Hertfordshire

Hertfordshire Partnership NHS
NHS Trust

Hertfordshire Mental Health

Service Redesign

Steering Group Report

North Hertfordshire and Stevenage NHS
Primary Care Trust

St Albans and Harpenden NHS
Primary Care Trust

Watford and Three Rivers NHS
Primary Care Trust

EASTERN Development Centre

Contents

Appendices

Acknowledgments

The members of the Steering group would like to extend their thanks to the GP practices involved with the pilots, Primary Care Mental Health Team and CMHT staff, HPT Sector Managers; Phil Bolland, Ian Scammell and Cabrini Farquharson, and service users involved with the pilots.

Executive Summary

Aim:

To provide feedback from the 3 pilot mental health service redesign sites in Hertfordshire established following the recommendations in Investing in your Mental Health. The sites in Letchworth, St Albans and Watford adopted the same model of service redesign but delivered it in slightly different ways. However, they are all based on the same key principles;

1. Based on the stepped care model
2. Development of new primary care mental health roles
3. Integrated primary, secondary and non-statutory service
4. Improving efficiency and effectiveness of mental health services
5. For people with non-urgent mild to moderate mental health problems.

Methods:

Each site collected information from the commencement of their project and a core data set was collected for the 4 months between September and December 2006. The key developments in Letchworth were the Primary Care Mental Health Team and Improving Access to Psychological Therapies. The key developments in St Albans were the Enhanced Mental Health Service, Improving Access to Psychological therapies and New Ways of working for Psychiatrists. The key developments in Watford were the Primary Care Mental Health team and Improving Access to Psychological Therapies.

Key Findings:

Efficiency

Referrals

- There was an overall increase in combined referrals to primary and secondary care services due to the introduction of a new service as experienced in Letchworth and St Albans. However, a reduction in referrals to the CMHT's by 35% from the pilot surgeries and 16% overall in St Albans (Mar-Oct 06) and 54% in Letchworth (Feb-Jul 06). This is an indication that the pilots are providing a service for a previously un-met need.

Waiting times

- Time between referral to first face to face assessment is relatively short for the PCMHT's. On receipt of referral, first contact is made and an assessment is arranged. On average 19 days in Watford, 32 days in Letchworth and 35 days in St Albans for an assessment.
- Waiting times for secondary care appear to have reduced. Forty-seven percent reduction in average waiting time for outpatient appointments in Letchworth and 60% reduction in St Albans for all types of assessment.

Presenting Problems

- Most common presenting problem presented on each site was anxiety/ stress and depression/ low mood.

Interventions

- In Letchworth the majority of people received guided self help and self help information. For St Albans EMHS the majority of people received

Psychological Therapy or CCBT. In Watford the majority of people were signposted or received self help information.

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Effectiveness

Clinical Outcomes

- General trend for reduction in clinical severity after intervention from the PCMHT's.
- Some people assessed scored in the healthy range of clinical severity.
- Further data required to draw firm conclusions.

Discharge – Discharge information varied for each site however the majority of people were passed back to the GP, referred to the CMHT or for counselling.

GP Feedback - GP satisfaction positive on each site.

Service User Experience

- Service user satisfaction positive on each site.
- Availability of psychologically based therapies is clearly improved.
- Greater choice of intervention.
- Clearer pathways for people suffering from mild/ moderate mental health problems.

The 'New Ways of Working for Psychiatrists' pilot in St Albans has also demonstrated positive outcomes such as closer working relationships and increased availability of the Consultant Psychiatrists for medication advice and GP phone consultations.

Further work required

In developing the primary care teams we recognise that we have only redesigned the front end of the service and future re-configuration may include configuration of both primary and secondary care services into a primary care mental health team.

In spite of the achievements made there is much more to do in respect to further evaluation of the projects of the three sites and further development of mental health services within the pilot site areas. Further evaluation of the projects include assessment of secondary care caseloads, re-referrals rates in primary and secondary care, the people signposted to alternative services and the people that DNA. Specific requirements are also set for IAPT and NWW in St Albans.

Further work required with regards to development of mental health services include consideration of core competencies of staff, the discharge of people back to primary care, further development of care pathways for people with severe mental illness, and consideration of the inclusion of other agencies as part of the model and whether the primary care teams should be for working age adults only or be an inclusive service for all ages. It has also been recognised that a key issue relates to up-skilling of primary care staff in meeting needs of people with mental health problems.

Issues identified and Recommendations

There are several key issues identified from the development of the PCMHT's which can be addressed as recommendations and learning points for the development of

similar teams. The models have been influenced by several different factors such as local resource availability and levels of workforce; each of these therefore needs to be considered in service redesign. Further issues identified include lack of funding, difficulties in training staff about cultural shift and accommodation of teams. Considerations of such issues are recommended for service redesign.

An appropriate level of staffing with essential skills and capabilities should be established for further development of enhanced mental health service including management, supervision, training and clinical provision. Improved links with voluntary services are recommended and continual dialogue between all stakeholders involved is considered key in service redesign.

Future Direction

The steering group recognise that further detailed work will now take place between commissioners and specialist secondary care services. The future development and roll out of these models will be determined by such discussions. Links will also be made between commissioners and the Trust to work on reviewing community services which is also taking place concurrently. The pilot sites will in the interim continue to develop the present model which is demonstrating improved outcomes and each site will continue to collect data.

This report has been produced by members of the multi-agency steering group and can be used by the respective parties of the group.

1. Introduction

The purpose of the report is to provide feedback from the 3 pilot mental health service redesign sites in Hertfordshire. The main aim is to show if the pilot services developed have had the expected impact and the implications for implementing a future model or models of service. This report has been produced on behalf of the Hertfordshire Mental Health Service Redesign Steering Group and the member organisations. The individual organisations may make reference to particular sections of the report for their own purposes.

The 3 pilot sites in Hertfordshire had differing origins and purposes which have come together over time. Consequently some of the aims and direction of the pilots have developed since their inception and been negotiated in an organic way. They have been brought together in one framework under the steering group, which acknowledges there are similarities and differences. Overall, there were a number of common aims for each of the pilots, including:

- Improving efficiencies between primary and secondary care
- Improving effectiveness of treatment in primary and secondary care
- Improving access to psychological interventions
- Developing a closer working relationship between primary and secondary care staff giving service users more involvement and choice about their care.

The pilots were based in part on the need to improve access to psychological therapies (Improving Access to Psychological Therapies programme, IAPT) and to implement the new roles described in the NHS plan and the local Investing in Your Mental Health plan. This included development of graduate primary care mental health worker posts.

The pilot sites expected to provide evidence to support the hypothesis that access to evidence-based psychological interventions could be provided in primary care by graduate and Link workers via service-redesign. It was further postulated that such redesign would result in:

- Fewer, better targeted referrals into secondary care
- Improved well-being, service user satisfaction and choice
- Assisting in maintaining people in work and to helping them to return to work
- Evidence that increased capacity can be funded from savings in other parts of the economy, particularly Incapacity Benefits (The Depression Report, 2006)
- Identify the appropriate pathway and promote a recovery programme that is person centred, clinically effective and socially inclusive.

Other expectations included, improving communication between primary and secondary care staff, reducing the number of obstacles in the referrals process and enhancing the mental health services available in primary care.

2. Background

2.1 National

There are many reports on the social and economic impacts of poor mental health on society generally. For example, it is acknowledged that around 30% of GP consultations have a mental health component and a large proportion of all people with a mental health problem may only receive a service in primary care. Prescribing costs can be very high and evidence indicates alternative treatment for some conditions can be equally effective.

Depression is the most common mental disorder presenting in primary care and the estimated prevalence for major depression among those aged 16 to 65 years in the UK is 21 per 1000. However, if the less specific and broader category of mixed depression and anxiety is included, the figure is much higher. The World Health Organisation forecasts that depression will be the most common chronic disorder by 2010. It is also estimated that between 15% and 50% of presentations of depression may go undetected by GP's (Goldberg and Bridges, 1988). Many patients consult their GP for a somatic condition may have an undetected depressive illness. This represents a significant unmet need whilst prescribing costs for depression in primary care remain very high.

In circumstances where GPs feel an additional service is required for such a mental illness, they will generally refer people to the Community Mental Health Team (CMHT) or, in some cases, another service provider, such as a counselling service. The CMHT provide a service directly or give access to other specialist mental health services. However, people suffering from mild mental health problems often fall between the remit of the primary and secondary services. GPs may also make a diagnosis where they can access a useful intervention or treatment; this may uncover unmet need once a service is established, which in turn has an impact on the referral rates.

Once a referral is made, people accessing mental health services often have to negotiate a number of obstacles along their way between primary and secondary care, and within secondary care, particularly repeated assessments for services. This process is often due to historical service structures and resource allocation that has led to an organisational, professional and cultural separation between primary and secondary care.

Due to rising workload demands and increases in bureaucratic and process oriented functions, the ability of specialist mental health staff to assist primary care to improve and enhance their ability to manage people with mental health problems is limited. In addition to this there is limited mental health resource in primary care.

The opportunity for specialist to use their considerable skills and knowledge in addressing the mental health needs of the whole community without a review of service design.

The National Service Framework for Mental Health highlighted access to effective mental health care in primary care through standard 2. In order to support the implementation of the standard, the NHS plan proposed the creation of 1000 primary care mental health workers (PCMHWs). 'One thousand new graduate primary care

mental health workers, trained in brief therapy techniques of proven effectiveness, will be employed to help GPs manage and treat common mental health problems in all age groups, including children.'

During 2006, 2 pilots were set up in England as part of a national programme to improve access to treatment for people with common mental health problems. The schemes are based in Newham and in Doncaster, which serve very different populations with different health needs. They offer different treatment models such as community-based, voluntary sector-led, or employer-led. An update in November indicated that they schemes had seen 1000 clients in just its first three months of operation and is now taking on up to 100 new clients a week. The Demonstration Site programme costs £3.7 million over the lifetime of the project (2006/07 – 2007/08) and is being funded by the Department of Health.

2.2 Local

The 3 pilot sites were based on the above concerns and new initiatives piloted elsewhere around the UK. These initiatives are aimed towards bridging the gap between primary and specialist mental health services and facilitate closer and more effective models of shared care. The impact of this aims to provide meaningful improvements for service users and their carers by improving the detection and treatment of mental health problems in primary care, providing more information and choice for patients about their treatment.

The common aim for all the local projects were to establish an integrated Mental Health Service from the first point of contact with primary care through to specialist secondary care and non-statutory services involving a smoother transition between organisations whilst improving access to psychological therapy and promoting social inclusion and the recovery approach. The specific objectives being:

An integrated Mental Health Service will:

- Develop and establish an integrated care pathway between primary care, specialist secondary services and non statutory organisations
- Reduce the number of steps in the referrals process and waiting times for initial assessments.
- Develop and establish effective mental health interventions within primary care providing early detection and intervention to ensure rapid recovery and retention of employment and normal routine
- Provide more information and choice to patients about their treatment promoting social inclusion and the recovery approach
- Improve the quality of service and outcomes for people with severe mental illness
- Improve the quality of service and outcomes for people with mild to moderate depression and anxiety
- Generate closer working relationships between primary and secondary care
- Have effective education and training provision to support new ways of working and workers

The aim of the service redesign has been developing and supporting mental health services within primary care in order that they can manage most common mental health problems and non-complex psychiatric disorders. The result is a clear focus on primary care services and the development of mental health interventions within

this setting. Simultaneously in secondary care, roles and responsibilities of experienced specialist mental health care staff will be clarified, with the aim of allowing them to focus on the care of service users with the most severe and complex mental health needs and enable them to respond quickly to support primary care when required.

The St Albans CMHT at Edinburgh House is also a pilot site for the NIMHE "New Ways of Working" project. The aim of which is to develop the new ways of working for consultant psychiatrists and the multi-disciplinary team. Consultant psychiatrists will have smaller caseloads, be involved in less day to day routine case management, allowing them to focus on service users with difficult or complex mental health problems and be more available to both primary and secondary care teams for consultation and advice. The ST Albans pilot involves a rapid joint assessment of new referrals to the team and the development of functional specialist inpatient and community roles for the consultant psychiatrists commencing on 1st June 2006. Some changes in the core CMHT function have been made as a consequence of this project. For example, the link worker role has included the development of a Mental Health and Wellbeing clinic within a primary care setting. This has reduced the key worker capacity of the members of staff.

It is acknowledged that the timing and introduction of these initiatives has varied for each pilot site area and not all initiatives have been implemented in the same way**.** This may have some influence on the success of each pilot.

There were a number of specific requirements for information and data collection around the pilot sites, which varied slightly by organisation or purpose. These included information for:

- Primary Care Trusts (including Public Health information)
- Joint Commissioning Team (for commissioning information and efficiency data)
- Hertfordshire Partnership Trust (impact of the new teams on CMHTs)

The steering group agreed a core set of information which would serve these purposes and enable some evaluation of the effectiveness and efficiency of the pilot teams (see measures section for details). This included access to services, clinical measures, employment and benefits information and service user and GP satisfaction.

3. Pilot Sites

There are three principle sites across Hertfordshire aiming to integrate non-statutory organisations, primary and secondary mental health services whilst improving access to psychological therapy utilising a recovery and socially inclusive approach. Each site has developed a different model of service; however, they are all based on the same key principles.

3.1 Models

Letchworth and Watford have created teams known as Primary Care Mental Health Teams (PCMHT), which include Primary Care Mental Health Workers and Link Workers. The pilot in St Albans is called the Enhanced Service and also includes

Psychologists and a Counsellor. All the pilots also involve members of the local CMHT and local GPs. A summary of the teams is given below.

Letchworth:

- The PCMHT covers 6 surgeries and includes 2 link workers and 1 graduate worker.
- Staff are seconded from HPT
- The team are based within the CMHT and Letchworth Centre for Healthy Living.
- 0.5 WTE administrative support
- Supervision is provided by the CMHT Psychologist and CMHT Manager

St Albans & Harpenden:

Primary Care Enhanced Mental Health Team

- The Graduate Worker and Link Worker cover 5 surgeries.
- The graduate workers are PCT funded and the link worker funded by HPT.
- 0.2 WTE administrative support
- The team are based within a GP practice
- Supervision is provided by the EMHS psychologist.

Psychological Therapies Service:

- The Psychologists and Counsellor cover 13 out of 17 surgeries
- Funded by PCT.
- Part time secretarial support
- Base GP Practice

Watford:

- The PCMHT covers 3 surgeries and has 1 link worker and 1 graduate worker.
- The graduate worker is funded by the PCT and the link worker is funded by HPT.
- Base GP practice
- No formal administrative support
- Supervision is provided by the CMHT Psychologist and CMHT Manager

3.2 Interventions

The pilots employ a stepped care approach to treatment that aims to provide increased integration between primary and secondary care to close the gap that currently exists between the services. Figure 1 below shows how this relates to the NICE Guidance for the management of depression in primary and secondary care (Dec 2004). This means that the type of intervention provided increases stepwise rather than 2 tiers of care. The most common model for mental health services would currently represent steps 1 in primary care and steps 4 and 5 in secondary care, with some of steps 2 and 3 provided in primary care, in secondary care by voluntary services or not available at all.

The projects have also worked with an increased clarity about eligibility criteria for secondary (CMHT) services. This included diagnostic uncertainty, complex or difficult to treat disorders, severe mental disorders, mental disorder with significant risk and vulnerable adults (see appendix 1 for details).

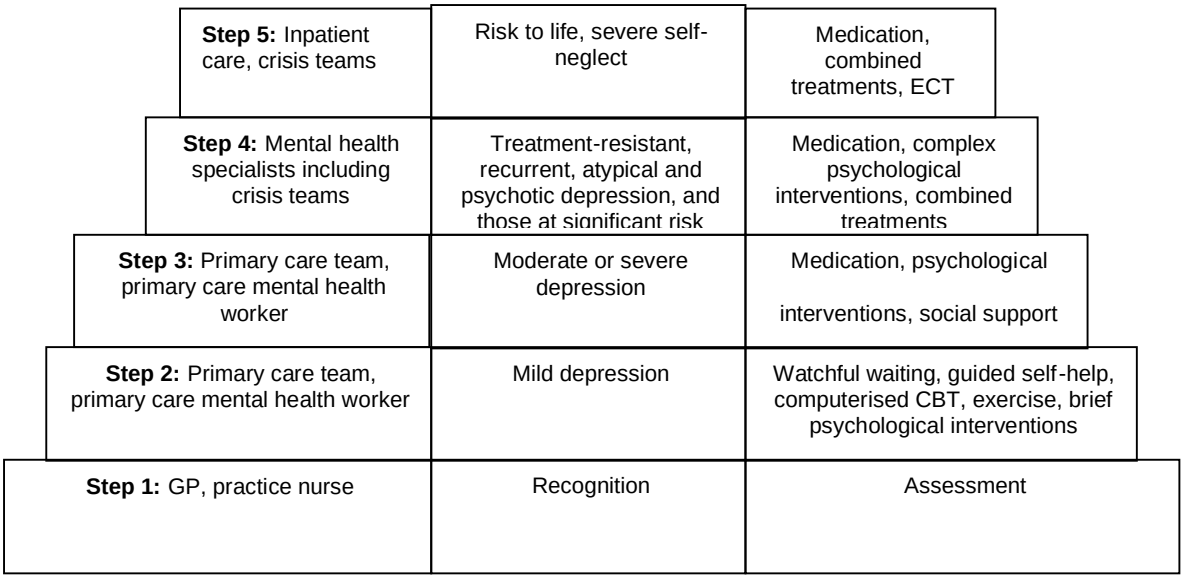


Figure 1: NICE guidance for depression - the stepped care model

The development of interventions was based around the NICE guidelines, for example, the pilots provide self-help information and signposting, guided self-help, group based psychosocial education and computerised CBT (CCBT). The introduction of CCBT took place after the initiation of the pilot projects due to licensing issues. The teams also provide a link to primary care based counselling. Formal access to Psychologists differs between the sites, with St Albans providing this as a key part of the PCMHT.

3.3 Staffing

3.3.1 Primary Care Mental Health Workers

The remit of Primary Care Mental Health Worker (or Graduate Worker) is to provide direct support to patients experiencing common mental health problems. The direct management and supervision for these workers varies for each pilot area. These workers are currently undertaking a years training course. Key components of the role include:

- Conducting assessments
- acting as a 'sign poster' to other services, both in the statutory and voluntary sectors
- providing brief guided self-help interventions
- Developing the use of treatment protocols and care pathways for care of people with mental health problems within the primary care setting.
- Providing very short-term and outcome focused interventions to patients with mild/moderate mental illness.

3.3.2 Link workers

Link workers are experienced mental health professionals drawn from the established CMHT staff. Some aspects of their role include:

- Conducting assessments
- acting as a 'sign poster' to other services, both in the statutory and voluntary sectors

- acting as an on-site expert to offer support and advice on mental health issues
- developing the use of treatment protocols and care pathways and achieve skills enhancement, and the implementation of protocols leading to increased competencies and better care of mentally ill people within the primary care setting.
- discussing potential CMHT referrals to ensure the most effective intervention is offered to the individual
- engaging with the whole primary care team to enable them to develop their skills and confidences in assessment, and ensure referral on, or advise on, further management as appropriate
- providing a direct link with the specialist services by attending team and allocation meetings, this ensures an effective two-way information flow between the different services
- providing education and supervision of primary care staff
- providing the link and develop a culture of partnership between the primary care team and local secondary services.
- providing very short-term and outcome focused interventions to patients with mild/moderate mental illness.

3.3.3 Psychologists:
The Psychologists provide specialist psychological assessments and treatments including Cognitive Behavioural Therapy (CBT). In primary care this is generally for non-psychotic patients referred by the GP, in secondary care it includes treatment of people with psychotic conditions and severe mental health problems. The psychologists provide clinical leadership and supervision to other staff in the primary care mental health team.

The enhanced service in St Albans also includes a Lead Counsellor, who works closely with the Consultant Psychologist and Lead General Practitioner in the development and ongoing management of a managed counselling service including accreditation standards, referral criteria and triage and audit. The General Practitioner Lead manages the enhanced service.

3.4 Supervision

Clinical supervision is provided by the psychologists either working within the PCMHT or from the CMHT. Management supervision is provided by the CMHT managers with the exception of the Enhanced Service in St Albans where management is provided by the Consultant Psychologist.

3.5 Project Management

Each pilot site has a project lead working from secondary services and linking with colleagues in primary care. The Enhanced Service in St Albans is project managed by the primary care GP Lead.

3.6 Project Evaluation

A sum of money was provided by CSIP and the Joint Commissioning Team to part fund the evaluation. This evaluation was carried out by Hannah Baron (Assistant Psychologist) and Kate Spokes (Practice Governance Facilitator).

4. Measures

Each PCMHT team has collected information about their activity since commencing each pilot. There are similarities in this data; however, not all the same information was collected by each team from the same time. Since September 2006 a core set of information has been collected locally by each of the teams and subsequently recorded onto an Access database. The Access database was set up by Andy Blaxill from the HPT Information Team. Both types of information have been used to contribute to the overall evaluation of the project. The CMHTs also collected information about referral rates, appropriateness of referrals, assessments and waiting times.

The pilot areas were evaluated from 4 different perspectives:

4.1 Access and clinical delivery:

PCMHT Front sheet (appendix 1)
Records demographic details of service users, waiting times, presenting problems, assessment outcome, date of discharge and onward referral details. This form is completed by the PCMHT on receipt of referral and updated post intervention on date of discharge.

4.2 Clinical Effectiveness:

4.2.1 Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) (appendix 2).
This 34-item questionnaire measures general distress, as well as four domains: subjective well-being, symptoms, functioning, and risk to self/others. Each item is scored on a five-point scale from 0 (not at all) to 4 (most or all of the time). Positively framed items are scored in reverse.

The CORE-OM is administered at assessment (pre-intervention) and at intervention completion (post-intervention) and is completed by the service user.

The scores break down into groups which indicate level of clinical severity. There are 2 in the non-clinical range which indicate healthy or low level and 4 in the clinical range which indicate mild level, moderate level, moderate to severe level and severe level. According to Barkham et al. (2006) a change of 5 clinical points or more indicates a reliable and clinically significant change.

4.2.2 Hospital Anxiety and Depression Scale (HADS) and Patient Health Questionnaire-9 (PHQ-9) (appendix 3/4).
The HADS questionnaire is designed to detect adverse anxiety and depression, measured on 2 sub scales. On each subscale higher scores indicate a greater severity of symptoms and a greater severity of the emotional state (Turner and Lee, 1998).

The PHQ-9 is a quick depression assessment with 10 questions. Higher scores indicate greater severity of depression ranging from minimal depression to severe depression.

Depending on local pilot site availability, the GP's are asked to provide the PCMHT with either a HADS or PHQ-9 score along with the referral. If this was not provided on receipt of referral, the team administer either questionnaire at assessment. All service users are then required to complete a post treatment HADS/PHQ-9 questionnaire on completion of treatment.

4.2.3 CORE- Therapy Assessment Form (appendix 5)
This form is completed only by Clinical Psychologists at assessment stage.

4.2.4 CORE- End of Therapy Form (appendix 6)
This form is completed only by Clinical psychologists at end of therapy.

4.3 Service Satisfaction:

4.3.1 Service User Questionnaire with Choice- (appendix 7).
Service users were asked to complete a questionnaire designed to measure satisfaction with the PCMHT service. Issues such as satisfaction with the help received and the quality of service were evaluated. This questionnaire also included questions addressing the quality of information given and if the person was given a choice to access the service after discussion about possible treatment outcomes. Items were scored on a four point (1-4) scale. This questionnaire was given (or posted) to the service users following intervention completion (planned or unplanned). Service users were asked to complete the questionnaire and post it back to the PCMHT anonymously. The forms were however coded for site and intervention offered.

4.3.2 GP satisfaction Questionnaire (appendix 8)
GPs were asked to complete a questionnaire designed to measure GP satisfaction with the PCMHT. Issues such as improved care, impact on workload and recommendations to continue in the long term were evaluated. Items were scored on a 3 point scale ranging from 'definitely yes' to 'no'. GPs were given an opportunity to comment on the service and to make recommendations. GPs were asked to post the questionnaire back to the local PCMHT.

4.3.3 Staff Experience
This information was gathered only in St Albans as part of the New Ways of Working pilot. The questions asked are indicated in the relevant pilot section.

4.4 Social/employment circumstances data set:

Current Employment and benefits circumstances (appendix 9)
Service users were asked to complete an employment questionnaire to measure any change in employment circumstances whilst receiving interventions from the PCMHT. Questions such as benefits, time off sick and ability to work were evaluated. This questionnaire was administered at assessment (pre-intervention) and on completion of intervention (post intervention).

5. Letchworth Pilot

Meetings about the Letchworth pilot began in February 2005, and included the PCT Mental Health lead as well as the locality Head of Psychology. Key principles included providing swift access to evidence-based therapies within primary care and reserving secondary services for people with severe and complex needs. Documents such as Investing in Your Mental Health, the NSF and 10 High Impact Changes highlighted the need for reducing waiting times for effective services provided in the most appropriate setting while improving the interface between primary and secondary care. The Letchworth service redesign project incorporates both the development of Enhanced Mental Health Services and Improving Access to Psychological Therapies.

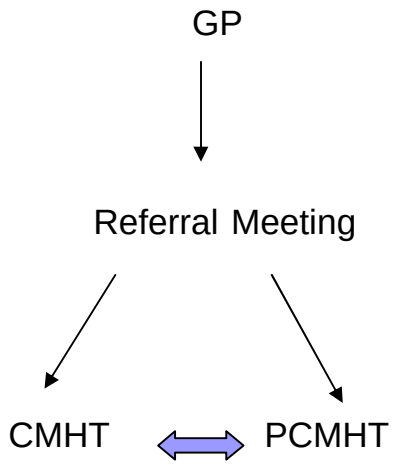
5.1 Primary Care Enhanced Mental Health Service:

Team Structure:

The Letchworth Primary Care Mental Health Team has been resourced from CMHT capacity: 0.8 CPN and 0.8 Social Work posts were seconded into the pilot team. The PCT contributed £16,000 to the project as a one-off pump-prime grant. As this was not sufficient to fund a Graduate Worker, a CST worker with appropriate qualifications in an adjoining locality was seconded into the pilot and a GP with a special interest in mental health is also part of the pilot team. The Letchworth PCMHT covers a population of approximately 54,466 and is available to all 6 GP surgeries within the locality.

The pilot purposely includes one CPN and one Social Worker to provide a balance of expertise within primary care. The team is managed by the CMHT manager who provides monthly supervision and is available for consultation as needed; additional clinical supervision is available from the CMHT psychologist who provides one hour of supervision per week.

Figure 2: Model of Service Delivery



All referrals received by the PCMHT are discussed in the weekly CMHT multidisciplinary referral meeting attended by consultant psychiatrist, psychologist,

team manager, lead CPN, PCMHT link worker and administrator. Referrals are then directed appropriately to psychiatric outpatient appointment, psychology, CMHT assessment, or PCMHT.

Once referrals are accepted the team assigns them to the appropriate team member (link worker/graduate) who makes contact by telephone or letter, offering an appointment. There is currently no waiting list for the PCMHT. The GP is always informed of the outcome of the contact with the PCMHT.

Assessments are usually done by one PCMHT worker; where appropriate joint assessments occur between link workers and heath visitors or other primary care professionals. Following the assessment, treatment is offered to service users who are judged to be appropriate for the PCMHT based on HADS score, level of risk and suitability for interventions offered. Cases can be discussed in weekly supervision with the CMHT psychologist; there are also opportunities for informal discussion with the CMHT manager, GP or other CMHT professionals.

A number of different treatments are available from the PCMHT. The treatments offered are highlighted below.

Computerised Cognitive Behavioural Therapy (CCBT) – Letchworth PCMHT were successful in their bid for 3 two-year licences for *Beating the Blues*, the CCBT program recommended in the NICE Guidelines for Depression. As a result, this has been installed on the workers' laptops, so it is available to clients seen in a variety of settings, and not dependent on being installed on a specific desk-top computer. Two simultaneous sessions are run at the Letchworth Centre for Healthy Living, with one worker in an adjoining room, available for setting up and any questions/ problems. This treatment has been offered since October, and each course lasts for eight sessions.

Self help/Guided self-help- Both the graduate worker and the link workers can provide guided self-help, using booklets produced by Northampton and Northumberland PCTs, MIND leaflets, and the SHADE material (Katrina Lovell). These leaflets will be available also on the LPCMHT website for GPs to download, as the hope is that increasingly GPs will be able to provide this service for their service users.

Group treatment- Anxiety management groups are run at the Letchworth Centre for Health Living; due to the increased number of referrals for anxiety in the weeks before Christmas, an additional 5-session group on managing anxiety about Christmas is being run. A supportive/educative group for Health Visitors is being run by the CPN Link worker to assist Health Visitors in their work with service users experiencing mental health difficulties.

Bibliotherapy/Books on Prescription – This is being set up as the evaluation is being written; approval for this service has just been received, and the books are being ordered by local libraries. The list has been compiled in conjunction with other counties offering this service, and the team's psychologist.

Signposting - All voluntary and statutory agencies in the area were visited by the link worker and graduate worker during the set-up phase of the pilot, and a computerised

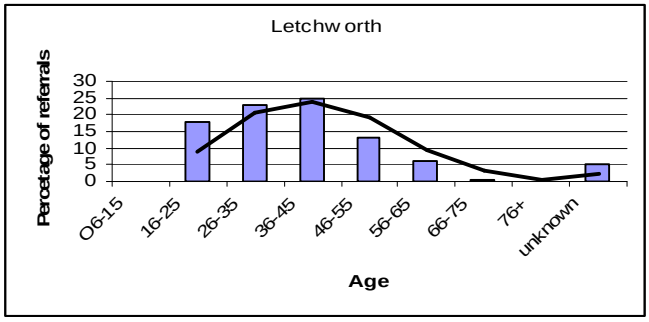
data-base of what services are offered, the eligibility criteria, who can refer, any cost, etc was compiled. Anyone seen for assessment by the PCMHT and deemed appropriate for signposting elsewhere is referred on to the relevant agency. This database is also available to GPs, both in hardcopy and on the PCMHT website; again, the hope is that as part of the educative function of the pilot, primary care staff will increasingly refer service users to the appropriate resource themselves.

Following treatment with the PCMHT, a discharge letter is sent to the referrer detailing intervention outcome. If appropriate, further referrals or contact with specific mental health agencies are recommended.

Referrals to the PCMHT

A total of 332 referrals were received between February 2006 and December 2006 from the 6 GP surgeries. These were for 206 (62%) females and 126 (38%) males. They were aged between 17 and 69 years of age with an average of 37 years. The following figure details the age distribution of the people referred to the PCMHT.

Figure 3: age distribution



If the information in the referral letter suggests that the PCMHT is not likely to be the most appropriate service for that particular service user, the link worker will liaise with the GP and referrals are redirected to an alternative service. Twenty-nine people were paper triaged without assessment and 4 unrecorded. Two people had further detailed liaison work but did not require an assessment.

The following graph illustrates the breakdown of service users referred to the PCMHT by their GP surgery.

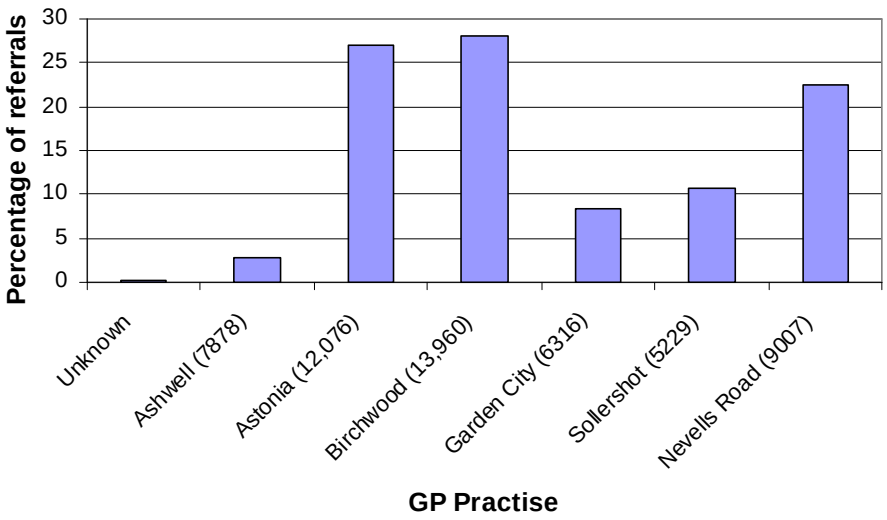


Figure 4: Usage of PCMHT by Surgery. The figure in the brackets is the population of the GP surgery.

Assessment

Between February and December 2006, initial PCMHT assessment appointments were appropriate for 297 service users out of 332. Two-hundred and twenty-five people (76%) attended their appointment with 21 (7%) awaiting assessment appointments. Twelve people (4%) cancelled, 2 (1%) did not make contact to accept their appointment and 37 people (12%) did not attend.

Assessment outcome

The following table describes the outcome of the 297 referrals that were appropriate for an assessment.

Outcome of assessment	No. of people	Percentage
Assessment only- unsuitable	1	0.4%
Attended assessment but DNA further	22	7%
Client cancelled	12	4%
Client did not make contact	2	0.7
DNA	37	12%
Assessment and unsuitable	2	0.7
Awaiting assessment	21	7%
Received intervention	200	67%
Total	**297**	**100%**

Table1: Assessment Outcome

Waiting Times

The date from referral and the date of first contact with the service user was recorded. The first contact date was taken to be the telephone contact or initial letter inviting the person to make contact. The average time between referral and first contact was 15 days from 0-75 days.

The date of the first offered assessment date was recorded. This date was taken to be the first assessment date the team offered to the service user for an assessment. This was on average 27.6 days ranging from 1-82 days.

The time between referral and first assessment date was also recorded. This was taken to be the first face to face contact the person had with the service. This was on average 32 days ranging from 1-97 days.

Breakdown of presenting Problems
The following table outlines the breakdown of presenting problems of the service users that were assessed by the PCMHT. The most common presenting problem was anxiety and stress, followed by low mood and depression.

Presenting problem	No. of people
Not recorded	45
Addictions	5
Anxiety/ stress	175
Bereavement/loss	11
Eating disorders	5
Interpersonal	9
Living/welfare	5
Low mood depression	128
Other	30
Personality problems	2
Physical problems	5
Work/academic	13
Self esteem	8

Table 2. Breakdown of presenting problems.

Ninety-six people had more than one problem and 46 had more than 2 problems. Forty-five people were also known to be taking medication (such as antidepressants) when they were referred.

Interventions:
Of the 297 people that were appropriate for assessment 200 (67%) people received an intervention, with the majority receiving guided self help (30%) or self help information (18%).

Table 3: Interventions

Type of Intervention	No. of people	Percentage %
Guided self-help	90	45%
Self-help information	56	28%
Signposting	26	13%
Group psycho education	8	4%
CCBT	8	4%
Individual psycho education	7	3.5%
Liaison work and assessment	3	1.5%
Phone consultation	2	1%
Total	**200**	**100%**

Clinical data
Pre-therapy questionnaires are normally completed at the point of assessment. Post-therapy questionnaires are sent in the post to the service user following the intervention.

HADS scores for anxiety were recorded for 194 people pre-intervention (mean score 12.7, range 1 to 21) and 34 post-intervention (mean score 10.5, range 2 to 19). Completed data sets (pre and post intervention) were available for 32 people. The post-therapy scores for the 32 people showed a reduction in average score of 3.2 points.

HADS scores for depression were recorded for 194 people pre-intervention (mean scores 8.5, range 1 to 20) and 34 post-intervention (mean score 5.0, range 1 to 15). Completed data sets were available for 32 people. The post therapy scores for the 32 people showed a reduction in average score of 2.8 points.

The following graph illustrates the pre and post intervention scores for the 32 people with completed data.

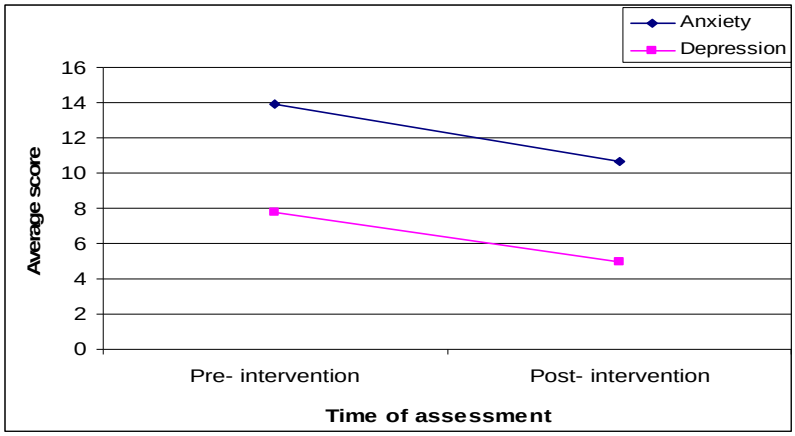


Figure 5. Average HADS scores for depression and anxiety pre and post intervention for the 32 people with completed data sets.

CORE-OM
CORE-OM scores were recorded for 98 people pre-intervention (average clinical score 16.9 range 0.3-35). Two people had post intervention scores (average clinical score 20.1 range 14-25 clinical scores) which showed a reliable and clinically significant change. One person however got worse in their clinical severity and was offered self help information and was signposted to an anger management group. The other, had a pre-intervention clinical score of 22.9 (moderate-severe) and a post intervention clinical score of 14.4 (mild), therefore reducing by 2 bands of clinical severity. Figure 6 displays the distribution of the pre-intervention CORE-OM scores.

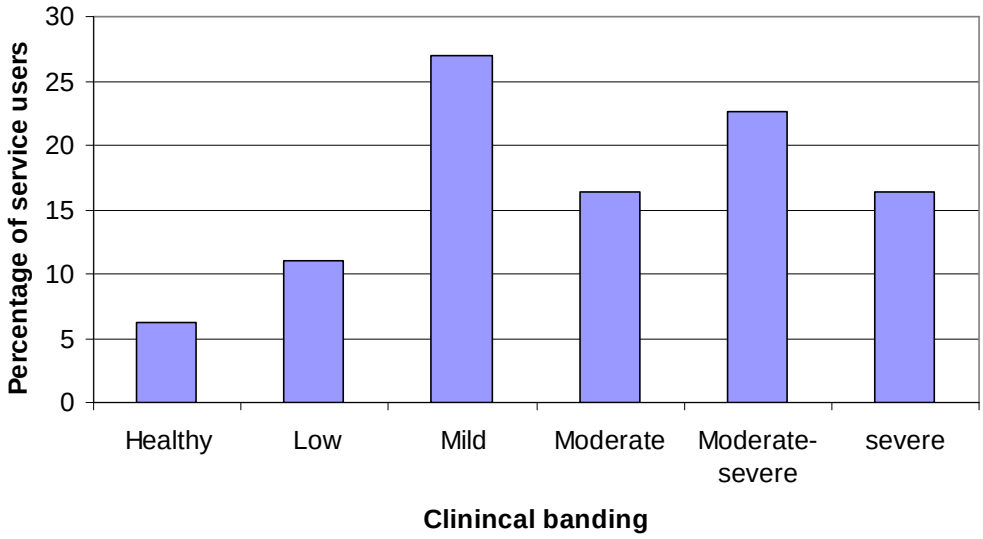


Figure 6: CORE-OM clinical banding

Sixteen people scored in the severe range; 7 people were signposted, 6 received guided self help, 1 self help information and 1 CCBT and 1 unrecorded. Eleven of these people have been discharged; 4 counselling, 2 discharged to care of GP, 1 eating disorders team, 1 employment service, 1 CDAT, and 2 CMHT.

Twenty-two people scored in the moderate to severe range; 4 received self help information, 2 group psycho-education, 10 guided self help, 2 signposted, 2 CCBT, 1 attended assessment but DNA further and 1 was unsuitable for PCMHT.

PHQ9 forms were not utilised by GP surgeries in this area.

Employment and benefits Questionnaire
At assessment 39 people were known to be in full time work, 1 a full time student and 14 were known to be receiving benefit. Seven people were known to be homemakers. Twenty-eight people reported that their emotional or mental health was stopping them from working.

Discharge Information
From February to December 245 people were discharged from the PCMHT, leaving 87 service users currently open. The following figure details the discharge information.

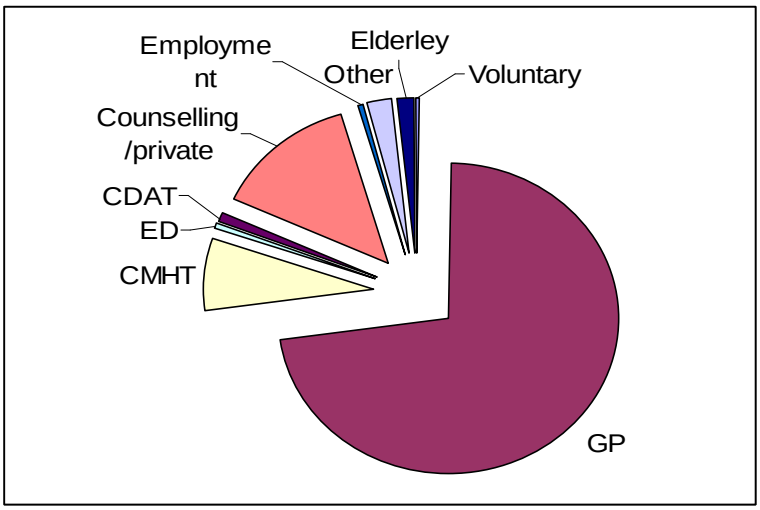


Figure 7: Discharge information

GP feedback and comments:
Fifteen GP satisfaction questionnaires were returned to the PCMHT in September 2006.

1). Has having the pilot PCMHT in your practice improved care for people with mental health problems?

60% definitely yes, 33% to some extent and 7% no.

2). Has the service had an impact on your day to day workload i.e. reduced referrals to secondary care/ prescribing rates/ follow up appointments?

60% definitely yes, 20% to some extent, 20% no

3). Has the service provided more options to you and your partners in the management of people with depression and anxiety?

87% definitely yes, 13% to some extent.

4). Would you like the service to continue in the long term?

93% yes, 7% no

5). Would you recommend the service to other colleagues in primary care?

93% yes, 7% no.

GP comments
A number of GPs provided feedback on their experience of the pilot:

"GP with a special interest in psychiatry, I am impressed by the resounding success of the pilot project at Birchwood surgery. I am delighted we have had positive feedback from service users and the whole surgery team."

"We find this a really useful service. The opportunity to have short case discussions is invaluable. I do hope the service is maintained."

"Maybe poor understanding, but unsure what service provides."

"Excellent Service. Patients are seen quickly and in a GP setting. Very positive feedback from patients."

"Marvellous!! Long may it last."

"It has been a valuable option for patients with mild/moderate anxiety/depression. Encouraging patients to manage their symptoms independently is excellent and also reassuring them that the symptoms are not abnormal. It has been beneficial discussing cases and then possible options. Hopefully we will get better at signposting patients onto appropriate help elsewhere and make more effective referrals to secondary care."

"Very helpful in improving/ enhancing the care of our patients with common mild/moderate mental health problems; depression and anxiety. Very responsive, prompt service. Many thanks."

"Has been useful to have somewhere to refer patients where they do not have to pay for further help. It would be useful if we could have the results of your assessments. E.g. the HADS assessment as it would be helpful for us to record such things."

PCT Perspective:
The following information was recorded by Dr Bond (Letchworth GP with a specialist interest in Psychiatry).

"Mental health problems are very common in general practice. Up to 40% of patients presenting have a mental health problem and for up to 25% (Goldberg 1991) this is the sole reason for attending. All GP's recognise that patients frequently present with unexplained physical symptoms such as chest pain, palpitations, tiredness, headaches and abdominal pain which occur because of a failure to tackle underlying emotional problems. Simply being sick is stressful and many chronic illnesses such as diabetes, heart disease and arthritis are associated with mental health problems.

A holistic approach is vital in general practice for mental and physical well-being. To this end, all GP's deserve a rapid and easy access to simple support and solutions to achieve mental health for our service users.

This is what the pilot project does so effectively. Prescribing costs for mental health in primary care are high so access to alternative solutions including help with social problems and psychological therapies is extremely beneficial. This approach also empowers patients to help themselves rather than adopting a sick role.

We must remember that this group of service users have mental health problems, not pathology. Working in this way will hopefully reduce the stigma and discrimination associated with mental illness.

This group of service users are not appropriate for community mental health teams

as they do not fit the diagnosis of severe and enduring mental illness. Thus a stepped care approach allows resources to be used more effectively."

GP analysis of cost benefit
One GP said that he was so impressed by the pilot that he wanted to look at the statistics of those referred from his practice, and estimate what would have happened for those service users had the PCMHT not existed. The following chart summarises the findings. This data was collected by Dr Ramsbottom, (Letchworth GP) and Vivienne Payne of North Herts and Stevenage PCT.

Forty-five people were referred from Nevells Road Surgery from February-August 2006; of those, 30 were treated and discharged during that period. It is estimated that ¾ of those referred into the PCMHT would have been referred into secondary services, had the pilot not existed. The GP concerned was clear that the improved outcome for the service user, as well as savings to primary and secondary care, was significant.

Cost Benefit

Sample 1	Patient would have been prescribed 6 months of Citalopram involving 2 GP appointments	Saving £54
Sample 2	Patient would have been referred to clinical psychologist in acute trust for 6 sessions	Saving £240
Sample 3	Patient would have been prescribed 6 months of Citalopram involving 3 GP appointments	Saving £72
Sample 4	Patient would have been prescribed 3-4 months of Venlafaxine involving 3-4 GP appointments	Saving £203
Sample 5	Patient would have been referred to CDAT team and seen 3-4 times by GP	Saving £533*
Sample 6	Patient would have been prescribed 6 months of Citalopram involving 3 GP appointments	Saving £72

* Cost of 6 month treatment by CDAT Team

Key: GP appointments £18 Citalopram £18 for 6 months Venlafaxine £40 for 1 month

Figure 8: GP analysis of cost benefit

Further evaluation of the above cost benefit analysis is required in order to balance the savings with the expenditure of the PCMHT.

Service User Feedback:
Letchworth CMHT manager met with the User and Carer involvement lead for HPT (Jo Burnham) in July to look at how best to involve service users. Three service users have expressed interest in being involved in presentations to the Local Implementation Team about their experience of the PCMHT and the difference it made to their lives.

Service user Questionnaire
Twenty-seven service user questionnaires were completed and returned to the PCMHT. The responses are detailed in table 4.

How satisfied are you with the amount of help you have received?	Very dissatisfied? 3.4%	Mildly dissatisfied 0%	Mostly satisfied 11%	Very satisfied 85%
Has the service you received helped you to deal more effectively with your problems?	Yes, it helped a great deal 37%	Yes, it helped a little 48%	No, it really didn't help 3.4%	No, it seemed to make things worse 3.4%
Did you get the kind of service you wanted?	No 3.4%	Not really 7%	Mostly 15%	Yes 74%
How would you rate the quality of the service you have received?	Excellent 67%	Good 26%	Fair 3.4%	Poor 3.4%
In an overall, general sense, how satisfied are you with the service you have received?	Very satisfied 67%	Mostly satisfied 26%	Mildly dissatisfied 3.4%	Very Dissatisfied 3.4%
If a friend/relative were in need of similar help, would you recommend our service to him/her?	No 3.4%	Not really 3.4%	Probably 15%	Yes 78%
To what extent has our service met your needs?	All of my needs have been met 18.5%	Most of my needs have been met 63%	Few of my needs have been met 15%	None of my needs have been met 3.4%
If you needed to seek help again, would you come back to our service>	No 3.4%	Not really 0%	Probably 26%	Yes 70%
How would you rate the quality of information that you were given about the service?	Excellent 52%	Good 37%	Fair 11%	Poor 0%
Were you given a choice to access this service after a discussion about possible treatment outcomes?	No 7%	Not really 7%	Probably 7%	Yes 77%

Table 4: Service user questionnaire

Service User feedback comments:
Again several people gave their comments on their experience:

"My back pains go hand in hand with my depression. With age, being 46 now I feel after being so active for years is much much harder to recover so I feel I am in a vicious circle. Hope this helps. Just filing this form out, my back has gone again. This is how bad things get."

"In question 7, I answered 'most of my needs were met' they all would have been met if I had been able to take part in group therapy but due to work commitments and the groups being during the day that was the only thing that I would have liked to participate in but was unable."

"Very friendly, welcoming. Felt comfortable. Enabled talking about issues easier".

"None- overly very satisfied with the service. If it did not miracles its only for my lack of sufficient commitment".

"The treatment I received has helped a lot, and I can control certain things now, although I was told it takes time and am hoping other aspects will improve in time with what I have learnt. I found the whole system extremely helpful and very professional. I would certainly seek help again if it was needed".

"The service was helpful, but I used it only for a shirt time- because that was all I needed. I am sure that it is a worthwhile and necessary benefit."

"The young lady I saw was extremely sympathetic and understanding of my anxiety but did not have true information about me which didn't help. The GP had made an error in her letter saying I was sleeping well when that was not the case. I've just learned that I have been referred to Diane Ellis at Lister Hospital. Xxx was very professional and suggested many ways of alleviating my anxiety but I've had cognitive therapy twice now and I'm still unable to use the learned skills for my depression as I have a bad memory due to emotional abuse."

"At the time of the appointment I was feeling very relaxed. So it wasn't much help at the time. My problem times are nov/dec and june/july."

"I have already recommended the service to people I know who have been in a similar situation as me. I have found the service very helpful in learning to deal with my thoughts and feelings and how changing them I can change my behaviour".

"I cant believe the change in me within weeks of seeing xxx and having the group session. I really enjoyed seeing xxx everything she said has been right for me and I really really like her she made me feel like a person again not just an item and has taught me to deal with hard situations".

"It helped me see what I needed to do to help myself. At first I thought the young lady was very young. How would she know how to help me and I was wrong and found her very good and she was very helpful. I opened my mind to things I forgot about that helped to sort out my problem. Very pleased with her."

"Having counselling has changed so much in my life. I am a much more positive person and so much happier, it put things into perspective. My family and friends have noticed how much better I am. So I just want to say thank you to everyone who helped me."

"The treatment I received was super. It only took an hour of discussion to work out my problems and administer some excellent advice."

"I was very impressed at the speed and professionalism of the service. Whilst I did not take up further help at that time I know that you exist and you take depression seriously."

"Referral to mental health has exacerbated my difficulties. But you'll ignore this in the same way that psychs ignore the real problem with the same dismissive attitude."

5.2 Letchworth Community Mental Health Team:

The Letchworth CMHT covers a general population of 71,684 and has a total of 15.8 WTE staff. The decision to second two CMHT staff, and thereby reduce CMHT capacity was taken on the assumption that within the first six months of the PCMHT, CMHT referrals would drop dramatically, replicating findings elsewhere. These assumptions have been proven with referrals to the Letchworth CMHT reducing by 54% in February-July 2006 compared with the same period in 2005 (see table 5: data source: Tracking books).

Month	2005	2006	Reduction	Percentage reduction
Feb	44	26	18	41%
March	53	30	23	43%
April	45	22	23	51%
May	38	13	25	66%
June	52	17	35	67%
Total	270	124	146	54%

Table 5: Referrals to Letchworth CMHT Feb to June 2005 and 2006.

For March to May 2005 and 2006 the total number of referrals was analysed which includes referrals to the CMHT and the PCMHT. For these 3 months the total number of referrals increased demonstrating that the PCMHT appears to be tapping into an unmet need. Figure 9 demonstrates these findings.

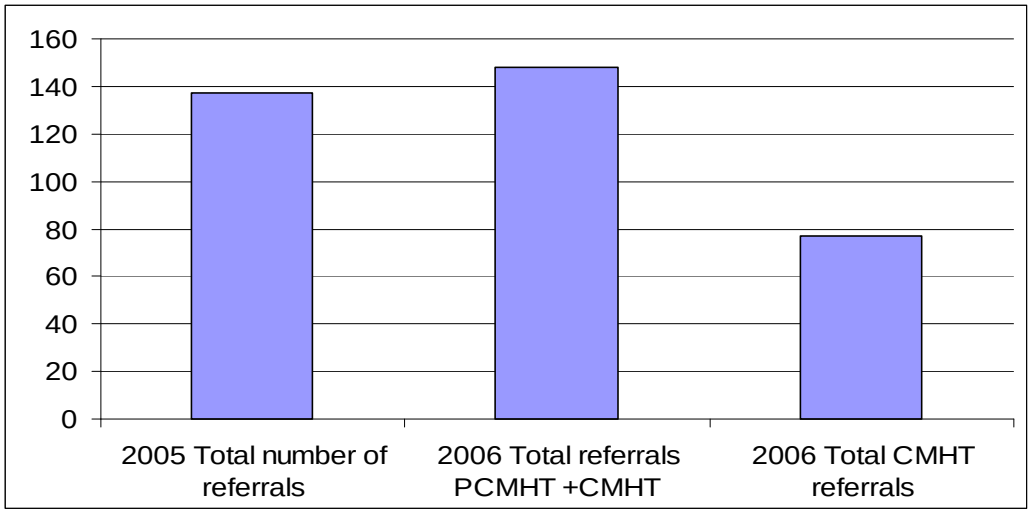


Figure 9: Total referrals to CMHT and PCMHT March to May 2005 and 2006.

An audit in December 2004 showed approximately 50% of referrals to the CMHT were for people with mild-moderate mental health problems or situational distress; people with these problems are now being seen by the PCMHT. The decrease in the rate of CMHT referrals means that mental health service users in both primary and secondary care will be treated faster and more appropriately.

The following table details the average waiting time for outpatient appointments 2005 and 2006 (data source: Infoview team)

Month	2005 (days)	2006 (days)	%Change
Jan	61	65	6.5% increase
Feb	63	16	75% decrease
March	84	10	88% decrease
April	75	66	12% decrease
May	124	42	66% decrease
June	84	45	46% decrease
July	83	28	66% decrease

Table 6: Outpatient waiting time
Note – the Letchworth PCMHT began accepting referrals in February 2006.

Local project issues identified by local project lead, Wendy Abondolo:

- The effect on the CMHT of seconding two CMHT workers into primary care will need to be evaluated at the end of the pilot's duration. Data thus far would suggest that the decrease in incoming work to the CMHT will allow this shift in resources without detriment to the CMHT service quality. The assumption is that with fewer but more appropriate referrals, the CMHT will be able to provide improved and more effective services for those recovering from severe and complex mental health problems.
- In the Letchworth service redesign, the psychologist continues to be sited within the CMHT, offering clinical supervision to the PCMHT and this is seen as strength of this model. Evidence has shown that there is a range of evidence-based treatments which are effective in treating mild-moderate depression and anxiety which do not require the level of expertise possessed by psychologists (*NICE Guidelines for Depression and Anxiety 2004*); the Letchworth model has deliberately chosen to retain the psychologist within the CMHT so that those with more complex problems can benefit from her level of expertise and training. The psychologist's role in the Letchworth pilot is one of offering weekly clinical supervision to the pilot staff team.
- Following the Community Mental Health Services Review, the management of Letchworth CMHT will be merged with Hitchin CMHT into the North Herts CMHT. The implications of this for the Letchworth Primary Care Mental Health Team will need to be considered.

6. St Albans and Harpenden

St Albans and Harpenden have taken a whole system approach to their service redesign across primary and secondary care which began in early 2005. There are three concurrent projects “New Ways of Working in Psychiatry”, development of a primary care Enhanced Mental Health Service (EMHS) and “Improving Access to Psychological Therapies” (IAPT).
The aim of the service redesign was to establish an integrated Mental Health Service from the first point of contact with primary care through to specialist secondary care services involving a smoother transition between organisations whilst promoting social inclusion and the recovery approach.

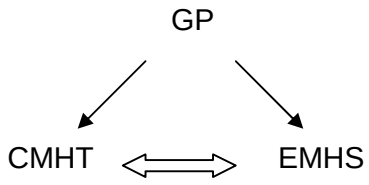
6.1 Primary Care Enhanced Mental Health Service:

The Enhanced Mental Health service is a complex service comprising of:

1. A managed counselling service including family therapy
2. A Primary Care Mental Health Service in 5 pilot practices
3. A Psychological Therapies service
4. Management of all the above including advising the PCT on their various mental health contracts within the voluntary sector.

Psychological Therapies Service:
This service comprises of 1.0 WTE (0.3 Consultant Psychologist, 0.2 and 0.4 WTE Counselling Psychologists) clinical service. The clinical triaging and supervision is managed by the Consultant Psychologist. This team serves all 13 surgeries within the St Albans and Harpenden (Historic PCT) catchment area covering an approximate population of 141,960. The psychological therapies service absorbed the Harpenden counselling and psychology waiting list which unfortunately had a 2 year waiting list and this has contributed to the new service’s lengthy wait. This has also been exacerbated by a number of referrals from the CMHT psychology waiting list. In sum, there has been an historic limited psychology resource within the area which has resulted in the new service being overstretched initially both through existing referrals and through a considerable level of unmet need resulting in a higher than expected volume of new referrals to the service.

Figure 10: Model of service delivery



Referrals to the Psychological Therapies Service
A total of 167 referrals were received between February 2006 and December 2006 from the surgeries outside of the pilot. These were for 107 (64%) females and 60 (36%) males. They were aged between 17 and 79 years of age with an average age of 40 years.

If the information in the referral letter suggests that the psychological therapies service is not likely to be the most appropriate service for that particular referral, the referral is re-directed to an alternative service. Four people were paper triaged without an assessment and 6 were unrecorded.

Referrals for Psychological therapies from the surgeries outside of the pilot are put onto the same waiting list as referrals from the pilot practice surgeries.

The graph below displays the breakdown of service users referred to the Psychological Therapies service by their GP surgery.

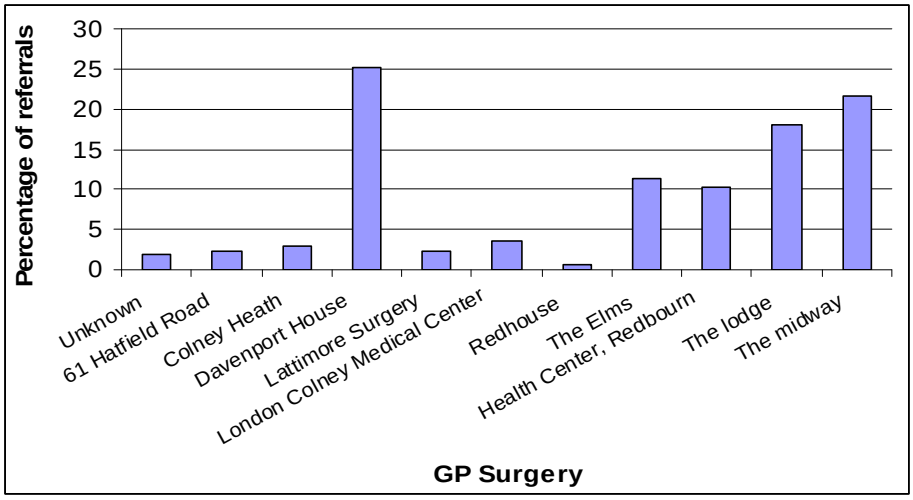


Figure 11: Referrals by GP surgery

Assessment

Between February and December 2006, initial assessments were appropriate for 157 people out of 167. Twenty-one people (13%) attended their assessment in this time and 119 (76%) are awaiting their assessment. Two (1%) cancelled and 15 (9%) did not make contact to arrange an appointment.

Assessment outcome

The following table describes the outcome of the 157 referrals that were appropriate for assessment.

Outcome of assessment	No. of people	Percentage %
Awaiting assessment	119	76%
Received an intervention	18	11%
Client did not make contact	15	9%
Client cancelled	2	1.5%
Assessment and unsuitable	2	1.5%
Offered therapy but declined	1	1%
Total	**157**	**100%**

Table 7: Assessment Outcome

Waiting times
The date from referral and the date of first contact with the service user was recorded. The first contact date was taken to be the telephone contact or letter inviting the service user to make an appointment or the waiting list letter acknowledging the service user has been put on the waiting list. The time between referral and first contact was 18 days.

The date of the first offered assessment date was recorded. This date was taken to be the first assessment date the team offered to the service user for an assessment. This was on average 97 days ranging from 64-171 days.

The time between referral and first assessment date was also recorded. This was taken to be the first face to face contact the service user had with the service. This was on average 119 days ranging from 22-210 days.

Breakdown of presenting problem
The following table displays the breakdown of presenting problems of the people that were referred to the psychological therapies service. The most common presenting problem was anxiety and stress and low mood and depression.

Presenting problem	No. of people
Not recorded	91
Anxiety/stress	38
Low mood/depression	35
Other	7
Interpersonal	5
Bereavement/loss	4
Eating disorder	4
Self esteem	3
Trauma/abuse	2
Living/welfare	2
Physical	1
Addictions	1
Work academic	1
Total	**194**

Table 8: Presenting problems

Twenty-four people had more than 1 problem and 4 people had more than 2.

Interventions
Of the 157 people that were appropriate for assessment 18 (11%) people received an intervention with the majority receiving psychological therapy. Two people had CCBT and 2 people had group psycho-education.

Clinical data
Pre-therapy questionnaires are normally completed at the point of assessment. Post-therapy questionnaires are sent in the post or completed in the last therapy session with the service user. The completed set of measures was finalised in September 2006.

HADS
HADS scores for anxiety were recorded for 11 people pre-therapy (mean score 14 range 7-20). No post therapy scores were recorded. HADS scores for depression were recorded for 11 people pre-therapy (mean score 8.5 range 1-14). No post-therapy scores were recorded.

CORE-OM
CORE-OM scores were recorded for 13 people pre-therapy (average clinical score 13.6 range 3.5-21.7). No post therapy scores were recorded. The graph below displays the distribution of the pre-therapy CORE-OM scores.

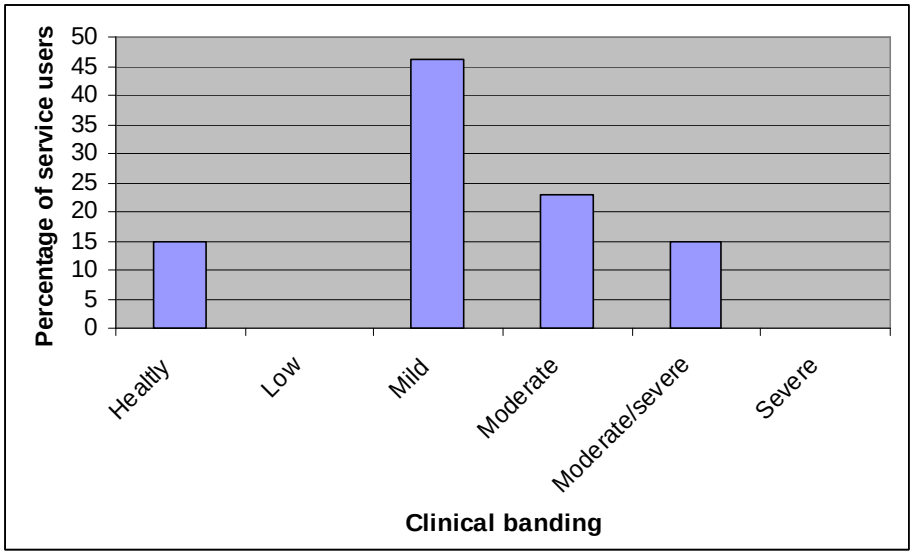


Figure 12: CORE-OM scores

Discharge information
Twenty- nine service users have been discharged from the psychological therapies service. The detail of discharge is displayed below. The majority of people were discharged back to the GP. Of the 29 discharged 6 had received an intervention and the remaining either did not make contact (15) cancelled (2), were paper triaged or did not require an assessment (5), or were unsuitable (1).

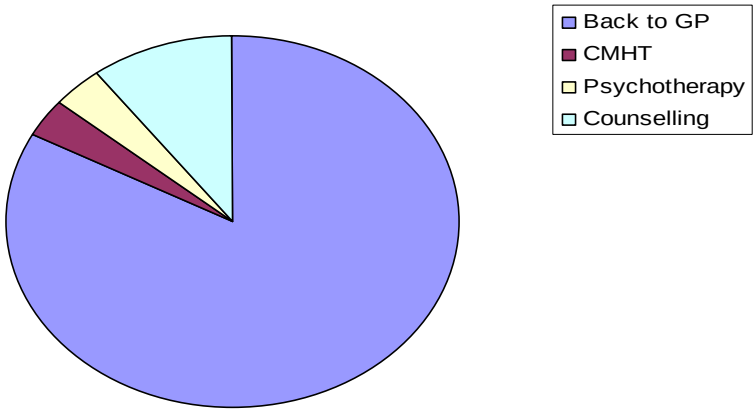


Figure 13: Discharge details of the 29 people discharged.

Primary Care Enhanced Mental Health Service: The Pilot

Team Structure:

This service comprises of 2 graduate mental health workers (GMHW) employed by the EMHS and one link worker. (This team will be referred to as the Enhanced Mental Health Team throughout this report). The CMHT provide a link worker who is employed full time by HPT. The graph below details the time allocation of the link worker.

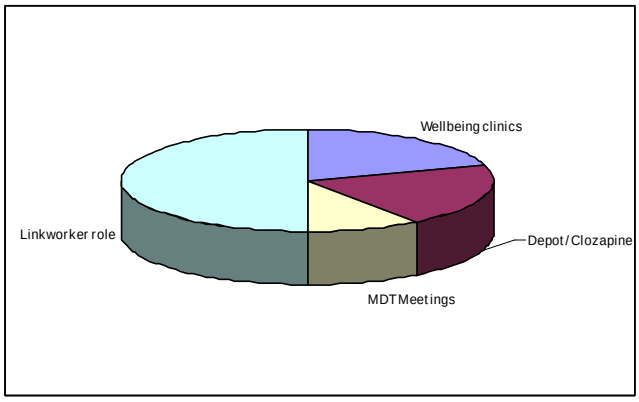


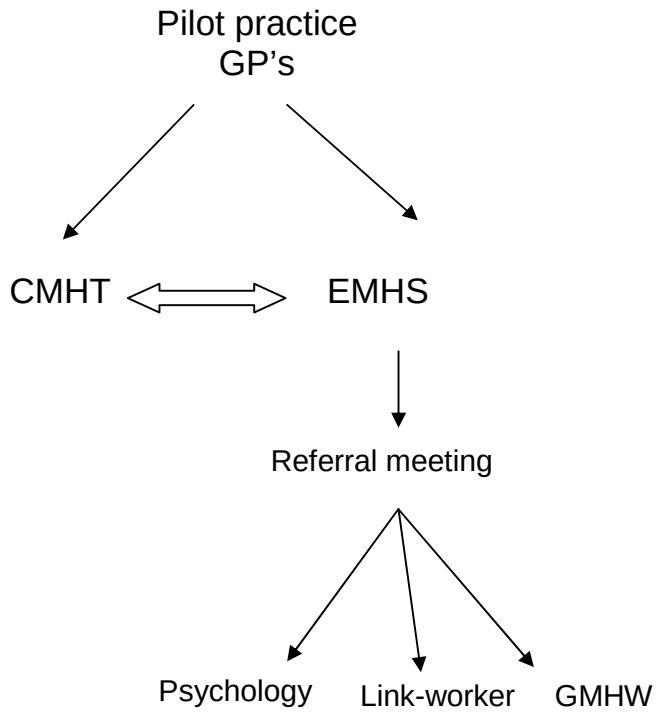
Figure 14: link worker role

The breakdown of the time of the link worker demonstrates that 0.2 WTE of the post is allocated to mental health and well being clinics in two pilot practices (Maltings and Harvey House). A further 0.2 WTE is allocated to depot and clozapine clinics at Edinburgh House and she also attends the MDT Referrals meeting there for a further 0.1wte. The remaining 0.5wte is allocated to the pilot practices for her work as a link worker. The link worker undertakes brief clinical work (guided self help and/or computerised cognitive behaviour therapy) with service users referred to the team who present with a significant risk or greater complexity of their symptoms not suitable for the GMHWs. She also carries out some of the clinical liaison between the GPs, HPT staff and the EMHS.

The team is managed by the Primary Care Consultant Psychologist (0.3 WTE) and lead G P(0.1 WTE). The Consultant Psychologist provides supervision to the graduate mental health workers (1 ½ hours per week), the counselling psychologists (2 hours per week) and the link worker (1 hour per week). The supervision equates to 0.1 WTE of the Consultant Psychologists time.

The primary care enhanced mental health service is available to 5 of the largest surgeries (The Maltings Surgery, Parkbury House, Harvey House Surgery, The Village Surgery and Grange Street Surgery) within the catchment area covering a population of approximately 71,919. The interventions available for each surgery vary with CCBT only available to patients from The Village Surgery, The Maltings Surgery and Grange) whilst guided self help is provided in all 5.

Figure 15: Model of service delivery:



Receipt of referral:
All referrals to the EMHS and psychological therapies service are discussed in a weekly referrals meeting attended by all members of the team. Referrals are then allocated to an appropriate member of the team. If the referral is deemed inappropriate for the EMHS a decision is made about the most appropriate onward referral (see appendix 11 for flow chart of available services within locality). The care pathway for all referrals means that referrals from the pilot practice surgeries for psychological therapy are put onto the same waiting list as the referrals from outside of the pilot practices.

Assessments:
Assessments are usually carried out individually and last 50m-1hour. However, if the referral letter is ambiguous or there is concern about complexity of the case, a joint assessment with GMHW and/or link worker/psychologist is offered. Liaison work is routinely carried out to gather more information prior to the assessment.

Intervention:
After the assessment the assessor discusses the range of therapeutic options available for the service user and together they decide upon an appropriate treatment plan. If the GMHW is unsure, or if service user is deemed to be too high risk for GMHW, decision on intervention is postponed and GMHW discusses service user with consultant psychologist in supervision.

A number of different treatments are available from the St Albans EMHS. The treatments offered include:

Computerised Cognitive Behavioural Therapy (CCBT):
The computerised CBT programme 'Beating the Blues' is run in 3 surgeries by the GMHW's and link worker. The GMHW's and link worker are responsible for making weekly appointments with service users, meeting and greeting them and being available to help if necessary. The computer programme assesses a service users risk of harm to themselves or harm to others on a weekly basis and the GMHW/link worker is responsible for monitoring this at the end of sessions and taking appropriate action. They arrange a review session with service user at the end of programme and after session 3 (if necessary). Onward referral or discharge is discussed and decided at this stage.

Guided self help and Self help information:
GMHW's and link worker use guided self-help materials for common mental health problems. Booklets produced by Northampton PCT, Northumberland PCT, Chris Williams, and Karina Lovell (SHADE/Overcoming OCD) are most often used. Also techniques from Mind over Mood and recommended S/H book list. GMHW's and link worker can provide up to 6 sessions of guided self/help.

Group Therapy
The team is currently running two groups – anxiety management and Mood Management. Anger management group is due to start in March 2007. A number of service users have been through anxiety management and mood management to date. The anxiety management group is a 6 weeks course and the mood management is a 10 week course. All groups are run by the EMHS and are run on a combination of cognitive behaviour and recovery models.

Psychological Therapies
Service users are approximately seen on average 6 sessions although some have been seen for the maximum offered of 24 sessions where appropriate. Service users are assessed and a psychological formulation is agreed upon that informs the treatment plan. This may involve CBT as well as psychodynamic interventions.

Referrals to the EMHS
The EMHS received 379 referrals from the 5 GP surgeries in the pilot area. These were for 244 females (64%) and 135 males (36%). They were aged between 13 and 80 years of age with an average age of 40 years (not all those referred are necessarily accepted). Figure 16 details the age distribution of the people referred to the EMHS.

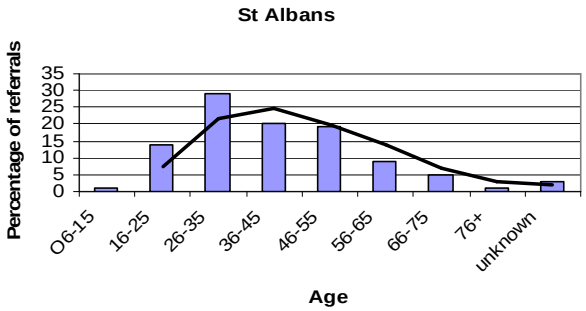


Figure 16: Age of people referred to EMHS

If the information in the referral letter suggests that the EMHS is not likely to be the most appropriate service for that particular service user the link worker will liaise with the GP and referrals are re-directed to an alternative service. More detailed liaison work occurred involving resources from the link worker but not requiring an assessment. Fourteen (4%) referrals were redirected without assessment or required detailed liaison work. Three (1%) were unrecorded.

The graph below illustrates the breakdown of service users referred to the PCMHT by their GP surgery.

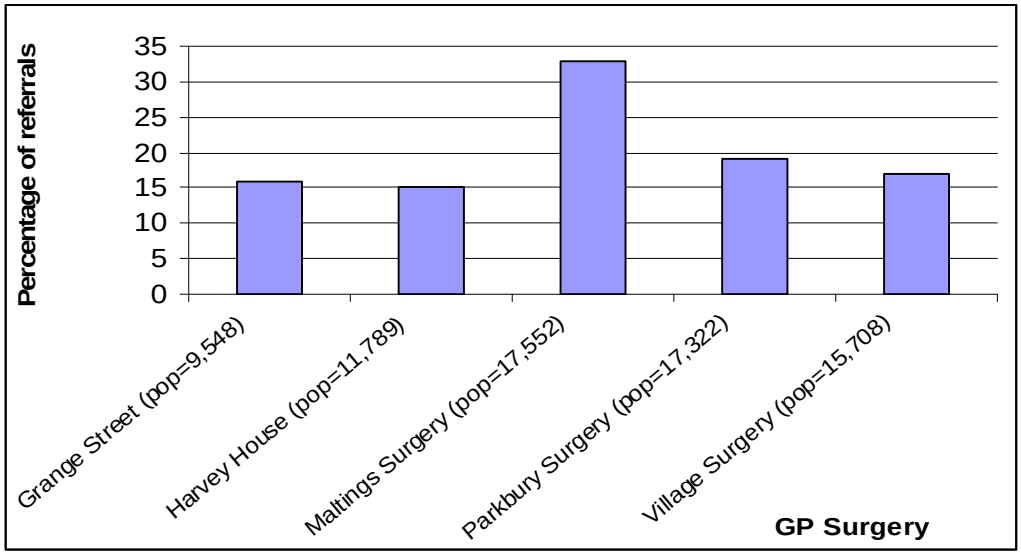


Figure 17: Usage of PCMHT by GP surgery.
In brackets is the population covered by that surgery.

Assessment

Between February and December 2006, initial assessments were appropriate for 362 (95%) service users out of 379. Two hundred and twenty-three people (62%) out of the 362 appropriate, attended their assessment with 81 people (22%) awaiting assessment appointments. Nine (2.5%) cancelled, 34 people (10%) did not make contact, 14 (3.5%) did not attend and one client (0.3%) deceased.

Assessment Outcome
The following table describes the outcome of the 362 referrals that were appropriate for assessment.

Outcome of assessment	No. of people	Percentage %
Assessment only	6	1.6%
Assessment on Psychology waiting and back to psychology	1	0.3%
Client cancelled	9	2.5%
Client did not make contact	34	9.4%
Deceased	1	0.3%
DNA	14	4%
Offered intervention but declined	4	1%
unsuitable	8	2.2%
On waiting list for assessment	81	22%
Received an intervention	204	56%
Total	**362**	**100%**

Table 9: Assessment outcome

Waiting Times
The date from referral and the date of first contact with the client was recorded. The first contact date was taken to be the telephone contact, the initial letter inviting the client to make contact with the service or a letter acknowledging that they have been placed on the waiting list for assessment. The average time between referral and the first contact was 14 days ranging from 0 to 115 days.

The date of the first offered assessment date was recorded. This date was taken to be the first assessment date the team offered to the service user for an assessment. This was on average 51 days ranging from 2 to 215 days.

The time between referral and first assessment date was also recorded. This was taken to be the first face to face contact the service user had with the service. This was on average 61 days ranging from 2 to 208 days.

The average time between referral and first assessment for the GMHW's was 43 days. The average time between referral and first assessment for the link worker was 35 days. The average time between referral and first assessment for the psychologists was 92 days.

Breakdown of presenting problems
Table 10 outlines the breakdown of presenting problems of the people referred to the EMHS. The most common presenting problem was low mood/depression and anxiety and stress.

Presenting problem	No. Of people
Anxiety/stress	159
Low mood/depression	153
Not recorded	130
Other	17
Self esteem	17
Work academic	17
Interpersonal	10
Physical Problems	7
Bereavement/loss	6
Trauma/abuse	5
Addictions	4
Eating disorders	4

Table 10: Presenting problems

One hundred and sixteen people were known to have more than 1 presenting problem and 35 had more than 2 presenting problems. Forty-eight people were also known to be taking medication when they were referred.

Interventions

Of the 362 people that were appropriate for assessment 204 (56%) people received an intervention with the majority receiving Psychological therapy or CCBT.

Type of intervention	No. of people	Percentage %
CCBT	63	31%
Group Psycho-education	14	7%
Guided self help	32	16%
Individual psycho-education	4	2%
Phone consultation	2	1%
Psychological therapy	74	36%
Self help information	7	3%
Signposting	8	4%
Total	204	100%

Table 11: Interventions

Clinical data

Pre-intervention questionnaires are normally completed at the point of assessment. Post intervention questionnaires are sent in the post to the client or completed in the last session.

HADS scores for anxiety were recorded for 163 people pre-intervention (mean score 13, range 2-21) and 38 people post intervention (mean score 8 range 1-15). Completed pre and post intervention scores were available for 35 people. For the 35 people there was an average reduction of 3 points in anxiety.

HADS scores for depression were recorded for 163 people pre intervention (mean score 8.7 range 0-20) and 38 people post intervention (mean score 3.9 range 0-10). Completed pre and post intervention scores were available for 35 people. For the 35 people there was an average reduction of 3.3 points in depression.

The following graph illustrates the pre and post intervention scores for the 35 people with completed data.

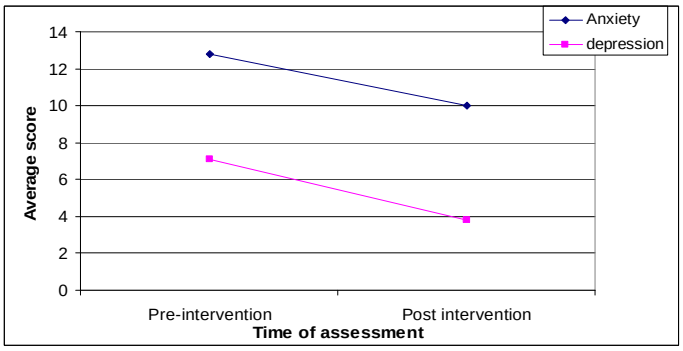


Figure18: Average HADS scores for depression and anxiety pre and post intervention for the 35 people with completed data sets.

CORE-OM

CORE-OM scores were recorded for 161 people pre-intervention (mean clinical score 16 range 0.3-35). The Figure below details the distribution of the pre-intervention CORE-OM scores.

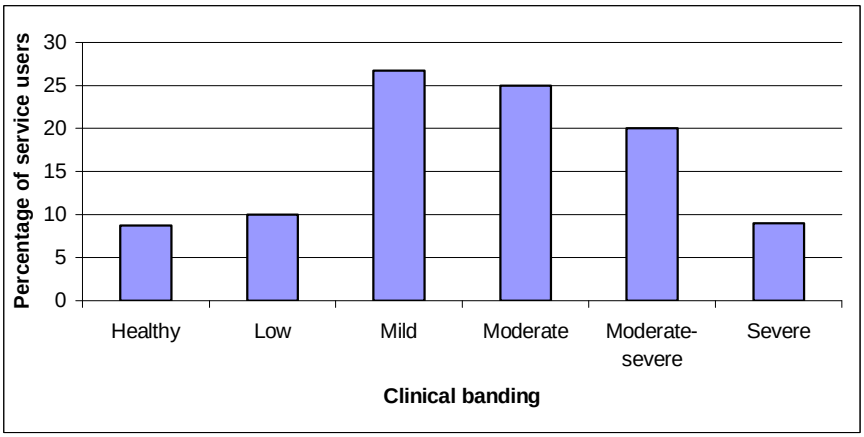


Figure19: Clinical severity score before intervention

Thirty-five CORE-OM scores were recorded post-intervention (mean clinical score 8.21 range 0.8-21). The following graph displays the mean CORE-OM clinical scores for people at pre and post intervention.

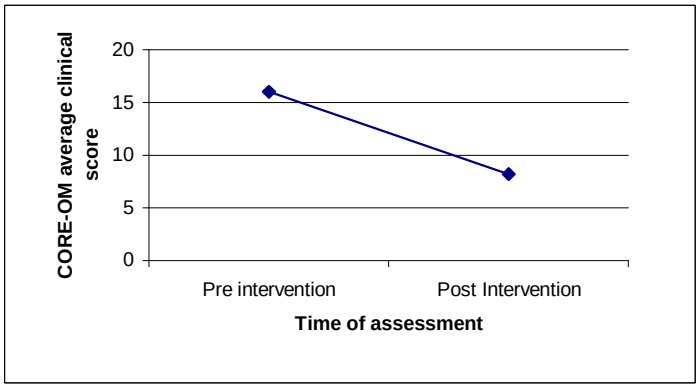


Figure 20: Mean clinical scores pre and post intervention

Eighteen people (51%) demonstrated a reliable and clinically significant improvement in CORE-OM clinical score thus improving in their clinical severity. sixteen (46%) people did not significantly differ in their clinical CORE-OM scores and 1 (3%) person significantly declined in clinical severity. Table 12 below summaries the clinical banding the intervention and the discharge information of the 16 clients that did not alter significantly post intervention.

Pre intervention severity level	**Post intervention severity level**	**Intervention**	**Discharge**
Healthy	Healthy	Group Psycho-education	Back to GP
Healthy	Healthy	CCBT	Back to GP
Healthy	Healthy	CCBT	Back to GP
Healthy	Low	Group psycho-education	Back on waiting list for Psychology
Healthy	Low	CCBT	Back to GP
Low	Low	CCBT	Back to GP
Low	Low	Guided Self Help	CMHT
Low	Healthy	CCBT	Back to GP
Low	Mild	CCBT	Open with psychology
Mild	Low	CCBT	Voluntary agency
mild	Mild	Group Psycho-education	Back to GP
Mild	Mild	Individual Psycho-education	Back to GP
Mild	Moderate	Group Psycho-education	Back to GP
Moderate	Moderate	CCBT	Back to GP
Moderate	Mild	Guided self help	Counselling
Moderate/severe	Moderate/severe	CCBT	

Table12: Interventions and actions for those people with no significant change

The following table details the severity level, intervention and discharge information of the 18 people that significantly improved in clinical CORE-OM scores.

Pre intervention severity level	**Post intervention severity level**	**Intervention**	**Discharge**
Mild	Healthy	CCBT	Back to GP
Mild	Healthy	Guided self help	Back to GP
Mild	Healthy	Psychological Therapy	Back to GP
Mild	Healthy	CCBT	Back to GP
Mild	Low	Guided self help	Back to GP
Mild	Low	CCBT	Back to GP
Mild	Low	Guided self help	Back to GP
Mild	Low	CCBT	Back to GP
Moderate	Low	Individual Psycho-education	Back to GP
Moderate	Mild	CCBT	Back to GP
Moderate	Low	Guided self help	Back to GP
Moderate	Low	Group Psycho-education	Back to GP

Moderate	Healthy	Psychological therapy	Back to GP
Moderate	Low	Group Psycho-education	Back to GP
Moderate	Mild	CCBT	Back to GP
Moderate/severe	Moderate	CCBT	Back to GP
Moderate/ severe	Healthy	CCBT	Back to GP
Severe	Low	Psychological Therapy	Back to GP

Table 13: Interventions and actions for those people with significant change

The one service user that appeared to get worse in clinical severity scored in healthy range pre-intervention and scored in the mild level post-intervention. This service user received CCBT and was discharged back to the care of the GP.

Discharge Information

The EMHS have discharged 190 people between February and December 2006, leaving 189 service users open to the EMHS. The following figure details the discharge information. The majority of service users were discharged back to the care of their GP.

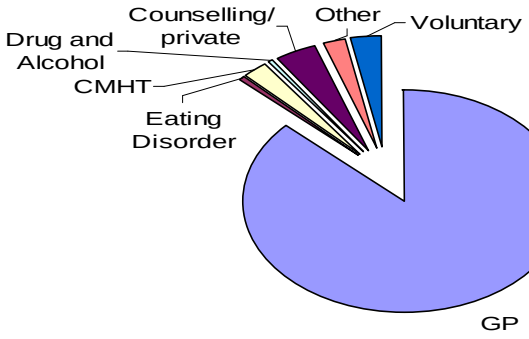


Figure 21: Service users discharge to services

GP experience:

A number of GPs provided feedback on their experience of the pilot:

Thirteen feedback forms were returned to the EMHS in January 2007 from the 5 surgeries within the pilot.

1). Has having the Pilot EMHS in your practice improved care for people with mental health problems?

85% definitely yes 15% to some extent 0% no

2). Has the service had an impact on your day to day workload such as prescribing rates or follow up appointments?

54% Definitely yes 38% to some extent 8% no

3). Has the service provided more options to you and your partners in the management of people with depression and anxiety?

100% definitely yes 0% to some extent 0% no

4). How would you like this service to develop in the long term?

“continue good communication about what you offer and who is appropriate”.

“I would like information as to waiting times, when patients start CBT and a discharge report.”

“CBT has proved very helpful to patients.”

“CCBT access”.

“To continue and to maintain reasonable waiting time by ensuring appropriate resources”.

“To continue. Knowledge of waiting times for different therapies”.

“Greater capacity. The increased waiting time recently has been off putting.”

“More appointments- patients really value no drug therapies”.

“Continue but will need to increase provision to prevent longer waits”.

“More of the same and more groups”.

“Needs more capacity”.

“Unfortunately became very busy very quickly- need quicker access to CBT a patients do benefit”.

“Now the teething problems have been sorted it really should be rolled out nationwide. Not sure of the computer based model as yet. Moves to include anger management

“Can we have information when a patient is started on a course and when finished.”

“Better feedback on those taken on by service”.

“Retain current practice based counselling and family therapy services. Don’t cut them”.

5). Would you recommend the service to other colleagues in Primary Care?

100% Yes 0% No.

GP comments:
Service user feedback has been variable but that is the nature of CBT. Being able to offer a specific therapy on site enables alternatives to prescriptive.

This is clearly an excellent service that fills a need and will resolve a lot of problems in the early stages before becoming entrenched.

Preliminary feedback from the GPs:

- Most felt the service has improved care for people with MH problems
- Most felt that the service had not affected their workload
- Most felt that more pt. management options were now available
- Most would recommend service to colleagues
- Harpenden GP's still waiting for full service

GP comments and suggestions:

- Very welcome service, long overdue
- Some serious concern re length of waiting list? Possibility of immediate initial assessment, better signposting at referral stage
- More education re clinical guidelines, esp. for PCMHW and link workers in pilot practices.

***Service user experience*:**

Fifty-six service user questionnaires were returned to the EMHS. They seem to indicate a positive response.

Question				
How satisfied are you with the amount of help you have received?	Very satisfied 62%	mostly satisfied 30%	mildly dissatisfied 4%	very dissatisfied 4%
Has the service you received helped you to deal more effectively with your problems?	yes, it helped a great deal 78%	yes it helped a little 18%	no, it didn't really help 2%	no, it seemed to make things worse 2%
Did you get the kind of service you wanted?	Yes 64%	Mostly 27%	not really 7%	No 0%
How would you rate the quality of the service you have received?	Excellent 57.5%	Good 37.5%	Fair 5%	Poor 0%
In an overall general sense, how satisfied are you with the service you have received?	very satisfied 66%	mostly satisfied 30%	mildly dissatisfied 4%	very dissatisfied 0%
If a friend/relative were in need of similar help, would you recommend our service to him/her?	Yes 86%	Probably 10%	not really 2%	No 2%
To what extent has our service met your needs?	All of my needs have been met 21%	most of my needs have been met 64%	few of my needs have been met 12%	None of my needs have been met 2%
If you needed to seek help again, would you come back to our service?	Yes 80%	Probably 16%	not really 0%	No 4%
How would you rate the quality of information that you were given about the service?	Excellent 34%	Good 39%	Fair 21%	Poor 4%
Were you given a choice to access this service after a discussion about possible treatment outcomes?	Yes 66%	Probably 10%	not really 14%	No 7%

Table 14: Service user questionnaire responses

6.2 St Albans Community Mental Health Team:

The St Albans CMHT covers a general population of around 146,000 with 17 GP practices and has a total of 30.27wte staff (3 staff down from 2005) comprising of 1.8wte Consultant Psychiatrists, 2.0 Staff Grade Psychiatrists, 2.0 SHO's, 1 SPR, 8.32 SW, 1.0 Professional Assistant, 6.65 CPN's, 2.6 Psychologists, 1.0 OT, 1 Senior Practitioner, 2 deputy CMHT Managers and 1 CMHT manager.

The aim of the EMHS is to increase capacity in primary care to deliver services for people with mild/moderate mental disorders which in effect enables secondary care services to focus resources on service users with complex/severe mental health problems.

The 'New Ways of Working' pilot has been implemented in St Albans CMHT since June 2006. (See 'NWW' report for further details). This involved a change in the referral process which impacts the way team members are working and how new referrals are assessed.

The objective of the New Ways of Working for Psychiatrists pilot project in St Albans is the creation of a more efficient interface between primary and secondary care in the management of mental health problems. There are a number of elements which combine to meet this objective including improvement in the range of services provided within primary care, enhancement of the skills of the multidisciplinary Community Mental Health Team and effective deployment of consultants in line with the proposals of New Ways of Working for Psychiatrists (Department of Health, 2005).

By adopting the "New Ways of Working" agenda within our CMHT, we aimed to tailor the job of the consultants to suit their particular training and skills within the team and in relation to colleagues in the wider health system. We proposed that consultants should have smaller caseloads, and spend less time seeing routine follow-up patients thus allowing more time for them to focus their skills on joint working with CMHT on complex cases. In addition we intended to facilitate the availability of consultants for consultation and advice across primary and secondary care, and create time for them to contribute actively to the establishment of a positive environment for training and practice innovation. We believed that this would result in an improved service for service users.

Referral data:

An audit in May 2005 showed approximately 45% of referrals to the CMHT had been for people with moderate mental health problems that may have been more appropriately treated in primary services or non-statutory bodies; people with these problems are now being seen by the PCMHT. (Data source: tracking book information).

As displayed in table 11 the number of referrals received within the CMHT has gradually declined since the implementation of the EHMS; a total of 688 referrals were made in March-November 2005 and 579 within the same period 2006 reducing by 16%. Coinciding with the reduction of referrals received, the number of referrals taken on by the CMHT has also reduced declining 26.7% from 232 in March-November 2005 to 170 in March- November 2006.

Although there appears to be a reduction in the number of referrals taken on by the CMHT, there appears to remain a high number of referrals sent back to the referrer after the introduction of this service indicating that the appropriateness of referrals is still an area of improvement.

There has also been a reduction in the number of steps in the referrals process for the CMHT, as they now implement a joint assessment clinic for all new non-urgent referrals. This has had a significant impact on the time between referral and initial assessment from an average of 52 days March- November 2005 to 21 days March-November 2006 improving by 60%. These findings indicate an improved, more efficient service resulting in a reduction in waiting times. A knock-on effect of a more efficient service has been in the number of clients not making contact with the service compared to last year declining 73% from 110 in 2005 to just 30 clients in 2006.

	March-November 2005	March – November 2006	Difference	% reduction
Number of referrals	**688**	**579**	**-109**	**-16%**
Number sent back to Referrer	99	109	+10	+10%
Diverted to CATT	24	30	+6	+25%
Referred elsewhere	41	65	+24	+58%
Number appropriate for assessment	**514**	**421**	**-93**	**-18%**
Did not make contact	**110**	**30**	**-80**	**-73%**
Number of assessments arranged	**390**	**334**	**-56**	**-14 %**
Did not attend	38	24	-14	-37%
Client cancelled	7	11	+4	+57%
Assessments carried out	**363**	**299**	**-64**	**-17.6%**
Number sent back to GP after assessment	163	104	-59	-36%
Number referred elsewhere	39	26	-13	-33%
Number taken on by CMHT	**232**	**170**	**-62**	**-26.7%**
Average time from referral to assessment	**52 days average**	**21 days average**	**-31 days**	**-60%**

Table 11: CMHT referral data March- November 2005 and March – November 2006. Data source: tracking book information.

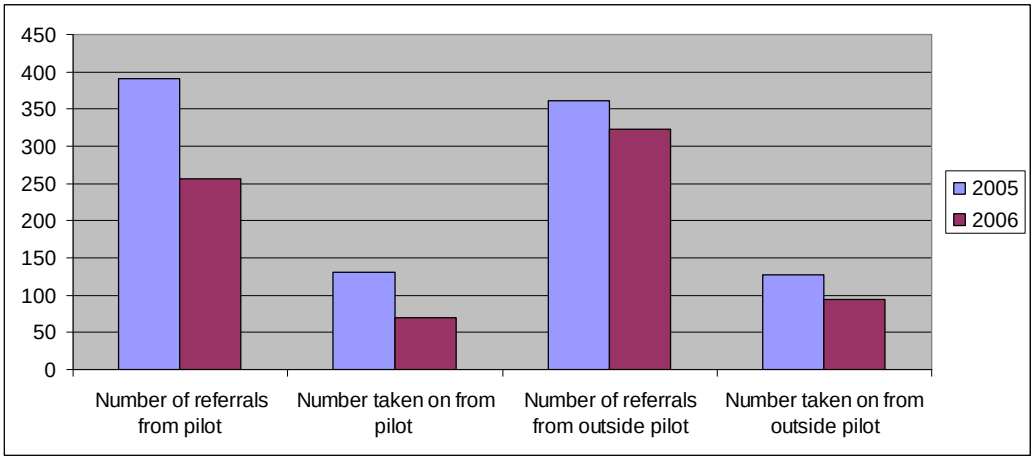


Figure 22: March- November 2006 and 2006 referral patterns from the GP Surgeries benefiting from the pilot

Since the implementation of the Primary Care Mental Health Service in St Albans, the CMHT received 256 referrals from the GP surgeries involved in the pilot. This is a decrease of 35% compared to last year. In contrast the surgeries outside of the pilot have reduced their number of referrals to the CMHT by 10%.

This data indicates that the CMHT are taking on fewer referrals from those surgeries benefiting from the interventions offered by the Primary Care Mental Health Team which supports the aims of increasing capacity within primary care to enable secondary care to focus on people with severe and enduring mental health problems.

The total number of referrals to the CMHT appears to have reduced since 2005 however when the total number of referrals to the CMHT are combined with the referrals received by the EMHS there is a large increase in overall referrals. In 2005 there was an average of 76.4 referrals per month and in 2006 there was an average of 112.5 referrals per month for the CMHT and the EMHS. This is an average increase of 47% demonstrating that the service is tapping into a huge previously unmet need.

Service user experience:

The Service user satisfaction questionnaire was given to all people assessed in the new joint assessment clinic in the CMHT beginning from June 2006 after the implementation of the changes within the CMHT as a result of NWW. Thirty-eight service user questionnaires were returned to the CMHT.

Question					
How satisfied are you with the amount of help you have received?	56% Very satisfied	37% mostly satisfied	5% mildly dissatisfied	2% very dissatisfied	
Has the service you received helped you to deal more effectively with your problems?	13% yes, it helped a great deal	71% yes it helped a little	8% no, it didn't really help	0% no, it seemed to make things worse	8% no response
Did you get the kind of service you wanted?	55% yes	42% mostly	0 % not really	0% no	3% no respons

					e
How would you rate the quality of the service you have received?	37% excellent	55% good	8% fair	0% poor	
In an overall general sense, how satisfied are you with the service you have received?	42% very satisfied	55% mostly satisfied	0% mildly dissatisfied	0% very dissatisfied	3% no response
If a friend/relative were in need of similar help, would you recommend our service to him/her?	63% yes	32% probably	0% not really	3% no	2% no response
To what extent has our service met your needs?	8% All of my needs have been met	53% most of my needs have been met	24% few of my needs have been met	0% few of my needs have been met	15% no response
If you needed to seek help again, would you come back to our service?	63% yes	34% probably	3% not really	0% no	
How would you rate the quality of information that you were given about the service?	21% excellent	45% good	26% fair	0% poor	8% no response
Were you given a choice to access this service after a discussion about possible treatment outcomes?	55% yes	29% probably	8% not really	0% no	8% no response

Table 12: Service user feedback

Staff experience:
Staff within the CMHT were given a staff satisfaction questionnaire to complete prior to the introduction of service change (June 2006) and completed in November 2006. This questionnaire was designed to assess the impact of NWW on the staff within the CMHT. (For a full report see NWW report appendix 12).

The results of the staff satisfaction questionnaire demonstrate that the team members are in greater agreement with the aims and objectives of the team. For example, the team are more certain of where teams responsibilities begin and end, feel the team has a clearer purpose to its work with service users and feel the role of the team is more clearly defined.

The team also felt greater satisfaction with various aspects of their present job. These include greater satisfaction with communication within the team, feelings of being valued, the job itself, the way changes are implemented and the extent to which the job taps the range of skills they posses. There does however appear to be greater dissatisfaction with job security and the level of salary relative to experience.

Care Pathways:
A considerable amount of time was spent meeting with local GP's discussing the changes within the CMHT and the development of a Primary Care Enhanced Mental Health Service. The guide depicted in appendix11 was an outcome of those discussions which gives a clear picture of the new care pathways. Having established clear guidelines around entry and exit criteria for GP's and other referrers' further work is under way to establish practical pathways for people who have personality disorders.

Local project issues identified by local project lead, Wayland Lousley:
Staff members anxieties have been raised due to the impact of the cost savings locally, community mental health service restructuring and the uncertainty of commissioning intentions around the development of primary care services. The "good will" that is the foundation on which this pilot is implemented is difficult to maintain in this context.

Impact on Team Capacity:
An analysis of the CMHT capacity and caseload profile is underway (Appendix 12) and clearly demonstrates the level of workload currently under taken. The team's total workload, which includes both clients care and non-care activities, is reported as 2739.3 hours for the four week period covered by this report. This information will be maintained on a monthly basis through supervision.

Despite the clear reduction in referrals the workload does not appear to have reduced yet with the Duty office being extremely busy with referrals, requests for advice and mental health act assessments.

Recovery:

The recovery approach underpins the redesign of mental health services. In a sense the local mental health services are going through their own recovery process and in so doing are gaining a growing sense of empowerment in redesigning and developing their services.

St Albans have introduced a regular fortnightly 2hr training and development session where all secondary care staff across the sector such as CMHT, CST, HST, AOT, Day Services, CATT and Inpatient services, Primary Care staff e.g. the Enhanced Mental Health service and non-statutory organisations such as Mind and Youth Talk have been invited. Unfortunately, the difficulty has been attendance, but when people have attended the response has been very positive with requests for further information on recovery and specifically for practical tools to help in developing their recovery based practice.

Further work is required and plans are in place for people to explore in more detail the lived experience gained from Jan Woodward's "Whole Life" tools and work in Hatfield Mental Health Services.

The Parkbury Mental Health and Wellbeing Clinic Pilot
A new clinic was set up in September 2005 at Parkbury House to provide a physical and psychiatric assessment by CPNs and a practice nurse for people on their severe mental illness register. This is a change in role for the link worker and takes additional time away from the CMHT. The impact of this clinic has shown significant benefits in terms of both mental and physical wellbeing for this particular group of service users.

Local results
The joint assessment clinic model has been associated with reduced waiting time for first assessment by an average of 31 days compared with the same time period in

the previous year, and there has been a dramatic reduction in the numbers of patients failing to make contact with the service. The duty administrator co-ordinates the referrals and arranges the joint assessments and adopts a pro-active role in contacting people and arranging suitable appointments. This has had a major impact on attendance and the efficiency of the process.

Prior to the pilot project, different disciplines held their own waiting lists, the longest of which was for a psychology assessment, which was 18 months at its worst point in 2005. Since the inception of the project, new referrals likely to need secondary care psychology services are seen as part of the joint assessment process and no waiting list has been built up for assessment or treatment. There is however a waiting list of approximately 30 patients who were referred for psychology treatment prior to NWW. It is anticipated that this will be cleared over the next few months, allowing psychologists to concentrate on providing a service for people with major mental illness in line with NICE recommendations.

The obvious explanation for the reduction in overall referral numbers and numbers of patients being taken on is the Enhanced Mental Health Service in Primary Care and the Primary Care Psychology Service. The Enhanced Service appears to be dealing with approximately one third of service users that would previously have been referred to CMHT by GPs with access to that service. For the other practices, most of which have access to Primary Care Psychology, the reduction in referral numbers of only one tenth is much less marked. It would seem that expanding the Enhanced Service to cover all GP practices in the locality could be expected to further reduce overall referral numbers. Whilst it is clearly important that service users requiring Secondary Care Mental Health Services do not have an appreciable delay before being assessed, the discrepancy between the delays to see the Primary Care based Mental Health Team is clearly undesirable and may be one explanation for the high proportion of referrals (37%) that are judged by the CMHT referrals meeting to be 'inappropriate'. Another possible explanation for the 'inappropriate' referrals is lack of information about the Primary Care Service, the changes to our service (entry criteria), and insufficient information in the referral data to make an accurate judgement about the suitability of the referral.

Next Steps:

The focus of this pilot has been the development of an integrated mental health service across the non-statutory sector, primary and secondary care. We are at an early phase of implementation with considerable further work to be done, namely developing further skills within primary care around mental health, creating further capacity within the CMHT through long term stable service users being effectively managed in primary care with link worker support and the ongoing training and development of all staff around the recovery approach and their mental health knowledge and skills.

7. Watford

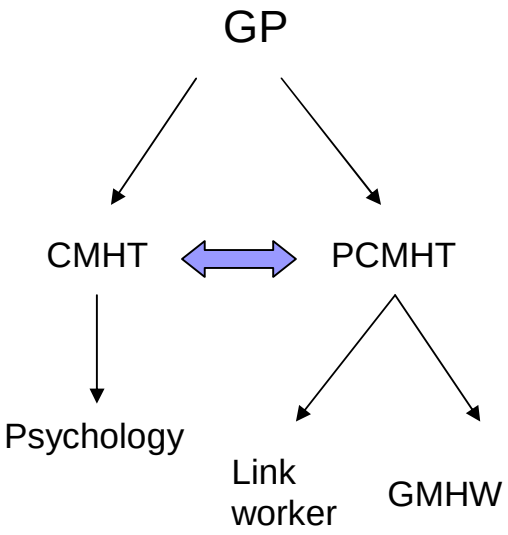
The Watford pilot is involved with the development of a Primary Care Mental Health Service in conjunction with the Improving Access to Psychological Therapies pilot. Watford and Bushey is an urban area with a significant ethnic mix it has a mixed social and economic group with significant deprivation.

7.1 Primary Care Enhanced Mental Health Service:

Team Structure:
The Enhanced Mental Health Service currently serves 3 out of 22 GP surgeries in the Watford catchment area and was implemented in February 2006. This service comprises of one Link worker (4 days/wk 0.8 WTE) funded by HPT and one Graduate Mental Health Worker funded by PCT. At present the link worker retains a small number of service users at the CMHT and provides one day a week of ASW duty to the CMHT.

Similarly to the Letchworth pilot the psychologist continues to remain in secondary care services and provides support and supervision to the Graduate Mental Health Worker one hour per week. The team felt fully operational in August following the recruitment of a new Link worker. The team is managed by the CMHT Manager who provides supervision.

Figure 23: Model of service delivery:



Referrals are sent directly to the PCMHT where each referral is discussed between the link-worker and graduate mental health worker. If further information is required the referrer is contacted. Once referrals are accepted the PCMH worker will make contact with the client to arrange an appointment via telephone or letter. Assessments are joint, wherever possible and take place in the GP surgery. Following the assessment interventions are offered to service users who are judged to be appropriate for the PCMHT.

Referrals to the PCMHT

A total of 113 referrals were received between February 2006 and December 2006 from the 3 GP surgeries. These were for 70 females (62%) and 43 males (38%). They were aged between 17 and 67 years with an average age of 36 years. The figure below displays the age distribution of the people referred to the PCMHT.

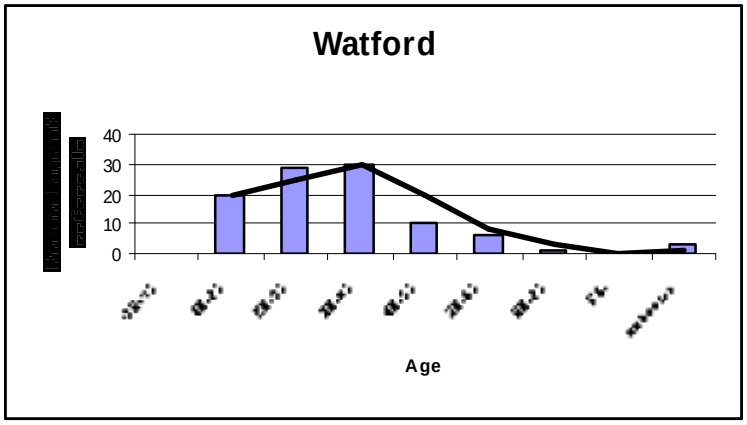
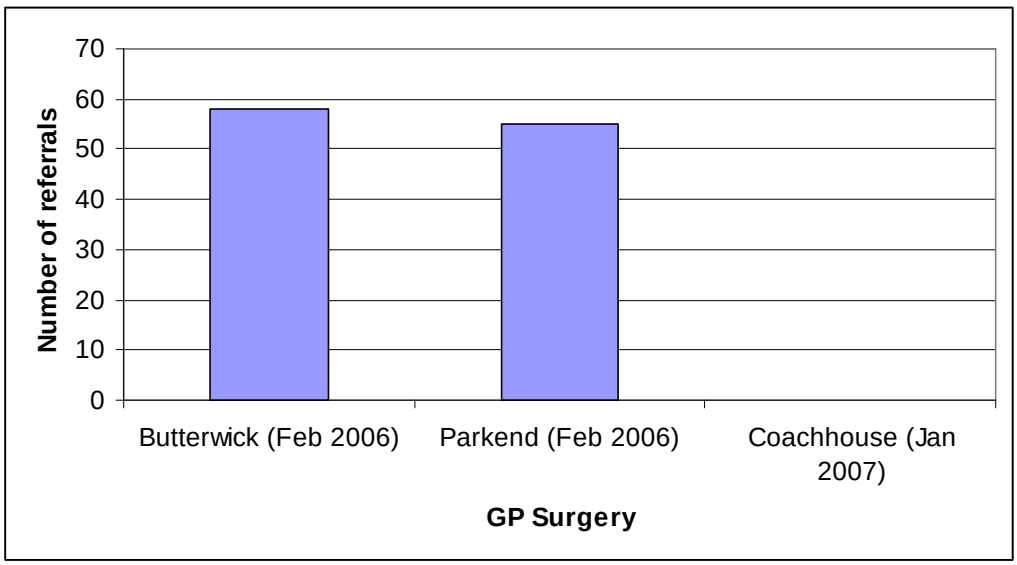


Figure 24: Age of people referred to the PCMHT

If the information in the referral letter suggests that the PCMHT is not likely to be the most appropriate service for that particular service user, the link-worker will liaise with the GP and referrals are re-directed to an alternative service. More detailed liaison work occurred involving resources from the link worker but not requiring an assessment. Ten (9%) clients were immediately re-directed without assessment or required liaison work.

The graph below illustrates the breakdown of service users referred to the PCMHT by their GP surgery. The Pilot launched into Coach House Surgery officially on January 9th 2007.

Figure 25: Referrals by surgery



Assessment
Between February and December 2006, initial assessments were offered to 103 (91%) service users out of 113, 9% were therefore not appropriate or didn't require an assessment. Seventy-nine service users (77%) attended their assessment. Twenty-Four (24%) service users did not attend, cancelled, did not make contact or informed the team they no longer wanted PCMHT input.

Assessment Outcome
The following table describes the outcome of the 103 people that were appropriate for an assessment with the PCMHT.

Outcome of assessment	No. of people	Percentage
Assessment attended- unsuitable	3	3%
Assessment attended- declined treatment	3	3%
Assessment attended- no longer requires input	2	2%
Assessment attended- DNA further	2	2%
No assessment- no longer requires input	8	7%
DNA	11	10%
Client did not make contact	2	2%
Client cancelled	2	2%
Awaiting assessment outcome	2	2%
Received intervention	68	67%
Total	**103**	**100%**

Table 13 Assessment Outcomes
***N.B**. percentages rounded to nearest whole.*

Waiting Times
The date from referral and the date of first contact with the client was recorded. The first contact date was taken to be the telephone contact or initial letter inviting the client to make contact. The average time between referral and first contact was 9 days ranging from 0-79 days.

The date of the first offered assessment date was recorded. This date was taken to be the first assessment date the team offered to the client for an assessment. This was on average 18 days ranging from 1-51 days.

The time between referral and first assessment date was also recorded. This was taken to be the first face to face contact the client had with the service. This was on average 19.5 days ranging from 1–59 days.

Breakdown of presenting problems
Table 14 outlines the breakdown of presenting problems of the service users that were referred to the PCMHT. The most common presenting problem was anxiety/ stress followed by low mood/ depression.

Presenting Problem	No. of people
Low mood/depression	72
Anxiety	79
Not recorded	2
Personality	19
Other	10
Physical	14
Trauma/ abuse	7
Eating disorder	3
Addictions	9
Cognitive/ learning	3
Interpersonal	7
Work/ academic	4
Self esteem	12
Bereavement/ loss	2
welfare	7

Table 14. Breakdown of presenting problems.

Eighty-two people had more than 1 presenting problem and 52 people had more than 2 presenting problems. Forty-seven people were also known to be taking medication when they were referred.

Interventions

Of the 102 people that were appropriate, 68 (67%) people received an intervention, with the majority of those signposted or receiving self help information.

Type of Intervention	No. of people	Percentage
Signposting	40%	9%
Self help information	18%	15%
Individual psycho-education	4	6%
Phone consultation	4	6%
Holding	1	1%
Guided self help	10	15%
Group psycho-education	4	6%
CCBT	6	9%
Total	**56**	**100%**

Table 15. Interventions

Clinical Data

Pre-intervention questionnaires are normally completed at the point of assessment. Post intervention questionnaires are normally completed in the last session or sent in the post to the client following intervention.

The Watford GP surgeries utilise PHQ-9 score forms instead of HADS questionnaires. PHQ-9 scores were recorded for 52 people pre-intervention (mean score 16 range 5-27). Figure 26 displays the severity of depression of the 52 people with pre intervention scores.

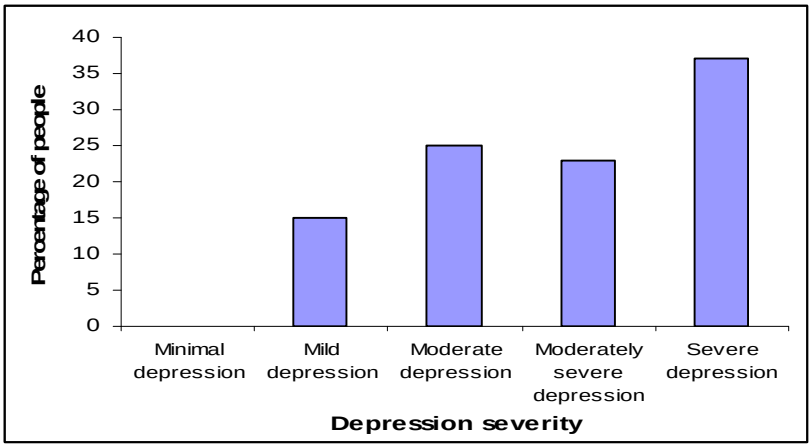


Figure 26: Clinical severity score before intervention

Four PHQ-9 score forms were returned post intervention (mean score 8 range 2-22). The average change was 6.7 points.

HADS scores

HADS scores for anxiety were recorded for 12 people pre intervention (mean score 14, range 5-20) and 3 people post intervention (mean score 8 range 2-12). Two people had completed data sets. The post intervention scores for the 2 people showed a reduction in average scores of 5.5 points.

HADS scores for depression were recorded for 12 people pre intervention (mean score 14 range 1-21) and 3 people post intervention (mean score 6 range 5-7). Two people had completed data sets. The post intervention scores for the 2 people showed a reduction in average scores of 8.5 points.

CORE-OM

CORE-OM scores were recorded for 55 people pre-intervention (mean clinical score 17.5, range 3-33). The following figure displays the distribution of pre-therapy CORE-OM scores.

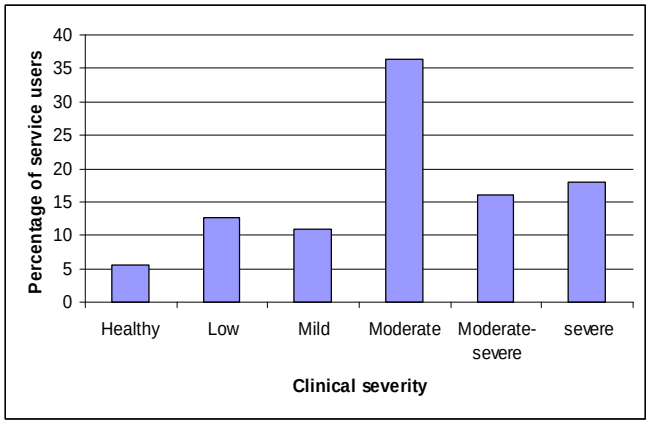


Figure 27: Clinical severity scores after intervention

CORE-OM scores were recorded for 8 people post intervention. Of the 8 returned 7 had completed pre and post intervention (mean clinical score 11.1, range 5-20). Three people demonstrated a reliable and significant improvement in clinical score. Four clients did not differ significantly.

The following graph displays the mean CORE-OM clinical scores for the 7 people at pre-intervention and post intervention.

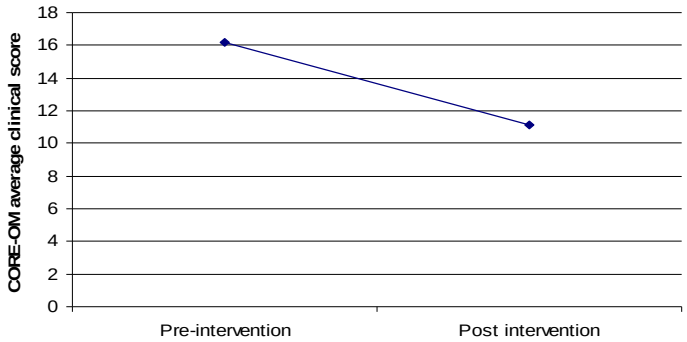


Figure 28: Changes in average clinical scores before and after interventions

The table below outlines the clinical banding pre and post therapy outlining the intervention offered and the discharge information of the 7 clients with pre and post intervention scores.

Client	Pre intervention Banding	Post intervention banding	Change in clinical score	Intervention	Discharge information	Clinically significant change
1	Low	Healthy	-4.4	Individual psycho-education	Back to GP.	no
2	Low	Low	-3.5	Individual psycho-education	Back to GP	no
3	Moderate	Low	-7.9	CCBT	Back to GP	Yes
4	Moderate	Moderate	-0.6	Guided self help	Back to GP	no
5	Moderate	Mild	-7	Group Psycho-education	Back to GP	Yes
6	Moderate-severe	Mild	-6	Guided self help	CMHT	yes
7	Moderate-severe	Moderate-severe	-0.5	CCBT/individual psycho-education	Back to GP	no

Table 16: CORE-OM outcome data

Discharge Information

From February to December 2006 93, clients were discharged from the PCMHT, leaving 20 clients currently open to the PCMHT. The following figure details the discharge information.

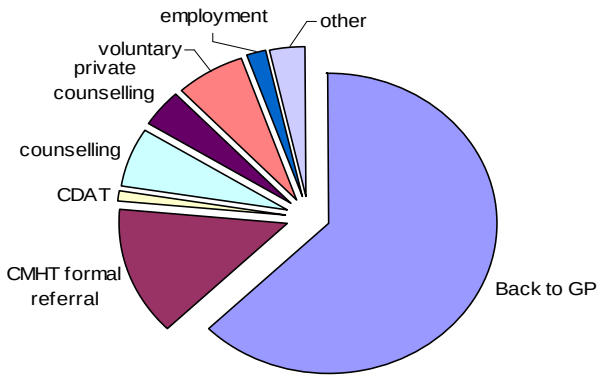


Figure 29: Discharge from PCMHT

GP Satisfaction:

Nine GP satisfaction questionnaires were returned to the PCMHT which indicated a positive feedback.

1). Has having the pilot PCMHT in your practice improved care for people with mental health problems?

100% definitely yes

2). Has the service had an impact on your day to day workload i.e. reduced referral to secondary care/prescribing rates/follow up appointments?

100% definitely yes

3). Has the service provided more options to you and your partners in the management of people with depression and anxiety?

100% definitely yes

4). Would you like the service to continue in the long term?

100% yes

5). Would you recommend the service to other colleagues in Primary Care?

100% yes

GP comments:

"This is a very useful service. I have valued the feedback and advice from the team and appreciated their role in liaising between primary and secondary care. It is very useful to be able to offer service users a service in a timely fashion when they are depressed/ anxious but not ill enough to need secondary care. The emphasis on facilitating self directed recovery is also very appropriate".

"We have over the years tried to engage with our colleagues, psychiatrists, CPN's etc. Having people on site is very helpful and even if you don't take the referral it is

useful to have discussions about what can be complex cases often reassuring to know we don't have to struggle."

"The service has definitely improved patient care".

"The start of something wonderful for all GP's in Watford".

"Invaluable service. Very helpful especially for the in-between patients who are depressed but not actively suicidal who could easily have been referred to CMHT but managed very well and in good time by the PCMHT. Provides lots of resources e.g. leaflets and other local services/organisations available. Friendly and approachable. Always willing to help. The one on one input with patients is fantastic, the patients really appreciate it. Very good feedback about patients/ communication back to GP."

"It is still early stages for most of the people I have referred but so far they have found it very helpful. I have made less referrals to secondary care and I feel that having a colleague to liaise with in house for questions regarding mental health services is really helpful. I t would be a real shame if this service didn't continue".

"Very good, impressive service. I do hope this is able to continue beyond this point".

"An excellent service".

Service user feedback:

Eleven service user questionnaires were returned to the PCMHT. The responses are illustrated below.

How satisfied are you with the amount of help you have received?	Very dissatisfied? 9.1%	Mildly dissatisfied 0%	Mostly satisfied 18.2%	Very satisfied 72.7%
Has the service you received helped you to deal more effectively with your problems?	Yes, it helped a great deal 72.7%	Yes, it helped a little 18.2%	No, it really didn't help 9.1%	No, it seemed to make things worse 0%
Did you get the kind of service you wanted?	No 0%	Not really 9.1%	Mostly 27.3%	Yes 63.6%
How would you rate the quality of the service you have received? Excellent	Excellent 72.7%	Good 27.3%	Fair 0%	Poor 0%
In an overall, general sense, how satisfied are you with the service you have received?	Very satisfied 81.8%	Mostly satisfied 18.2%	Mildly dissatisfied 0%	Very Dissatisfied 0%
If a friend/relative were in need of similar help, would you recommend our service to him/her?	No 0%	Not really 0%	Probably 18.2%	Yes 81.8%
To what extent has our service met your needs?	All of my needs have been met 27.3%	Most of my needs have been met 63.6%	Few of my needs have been met 9.1%	None of my needs have been met 0%

If you needed to seek help again, would you come back to our service>	No 9.1%	Not really 0%	Probably 18.2%	Yes 72.7%
How would you rate the quality of information that you were given about the service?	Excellent 36.4%	Good 63.6%	Fair 0%	Poor 0%
Were you given a choice to access this service after a discussion about possible treatment outcomes?	No 9.1%	Not really 0%	Probably 27.3%	Yes 63.6%

Benefits and employment circumstances*:*
At assessment 16 people were known to be out of paid work and 12 of those were known to be receiving benefit. Thirty-seven people were known to be in a paid job and 8 were not working because they were homemakers, 2 people were retired. Ten people reported they felt their emotional or mental health is stopping them from working.

7.2 Watford Community Mental Health Team:

The Watford and Bushy CMHT covers a population of approximately 110,000 and has 23.42 WTE staff. This comprises of 7.48 CPN's, 7.34 Social Workers .81 professional assistant, 1.00 Senior Practitioner, 0.89 OT, 2.00 Deputy managers and 1.00 Manager. I.00 Consultant Clinical Psychologist + 1.90 clinical psychologists. (At the present time the team has 3 vacancies and 6 staff on extended or temporary absence for various reasons).

Local project issues as identified by Karen Moody and link worker:
What has been really positive about the Watford project is that the initiative came from a really enthusiastic local GP. Despite all kinds of difficulties the project has been located in primary care. That people were seen in their local surgery and records kept in primary care. When it became essential for someone to be seen in secondary care, they were fast tracked into services by the link worker.

- Time needed to identify space, interview rooms, computer access and admin support. This was complicated by the delay in completion of the building of Park End Shared GP Practice. The move finally took place in July 2006.
- Challenges in changing staff attitudes, motivating staff at all levels of the team to become involved and see the potential for change.
- Lead in time to discuss with GPs about how the project might benefit.
- Change of link worker during the time of the project. Time needed for current link worker to get up to speed with the role, establish links with the current GP Practice and build a working relationship with the graduate worker.
- The need to identify clear supervisory arrangements for the graduate worker requiring supervision from a clinical psychologist. During the course of the project our CMHT Lead Clinical psychologist took this on and became involved in supporting the project.
- The link worker is still doing all initial assessments with the graduate worker, need to work towards the link worker screening/ referring onto graduate

worker. Need to free up time to move on to working with other GP practices. The link worker currently works 4 days a week (I day a week ASW for the District)

- Ability of the link worker to fast track referrals into the CMHT.
- Closure of DAS may account for an increase in referrals to CMHT.
- Difficulties in measuring on-going availability/ advice that the experienced link worker provides. It is this that the GPs really like. Any reporting of time in this activity is probably an underestimate.

Link worker issues/comments

- Support for anxiety management groups comes from staff at the CMHT and not the link worker.
- Lack of room availability for the PCMHT.
- Lack of infrastructure- no clear directives.
- Have seen how an integrated team could work effectively and be extended to other surgeries
- Many voluntary agencies closing due to lack of funding.

8. Discussion and Conclusions

Important Considerations of data:
There are several issues that are important to note when considering the results described in each of the sections.

Data set completion
It proved quite difficult to get completed data sets for all service users. The forms were formally agreed at the beginning of September 2006, 7 months after the teams were accepting referrals. Thus most service users prior to September did not complete the questionnaires.
Furthermore, it proved quite difficult to get people with unplanned endings to sessions to complete post-intervention forms, as this required the team sending forms in the post and the person sending them back to the team.
In addition, post intervention questionnaires were not administered to service users that only had one session with the team and thus included the people that were signposted and those that received self help information.

Waiting times
The waiting times for first contact and assessment may have been impacted in a number of ways. One major contributing factor to a potentially long waiting time is the liaison work that is carried out by the team. The link-workers may have to undertake information gathering or other detailed liaison work prior to offering an assessment and therefore increases the time between referral to assessment. This work was not formally recorded for all service users.
A further important consideration for the St Albans pilot is that the PCMHW's identified people from the psychology waiting list that may benefit from interventions such as anxiety management groups or CCBT. Therefore, the service user may have been on the waiting list for psychology for some time before being identified by the PCMHW which impacts on the average time between referral and assessment.

Interventions offered
In addition to the interventions outlined in each of the sections, interventions are often supplemented with relaxation techniques, diet and lifestyle advice etc.
Although all 3 pilot sites offer CCBT the date at which this was available varies for each site. It proved quite difficult to set up the licences and the technical requirements to run this. Letchworth and Watford have recently started to offer CCBT and the main type of intervention may therefore alter in due course.

Key Findings

Efficiency
A large number of people are being seen that most likely otherwise would have either been referred to the CMHT and potentially rejected, had no referral made or been subject to a long waiting list. This is an indication that there is an increase in the number of referrals to mental health services overall within the pilot site areas. This would suggest that the pilot sites are providing a service to people whose needs would have previously been unmet.

The waiting times are relatively short, roughly one month from referral to assessment which is shorter than the national average target for waiting times. There is a fairly broad range within the waiting times suggesting that some people are waiting much longer than others, this is likely to change as the services become more settled.

The waiting times for secondary care appear to have reduced. This could be explained by the capacity created in primary care.

Reduction in referrals to the CMHT, however, still a fair number sent back as inappropriate (i.e. did not meet CMHT criteria). This would appear to indicate that some further work with GPs is required.

The outcome of the initial assessment showed that a large proportion of people subsequently cancelled their appointment, did not want a service or did not attend further appointments. This drop-out rate should be monitored by comparing across the sites and with other services, such as the CMHT rates.

Effectiveness

The use of standardised clinical tools has enabled a level of effectiveness to be measured that was not previously possible. These tools give a better indication of level of severity at the first point of contact and a mechanism for monitoring of change.

The clinical outcome measures show a general trend in reduction in clinical severity at post-intervention with the primary care team. This is indicative of the effectiveness of the interventions, however, there is currently insufficient data to draw any conclusions from this information. Ongoing monitoring of these scores will enable a measure of the effectiveness

The information collected about the issues people presented with is not as clear as it might be, probably due to the number of recording options.

At initial inspection it does not seem to show that the level of severity as measured by the clinical tools is matched to the type of intervention received. This may be because the measures used (CORE, HADS) do not reflect all the factors used to decide on an intervention. It could also be that the interventions are not equally available (such as CCBT), that scores are not matched to appropriate interventions, or a combination of these. Not all the people receiving a service scored within the clinical range of scores.

Improved well being

Although the number of people completing a pre and post-intervention HADS and CORE-OM were small, the resulting changes in scores indicate a positive change in wellbeing for most people. There were a number of people within this group for whom the change was positive or negative but did not constitute a significant clinical change. However, because the PCMHT's are services that offer interventions for people with mild-moderate psychological difficulties, many people did not have high CORE-OM scores at pre-intervention. There may therefore be limited room for clients to show improvement at post-intervention.

Satisfaction
The responses to the satisfaction questionnaires were largely positive for service users in the PCMHTs and for the CMHT in St Albans. The responses from GPs were similarly rated.

Access
The availability of psychologically based therapies is clearly improved where the GPs are able to access the PCMHT. At this point, not all GP practices in the pilot areas have full access to the PCMHT, for example St Albans and Watford did not include all the surgeries.

Choice
The number and type of interventions available to people has increased significantly since the teams were created. The range of these is now more representative of the stepped care approach and NICE guidelines. There is greater choice of intervention and service as expressed by GP's and service users.

Relationship
There is a large amount of anecdotal evidence that suggests that a high level of communication occurs between GPs, members of the primary care mental health team and the CMHT. This is largely unrecorded; however, the staff report these links as crucial to the process and functioning of the PCMHT.

Benefits and Employment
There is very limited information to indicate numbers of people on benefits prior to and post treatment. No significant conclusions can be drawn.

Pathways
The development of a service remit for the PCMHT and the entry and exit criteria for the CMHT have helped to establish a clearer pathway for people suffering from some mental health problems. This is particularly clear for those presenting to the GP for the first time with depression and anxiety related difficulties and of a non-urgent nature. It is not clear exactly what the role of the PCMHT would be in relation to other more severe mental health problems and urgent cases.

The differences in the models for each pilot site indicate that there are some variations in the flow of communication, in particular for referral information, screening and assessments, which affect the pathway taken by service users. This variation can be at odds with the NICE stepped approach when the screening assessment is carried out in conjunction with the CMHT

Links with voluntary service have been established and are vital to the pilot sites areas. Availability in each pilot site area varies and needs to be monitored.

8.1 Issues Identified

In addition to the local project issues there are a few common issues as detailed below:

- Each of the models set up in the pilot areas has been influenced by different factors, such as local resource availability, levels of workforce and funding. Each of these need to be considered as key in any future developments.
- No funding was available for evaluation, training, IT interfaces, project management which has delayed the change management process.
- Service redesign is a difficult process and training is required to enhance understanding of team.
- Key skills required by staff for understanding of the different cultures within primary and secondary care to enable a shift in attitude beliefs and values which the recovery approach training can enable.
- GP practices and CMHT have difficulty in being able to release staff.
- Background experience with severe and enduring mental health of great benefit to PCMHW
- Consideration should be given to the cost of psychologically based therapies (whether by professional staff group or general training)
- A primary care solely funded/managed model could effectively transfer the gateway to secondary services into the primary care domain
- People with experience of secondary service like to have “fast-track” access back to services
- Accommodation of new teams
- Recognise the differences in care pathways and the findings need to inform that.
- We recognise that this is evaluating the front end of the service only and wider re-configuration will have a more significant impact.

8.2 Further work required:

Current pilot Evaluation:

- Budgeting and time allocated for project management and evaluation costs needs to be considered
- Assessment of secondary care caseloads and criteria for transfer back to PCMHT or GP services would involve an additional amount of work and/or resources
- Need to look at a future measure of re-referral rates and revolving door phenomenon (both for PCMHT and CMHT)
- Need to do further evaluation on the referrals re-directed/signposted to alternative services.
- Comparison of drop out rates with the CMHT’s and evaluation of the people that cancel and do not attend.
- Key tasks outlined for IAPT (appendix 13).
- Key tasks outlined for NWW in St Albans (NWW report).
- Focus group of service users to be convened.
-

Further Developments:

- Consideration should be given to core competencies of staff in any roll-out process, including provision of supervision mechanisms

- People with long-term contact but low level of need may need to be managed back to primary care
- Further development of the pathway for those people with a severe mental illness as distinct from those with mild to moderate mental health problems
- The detail of age is not answered by the pilot- Whether sites should develop service for working age adults only or be an inclusive service for all ages.
- Consideration should be given to the inclusion of additional agencies as part of a service model (e.g. Housing Association).
- The teams have been exploring the concept of separating the 2 key functions of the team into:
    - Primary Mental Health Care Team
        - To support the Enhanced mental Health Service who continue to focus on the mild to moderate mental health problems.
        - To focus on acute severe mental health problems with timely triaging, joint assessments, short term treatment and duty system support and advice
        - Close links with CATT where the duty ASW is currently piloting being sited.
    - Continuing Care or Recovery Team
        - Focusing on long term needs
        - Possibly bringing together the AOT, CST, HST, Day Services and part of the CMHT with one caseload using a traffic light system to indicate
            - High Risk/high intensity support e.g. AOT clients and some HST clients
            - Medium Risk/ Medium intensity support mainly HST, CST and some CMHT clients
            - Low Risk/Low Support clients. Those clients who are stable would likely be facilitated in returning to their GP with a clear discharge care plan.

8.3 Recommendations:

- Need to incorporate the outcomes from this evaluation into the wider re-configuration of services.
- Service redesign across primary, secondary and non-statutory organisations needs to be tailored to the local resource availability including managed counselling service, non-statutory organisations, and levels of available workforce.
- Consideration of funding for evaluation, project management IT interfaces is key for change management process.
- There must be a core performance standard for evaluation and consistency across the county, that will enable a level of flexibility in the type of service model used whilst maintaining key standards of practice
- An appropriate level of staffing with essential skills/capabilities should be established for further development of enhanced mental health service including management, supervision, training and clinical provision.
- Need to establish and create links with voluntary services in order to deal more effectively with referrals. Voluntary capacity should be part of the PCMHT.

- The development of a PCMHT is a joint initiative about redesigning services which requires continued dialogue and agreement for implementation of initiatives.
- Training should be built in involving primary, secondary and non-statutory organisations. We recommend that the recovery approach and social inclusion training are appropriate vehicles for enabling cultural change.
- Development of primary care mental health worker roles are fundamental to the team.

9. References:

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10. Contacts

CSIP/IAPT Programme:
Paul O'Halloran, Director of Training Education and Development
Tel: 01206 287541
Email: paul.o'halloran@nemhpt.nhs.uk

Hertfordshire Service Redesign Steering Group:
Maurice Burns, Chair
Tel: 07789864212
Email: maurice.burns@hpt.nhs.uk

Improving Access to Psychological Therapies:
Roger Ramsden, Psychology Lead
Tel: 01923 217441
Email: roger.ramsden@hpt.nhs.uk

New Ways of Working:
Frances Burnett, Consultant Psychiatrist St Albans CMHT
Tel: 01727 830031
Email: frances.burnett@hpt.nhs.uk

Letchworth Pilot Lead:
Wendy Abondolo, CMHT Manager
Tel: 01462 482982
Email: wendy.abondolo@hpt.nhs.uk

Hertfordshire Service Redesign S.G. Project Manager and St Albans Pilot Lead:
Wayland Lousley, CMHT Manager
Tel: 01727 830031
Email: wayland.lousley@hpt.nhs.uk

Watford Pilot Lead:
Karen Moody, CMHT Manager
Tel: 01923 811640
Email: karen.moody@hpt.nhs.uk

Enhanced Mental Health Service:
Mark Allen, GP Lead and Debbie Clarke, Consultant Psychologist
Tel: 01727 855500
Email: mark.allen@gp-e82031.nhs.uk, debbie.clarke@gp-e82031.nhs.uk

Evaluation Report:
Hannah Baron, Assistant Psychologist
Tel: 01727 830031
Email: hannah.baron@hpt.nhs.uk , and
Kate Spokes, Practice Governance Facilitator
Tel: 01727 897926
Email: kate.spokes@hpt.nhs.uk

10.1 Steering Group Members:

Judith Watt, Senior Project Manager (HPT)

Jess Lievesley, - Commissioning Manager. Joint Commissioning Team- Hertfordshire

Steve Knighton-Mental Health Lead East of England SHA

Uy Hoang, Senior Register Public Health

Steve Laitner- Public Health Consultant, St Albans and Harpenden PCT and GP.

Graham Munn University of Herts Recovery Centre

Ray Baird, CSIP/ NIMHE Primary Care Programme Manager.

Geraldine O'Sullivan, Medical Director (HPT)

Anne Markwick, Director of Operations (HPT)

Wendy Sainsbury GP Watford

Michelle Jeyaratnam, Deputy Director for Mental Health (HPT)

Anthea Bond, GP Letchworth

Simon Des Forges- Viewpoint.

Pru Noble – Watford Deputy CMHT Manager