Can targeted mental health support benefit patients?

Evaluation of the Sheffield Connecting into You project

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1. Aims and objectives

The Sheffield City Centre with Sheffield Hallam University Primary Care Network (PCN) received Transformation Challenge funding in 2019 to identify patient groups at risk for mental health issues for targeted support provided by an integrated primary, secondary and third sector service team. The project is called City Connecting into You (C.i.T.Y). The C.i.T.Y project is an innovative service on many levels, representing a new way of coordinating working across primary, secondary and third sectors as well as being innovative in the ways that patients are targeted and outreach is offered.

The C.i.T.Y. project team asked ScHARR to act as consultants, providing technical assistance with the monitoring and evaluation of their service.

The proposed aims of this service evaluation are to

* Assess the benefits of the C.i.T.Y. programme in relation to (1) the identified cohorts of patients; (2) operational changes in the primary care network; (3) interface with community services; and (4) impact on general practices.
* Establish the value of connecting primary, secondary and voluntary sectors to increase mental health support.
* Establish how a primary care neighbourhood network approach impacts on general practices

2. Methodology

The approach used by the C.i.T.Y. project can be described as participatory monitoring and evaluation (M&E). This approach includes project staff as key stakeholders in M&E, responsible for collecting and co-analysing data. Stakeholders agreed on the process for collecting information, helped to frame the interview questions, and organised learning forums to analyse and reflect on the challenges and benefits of the project. ScHARR evaluators (JH

and AF) conducted patient interviews and facilitated online learning forums, where C.i.T.Y. staff reflected on progress with referral, challenges and benefits of the service. The resources required to achieve operational changes, and staff capacity, were also documented via meeting notes. The learning was circulated to all staff for further comments, and used with patient interview data to establish the value of connecting primary, secondary and voluntary sectors to increase mental health support.

Ownership of the project was maintained by the PCN responsible for providing the service. This is common in participatory evaluation, where organisations call upon outside experts for assistance. In this instance, the C.i.T.Y. project asked ScHARR evaluators to assist with the design of the evaluation, and strategies for collecting patients’ and project staff perceptions of the value of the service.

The monitoring and evaluation consisted of three components: impact on patient cohorts; impact on general practices; and impact on the primary care network.

C.i.T.Y. staff anticipated that patients receiving services under the auspices of the project might experience changes in relation to:

* Increased self-care.
* Increased confidence in managing condition.
* Knowing where to go/ how to access non-medical advice (rather than contact GP).
* Increased connection with community activities – increased wellbeing.
* Support for non-medical issues that affect health (e.g. relationships/ work/ housing).
* Ability to meet personal goals.

At the general practice and primary care network level, the project anticipated that as a result of the project, practices might experience:

* Integration of third sector support and prevention services within practices
* Improved access to patient information and better communication between GP and third sector. Including data sharing protocol, issues concerning GDPR and data consent, keyworker access to GP systems
* Possible changes in group activity within practices e.g. social café, support groups, shared medical appointments (diabetes, pain management etc)

Exploring impact for patients

The project aimed to reach 4 specific cohorts with mental health needs (Table 1). For the evaluation, project staff decided to focus on 3 of the 4 cohorts that the Sheffield City PCNN originally identified as being of concern in terms of mental health.

Table 1 Definitions for Patient Cohorts

|  |  |
| --- | --- |
| **PATIENT COHORTS** | **DESCRIPTOR** |
| **Cohort 1** | **Patients who suffer with their mental health and Diabetes (poorly controlled and could be better), to patients in the pre-diabetic range [Cohort 1a = Pre-diabetic 42-47 HbA1c and 1b = diabetic 48-79 HbA1c].** |
| **Cohort 2** | **Patients in the last 9 days have been coded as having a Drug Overdose/ Suicide attempt or intention / self-harm or intention to self-harm.** |
| **Cohort 3** | **Severe Mental Illness patients who have had no appointment contact (clinically) in the past 12 months.** |
| **Cohort 4** | **Patients with long-term mental health conditions (including PTSD and Personality Disorder) who are socially isolated and would benefit from support to get them more connected.** |
|  |  |

Cohort 3 was excluded because the pandemic severely restricted ability to encourage patients to attend general practice.

Cohorts were constructed using the primary care patient record system. A staff member experienced in creating reports from patient records was employed to operationalise the definition for each cohort, by selecting Read codes that would enable retrieval of patients with the required characteristics. The GPs reviewed the initial search strategy to ensure that it was actually retrieving patients with mental health needs who were of concern, potentially requiring further support via the C.I.T.Y project. The list of potential patients was then given to the participating general practices, who invited their patients to participate in the project. In some cases, GPs identified patients who were not on the initial list but they felt would benefit from support.

A total of 341 potential patients in cohorts 1, 2 and 4 (Table 1) were identified. It was noted that there was considerable variation across practices.

Table 1 Patients identified by practice

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Cohort** | **Total** | **Number by practice** | | | | |
| **1** | **41** | **0** | **2** | **2** | **16** | **23** |
| **2** | **193** | **0** | **65** | **15** | **95** | **18** |
| **4** | **107** | **0** | **35** | **0** | **22** | **50** |
| **Total** | **341** | | | | | |

Further, some of the smaller practices actually had a much higher number of eligible patients, indicating that mental health needs are unevenly distributed across the primary care neighbourhood network.

Patients were offered support in various ways, including during consultation, via text message, and through telephone calls from project workers. Patients indicated their preferred mode of contact to project staff at the beginning of the project. These include text messages, emails and phone calls. Due to Covid-19, the project were not able to meet face-to-face with people and focused instead on delivering support by the phone call.

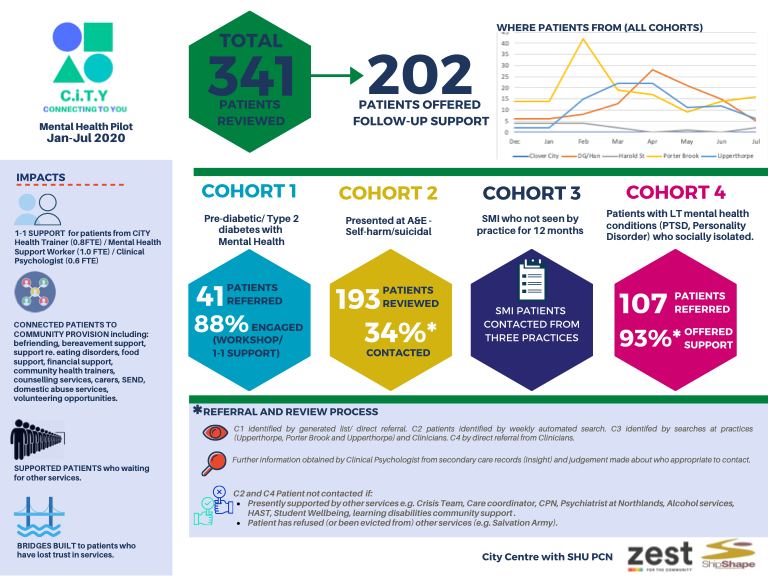
Referrals to the third sector and other parts of the PCN Network were monitored by the primary care team to determine uptake and use of the services.

Monitoring activity for each respective cohort was documented monthly in terms of:

* Numbers contacted; numbers referred; type of service referral.
* Numbers receiving ongoing support by cohort; type of support.
* Numbers followed up (for appropriate cohorts)
* Numbers completing/moving on

Figure 1 shows that the process of identifying patients was useful inseveral ways. Of the 41 people who were pre-diabetic or had type 2 diabetes (cohort 1), 36 took up the offer of support with mental health. The review identified that over one third of people presenting at A&E after self harm were not receiving support elsewhere (cohort 2). Clinicians also identified a large need for support in their patients with long term mental health conditions (cohort 4), referring over 90% of the patients seen in this group for further support.

Figure 1 Patients offered support by cohort



We evaluated patient experience of the service via interviews, where we collected stories using the Most Significant Change technique. This technique uses an open-ended interview approach to elicit stories from beneficiaries about changes in their life that are related to a programme or service.

(Dart & Davies, 2005

<https://www.mande.co.uk/wp-content/uploads/2005/MSCGuide.pdf> )

It is used in situations when little is known about the potential changes that may be experienced by participants and was therefore appropriate for the C.i.T.Y project, which represented an innovative service. Patients were recruited by project workers who selected people who were deemed capable of participating based on project staff knowledge of their mental health and capacity.

The project was categorised as service evaluation, by both the NHS and the University Ethics Committee, so did not require ethics approval. Principles of good ethical practice, however, were followed. Eligible patients were contacted by the workers, who gave a Patient Information Sheet to each potential participant.

Although this was a low risk project, we were aware that some participants could be distressed while sharing their story, and arranged for a follow up call from the project team when this was the case. Workers were also able to refer them to specific support services where needed. We reminded people that they could spend as little or as much time as they wanted, and that they could stop at any time.

The interviewers for the MSC stories were Janet Harris and Alexis Foster (ScHARR). Information was collected via telephone, using a set of questions that explored the situation at the time of referral, the type of support received, what happened as a result, and the changes that people felt were most important. Data was then organised for each question and thematic analysis was done to identify cross cutting themes. The analytical framework was drafted by one evaluator (JH) and cross checked by the second (AF).

Information on the the value of the service for general practices and for the PCNN was collected via online learning forums, where the project staff participated in structured reflection using a set of questions that had been co-designed by the project team and the evaluators. People who could not participate in the forum were contacted individually and asked to add their comments. The final document was circulated for further review and comment before being added to the thematic analysis.

The project ran from September 2019 through August 2020. Activity data was collected monthly. Staff learning forums were held in October 2020 and interview data was collected between September and November 2020.

Findings

Service uptake

Uptake of the service was higher than expected, despite the fact that major changes had to be made 2 months into the service as a result of the pandemic.

At the mid point of the project, referrals had to be curtailed and some people were placed on a waiting list. The project team felt that accepting referrals directly from GPs contributed to the increased uptake.

People felt more trusting of the service because of it being recommended by their GP and offered in conjunction with their practice:

‘The *GP knows me well enough so I had trust it would be appropriate’.[10]*

In another case, the participant’s GP has not told them that they were being referred to the service and instead they received a call directly from the service. This was advantageous for this person because they had turned down support in the past and if their GP has mentioned the referral to them, they would have declined it:

*‘She phoned me out of the blue, whilst she was on the phone I thought I will give her a chance and see how it goes’ [2]*

This highlights the importance of different approaches being take between the GP practice and C.IT.Y to engage people, especially those who may have difficulty engaging in more traditional mental health services.

Benefits and impact for patients

Valuing the type of support

Patients described why this type of support was valuable, and how it helped them to manage non-health situations alongside managing health conditions. Throughout the interviews, patients often discussed the advantaged of the C.I.T.Y support in comparison to other health services they had been referred to.

Flexibility and tailored to an individuals’ needs

Patients valued the flexibility of the C.I.T.Y project and how individual workers could shape the service to meet the individual needs’ of a patient including spending more time with them than other services.

*‘I could always change the time at short notice if I wasn’t well enough…I could get another time without having to wait weeks [unlike other health services].’ [4]*

*‘I had individual calls with her, they started after the March lockdown. Supposed to be weekly but varied a bit...[if I forgot] I was able to text her, she would always answer within 15 minutes, and remind me of the date. She never minded. When I texted to say that I was on the edge [of self harm] she was able to respond within a couple of minutes.’ [5]*

Others felt able to email about things which came up between appointments and received emails from the worker with useful information [9]

Solution focused support

The approach to support was valued by patients because it offered practical support, in manageable steps, rather than counselling or therapy.

*‘She never wanted to know why [I am the way I am], she just talked about everyday things.’ [4]*

The support was solution focused which was what users wanted.

*‘I wasn’t in the place for deep therapy, I just wanted to get support with getting out’ [10]*

*‘It was not just talking about feelings but actually focusing on how to cope with life. ‘ [2]*

Small changes were suggested which patients were able to achieve.

‘She got you to do things without you realising you were doing it. Small things like opening the back door. You’re in control.’ [4]

The support helped people to accept the long term nature of their conditions and work on things that could be improved over the short term. For example, although one patient had a lot of pain and unstable blood sugars, the focus was on improving diet and feeling better in self:

*‘It was never about stopping eating anything, or eating a perfect diet, but making sustainable changes.’ [9]*

Another patient confirmed that accepting and managing worked better for her than aiming for major change.

*‘The psychiatric nurse called first, but I can’t be getting on with that. I’ve been down that route and I’ve still got OCD. I’ve learnt now to live alongside it, not*

*beat it or try to cure it. I can’t get rid of the OCD because it’s me, part of who I am.’ [4]*

Patients valued the non-judgemental, skilled support from the C.I.T.Y workers

The patients valued the C.I.T.Y workers, feeling they were non judgemental, easy to develop a rapport with and understood their needs:

*‘It was like having a chat with someone you know, who’d never judge you for what you’re doing ‘[4]*

*‘Having someone there I could trust that didn’t judge… she could understand for example if I missed my medications for a couple of days.’ [5]*

*‘She was so easy to talk to, don’t talk down to you, talked with me’ [9]’*

The ability to connect on a personal level helped people to discuss challenges.

*‘It was somebody being interested in me as a person.’ [4]*

Participants felt they could be open about what was going on

*She ‘made me feel I could trust and I could speak about anything. She’s very different to most people [in other services], she knew what she was talking about.’ [2]*

The personal and individual support was viewed as preferable to other health services, which were considered as untailored and as giving instructions:

*‘Somebody who isn’t too authoritarian or sounding too NHS like a script.’[5].*

*‘It didn’t sound like she was reading from a script. We didn’t separate out all of this like chapters in a book where they tell you these are the stages you go through.’ [4]*

People gave many examples of how the advice was tailored, which contrasted with generic support they had been previously given such as by diabetic nurses who don’t have much time.

Patients felt they were more able to utilised the signposting, advice and information given from the C.i.T.Y project because the worker would support them with accessing, interpreting and processing the information especially in the context of discussing a specific challenge they were experiencing:

*‘It makes you understand your disease a lot. [I have a] better understanding of what to look for in the labels’ [9]*

Receiving support for non-medical issues that affect mental health

Patients said that they received support for non-medical issues that affect mental health. The support that was given for non-medical issues was seen as very valuable.

One person who was moving house described the help that was given by signposting the participant to second hand furniture sites, and discussing which tasks to prioritise. She also received support to help manage work related stress. Another person resolved the challenges of a wakeful toddler:

*‘She helped me talk through challenges of having a 3 year old who doesn’t sleep in her own room. She helped me to look at it from a different angle. I realised there are other ways to figure it out. Now she’s settling in her own bed .’ [5]*

Ability to meet personal goals and take control of their lives

People valued how the support help them identify things they wanted to do and the C.I.T.Y worker would support them with achieving it.

*‘I started working on ways I could go out as I had lost the ability and didn’t know how to go out anymore.’ [10]*

People felt that small achievements were recognised as big changes by the worker, and celebrated. As a result of achieving small things, people were able to go on to make bigger and more sustained changes.

*‘She was so pleased for me when [the decorating] was finished. She understood that it was a huge thing, for me to redecorate it. Now I’m looking to the future. Going to get the lounge redecorated [because I managed it with the first room], now I feel capable of doing another as a result of the support.’ [4]*

*‘I’ve changed my lifestyle about 90%...I’ve not eaten a chocolate in 12-13 months, I eat fruit or mussels when watching the tv now…physically I feel great’ [9]*

One person who ‘got to the point I was able to get out and go out’ has managed to go out about once a week. This is helping improve her mood and she continues to draw upon the strategies she developed.

Conversations reduced anxiety which meant the people could take control of managing things.

*‘Talking to her helped me get the anxiety out of my head; that’s lessened my depression so I could concentrate on taking the medication and managing the diabetes.’ [5]*

Several people said that support with having conversations with the GP made a difference in terms of medication review.

*‘She encouraged me to talk to the GP about my antidepressant medication, which was fine. They said if you feel you can reduce the antidepressants, we can do it very slowly. Which is huge.’ [4]*

Increased self-care

Participants gave examples of how the support had helped them with self-care. The support encouraged people to try different ways of managing their condition.

*‘I was worried that If I try the CPAP machine again and have the same experience it could make me feel even worse. But she said they’ve changed the machines. She encouraged me to give it a go. She gave me confidence to try it again. With the tray system I was getting thrown about whether I’d taken them or not. Liz suggested picking up 1 week of meds at a time. Now it’s easier to notice and track. That’s a change that I’ve stuck to.’ [5]*

*‘After 3 years of 200mcg antidepressants, I’m down to 125 mcg.’ [4]*

Project staff noted that patients have successfully reduced HbA1c which is usually difficult to do in the amount of time they have with the Health Trainer.

Increasing connections

The project originally aimed, through partnership working with community organisations, to increase connections for people but this was difficult as a result of the pandemic. Some patients lost their usual forms of socialising and were unable to replace them.

*‘With having the lockdown I didn’t have the coping mechanisms I would normally be in place. Shops I would go to, where I could chat, were closed.’ [5]*

Some patients were more focused on becoming capable of managing than getting connected to other people. For example, several specifically wanted support to get out and about, two wanted support in managing medications, others wanted help with diet. People were not expecting to get connected to other sources of support during the pandemic.

Impact for general practices

Overall, the project produced positive changes in terms of connecting primary, secondary and voluntary sectors to provide mental health support services. These changes were triggered by the project, but given further impetus by the pandemic, which promoted a different kind of communication and enforced the clear need to do some things differently. The changes include creation of data sharing protocols across the primary and voluntary sectors; increased confidence in dealing with mental health issues; more efficient GP referral; and a better feedback loop to report progress back to GPs.

Improved access to patient information and better communication between GP and third sector.

Over the first 3 months, the project established a data sharing protocol with the third sector organisations, and sorted issues concerning GDPR, data consent, keyworker access to GP systems. The team worked with a nurse experienced in managing data on GP systems. He was able to explain how information is organised by Read codes, and set up codes for the project. The team co-developed the information that needed to be entered into patient records as well as the reports that needed to be generated. This collaboration had several benefits. It ensured that staff agreed on the information that was important to collect and also feasible for workers to gather.

Project staff had opportunities to learn data management skills and increased their understanding of the terminology that is used in general practice information systems. As a result, community organisations were able to consider how they might want to adapt their information collection to communicate better with general practice systems. This will become increasingly important as PCNNs move toward more partnership working with the third sector.

After access to the system was set up, workers were able to generate lists of eligible patients. One of the aims for cohort 2 patients, was to check whether they had support already and how it was working. Although this was very time consuming, it was possible to find out when patients had contact with other services that the GP might not be aware of, and liaise with those services. This meant that information could be exchanged to further the patients’ care, and the understanding of anyone working with them. The psychologist on the project was able to check what people were already receiving in terms of mental health services and advise on what to do. This clinical support was instrumental in terms of being able to give both primary care and community organisation workers the ‘whole picture’ of what was going on for different patients, based on review of secondary care records. The mental health worker also provided support the other workers in terms of them being able to get their clinical perspective on specific patients and ‘check out’ the approach they were taking with a patient.

The general practice record review also meant that patients who had moved on could be identified and practice lists could be updated.

A specific challenge for Porter Brook is that a considerable proportion of their patients are students. However, it is not always clear whether someone is actively a student or if they have graduated/ on a leave of absence. It can make it challenging to know whether practice based or university-based support would be most appropriate.

Closer relationships have also been developed by the two voluntary sector organisations involved. The two community organisations are sustaining this relationship by applying for future funding together where it is advantageous for the organisations to work together.

Project staff also described some unanticipated findings and challenges. The process of identifying patients from practice lists was useful because it led to the realisation that there was an uneven distribution of patients from across the network. Smaller practices had much higher numbers in some cases.

This led to the network allocating resources between practices based on patient needs rather than list size. However, there was still an uneven allocation of resource, because workers were spread across the practices, which meant that some GPs were less aware of the service and therefore less likely to refer into it.

The strategy of targeting services to specific mental health groups did serve to identify people who had fallen through the cracks. Patients who were identified in Cohort 2 really benefited in terms of getting a bit of support and encouragement. They were grateful and expressed that they felt cared for, that people were thinking of them. Engagement was variable though and while some people had several appointments, others did not engage beyond the first contact even if that seemed to have been positive. This indicates that active outreach will only be taken up by a proportion of eligible patients (Figure 1).

GPs valued the C.IT.Y project as they felt the service could spend more time with individual patients than they could. This was especially in relation to patient who had presented at AE for self-harm. The GPs felt the C.i.T.Y project could provide these patients with after-care whereas often these patients get sent home from AE without further support in the immediate aftermath. Clinicians felt it is important to prioritise support this group of patents in future services. [

Although project staff knew that patients in the cohorts were likely to have multiple needs, it became apparent that the patients had really complex needs. Some were experiencing long term issues while others were dealing with a stressful situation that required intensive, short term support. Some patients had tried a support service before the project started, which hadn’t been a good fit for them. This was confirmed by some of the patients in interviews. In particular, both project staff and some patients preferred 1 to 1 instead of group support. When their first offer from the project wasn’t right, the project was able to work as a team to find the right kind of support for different people. Team discussions were used to decide what sorts of support would be best, and who was the best person to speak to the patient.

Project staff perceived that there were a number of benefits for patients, which also fostered more efficient use of primary care services. Cohort 4 people experienced a clear impact. Patients reported that the calls were really helpful in helping them shift from feeling stuck to doing other things.

For example, people reported that they had turned down support options after trying services such as counselling, which hadn’t worked. After engaging in the support provided by the project, people realised that some sorts of support can be beneficial. One patients said that it was a ‘complete shock that it helped’ and decided to access IAPT.

The team was aware that people may agree to go to IAPT after suicide attempts/crises, but they don’t always actually follow through. Although they tried to encourage people to take up IAPT and other services, it was not possible within the timelines of the project to establish how many acted on the advice. The team was able, however, to support them with the plan that the Mental Health Liaison team came up with at the crisis assessment.

Staff were able to find out what people were afraid of in terms of engaging with services, and try to find a way around it. This was important during the pandemic (see Box 1).

Box 1

One woman with bipolar disorder hadn’t picked up her prescription for quite a while despite GP attempts to contact her. We had the time to spend trying to contact her which revealed that she thought she had to go a distance for a blood test and was afraid to do that, which we were then able to negotiate with the practice to be able to do the test on site there. The woman felt more comfortable about that, and she was then able to get her long term medication. It/s an example of a little bit of support that helped her to sort her meds which made a significant positive difference for her for which she expressed gratitude.

People felt that the service was something a bit different from what they’d had before. Specifically, project staff had the time to follow up and get back to people so they didn’t feel lost in the system (Box 2).

Box 2

A young man who had a head injury was very worried about covid, and angry with people who weren’t following the rules. All of his social connections were cut off as a result of covid restrictions. His mother thought he wouldn’t speak to a stranger, but we were able to phone several times to establish a relationship. Phoning him several times, and liaising with the head injury service that he had used in the past, led to a referral back to the head injury service. He was very happy about that. He also had some misconceptions, such as believing that he could catch covid through a closed window. The conversations helped him to talk through some of his concerns and he was able to understand the correct information. He expressed gratitude for the calls.

People also felt that they were being given a connected service, contrasting it with previous experiences where “you just get passed from one service who says you’re not eligible back to the GP. Who refers you to another service. It’s like being passed from pillar to post.”

For people were waiting for assessment, the calls provided support during the wait.

Some people made phone appointments, but didn’t keep them. Where normally they may have been lost to follow up, the team had the capacity to try to follow them up. Support was also offered to families, e.g. one person with a serious MH diagnosis would not engage with mental health services and the team was able to offer his partner some support to help her understand why he could not be made to engage and also to inform her about how she could get support for herself and what to do in a crisis. It was also an opportunity for her to be able to talk about how she was feeling.

Capacity of the service became an issue was more referrals were received. Practices realised the benefit and referral rates increased to the point where the project had to set up a waiting list. This could have been detrimental, but the team called patients while they were waiting. The acknowledgement was really important, it actually made patients feel they were not forgotten. Even though they were waiting for all sorts of services after the pandemic started, they didn’t feel like they were falling through the cracks.

Transitioning patients to other services

General practices noted that a key challenge for the service is managing endings, patients really value the support and develop positive bonds with their worker but this makes it difficult when finishing in the service. Some of the patients felt the support had reached a natural end whereas others wanted to continue receiving support from their worker. This problem was accentuated because of the pandemic with there being disruption to community-based activities or mental health services, which people may have been signposted to. Furthermore, many of the people accessing the C.I.T.Y support were reluctant to engage in group support because they found it challenging, instead preferring the one to one nature of the C.I.T.Y project. So the question remains whether the type of support provided in this sort of targeted initiative can help people to engage with networks/connecting communities. Given the popularity of the pilot, which challenged capacity, future consideration may need to be given to how to support people to move onto accessing further support [PB MDT]

Beyond the patients, the GPs themselves feel there is a gap in provision since the service finished. [PB MDT]. This is particularly notable for patients who have visited A&E for self-harm.

Impact for the PCNN

The project aimed to use a person centred approach and motivational engagement strategies in order to bring about an improvement in mental wellbeing alongside the patient being more motivated and better able to manage their own health and wellbeing.The evaluation data from both patients and staff shows that the original aims were achieved. The network will now need to consider whether the benefits of the pilot justify investment in the model over the longer term.

The model had several key ingredients that contributed to the success of the project. There was a small core ‘worker team’ that met regularly to decide on what sort of support to offer, and to review case loads, and the multidisciplinary team had a wide range of expertise. This meant that the team was able to learn skills from each other, as well as develop understanding of the different organisational cultures across primary, voluntary and secondary care. Teamwork was facilitated by an administrator, whose role was to organise regular meetings, monitor communication, and keep the flow of information going. The project needed clinical champions; the GPs and clinical directors were instrumental because they took an active role in the development and advertising of the service. The team also had a knowledgeable information manager, who sorted shared access to patient records for staff in the voluntary sector and supported them to enter data into the records. The information manager had a unique blend of knowledge of the primary care setting and knowledge of how Health Trainers and other voluntary sector workers operated. He also had knowledge of how to modify general practice systems to collect relevant information and generate useful reports. Finding the different ‘gatekeepers’ or person in each general practice who could facilitate the project work was key. Medical secretaries were instrumental in helping with the ‘message flow’. The knowledge of GPs was invaluable in terms of identifying the right patients and targeting outreach.

If the service was to be continued, decisions would need to be made about how to target people with existing resource. Unfortunately, the plan for having consultations with GPs wasn’t realised because of covid shutdown. It seemed that discussions with GPs did help them to understand why some people weren’t getting secondary Mental Health services.

Discussions with a Mental Health professional about what would be possible for patients, and what isn’t, is useful in helping GPs to see what can be done, and where and when it might be most useful to refer patients. The project work indicated that communication between secondary and primary care needs to be better, in terms of finding time for discussions about what can be offered,

The knowledge of community services is a key component in mental health support. The voluntary sector knows what services are still operating, which ones have changed or disappeared (because it is part of their everyday job to know). This was essential after the pandemic started. General practices saw how this knowledge enabled a responsive and patient centred approach, based on what was available. At the same time, patients were able to see that support with health can be obtained from many places that are actually outside the general practice. GPs now feel that they can make a referral and trust that it will be effectively managed.

There were also changes in working with secondary care mental health. Our psychologist was a link person, working across community organisations and primary care, who had access to patients records in secondary care. As a result, she could inform workers on what the patient was already accessing, which helped with decisions about whether to offer additional support via the project.

How can the service be continued in the future?

Practices see the service as providing support that goes beyond general practice consultations to help people manage mental health challenges in everyday life, as well as supporting them to access mental health services when needed.

Practices could continue to invest in determining whether Cohort 3 patients are getting health checks. During the project, it was possible review practice lists, check who patients were seeing in secondary care, if they were in contact with anyone. It was sometimes possible to get information about whether they had a physical health check from secondary care, and to liaise with secondary care to send information about the health check to the GP. The information flow also revealed other useful information, for example that one person didn’t need a blood test; another no longer needed a check so the GP could exempt them. We were able to see that secondary care records had the wrong GP on record; that people were in prison or long term rehab, had left the country etc, which meant records could be amended and then GPs could take them off the list.

The team also had the time to make several calls to particular individuals in order to be able to encourage them to attend the practice for their required health checks.

Since the project finished, the Porter Brook team reported that there is no one supporting this cohort of patients and there are safeguarding issues with them not receiving follow-up support.

A mental health post is needed over the longer term to continue to act as a bridge person, who can promote linked support for patients across community, primary and secondary care. Closer relationships have been developed with the mental health Trust from the project, the learning from the project can be used going forward to link with the wider Mental Health Transformation funding that is coming to Sheffield.

Although data management is not funded as a general practice role, the resource in Porter Brook will continue to be shared with new primary care business managers. We will continue to explore what practice staff and community organisations need to support information sharing and data collection.

Community organisations in the voluntary sector are considering how to continue to access mental health specialists, to support their workers. For example in another PCN, they have employed a MH Nurse fulltime to support patients who have mental health needs who would not meet the criteria or would be reluctant to engage in IAPT or secondary mental health services. This highlights that the need for such support has been recognised within GP practices generally but also demonstrates potential ways of developing the C.I.T.Y project going forward.