Co-creating Health phase 2

Local evaluation report – Torbay Care Trust and Devon Partnership Trust

This report was produced by Torbay Care Trust and Devon Partnership Trust as a local evaluation of the Health Foundation's Co-creating Health improvement programme.

In their local evaluations, participating sites aimed to assess the impact of Co-creating Health on service use, costs and patient experience in their local health economies.

The report was initially produced for internal use and to inform the independent evaluation of the programme. However, Torbay Care Trust and Devon Partnership Trust have kindly agreed for it to be made more widely available so that others can learn from their experience.

The full independent evaluation of phase 2 of Co-creating Health is available at: www.health.org.uk/publications/sustaining-and-spreading-self-management-support

TORBAY CO-CREATING HEALTH EVALUATION REPORT

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Background

The Co-creating Health programme is a large-scale demonstration programme, run by the Health Foundation, that aims to embed self-management support within mainstream health services across the UK and equip individuals and clinicians to work in partnership to achieve better outcomes. The Co-creating Health model focuses on three equally important factors which determine how much individuals are able to play an active role in managing their own health:

- Giving **people with long-term conditions** the skills, confidence and support to self-manage.
- Helping **clinicians** to develop the skills, knowledge and attitude to support and motivate people with long-term conditions.
- Changing **health systems** so that they encourage and facilitate self-management.

Phase 1 of the programme began in 2007 and lasted for three years, when eight demonstration sites were chosen, each site focusing on one of four clinical areas: chronic obstructive pulmonary disease (COPD), depression, diabetes and musculoskeletal pain. All the demonstration projects spanned primary and secondary care and involved local teams of service users, clinicians and managers. Following the first phase, seven of the sites were chosen to proceed to Phase 2 which continued in a similar fashion from January 2011 to December 2012.

These clinical areas were chosen as they were relatively common, long-term conditions i.e. ones that cannot currently be cured but can be controlled with the use of medication and/ or other therapies. In addition to the suffering that they cause they also lead to a large financial challenge to both the NHS and the country. In fact the Nuffield Trust have described the four biggest 'efficiency frontiers' (where the major costs in healthcare exist) as: management of people with long-term medical conditions, care of older people, reducing avoidable emergency admissions and care for people at the end of their lives.[1]

In order to deliver the Co-creating Health model, each of the sites delivered three training and information programmes:

- **Self-Management Programme (SMP)** – this supports people with long-term conditions to develop the confidence, knowledge and skills that they need to manage their condition while working in partnership with their clinicians. This includes problem-solving and action planning, which help people increase their confidence and self-management skills. The SMP largely consists of generic elements common to all conditions.

- **Advanced Development Programme (ADP)** – this supports clinicians to develop the skills required to support and motivate people to take an active role in their own health.

- **Service Improvement Programme (SIP)** – this supports the Co-creating Health sites to change and improve the way their health services are designed and operated so that they better support self-management. As well as providing information it is designed to build skills and capability in order to ensure that improvement lasts beyond the life of the programme.

In Torbay, Co-creating Health was implemented by staff from two local NHS trusts, Torbay Care Trust (TCT) and Devon Partnership NHS Trust (DPT). The local Co-creating Health implementation team consisted of medical staff and staff from allied professions from both these trusts and focused on depression. This is a relatively common condition that has been estimated to have a prevalence of approximately 8.1% of general practice patients[2] and to cost the UK economy £11 billion a year.[3] There is evidence that simple, self-management techniques such as increasing activity levels can produce clinically significant benefits in such patients.[4] Therefore, depression provides a combination of a high cost to treat together with a potential amenability to respond to self-management techniques that makes it a good test-bed for self-management promotion.

Overview of local evaluation

The Co-creating Health programme was launched by the Health Foundation in November 2007 with the aim of demonstrating that increased self-management by patients with long-term conditions, appropriately supported, leads to improved health outcomes. The first phase of this project lasted for 3 years and has already been evaluated with the help of Coventry University.[5]

In Torbay, the evaluation theme was "Influencing the commissioning agenda" and prior to commencing the evaluation we held discussions with local health service commissioners to find out what their priorities were and which information they would find most persuasive in order to re-commission ADP, SMP and SIP. (Whereas in Phase 1 of the programme the Health Foundation had provided the funds for the courses, in Phase 2 the Health Foundation funding was on the basis that it was matched by local funding so, effectively, the local NHS trusts paid half of the costs of the programme. The outcome of these discussions was that, while they were undoubtedly very concerned about the quality of the patient experience, we were left in no doubt that the overwhelming priority of the commissioners was to show that carrying on these programmes would result in cost savings when compared with not doing so. A major driver for the commissioners was the government's Quality, Innovation Productivity and Prevention (QIPP) agenda. This is a programme designed to improve quality and increase cost-efficiency to provide £15 to £20 billion of efficiency savings by 2014–15.[6] Similarly, though they were very interested in any qualitative evidence that we could provide, in the end it would be primarily quantitative evidence that would influence their decision making.

Therefore, when it came to planning the evaluation framework that we would use, it was clear that in order to comply with the theme it had to be heavily weighted towards quantitative evidence which would look at clinical parameters as compared with treatment-as-usual together with evidence of cost savings, for example by reduced service usage. In order to do this we decided to use the following four main evaluation questions.

1. How effective is the self-management programme for depression?

2. How does the cost-effectiveness of the self-management programme for patients with depression compare to the standard psychological therapy for depression as currently used locally?

3. Does attending the self-management programme reduce healthcare costs?

4. Does utilizing the Co-creating Health model change the patterns of prescribing and referral for GPs?

In addition to these main evaluation questions, during the course of the evaluation we had the opportunity to deliver an ADP course to first-year medical students We decided to evaluate the medical students' beliefs about self-management and any changes to these following attending an ADP in addition to the above questions.

Key findings

1. **Completing an SMP course is associated with a decreased level of psychiatric symptomatology and an increased level of the participant's confidence to self-manage their illness.**
2. **This increase in confidence is significantly correlated with the reduction in psychiatric symptoms.**
3. **The SMP for depression has a similar rate of successful response as the standard talking therapy available locally on the NHS but at a lower financial cost.**
4. **Completing an SMP course is associated with a significantly reduced number of primary care contacts in the six months after the course as compared to the six months before.**
5. **Utilizing the Co-creating Health model in primary care is associated with a decreased number of psychiatric secondary service referrals.**

TORBAY EVALUATION RESULTS

1. How effective is the Self-Management Programme for depression?

BACKGROUND

The Self-Management Programme (SMP) is a seven-session course delivered once a week over consecutive weeks. In order to increase availability courses are run at a variety of locations across Torbay and include evening and weekends. Each course was run by a clinician and a lay facilitator and was based on the use of agenda setting and problem solving in order to increase the participant's confidence to self-manage their condition. While in many ways the skills taught were generic and so could be applied to many medical conditions, the SMP was focused on helping patients with depression improve their self-management skills. The details of SMP courses run between January 2011 and May 2012 are included in Appendix A

In order to evaluate the effectiveness of the SMP each participant was invited to complete a questionnaire at the start and end of the course. A further questionnaire was also sent out by post to participants several months after the course ended.

The questionnaire can be divided into two main areas. The first of these are the clinical indicators, which are quantitative measures that capture information about symptom severity and clinical response. In this case, three rating scales were used, the Patient Health Questionnaire, Generalized Anxiety Disorder 7-item scale and the Work and Social Adjustment Scale (PHQ9, GAD7 and WSAS), which measure levels of depression, anxiety and social functioning respectively. The second area of the questionnaire was designed to capture non-clinical indicators, such as levels of confidence in self-managing their illness.

CLINICAL INDICATORS

The three rating scales used to assess the participants level of psychiatric symptomatology and functioning, the PHQ9, GAD7 and WSAS, are all well-established scales which are in widespread use. The PHQ9 is a 9-item self-administered scale which has been validated for the measurement of severity of depression.[7] Scores are from 0 to 27, higher scores indicating a more severe level of symptomatology. Also the PHQ9 has been shown to be an effective way of monitoring treatment outcomes in depressed patients[8]. The GAD7 is a similar scale, assessing levels of anxiety using 7 items giving scores from 0 to 21, higher scores indicating more anxiety. This has also been validated as a method of assessing the severity of anxiety.[9] Finally, the WSAS scores patients from 0 to 40 on their functional impairment with higher scores indicating increased functional impairment. Again this is a reliable and valid indicator of a patient's ability to carry out day-to-day activities, such as working and leisure and social activities.[10]

As well as their validity, these three scales were chosen as they are used as key performance indicators for the Improving Access to Psychological Therapies (IAPT)[11] programme. This is a Department of Health initiative to expand local psychological therapy services to people suffering

from depression and anxiety disorders. As this is the least expensive "talking therapy" available on the NHS, in Torbay it was decided to use this as the local comparator when measuring effectiveness.

When analyzing the scores on the questionnaires for this evaluation they were scored in the same way as is recommended for IAPT i.e. if one item was left unfilled, most commonly the item on work in the WSAS, the score was increased by the average of the completed scores.[12] Thus, by using the same evaluation tools in the same way a comparison could be made between the SMP and treatment-as-usual.

NON-CLINICAL-INDICATORS

The main non-clinical indicator that we studied was the patient's confidence to manage their depression. According to Bandura's theory of self-efficacy, a person's perceived confidence in their own ability affects how they think, how they motivate themselves and how they behave.[13] In the health sphere there have been a number of studies that have shown that increasing a patient's confidence to self-manage their health-related activities can lead to improvements in both lifestyle and clinical indicators (e.g. review by Bodenheimer and Holman[14]). Increasing this confidence level was therefore the primary aim of the SMP.

METHOD

All participants in the SMP were requested to complete a questionnaire at the start and end of the course that included questions on e.g. their confidence to self-manage their depression on a 0 to 10-item Likert scale. A Likert scale is a method of gaining quantitative data, which can then be subjected to statistical analysis, from a person's response to their attitude about the topic in question by linking their responses to an analogue scale. All the data was uploaded to a computer database, Microsoft Access. This was then statistically evaluated using Microsoft Excel and IBM SPSS. In the evaluation, in order to reduce bias, only scores from patients who filled in the forms at the start and end of the course were used.

RESULTS

1a Clinical indicators

DEPRESSIVE SYMPTOM SEVERITY

PHQ9 depression scores pre- and post-SMP were requested from all participants on consecutive SMP courses that started from 30/6/10 to 5/5/12. From this cohort of 236 participants paired scores were obtained from 128 i.e. those who completed a PHQ9 score at the start and end of the course. The average was then taken for each of these scores and a paired t-test performed to look for statistical significance. These results are shown in Table 1 below, higher scores indicate a greater degree of severity.

TABLE 1 RESULTS OF PHQ9 DEPRESSION SCORES PRE- AND POST-SMP

Group	Average PHQ9 at start	Average PHQ9 at end
Mean	15.14	9.87
Standard Deviation (SD)	6.76	6.55
Number of participants (n)	128	128

This shows a marked reduction in average PHQ9 depression scores at the start and end of the SMP course, the two-tailed P value is less than 0.0001 which is highly statistically significant. Furthermore, a reduction of 5 points or more in the PHQ9 score, as shown here, is also considered to be clinically significant i.e. an improvement in the person's depression that is obvious and important to the person and their family.[15]

ANXIETY SYMPTOM SEVERITY

GAD7 anxiety scores pre- and post-SMP were requested from all participants on consecutive SMP courses that started from 15/06/11 to 5/5/12. From this cohort of 143 participants paired scores were obtained from 76 participants. These results are shown in Table 2 below, higher scores indicate a greater degree of severity.

TABLE 2 RESULTS OF GAD7 ANXIETY SCORES PRE- AND POST-SMP

Group	Average GAD7 at start	Average GAD7 at end
Mean	13.30	8.71
SD	5.19	5.91
n	76	76

Again there was a highly statistically significant reduction in the average anxiety levels of participants' pre- and post-SMP, the two-tailed P value being less than 0.0001. Anxiety is a common and normal experience and in order to decide what is a level of anxiety that denotes an illness a cut-

off point of 10 or over on the GAD7 score is used.[16] Therefore, as the average GAD7 anxiety score of the participants drops from 13.3 to 8.71 this is likely to be evident to the responders and their families as a genuine and marked improvement in their wellbeing, and not just a statistically significant finding.

WORK AND SOCIAL ADJUSTMENT SCALE

As with the GAD7 anxiety measure, WSAS scores pre- and post-SMP were requested from all participants on consecutive SMP courses that started from 15/06/11 to 5/5/12. From this cohort of 143 participants, paired scores were obtained from 65 participants. These results are shown in Table 3 below, higher scores indicate a greater degree of impairment.

TABLE 3 RESULTS OF WSAS PRE-AND POST-SMP

Group	Average WSAS at start	Average WSAS at end
Mean	21.91	16.52
SD	10.15	9.74
n	65	65

Again, the two-tailed P value is less than 0.0001, which is considered to be extremely statistically significant. This decrease in functional impairment would be consistent with the reduction in depression and anxiety symptom severity as a score of 20 or above appears to suggest moderately severe or worse psychopathology.[17]

1b Non-clinical indicators

In order to assess the effectiveness of the SMP course in improving a patient's self-confidence to manage their health, SMP participants were asked to rate their self-confidence to manage their conditions in general and depression in particular pre- and post-SMP on a 10-point Likert scale. Here a higher score indicated a higher level of confidence. Again this data was requested from all participants on consecutive SMP courses that started from 15/06/11 to 5/5/12.

CONFIDENCE TO SELF-MANAGE ALL THEIR CONDITIONS (i.e. both psychiatric and physical)

From the cohort of 143 participants paired scores were obtained from 84 participants. These results are shown in Table 4 below.

TABLE 4 RESULTS OF CONFIDENCE TO SELF-MANAGE THEIR CONDITIONS SCORES PRE- AND POST-SMP

Group	Average confidence at start	Average confidence at end
Mean	4.14	5.94
SD	2.28	1.83
n	84	84

This difference is considered to be extremely statistically significant, the two-tailed P value is less than 0.0001.

CONFIDENCE TO SELF-MANAGE THEIR DEPRESSION

From the cohort of 143 participants paired scores were obtained from 84 participants. These results are shown in Table 5 below.

TABLE 5 RESULTS OF CONFIDENCE TO SELF-MANAGE THEIR DEPRESSION SCORES PRE- AND POST-SMP

Group	Average confidence at start	Average confidence at end
Mean	3.84	5.87
SD	2.13	1.91
n	85	85

Again, this difference is considered to be extremely statistically significant, the two-tailed P value is less than 0.0001.

1c Correlation between improvement in clinical indicators and self-confidence to manage depression

From the above data there is good evidence that attending an SMP course leads to improvement in a patient's confidence to manage their depression and reduced severity of psychiatric symptoms. This leads to the question as to whether these two changes are linked. In order to test this we compared the change in confidence scores with the changes in clinical indicators for each participant that completed both sets of paired values (i.e. those for whom we had pre- and post-SMP data for

both confidence to self-manage depression and either PHQ9, GAD7 or WSAS) using a Pearson test to look for correlation.

PHQ9 depression scores

The results for the 86 patients who provided data for both self-confidence to manage their depression and PHQ9 severity of depression scores pre- and post-SMP are shown in Table B1 and Figure BA in Appendix B. This shows a statistically significant and positive correlation between the improvement in PHQ9 scores and improvement in the patient's confidence to self-manage their depression.

GAD7 anxiety scores

Sixty participants completed both the confidence and the GAD7 scales pre- and post-SMP. These again showed a positive and statistically significant correlation between the improvement in GAD7 scores and improvement in the patient's confidence to self-manage their depression. The results are presented in Table B2 and Figure BB in Appendix B.

WSAS work and social functioning scores

Both the confidence and the GAD7 scales pre- and post-SMP were completed by 58 participants. Once again there was a positive and statistically significant correlation between the improvement in WSAS scores and improvement in the patient's confidence to self-manage their depression. The results are presented in Table B3 and Figure BC in Appendix B.

Discussion

One caveat that has to be applied to this and the correlation results in Appendix B is that correlation does not prove either causality or the direction of the link. For example, we cannot exclude that attending the groups is a powerful treatment for depression and it is the improvement in depression severity, as shown in the changes in PHQ9 scores, that improves a patient's confidence to self-manage. Equally, the open nature of the evaluation means that an as yet unknown third factor, such as changes in antidepressant medication, that would cause both the improvements in PHQ9 and confidence to self-manage, cannot be excluded. These considerations aside, however, it seems feasible that attending the SMP improves attendees self-management confidence and skills that produce behaviour change which leads to a reduction in the levels of depression and anxiety and hence an increase in social functioning.

1d Is there evidence that the benefits of the SMP course persist beyond the end of the course?

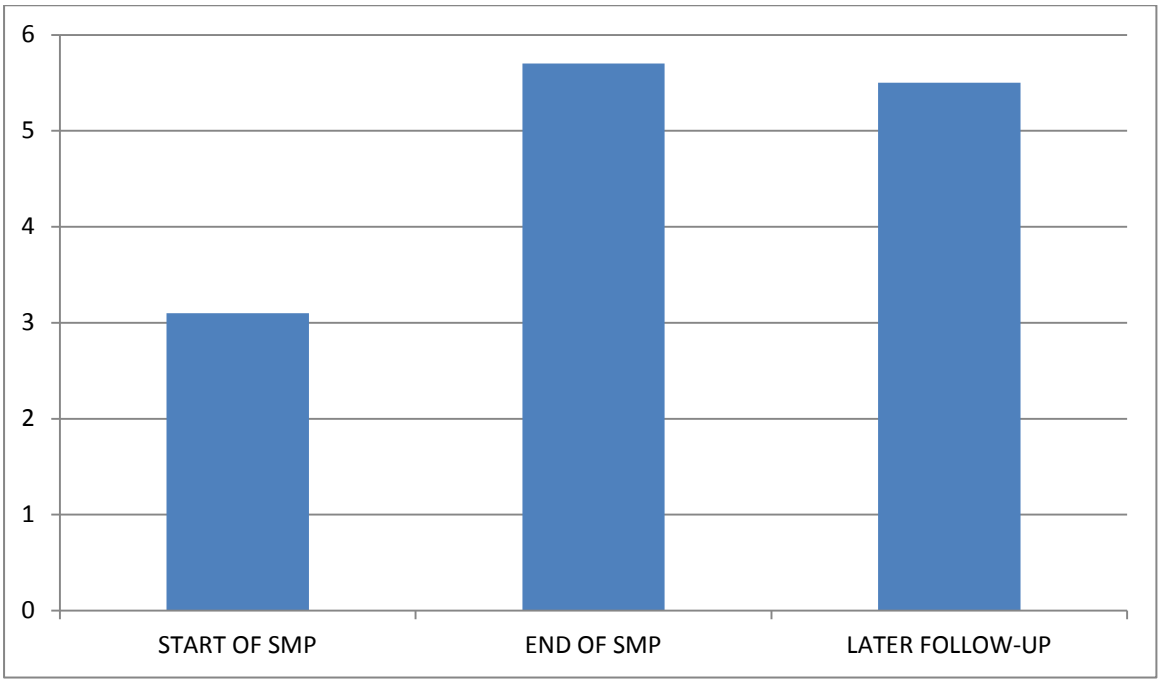
Participants of past SMP courses were sent copies of the SMP evaluation questionnaire as a postal survey. The range of times between finishing the SMP course and follow-up varied from seven weeks to over one year.

When asked if they are still benefitting from the tools that they learnt on the course on a 0 to 10 scale the average score was 6.72 (46 participants). So there is good evidence that participants feel that the benefit carries on after the course ends.

Confidence to self-manage depression

This continuing benefit is also borne out by when the participants were asked to rate their confidence to self-manage their depression on a 0 to 10 scale as shown below in Figure A (below). In order to accurately study the changes in confidence SMP participants were included who completed the confidence scale three times, at the beginning and end of the SMP and for the later follow-up questionnaire. There is a clear and statistically significant increase in this confidence from the start to the end of the SMP course ($p<0.001$) which is maintained after the course ends as there is no significant difference between these scores.

FIGURE A SHOWING THE AVERAGE CONFIDENCE TO SELF-MANAGE DEPRESSION AT THE START AND END OF SMP TOGETHER WITH THE FOLLOW-UP QUESTIONNAIRE (22 PATIENTS)



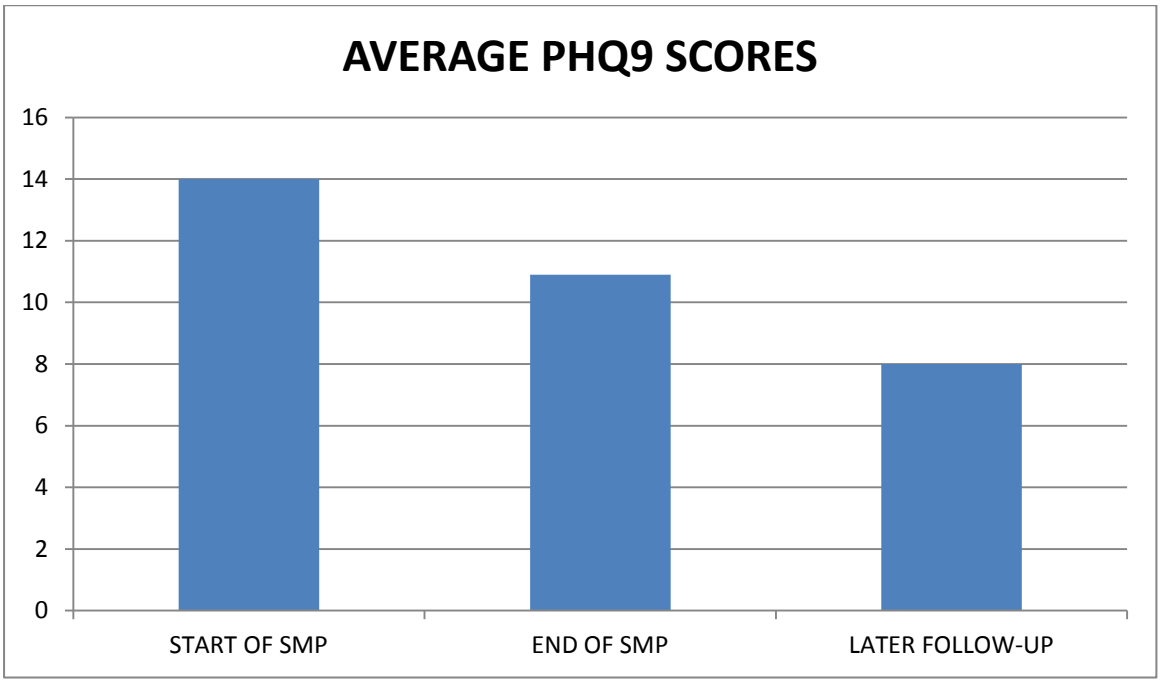
Results from comparing clinical indicators of depression, anxiety and work and social functioning at the start and end of the SMP course have already shown that they are positively correlated with confidence to self-manage depression. The question is whether this continued confidence is translated into a continued improvement in clinical indicators.

When average follow-up scores for the severity of these clinical indicators are compared with those pre- and post-SMP there appears to be maintained improvement in levels of depression, anxiety and social functioning as shown in Figures B, C and D respectively.

PHQ9 depression scores

Twenty-seven participants completed the PHQ9 questionnaire at the start and end of SMP and the postal questionnaire. As before, comparing the pre- and post-SMP scores showed positive and statistically significant change. ($p<0.02$, paired t-test). Though there was a trend for an improved PHQ9 score between the end and later follow-up scores this was nearly but not quite statistically significant ($p=0.055$, paired t-test).

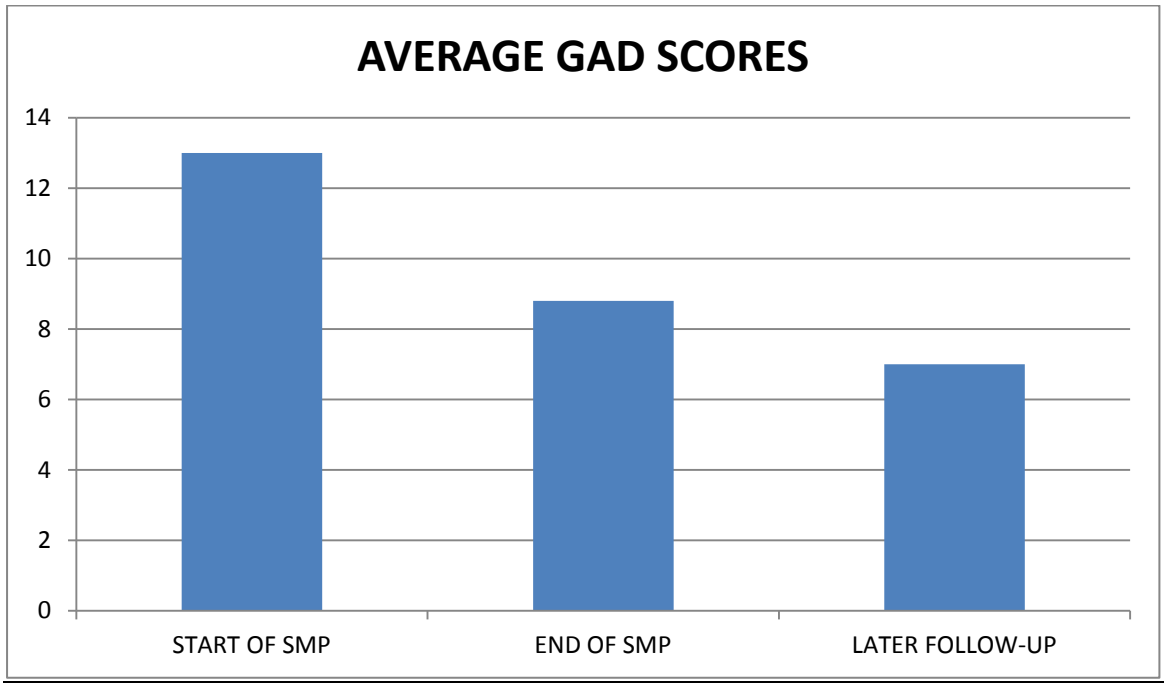
FIGURE B SHOWING THE AVERAGE PHQ9 DEPRESSION SCORES AT THE START AND END OF SMP TOGETHER WITH THE FOLLOW-UP QUESTIONNAIRE (27 PATIENTS)



GAD7 anxiety scores

This group consisted of 20 participants. Again there were statistically significant differences between the start and end scores ($p<0.01$, paired t-test) with a non-statistically significant trend for an improved GAD7 score between the end and later follow-up scores.

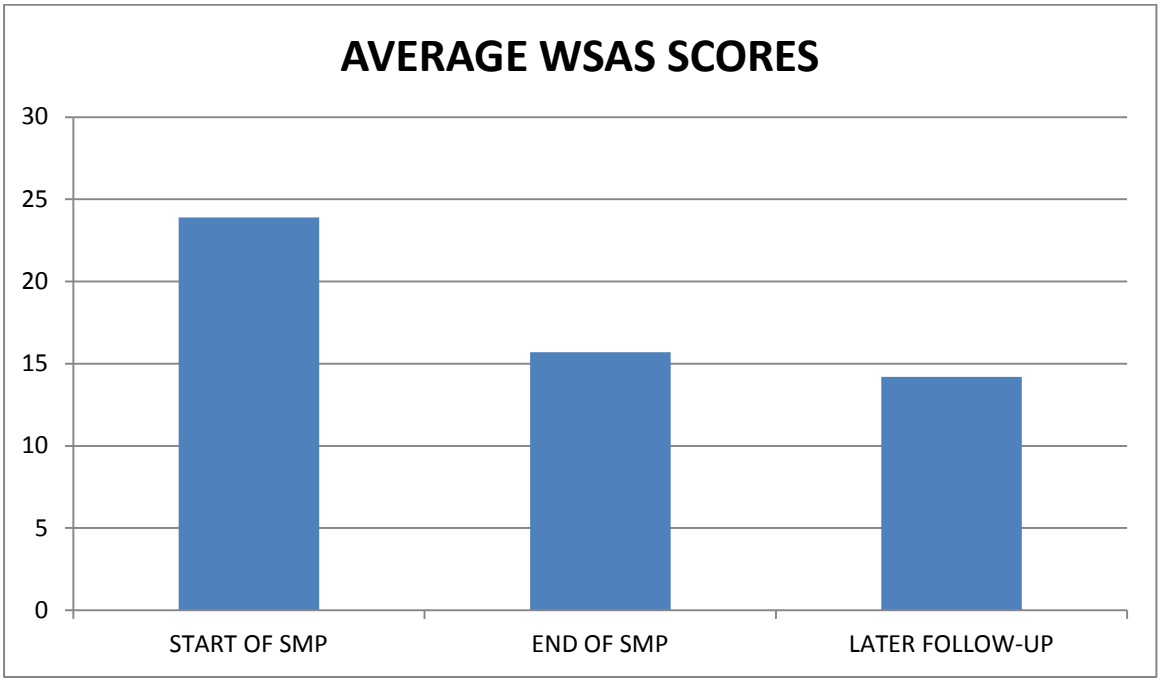
FIGURE C SHOWING THE AVERAGE GAD7 ANXIETY SCORES AT THE START AND END OF SMP TOGETHER WITH THE FOLLOW-UP QUESTIONNAIRE (20 PATIENTS)



WSAS work and social function scores

Here we had three scores from 19 participants. Again there were statistically significant differences between the start and end scores ($p<0.01$, paired t-test) with a non-statistically significant trend for an improved WSAS score between the end and later follow-up scores.

FIGURE D SHOWING THE AVERAGE WSAS SCORES AT THE START AND END OF SMP TOGETHER WITH THE FOLLOW-UP QUESTIONNAIRE (19 PATIENTS)



Therefore, there seems to be good evidence that SMP participants sustain their increased confidence after the course has finished which results in maintained, and possibly further, clinical improvement.

Discussion

Certainly this cannot be regarded as the most rigorous of research protocols as possible confounding factors, such as the use of antidepressant medication, were not controlled for. However the results obtained here are highly statistically significant and show that completing the SMP course is associated with increased confidence to self-manage illness, reduced illness severity and increased social functioning. These benefits then continue after the course has ended.

2. How does the cost-effectiveness of the Self-Management Programme for patients with depression compare with the standard psychological therapy for depression as currently used locally?

BACKGROUND

The NHS treatment for depression is based on guidance given by the National Institute of Health and Care Excellence (NICE). This recommends a stepped-care model whereby the therapy a patient receives depends on the severity of their illness, together with response to treatment. Most patients begin their treatment at step 2 with low-intensity interventions, such as computerized cognitive behavioural therapy and guided self-help. SMP would therefore fit into this step 2, low-intensity model.

In Torbay, the standard course of low-intensity intervention consists of seven sessions with an Agenda for Change (AfC) Band 5 worker. Each of these sessions lasts for one hour, 50 minutes with the patient and 10 minutes for note-making. The unit costs of a Band 5 Mental Health worker doing 25 therapeutic sessions a week have been estimated to be £53.37 per hour (2010–11 costs, see Appendix C). Therefore, for a course of seven sessions the cost of an IAPT treatment course is £373.59 – again 2010–11 costs, see Appendix C. This of course does not include the costs of people who start the IAPT therapy and then drop out or those who do not attend sessions which then have to be repeated.

However, low-intensity IAPT is a one-to-one therapy whereas SMP is a group therapy, therefore costs per person should be lower. Also the SMP courses are run in hired rooms in local hotels etc. This has several advantages – as well as there being no on-going costs with regard to maintenance etc. when the buildings are not in use, the venues give more opportunity for flexible geographical locations and timings to increase the availability of the courses to those patients who are working or have childcare issues etc.

The costs for running an SMP course are detailed in Appendix D. From these, the cost of one SMP course has been calculated as £2,203 per course. Given that 18 patients are invited to each course, this gives a total of £122.39 per person per course. Of course, not all patients complete the course, so taking the average number of completers per course between 27/1/11 and 5/5/12 which was 8 per course (see Appendix A) this total becomes £276 per completer. This compares favourably with the estimated Improving Access to Psychological Therapies (IAPT) figure as shown in Table 6 below. (These figures have been complied with the help of advice from Diana Sanderson, Health Economist recommended by Firefly).

TABLE 6 DISPLAYING COSTS OF A STANDARD COURSE OF SMP AND IAPT TREATMENTS

	SMP	IAPT
Cost per patient per completed treatment course (£)	276	373.59

Therefore there does seem to be a cost-saving with regard to a patient attending an SMP course as opposed to standard treatment via IAPT. However, this is of little importance if the outcomes of SMP are inferior to those of IAPT. Hence we decided to compare the two treatments with regards to efficacy.

Method

Here we have compared results from patients who attended the SMP in Torbay with the returns from the IAPT team in Torbay, using the designation of a successful treatment that the IAPT service use, called "moving toward recovery". In order to assess the effectiveness of IAPT treatments, patients are assessed at each contact using the PHQ9, GAD7 and WSAS. "Moving toward recovery" is defined as those patients who had completed an IAPT treatment course where their last PHQ9 depression score was equal to or less than 9 and their last GAD7 anxiety score was equal to or less than 7.

As there is a gap between referral and being seen by IAPT or SMP, some patients would have started the treatment course with scores less than these already, perhaps due to having improved via the prescription of antidepressant medication for example. Therefore the number of patients in this position are assessed and removed from the evaluation. Thus only those who have had a reduction in either PHQ9 or GAD7 scores from above to below a set level of severity are counted as "moving towards recovery". This figure is then compared to the total number of patients with either a PHQ9 of at least 10 or a GAD7 score of at least 8 that started the IAPT treatment course to arrive at a percentage.

Given that patients in the SMP course completed the same scales at the start and end of the course this facilitated a comparison of the level of successful treatment with IAPT. The study group consisted of consecutive patients who completed an SMP course between July and November 2011 inclusive with those patients who completed IAPT treatment at the same time.

Results

The total number of patients in SMP courses that ended between July and November 2011 was 78. Of these the number of completers (i.e. those that completed the PHQ9 and GAD7 scales at the first and last session) was 53. The results of these SMP patients, using the IAPT "moving towards recovery" definition, are shown below:

Last PHQ9 score <=9 and last GAD7 score <= 7 = 22 patients

We then removed the patients who did not fit the severity criteria (first PHQ9 score <=9 and first GAD7 score <= 7) = 6 patients

Therefore the percentage of patients “moving toward recovery” =16/53 = 30.2%

Over the same period the IAPT team treated considerably more patients, a total of 422. Of these the total returned as “moving toward recovery” was 144 (34.1%).

This difference was not statistically significant. (Fisher's exact test – the two-tailed P value = 0.645).

Discussion

As it is a group, as opposed to an individual therapy the SMP has inherent cost advantages over IAPT. The numbers completing the SMP course were much less than IAPT so there is the possibility that a significant difference between the two approaches would have emerged with a larger sample. However, given that SMP is a cheaper therapy even an advantage in efficacy for IAPT would not necessarily make it more cost-effective in terms of patients treated per £10,000.

It must be emphasized here that IAPT is a well-recognized approach and that even if these, very preliminary, results are proved correct there is no evidence here to say that SMP should replace IAPT. What it does show is that even the recognized therapy, by its own criteria, is only successful in about 1/3 of patients that complete the course in Torbay. Whereas SMP also achieved about the same level of success as IAPT, the therapeutic approaches are very different. It may well be that each approach favours a different group of patients and that the two therapies are complimentary.

It is of note that the completion rate for SMP attendees is markedly better than other, similar, interventions published in the past. For example, Lovell et al (2008) described a trial of 10 largely face-to-face sessions, but with some telephone and email follow-up. Of the 29 patients allocated to the guided self-help intervention, 22 (76%) attended at least 1 session. The mean number of sessions attended was 3.5 (SD 3.5, range 1 to 10).[18] Richards et al (2003) didn’t fare much better. In a study of 3 sessions of individual self-help advice, 64 people were allocated to ordinary care and 75 to self-help, 47 of whom attended for one or more appointments.[19]

3. Does attending the Self-Management Programme reduce healthcare costs?

Background

In our discussions with commissioners it was clear that showing that the programme was cost-effective i.e. that money spent on the programme was recouped by reduced service usage elsewhere, was the most important aspect that they were looking for. Therefore the prime aim of this evaluation was to look for this cost-efficiency. The evaluation took two forms, the first looking at primary care and the second involving secondary care.

3a Primary care

Method

The evaluation in primary care concerned the patients at Mayfield Surgery in Paignton. The patients from this surgery who had completed SMP were identified and their face-to-face and telephone contacts with the surgery were retrospectively measured for the six months before and after SMP. These results were then analysed for statistical significance using a chi-square test.

The study group consisted of 57 patients who, on starting an SMP course between 1/3/09 and 1/3/11, stated that they were referred from the study practice. Of these 57, 40 completed the SMP which gave a 70% completion rate (completion being defined as completing 5 or more sessions of a 7-session course). Of the 40 completers, 12 were screened out as they moved either to or from the practice during the study period, or they were not actually patients of the practice. This left 28 completers with 6 months data on appointments before starting the course and 6 months data on appointments after finishing the course.

Results

The raw data for this study is shown in Table 7 below. There is a modest, non-statistically significant, reduction in telephone consultations in the 6 months following the course, compared with the 6 months preceding it. However there was a larger reduction in face-to-face appointments from an average of 6.7 appointments per patient to 5.1. This was statistically significant (t-test two-tailed P value equals 0.0377).

TABLE 7 SHOWING SIGNIFICANT CHANGES IN THE NUMBER OF GP APPOINTMENTS PRE- AND POST-SMP

Appointments during the 6 months **before starting** the SMP course		Appointments during the 6 months **after completing** the SMP course	
Face-to-face appointments	Telephone encounters	Face-to-face appointments	Telephone encounters
187	22	143	19

DISCUSSION

Of course a simple reduction in contacts is welcome but is not always a sign of money saving or good practice. For instance, if a patient found a mole on their skin that had grown and changed colour it is important that the patient seek medical advice and not attempt to self-manage. The GP who performed the study made the following comment:

"*One observation I made looking through all the records was that the effects of the course did seem, in part, to depend upon what stage the patient was at with their particular problem. In certain cases the course had an 'activating' effect on people, and I could see they had become empowered to seek advice from health professionals, very appropriately, whereas there had been little evidence of contact beforehand. However, other individuals, who had had extensive input from the practice beforehand, seemed empowered to become more independent self managers."*

It seems therefore that the overall effect of SMP is to increase the chance that patients contact health professionals appropriately rather than to simply reduce the numbers of contacts across the board, but that this has the overall effect of reducing primary care contacts.

KEY POINT

COMPLETING AN SMP COURSE IS ASSOCIATED WITH A SIGNIFICANTLY DECREASED NUMBER OF PRIMARY CARE CONTACTS IN THE SIX MONTHS AFTER THE COURSE AS COMPARED TO THE SIX MONTHS BEFORE

3b Secondary care

Method

In order to evaluate the impact of an SMP on secondary care use we took as the study group all those patients who had been enrolled onto the SMP course in the year 2010. To assess this we decided to compare the secondary service usage of those that had completed the course (defined as attending 5 or more of the 7 sessions) with those who had commenced the course but not completed it (attended 4 or less of the 7 sessions.) This number of sessions was chosen as it was the definition of completion used in the evaluation of phase 1. In the following data the number of contacts with each service has been measured 1 year prior to, and 1 year after completion, of the SMP.

The ratio of secondary service contacts per patient was calculated for one year pre and post in order to look for a change in service use.

Results

A total of 165 patients began an SMP course in 2010, of which 64 (39%) dropped out before completing the programme.

PSYCHIATRIC OUTPATIENTS

Here we assessed the number of contacts with Devon Partnership NHS Trust, who provide the secondary service to the Torbay area. Of the 165 patients, 114 (69%) previously had no contact with Devon NHS Partnership Trust. Table 8 below shows the total number of contacts with this service for completers and non-completers for the 12 months before and after SMP, together with the ratio of contacts per patient.

TABLE 8 SHOWING THE NUMBER OF DEVON NHS PARTNERSHIP TRUST PSYCHIATRIC APPOINTMENTS FOR ONE YEAR PRE- AND POST-SMP

	Completed programme			Non-completers		
	Contacts	Patients	Ratio	Contacts	Patients	Ratio
Pre	309	30	10.3	223	21	10.6
Post	360	25	14.4	160	15	10.7

This shows that for non-completers the ratio of contacts was identical before and after the SMP, but that the number of contacts for completers increased significantly.

There was a fairly similar increase in community care contacts for both completers and non-completers, as shown in Table 9

TABLE 9 SHOWING NO SIGNIFICANT CHANGES IN THE NUMBER OF COMMUNITY CARE APPOINTMENTS IN THE YEAR PRE- AND POST-SMP

	Completed programme			Non-completers		
	Contacts	**Patients**	**Ratio**	**Contacts**	**Patients**	**Ratio**
Pre	85	22	3.9	46	15	3.1
Post	115	22	5.2	73	15	4.9

ACUTE CARE

The local provider of acute medical care is South Devon Healthcare NHS Foundation Trust (SDHFT). Again, there was no evidence that completing an SMP course altered the numbers of outpatient appointments or admissions for medical or surgical reasons as shown in Table 10.

TABLE 10 SHOWING NO SIGNIFICANT CHANGES IN NUMBER OF SDHFT APPOINTMENTS AND ADMISSIONS FOR ACUTE MEDICAL CARE IN THE YEAR PRE- AND POST-SMP

	Completed programme			Non-completers		
	Events	**Patients**	**Ratio**	**Events**	**Patients**	**Ratio**
Outpatients						
Pre	395	60	6.6	162	38	4.3
Post	426	61	7.0	200	41	4.9
Inpatients						
Pre	41	24	1.7	37	21	1.8
Post	46	22	2.1	37	22	1.7
A&E						
Pre	61	31	2.0	69	25	2.8
Post	62	35	1.8	42	24	1.8

KEY POINTS

Outpatients

- **An increase in patient ratio attendance post-attending the SMP for both completers and non-completers.**

Inpatients

- **A slight reduction in patient ratio attendance for patients who did not complete the SMP.**

A&E

- **A reduction in A&E attendances for patients attending the SMP post-completion and a larger reduction in patient ratio of attendances for those not completing the SMP.**

Overall there is no evidence from these results that attending an SMP will decrease secondary service contacts for medical or psychiatric care.

DISCUSSION

There is evidence that attending the SMP does alter and reduce patterns of service usage in primary care but not secondary care. There are several factors that do come into play for secondary care however that might partially explain this. For instance, the SMP was aimed at mild-to-moderate depression and such patients would be more likely to be seen in primary than secondary care than those with a more severe depressive illness. Given that two-thirds of SMP attendees had no prior contact with secondary psychiatric services this does indeed suggest that their illnesses were of lesser severity. An alternative explanation is that the SMP was attracting patients who had an aversion to being seen by the psychiatric service, perhaps due to a certain stigma.

Of course, showing a reduction in secondary service usage with patients of whom the majority were not in the service at the start of the course, or indeed had any prior contact with the service, was always going to be a difficult task given the small numbers of participants. Also, while we looked at attendances in A&E and medical services there is no particular reason why attending a self-management course for depression would decrease these numbers.

However, this study showed that there was an increase in secondary care contacts for patients who completed the SMP as opposed to those that did not. Again there might be several reasons for this. It could be that there is a common factor in this, namely levels of individual patient adherence. This means that, basically, those patients who are more likely to attend the SMP sessions would also be those who would be more likely to attend appointments and complete a treatment course in secondary care. Equally, one patient who was interviewed for a previous study said that attending the SMP, with its emphasis on skills, such as shared agenda and goal setting, enabled her to make better use of her secondary service sessions. This synergy between the SMP and secondary service could have led to the increased secondary service usage.

4. Does utilizing the Co-creating Health model (as described below) change the patterns of prescribing and referral for GPs?

METHOD

In order to assess the effectiveness of the Co-creating Health model on GP behaviour and referring practice, we chose a practice that, prior to the evaluation, had little involvement in the Co-creating Health programme. We wished to look for what has been described as 'white light', where clinician training, patient self-management and service improvement went hand-in-hand. In order to do this we chose to study a GP practice that had little contact with Co-creating Health prior to the study period.

The GPs in the chosen practice all went through the ADP and were visited by members of the Torbay Co-creating Health team as part of the SIP to encourage them to use small cycles of change to facilitate self-management in their practice. Given that we were focusing on depression we decided to look at secondary service referrals for mental illness in the two months prior to and following the GPs attending an ADP training course. The secondary service providers to the GP practice under observation are Devon NHS Partnership Trust (DPT) for mental health and South Devon Healthcare NHS Foundation Trust for non-mental health services.

The ADP course is designed to help health staff work collaboratively with patients by fusing the 'three enablers' of joint agenda and goal setting together with relatively quick follow-up. As part of the joint agenda and goal setting on the course, GPs are encouraged to, for example, ask patients questions "would you like me to refer you to..?" or "how do you feel about me referring you to…?" as opposed to saying " I am going to refer you to..". Therefore, if GPs practice is changing as a result of the course we might expect to see a change in referral patterns or prescribing, which is the focus of this section of the evaluation.

As the ADP course was held in the autumn a confounding factor could have been that the rates of GP patients with depression were higher in winter than summer due to conditions such as seasonal affective disorder that has as its characteristic a worsening of symptoms of low mood during the winter months. Alternatively there are conditions, such as influenza, that are at a much higher rate in winter months which could reduce the percentage of patients with depression attending a GP surgery. Therefore we compared the referral rates to secondary services for depression to total attendances at the GP surgery and to the numbers of acute prescriptions for selective serotonin reuptake inhibitors (SSRIs) which are the most common antidepressants prescribed by GPs and are the first line drug treatment for depression as recommended by NICE. It was hoped that this would provide an accurate approximation of the number of patients that were seen by GPs for depression.

To do this we compared the total number of patients see by GPs, SSRI prescriptions and secondary service referrals in the two months before and after attending the ADP course, namely, July/August and November/December 2011. We also checked the number of referrals to the self-management courses from the surgery for the same period from our own database. We excluded referrals to the child psychiatry and drug and alcohol services.

RESULTS

As expected there was an increase in patients in the winter months and a corresponding and relatively proportional increase in SSRI prescribing. This is shown in Table 11 below.

TABLE 11 SHOWING NUMBERS OF PATIENTS AND GP ACUTE ANTIDEPRESSANT PRESCRIPTIONS PRE- AND POST-ADP

	Pre-ADP July/August 2011	Post-ADP November/December 2011
Number of patients	3,450	3,923
Number of SSRI prescriptions	261	280
Number of SSRI prescriptions per 1,000 patients	75.7	71.4

However, the major change was in the reduction in the number of secondary service referrals to adult and older person's mental health services before and after ADP which were 34 and 21 respectively. If we take the number of SSRI prescriptions as indicative of the number of depressed patients seen then we can get a better indication of the change in referral patterns by looking at the number of secondary service referrals per 1,000 antidepressant prescriptions as shown in Table 12.

TABLE 12 SHOWING TOTAL PSYCHIATRIC SECONDARY SERVICE REFERRALS PER 1,000 GP ANTIDEPRESSANT PRESCRIPTIONS PRE- AND POST-ADP

	Pre-ADP July/August 2011	Post-ADP November/December 2011
Number of SSRI prescriptions	261	280
Number of secondary service referrals	34	21
Number of secondary service referrals per 1,000 SSRI prescriptions	130.3	75

Correspondingly, the number of referrals to the self–management of depression course (SMP) increased markedly before and after ADP – from 7 to 13.

TABLE 13 SHOWING TOTAL SMP REFERRALS PER 1,000 GP ANTIDEPRESSANT PRESCRIPTIONS PRE- AND POST-ADP

	Pre-ADP July/August 2011	Post-ADP November/December 2011
Number of SSRI prescriptions	261	280
Number of SMP referrals	7	13
Number of SMP referrals per 1,000 SSRI prescriptions	26.8	46.4

FIGURE E SHOWING CHANGE IN SECONDARY SERVICE AND SMP REFERRAL PATTERNS AFTER SELF-MANAGEMENT TRAINING (ADP) AND SERVICE IMPROVEMENT IN A LOCAL SURGERY

Figure E above shows the number of secondary service referrals for adult/older person's mental health to DPT in one practice in the two months prior to and after training in self-management by the ADP and implementation of service improvements (SIP). In spite of their being more patients in total seen, the number of secondary service referrals reduced significantly which was partly, but not entirely, compensated for by an increase in referrals to the SMP.

DISCUSSION

As stated in the method, the changes to GP practice with regard to referrals (i.e. asking rather than telling) are relatively small. In spite of this, however, they are associated with a large reduction in secondary service referrals. A limitation here would be the fact that there was also a SIP going on at the practice at the same time as the ADP. Here other members of the Co-creating Health team were going into the practice to help them set up small changes to improve self-management support. This might have increased the awareness of the SMP and thus prompted GPs to change from referring patients to the secondary services to the SMP instead. However, this increased awareness would not be able to explain the overall drop in referral numbers when SMP and secondary service referrals were combined.

It is difficult to evaluate the separate effects of SMP and SIP on GP referral practice. However, here it must be remembered that there was an overall increase in patients and a corresponding increase in antidepressant prescribing indicating a higher number of acutely depressed patients being seen. Yet, in spite of this the increased number of SMP referrals combined with the secondary service referrals still did not even match the total number of referrals from when fewer depressed patients were seen. Therefore this indicates a change in the referral process rather than SMP replacing other methods of treatment. Also, given that the plan for the evaluation was designed to study to the Co-creating Health model, which includes both ADP and SIP, then an element of SIP changing GP referral practice would be both expected and welcomed.

This would have resulted in a marked cost-saving for the NHS.

Other evaluation activity

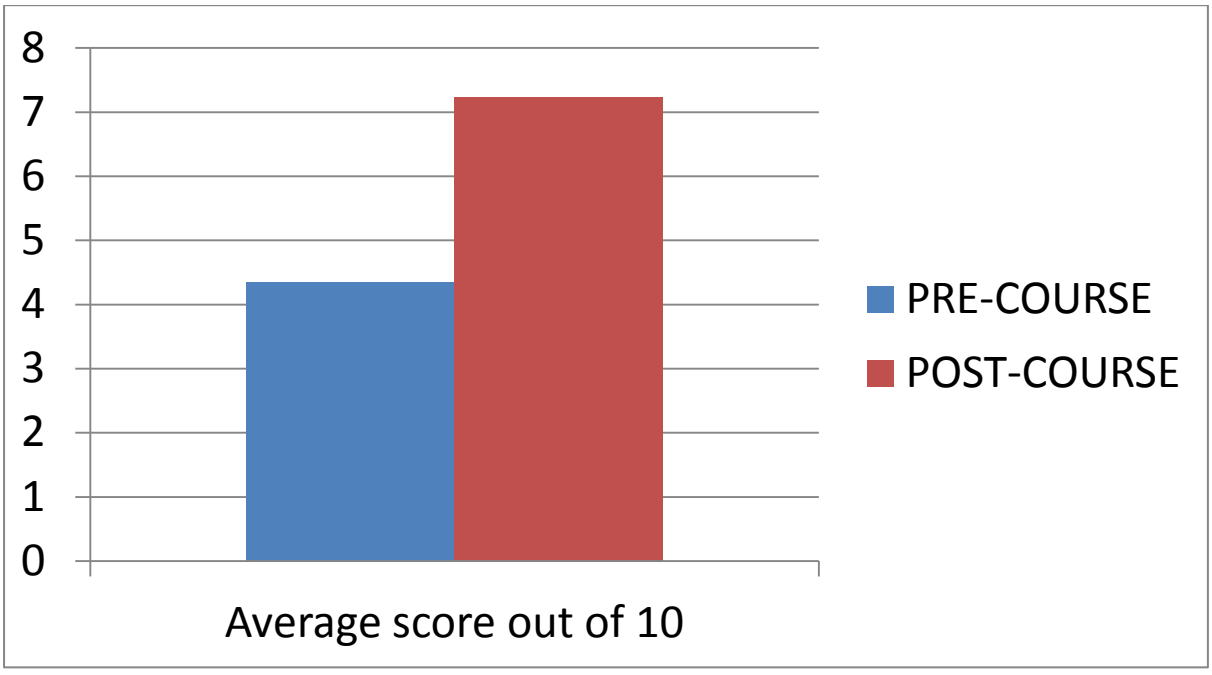
ADP for medical students

The local medical school, the Peninsula Medical School, has as part of the curriculum "Special Study Units" (SSU) which students take at intervals throughout their five years at medical school. These are designed to give the students experience in, for example, interesting healthcare environments. We have delivered an ADP course as one of these SSUs to 7 medical students at the end of their first year.

To evaluate the effectiveness of the course we first measured the student's attitude to the balance of power between doctor and patient at the start and end of the training. Interestingly when asked their views of the statement "The person with a long term health condition and the health care professional share responsibility", there was a general agreement both before and after the course. However at the start of the training most of the students disagreed or were not sure about the statement "The person with a long term condition and the health professional are equals and experts". However, by the end of the course they all either agreed or strongly agreed.

We also studied the student's confidence to help patients self-manage their depression using their responses to a 12-item questionnaire testing their confidence in collaborative working on a Likert scale. Here a higher score indicated a greater confidence in collaborative working. Again we compared their answers before and after the course. As seen in Figure F below there was a marked increase in their confidence to help patients self-manage at the end of the course when compared to the beginning.

FIGURE F MEDICAL STUDENTS AVERAGE COLLABORATIVE WORKING SCORES



Does attending an SMP course influence participant's confidence to find work?

A major driver for the NHS strategy on depression is to reduce the number of claimants for benefits. Indeed, one of the original performance indicators set for the IAPT programme in 2008 was to have 25,000 fewer patients with depression on sick pay and benefits, by 2010–11.[20]

As part of the evaluation of the self-management of depression course (SMP) we asked participants to fill in a questionnaire at the first and last session to look for changes. To evaluate their confidence to seek and retain employment, participants were asked to rate their confidence to find employment on a 0- to 10-point Likert scale. Higher scores indicated greater levels of confidence.

The study group consisted of consecutive participants that commenced an SMP course between 11/10/10 and 5/5/12. Of these, 56 patients answered the question on employment confidence at the start and end of the SMP course. These responses were then analysed using a paired t-test and showed a statistically significant increase in confidence to find work after the course as opposed to before. The results are shown in Table 14 below.

TABLE 14 SHOWING SIGNIFICANT INCREASES IN CONFIDENCE TO GAIN EMPLOYMENT PRE- AND POST- SMP

	Employment confidence before SMP	Employment confidence after SMP
Mean	3.32	4.36
SD	3.17	2.82
n	56	56

The two-tailed P value equals 0.0068.

These results show that attending an SMP course is associated with a significant increase in participants' confidence to find work.

Overall discussion and reflections

The remit of this evaluation was to consider how to best influence the commissioning agenda. As stated in the introduction, local commissioners had informed us that the best way to do this was to provide evidence of cost savings given the current economic climate. The small numbers and lack of previous psychiatric treatment for the majority of patients made it difficult, if not impossible, to have any chance of showing a decrease in secondary service referrals for the SMP participants. However we did demonstrate a decrease in primary care contacts for SMP completers together with a decrease in referrals for a GP practice pre- and post-ADP. It therefore seems that the majority of savings from SMP are going to be made in primary care. This really isn't that surprising given that the use of secondary services is mainly for acutely ill patients where the use of a medical, as opposed to a collaborative, model is more likely to be appropriate.

In order to consider the implications of this evaluation for the future sustainability and spread of the Co-creating Health model it is best to assess the impact in a number of distinct areas. The results presented here have been utilized locally, nationally and internationally and these areas will now be considered in turn.

Locally, the results obtained were passed on to commissioners and, partly due to this, continued funding for self-care was commissioned at the rate of £100,000 per annum which will be recurring. This was a somewhat bittersweet success as the changes to the NHS structure meant that the trust employing the majority of the local Co-creating Health team were becoming "purchasers" and so could not be "providers". And so, though self-management will continue, it will not be delivered by the same team, as many of their jobs are now at risk.

In the immediate future (i.e. before the end of 2012) a service specification tender for self-care will be written. The tender will be offered to an external provider through the procurement process. As this tender is being written by members of the local Co-creating Health team, it is anticipated that the specifications of the tender will be based on the Co-creating Health model and that the new provider will be expected to continue to run self-management courses as well as ADP training for health and social care staff and teams.

When considering why the results here were effective in helping persuade the local commissioners' minds it is clear that a number of factors came into play. Undoubtedly, first consulting them on the type of evidence that they were looking for was vital. Throughout the first few years of the Co-creating Health project the lack of "hard evidence" was often bemoaned by local managers and opinion formers. These people, often general practitioners (GPs), had been imbued for the last few years with the drive for "evidence -based medicine". This meant that by "hard evidence" what they were looking for was quantitative data with a robust statistical analysis containing P values etc., hence the heavy quantitative bias in this evaluation.

Nationally we have received requests for the data from North Devon and Hertfordshire. The first of these was from an NHS worker who was bidding to run an SMP for chronic pain and who described the data as "just what he needed" to help support his case. The request for this followed the worker in question visiting the Health Foundation website and being re-directed. The second request came from a GP commissioner who wished to set up a self-management course for depression and who also asked for supporting data. I believe that this contact came after a colleague of his had been

invited to, and attended, a showcase event for the local Co-creating Health team run by the Health Foundation. Clearly the Health Foundation has a vital role to play in disseminating this information.

Internationally, some of the results of this evaluation were presented at the ISQUA conference in Geneva, leading to uniformly positive verbal feedback from the attending delegates. One delegate from Abu Dhabi asked if the results could be presented in a forthcoming conference that she was considering holding there. As well as comprising part of the conference programme,[21] Torbay evaluation results were also published in the conference documentation.[22]

The evaluation here certainly is not the last word in scientific rigor. In order for this, possible confounding issues, such as antidepressant medication, should have been accounted for. Alternatively, a control group, perhaps who received “tea and sympathy” but no advice, could be compared to SMP in order to further test the effectiveness of the process of self-management support. Such a study would be time consuming and expensive and is unlikely to be completed. Therefore, given the lack of quantitative research already published on this subject, particularly centred around potential cost benefits, the intention is to submit further papers for publication from this evaluation.

Appendix A: SMP course registration and completion data

Course date	Registered	Completers (5 sessions or more)
27 January 2011	18	11
2 February 2011	19	9
5 March 2011	9	6
5 April 2011	20	11
15 June 2011	18	7
25 June 2011	18	8
4 August 2011	20	10
31 August 2011	15	6
5 September 2011	18	5
3 October 2011	16	7
20 October 2011	18	6
5 November 2011	18	8
11 January 2012	18	3
6 February 2012	22	4
28 February 2012	22	12
3 April 2012	19	8
5 May 2012	23	12

Appendix B: Further tables and figures

TABLE B1 SHOWING SIGNIFICANT CORRELATION BETWEEN IMPROVEMENT IN PHQ9 DEPRESSION SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION

		Improvement in PHQ9 pre- and post-SMP	Improvement in confidence
Improvement in PHQ9 pre- and post-SMP	Pearson Correlation	1	0.367**
	Sig. (2-tailed)		0.001
	n	86	86
Improvement in confidence pre- and post-SMP	Pearson Correlation	0.367**	1
	Sig. (2-tailed)	0.001	
	n	86	86

**. Correlation is significant at the 0.01 level (2-tailed).

FIGURE BA SCATTER PLOT SHOWING CORRELATION BETWEEN IMPROVEMENT IN PHQ9 DEPRESSION SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION

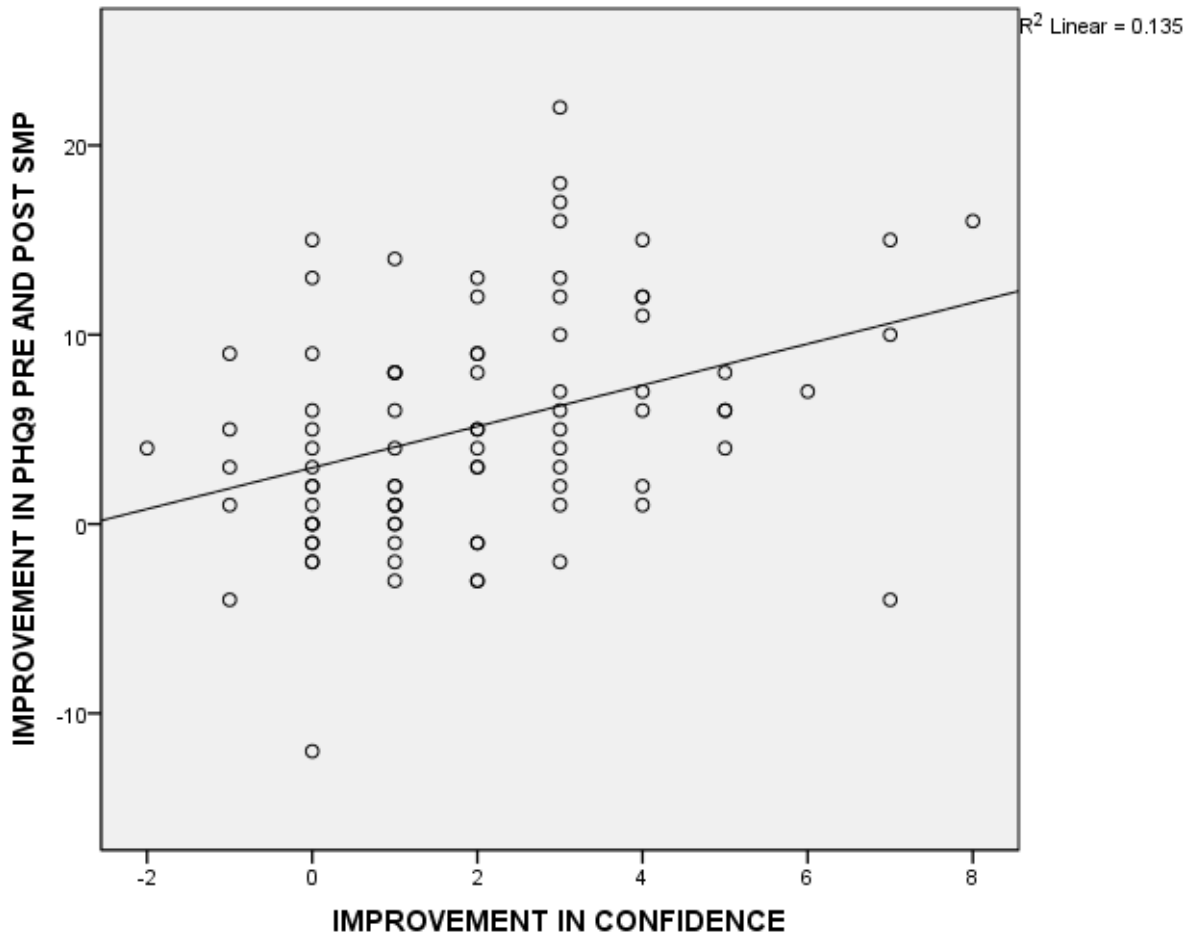


TABLE B2 SHOWING SIGNIFICANT CORRELATION BETWEEN IMPROVEMENT IN GAD7 ANXIETY SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION

		Improvement in GAD7 anxiety scores	Improvement in confidence
Improvement in GAD7 anxiety scores pre- and post-SMP	Pearson Correlation	1	0.446**
	Sig. (2-tailed)		0.000
	n	60	60
Improvement in confidence pre- and post-SMP	Pearson Correlation	0.446**	1
	Sig. (2-tailed)	0.000	
	n	60	60

**. Correlation is significant at the 0.01 level (2-tailed).

FIGURE BB SCATTER PLOT SHOWING CORRELATION BETWEEN IMPROVEMENT IN GAD7 ANXIETY SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION

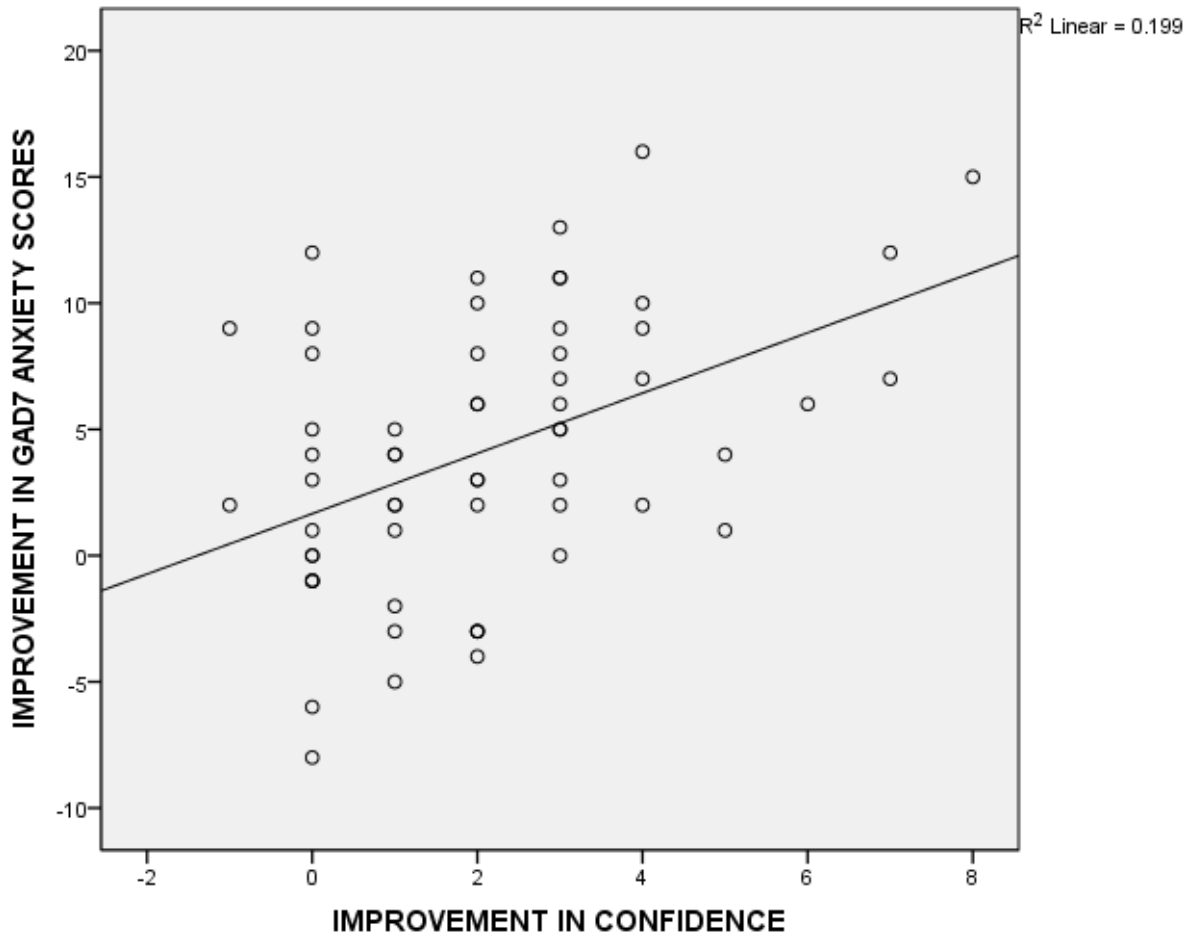
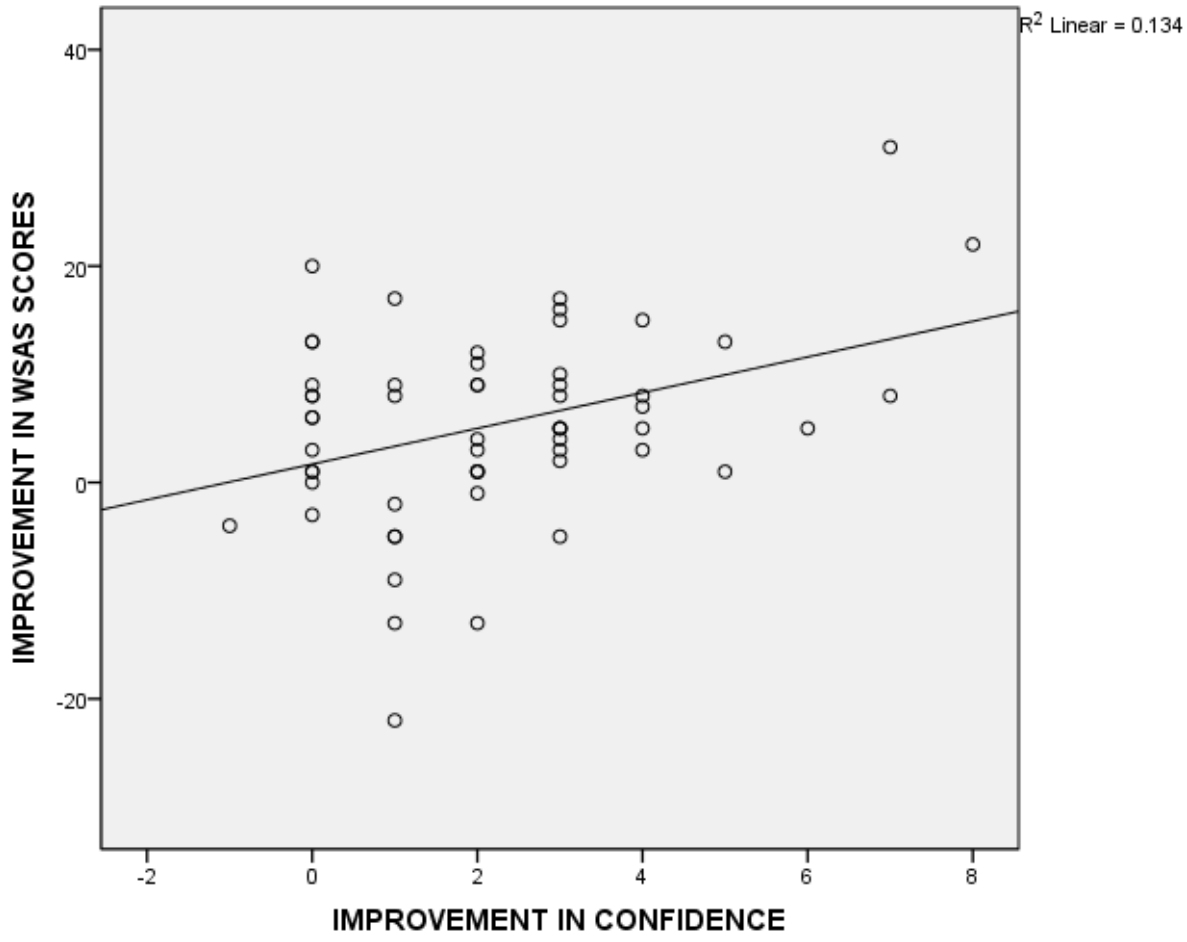


TABLE B3 SHOWING SIGNIFICANT CORRELATION BETWEEN IMPROVEMENT IN WSAS SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION

		Improvement in WSAS scores	Improvement in confidence
Improvement in WSAS scores pre- and post-SMP	Pearson Correlation	1	0.446**
	Sig. (2-tailed)		0.000
	n	60	60
Improvement in confidence pre- and post-SMP	Pearson Correlation	0.446**	1
	Sig. (2-tailed)	0.000	
	n	60	60

**. Correlation is significant at the 0.01 level (2-tailed).

FIGURE BC SCATTER PLOT SHOWING CORRELATION BETWEEN IMPROVEMENT IN WSAS SCORES AND SELF-CONFIDENCE TO MANAGE DEPRESSION



Appendix C: The IAPT staffing costs calculation

The cheapest form of "talking therapy" delivered locally is by low-intensity IAPT mental health workers who are on Agenda for Change Band 5.

UNIT COSTS OF A BAND 5 MENTAL HEALTH WORKER AS EMPLOYED IN LOW-INTENSITY IAPT – (last available costs 2010–11)[23]

All costs below are calculated using PSSRU Unit Costs in Health and Social Care 2011. According to these, the annual (adjusted) cost of a Band 5 Mental Health worker = £53,041.

Therefore the cost per week of this worker = £1,284 (based on 41.3 weeks per annum, taking into account annual leave and so on).

It is the policy of Devon Partnership NHS Trust that each worker undertakes 25 x 1 hour of therapeutic sessions a week – the rest of the time is taken up with supervision requirements etc. On this basis the cost per session = £53.37.

Therefore if the standard IAPT treatment course is 7 sessions the cost of this per patient is

7 x £53.37 = £373.59.

Appendix D: Costing analysis for running an SMP course (local 2011–12 costs)

TABLE DI TYPICAL COST OF RUNNING A SINGLE SMP COURSE – STAFFING/VENUE COSTS

These costs are local to Torbay and are based on a typical SMP course. Each course consists of seven sessions and is run by two tutors – a health service worker and a patient tutor. Each patient is given a self-help manual to take away. The SMP courses are run in various venues across Torbay, e.g. hotels.

				Cost per course (£)
Tutor 1 health professional	£17 per hour	4 hours per session	7 sessions/weeks	476.00
Tutor 2 lay person	£10 per hour	4 hours per session	7 sessions/weeks	280.00
Venue hire	£100 per week including coffee		7 sessions/weeks	700.00
Manuals	£12 each	18 delegates		216.00
TOTAL				**1,672.00**

TABLE D2 ADMINISTRATION/SUPERVISION COSTS OF RUNNING AN SMP COURSE (LOCAL 2011–12 COSTS)

Tutor training	£2,200 per person	4 days	One-off payment	£2,200	Assuming average tutor does 10 courses and then leaves	£220.00
Tutor assessment	£200 per assessment	2 assessments per person		£400.00	Average tutor does 10 courses and then leaves	£40.00
Tutor supervision	£200 per person	Annual per person	Annual payment	£400.00	Divided over a 2-year period covering 4 courses	£100.00
Tutor meetings	£17.00 per hour	3 hours per session	Quarterly meetings	£204.00	Covering 4 courses per annum	£51.00
Administration		2 days per week helpdesk	Band 2 pro rata	15 hours @ £8.00 per hour per course	Calculated on 2-days administration per course	£120.00
			TOTAL			£531.00

These costs are based on a number of factors. Though they include health service personnel, each tutor is required to attend a four-day training course to be able to deliver the SMP. The current cost of a tutor attending the programme to be able to deliver an SMP course is detailed in the first row at £2,200. Given that tutors retire, relocate and so on we have taken a conservative estimate that each tutor will deliver 10 SMP courses in their Co-creating Health career. Therefore, on this basis the cost of tutor training is £220 per SMP course. Following completion of the training course, each tutor then needs to be assessed to ensure competence. This is done twice by an external assessor and costs £200 per assessment per person. Again this would cost an average of £40 for each course in a 10-course career. As part of their continued professional development, each tutor is required to attend an annual supervision and quarterly peer group meetings.

From combining these two figures, the **GRAND TOTAL PER SMP COURSE = £2,203.**

Glossary

ADP	Advanced Development Programme – clinician training in techniques to support self-management
DPT	Devon Partnership NHS Trust – the local psychiatric secondary service provider
GAD7	Generalized Anxiety Disorder 7-item scale – an anxiety rating scale
IAPT	Improving Access to Psychological Therapies – a programme of treatment for mild/moderate depression and anxiety using cognitive behavioural techniques
PHQ9	Patient Health Questionnaire – a depression rating scale
SIP	The Service Improvement Programme – advice and support given to GP surgeries to improve service delivery to facilitate self-management
SMP	The Self-Management Programme for depression – a seven-week self-management course for patients with mild/moderate depression
WSAS	The Work and Social Adjustment Scale – a simple measure of impairment in functioning

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