

**"Bridging the Gap”: Assessing the Efficacy of Co-Locating a Physical Health Clinic in a Community Mental Health Setting**



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Evaluating the impact and implementation of a Physical Health Clinic (PHC) programme to support chronic physical health conditions in patients with severe mental illness in Kent

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1.0 Executive Summary Report

**Background:** This rapid evaluation study aimed to assess the efficacy of a physical health clinic (PHC) within Laurel House and Kings Road Practice, a community-based mental health service for adults with moderate to severe mental health needs in Kent and Medway, UK. The clinic, led by Dr Will Davis, provides support and treatment for adults aged 18-65 with moderate to severe mental health needs.

The study used a mixed-methods approach, combining audit data and qualitative semi-structured interviews with seven health practitioners involved in the PHC between January and March 2023. This methodological choice was aimed at gaining a comprehensive and holistic understanding of the PHC practice.

**Quantitative Data Results:** The quantitative data shows that the PHC had 170 referrals since its inception and provides high value to the community Mental Health Team. Of the group reviewed (n=87) 37% Did Not Attend (DNA), although this is not uncommon in the mental health sector, it highlights the need for strategies to improve patient attendance and reduce the associated impact on healthcare resources. The core physical health needs discussed in appointments were related to weight management, highlighting a specific demand in this area for service users.

The clinic is focused on providing a service user-centered approach, with the main value being on general reviews of the service user's health and addressing any concerns they may have. In addition, it pays attention to any other concerns the service user may discuss during appointments and can help with any issues related to accessing GP services. The clinic also collects and records Core Physical Health Data during appointments.

**Qualitative Data Results:** Qualitative analysis of the data identified three main themes: Service user Outcomes, Collaborative Working Practices, and Resource Management. The subthemes under Service user Outcomes include addressing health inequality, physical health objectives, service user-centered care, and time. The subthemes under Collaborative Working Practices include the benefits of having a GP in the mental health team, supportive staff culture, clinician skills, knowledge and understanding, risk management, training, experience, development, and support value. The subthemes under Resource Management include communication systems and administration, referral pathways and information exchange, and cost-benefit opportunities.

**Conclusions:** Overall, the evaluation found the PHC to be effective in providing support and treatment for service users with severe mental illnesses. The clinic's service user-centered approach and collaborative working practices contributed to positive outcomes for service users, additionally there were opportunities identified that have cost-benefit saving to primary health, particularly within the area of weight management advice, and the gathering of Physical Health Core Data.

Findings also suggest that the combination of the in-house clinic together with the expertise of the PHC GP has high value from the perspective of the Community Mental Health Team. However, resource management could be improved, particularly in the areas of communication systems and referral pathways, potentially addressing the DNA rates. The report recommends that the physical health clinic continues to be offered within Laurel House, and further research is needed to assess the long-term impact on service user outcomes.

**The Key Recommendations** are discussed in depth in section 6.0. In summary the key recommendations are:

1. **Ensure adequate resourcing:** Ensure all resourcing needs are costed into any future delivery models, including GP trainee costs and supervision times.
2. **Expand accessibility of care:** An afternoon clinic is recommended, making service more convenient for the service users, potentially reducing the rate of DNA’s, and increase the clinic’s cost-effectiveness.
3. **Promote collaboration and build awareness:** it is recommended that mental health and physical health services promote collaboration and foster collaborative working practices to ensure integrated care for service users.
4. **Maintain and prioritise longer Clinic GP appointments** in any future delivery model. Additional time given for appointments is the largest benefit enabling service users to engage.
5. **Utilise the weight management opportunities:** The largest proportion of referrals and discussions within appointments concerned weight management.
6. **Tighten up referral routes:** Any future delivery model needs more systematic referral routes.

1. **Monitor and evaluate success:** Monitor and evaluate the success of the PHC as it is rolled out to other areas, to help identify areas for improvement and ensure that the clinic is meeting its objectives.

**Key Terms** used throughout the report:

PHC- Physical Health Clinic

LTHC – Long Term Health Condition

SMI – Serious Mental Illness

2.0 Background (Case Study of PHC)

2.1 Supporting literature

People with serious mental illness (SMI) have lower life expectancies by 13-30 years (Piatt, Munetz & Ritter, 2010). Around 60% of this mortality gap is due to physical health (De Hert et al., 2011). A meta-analysis looking at causes of death in those with Schizophrenia found the standardised mortality ratio for cardiovascular disease was 2.01. This means that those with schizophrenia had double the number of deaths due to cardiovascular disease that the average population. The same study found that for all causes of mortality apart from cerebrovascular disease, people with schizophrenia die from physical health causes at a higher rate than the average population (Saha, Chant & McGrath, 2007). Similar findings have been found for people with other SMI such as Bipolar Affective Disorder and Depressive Disorders (De Hert et al., 2009; Hayes et al., 2017).

These people report that some of the barriers to accessing primary care include access to care, service user issues such as cognitive difficulties, fragmented care, and communication difficulties to name a few (Kaufman et al., 2012).

2.2 Description of the PHC, Original objectives and service user needs

Individuals with SMI have a lower life expectancy due to physical health concerns, with cardiovascular disease being a leading cause of death. Service users face multiple barriers when accessing primary care, such as cognitive difficulties and fragmented care. To address these issues, a GP-led service was introduced within a local community mental team building to bridge primary care and mental health services. The service provides a starting point for service users to discuss chronic health issues and improve their physical health, empowering them to access their own GP. The PHC had six objectives, including improved access to physical health reviews, better links between physical and mental health services, and evaluating the success of the PHC to extend to other areas. Service users accessing Laurel House services present with various chronic physical illnesses, including diabetes, heart disease, and chronic lung diseases. The PHC aims to improve quality of life and life expectancy for individuals with comorbid physical conditions and SMI.

2.3 Methodology and Evaluation Design

This process evaluation focuses on assessing the implementation and context of the pilot programme. The evaluation includes both qualitative and quantitative data collection methods to provide a comprehensive understanding of the pilot’s effectiveness.

The evaluation assesses the overall efficacy of the programme by measuring its successes against its original goals or objectives. Both quantitative and the Qualitative aspects of the evaluation provide evidence of how the PHC has improved access to general practice services for service users with Severe Mental Illness (SMI) and LTHCs who attend Laurel House and the practice at Kings Road, Herne Bay.

Quantitative data was collected through primary care data capture to determine the "reach" and impact of the programme, including the number of appointments, physical conditions presented, onward referral pathways, and engagement with previous and current NHS Health Checks.

Qualitative data were gathered through semi-structured interviews with healthcare professionals working in secondary mental health, healthcare professionals (e.g., GPs, community mental health workers) working in primary care, and two reflexive interviews with the PHC GP and a recent GP trainee on placement. The structure of the interviews was guided by key implementation outcomes such as acceptability, appropriateness, feasibility, penetration, and sustainability (Proctor et al., 2011)

Interview Data were analysed using framework analysis, consisting of five stages: familiarization, identification of a thematic framework based on the interview topic guide, indexing, charting and mapping, and interpretation (Ritchie & Spencer, 1994)

A triangulation of both quantitative and qualitative data was mapped against the study's aims and the PHC's original objectives, which informed conclusions drawn and recommendations made for future service design. Work package description can be found in Appendix 1.

2.4 Ethics Approval and Data collection process

Ethics approval for the interviews was sought and granted by the LSSJ Ethics Committee at the University of Kent reference 0768.

The audit data was obtained, collated, and analysed by the Medical Team. All identifiable service user information has been removed. Data was obtained by reviewing:

• Medical notes held on the KMPT RIO IT System

• GP records on the shared MIG system

• Medical summaries supplied by GP practices.

These routine data were not shared with the Principal Investigator. This data was used to write a synopsis of how many patients accessed the GP service, and if they have engaged with their referral into primary care. The synopsis was then shared with the Principal Investigator.

2.5 Evaluation Aims and objective/s

The present study evaluates the efficacy of the PHC that has been operational since February 2022.

The broad objectives of this evaluation are twofold: to ascertain whether the clinic has met its objectives, and to identify potential areas of improvement. Of particular interest is the expansion of the clinic's services to a neighbouring locality, which adds further complexity to the evaluation.

The objectives of the study align with the original objectives of the PHC programme. More specifically, the study seeks to investigate whether informal GP conversations during mental health services help individuals with serious mental illness (SMI) and long-term health conditions to access primary care services. This study examines whether the following objectives have been achieved:

1. Appropriate usage of the service by the target population
2. Fulfilment of physical health objectives
3. Improvement in communication between the community mental health team and primary care providers
4. Empowerment of service users with SMI to take an interest in their physical health.

To achieve these objectives, the study utilised both quantitative audit data and qualitative semi-structured interviews, with the study aims being to:

1. Explore the 'reach' of the PHC by analysing primary care data on appointment attendance and referral pathways following a service user's use of the GP service within Laurel House
2. Understand how mental health professionals working in Laurel House and GPs/health care professionals who receive referrals utilise the PHC programme.
3. Understand the implementation processes and impact of the PHC programme from the perspective of the GP and GP trainee delivering the programme.
4. Provide recommendations for future service design based on the findings of the study.

3.0 Quantitative Data Report

The Physical Health Clinic received referrals since February 1, 2022, with data reviewed for one year until January 31, 2023. For practical results, a subset of all service users referred between February 1 and July 31, 2022, was used for this evaluation, and will be referred to as the Audit Group.

Of the 170 referrals made during the year, 87 were included in the Audit Group, with 37% (n=32) not attending or declining appointments, therefore 55 service users are included in the ‘active audit group’. Laid out in table 1 below.

|  |  |  |
| --- | --- | --- |
| **Core data** | **N**  | **%** |
| Total Referrals made (1/2/22-31/1/23) | 170 |  |
| Audit Group (Patients Reviewed) | 87 |   |
| DNA or Declined (from Audit Group) | 32 | 37% |
| Leaving the Active Audit Group  | 55 | 63% |
| Of the Audit Group  |  |  |
| Seen in clinic once | 41 | 47% |
| Seen in Clinic More than once | 14 | 16% |
| Proportion of Audit group reviewed (Active Audit Group) | 31 | 56% |

**Of the Active Audit group 56 % of patient records were reviewed (n=31)** at the point of referral and six months later, with the percentage of Core Data items available at both times presented in Table 2.

|  |
| --- |
| **Table 2** shows the percentage of Core Data items available at referral and up to six months, and actions taken by the PHC after 6 months.  |
| **Core Data Item** | **% Available at Referral** | **% Available at 6 Months** | **% Obtained after appointment \*** |
| Weight | 79 | 100 |  |
| Blood Pressure | 93 | 100 |  |
| Pulse | 86 | 100 |  |
| Cholesterol | 76 | 86 |  |
| HbA1c / Blood Sugars | 76 | 83 |  |
| BMI | 72 | 100 |  |
| ECG | 66 | 93 |  |
| Alcohol Use \* |  |  | 100 |
| Smoking Status\* |  |  | 100 |
| Lifestyle and Exercise\* |  |  | 100 |
| Up to date with national screening programmes\* |  |  | 83 |
| **Feedback to GP \*\*** |   |   |   |
| Action Requested | 59 |   |   |
| Request Actioned | 97 |   |   |
| **Tests in Clinic \*\*\*** |  |  |  |
| % investigations were performed | 41 |   |   |
|  % investigations reviewed with results fed back to Service User | 100 |   |   |
| *\* There are further Core Data items which were elicited during the Physical Health Clinics. Note that these percentages relate to information obtained, and not whether they were improved or changed. During the clinic health advice, for example around smoking or exercise, was given opportunistically.*  |
| *\*\* After each appointment a letter is sent to the Service User and copied to the GP. On some occasions requests are made for action by the GP. It was assessed whether action had occurred as suggested after six months.* |
| *\*\*\* Where appropriate, blood tests and ECGs are performed in the Physical Health Clinic. The results of these are reviewed by the PHC and results fed back to the Service User.*  |

**Table 3** shows the reasons for referral to the PHC. The highest proportion of reason was for weight related concerns, including weight loss, diet control, obesity, and related health condition. More general health concerns likely to be presented within normal GP appointments was the second largest reason for referral. However, it should be noted that 24% presented with multiple reasons.

|  |  |  |
| --- | --- | --- |
| **Examples of reasons for referral to the Physical Health Clinic**  | **N** | **% (of Active audit group data reviewed n=31)** |
| Weight/ Diet (management, loss, related physical issues)  | 8 | 27.5 |
| General physical concerns (i.e., limited movement, leg pain)  | 6 | 20.6 |
| Smoking (wanting to quit, relapse, advice, SOBOE) | 3 | 10.3 |
| Diabetic related concerns (eye screening, control, S.O.B)  | 3 | 10.3 |
| General Sickness concerns (i.e., sickness, enlarged tonsils)  | 3 | 10.3 |
| Heart (high HR, Postural Drop) | 2 | 6.8 |
| Health Anxiety (investigations, family cancer)  | 2 | 6.8 |
| Self-Neglect | 1 | 3.4 |
| MH meds concerns (i.e., drowsiness)  | 1 | 3.4 |
| CV (cardiovascular Risk)  | 1 | 3.4 |
| Cognitive concerns (i.e., memory decline)  | 1 | 3.4 |
| Existing Physical disorder | 1 | 3.4 |
| No Concerns | 1 | 3.4 |
| **Of the Active Audit Group data reviewed (n=31), 24% presented with multiple health concerns (n=7).** | **7** | **24** |
|  |  |  |
| **Reasons for Service User (from Audit Group n=32) not attending**  |
| Happy to see own GP |   |   |
| Only available during the afternoons |   |   |
| Lives out of area |   |   |
| States did not get appointment information |   |   |
| **Where the Core Data was not available the following reasons were noted:** |
| Appointment focus was on other subjects |   |   |
| Service User did not attend follow up appointments |   |   |
| **Where GP action did not occur, the following reasons were noted:** |
| Service User did not make an appointment with the GP practice |
| GP has been seen but addressing different issues (e.g., new cancer diagnosis) |

## 3.1 Data Summary

The analysis of audit data revealed a higher-than-expected proportion of Did Not Attend (DNA) cases among referrals. However, a closer examination of the reasons behind this pattern emphasised the necessity of establishing more effective referral pathways and extending the Physical Health Clinic's operational hours. Encouragingly, the percentage of Core Data items available for those who attended both the referral and six-month follow-up was found to be high. Furthermore, the data shed light on the prevalent reasons for referrals to the PHC, with weight-related concerns being the most frequently reported issue, followed by general physical concerns.

4.0 Qualitative Data Report

Qualitative data were gathered through semi-structured interviews with healthcare professionals working in secondary mental health, healthcare professionals (see table 3) working in primary care (n=5), and two reflexive interviews with the PHC GP and a recent GP trainee on placement.

**Table 4** shows participant professional roles

|  |  |
| --- | --- |
| **Participant** |  **Job Role** |
| 1 | Consultant Psychiatrist  |
| 2 | Community Consultant Psychiatrist |
| 3 | Community Psychiatric Nurse |
| 4 | MH Support Worker |
| 5 | Salaried GP |
| 6 | PHC GP  |
| 7 | GP trainee |

Semi-structured interviews explored perceptions of any improvements to health services occurring since the PHC's existence, identifying the barriers and enablers affecting the delivery of the programme and any unintended consequences, unintended outcomes of the services, resourcing, referral pathways, and service user experience, Interview schedules can be found within Appendix 2. The data analysis from the interviews revealed several key themes and sub-themes that reflect the success and challenges of the PHC.

**Table 5** Themes and Sub-Themes

|  |  |
| --- | --- |
| **Theme** | **Sub theme** |
| Service User outcomes    | Addressing Health Inequality  |
| Physical Health Objectives  |
| Service user Centered Care  |
| Allocation Consultation Time |
| Collaborative and Cross Disciplinary Approaches to Health Care      | Benefits of having a GP in MH team  |
| Supportive staff culture  |
| Clinical expertise in mental health and physical health care  |
| Risk Management  |
| Training, Experience, Development and support value. |
| Resource Management  | Communication systems and Administration |
|   | Referral Pathways and Information Exchange  |
|   | Cost benefit opportunities |

In terms of **service user outcomes**, addressing health inequality was identified as a significant sub-theme, alongside service user-centered care and the allocation of consultation time.

**Collaborative and cross-disciplinary approaches to health care** were also highlighted as essential for success, with sub-themes identified as the benefits of having a GP in the MH team, a supportive staff culture, clinical expertise in mental and physical health care, Training, Experience, Development and support value and risk management.

**Resource management** was also a key theme, with sub-themes including communication systems and administration, referral pathways and information exchange, and cost-benefit opportunities highlighted.

The qualitative analysis shows that the PHC has significant potential for improving service user outcomes, particularly in addressing health inequality, and that a collaborative and cross-disciplinary approach to healthcare is crucial. However, it also highlights the importance of effective resource management, risk management, and support for staff training and development in achieving these goals.

## 4.1 Theme 1 Service user outcomes

The PHC aims to reduce disparities in health by providing both physical and mental health appointments in the same building. Enablers, such as longer appointment times, help service users to meet their physical health objectives. Communication between medical professionals and service users is crucial for achieving service user-centered care. Having longer appointment times can establish that mental and physical health come hand in hand and is important for service users.

Sub Theme: Addressing Health Inequality

Those who face the most significant disadvantages in life also face the greatest risks to their mental and physical health. This PHC goes some way to addressing these disparities. One participant stated, *"if they are truly severely unwell with their mental health often they don't really care about the other physical stuff that's going on. So yeah, I think it would be a definite way of getting them engaged with looking after their physical side of health"* (Salaried GP).

Sub Theme: Physical Health Objectives

Enablers outweigh barriers to service users' physical health objectives being met. A consultant psychiatrist noted that individuals with chronic mental health difficulties often neglect their physical health, so having appointments for both physical and mental health in the same building is more likely to get them to see a GP than asking them to go see their GP or going back, which they may be unlikely to do.

*"especially people who have more chronic mental health difficulties, they often neglect their physical health. So it feels that we're more likely to get them to see a GP if it's in the same building than asking them to go see their GP or going back, and they're probably unlikely to do that"* (Psychiatrist).

Sub-Theme: Service user-Centered Care

Increasing constraints put pressure on the NHS and make service user-centered care difficult to achieve. However, this PHC has obvious enablers to this core objective being met. Participants commented on the importance of clear communication between medical professionals and service users. An MH support worker mentioned that service users who see the Pilot GP are more involved in their care, and have a better understanding of the, sometimes complex, processes that are happening (or not happening) helping to prevent confusion and disengagement:

*"even when they're discharged from the hospital, ask them what the discharge letter says? They say, Oh, I haven't received one. I'm really not I say please, can you call your GP and find out? Because we'd like for example, we had someone with chest pains. And I call 999. They went to the hospital, and they were discharged, and they're not really sure what's happening next, if you see what I mean, whereas those service users will see [the pilot GP], they're able to tell me how he will review me in three months. He's writing to my GP and you know we discuss a, b and c"* (MH Support Worker).

Sub-Theme: Allocation Consultation Time

The PHC offers appointments up to 30 minutes, which has a multitude of benefits. A trainee GP noted that when individuals have mental health issues, they tend to focus on that and may ignore their physical health issues until they cannot be ignored anymore. Having a longer time for appointments can establish an understanding that mental and physical health come hand in hand, and is important for service users:

*"because when you do have mental health issues, you do tend to focus on that or it can be consuming, and you do ignore a lot of your physical health issues until they cannot be ignored anymore. And so having a longer time just to establish that understanding that they are, you know, they do come hand in is important"* (Trainee GP).

## 4.2 Theme 2 Collaborative and Cross Disciplinary Approaches to Health Care

*The importance of collaboration and communication between healthcare professionals, especially between mental health teams and GPs, to provide comprehensive care for service users. The quotes highlight how having a GP who is knowledgeable about both physical and mental health can provide additional support to service users and improve communication between different healthcare professionals. The quotes also emphasise the value of having easy access to a GP for advice and support, especially when it comes to reviewing test results or discussing medication.*

Sub-Theme: Benefits of Having a GP in the MH Team

Core skills and knowledge in complex physical and mental health needs and where they intersect from the lead clinician can be very helpful. A consultant psychiatrist noted that having advice from a GP feels much more accessible in the clinic.

*"I guess sometimes I would find a GP, but it's not always easy to get hold of a GP if I wanted to discuss something, or they might write to me or just sort of try to contact me, but it's very rare. So I think the nice thing about Will's clinic is it feels much more accessible to have advice from a GP"* (Consultant Psychiatrist).

Sub-Theme: Supportive Staff Culture

Multi-professional approaches to health intersectionality issues help to address complex needs. Supportive staff cultures and cross-disciplinary knowledge exchange can add capacity to primary and secondary health services.

An MH support worker noted that they encourage service users to see their own GP, but if they cannot access it due to the system, it is easier for them to email and ask if Dr. Davis could see them:

*"So we did it where we are like what I'm doing, we do try to encourage them to see their own GPS, but obviously, if they can access it because of the system, it is easier for us to email and ask if Dr. Davis could see them because we have concerns about there are so many times when I email a GP, I asked a question, and I never get an answer"* (MH Support Worker).

Sub-Theme: Clinical Expertise in Mental Health and Physical Health Care

The PHC GP having knowledge, skills, and experiences of not only SMH, but of MH services, complexities of the system, and connections with MH colleagues adds high value to the success of the PHC. A community psychiatric nurse noted that having Dr. Davis's support was particularly helpful for a complex service user who had recently been admitted to the hospital with physical needs:

*"Because the service user that I had, is incredibly complex. He does have a long-standing mental health issues like issues. However they’re have been just recently he was admitted to the hospital with physical needs, and I felt like it was a little bit out of my comfort zone. So I needed a little bit extra support. And it was quite nice having Dr. Davis. Hence, he knew that the best interest meeting was coming up, so he said, well, we're sort of revisited once you've had the best interest meet".* Community Psychiatric Nurse

Sub-Theme: Risk Management

The participants emphasised the importance of timely communication from the PHC GP for mitigating the risk of adverse drug reactions resulting from the intersection of mental health (MH) medications and physical health (PH) medications. This is particularly important given that service users' registered GPs may face delays in responding to urgent requests, potentially impeding prompt resolution of such issues:

One participant highlighted the challenges of delays in communication, stating, *"We cannot get there straightaway which we need on duty. So we ring up, and they go 'you're 19 in the queue.' We can't wait an hour in the queue. We can't wait. So then we have to email, and then we won't get a response probably 2 to 3 days."*

Sub-Theme: Training, Experience, Development, and Support Value

The participants acknowledged that GP trainees' exposure to service users with severe mental health conditions aids professional development and understanding where physical and mental health intersect. The GP Trainee praised the PHC GP's experience and knowledge of proper channels to refer service users to, stating, *"And then him just knowing all the proper channels to refer the service users to like, forward trust and what to do if the service users are not engaging with forward trust because they cannot necessarily take them on unless they go to this certain channel. So, I have yet to learn all these intricacies between, like the algorithm to follow in terms of referrals, so it's good to have Dr. Davis there."* However, another participant GP noted that some trainees may be shielded from working with service users with severe mental health conditions, stating*, "She hasn't really said much. Apart from that the service users are sicker than she was expecting, you know like she has been shielded from them by the practice."*

## 4.3 Theme 3 Resource Management

Within this theme, several sub-themes were identified, including communication systems and administration, referral pathways and information exchange, and cost-benefit opportunities. Participants acknowledged the positive impact of efficient communication within and between teams, as well as the benefits of slick referral pathways on service user outcomes. They also recognised the value of the PHC in terms of cost-effectiveness and preventative medicine.

Sub Theme: Communication Systems and Administration

The participants recognised that communication between the PHC GP and service users, between primary and secondary health colleagues, and internally between teams is positive and has added benefits of quicker risk identification. The PHC GP acknowledged the importance of efficient communication, stating, *"But there's enough, the admin team are very helpful there. So, what I do is actually write in the progress notes on RIO, which is this the IT system, I just write the letter that's also to notes and then they copy and paste that into a sort of proper letter if you see what I mean and that's what goes out."*

Sub-Theme: Referral Pathways and Information Exchange

Mental health support workers may not always have access to information about service users after they have seen a GP or been referred to a hospital. This can make it difficult to follow up with service users and monitor their progress.

The participants noted that slick referral pathways increase the chance of service user outcomes being met, although challenges exist, these pathways are becoming established. One participant praised the accessibility of the service, stating, *"I guess sometimes I would find a GP, but it's not always easy to get hold of a GP if I wanted to discuss something, or they might write to me or just sort of try to contact me, but it's very rare. So I think the nice thing about Will's clinic is it feels much more accessible to have advice from a GP."*

SuB-Theme: Cost Benefit Opportunities

The participants noted that the service adds value to primary and secondary health care costs. One participant stressed the benefits of the service, stating, *"This is an absolutely good use of resources on several counts, because it means that physical problems that could otherwise not having picked up all the symptoms up. So in terms of preventative medicine, that's a good thing."*

5.0 Conclusions

Based on the both the audit data and the qualitative data gathered, the Physical Health Clinic PHC Evaluation appears to have been successful in meeting its objectives. The PHC has improved access to physical health reviews and follow-up, provided experience for trainee GPs in delivering physical health support for people with serious mental illness, better linked physical and mental health services, improved information sharing on physical health checks between primary and secondary care, and led to better physical health for people with comorbid physical health conditions. Both Audit and interview data were mapped against PHC core objectives, below is a synopsis how these objectives have been met.

1. **Appropriate usage of the service by the target population**

The Physical Health Clinic has been successful in attracting referrals, indicating that there is perceived value from the perspective of the Community Mental Health Team. Although the DNA rate is disappointing, it is not uncommon in the Mental Health sector, and the clinic has implemented a process to follow up with Service Users who do not attend.

1. **Fulfilment of physical health objectives**

Both the Audit and Interview data suggests that the PHC has gone some way towards addressing health inequality, with the highest proportion of referrals for weight/diet-related issues and general physical concerns. The appointments at the clinic are crucial in obtaining Core Data and reviewing the Service User's health.

The success rate of physical health indicators such as weight, blood pressure, pulse, and BMI after six months was recorded at 100%, and alcohol use, smoking status, lifestyle, exercise, and information on national screening programmes.

The PHC records audited show that there is a 100% success rate in obtaining PH data on weight, blood pressure, pulse, BMI after six months and data on alcohol use, smoking status, lifestyle, exercise, and up-to-date national screening programs were obtained at a 100% success rate after an appointment. The clinic has a high success rate in investigations being undertaken within the clinic, and 100% of these investigations are reviewed by the PHC GP, with results fed back to service users.

1. **Improvement in communication between the community and primary care providers**

The PHC has also facilitated collaborative working practices, with a GP in the mental health team providing core skills and knowledge in complex physical and mental health needs and where they intersect. Supportive staff culture and cross-disciplinary knowledge exchange have added capacity to primary and secondary health services.

1. **Empowerment of service users with SMI to take an interest in their physical health.**

The longer appointment times offered by the PHC have been beneficial to service users, helping them establish an understanding that their physical and mental health are interconnected, which is aligned with the objective of empowering service users with SMI to take an interest in their physical health. The clinic's approach is service user centered, starting with discussions about specific concerns and then developing into a more general discussion about their health.

Overall, the PHC is successful in managing the physical and mental health needs of complex service users. By having a GP within the MH team, the clinic is better equipped to manage complex physical and mental health needs that intersect. The clinic's risk management is timely, with communication being effective between the PHC GP and other members of the health care team. Additionally, the clinic provides reassurance that a review of physical health has taken place and can supplement the medical input from primary and secondary care. The PHC appears to have been successful in meeting its objectives and has the potential to be extended to other areas successfully.

6.0 Key Recommendations for Service Expansion and Improvement Top of Form

Bottom of Form

1. **Ensure adequate resourcing:** Ensure that there are enough resources, including administrative staff to help with appointment booking and DNA’s, effective and accessible referral pathways for Primary and Secondary health staff to use, appropriate equipment, and physical infrastructure like clinic rooms, to support the physical health clinic GP. Ensure all resourcing needs are costed into any future delivery models, including GP trainee costs and supervision times.
2. **Expand accessibility of care:** The PHC is an example of accessible care that offers easy to access advice from a GP, which can also serve as a bridge back into service users utilising their own GP’s. Familiarity with the clinic and convenient appointment times make it easier for service users to attend their appointments, therefore an afternoon clinic is recommended, making service more convenient for the service users, potentially reducing the rate of DNA’s, and increase the clinic’s cost-effectiveness.
3. **Promote collaboration and build awareness:** To ensure integrated care for service users, it is recommended that mental health and physical health services promote collaboration and foster collaborative working practices. This can be achieved through staff training to enhance their understanding of the interplay between mental and physical health conditions, and to increase awareness of the services offered by the PHC. Potentially ‘Health champions’ within KMPT who have used the PHC can help raise awareness of benefits. Additionally, incorporating the expertise of PHC GPs in mental health MDT meetings can provide a broader perspective and benefit to the team's decision-making process.
4. **Maintain and prioritise longer Clinic GP appointments in any future delivery model.** Additional time given for appointments is the largest benefit arising from this evaluation identified by clinicians and MH workers, enabling service users time to engage. This approach can help to build trust and rapport with service users and ensure that their needs are addressed in a holistic manner.
5. **Weight Management opportunities:** The largest proportion of referrals and discussions within appointments concerned weight management, this presents the clinician with the opportunity to emphasise the role of physical activity, not only for weight management but also for the benefits to mental health and well-being.
6. **Tighten up referral routes:** Referral routes currently work well within the small model the current PHC works within, however with any future models it is recommended that having a systematic way of feeding back service user engagement to GPs and secondary health professionals will help them see the positive affect on service user engagement and care.
7. **Monitor and evaluate success:** Monitor and evaluate the success of the PHC as it is rolled out to other areas, using both quantitative and qualitative KPI’s. This will help to identify areas for improvement and ensure that the clinic is meeting its objectives. Regular audit data and qualitative feedback from both service users and staff can be used to inform ongoing improvements and adaptations to the PHC. Recommended metrics that could be used for future evaluation of service include:
* **Referral rates:** The success of the PHC in attracting referrals can be measured by the number of referrals received from the Community Mental Health Team. This metric can be tracked over time to evaluate the PHC's efficacy in meeting the needs of its target population.
* **DNA rate:** The rate of service users who do not attend appointments can be measured to track the efficacy of the clinic's follow-up process and identify areas for improvement.
* **Success rate of physical health indicators:** The PHC's success rate in addressing physical health concerns can be measured by tracking the success rate of physical health indicators such as weight, blood pressure, pulse, and BMI after six months. This can help to evaluate the clinic's impact on improving the physical health of service users.
* **Success rate of investigations:** The PHC's success rate in investigating physical health concerns can be measured by tracking the success rate of investigations being undertaken within the clinic and the rate of review and feedback by the PHC GP to service users.
* **Collaborative working practices:** The PHC's success in promoting collaborative working practices can be measured by tracking the extent of cross-disciplinary knowledge exchange and the capacity added to primary and secondary health services. The PHC presents mutually beneficial opportunities for professional groups involved to improve quality of care for their patients. The benefits to each need to clearly illustrated and recognised- motivator for continued engagement.
* **Empowerment of service users:** The PHC's success in empowering service users with SMI to take an interest in their physical health can be measured by tracking the level of service user satisfaction and their willingness to engage in discussions about their physical health.

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**PHYSICAL HEALTH CLINIC PILOT EVALUATION**

# PHYSICAL HEALTH CLINIC PILOT EVALUATION ADDENDUM REPORT JULY 2023

J.Monkhouse & Dr W.Davis

### Addendum: Background

A review of the GP pilot data was completed in June 2023 by the General Practitioner. Data was anonymised and securely transferred to the researcher.

The Physical Health Clinic received referrals since February 1, 2022 through to the present time .

Data provided in Table 1 presents a subset of the referral information for service users within the timeframe of 1/2/22 - 31/7/22 (n=29). This subset includes service users who were referred to and seen by the clinic GP, with known outcomes at the 6-month mark. The table provides details such as service user age, gender, presence of long-term conditions (LTC), mental health conditions (MHC), mental health treatment, reason for referral to the pilot GP, tests organized by the GP, referrals made or liaisons, and the outcome known at 6 months.

It is important to note that the findings presented in this report complement the information provided in the April 2023 report. For a more detailed understanding of the methodology employed and the specific insights gained from the qualitative interviews with staff members, reference should be made to the previous report.

### ADDENDUM Results

The data indicates that the program demonstrates a multidisciplinary approach, involving healthcare professionals from different specialties, such as psychiatrists, chest physicians, GPs, and support workers. This suggests an effort to address the complex needs of the individuals involved.

Referrals to other teams, such as Chest Physicians, Forward Trust, medicines management, and smoking cessation services, indicate an attempt to provide comprehensive care and involve specialised expertise when necessary.

The outcomes reported in the pilot vary for each individual, ranging from changes in medication to improvements in weight, mental state, and diabetic control. It suggests that the interventions implemented had some positive impact for certain individuals.

The pilot acknowledges the importance of regular tests, such as bloods, ECGs, and eye tests, to monitor the individuals' health status and make informed decisions regarding their treatment.

Additionally, the pilot seems to emphasise communication and collaboration with the individuals' own GPs, which can be valuable for coordinating care and ensuring continuity.

To enhance clarity and improve readability, we have included a selection of case studies in Appendix 3 extracted from the table data presented in Appendix 1.

### ADDENDUM: Discussion and recommendations

Given the diverse physical and mental health conditions of the participants, the involvement of both GPs and nurses would be beneficial. GPs can provide medical expertise, evaluate test results, and make informed treatment decisions and referrals. Nurses can offer ongoing support, ensure adherence to treatment plans, and coordinate care among healthcare providers and community

The original report's key recommendations, including improving communication and referral pathways, increasing the visibility of the pilot to GPs outside of the community mental health teams, and the value of the Physical Health Clinic for GP trainee opportunities, still hold significance.

# ADDENDUM: Data Overview

### Long-Term Conditions (Physical):

Most common long-term physical conditions mentioned: Type 2 Diabetes, Obesity, Hypertension, and Chronic Pelvic Pain.

Other conditions mentioned: Breathing Difficulties, Alcohol Dependence, Angina, Crohn's Disease, Venous Thromboembolism, Hypermobility Syndrome, Obstructive Sleep Apnoea, Stroke, Cirrhosis of the Liver, Polycystic Ovary Syndrome, Eczema, Melanoma, Iron Deficiency Anaemia, and Severe multi-system issues related to Ehlers-Danlos Syndrome.

### Mental Health Conditions:

Most common mental health conditions mentioned: Schizophrenia(n=12), Emotionally Unstable Personality Disorder(n=4), Depression (n=4). Other conditions mentioned: Schizoaffective Disorder (n=2), Autistic Spectrum Disorder (n=1), Delusional Disorder (n=1), and Learning Disability (n=1):

### Mental Health Treatment, most common forms of treatment mentioned:

Depot Antipsychotic, Oral Antipsychotic, SSRI, and Antidepressants. Other treatments mentioned: Promethazine, Lamotrigine, Opioids, and Clozapine

### Reasons for Referral to the GP:

Various reasons were mentioned, including breathing difficulties, weight loss, abdominal bloating, self-neglect, concerns about smoking and drinking, low back pain, weight gain, belching symptom, joint pains, jaw pain, shortness of breath symptoms, and memory/brain fog.

### Tests and Referrals:

Blood tests were frequently organised by GPs. Other tests and referrals included ECG, onward referral/liaison with other teams, psychiatry medication review, medication adjustments, review of cardiovascular risks, eye tests, and referrals to specialists (such as chest physicians, gastroenterologists, and sleep apnoea studies).

### Outcomes

The outcomes varied for each individual, ranging from investigations and adjustments in medication to lifestyle advice, ongoing support, and improvements in symptoms or conditions.

Overall, based on the data provided, the GP organised a total of 11 tests.

## Addendum: Discussion and Recommendations

The data suggests that whilst many service users have benefited from the GP’s clinical expertise, some service users could have equally have benefited from a specialised nurse working in conjunction with the GP, creating a physical health team or hub within community mental health provisions. This would also benefit the continuity of service if either nurse or GP if absent.

Collaboration between GPs and nurses is often key to providing comprehensive and coordinated care to patients. Therefore, a team-based approach involving both skilled clinicians, such as GPs and nurses, could be beneficial for the successful implementation of the pilot. The specific distribution of responsibilities and roles within the team would depend on the scope and goals of the pilot, as well as the available resources and staffing considerations.

Both GPs and nurses play vital roles in healthcare delivery, and their expertise can be valuable in different ways. GPs have comprehensive medical training and are often considered the first point of contact for patients. They have a broad understanding of various health conditions and can provide holistic care, including diagnosis, treatment, and ongoing management.

Nurses, on the other hand, possess specialised skills in patient care, health education, and coordination of healthcare services. They often work closely with patients, providing support, monitoring their conditions, and assisting with treatment plans. Nurses can also play a crucial role in liaising between different healthcare providers and ensuring effective communication.

Considering the nature of the pilot, which involves individuals with various physical and mental health conditions, the involvement of both GPs and nurses would likely be beneficial. GPs can provide medical expertise, evaluate and interpret test results, and make informed decisions regarding treatment and referrals. Nurses can provide ongoing support, ensure adherence to treatment plans, and coordinate care between different healthcare providers and community resources.

**Other key recommendations still stand from the original report, including improving communication and referral pathways, increasing the visibility of the pilot to GP’s outside of the community mental health teams and the high value attached to the Physical Health Clinic providing excellent GP trainee opportunities.**

Appendix 1 – Work Packages

Project set-up activities (November to January 2022)

* Design data collection tools- case study template, output data collection template and interview guides
* Submit University of Kent ethics application
* Identify and confirm output data and indicators of success from routinely collected primary care data.
* Stakeholder Mapping (whom to interview).

Work Package 1 (WP1): Gather Healthcare professional perspectives (January to February 2023):

* Conduct interviews with HCPs in secondary mental health settings who have referred patients to the pilot and/or have knowledge of the programme (n=5)
* Conduct interviews with healthcare professionals in primary care (n=5) who have received referrals from the pilot programme and/or have knowledge of the programme
* Reflective interview with Will Davis (GP in situ)

Work Package 2 (WP2): Analysis of output data (February to March 2023)

* Extract relevant data from primary care systems to enable reporting on patient demographics, referral pathways and subsequent contacts with primary care.

Work Package 3 (WP3): Analysis and write up (March to April 2023)

* Analysis of quantitative output data
* Analysis of qualitative data
* Triangulation of quantitative and qualitative data
* Writing report and recommendations

Appendix 2 – Interview Schedules

Interview Schedule: Health Care Professionals referred to.

Thank you for agreeing to be interviewed today as part of a small evaluation of a GP pilot service within Laurel House. [read consent script]

We have a few questions to ask about your knowledge and involvement with the pilot to help us assess is ongoing impact and feasibility. We are not asking for any personal details on any patient. The interview will take no longer than half an hour.

Firstly, can you tell me a bit about your current role and how you are involved with the pilot

1. How many patients are you aware of that Dr Davies has referred to you or your practice (formally or informally) from Laurel House?
2. Of the people you / your practice did see:
* Were they already registered with you?
* Had you (or another GP in your practice) seen them in any capacity before? *If so, do you know how long ago was this?*
* Were their long-term health conditions already diagnosed? *If yes, are you aware if they had accessed any primary care or specialist care services regarding their health condition before?*
* Are you aware if any of these patients failed to attend any past appointments specifically relating to their long-term health condition in the past (for example physiotherapist, pulmonologist**,** diabetologist etc)?
1. Did any patients present with additional LTHC’s that you were previously unaware of? *If yes, did this require onward referrals to specialists?*
2. Are you aware of any specific barriers these patients have faced in accessing primary care currently or in the past? *If yes, could you tell me a bit about these?* *You do not need to disclose personal information, a brief description will suffice.*
3. Do you think that the Laurel house GP service is a good use of resources?
* If yes, why?
* If no, do you have any suggestions on how this service could improve specifically to enable patients with SMI and LTHC to access to Primary care?

Reflexive interview questions for Dr Davies

Thank you for agreeing to be interviewed today as part of the evaluation. [read consent script]

1. Can you tell me a bit about the pilot, and why the service pilot set up? *What problems were identified and by whom?*
2. What were you or your service hoping to achieve?
3. Are you aware of additional patients with LTHC that access Laurel House services that you have not seen?
4. If yes, do you know if this is because they are already accessing Primary Care, or if they refused the service?
5. If any patient refused your service, do you know this was? *Did you work with other clinicians and MH professionals at Laurel House to try and over-come any identified barriers?*
6. What do you feel that you/the service have/has achieved?
* What have been the successes?
* What have been the challenges?
* What weren’t you expecting?
* If you could change any aspect of the service moving forward, what would it be?

Interview Schedule (Mental Health Clinicians)

Thank you for agreeing to be interviewed today as part of a small evaluation of a GP pilot service within Laurel House. [read consent script]

We have a few questions to ask about your knowledge and involvement with the pilot to help us assess is ongoing impact and feasibility. We are not asking for any personal details on any patient. The interview will take no longer than half an hour.

**Firstly, can you tell me a bit about your current role and how you are involved with the pilot**

1. How many patients have you referred to Dr Davies?
2. Can you tell me a bit about why you referred them? *You do not need to disclose personal information, a brief description of why you felt they would benefit seeing a GP would suffice.*
3. *Are you aware if these patients faced any barriers in accessing their own GP’s regarding their physical health condition? If yes, could you tell me a bit about this?*
4. *Do you think being able to see a GP within Laurel house is beneficial for your patients physical and/or mental health outcomes? If so, why?*
5. *Do you think the service requires any improvements (what else would you like to see that could benefit your patient’s physical health needs?)*

**Note:** Interview Transcripts are available upon request.

Appendix 3 – participant information sheet

**GP Pilot at Laurel House Evaluation - Invitation to Participate in a Service Evaluation**

We are doing a review of a GP pilot that has been operating at Laurel House since March 2021 with Dr Will Davis. This pilot enables MH clinicians to directly refer patients who have long term health conditions (LTHCs) to a GP whilst accessing services at Laurel House.

You are receiving this letter because you are / have been involved in referring into, or taking referrals from, Dr Davis.

We would like to invite you to take part in this service evaluation. This information sheet explains why it is being done and what it would involve for you. Please do contact us if you have any questions. Our contact details are at the end of this information sheet.

**Purpose of the study**

Since February Dr Will Davies has held a weekly chronic illness clinic within Laurel House and for the last 3 months spent alternate weeks at Laurel House in Canterbury and Kings Road in Herne Bay.

The purpose of this clinic is to encourage Laurel House service users to access primary care for any long-term physical conditions or needs they may have.

This Pilot was set up as it was identified that many Laurel House service users do not routinely attend primary care appointments for any long-term physical health conditions, diagnosed or undiagnosed, for example diabetes. This project will evaluate the effectiveness of this Pilot, it’s successes and areas for improvement.

**Why have I been invited?**

We want to find out from professionals that have been involved in this pilot if the service is effective, what hasn’t worked so well, and your thoughts about service improvement. Specifically, we would like to know if this pilot has improvement patients that present with SMIs and LTHCs access to Primary Care Services.

**What will happen?**

We would like to invite you to take part in an interview with Jennifer Monkhouse, a researcher from the University of Kent managing this evaluation.

This interview will take place online using MS Teams or Zoom or by telephone, whichever you prefer. We would like to spend between 30 minutes talking to you about the pilot. For example, strengths and weaknesses of the pilot, routes of referral, effective pathways to accessing primary care for patients with LTHCs. With your permission we would like to audio-record the interview so that we can better analyse it.

**Do I have to take part?**

It is entirely up to you whether you decide to take part. If you do decide to take part, you are free to withdraw at any time up to and during the interview. If you decide to do this we will premantly delete any recorded interview data we have from you and it will not be used in the evaluation. The decision to take part or not will have no impact on your employment in any way.

**Will my taking part in this study be kept confidential?**

We would like to reassure you that any information collected about you will be coded and kept strictly confidential, and we will protect your identity. It will be stored on a password protected computer network at the University and will only ever be accessed by the evaluation team. Once the project is finished, data collected for the evaluation will be kept for a short period of up to three months. We will immediately destroy any personal data collected about you and anonymised data will also be destroyed after five years. You will not be identifiable in any written reports. Things you say during the interview may be directly quoted in written reports and publications, but your name or anything else that could make you identifiable will be removed.

The University of Kent’s Privacy Notice can be found here:

<https://cdn-researchkent.pressidium.com/ris-operations/wp-content/uploads/sites/2308/2020/06/GDPR-Privacy-Notice-Research.pdf>

**Benefits and risks of taking part**

We will ensure that there are no risks to you by taking part in the study. Furthermore, any information you give us regarding yourself, other health professionals or patients will not be shared with anyone.

**What will happen to the results of the study?**

The results of the study will be used for a service evaluation report asked for by the Kent and Medway Integrated Care Board to understand this pilot’s feasibility moving forward.

They may also be published in an academic journal and presented at health and social care conferences. Your participation in the research will be anonymous and any data collected from you will remain confidential.

**Who can I contact if I have any further questions?**

If you have any further questions about the study, please do not hesitate to contact:

Jenny Monkhouse

Phone: Email: j.monkhouse@kent.ac.uk

OR

Monica Sangha

**Who can I contact if I want to make a complaint about the study?**

If you are unhappy about any aspects of the study and wish to make a formal complaint, you can do this through contacting Nicole Palmer, Research Ethics and Governance Officer, University of Kent

Phone: 01227 824797 Email: N.R.Palmer@kent.ac.uk

**What do I need to do next?**

If you would like to take part, please contact:

Jenny Monkhouse Email: j.monkhouse@kent.ac.uk

Jenny will then contact you by email or telephone to arrange a convenient date and time for the interview to take place.

If you do not want to take part, you do not need to do anything.

**Thank you for taking the time to read this information**

Appendix 4 – consent script

Hello, my name is Jenny Monkhouse*.* Thank you for agreeing to take part in this interview as part of an evaluation of the Laurel House GP Pilot

Have you read the Participant Information Sheet, which was sent to you in advance?

Do you have any questions regarding this evaluation? *[chance to ask any questions]*

As part of the ethical process, I need to ask a few questions. Can you all confirm that:

* You have read the information sheet on the above project and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily?
* You understand that your participation in the evaluation is entirely voluntary and that you can withdraw at any time without giving a reason and without detriment to yourself?
* You understand that your data will remain confidential?
* You agree to this interview being audio-recorded?
* You understand that we will use anonymous quotes in reports, other publications and presentations but you will not be able to be identified from these?
* You agree to take part in this interview today.

**Thank you.**