in being interviewed for the evaluation. From this sample, three patients subsequently dropped out before the interview took place due to deteriorating mental health and five participants did not respond to messages left by the research team when attempting to arrange the interview.¹ Consequently a final sample of $N=12$ (5 male, 7 female, age range 23- 64 years, $M = 50.8$ years) patients, across the three CCGs (5 Thanet, 3 C&C; 4 Medway) were interviewed and responses analysed.

The cohort of patients interviewed described a range of mental health illnesses, either current or historic –for example, depression, bi-polar, self-harm, general anxiety, a range of phobias, and schizophrenia. As expected, all of the interviewees had some previous experience with secondary care mental health services. Other NHS services accessed now, or historically, included community psychiatric teams, counselling services, and KCA. Two participants received mental health care under a private provider. Five participants highlighted support from charities (e.g., The Samaritans) or local support groups. When interviewed participants had been receiving care from the PCMHS for varying amounts of time, ranging from 5 – 14 months. Patients had been referred to the PCMHS service from a variety of avenues- for example, GPs, counselling services, psychiatrists, care coordinators, and clinical staff based in secondary care.

Materials

The primary aim of the interview was to explore the impact of PCMHS on patient wellbeing and mental health, whether patients valued receiving mental health care in a primary setting, and overall satisfaction with the service. Accordingly, the research team developed an interview topic guide to probe these areas (see Appendix A).

¹ Generally the researcher left two messages- although possible to contact these patients more often, the research team was mindful to not overwhelm patients with requests.

Procedure

Consent to participate in the study was obtained from all patients by signing of a consent form before the start of the interview. Topics to be addressed in the interviews were not considered to be of an exceptionally personal nature; however, the interviews did contain questions regarding participants' experiences of mental health care or support (patients). Therefore it was possible that some participants could find reflecting on these periods on their life distressing. Accordingly, participants were reminded of their right to terminate the interview at any point, without explanation, and of their right to decline to answer questions. Finally participants were reminded that the interviews would be recorded for analysis purposes and only broad trends would be reported. Interviews lasted between 20 minutes to 1 hour.

Analysis

The patient interviews were recorded and later transcribed verbatim. The transcripts were uploaded on to NVivo- a software package that allows qualitative data to be coded and organised according to identified themes and subthemes.

To analyse the interviews, The Framework Method (Ritchie & Spencer, 2011) was utilised. This method involves the identification of commonalities and differences in the qualitative data, developing themes and subthemes from which broad conclusions can be drawn.

The 'framework' for the analysis of the patient interviews was based on the interview guide developed by the research team. Consequently, three main themes were used:

1. Patient experience of the PCMHS service;
2. Impact of the PCMHS serviced on their mental health and wellbeing;
3. Overall reflections.

Subthemes were then developed within each of these three main themes. To ensure a reliable and valid analysis, the process of developing subthemes involved two researchers. The first researcher (NC) read all transcribed interviews and coded responses to one of the initial three main themes. Having coded responses to a main theme, NC then developed subthemes by identifying common responses provided by the patients. Once completed, a second researcher (SH) reviewed the transcripts, themes and subthemes developed to assess content validity. Differences in how responses were coded or the need to change/expand subthemes were discussed between the two researchers and a consensus reached.

Ethical considerations

In consultation with local NHS Research and Development colleagues it was agreed this piece of work constituted 'evaluation' as opposed to 'research', hence, full NHS ethics was not necessary. However, ethical principles were adhered to throughout the evaluation regarding data confidentiality and informed consent.

Care was taken in designing this evaluation to ensure that all participants, from patients to PCMHS were given full information about the study. Patients' GP or host organisations

(PCMHS) were also informed of the study and asked permission to invite the potential participant for interview.

Prior to the interviews commencing participants were given the opportunity to ask any questions about the study or the interview. They were reminded that they were not required to answer any questions that they felt uncomfortable with, and they were free to terminate the interview, without giving a reason, and without affecting any of the services that they currently receive (patients).

Participants were also made fully aware of their right to refuse or withdraw from the study at any time, and were made fully aware of the confidentiality with which all data would be treated. All participants were assured that data from them would be treated in absolute confidence and at no point would individual users be identified. Only those who were specifically assigned to work on this project had access to the data collected. Electronic data were stored on a password protected database at the CHSS, while hardcopies were stored in a locked filing cabinet at the CHSS.

Results

To present a logical picture of the findings, results will be broken down by main theme and the key subthemes that emerged from the analysis. Quotes, drawn from participants will be utilised to illustrate pertinent points.

Experience of PCMHS

This part of the interview was designed to explore whether patients found the PCMHS service beneficial. Responses were coded under **three** subthemes discussed below.

How the PCMHS was different to previous care received

When asked about how the PCMHS service differed to previous experiences of mental health care (both primary and secondary care) a number of different aspects were highlighted. First participants mentioned how continuity of care has improved under the PCMHS service. Having the same specialists allowed for a relationship to build between themselves and the specialist; hence, building trust and subsequently benefiting the patient.

“I was always fighting to be seen... .., months in between, sometimes years between appointments and this time I’ve been able to have continuity.” (P002)

“From here it’s been more hands on without a doubt and as I say, the PCMHS understand a lot more about me because it’s constant care, with the same people.” (P003)

In addition, one patient also highlighted how this continuity of care prevented a constant repeating of information to clinical staff:

“ I like it because I don’t have to keep going over like past experiences that I’ve been through with somebody new every time because she knows all about me and she knows what I’m taking and if there’s a problem, you know, I know I can turn to her

and she'll get back to me so... It's nice not keep seeing different people all the time." (P011)

Building on the consistency of care, a number of patients reported the care being received from the PCMHS was more tailored to their individual needs and less generic than previous care. As specialists built relationships with the patients, this afforded them the opportunity to design and develop individualised interventions and approaches to aid recovery in their patients.

"I said it's totally amazing that they've got this (PCMHS), there's just this little group, I says where secondary care has got all these people and you know didn't give you really time of day you was just like a number to them." (P018)

"They (PCMHS) can basically tell when they come in the door I'm having a bad time or I'm up. You do need to have somebody who can read that rather than maybe somebody you've seen once in a few months and then they seem to think they know everything about you and they don't." (P003)

Finally, another identified difference was in the approach taken by the specialist- patients see the care as potentially more person- centred than previous experiences in mental health care. For example, one participant described how they perceived the difference:

"One big difference is the psychiatrist, the doctor, will would have their agenda and they very much want to get through their agenda on what they want to ask you, what you want to talk about before you get a chance to say your little bit towards the end. I used to find that greatly some while ago, whereas this is completely the opposite. I'll say something like to them; do you want to take the lead. They say; no, no we like to hear your experiences so I come out with that" (P002)

While another emphasised how specialists and patients work together

"I mean the connection with the specialists is good because I mean when I say to them like "maybe we could do this". They go "Yeah of course we can". (P006)

Benefits of the PCMHS service

Moving on to specific benefits of the PCMHS, the main positive cited was how the service contributed to the prevention of relapses. Having the consistent support in place – where before this may have been lacking- served as a 'safety net'. For example:

"Kept me out of hospital. I know I can ring any time and there'll be somebody there. Knowing that there's somebody there at the end of the phone if you ever need it. I haven't had to use it yet but I know it's there" (P011)

"They, I've always been treated with a great deal of sort of courtesy and professionalism. I've never felt embarrassed or that I was a nuisance, quite the reverse and it's all worked extremely well to not just keep me out of hospital but to keep me you know well in the community.... I've been assured there will always be a

safety net there for me should I ever need it in some form or another so I feel quite optimistic that I won't be totally abandoned.”(P019)

Reiterating this notion of a safety net- one participant explicitly states how the assistance from PCMHS prevents them relapsing:

“They are more there to make sure I'm not sliding too far. It's really a helpful thing to know that you can just come in and say “right this is happening in my life - please help me”, and the help is there.” (P003)

Accessibility was also a key benefited cited. Patients highlighted how quickly they were seen once referred and how responsive the service was once accessed. Specifically patients mentioned how they can rely on specialists to return calls promptly and felt specialist were open to being contacted at any time.

“I leave a message and they get straight back to me as soon as they get the message.” (P003)

Again the ease of accessibility feeds in to this notion of a safety net being there for patients- they have someone to turn to who will be able to offer immediate help.

“I have found they are very, very responsive if I have a problem during the week I can drop in, or drop (them) a line.” (P002)

Finally, the type of support provided by the specialists was seen by patients as useful, relevant and important to the improvement of their mental health. Specialists were seen as being empathetic and understanding of mental health issues- experts in their field.

“I think it's the dignity with which you're treated. Nobody patronises me or assumes that I just can't cope or anything like that, it's just sensitive help at the right time.” (P019)

“The fact that I can talk to somebody that I can talk to people who are knowledgeable in mental health. I'd rather talk to them than to my GP.” (P015)

Patients highlighted how they appreciated assistance with practical tasks (i.e., benefit forms and housing claims), expressing the positive impact this had on their mental health. In addition, having the protected space to discuss problems with someone was seen as invaluable by a number of participants.

“It's sort of unlocked all these weights I'm carrying around with me. It slowly unlocks it.”(P009)

“When I talk to my PCMHS I feel I can get a load off my chest, which as a result means I can think clearly.” (P017)

Disappointments with the PCMHS service

Overall, patients spoke with high regard about the PCMHS service and the impact this had on their quality of life. Two items were highlighted as potential disappointments- one regarding the length of time it takes to receive appointment letters and another regarding the struggle to be referred to the service:

“My disappointment was actually finding out it existed and my battle with the GP to get it but once I’ve been having that, no not at all. I would have liked to have known it existed to even enquire whether I’d be eligible for it; yeah it was very tucked away at the time” (P002)

Impact on mental health and wellbeing

When asked about how the PCMHS service had impacted on their everyday life, patients discussed positive changes in their mental and physical health. Of the 12 participants, 10 mentioned a positive change in their mental health as a direct result of receiving care from the PCMHS. Common changes highlighted by patients included feeling less lonely, a reduction in anxiety/stress levels, feeling more confident about coping with their mental health illness, and feeling more optimistic about their future as a consequence of increased confidence in their ability to cope. A quote below provides a typical illustration of these feelings:

“I think increasingly I’m looking forward to the future rather than when I was in my lowest time, I always treated the tomorrow as the last day. And I didn’t always know how to be happy or to be sad about it because I was in such a mess, but now I see myself as having a future.” (P017)

A number of patients mentioned how they felt a burden has been lifted since receiving care from the PCMHS.

“And less stressed and I don’t get so many panic attacks I feel like I’m - cos I feel like I’m dragging weights around and they seem to be lifted a bit.” (P009)

“Every time they’ve been I’ve felt really good inside like as if a weight had been lifted from... As if a weight had been lifted from my shoulders.” (P015)

For some patients, the lifting of this burden and reduction in stress and anxiety levels had a direct impact on their quality of life. Patients highlight quite simply:

“I’m able to live my life to the full now” (P015)

“My quality of life is very highly impacted but it does help, yeah. It helps my moral as well in general.” (P002)

Finally, a number of patients also highlighted how they felt better equipped to cope due to an increased understanding of the illness. For example,

“Yeah I’m a lot more able to cope with myself which obviously makes everyday life easier for me because I know more about what’s happening to me, so therefore it makes it a lot easier to deal with what’s going on.” (P003)

“I’ve found out more about myself now and why I feel the way I do.” (P009)

Consequently patients indicate a sense of empowerment and increased control over their mental health. By working with patients to improve their understanding of the symptoms and potential triggers, the PCMHS provide the tools a patient requires to aid long-term recovery and eventual discharge from the service.

Two patients also highlighted how the positive changes in their mental health consequently impacted on their physical health- improved coping with mental health has allowed patients to time to now address their physical health. For example:

“.....but because I’m dealing better with the mental health side of my condition, it does help me to deal with the physical side of the conditions.” (P003)

Finally patients also highlighted how their ability to engage in life had increased. For example, patients were now able to go out and engage in activities, whereas before receiving care from the PCMHS this was not possible.

“And also getting out and about a lot more and doing different things, things I hadn’t tried before with the help of the PCMHS.” (P011)

Some patients also describe how they are now able to complete tasks that beforehand they find difficult – for example, household chores, keeping appointments, gardening. Overall patients did not provide specifics on how daily activities had changed; instead responses reflected a more general acknowledgement of improvement. Although in the greater scheme some of these changes may seem small, patients appreciated the larger impact these changes had on their life and in general viewed these changes as important steps towards recovery.

Overall reflections

When concluding the interview, patients were asked to comment on their overall satisfaction with the service and what, if any, hopes they had for the future of the service. All 12 of the patients interviewed indicated they were satisfied with the service. Asked why they were satisfied, comments ranged from a straight forward:

“I think it’s brilliant” (P018); “I think it’s been excellent” (P019); “I’ll be honest I don’t think this lot could improve.” (P006)

To more detailed explanations as to why they were so satisfied:

“Yeah, it’s more than that, more than satisfaction. They’re kind, easy to talk to, trustworthy. And they’re just, you know, there for you if you need them.” (P007)

“I think it’s been excellent. They, I’ve always been treated with a great deal of sort of courtesy and professionalism. I’ve never felt embarrassed or that I was a nuisance, quite the reverse and it’s all worked extremely well to not just keep me out of hospital but to keep me you know well in the community.” (P019)

In terms of how the service could be changed, no specific thoughts were offered; however, three patients did express concerns about removal of the service and how this may impact on their mental health. For example:

“Well I would hope that they would keep going because I think I would fall apart if it was just left to me on my own. As long as they don’t just start leaving me stranded somewhere thinking “Oh she can cope now and get on with it.” (P006)

Summary

The overarching conclusion drawn from these 12 interviews is that the PCMHS benefited patients on a number of different levels. Patients expressed high levels of satisfaction with the service and report specific examples of how their quality of life has improved since receiving care from the PCMHS.

Although overwhelmingly positive, when interpreting these findings it should be noted the 12 patients interviewed represented a relatively small number of the total patients seen by the service. In addition, patients who agreed to be interviewed may only represent those who are in recovery – as described earlier; a number of patients withdrew from the evaluation due to deteriorating mental health so their views were not able to be sought. Nevertheless, the conclusions drawn from this analysis should be taken forward as indicative evidence that work done by the PCMHS has had a positive impact on the lives of those interviewed.

3. Analysis of Primary care mental health specialist (PCMHS) responses

Background

The two main purposes of the primary care mental health specialist role are: to offer additional support to those service users who have long term, stable, mental health needs and to increase capacity and skills within general practice so GPs and other staff can support service users appropriately.

Dimensions of the role outlined in the primary care mental health specialist job description are:

- a. Support recovery by pro-actively enabling medically-stable individuals to move from secondary to primary care. Ensuring that support is personalised to their (and their family/carers) needs. Agreed shared care responsibilities are to be in place and clearly documented.
- b. Provide leadership and expertise to primary care clinicians and practice staff in the management of mental health conditions in primary care. Support the effective 'navigation' of patients through the various mental health systems and services. Ensuring that local voluntary sector, health and social care provision are used effectively.
- c. Propose and lead initiatives which improve the physical health outcomes of those with a long term mental health condition, and the mental health outcomes of those with a long term physical health condition.

Recruitment procedure and participants

Permission to recruit the PCMHS was initially sought from relevant host organisations – Invicta Health CIC, mcch, and hosting GP surgeries. All hosting organisations granted permission for the research team to approach the PCMHS and discuss participation in the evaluation. Information sheets were developed by the research team to explain the aims of the evaluation and what the interview would entail. These information sheets were distributed to the PCMHS and subsequently all PCMHS approached ($N=13$) agreed to be interviewed as part of the evaluation. A selection of these specialists ($N=8$) were also interviewed 4-6 months later to explore how the service progressed since the initial interview.

Regarding previous experience prior to this role, three specialists were Occupation Therapists based in mental health care and 10 mental health nurses. Overall the cohort represented a highly experienced team with number of years working in mental health care ranging from 5 to 26 years. When interviewed, specialists had been employed in their current role from 3 months to 1 year.

Materials

The primary aim of the interview was to evaluate the implementation of the new service from the perspective of those providing it. Accordingly, the research team developed an interview topic guide to probe these areas (see Appendix B).

Analysis

The PCMHS interviews were all conducted face-to-face, recorded and later transcribed verbatim. The transcripts were uploaded on to NVivo- a software package that allows qualitative data to be coded and organised according to identified themes and subthemes.

Replicating the analysis of the patient interviews, The Framework Method (Ritchie & Spencer, 2011) was utilised.

The 'framework' for the analysis of the PCMHS interviews was again based on the interview guide for this group. Consequently three main themes were identified:

1. Main responsibilities of the PCMHS and working models;
2. Evaluation of service- implementation and patient outcomes;
3. Overall reflections and future thoughts.

The next step was to develop the subthemes from these three main themes. To ensure a reliable and valid analysis, the process of developing these subthemes involved three researchers. The first researcher (SH) read the majority of transcribed interviews and coded responses to one of the initial three themes. Having coded responses, SH developed subthemes by identifying common responses, within each main theme. A second researcher (JH) reviewed the remaining transcripts and replicated the same process as SH. Once completed SH and JH compared subthemes and discussed rationale for coding responses. Any differences in opinion were discussed and a consensus reached. Overall the level of agreement between researchers was high, with few changes to how interview responses had been coded and the subthemes that had emerged. The final step involved a third researcher (KH-W) reviewing the coding and development of subthemes developed by SH and JH. Differences in how responses were coded or the need to change/expand subthemes were discussed between the three researchers and a consensus reached.

Results

To present a logical picture of the findings each main theme, and the key subthemes that emerged from this theme, will be discussed separately. Quotes drawn from the specialists will be utilised to illustrate pertinent points.

1. Main responsibilities of the PCMHS

The first topic covered in the interview explored the specialists' assessment of the main responsibilities in the role. From the responses three key areas of work emerged as strong subthemes regarding: building relationships with other health professionals and

organisations; identifying patients suitable for discharge to the new service; and therapy work conducted with patients.

Building relationships

All specialists discussed the importance of liaison work with GPs and secondary care staff as a way of building relationships with them. For example, efforts were made to engage with GPs and practice managers to inform them of what the new PCMHS service could offer to them and their patients. Training was also provided by many of the PCMHS to GPs, Nurses, and practice staff:

“The first Tuesday of every month, educational for all GPs, so we would go there and nine times out of ten we give input in the training. They will ask us questions and explain our role and do that as well, so that is how we promote ourselves as well.” (P011)

Specialists also highlight the importance of building relationships with care coordinators, community mental health teams, and secondary mental health services as part of the role. It was viewed by specialists that investing time and effort to build these links and, potentially bridge gaps in service, was pivotal to providing a primary care service beneficial to patients. For example, two specialists highlight examples of how building strong relationships can benefit patients and the service provided:

“We’ve found it’s been really helpful to actually build relationships with GPs because you need them to be on board with this pilot to give you a room if you need to see somebody (or) to be agreeable to taking people back” (P005)

“ It is a lot better because we’re in a relationship with the care co-ordinators for access and recover.... the more you work with care co-ordinators they know what the patient looks like that you can work with.” (P001)

Alongside educating GPs about the new role, specialists built relationships by offering expertise to GPs - supporting GPs with patient advice and signposting. Specialists reported GPs would look to them for expert advice as they are seen as they were both knowledgeable and easily accessible.

“Also I give advice to GPs....., so we will see them and help out as much as we can.” (P005)

In this arrangement an element of goodwill exist in that while assisting GPs, it was hoped this collaborative approach to working would also encourage GPs to refer appropriate patients to the new service. For example, one specialist typifies this feeling below:

“What we will do with GPs is as goodwill because we’re really trying to build up you know links with the GP, occasionally ring us up and say look we’ve got a client here, we’re really not too sure what to do, could you just come in and give us some advice, so we are starting to do some assessments” (P014)

Relationships were also built outside of the NHS- for example, with third sector organisations (e.g., Porchlight) and community support groups (e.g., Umbrella centre in Canterbury)

“You’ve got to meet them, you know find out about their role and explain ours and also see if they are appropriate, test them out so you kind of do referrals and then you see if it works, if it’s a kind of good service linking with or not, so yeah over time you kind of build up a bit of a resource file of what’s useful and what’s not.” (P002)

In summary, the building of relationships spanned numerous organisations within, and outside, of the NHS. This work ensured the new service was not only visible, but also well understood in terms the aims of the pilot and how the service worked.

Patient identification

A second key responsibility discussed by all 13 of the specialists was the role of identifying appropriate patients currently either in secondary care or known to GPs. In some cases PCMHS aided GPs with the screening patients, who may normally have been referred for counselling, to assess if they would be appropriate for the new service. Assessments for GPs were also completed by specialists in certain CCGs- again this was seen as a way of offering additional help to GPs and also facilitated an avenue by which patients could be referred in to the service.

Responses suggested specialists also worked with clinical staff based in secondary care (e.g., care coordinators, consultant psychiatrists, KMPT service managers) to identify suitable patients in their care that could be discharged in to primary care. This process is illustrated by the quote below:

“We’re attending the meetings of the teams (based in secondary care) and we’re pushing, saying look, look at your 7,11 & 12.....highlight who you think may benefit from sort of coming out with us and we’ll come in, we’ll do the bulk of the work, let’s get a CPA arranged and we’ll get them out.” (P004)

Alongside discussions about building relationships and identifying patients, specialists highlighted some initial challenges in fulfilling these responsibilities. For example, initially accessing patients in secondary care to begin the identification process was sometimes difficult; however, as the pilot progressed and relationships were built, this barrier was progressively broken down.

Therapy work

The final main responsibility discussed by the specialists was the type of therapy work done with patients. The majority of specialists provided some description, with responses highlighting psychoeducational work on medication, diagnosis and relapse, building trust between them and the patients, helping patients’ complete forms and provide them with the tools to organise and structure their lives (signposting), reducing the social isolation and overall developing a sense of purposefulness in the patients’ lives. One specialist summarises the aim of the therapy work as such:

“To try and help them move forward with their recovery, so spend a bit more time on the things that they mightn’t have had time to develop in secondary services like looking at maybe voluntary work, further education and just to try and help them a bit further along in their recovery .” (P009)

This list is not an exhaustive account of all the work done by the specialists, but illustrates the wide range of support offered to patients under their care.

Responses from the specialists suggest the aim of this therapy work was to provide a person-centred approach to recovery. For example:

“You’ve got to think about what’s going to be the thing for them, or they might come to you with completely different need and then you’ve got to find a way round that so it’s been quite organic and you kind of work through it.” (P002)

Therapy work was conducted in different places, according to the working model in the specific CCG- for example, in the patient’s home, in the local GP practice or in other locations such as a café or park.

Description of working model

In describing the role and responsibilities, specialists also described the different types of working models implemented to deliver the pilot programme across their specific CCG area. Not all CCGs adopted the same working model so the interviews presented an opportunity to discuss the different approaches.

One key difference was in where specialists were based – Specialists based in Thanet worked primarily from GP practices while specialists in the remaining five CCGs were mainly hosted either by mcch or Invicta CIC. Responses from the specialists indicated patients can be seen in the home or, for those who had access to GP practices, a room would be booked and the patient seen there.

From the specialists’ responses, a second difference was the emphasis placed on the different responsibilities. For example, some CCGs facilitated for GP screening (e.g., Thanet, SKC), while others opted to focus instead on discharging patients from secondary care (e.g., DGS, Swale). Specialists in DGS and Swale highlighted that although initially engaging with GPs was seen as a key task, the focus changed mid-pilot to working with patients ready for discharge in to secondary care.

How patients were referred in to the service also differed across CCGs- while C&C and SKC sought referrals from GPs and secondary services, Swale, Medway, DGS focused mainly on referrals from secondary services and did not necessarily proactively ‘recruit’ GP practices. The type of patient taken by the service also differed – for example, not all CCGs accepted ‘transitional’ patients (e.g., SKC, DGS).

The merits and disadvantages of these different approaches are not easy to capture or understand- each area has its own unique set of patients, GP practices, geography, volunteer organisations, shared care arrangements, depot arrangements, and personal leading the

initiative; hence, differences in implementation were inevitable. Specialists in areas where GP assessments are not completed, or referrals from GPs not proactively sought, cite sheer volume of GP practices as one reason why under current arrangements this type of working model could not be achieved. However, building relationships with GPs has also been highlighted as a valuable asset to the successful implementation of the pilot.

Despite the differences between CCGs in how the pilot has been implemented, patients across three CCGs (Medway, Thanet, C&C) all report a positive impact of the service. Furthermore, the specialists themselves highlight the success of the pilot in all 6 of the CCG areas; hence, it may be the best type of model is flexible, with the ability to react to the needs of the local community, as opposed to a 'one size fits all' approach.

2. Evaluation of the service

The second main theme focused responses evaluating the PCMHS role and the service provided patients. How the role works well will be discussed first, followed by the challenges.

What works well?

All 13 highlighted positive impacts on the implementation and the impact on patient care. In analysing the responses, and by looking for commonalities across specialists, four consistent positive impacts emerged from the data- prevention of relapse; speed of response; bridging of gap between primary and secondary care; and the type of care provided being more appropriate for the population targeted.

Prevention of relapse

Specialists highlighted views on how the service contributed to the prevention of relapses and, in some cases, readmission to secondary care. A number of reasons were cited for this- for example, one specialist attributes the building of a relationship through the one-to-one therapy work as a key factor.

“If you’re in relationship with them then you can genuinely prevent a crisis, so from their point of view it’s great, they’ve got consistency.” (P002)

While another specialist reiterated a point raised by patients that specialists act as a reliable and trustworthy back-up, to be contacted in times of crisis- something patients may not have had access to before.

“In the past when a patient was discharged from the secondary care into the primary care back to the GP they felt lost. There was nobody for them to contact. Then for the smallest thing they would relapse because they don’t have an anchor to hold onto, but at least here when they’re being discharged they know that they’ve got somebody to call to talk to.” (P010)

Educating patients to recognise signs of relapse was also highlighted as a vehicle for preventing relapses, and the type of care provided by the specialists allows for this investment in long-term recovery.

“.....you educate them anyway about their relapse signs. That’s the first thing you do. You let the patients know what the signs (are) you ask them and also their carer’s.” (P013)

Patients are encouraged to contact the specialists before things escalate; thereby allowing for an early intervention to prevent relapse.

Example provided by PCMHS as an illustration of how relapses are prevented.

P010: I went out last week to see a patient. Her children had left and she felt lonely. She just needed somebody to talk to her, but had been discharged from the secondary service because of recurrent depression and anxiety; however she suddenly felt low so I was happy to go and talk to her and give her the re-enforcement. She felt she was being heard.

This prevented her from going to her GP. In the past, if something happens like this, then she has to go to the GP. The GP will do a referral to the secondary service and the by the time the secondary services go through the referral and contact her that will be a good three months. In three months the whole thing could have escalated to what degree?

You know, the role is very good because in the past they *never* had anybody in the community just to talk to them when they were discharged from the secondary service.

Speed of response

Moving on to the second benefit of the service, specialists highlighted the ability to react quickly to changing situations- often contributing to the prevention of relapses, but also facilitating rapid readmissions to secondary care (i.e., fast tracking) as a key element of the new service.

One specialist provided a specific example of how quickly readmission to secondary care can happen:

“I’ve had one bipolar patient, clearly relapsing; I monitored her over the week and could clearly see they needed to go back. They very promptly got taken back.....on the same day of referring back the duty could actually go out and assess her and they took her back.” (P014)

Speed of response was also referenced in regard to how quickly patients referred in to the service can be seen and treated. One specialist described the service as providing “instant access”. This expediency benefits the patients as it prevents their mental health deteriorating further. A point illustrated by a number of specialists, and reiterated by the quote below:

“I think the thing we’re doing well is that we’re seeing people quickly, we’re basically preventing a lot of people from having to even go anywhere near secondary services.” (P004)

Reference is also made to how the speed of this service differs from what patients would have experienced previous when trying to access support. For example, a specialist describes the process beforehand potentially taking up to a month.

“It would probably take them a week to get an appointment with the GP, and then for the GP to write the letter, and then for the letter to get to KMPT, and if they weren’t high risk then another probably week to two weeks before they would get an appointment. That’s almost a month which somebody with mental health, a month can be a long, long time.” (P006)

Providing a ‘bridge’ for patients and professionals

Specialists bridge gaps between different types of organisations and between organisations and patients. For example, the role of the specialists often requires interaction with secondary care, primary care, social care, and voluntary organisations – this wide scope can facilitate communication between all sectors. The specialists can serve as a ‘hub’ to collect information from all avenues and facilitate better collaborative working practices. As illustrated by the quote below:

“I say it’s about being that bridge, you’ve got someone the GPs can talk to, you’ve got somebody the voluntary services can talk to, you’ve got somebody that the KMPT can talk to, so it kind of helps. Instead of it being very in their own sort of bubbles you sort of help them communicate.” (P006)

Being deeply involved with the referral process helps prevent breakdown in communication between GPs and secondary services- as highlighted by the quote below:

“The GP might get back to me and say; what’s happened about this person hypothetically and I can say; I can go and find out. So the actual risk of it breaking down should be less because of our roles if we’re involved in any kind of referral.” (P005)

In summary, a number of the specialists felt the introduction of this new service has provided a positive opportunity to build professional relationships and develop a greater sense of integrated working.

Regarding patients, crucially specialists also act as a bridge between primary and secondary care. A number of specialists’ report how anxious patients are regarding the move out of secondary care, as historically this service would have entailed little-to- no structured mental health care- patients would leave an intensely monitored type of care, to one in which only GP care would be available.

However, with the introduction of the PCMHS role, specialists view this as a positive step towards bridging this gap between secondary and primary mental health care- mechanisms are now in place to assist patients' recovery in primary care.

"I'm bridging that discharge and getting to know them sometimes a little bit before they are discharged. I'm monitoring them and seeing them every month maybe, so they continue to have a worker and it eases that process with them." (P005)

Importantly, the movement of patients in to primary care is done so gradually over time and the PCMHS service seems to be able to accommodate this approach. Specialists highlight how a relationship is established with the patient before discharge to encourage the patient to view the move as a positive one.

"The CPA is a worthwhile thing because people sort of understand- they've met you, they understand you're going to kind of see them. And then we spend reasonable a time so that we can establish where you're going to see them and all this. And then they feel quite, you know, they feel quite happy." (P001)

Again, this ground work eases anxiety about the move and reassures patients that a service will be available to them on discharge.

Type of care the PCMHS can provide

All the specialists expressed views on how the type of care provided by the service benefits patients; thereby providing a crucial example of how the service works well.

Specialists highlighted a number of elements – for example, the one-to-one model allows for in-depth relationships to be built and patient-centred care provided. Instead of a reactionary service – the PCMHS service is able to proactively address patients' mental health needs, before escalating to a major relapse.

It also provides care in an environment patients are comfortable with – either in the home or local GP surgery- which was noted by some specialists as an aid to recovery by reducing the stigma attached to mental health care provided by secondary services

"We're normalising their mental health, we're seeing them somewhere where they're comfortable." (P004)

Furthermore comments were made regarding how seeing patients in their home can aid recovery as it provides a chance to view living situations and potentially work with relatives to reflect on how the patient has been progressing. For example, a PCMHS highlights:

"They are more relaxed as well because they are in their home environment and often other family members can be around as well, so sometimes it's quite helpful around relapse issues. You kind of have that general discussion because often people say; I was perfectly fine and then you the partner might chip in and say: well actually you were doing this, this and this and you didn't sleep for three days before you went manic." (P002)

Challenges

As part of the interview specialists were also asked about the challenges they have faced when implementing the pilot. A wide range of topics were highlighted as areas of concern- not all will be discussed in detail as part of this report, but instead discussion will focus on concerns consistently raised.

Accessing patients

The majority of specialists were interviewed towards the beginning of the pilot and so captured a number of challenges associated with starting a new service. One of these was accessing records and patients under the care of secondary services and, in some cases, those under the care of GPs. Specialists report a lack of initial understanding as to what the role entailed and how PCMHS could help relieve the burden on secondary care.

“A lot (of GPs) were too busy and didn’t really understand the pilot and for them it was more work and didn’t really want to know.” (P012)

Specialists were also not initially able to access patient records in secondary care, so were reliant on staff to suggest cases; however, possibly due to resource constraints, specialists did not always receive referrals.

“You know you might think that they (secondary care) would just automatically refer to you, but that wasn’t the case.” (P005)

However, as the pilot progressed and relationships were built, specialists report that in general this challenge was overcome. Specialists worked to educate other professionals about the role and, in some cases, took on additional duties to facilitate the identification of patients- for example, manually reviewing lists of patients in the appropriate clusters, or completing background work for care coordinators and GPs.

Availability of service

A challenge highlighted in many of the interviews was problems associated with accommodating patients from secondary care with care packages. Specialists from Thanet and Medway make specific mention of this difficulty; highlighting how it affects a number of patients in their area. Specialists express frustration about many suitable patients being prevented from accessing the service. Essentially keeping patients in secondary care, when this is not necessarily suitable, and at a time when secondary care is already oversubscribed. One specialist sums up the frustrations below:

“So the system is forcing people, is stigmatising patients saying because you’ve got this diagnosis and you require this package of care, you have to stay in with the mental health, you can’t. There’s a barrier” (P004)

Another group of patients highlighted by the specialists as challenging to include in the service were those patients on depot injections. Specialist able to administer these injections made individual arrangements within their CCG; however, specialists express concern about how these arrangements will be maintained going forward and, for the service to run as effectively and efficiently as possible, CCGs need to look at long-term arrangements for

depot patients. In addition some specialists report that while they are able to provide depot injections, they don't always have the right equipment to do so- for example, syringes and blood pressure machine.

"The other issue with the depots is that we haven't been given the right equipment basically."(P008)

"I have to ask KMPT to help me with that and also things like blood pressure machine, these are the things that I think the pilot needs, you know if you...these are basic needs, basic needs for me. I need these tools to do my job." (P013)

Capacity/Resources

A number of specialists also highlighted concerns about their workload and capacity to take more patients in the future. In particular specialists raise concern about balancing administrative duties, with a growing clinical caseload. For example:

"I think a lot of the issues that most people have are not to do with the work itself, not the kind of clinical contact, it's more the kind of pressures that you get you know through typically your paperwork or stuff that you kind of have to constantly have to update and things like that, which feels less integral to your role and you can spend literally 70% of your time updating Rio and 30% of your time seeing clients." (P002)

"Our caseload gets bigger and bigger and bigger it's alright seeing the clients, it's all the admin that goes alongside that; the risk assessments, the notes."(P006)

Specialists in CCGs that do not have access to Primary Care Link Workers also highlighted how capacity in the role could be increased if support workers were used to cover some elements of their current work- for example, accompanying patients to groups/activities, and assisting in the completion of housing/benefit forms. Utilising care workers could ease the pressure on caseloads and allow for more patients to be discharged from secondary care.

Protocols/ IT systems

A number of specialists expressed concerns about inadequate protocols and safeguarding procedures in place to protect and guide them. Specialists report feeling vulnerable and open to risk without these policies. Furthermore, specialists report not having a protocol also hindered the initial stages of the pilot. For example,

"There was no sort of real agreement, so even though the protocol was saying everyone in cluster 7, 11 & 12 should be discussed with the mental health specialist, CMHGs hadn't had that. Nothing in concrete so that was quite difficult early on." (P005)

In addition, many also highlighted a major concern for them was the secure storage of patient data. Specialists without a base stored patient data on laptops- although encrypted and safe to store such information, specialists still found this method of data storage worrying. Concerns were further compounded by specialists being unable to access the appropriate IT systems to

upload patient notes and share with other professionals. For example, specialists could not access RIO- the system used by KMPT- via their own computers/laptops, hence were not able to update patient records without visiting a KMPT site.

The issue of accessing the different IT systems was also encountered with GP practices. Specialists report having to type notes and email these to the GP practice manager to include in the patients file.

“As we don’t have access to the patient notes in the GP surgery, we write our notes on the laptop and then we have to save the document, email the document over to the GP surgery and ask the GP surgery to upload it onto their computer system for each and every patient that we see for each and every visit.” (P009)

This lack of integration between IT services was seen as key challenge in taking the service forward. Not having regular access to these systems affects day-to-day communication as case notes cannot immediately be uploaded on to GP systems; hence ‘real-time’ information about a patient is not immediately available.

Other concerns were noted by individual specialists- for example, concerns around the accuracy recorded on the activity data sheet, frustrations at not being able to refer patients to the full range of service (e.g., treatment for Autistic spectrum disorders), lack of room availability in GP practices, and lack of appropriate equipment (e.g., laptops, phones).

3. Overall reflections

The specialist interviews were concluded with questions about overall reflections and future hopes for the service.

All 13 specialists provided an overall positive assessment of the service. Specialists mention expectations are being fulfilled for both GPs and patients, with overall both groups expressing positive statements about the role. For example, a specialist highlights:

“Certainly the patients we’re seeing the surgeries we’re in the GP and the patient gets a very good service from us and so that’s really it’s very fulfilling.” (P004)

Eight of the specialists were followed-up with a brief interview 4-6 months after the first. This provided an opportunity to reflect on how the pilot had progressed and challenges for the future of the service. Again all the specialists express an ongoing positive impact of the pilot- for example, strong links with GPs and secondary care continue to be built, patients are still receiving an improved service in primary care and in general seem pleased to be out of secondary care. In summary, the specialists still felt the PCMHS allows for the provision of good quality recovery work that can make a real difference to individuals.

Specialists reported that in some cases engagement with GPs has improved as the service becomes more widely acknowledged and the benefit to patients is seen. However, specialists also highlight there are still some GPs to reach – it can take a long time for a new service to make its mark within the NHS so this work should be ongoing if the pilot was to be commissioned.

“You need to kind of promote it. I felt like that, so it wasn’t there laid out for us. We’ve had to actually be, carve a road all of us in different areas, carve a sort of road and yeah it takes quite a lot.”(P005)

When speaking with specialist at the follow-up interview, it also became clear how the job had changed over the course of the pilot. In speaking with the specialists early in the pilot, the majority of the work focused on building relationships with other professional, establishing systems and protocols, and educating others on what the role entailed. Naturally as the service has progressed, and more organisations are aware of the role, emphasis seems to have moved away from liaison work towards more one-to-one work with patients. This change also reflects the success of the service in that more patients are being discharged to primary care. However, alongside this increase specialists also expressed new concerns regarding capacity and highlighted the need for staffing levels to be considered if the pilot was to be commissioned.

In reflecting on the service, a number of challenges about how the service will be developed in the future were raised. A number of these concerns reiterated those voiced in the initial interview- for example, patients with social care packages, adequate protocols in place, and the arrangements for patients with depots. Alongside these concerns specialists expressed concern for the future of the service. At the time of conducting the follow-up interviews, specialists were unsure as to whether the pilot would continue. Specialists expressed concern about what would happen to patients if the service was withdrawn and no firm plans were in place.

Summary

The role of the PCMHS is seen as twofold- to build relationships with other mental health professionals and to support patients’ transition from secondary to primary care.

The overarching conclusion drawn from the 13 interviews is that the service provided by PCMHS does fulfil these two criteria and, crucially, benefits patients while providing a bridge between primary and secondary care, and between patients and secondary care. Regarding implementation of the pilot a number of concerns were raised around accessing appropriate patients, protocols, safe working practices, data storage, and capacity; however, these concerns did not affect the positive benefits of the service regarding patients’ mental health and wellbeing.

4. Analysis of responses from other professional groups

Another important facet of the evaluation was to collect the opinions of other professionals who, through their work, had experienced the pilot- for example, GPs, Psychiatrists, and CPNs.

Methods

To this end, a brief questionnaire was developed by the evaluation team and placed online using the secure Qualtrics® system. The questionnaire probed three keys areas of the pilot: assessing whether the PCMHS role worked well, and whether the PCMHS role and new service benefited patients, while also finally gathering thoughts as to how the service could be improved. Results from these three areas are described below. It contained a combination of Likert-type questions and free text responses that invited the respondents to elaborate further. The questionnaire was forwarded to PCMHS, CCGs, and host organisations (i.e., Invicta Health, mcch) that subsequently cascaded the link to relevant contacts. The link was also posted on local CCG noticeboards.

Participants

A sample of fifty individuals completed the online questionnaire from a range of professions and CCG areas (see Figures 4-1 and 4-2 for breakdown). It was important for the validity of the results that the questionnaire was completed by individuals who had knowledge of the pilot and/or worked with the PCMHS. Importantly, 100% of respondents reported they were aware of the pilot and 92.0% ($n = 46$) reported working with a PCMHS. From these figures, we were confident this sample represented a group of individuals appropriately experienced with the pilot.

Figure 4-1 Professional breakdown of respondents to online questionnaire

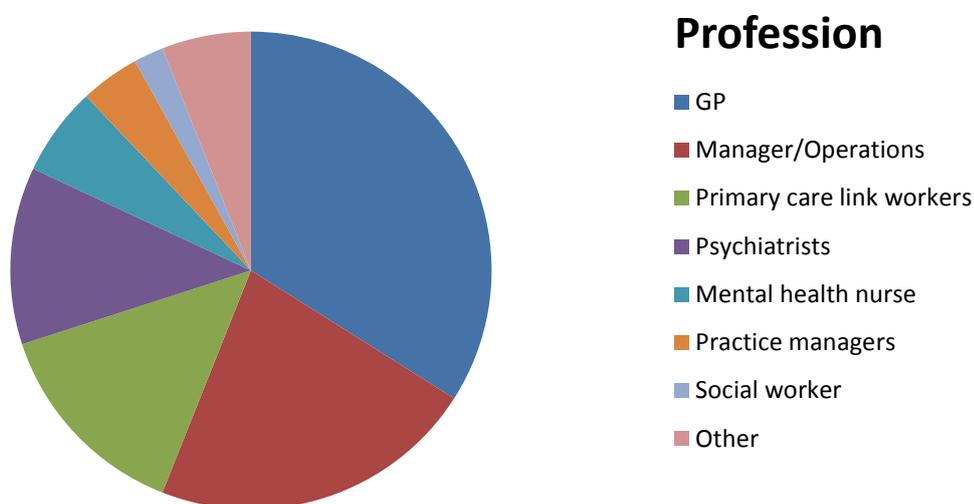
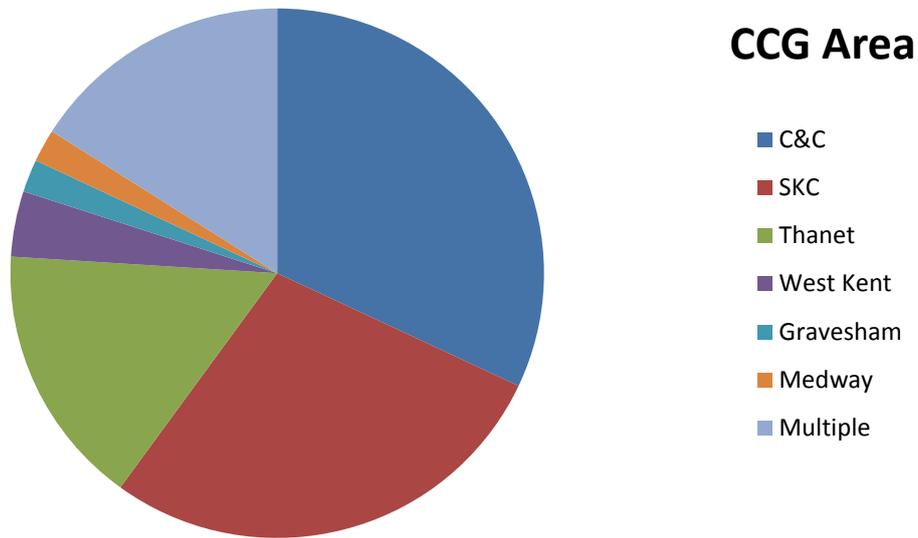


Figure 4-2. CCG breakdown of respondents to online questionnaire

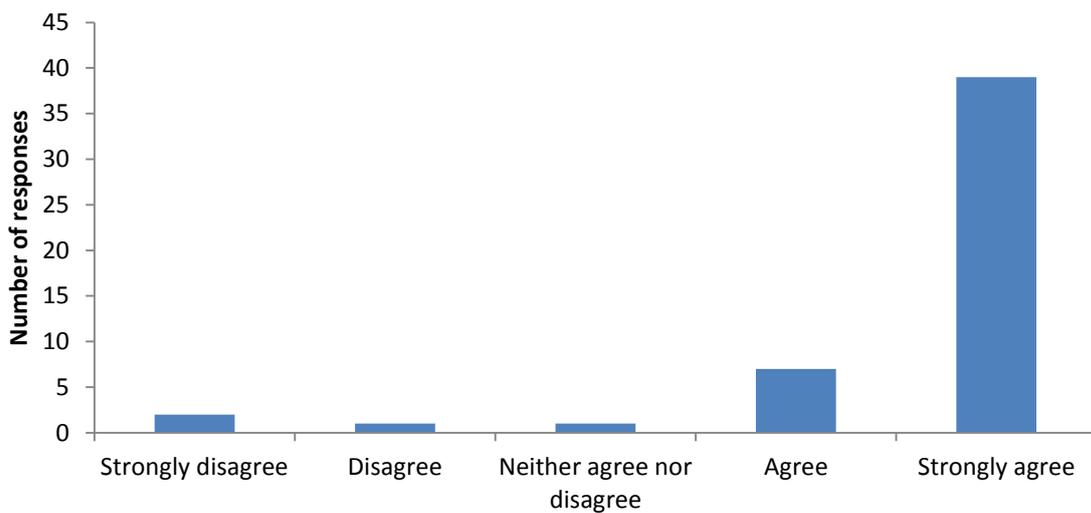


Results

Assessment of PCMHS role

Question 1 asked “*In your view do you think the PCMHS role works well?*” and was scored on a Likert-type scale from 1 (Strongly disagree) to 5 (Strongly agree). Figure 4-3 shows a breakdown of responses to this question.

Figure 4-3 Breakdown of responses for Question 1.



Key points from the responses to Question 1.

- Mean response across the sample was 4.60 ($SD = .95$);
- 92% ($n = 46$) of respondents either agreed or strongly agreed that the PCMHS role worked well;
- 6% ($n = 3$) of respondents either disagreed or strongly disagreed that the PCMHS role worked well.

Respondents were also asked to elaborate on their assessment of the role, with 44 of the 50 respondents providing some feedback. Regarding the answers for those who assessed the role as ‘not working well’, two of the comments conflicted with the initial view with both expressing positive aspects of the pilot- for example, highlighting the expertise the PCMHS offer and their ability to facilitate a smooth discharge from secondary to primary care services. The third comment was more in line with the initial assessment, highlighting a lack of contact with the PCMHS as a reason for the dissatisfaction.

Regarding the reasons why respondents thought the PCMHS role worked well, **five** key themes emerged from the free text responses:

- PCMHS help prevent relapse and/or readmission to secondary care;
- Patients benefit from the service;
- The pilot provides an opportunity to work together across professional groups;
- The type of service (e.g., consistent support, speed of response) provided by the PCMHS;
- The service helps reduce the gap between primary and secondary mental health care.

Preventing relapse and/or readmission in to secondary care, was the most frequently cited reason as to why the PCMHS worked well. Having a PCMHS in place often allowed for patients to access the help they needed quicker than previous. In addition, the type of care provided by the PCMHS – consistent, one-to-one, and easily accessible- allowed for potential declines in mental health to be detected earlier and further deterioration prevented.

Responses illustrating this theme came from across professional groups- for example:

“It simply prevents relapse through early detection of relapse indicators. The primary care specialist kept closely monitoring and we worked together to prevent relapse and rehospitalisation.” (P024, Psychiatrist)

“The clients with whom I have joint worked have found the service incredibly supportive and I believe this support is invaluable to preventing people from having to re-enter secondary services”. (P017, Primary Care Link Worker)

Supporting the assertion that PCMHS help to prevent relapse, a second theme emerged around how beneficial the service is seen to be for patients. A number of responses indicated receiving positive feedback, while some offered specific examples:

“Patients have expressed satisfaction with the service and it has provided care to patients to enable them to begin to engage with community services” (P006, Operations/Management)

“A patient was discharged when improved but was still having problems. As a result of the mental health specialist, she was well monitored and feels safe in the community setting.” (P047, GP)

A number of responses also highlighted how the pilot has provided the opportunity to build relationships with other professions and, in doing so, encouraged a more co-ordinated approach to the management of patients care. For example:

“I can highlight patients in crisis or those not attending and often they (the PCMHS) know what is going on and avoid duplication of tasks.” (P019, GP)

“By attending one of our team meetings and giving a clear explanation of their role and how they fit in with secondary and primary care. Our counsellors felt supported by them, and, as a team, felt we had a named person to consult with should issues arise” (P043, Operations/Manager)

The type of support provided by PCMHS and the design of the pilot service was complemented by a number of respondents, with recognition that providing mental health care in a primary care setting can benefit certain groups of patients. The quotes below illustrate the type of feedback classified under this theme:

“I have patients who do not want to go to secondary care mental health service because they did not have good experience with the service. However they were very receptive to receive support from the primary care mental health specialist in the community.” (P045, GP)

“They (the PCMHS) provided on-going support for clients who no longer require the intensive mental health treatment and care but who still require some level of monitoring, treatment and care. This allows clients who would have remained in secondary care to be discharged which is both positive for the client to see their progress and also for the service to have more space to see clients who require more intense care.” (P037, Care Coordinator)

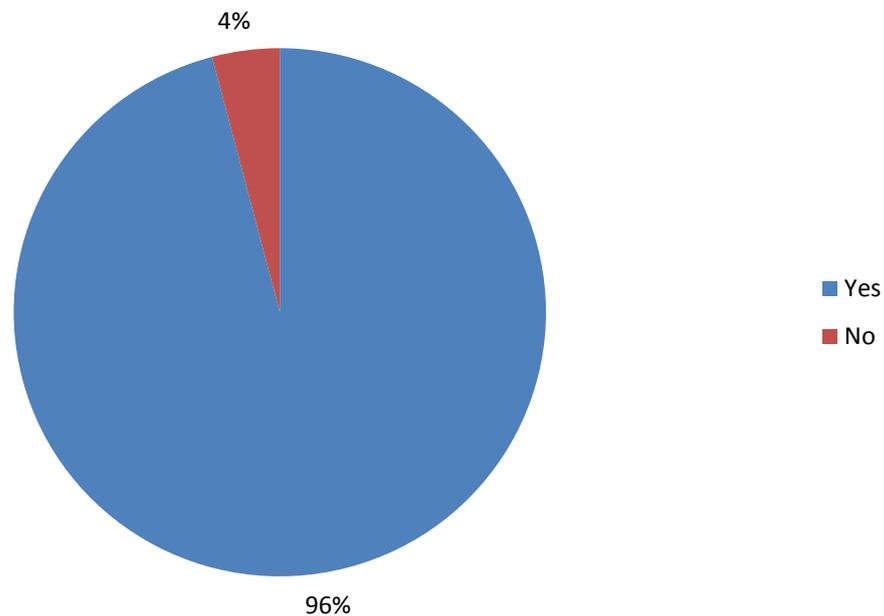
The final theme to emerge highlighted how the PCMHS can impact on a patients’ transition between primary and secondary mental healthcare services. Responses illustrated the positive effect of the PCMHS on this process- for example, emphasising how the specialists act as a bridge, for patients and professionals, between primary and secondary care. Furthermore it was acknowledged that having this ‘bridge’ enabled a smoother transition between services and therefore benefited the patient.

“Primary care mental health specialists are a key tool to help our patients adjust to the transition to primary care whilst still having preferential access to mental health services.” (P026, Consultant Psychiatrist)

How has the new service benefited patients?

Question 2 focused on whether the new service benefited patients and, if so, what these benefits might be. Accordingly, respondents were asked to answer ‘yes’ or ‘no’ to the following question: *‘In your view, have patients benefited from the support provided by the PCMHS?’* Figure 4-4 shows a breakdown of responses to this question.

Figure 4-4 Breakdown of responses for Question 2: Do you think patients have benefited from the support provided by PCMHS?



Key points from the responses to Question 2.

- 96% ($n = 47$) of respondents indicated they thought patients had benefited;
- 4% ($n = 2$) of respondents indicated they thought patient had not benefited.

Again, respondents were also asked to elaborate on their assessment by providing an example of how the service had either benefited, or failed to benefit, patients. Examples were provided by 42 respondents.

Taking the two respondents who indicated that they did not feel the service had benefited patients- one indicated they had not received any feedback from patients, so did not feel they could accurately comment, while the second expressed they were unable to decide so chose the ‘no’ option.

Regarding the reasons why respondents thought the PCMHS role benefited patients, **three** key benefits to patients emerged from the free text responses:

- Location of the appointments;
- Improvements in quality of life;
- Reduction in anxiety regarding transition from secondary to primary services;

Regarding the first benefit- location of appointments, respondents emphasised that providing appointments in a familiar community setting (i.e., either at home or in local GP surgeries) seemed to be appreciated by patients. For example, respondents emphasised:

“They (the patients) appreciate the local appointments in the practice- it’s a seamless process.” (P005, Practice Manager)

“The patients are seen in their own environments.” (P010, Consultant Psychiatrist)

Improvements in well-being and quality of life were also cited as an example of how patients had benefited. Some responses did not contain specifics, instead referring to a ‘general’ improvement in patients who had been referred to the PCMHS. However some also provided more details, highlighting patients who could now lead more independent and fulfilled lives as a consequence of the support provided by PCMHS. For example:

“Many (patients) have avoided eviction and entered the community in a positive way.” (P032, Inclusion worker)

Furthermore, improvements in patient quality of life were seen as a result of patients being empowered by the specialists to understand and manage their mental health needs. For example, responses emphasised:

“.....Individuals are taking responsibility of their own recovery and linking in with community resources.” (P003, Operations/Management)

“A service user was discharged to shared care. This has worked well for the service user and feels more empowered.” (P015, Member of CMHT)

Finally, building on a previously identified theme regarding how PCMHS facilitate a smoother transition between secondary and primary care, respondents indicated how this improvement benefited patients by decreasing the anxiety about the transition. For example:

“The transition for patients who have been supported in secondary care to primary care is anxiety provoking and has led, for some patients, their mental health deteriorating - the support provided by the mental health specialists ensures that the transition and discharge process runs smoothly and patients are reassured throughout.” (P002, Operations/Management)

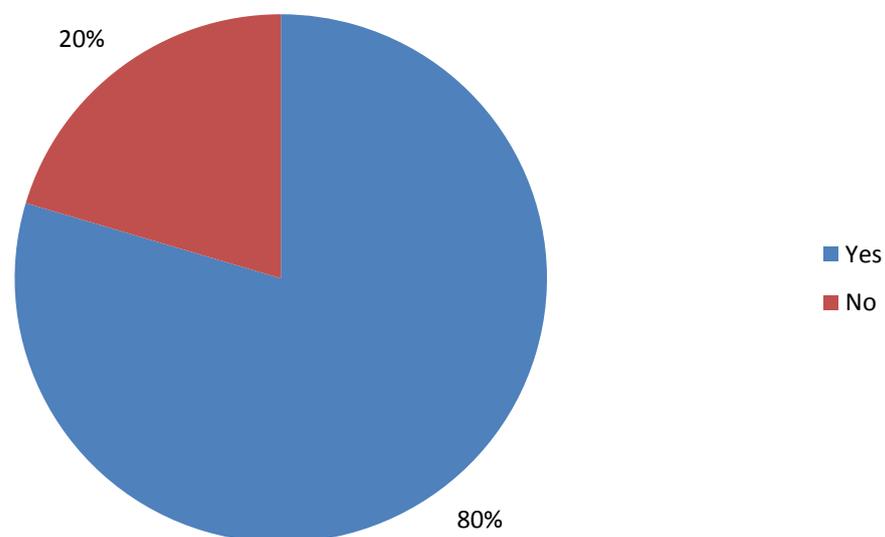
“Patients feel safer during the transition and are not reluctant to leave secondary services.” (P026, Consultant Psychiatrist)

How do you think the service could be improved?

As this is a pilot project, it was also essentially to assess views on how the service and role could be improved upon. Accordingly Question 3 probed first whether improvements could be made to the service and secondly, what these improvements might be

Accordingly, respondents were asked to answer ‘yes’ or ‘no’ to the following question: *‘In your view, are there any improvements that could be made to the specialist role and/or service?’* Figure 4-5 shows a breakdown of responses to this question.

Figure 4-5 Breakdown of responses for Question 3: Are there any improvements?



Key points from the responses to Question 3.

- 80% ($n=39$) of respondents indicated improvements could be made;
- 20% ($n=10$) of respondents indicated no improvements were necessary.

None of the 10 respondents who indicated the service required no improvements provided any further comment. Regarding those respondents who indicated an improvement, all 39 went on to provide specific examples. These responses were categorised in to **four** themes:

- Increasing capacity;
- Widening of job description/responsibilities of PCMHS;
- Practical elements of the pilot (e.g., IT, protocols, safeguarding);
- Increasing presence.

Regarding increasing capacity, this theme encompassed a number of areas in which respondents indicated an ‘increase in capacity’ would improve the service- for example, employing more specialists, expanding eligible clusters and the number of GP surgeries covered. For example:

“With more practitioners this service may be able to take referrals from primary care reducing referrals to secondary services.” (P025, Mental Health Nurse)

“To expand the role and not just to restrict them for clusters 7,11 & 12.I hope they will be able to see patients with complex needs that they are not in those specific clusters, (but are) too complicated for GPs & IAPT services to look after and do not meet the criteria for secondary mental health services.” (P009, GP)

A number of responses reiterated frustrations expressed by the PCMHS regarding shared care patients and those on depot injections being unable to easily access the PCMHS (or shared care as it is referred to in the quote below). An example of this is illustrated in the quote below:

“Only a small number of service users have managed to go to shared care on this medication. Service users who are settled with a care package are not able to be discharged to shared care.” (P015, Member of CMHT)

Widening the responsibilities of the specialists was a second improvement cited, with specific additional duties potentially facilitating an improved service- for example:

“They (the PCMHS) should be in the position to reject inappropriate discharges from the secondary care and should be able to re-refer patients back to the secondary care, bypassing GPs.” (P045, GP)

“They (the PCMHS) could be given more autonomy to sign off personal health budgets.” (P033, Primary Care Link Worker)

“Perhaps widening the triage role in primary care, and also being able to assess those who IAPTS find difficult” (P036, GP)

A number of practical concerns were also highlighted, and in some cases mirrored those expressed by the specialists themselves- for example, not having adequate protocols in place and difficulties accessing IT systems and records across primary and secondary care.

“Basic structures are not in place for everybody involved to understand the processes.” (P014, Psychiatrist)

“It would work better if they had joint access to Rio to ensure seamless handovers and better communications” (P030, CPN)

Finally, as mentioned in Question 1, some respondents felt disconnected from the new service and would benefit from more personal contact with the PCMHS.

5. A Unit Cost Analysis for Primary Care Mental Health Specialist Service

A unit cost analysis was conducted to understand the amount of additional resources needed for a patient to receive care from the Primary Care Mental Health Specialist (PCMHS). A unit cost can be defined as:

‘The total costs (over a month period) associated with the PCMHS divided by the number of patients.’

A unit cost analysis does not take into account the costs associated with the services/care a patient *normally* receives; however, it is still an important measure as it provides information on the *relevant* costs associated with the PCMHS. It also assists policy makers to decide whether it is possible to implement this service on a large scale, given the resources they have.

Methods

Accordingly for the purpose of this evaluation, a unit cost analysis is performed from a health service perspective, hence only costs associated with implementing the PCMHS service are considered. This analysis does not take into account the costs relating to societal inputs (e.g., carer support), whether or not these costs are associated with receiving the service. In addition, it was noted that specialists are expected to attend additional events organised by local Clinical Commissioning Group (CCG), and the analysis needs to take into account the costs associated with attending these events. Therefore, the main unit costs we are interested in are:

- **The monthly unit cost per patient for receiving the PSMHS service (based on the data of October 2014);**
- **The monthly unit cost per specialist for delivering additional events (based on the data of October 2014).**

Study design and data collection

A total of 11 specialists were asked to record their activities from 1 October 2014 to 31 October 2014 using Time and Activity Recording Sheets (TARS) (Appendix D). The TARS contains three sub-sheets:

- An instruction sheet explaining how the time and activity of a specialist should be recorded;
- A patient sheet (template) explaining the activity categories that need to be recorded (this sheet should be recorded separately for each individual patient);
- An additional activity sheet recording various activities organised by CCGs and time spent on liaison with CCGs (e.g., Awareness Day) in October 2014;
- A summary sheet which summarises specialist's time and activities for all patients in October 2014. (All sub-sheets can be found in Appendix D)

Before disseminating the TARS, a pilot questionnaire was disseminated and tested among the specialists. A meeting which involved six specialists and the health economist was also held to discuss the questionnaire. Comments from the specialists were taken into account in designing the final questionnaire.

Measurements

Cost measures for the PCMHS were collected for the main categories described in Table 5-1. Information was then summarised in an excel sheet, and analysed using STATA 13 software. The analysis distinguishes main activity (i.e., contact with patients), and additional activities (i.e., additional events organised by CCGs as well as time spent on liaison with CCGs).

Table 5-1. List of measurements

Major Activities
Number of patients Screening time Number of new patients Contact hours Number of sessions delivered Preparation time for sessions Fuel costs for additional events Travel time Time spent on admin tasks Number of patients being discharged
Additional activities
Time spent to liaison with GP and CCP Time spent on additional events Number of additional events Travel time for additional events Fuel costs for additional events
Monthly salary

Analysis

The monthly unit cost per patient receiving support from a PCMHS is calculated as **the cost for a consultation, multiplied by the average number of sessions a patient receives for a month.**

The monthly unit cost per specialist for delivering additional events is calculated as **the cost for delivering a session multiplied by the average number of events a specialist delivers for a month.**

In order to calculate these unit costs, the analysis calculated the following cost items:

- average hourly cost for a specialist time;
- average cost per patient consultation session;
- average cost per additional event;
- average cost for screening a new patient;

Finally, the unit cost accounted for the specialist' salary and travel costs. Information on specialists' salary was provided by local commissioners, and was adjusted by the actual number of days they worked in October.

Results

Table 5-2 displays the summary statistics of the data. Key points from this table are:

- The average number of working days per specialist was 16.64 days;
- The average number of working hours was 137.14 hours (based on 20 working days in October 2014);
- A total of 399 patients (including new and discharged patients) received the PCMHS intervention in October 2014. Each specialist covered 36 patients. The average cost for one hour of the PCMHS time was **£15.95**.

Table 5-2. Summary statistics by CCGs

CCG (# Specialist)	# Working days per specialist	# Patients	# Patient per specialist	# Total working hours per specialist	Cost per hour
Canterbury (N=2)	15.50	60	30.00	134.00	15.79
Dartford (N=1)	8.00	45	45.00	83.00	10.12
Medway (N=3)	16.67	98	32.67	136.83	15.75
South Kent (N=1)	17.00	40	40.00	139.50	18.04
Swale (N=2)	20.00	59	29.50	178.25	12.43
Thanet (N=2)	18.50	97	48.50	125.52	21.82
Average (N=11)	16.64	399	36.27	137.14	15.95

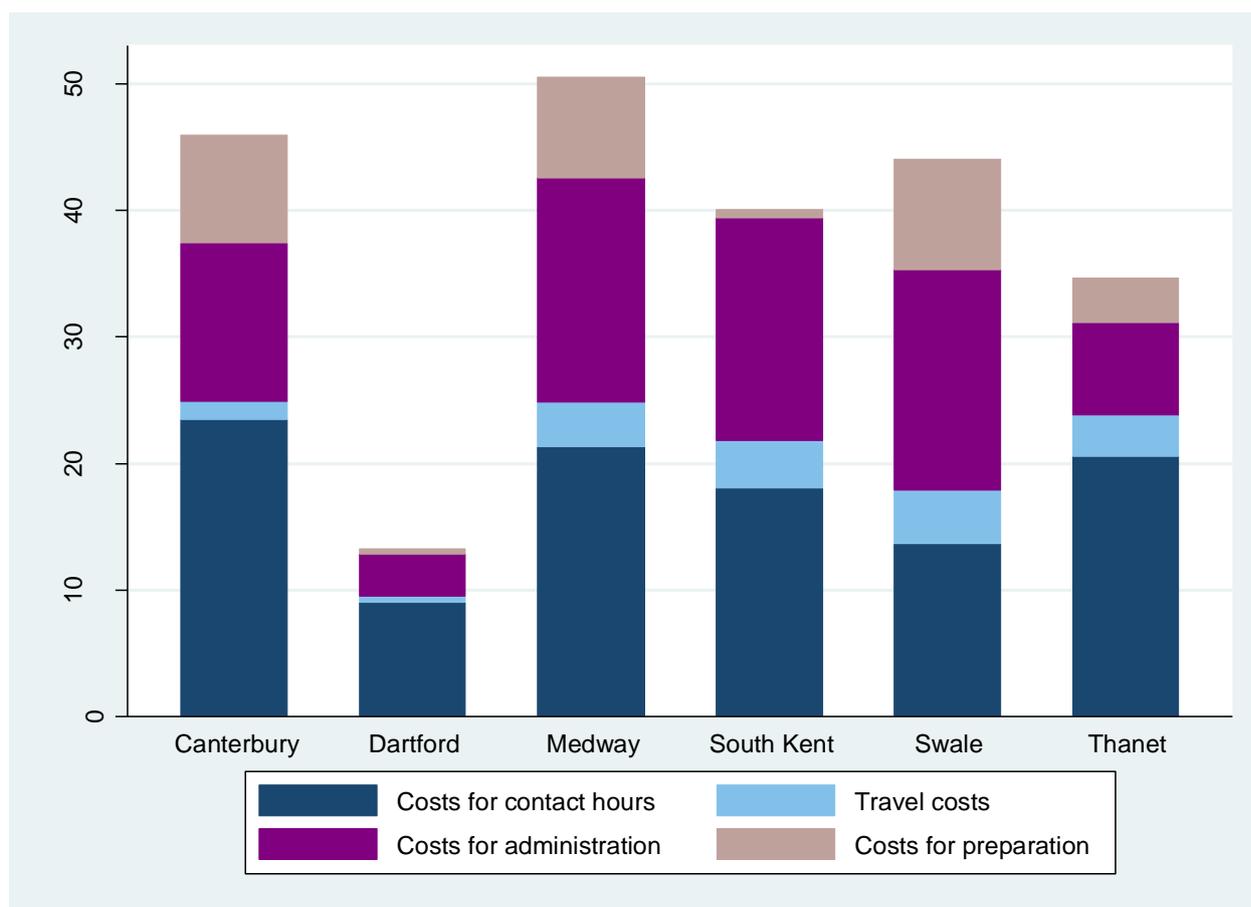
Table 5-3 displays the summary statistics of the main activities (i.e., patient consultation) and the related costs. In October 2014, each specialist delivered an average of **36.36 sessions**. On average, each session lasted for **2.93 hours**, with a cost of **£41.28**.

Table 5-3. Summary of the main activities

CCG (# Specialist)	# Sessions per specialist	Hours per session ²	Costs per session ³
Canterbury (N=2)	36	3.49	45.93
Dartford (N=1)	45	1.71	13.26
Medway (N=3)	30	3.26	50.52
South Kent (N=1)	40	2.59	40.06
Swale (N=2)	33.5	3.64	44.04
Thanet (N=2)	43	1.93	34.65
Average (N=11)	36.36	2.93	41.28

Figure 5-1 shows the per session cost broken down into different categories (i.e., contact hours, travel time, administration time, and preparation time). The finding shows that contact hours and administration are the major costs associated with delivering a patient session.

Figure 5-1. Costs per session by CCGs (£)



² Hours per session includes contact hours, travel time, time for preparation and administration time.

³ Hours per session includes costs or contact hours, travel, preparation and administration.

Table 5-4 shows the time and costs for screening a new patient. The screening process lasted for **1.40 hours** with a cost of **£20.92** per patient.

Table 5-4. Cost for screening a new patient

Hours spent on screening a new patient	1.40
Costs for screening a new patient	20.92

Table 5-5 shows the summary characteristics for additional activities—number of additional events, average hours spent per additional events, and time spent on liaison with CCGs per specialist. In October 2014, each specialist attended an average of **3.45** additional events. Each event lasted for approximately **6.98 hours**, with a cost of **£121.87**.

Table 5-5. Summary statistics for additional events

CCG	# Additional events per specialist	Average hours spent per additional event	Average cost per additional event	Hours on liaison with CCGs per specialist
Canterbury (N=2)	1.00	1.50	17.60	3.00
Dartford (N=1)	4.00	0.50	8.06	2.00
Medway (N=3)	3.67	11.83	196.79	7.33
South Kent (N=1)	3.00	7.50	171.42	12.00
Swale (N=2)	3.50	11.20	160.32	5.00
Thanet (N=2)	5.50	3.94	107.41	8.00
Average (N=11)	3.45	6.98	121.87	6.2

Figure 5-2 shows the per session cost broken down into different categories (i.e., contact hours, travel time, administration time and preparation time). The finding shows that contact hours and administration are the major cost items associated with delivering a patient session.

Figure 5-2. Costs per additional event by CCGs (£)

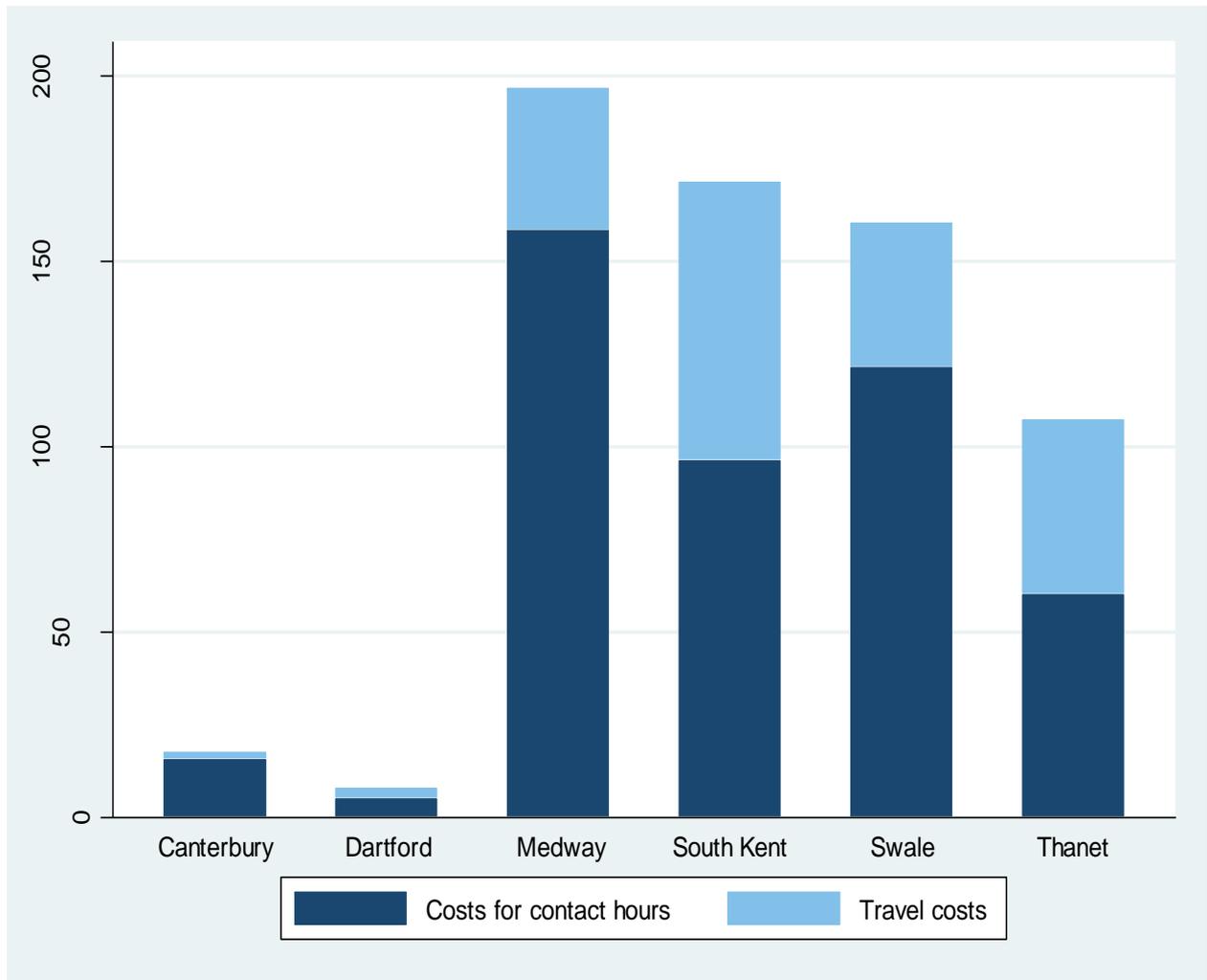


Table 5-6 shows the monthly unit cost per patient for consultation sessions and monthly unit cost per specialist for delivering additional events. On average, monthly unit cost per patient for delivering patient consultation sessions is £73.01, and monthly unit cost per specialist for delivering additional events is £607.41.

Table 5-6. Unit costs by CCGs

CCG	Monthly unit cost per patient for PCMHS support	Monthly unit cost per specialist for delivering additional events
Canterbury	91.54	82.81
Dartford	82.90	131.20
Medway	103.43	887.75
South Kent	55.44	859.73
Swale	49.80	603.63
Thanet	35.92	827.23
Total	73.01	607.41

Note: the unit cost estimations are based on full time and 20 working days per month. The estimations do not take into account of annual leave.

Conclusion

- The unit cost analysis found that the hourly cost for a specialist time is **£15.95**, and each patient consultation session cost **£41.28** to deliver. The typical unit costs per patient, for a month were **£73.01**.
- The average cost for delivering an additional event is **£121.87**. The unit costs per specialist for delivering additional events (per month) are **£607.41**.

This analysis has limitations: First, the data were collected from 1 October 2014 to 31 October 2014. The time period may not be representative because patient activities may vary across the years. It would be ideal to collect data for a period of six months or more to allow enough variations in the data, and consequently more robust estimations. Second, the data collected were self-report data and can be open to bias from those completing. However, these are imitations of most health care measurements in the absence of other possible objective variables.

6. PCMHS activity data

Methods

Activity data was collected from PCMHS in each of the six participating CCG areas. For the purpose of the evaluation we have utilised data collected April 2013- March 2014 (Year 1) and data for the first two quarters of 2014- April- September (Year 2) and focused on two key areas: discharge from secondary care in to primary care and readmissions in to secondary care.

Data

Discharge from secondary care

Tables 6-1 and 6-2 summarise data on the first key outcome of the pilot -discharge of patients with stable long term mental health long term conditions from secondary care services in to primary care.

Table 6-1 Activity data: Discharged patients for Year 1 (April 2013- March 2014) in clusters 7, 11, and 12 by CCG area.

CCG	Month started (2013)	Total number of patients discharged from KMPT now in primary care				Target Year 1*
		Cluster 7	Cluster 11	Cluster 12	Total	
Canterbury & Coastal	Feb	15	38	14	67	57
Dartford Gravesham & Swanley	Mar	11	39	3	53	50
Medway	Sep	24	24	2	50	55
South Kent Coastal	May	12	28	5	45	45
Swale	Aug	3	13	5	21	38
Thanet	Apr	26	16	13	55	49
Total		91	158	42	291	294

*Targets for Year 1 were increased during Q3, 2013-2014

Table 6-2 Activity data: Discharged patients for Year 2 (April 2014- September 2014) in clusters 7, 11, and 12 by CCG area.

CCG	Total number of patients discharged from KMPT now in primary care			
	Cluster 7	Cluster 11	Cluster 12	Total
Canterbury & Coastal	2	12	5	19
Dartford Gravesham & Swanley	4	17	1	22
Medway	14	19	3	36
South Kent Coastal	15	17	4	36
Swale	10	6	6	22
Thanet	10	5	3	18
Total	55	76	22	153

Key points:

- The number of patients discharged from secondary in to primary care, across the six CCGs, for Year 1 was **294** and **153** in the first two quarters of Year 2;
- In Year 1 four CCGs either met or exceeded their target;
- The Year 1 number fell marginal short of the overall target ; however, it should be noted that two CCGs (Swale & Medway) did not start to take patients until relatively late in the year (August & September respectively) so this would impact on their numbers compared to CCGs areas who started earlier in the year (i.e., Canterbury & Coastal);
- As highlighted in the analysis of the PCMHS interviews, some PCMHS described a slow start, in terms of numbers of discharges at the beginning of the pilot. However, over time, the process of identifying and accessing patients became easier and quicker as the service has developed;
- Regarding clusters, in Year 1 **31.3%** of patients discharged came from **Cluster 7**, **54.3%** from **Cluster 11**, and **14.4%** from **Cluster 12**;
- In the first two quarters of Year 2, **35.9%** of patients discharged came from **Cluster 7**, **49.7%** from **Cluster 11**, and **14.4%** from **Cluster 12**.

Readmission in to secondary care

A second key outcome from the activity was to record number of patients who relapsed while under the care of the PCMHS, hence needed to be ‘fast-tracked’ back in to secondary care.

Table 6-3 displays the patient numbers recorded.

Table 6-3 Activity data: number of patients ‘fast-tracked back to secondary care in Year 1 and Year 2 (April 2014-September 2014) by CCG area.

CCG	Total number of patients ‘fast-tracked’ back in to KMPT		
	All Clusters (7, 11, & 12)*		Total
Year	1	2	3
Canterbury & Coastal	11	5	16
Dartford Gravesham & Swanley	2	0	2
Medway	2	4	6
South Kent Coastal	2	6	8
Swale	0	1	1
Thanet	2	5	7
Total	20	23	43

*Data not collected by individual cluster

Key points:

- A relatively low proportion of patients referred in to primary care from KMPT were fast-tracked back- **6.8%** (Year 1) and **15%** (Year 2);
- The activity data sheet did not ask PCMHS to identify why patients had been fast-tracked back so we are not able to elaborate further on the circumstances that led to the readmissions.

7. Summary

The research team at CHSS were commissioned to provide an evaluation of the PCMHS service piloted in Kent and Medway. To fulfil this aim a mixed-method approach was utilised to explore the impact of the new service from a number of different angles (i.e., patients, PCMHS, other professionals) and provide some financial context to implementing the new service.

In the original proposal the research team had also hoped to gather feedback from carers of patients; however, this proved difficult to implement and resulted in no carers willing to come forward and participate. We did receive initial expressions of interest from a number of carers; however when the researcher tried to follow-up calls were not returned.

Various reasons may have contributed to the reluctance of carers to come forward- carers may have not known about the service, they may have felt uncomfortable about discussing the patient's condition; the interview may have been viewed as too time consuming or difficult to arrange. However it is difficult to comment with any certainty as the research team did not receive any feedback as to why this group were so reluctant to engage.

Nevertheless the evaluation reached a broad scope of individuals to assess the impact of the new service and produced a valid, reliable, and thorough evaluation of the service. The key findings are summarised below:

- 12 patients were interviewed as part of the evaluation and all expressed positive changes in their life as a consequence of the care received from the PCMHS service;
- Specific benefits highlighted by patients included reduction in feelings of loneliness, reduction in stress and anxiety levels, and improved confidence in coping with their illness;
- All 12 patients felt satisfied with the service provided, highlighting how the service was an improvement on previous care received. Reasons given for this focused on improved continuity of care, opportunity to build relationships with professionals contributed to a feeling of a 'safety net' - ultimately preventing relapses and readmissions to secondary care;
- 13 PCMHS across 6 CCGs were interviewed to explore the implementation and impact of the new service. The role of the specialist was primarily seen as two fold- building relationships with professionals, educating them about the role and working one-to-one with patients;

- The PCMHS report consistent support for the service and the positive impact it has on patients. Prevention of relapse, speed of response, providing a bridge for patients and professionals, and providing patient-centred care were consistently noted as benefits;
- PCMHS also offered feedback on the implementation of the pilot. While the introduction of the service was viewed as a positive move, concerns were expressed regarding protocols and safe working practices, the service not being available to patients with social care packages, access to appropriate IT systems, and ongoing capacity to increase workloads;
- Overall a positive view was expressed from other professional groups about the PCMHS service, with **92%** of respondents indicating the PCMHS role worked well and **96%** of respondents agreeing the PCMHS service benefited patients;
- The benefits of the service cited by the other professional groups often overlapped with those identified by the specialists themselves- for example, contributing to prevention of relapse, reducing the gap between primary and secondary care, and facilitating consistent one-to-one support for patients;
- Furthermore the patients also recognise similar positive impacts- for example, the view that PCMHS provide a trusted support network for them;
- When asked about improvements, increasing capacity of the service, improving protocols, and widening the PCMS job description were suggested;
- A unit cost analysis established that the hourly cost for a specialist time was **£15.95**, and each patient consultation session cost **£41.28** to deliver. The typical unit costs for the PCMHS service, per patient (for a month) were calculated at **£73.01**.
- Analysis of the activity data showed that in Year 1 of the pilot, the target number of patients to be discharged from secondary care in to primary care reached **99%**;
- Activity data showed Cluster 11 patients to be proportionally the largest group of patients discharged to the PCMHS service in Year 1 (**54.3%**) and Year 2(**49.7%**).

In conclusion, responses collated as part of this evaluation reflect a positive impact for both patients and mental health services in the locality. Reassuringly responses from the three main groups- patients, PCMHS, and other professionals- overlap in how they view the service to impact on patients. Importantly patients recognise the similar benefits to those highlighted by the professional groups, validating these responses. The overarching theme

from this evaluation is the notion of PCMHS acting as a ‘bridge’ between patients and services and how prior to this service, such a ‘bridge’ did not exist.

References

Department of Health (2011) No Health without Mental Health: A cross government health outcomes strategy for people of all ages.

Department of Health (2013) Mental Health Payment by Results Guidance for 2013-14

Appendix A: Patient interview guide

PCMHS Patient interview schedule

Explain about the evaluation, and what is expected from the interview (talking through the information sheet)

Ask if it is ok to record the interview

Ask if they have any other questions

Sign consent form

1. Background information about use of services

- Can you tell me a bit about the types of mental health care or support you received from the NHS?
- Do you receive any other mental health care and support outside of the NHS? For example, support from voluntary organisations (e.g. Samaritans), charities (e.g. Rethink Mental Illness or Mind), family or friends?

2. Moving of care or support from your GP surgery

- I understand that the mental health support you receive has changed and is now provided through your GP surgery. Is this correct?
- How long ago was this change to your care?
- Who was involved in this change?
- Can you explain how this change happened?
- How did you feel about this change?
- What were your hopes and aspirations for mental health support from your GP surgery?

3. Contact with GP services for mental health needs

- Can you tell me of any notable changes to your mental health care since it moved to your GP surgery?
- Can you tell me more about the care you have received since then?
 - probe who they see and what they thought
 - Probe how often
 - Probe what treatment they receive and what they thought about it
 - probe to discover what time points were crucial

4. Experience of GP service

How does the mental health care received from your GP differ from the mental health care you experienced in the past?

- Can you tell me some of the things you've liked about receiving your mental health care at the GP surgery?
- Have you experienced any disappointments in the mental health care you received at your GP surgery?
- If so, would you mind telling me a bit more about the disappointments you experienced?
- Do you think you have benefitted in any way from your care now being provided by your GP surgery or not?
- [ask following only if move positive?] Do you think you could have been moved back to your GP earlier than you were, with the right support?

5. Impact of the change of service on your life

- How else did your life change as a result of your care now being provided by your GP surgery?
- Are there any other services that you use for support?
- Has support needed from these services changed?
- What changes have you noticed in your life since receiving care from your GP surgery? [see NB below]

(probe if needed: how? your health ? in a good or bad way?)

- How has this change affected support from family or friends?
- What are your hopes and aspirations for future mental health services?
- What are your hopes and aspirations for you personally?

[NB: Mental health, life skills, safety & comfort, physical health, exercise & activity, purpose & direction, personal network, social network, valuing myself, participation & control, self-management, hope for the future (recovery outcome indicators I ROC tool).

6. Reflection Overall

- On reflection, do you think you receive the care that matters to you?

- On reflection, do you think the service you receive is appropriate in meeting your needs?
- Overall are you satisfied with the care you are receiving?
- How satisfied do you feel with the mental health support you are receiving from your GP surgery?
- What do you like most about the service?
- What areas do you think this service needs to improve on?
(potential probe if needed: e.g. thoughts on time to get an appointment)
- Are there any other changes you would like to see to the service?
- Do you think your expectations in mental health services have changed since receiving this service?

7. Summing up

- Would you like to discuss anything else about your mental health care experiences?
- Do you have any questions?

Thank you very much for taking the time to participate in the interview.

Further information to discuss following the interview

We will provide them with a summary of the research findings

Ask if it would be ok to follow up with a phone call in around three months if we need to, to find out how they are getting on with the service and how things might have changed, when would be the most appropriate time to call them? e.g. morning or afternoon.

Do they have a carer who would be interested in a telephone interview about the service? For example this could be a family member or support worker if this is relevant [need to establish if in supported living services as part of demographic information collected before interview].

Appendix B: PCMHS main interview guide

PCMHS Specialist Interview Schedule

Explain about the evaluation, and what is expected from the interview (talking through the information sheet)

Ask if it is ok to record the interview

Ask if they have any other questions

Sign consent form

Thank you for seeing me. We want to find out more about the specialist role and your perspective on what the service contributes; but also where there are gaps or development needs.

1. The specialist role

- Can you tell me about your role?
 - How long have you been in post?
 - What are your responsibilities?
 - What expertise offered?
 - What are the different aspects of the role? (Liaison with other service providers, patients, handover meetings GP advice & training, link working with KMPT)
 - Who else do you work with?
 - What is the coverage geographically?
 - Can you describe how you work (working model/processes/link working with KMPT)?

2. Evaluation of the role and overall service

- In your view, how does the specialist role work well?
 - can you give a specific example?
- How does the overall service being provided to patients work well?
 - can you give a specific example?
- In your view, how does the specialist role not work well?
 - can you give a specific example?
 - can you identify how this could be further developed and improved?
 - are there any perceived barriers to achieving this?
- In what ways does the overall service being provided to patients not work well?
 - can you give a specific example?
 - can you identify how this could be further developed and improved?

- are there any perceived barriers to achieving this?
- Can I ask about the patients identified who could have this service but have chosen not to move and remain in secondary care?
 - can you give a specific example?
 - can you identify potential ways of overcoming this?
 - are there any perceived barriers to achieving this?

3. Performance & service monitoring

- I understand you have been completing the template that was provided on a monthly basis [show them the example template-highlight any points from data received for further discussion]
- Are there any other performance indicators that you use or other monitoring of the service?
- How are they reported back?

4. Reflection Overall

- Do you think the aims and objectives set out for the role are being met in practice?
- Has the specialist role been what you expected it to be so far?
- Has the service being provided to patients changed as you expected?
- What are your thoughts for the future of the role and service provision?

5. Summing up

- Would you like to add anything else to our discussion?
- Do you have any questions?

Thank you very much for taking the time to participate in the interview.

We will provide them with a summary of the research findings

Ask if it would be ok if needed to potentially follow up with a phone call later in the evaluation to see how they are getting on and how things might have changed.

If they are an in depth site discuss how they can help to identify patients (and carers) and other practice staff for interview. [May need to discuss the potential of this with other sites if required].

Appendix C: PCMHS guide for follow-up interview

PCMHS Specialist Follow-up Interview Schedule

Ask if it is ok to record the interview

Ask if they have any other questions

Thank you for agreeing to a follow-up interview. The purpose of this interview is to discuss how the role and service has been going since we last spoke.

1. The specialist role

How has your role been going since we last spoke?

Has your role changed at all?

If so, could you provide me with a specific example?

2. Evaluation of the role and overall service

How has the service provided to patients been going since we last spoke?

Has anything changed at all?

If so, could you provide me with a specific example?

3. Reflection Overall

Do you have any final thoughts you would like to mention about your role and/or the service in general?

4. Summing up

Would you like to add anything else to our discussion?

Do you have any questions?

Thank you very much for taking the time to participate in the interview.

Appendix D: Time and Activity Recording Sheets (TARS)- see attached excel spreadsheet

Appendix E: Example activity data sheet

Primary care mental health specialist activity by CCG Q1									
	Q1 2013-14 (April - June)								
	West Kent	DGS	Swale	Medway	Ashford	Canterbury & Coastal	SK C	Thanet	Q1 Total
No. patients in cluster 7 discharged from KMPT now in primary care	0	3	0	0	0	0	0	4	7
No. patients in cluster 11 discharged from KMPT now in primary care	0	5	0	0	0	5	3	4	17
No. patients in cluster 12 discharged from KMPT now in primary care	0	1	0	0	0	2	0	2	5
No. patients in cluster 7 in transitional care arrangements with KMPT	0	0	0	0	0	0	0	0	0
No. patients in cluster 11 in transitional care arrangements with KMPT	0	0	0	0	0	1	0	0	1
No. patients in cluster 12 in transitional care arrangements with KMPT	0	0	0	0	0	0	0	0	0
No. patients in clusters 7, 11 or 12 'fast-tracked' back into KMPT	0	1	0	0	0	4	0	1	6
No. patients in any other cluster	0	0	0	0	0	0	0	24	24
No. of GP referrals screened and signposted to other support mechanisms	0	0	0	0	0	6	4	29	39
No. of GP referrals screened and referred on to KMPT	0	0	0	0	0	5	1	22	28
No. of new patients (not in cluster 7, 11 or 12) seen for short term intervention (up to 6	0	0	0	0	0	9	1	8	18

sessions)									
No. of patients in clusters 7, 11 or 12 already in primary care (discharged from KMPT before service was started)	0	0	0	0	0	0	0	1	1
Total no. of patients seen by the service^	0	23	0	0	0	32	11	120 (37 DNA)	186 (37 DNA)
No. of patients discharged to GP only care	0	0	0	0	0	2	0	9	11
No. of GP practices engaged with the service	0	8	0	0	0	6	8	9	31
No. of times patient-related advice given in the last month (to GP or other Practice staff)*	0	13	0	0	0	23	9	Daily/ almost daily/ on going	45
No. of training or education sessions delivered (formal or informal)	0	3	0	0	0	1	6	1	11
Details of any local project or initiative you are involved in?	0	5	0	0	0	1	0	1	7
Details of service delivery issues arising in the last month or ongoing?	0	2	0	0	0	2	0	3	7
Details of service delivery issues resolved in the last month?	0	1	0	0	0	0	0	0	1
Number of people in post (actual not cumulative) - noting different start dates	0	1	0	0	0	2	1	2	6
General Reports	See individual CCG by month								