Evaluation of the TAPP Programme

March 2022 – March 2023

University of Central Lancashire
UCLan

NHS
Lancashire & South Cumbria
NHS Foundation Trust

Academic, Clinical Service and Economic Evaluation of the Postgraduate Diploma Associate Psychological Practitioner (PgDip APP) Programme

Cohort 2

March 2022 – March 2023

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Executive Summary

Introduction to the Evaluation

Early in 2019 the NHS Long Term Plan (LTP), followed by the NHS People Plan in 2020, both recognised the need to increase workforce supply of appropriately skilled and motivated psychological practitioners to meet need and improve outcomes. Challenges exist at all career levels: entry, transition and development towards senior clinical and/or leadership roles. Strategic workforce programmes across the North-West Coast system (Lancashire & South Cumbria, L&SC; Cheshire & Merseyside, C&M), anticipating this, commissioned this project to support sustainable expansion of a new psychological professions workforce to support NHS policy aims of improve access to psychological interventions. Sponsored by Health Education England (HEE) and led by The Innovation Agency (IA), The Academic Health Sciences Network for the North-West Coast, in partnership with Lancashire and South Cumbria Foundation Trust (LSCFT) and The University of Central Lancashire (UCLan), the (Trainee) Associate Psychological Practitioner (T/APP) was developed. Cohort 1 included 50 funded roles and ran January 2021 to January 2022, with evaluation of this cohort evidencing the many successes and value of this new role, from the point of patients, services, NHS staff and the TAPPs themselves. Cohort 2 included 90 roles and expanded to Greater Manchester, running from March 2022 to March 2023. Cohort 2 is the focus of this evaluation report.

Aims of the Evaluation

The overall aim of this report led by UCLan and LSCFT, was to evaluate the success of the programme and TAPP role in Cohort 2, via three criteria:

1) TAPP progress and competence development during the 12-month training period alongside academic training experience (academic evaluation);
2) The acceptability and impact of TAPPs in clinical settings (clinical service evaluation);
3) The cost effectiveness of introducing this new workforce into specific pathways (primary care economic evaluation).

Method

The academic and clinical service evaluation involved triangulation of data from: 1) patients, 2) clinical supervisors, and 3) the workforce (TAPPs). The economic evaluation used primary and secondary data to estimate and compare the costs and outcomes associated with Primary Care TAPPs' activities and usual care.

Summary of Key Findings across all three components of the evaluation

1. The PgDip APP educational training programme continues to effectively develop Psychology graduates into competent psychological practitioners, thereby helping to meet the ambitions of the NHS LTP and community transformation to improve workforce supply and meet need.
2. In primary care, secondary care and living well services, support from a TAPP leads to positive patient outcomes (e.g., reduced depression and anxiety and/or improved resiliency and wellbeing), with many patient experience questionnaires also attesting to positive experiences and impact.
3. The positive impact of TAPPs extends beyond the delivery of one-to-one or group interventions to wider service benefits appropriate to the needs of the service and pathway in which they are working, with benefits such as additional capacity to manage referrals, supporting waitlist initiatives, completing service audits, and working with the community.

4. TAPPs generate capacity by providing a psychological presence in PCNs and enhance existing psychology teams/freeing up capacity in other primary and secondary care services.
5. With appropriate support and clear scope of practice for specific pathways, TAPPs effectively embed, add value and are a welcomed workforce.
6. The evaluation highlighted significant areas of strength (e.g., University teaching and learning, the clinical work exposure to enable skill development and broadening career opportunities).
7. Challenging aspects to address inherent in any new role include working with services to ensure service readiness for effective deployment, particularly in PCNs and services where there is complexity in need.
8. Preliminary cost-effectiveness analysis of TAPPs in primary care identified potentially similar costs and gains in patients' generic health-related quality of life (when measured in quality-adjusted life years or QALYs) compared with usual care, which could liberate resources from GP time. A fuller economic analysis is needed to confirm these findings and to expand the cost effectiveness analysis in relation to outcomes other than QALYs and in relation to comparative 'treatment as usual' data.

Recommendations

The specific recommendations emerging from this evaluation will require joint action from provider organisations, HEE and HEIs. The recommendations from the evaluation report are set out below:

1. Given the success of the TAPP role, to move towards a sustainable commissioning framework to train APPs, working with HEE and NHSE.
2. To obtain BPS accreditation of the APP role and standardise University Quality Assurance processes and governance standards, supporting career development.
3. To support TAPPs in training (Cohort 3) and continue to embed the APP role in local services, starting with locally led approaches to recruitment and engagement with services early in the process.
4. To foster ongoing collaborative partnerships between the education provider and all services.
5. Ongoing evaluation of academic success and clinical and economic impact of TAPPs, and where possible, qualified APPs.
6. To complete the final evaluation of the three year 'test of concept' in May 2024.

Conclusions

Evaluation of Cohort 2 highlights significant successes, the value the role contributes, and challenges embedding this new role. This project has continued to demonstrate both excellent supply (over 500 applications for cohort 1, over 600 for cohort 2 and over 700 for cohort 3) and the benefits of recruiting career focussed psychology graduates to work in healthcare. This is a key area for development among psychological professions where there is currently no direct route from undergraduate degree completion to working in healthcare in a professional role. The APP role is responsive to current rising demand and gaps in provision for mental health services; the TAPPs are improving population health outcomes. The role is helping to meet the strategic priorities of NHS LTP that relate to growth of the psychological workforce, new career pathways and new ways of working.

The T/APP role has won multiple awards: 1) LSCFT outstanding contribution to education and research, 2021; 2) HSJ Patient Safety, Primary Care Initiative of the Year, 2022; 3) North-West

Coast Research and Innovation: Ruth Young award, 2022, and 4) Educate North Employer Engagement award, 2023. There is also reference to the role in the NHS 'Psychological Professions workforce plan for England' (2021).

The evaluation continues for Cohort 3 and this year represents the final year of the proof-of-concept project in developing a new role that can deliver psychological intervention work in a range of settings. The role has been well-received and TAPPs are highly valued within the North West region, as key contributors to workforce supply, delivering improved outcomes for patients. Consideration of future cohorts is an essential priority for this year and clarification around future funding models is required. There has been interest in developing this role outside the North West of England as well as HEI interest in developing the courses more widely. Ensuring sustainability of the model will require investment from HEE/NHSE and a timeline for next steps needs to be determined.

Section 1: Introduction

1.1 Background/National Context

Early in 2019, the National Health Service (NHS) issued the Long-Term Plan (LTP; NHS England, 2019) followed by the NHS People Plan in 2020 (NHS,2020). Both plans recognised the need for an increased supply of an appropriately skilled and motivated workforce, to meet predicted demand and improve outcomes for the population. These included increasing the numbers of staff in mental health services by over 27,000 by 2024 (Health Education England: NHS, 2021). This emphasis on the need for increased workforce supply into the mental health sector has been made in many other policy documents over the past five years e.g., Five Year Forward View for Mental Health (NHS: Mental Health Taskforce, 2016) and Stepping Forward to 2020/21 (Health Education England (HEE), 2017). At least one in six people in England currently report experiencing mental health symptoms such as depression and this is higher than pre-pandemic levels (NHS Digital, 2016; Office for National Statistics, 2022[a]; Office for National Statistics, 2022[b]).

Yet, there are workforce challenges across disciplines in the NHS, particularly in the field of mental health, with vacancies standing at 9.7% for all staff working in the mental health sector and 11.8% for nursing in the MH sector (NHS Digital: Q1 2022/23, 2022) and in the NW specifically, vacancies in June 2022 for MH stood at 3,530 (NHS Digital: Vacancy Stats, June 2022). These vacancies, coupled with the rising demand, puts significant pressure on services and has a negative impact upon the care patients receive. Neither the existing nor traditional approaches to increasing the workforce can meet these ambitions. Innovative new roles and new ways of working are required to expand the psychological workforce.

"79% of the 29,405 Psychology graduates each year want to work in mental health care. Yet only 1,300 eventually become registered Practitioner Psychologists. Many talented graduates are forced to find an alternative career path."

Alongside the rising demand for mental health services there is a substantial demand among a high proportion of psychology graduates for entry into a psychological healthcare career. However, graduates face a 'bottle neck' embargoing these professional development aspirations, metaphorically this is the 'Leaky Pipeline' where early career graduates abandon this career goal and leak away to non-healthcare futures. In the UK BPS accredited psychology degrees are awarded to around 29,405 graduates a year (HESA, 2019/2020). Based upon UCLan graduate data between 2018-22 (UCLan Dashboard accessed 25 April 2023), 90% of Psychology degrees were honours degrees, conferring GBC (eligibility for graduate membership of the BPS). Surveys of graduates and undergraduates indicate a majority wish to pursue a career in mental health care upon graduation (e.g. 79% in Palmer et al., 2021). In comparison to other degrees which lead to NHS employment Psychology is an outlier, with a huge aspiration-career disparity (Budd, et al., 2022; Palmer et al., 2021). A major reason for this disparity is that Psychology has no immediate graduate entry route into the NHS, despite the demand for many of the degree-

related skills sought by NHS psychological services. Rather, psychology graduates who do go on to work in psychological roles typically spend over three years in an ad hoc process of gaining clinically relevant experience (National Collaborating Centre for Mental Health, 2019), with the hope of securing a place on a HEE three-year funded Doctorate in Clinical Psychology. This is a major deterrent to psychology graduates fuelling the leaky pipeline and the loss of a potential workforce, and only a small proportion of all psychology graduates are conveyed by the pipeline (around 1,300; Palmer et al., 2021), eventually becoming registered Psychologists. Other psychology graduates do find alternative routes into the NHS psychological workforce, but far fewer than the number aspiring to.

In 2021, UCLan partnered with HEE and the Innovation Agency (North-West Coast Academic Health Science Network) to launch a new Psychological Practitioner role across the North-West Coast system. The Postgraduate Diploma Associate Psychological Practitioner (PgDip APP) programme skills up psychology graduates in core competencies to enter the NHS workforce at increased and higher volumes, thereby producing a sustainable supply of practitioners into psychological roles to reduce significant workforce gaps and change NHS workforce structures. Individuals train for 12 months in the NHS as a Band 4 Trainee Associate Psychological Practitioner (TAPP), progressing to a Band 5 role as an Associate Psychological Practitioner (APP) upon qualification.

The PgDip APP programme's first cohort commenced in January 2021 and completed in January 2022. Expressions of Interest were requested from Trusts across the North-West Coast, and 50 TAPPs were deployed. The role was funded via a Business Case to HEE for 1.3m, developed by the project team to secure training and supervision of the TAPP. The project identified a host organisation (Lancashire and South Cumbria NHS Foundation Trust) to administer the training contract with UCLan and the TAPP training support funds and coordinate the recruitment of TAPP roles. The role also required the development of close relationships between HEIs and the NHS via a Clinical Supervision Network to ensure high quality and sustainable supervision.

As soon as Cohort 1 began their training a rigorous evaluation was implemented which included an academic and clinical service evaluation, both of which attest to the success and value of the role in a range of services (Budd, et al., 2022; Gardner, et al., 2022). For cohort 2, the evaluation has been extended to include a preliminary economic evaluation. This report therefore includes an academic, clinical service and preliminary cost effectiveness analysis based on Cohort 2 TAPPs in primary care.

1.2 'Trainee Associate Psychological Practitioners' and 'Associate Psychological Practitioners': Scope of Practice

"T/APPs are filling important gaps in the mental health workforce. The role compliments other psychological practitioners and wider multi-professional roles within teams."

The primary objective of TAPPs and qualified APPs is to provide focused psychological assessment, structured formulation and brief interventions drawn from different therapeutic modalities, in the pathway in which they are working. APPs are trained in 7 core competencies

and this framework, in tandem with the knowledge and skills-based education model, enables them to use skill-based intervention techniques drawn from a range of approaches to meet presenting need and provide individualised care, appropriate to their level of training. The role compliments other psychological practitioners and wider multi-professional roles found within teams. APPs also engage in other psychologically informed activities that prevent mental health deterioration and/or improve service delivery, as appropriate to the needs of the service and pathway in which they are working, examples include:

- Working with multi-professional team members, bringing a psychological understanding to presenting need.
- Forming important links with community partners and organisations and fostering relationships between patients and community groups.
- Completing brief assessments and supporting the completion of more in-depth and complex assessments and review processes.
- Completing screening tools alongside a psychosocial assessment to help bring understanding to presenting need and inform the care pathway.
- Conducting structured psychological formulations and based on these, offer one-to-one brief interventions (this may involve working with important others, where appropriate).
- Co-facilitating group interventions using techniques drawn from a specific therapeutic modality that is fitting for patients within their pathway.
- Providing brief psychological interventions relating to mental health need presenting at step 1 and step 2 within a stepped care framework. This work can be done in a variety of settings and with a variety of patient groups, as appropriate to the service.
- Engaging in resource and, or service development (this may include service evaluation and audits).

"The T/APP role has been developing in exciting ways over the past two years. The flexibility that comes with this new role means there are now varied examples of how this new workforce is helping services meet presenting need."

1.2.1 Primary Care Settings

For this report, 'Primary Care Settings' refers to Primary Care Networks (PCNs), NHS Talking Therapies, or services for complex needs that sit within primary care.

The way the T/APPs work within primary care has evolved in exciting ways to meet presenting need. In brief, they have supported to increase capacity of General Practice colleagues (Budd et al., 2022), but also to meet the ambitions of community transformation and the Community Mental Health Framework.

T/APPs have worked to provide brief interventions to meet need early and support individuals to navigate both mental health services and community partnerships. Often their focus has been on improving population health and improving emotional wellbeing for those with physical health conditions - to provide a holistic healthcare service. The role is developing further in some areas

to support with screening for presenting difficulties, such as ADHD, then signposting and providing appropriate support.

T/APPs in primary care settings generally provide 20 hours a week of direct clinical work. If appointments last for 45 minutes, this means seeing 25 patients for a full-time APP staff member. This is in line with similar banded psychological practitioner roles.

A paper detailing an example service delivery model of T/APPs working in PCN settings has recently been **published.** Section 4 of this report further presents the results of modelling completed by the workforce experts of the NHS Workforce Repository and Planning Tool (WRaPT) team which looks at the impact of the APP role in Primary Care in terms of additional capacity to provide mental health care and the impact on General Practitioner (GP) capacity within the sector.

1.2.2 Secondary Care Settings

T/APPs have worked and are currently working within Community Mental Health Teams (CMHT), Home Treatment Teams (HTT), and Child and Adolescent Mental Health Services (CAMHS). T/APPs in these settings typically work with more complex cases but usually those presenting with mild to moderate risk and who are deemed stable enough to complete and benefit from a focused piece of work. One-to-one work may range from around 3 to 4 patients per week up to around 10, depending on service role, need and capacity.

Different services have flexibly used the T/APP role in different ways. T/APPs have supported to complete complex assessments and data gathering, reducing the time qualified staff members spend reviewing notes (for example). They have provided one-to-one work and supported in group work delivery. T/APPs have provided waiting list initiatives to support with therapy readiness and stabilisation, focusing with complex patients on specific and focused goals.

Evaluating service developments and conducting audits, depending upon service need has been another area where T/APPs have added value.

1.2.3 Physical Healthcare/Neuro Pathways (Primary and Secondary Care Settings)

T/APPs working in physical healthcare and, or neurological settings and pathways may work in similar ways to their peers in primary and secondary care. For example, providing brief, goal-focused psychological assessment, formulation and interventions. In such settings, this psychological way of working has enhanced the holistic healthcare an individual receives.

T/APPs have and are working in both primary and secondary care settings. For example, in some PCNs T/APPs have been working with patients with psychological needs who have a diagnosis of a cardiac and/or respiratory disease.

In hospital settings T/APPs have embedded within neurorehabilitation teams, stroke teams, cancer services and critical care. In critical care services for example, T/APPs have provided support for inpatients, outpatients and staff. For inpatients, T/APPs might provide low-level support to individuals with psychological difficulties arising from critical illness and a stay on the Critical Care Unit (CCU), whilst they are on CCU or a step-down ward. This could include conducting brief psychological assessment, providing emotional support, and equipping patients with effective coping strategies for managing psychological difficulties. For outpatients, T/APPs in critical care services have provided psychological triage assessments for patients who have been discharged from CCU and are experiencing persistent psychological difficulties after

their discharge. Finally, T/APPs have provided advice to other non-psychology staff within the team. As another example, in Long Covid clinics T/APPs have been conducting initial psychological assessments for the service and offering brief interventions and groups for patients on the waiting list.

1.2.4 Living Well Services

Living Well services were set up to support people whose needs mean they don't meet the criteria for either primary or secondary care. The role of TAPPs in Living Well services is similar to those working in Primary Care, except T/APPs working in these services are typically working with patients who need more support for their mental health than the GP can offer but a bit less than a Community Mental Health team. Living Well services are community mental health services that include a multidisciplinary team, including an occupational therapist, nurse, recovery worker, psychiatrist, psychologist, TAPPs, peer mentors and social workers.

1.3 The UCLan Postgraduate Certificate Associate Psychological Practitioner (PgDip APP) Programme

1.3.1 Entry Requirements and Admissions Process

Acceptance onto the programme is conditional on applicants being in a position to work as a Trainee Associate Psychology Practitioner (i.e., having successfully secured a position as a TAPP in the NHS). Entrants need an undergraduate degree in Psychology at 2.2 or higher (or have passed an equivalent Psychology conversion course) that is accredited by the British Psychology Society as providing the Graduate Basis for Chartered Membership. Hence, positions are advertised and applied for on the NHS jobs website rather than submitted directly to UCLan. Shortlisted applicants were interviewed and those who successfully secured a position enrolled onto the funded Postgraduate Diploma Associate Practitioner Psychology programme.

1.3.2 Course Structure and Teaching and Learning Strategy

The PgDip APP enables psychology graduates to enter the NHS as a Band 4 TAPP for 12-months, progressing to Band 5 APP upon successful qualification. TAPPs also engage in university classes and study at UCLan. The course is structured as follows:

- Average of 4 days per week as Band 4 Trainee APP (TAPP) / 1 day per week UCLan to engage in learning and professional development (classes or independent study over the 12-month training period).
- Blended learning (campus and online delivery) to aid flexibility and support T/APPs who travel from across the North West.
- Frontloaded delivery with an intense teaching block at UCLan in the first few months, to prepare TAPPs for clinical practice.
- Interactive lectures, workshops, case study discussions, reflective practice, and clinical role play simulation and observation with actors to develop skills.

1.3.3 Competence Framework

The course, curriculum and clinical training are structured around an evidence-based competence development ethos via a core competence framework (e.g., working psychologically in relation to assessments, formulations, interventions). The competence framework underpins and guides the design and delivery of the course, curriculum and training.

This approach equips T/APPs with the skills required to work psychologically to meet presenting need.

"The course, curriculum and clinical training are structured around an evidence-based competence development ethos via a core competence framework."

Each of the seven general competence areas (Figure 1) includes a more specific set of 'descriptors'. These descriptors outline the skills, activities and expectations of professional and clinical practice embedded within the TAPP Job Description (Appendix 1). TAPPs who are working effectively are expected to meet the majority (not necessarily all) specific descriptors within a competence area. The curriculum centres on topics that are transferable to these competence areas.

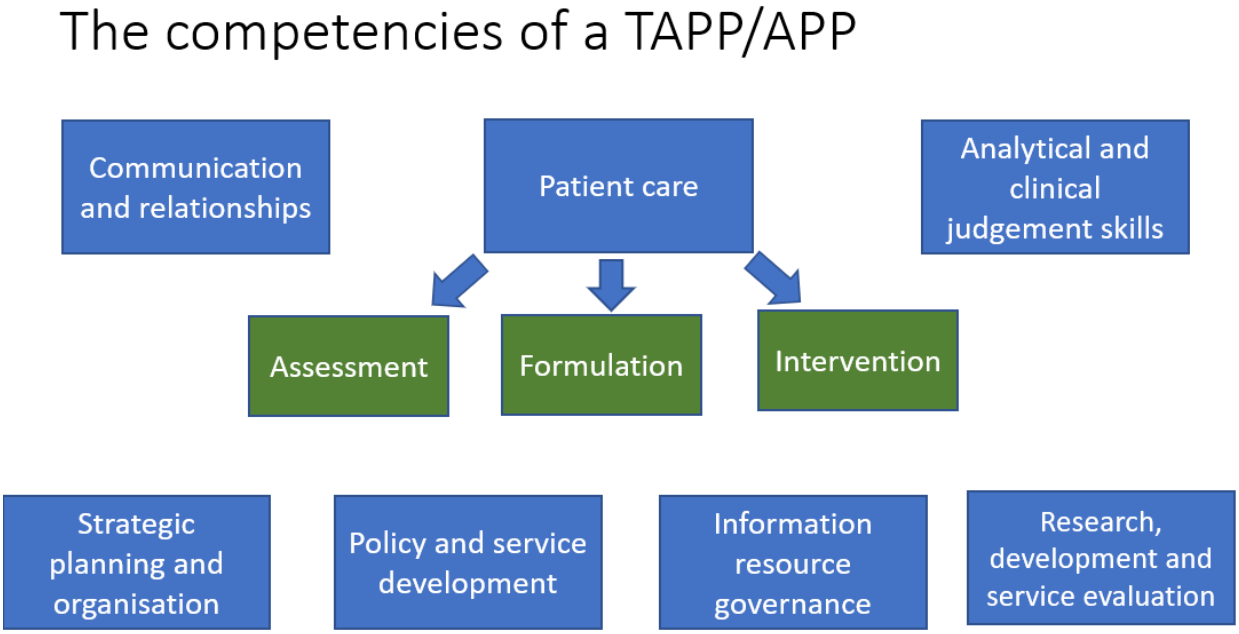


Figure 1: TAPP/APP competencies

1.3.4 Assessment

To pass the course and obtain the Postgraduate Diploma award, TAPPs must:

- Undertake 12 months training as a Trainee APP (TAPP) under the supervision of a qualified psychological professional.
- Submit and successfully pass the assessments encompassed within the course to a standard appropriate for Level 7 postgraduate diploma where the outcome is ratified by the assessment board:
    a. Clinical Competence Assessment (clinical case report of assessment, formulation and intervention skills)

b. Supervised Clinical Practice Assessment
c. Professional and Reflective Knowledge and Practice Component
d. Professional Competence Poster Presentation

1.3.5 Supervision Model and Arrangements

Clinical supervision is provided by accredited psychological practitioners. Clinical supervision is designed to facilitate TAPPs' work and ensure safe practice through discussion of clinical cases and other clinical activity. Supervision also provides each TAPP with an environment within which they can develop their reflective awareness as a practitioner, the wider meaning of working psychologically, and developing a clinical understanding. TAPPs are expected to respond to and implement supervision suggestions by supervisors regarding their clinical practice and personal and professional development. The supervision includes the following principles:

- TAPPs receive the equivalent of one hour one-to-one clinical supervision per week.
- All TAPPs and supervisors must produce a clinical supervision contract.
- Standing items for weekly clinical supervision include clinical cases, wider clinical activity, competence development and directed workplace activities that will help meet competencies and ensure appropriate self-care.

1.4 Recommendations From the First Evaluation of Cohort 1

The first evaluation (**Gardner et al., 2022**) led to four key recommendations:

1. Ongoing evaluation of the academic success of the programme, workforce need, and clinical impact of T/APPs that runs alongside standardised University Quality Assurance processes to ensure quality standards.
2. Implement changes to further enhance the quality of the programme based on these evaluation data/feedback, whilst using the British Psychological Society (BPS) quality standards for 'Associate Psychologists' as an external reference point to explore as the T(APP) programme moves towards BPS accreditation.
3. Post-training period evaluation of the clinical and service level impact of qualified Associate Psychological Practitioners (APPs).
4. Full economic evaluation of TAPPs/APPs to model the impact of introducing this new workforce into specific pathways (e.g., primary care).

"The course is evolving all the time. The recommendations from the first evaluation led to key changes, to enhance the overall learning experience and quality delivered."

The recommendations set out in the first evaluation report have led to key changes to the course content, teaching and learning strategy, assessment, and competence framework. Evaluation of Cohort 2 both replicates and extends the comprehensive evaluation of Cohort 1 (Appendix 2 and 3).

1.5 Evaluating the PgDip APP Programme (Cohort 2)

1.5.1 Evaluation Aims

The overall aim of this report led by UCLan and LSCFT, was to evaluate the success of the programme and TAPP role in Cohort 2, via three criteria:

1) TAPP progress and competence development during the 12-month training period alongside academic training experience (academic evaluation);
2) The acceptability and effectiveness of TAPPs in clinical settings (clinical service evaluation);
3) The cost effectiveness of introducing this new workforce into specific pathways (primary care economic evaluation).

1.5.2 Evaluation Strategy

The evaluation was structured around an extended version of Kirkpatrick's (1959, 1996) framework for evaluating training programmes at five different levels, as described below. Kirkpatrick's framework included the first 4 levels, and this was later extended by Hamblin (1974) who separated the financial organisational outcomes in level 4 into a fifth level (see also Tamkin et al., 2002, for review for these frameworks). The levels of the framework are not hierarchical, but rather use of the framework ensures a holistic and comprehensive evaluation, the results of which can have direct implications for policy and practice and meet the needs of services. Levels 1-3 were assessed via an academic evaluation, level 4 via a clinical service evaluation and level 5 via an economic evaluation (Table 1).

Table 1: Evaluation framework

Evaluation component	Framework level	Focus/objectives
Academic evaluation	**Level 1 (reaction/experience)**	How did TAPPs react to and experience various aspects of their training / course?
	Level 2 (learning)	Did TAPPs acquire the intended knowledge, skills and confidence and therefore have the ability to apply their learning?
	Level 3 (behaviour)	Did TAPPs develop and apply their competencies in the workplace? Assessment of transfer of learning to workplace clinical service and development of clinical competence
Clinical service evaluation	**Level 4 (organisational results)**	Did the training/course have a measurable beneficial impact on the organisation (patients, NHS services/trusts)?
Economic evaluation	**Level 5 (value)**	Economic evaluation (cost effectiveness) of TAPPs/APPs to model the impact of introducing this new workforce into specific pathways (e.g., primary care)

The three components of the evaluation outlined in Table 1 are presented in three sections below. The evaluation strategy involved triangulation of data from multiple sources to obtain a comprehensive understanding and corroborate findings. Within each section data were obtained from one or more of the following sources: 1) patients, 2) clinical supervisors, 3) the workforce (TAPPs)

1.6 TAPP Roles/Services for Cohort 2

"With over 500 applications received for cohort 1 and over 600 for cohort 2, there is a clear supply of psychology graduates wanting to work in the T/APP roles."

Cohort 2 included 90 funded roles and shows the growth from Cohort 1 which included 50 roles (Figure 2). Table 2 shows the distribution of the TAPPs across clinical services.

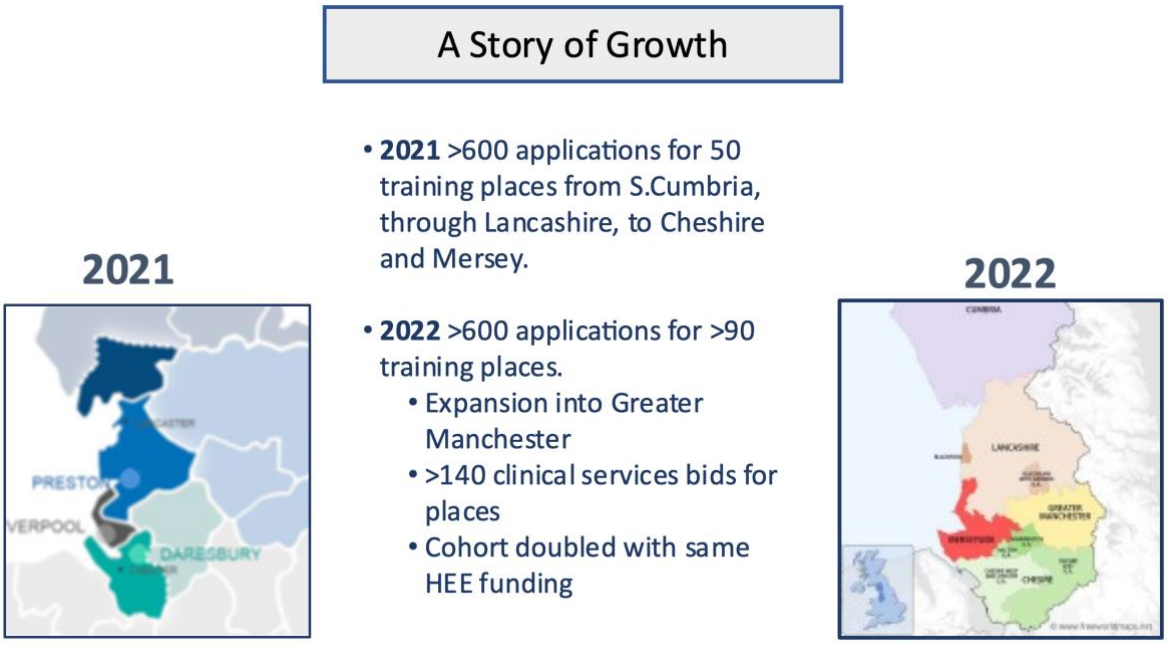


Figure 2: Growth in TAPP training places from Cohort 1 (Jan 2021 – Jan 2022), to Cohort 2 (March 2022 – March 2023)

Table 2: Distribution of Cohort 2 (N = 90) across NHS Trusts and Services

GMMH	**No.**	**LSCFT**	**No.**	**EHLT**	**No.**	**BTHFT**	**No.**	**CWP**	**No.**	**PCFT**	**No.**	**PCSS**	**No.**
PCN	9	PCN	18	Stroke	1	Stroke	1	PCN	9	PCN	6	PCN	6
Living well	3	IAPT	3	Neuro-rehab	1			Cancer	1	LD	2		
		CMHT	4	Critical Care	1			Primary care other	5	CAMHS	6		
		HTT	1	Clinical health	1			CMHT	1	EIT	1		
										CMHT	10		
TOTAL	**12**	**TOTAL**	**26**	**TOTAL**	**4**	**TOTAL**	**1**	**TOTAL**	**16**	**TOTAL**	**25**	**TOTAL**	**6**

Notes: GMMH = Greater Manchester Mental Health Trust; LSCFT = Lancashire and South Cumbria NHS Foundation Trust; EHLT = East Lancashire Hospitals NHS Trust; CWP = Cheshire and Wirral Partnership NHS Foundation Trust; PCFT = Pennine Care Foundation Trust; PCSS = Primary Care South Sefton; PCN = Primary Care Network; IAPT = Improving Access to Psychological Therapies; CMHT = Community Mental Health Team; HTT = Home Treatment Team; LD = Learning Disability; CAMHS = Child and Adolescent Mental Health Services; EIT =Early Intervention Team.

Section 2: Academic Evaluation

2.1 Aims

The academic evaluation aimed to examine TAPP progress and competence development during the 12-month training period alongside academic training experience.

2.2 Method

This academic evaluation ran alongside standardised Quality Assurance processes (e.g., soliciting TAPPs' feedback) inherent in the Continuous Course Enhancement (CCE) processes that operate for any UCLan course. A longitudinal mixed-methods design was adopted, asking TAPPs to respond to self-report questionnaires and open-ended qualitative questions, at multiple time points during the course:

- Time 1: Pre-course/training
- Time 2: Six months into the course/training
- Time 3: After TAPPs have completed all training
- Time 4: 3-6 months after completing training (*post qualification period - to be completed*)

For succinctness, this report synthesises and presents TAPPs' qualitative feedback collected from *either* Time 1, 2 or 3 (additional analysis is underway to identify *changes* in feedback and a range of quantitative psychometric self-report measures that will provide broader context and understanding to the main findings reported in later papers).

2.3 Results

2.3.1 TAPP Progress (Attrition/Withdrawal and Course Completion)

TAPPs' progress and competence development during the training period was operationalised in terms of a) attrition rates/withdrawal, and b) successful course completion.

Ninety places were funded, however 3 applicants never enrolled onto the course/training, leaving 87 in total. Of these 87, 17 (20%) withdrew part way through the course for a variety of reasons leaving, as shown in Table 3. Eight withdrawals were potentially avoidable (see **) and these data have helped inform our approach to Cohort 3. These avoidable incidents include a breakdown in supervisor relationships and capacity, challenges with employment and/or hosting arrangements, and isolation and lack of support experienced by TAPPs. The project team has worked hard to mitigate the impact of these issues for Cohort 3 to reduce attrition rates. Actions include a more locally led approach to recruitment and engagement with services earlier on in the process, thus socialising them earlier to the training model and role. The quality assurance process, used to prioritise successful TAPP posts, has also interrogated these issues more closely.

Table 3: TAPP Cohort 2 Withdrawal Reasons

Number of TAPP's	**Withdrawal reason**
5	Secured places on the HEE funded Doctorate in Clinical Psychology
1	Did not provide a reason for withdrawal
2	Health reasons
1**	Financial reasons (workplace payment issue)
3**	Wrong course/career path for them
1**	Travel distance to service (too far to commute – 1 ½ hours each way)
3**	Service-related reasons
1	Dismissal

Note**:** Withdrawals = 17 out of 87 TAPP's who began the course. Of these, 8 were potentially avoidable withdrawals (see **). Withdrawing for a place on the Doctorate in Clinical Psychology will be a non-issue for Cohort 3 due to the new 2 year **HEE funding rule**

Of the remaining 70 TAPPs, 6 have mitigating circumstances extensions and as of May 2023 are still enrolled on the course. Of the 64 who completed the course within 12 months, 100% achieved the required clinical competencies and passed the PgDip APP programme (this figure excludes those with extensions due), allowing them to progress to a qualified Band 5 APP role. Thus, the overall success rate is 74% (64 of 87 TAPPs), which could rise to 79% following a successful course completion of the remaining 5 TAPPs. This success rate is slightly lower than the 88% for Cohort 1.

"Of the TAPPs who completed the course within the 12-month training period, 100% passed."

2.3.2 TAPPs' Experience of the Overall Course/Training (Level 1)

Between 24 and 26 (approx. 37%) TAPPs responded to the online 'academic evaluation' survey requesting feedback at three time points during training. Four main themes were identified with between two and three subthemes each, as shown in Figure 3 below. For succinctness, we have extracted and summarised the key issues for TAPPs within each of these themes and presented them in two additional diagrams that show 'what is working well for TAPPs' (Figures 4) and 'what changes TAPPs would like' (Figure 5).

Figure 3: Qualitative analysis of TAPP feedback (four main themes and their subthemes)

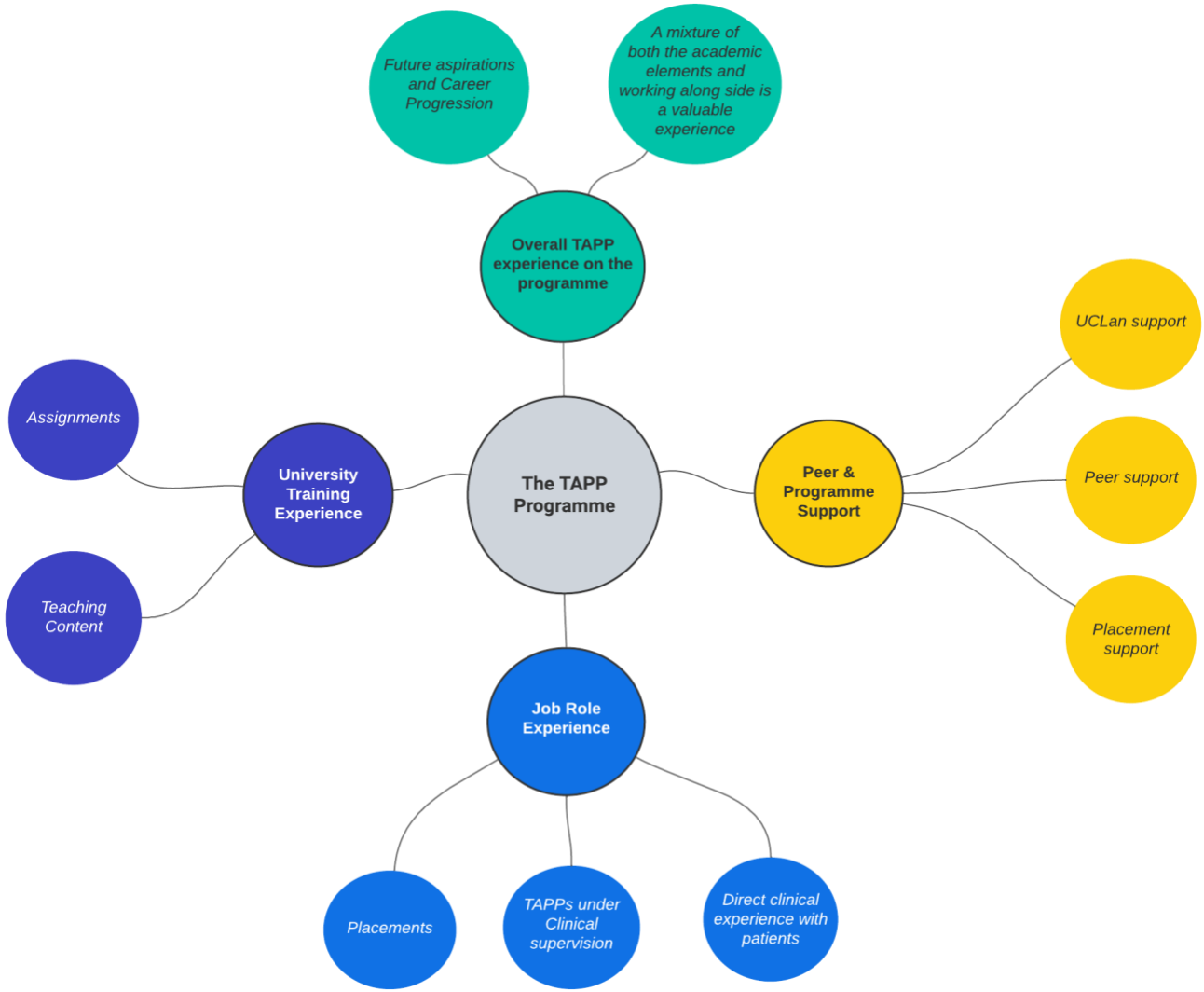


Figure 4: Summary of what's working well for TAPPs across the four main themes

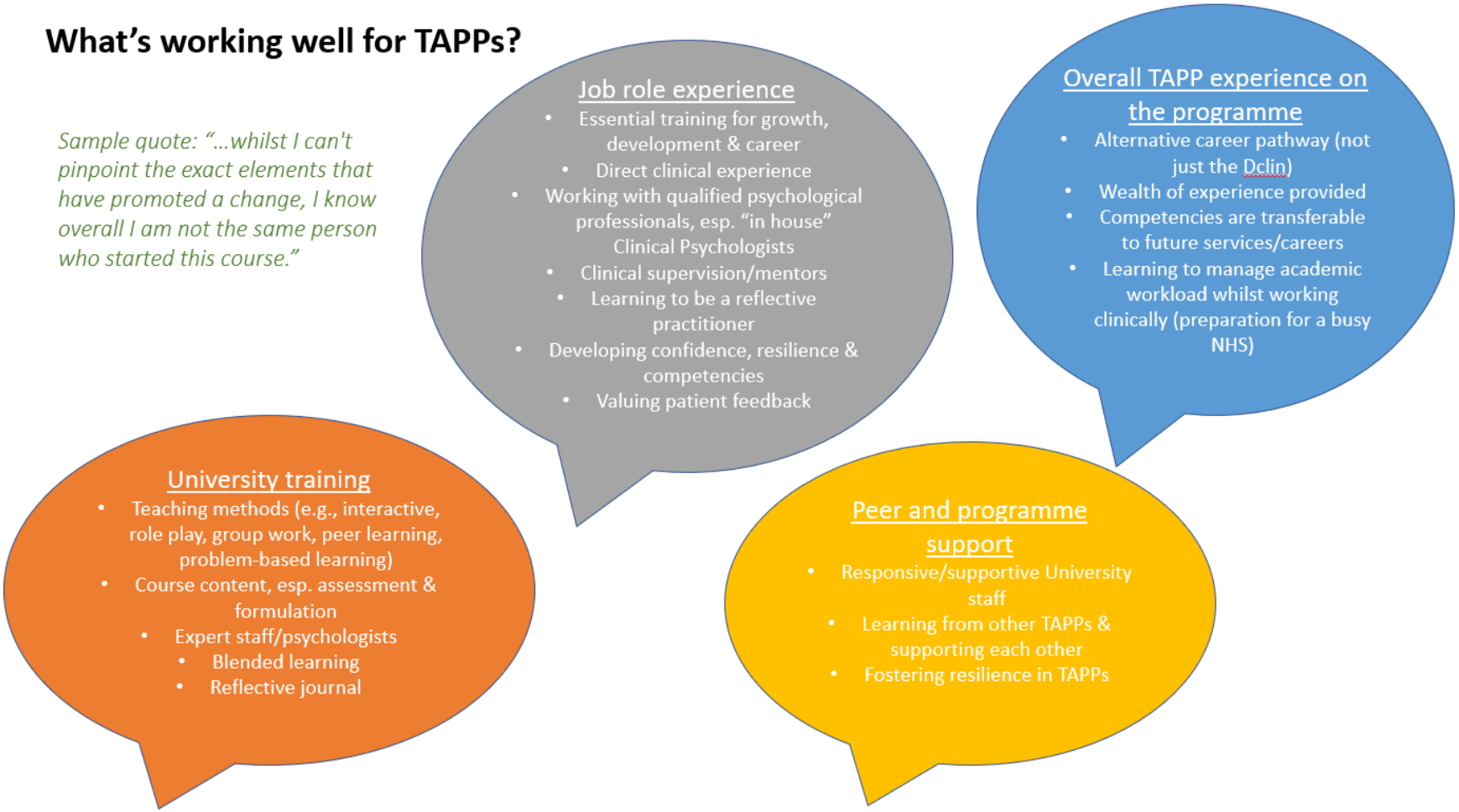
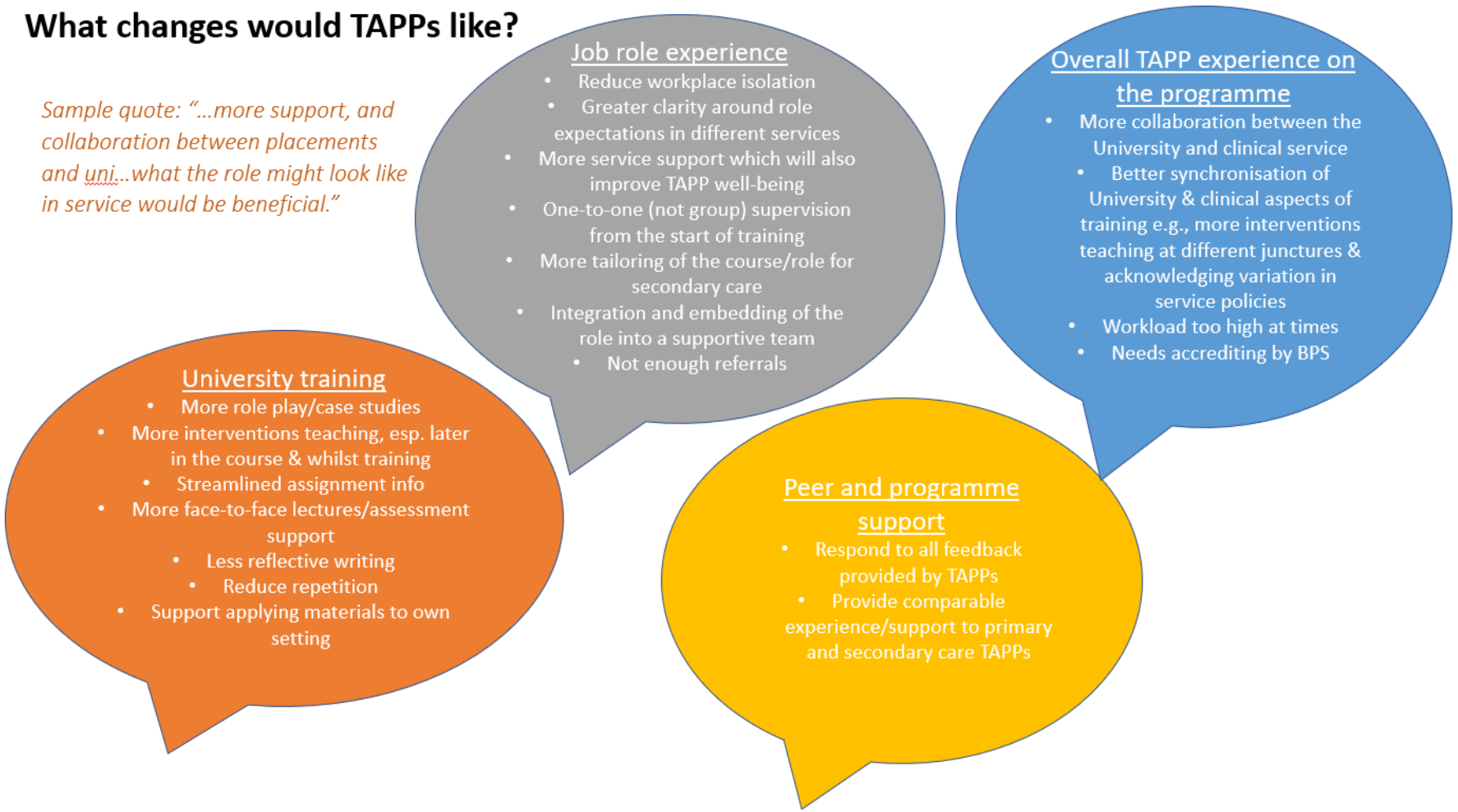


Figure 5: Summary of what changes TAPPs would like across the four main themes



2.3.2.1 What is Working Well for TAPPs?

As shown in Figure 4, the TAPP role is a valued career pathway that can provide direct clinical experience and support personal and professional development. Key facilitators of these positive experiences included support from University staff, workplace colleagues, fellow TAPPs, University material and teaching strategy, positive patient feedback, and workplace experiences and opportunities.

"The TAPP role is a valued career pathway."

2.3.2.2 What Changes Would TAPPs Like?

As shown in Figure 5, key themes included changes to University teaching content, delivery and timing of sessions, additional support from University and workplace staff, support with TAPP wellbeing, assistance with developing the role, more effective embedding of TAPPs in specific services, and a more collaborative relationship between the University and services.

The above is not exhaustive list and neither are the points listed in either diagram reflective of the majority of TAPPs who responded to the survey. Rather, these reflect potentially pertinent issues, many of which were shared by more than one TAPP. Some of these requested changes contradict the positive feedback regarding what is working well, highlighting the somewhat variable nature of TAPPs' experiences. Similar to the Cohort 1 evaluation therefore, the feedback from TAPPs on the course was varied. This difference may have emerged for several reasons:

- The clinical work TAPPs engaged in varied depending on service need and may have been more/less challenging depending on the TAPPs' previous experiences and patient complexity.
- Services' engagement with the TAPP role differed, likely due to a multitude of factors, such as service readiness, understanding of the PgDip APP programme, expectations of the role, and capacity constraints of staff.
- Level and depth of pre-existing clinically relevant experiences prior to the TAPP role i.e., less experience may in *some* cases have impacted confidence and the speed with which TAPPs could begin to work relatively autonomously with patients.

2.3.3 TAPP Learning Acquisition and Impact on Clinical Practice Within the Workplace (Level 2 and 3)

TAPPs who completed the PgDip APP training all passed. Therefore, the academic course and clinical role led to the acquisition of the intended knowledge, skills and confidence. The TAPPs were then able to apply their learning and competencies to clinical practice within the workplace.

"The academic course and clinical role led to the acquisition of the intended knowledge, skills and confidence. The TAPPs were then able to apply their learning and competencies to clinical practice."

Section 3: Clinical Service Evaluation

3.1 Aims and approach to the service evaluation

The clinical service evaluation aimed to evaluate the acceptability and impact of TAPPs in clinical settings. The main objectives were to examine:

- Acceptability of the TAPP role to patients.
- Impact of work delivered by the TAPP on patient outcomes.
- Acceptability of the workforce to clinical supervisors.
- Acceptability of being a new workforce (the experience of TAPPs).

First, to identify whether patients perceived TAPPs to be an appropriate psychological workforce and their interventions made a difference, cross-sectional quantitative and/or qualitative data were collected towards the end of the 12-month training period from multiple services:

A. **Patient data:** TAPPs were provided with a template to complete which asked them to provide a summary of their findings (as opposed to providing raw patient data).
    i. **Anonymous routine patient outcome measures (ROMs), pre and post intervention:** these data were analysed quantitatively to determine whether there are changes over time on each measure.
    ii. **Anonymous patient feedback questionnaires post intervention:** these data were analysed qualitatively using thematic analysis to extract key themes from patient feedback.

Second, to understand the acceptability of the workforce, qualitative feedback was collated from TAPPs on an ongoing basis, and from clinical supervisors once the training was completed.

B. **Clinical supervisor feedback:** these data were analysed qualitatively using thematic analysis to extract key themes from supervisor feedback.
C. **TAPP feedback:** these data were analysed qualitatively using thematic analysis to extract key themes from supervisor feedback.

The findings were summarised within three sections: Primary Care, Secondary Care and Living Well services. Each section includes one Table and narrative summary that summarise the patient data, followed by a summary of feedback received from both clinical supervisors and TAPPs.

3.2 Primary Care Services

3.2.1 Patient data

Table 4 and the supporting narrative below summarise the results based on patient data, and impact based on data collected from TAPPs working in the following Primary Care services:

- Primary Care Networks/GP practices (standard pathway or physical health pathway seeing patients with cardiac and/or respiratory problems)
- Older adults
- IAPT

- Psychological Services Step 4 Psychology
- Enhanced Psychological Therapies for primary care
- Complex Needs Service for primary care

"For Primary Care settings included in the service evaluation, 2,612 users of services benefitted from working with a TAPP, with evidence of significant improvements in their mental health, new ways of coping learnt, and recovery reported."

Table 4: Summary of Patient Data Results from TAPPs Working within Primary Care Settings

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Method	Number of patients seen	Number of patients analysed	Analytic Strategy	Results
LSCFT[1]	Mental Health	MH/Wellbeing support	ROMs: • PHQ-9 • GAD-7 • WEMWBS • BRS	1693	440	Quantitative Paired - samples t-tests	• Significant ***reductions*** in low mood • Significant ***improvements*** in wellbeing and resilience
LSCFT[1]	Mental Health	MH/Wellbeing support	Patient experience questionnaire	319	319	Qualitative - Thematic analysis	• Three positive themes: 1) Having someone to talk to, 2) TAPP's personal attributes, 3) Usefulness of material covered • Two constructive themes: 1) Session amount/frequency, 2) Use of questionnaires or handouts
GMMH	Mental Health Referrals	MH/Wellbeing support	• ReQol: Recovering Quality of life • DIALOG • Goal based outcomes • Patient experience questionnaire	257	PEQ – 38 ReQol: Session 1 – 56 Session 4 – 55 Follow up – 21 DIALOG: Session 1 – 52 Session 4 – 51 Follow up – 21 Goal based outcomes: Session 1 – 50 Session 4 – 49 Follow up - 21	Qualitative – Thematic analysis Quantitative Means across 3 time points (1st session, 4th session and follow-up)	• Four positive themes: 1) Effective interpersonal skills demonstrated by the TAPP, 2) Learning ways of coping, 3) Gaining support through talking, 4) No improvements needed. • One constructive theme: 1) More sessions • 95% of those asked said they would recommend the TAPP service to others (5% did not respond to the question), and the helpfulness of the support was rated as 4.7/5 (with 5 being extremely helpful). • Patients demonstrated ***improvement*** across all three measures: quality of life, treatment satisfaction, achieving goals
PCFT	Mental Health	Mental health and Wellbeing support	Patient experience questionnaire	193	73	Qualitative - Thematic analysis	• Five positive themes: 1) Session content (e.g., learning and psychoeducation), 2) Workforce qualities of the TAPP (e.g.,

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Method	Number of patients seen	Number of patients analysed	Analytic Strategy	Results
							understanding), 3) Recovery, 4) TAPP service, 5) Therapeutic relationships • Two constructive themes: 1) Session amount/frequency, 2) Session content
Physical Health Pathway							
CWP	Cardiac and respiratory conditions	Difficulty managing physical conditions & MH/wellbeing support	Pre and Post Testing - PHQ-9, GAD-7, LIM, SWEMWBS, Distress Thermometer, PEI, Friends & Family Test	40	6	Quantitative - Mean and Standard Deviation across two time points (pre and post)	• Results indicate ***reductions*** in low mood and anxiety, with patients finding that their condition was also affecting their life less severely and they can manage it better
Complex Needs Services in Primary Care							
Trust	**Clinical Service and focus**	**Main reasons for patients accessing TAPP support**	**Method**	**Number of patients**	**Number of Patients Analysed**	**Analytic Strategy**	**Results**
CWP	Older Persons Psychology - Chester	1:1 DBT skills (12 sessions), additional support whist in therapy with CP (6-16 sessions), waitlist support (8-12 sessions) as well as opt-in support (1-2 sessions)	Patient experience questionnaire	34	2	Qualitative - Thematic analysis	• Two positive themes: 1) Supportive treatment and 2) Workforce qualities of TAPP • One Constructive theme: 1) Practitioner in-training
CWP	Primary Care Psychological Services Step 4 Psychology	1:1 DBT skills (12 sessions), additional support whist in therapy with CP (6-16 sessions), waitlist support (8-12 sessions) as well as opt-in support (1-2 sessions).	Patient experience questionnaire	34	3	Qualitative - Thematic analysis	• Three positive themes: 1) workforce qualities of TAPP, 2) Good quality of treatment, 3) Long-term impact • One Constructive theme: 1) Short-term impact
CWP	Primary Care Enhanced	Support whilst on waiting list for long-term therapy.	PHQ-9, GAD-7 and W&SAS administer pre and post intervention.	12 one to one	6	Quantitative - Found means and standard deviation of pre and	• The results show that overall, all psychometric measures were lower post

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Method	Number of patients seen	Number of patients analysed	Analytic Strategy	Results
	Psychological Therapies - East	Lifestyle, positive steps to well-being, psychoeducation, skills, managing emotions etc.		9 patients in DBT skills group		post intervention psychometrics.	intervention, ***demonstrating improvement***
			Patient experience questionnaire		3	Qualitative - Thematic analysis	• Two positive themes: 1) Helpful treatment and 2) Workforce qualities of TAPP • One constructive theme: 1) More time needed
				12 one to one			
				9 patients in DBT skills group			

Notes: 1) Most service evaluation data summarised in Table 4 were extracted from the template (Appendix 4) that TAPPs completed. For two Trusts however, we received a more detailed service evaluation led by senior colleagues in the service. These are in Appendix 5 and 6 for LSCFT and GMMH, respectively. 2) Some of the qualitative themes are identical across evaluations because TAPPs working within the same service analysed data together.

3.2.1.1 Acceptability of the TAPP Role to Patients

The 6 qualitative analyses of patient feedback included data from LSCFT, PCFT, CWP and GMMH (Table 4) with sample sizes ranging from 3 to 319, supporting the acceptability of TAPPs in primary care. Common themes across the qualitative analysis are summarised below, highlighting the benefits of receiving a TAPP intervention and the desire for more sessions:

What's working well for patients?

- Session content (e.g., adapted to the patient's needs, easy to understand).
- Personal and workplace qualities of the TAPP (e.g., good understanding)
- Supportive treatment (e.g., good therapeutic relationship and a space to talk)
- Beneficial treatment (e.g., learning coping skills)

"I don't think it could be improved. More has been done about my mental health over the past 4 weeks than an entire lifetime beforehand."

What changes would patients like?

- More sessions and time needed
- Session content can be somewhat limited by a focused agenda or structure (as would be by these brief interventions), leaving patients wanting more.

3.2.1.2 Impact of the TAPP role on Patient Outcomes

Table 4 includes 4 quantitative analyses of routine outcome measures (ROMs), 1 from LSCFT, 1 from GMMH, and 2 from CWP, with sample sizes ranging from 6 to 440. All analyses showed improved patient outcomes such as reductions in low mood and anxiety and improvements in wellbeing and resilience. Since the LSCFT evaluation used a large sample of 440 patients and used statistical significance testing, this evaluation is summarised in more detail below.

"Analyses across services showed improved patient outcomes such as reductions in low mood and anxiety and improvements in wellbeing and resilience."

LSCFT: Clinical Impact on Patient Outcomes

- For each outcome measure, there were clinical improvements in wellbeing from session 1 to session 4 and at follow-up.
- There were statistically significant ($p < .001$) reductions in low mood (PHQ-9), with average scores reducing from 'moderate' at session 1 to 'mild' at session 4 and follow-up.
- There were also statistically significant ($p < .001$) reductions in anxiety (GAD-7), with average scores reducing from 'moderate' at session 1 to 'mild' at session 4 and follow-up.
- There were statistically significant ($p < .001$) increases in resiliency (BRS) and in emotional wellbeing (WEMWBS). Scores on the WEMWBS increased on average from 'probable levels of depression' at session 1 to 'average mental wellbeing' at session 4 and follow-up.
- The GAD-7 and PHQ-9 both showed large effect sizes (i.e., a large difference between pre and post scores) around d = 0.80. The WEMWBS showed a medium effect size (d > 0.60) and the BRS a small effect size (d > 0.20) at session 4 and follow up.

3.2.2 Clinical Supervisor Feedback

Clinical Supervisors were asked about the impact they had noticed on patient care, because of TAPPs' work. Seven responded and their comments are summarised below:

"Clinical Supervisors noted significant benefits as a result of the TAPPs' presence including increased capacity, the delivery of psychological interventions and patient satisfaction."

Delivery of Psychological Interventions

- Increased ability to deliver mental health interventions, group work and mental health promotional activities.
- Offering support for those who don't meet other services' referral criteria and helping to meet unmet need.

- A focus on psychological needs by utilising psychological models and a broad range of skills.
- Setting up referral pathways and seeing patients with cardiac and respiratory conditions that would not have been seen otherwise, addressing an unmet need.

Increasing others' capacity

- Helpful completion of review calls and screening of referrals.
- Freeing up capacity and reducing demand on other clinicians and senior practitioners so they can focus on other tasks.
- Generating capacity i.e., working in teams where there may not have been psychological practitioners before.

Increased patient satisfaction

- Supporting waiting list initiatives, leading to increased satisfaction from patients.
- Many people reporting that speaking to someone when they were beginning to struggle, in their local GP practice was of huge benefit. Nice reductions in psychometric scores plus great patient and staff feedback.

Wider service benefits

- Valued audit and review skills of services delivered.
- Additional resource to support training and co-facilitation.
- Bringing a psychological voice to case discussions.
- Working with community services, building partnerships and helping all to understand what services there are within the local community.
- New ways of working to meet the ambitions of the NHS LTP and community transformation.

The challenges of the role, from the perspective of 4 supervisors were as follows:

Embedding new roles

- A challenge to 'carve out the role' and embed into the team. Role boundaries and scope of practice can be a challenge.
- The TAPP role is difficult to embed within NHS Talking Therapies Service due to the nature of the role and not being 'IAPT' trained.
- A closer, more collaborative relationship with the University may be beneficial.
- The need for support to embed the role and a new staff member from the service where they are based.

3.2.3 TAPP Feedback: Acceptability of Being a New Workforce

Five TAPPs responded to the survey from PCNs and Primary Care services with greater complexity. The feedback shows that TAPPs valued the role and the opportunity to provide support and interventions to patients within primary care services and to tailor the role to service need. There was a perception that without the TAPP role some patients could have been without treatment for much longer.

Some TAPPs reflected on the challenges with integrating and embedding a new role within a service and across the system more generally.

"TAPPs valued the role, the opportunity to support individuals with mental health need and the ability to tailor their work to meet service demand."

3.3 Secondary Care Services

3.3.1 Patient data

Table 5 and the supporting narrative below summarise the results based on patient data collected from TAPPs working in the following Secondary Care settings:

- Community mental health teams (LSCFT, PCFT)
- Child and adolescent mental health team (PCFT)
- Home treatment team (LSCFT)
- Early intervention team (PCFT)
- Inpatient unit (PCFT)
- Physical health care pathways - Integrated stroke and community neuro rehab service (BTHFT)

"433 individuals from secondary care services included in the evaluation benefitted from working with a TAPP. Some of this was via working in groups, some of it related to 1:1 work. Improvements are demonstrated both through reductions of scores on mood measures and individual patient stories."

Table 5: Summary of Patient Data Results from TAPPs Working within Secondary Care Settings

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of patients seen	Number of Participants Analysed	Analytic Strategy	Results
LSCFT	• Chorley Community Mental Health Team (CMHT) • South Ribble Community Mental Health Team (CMHT)	Stabilisation, sleep work, emotional regulation, anxiety	In screening assessments, administer BAI, BDI, ISI, GAD-7 or PHQ-9. Patient Experience Questionnaire	Chorley= 14 South Ribble = 17 Total= 31	6 10	Quantitative - Pre and Post intervention psychometrics. Qualitative - Thematic Analysis	• Anxiety pre-Mean = 28.67 • Anxiety post-Mean = 20.00 • Depression pre-Mean = 28.00 • Depression post-Mean = 18.33 • Sleep pre-Mean = 19.4 • Sleep post-Mean = 9.8 • Two positive themes: 1) Helpful treatment and 2) Workforce qualities of TAPP • One Constructive theme: 1) Treatment approach not right
LSCFT	• Hyndburn, Ribble Valley and Rossendale Community Mental Health Team (CMHT) • Burnley and Pendle Community Mental Health Team (CMHT)	Safety and Stabilisation work, preparatory work for formal therapy, sleep hygiene, trauma psychoeducation, group interventions.	PHQ-9 and GAD-7 Patient Experience Questionnaire	Hyndburn, Ribble Valley and Rossendale CMHT = 25 Burnley and Pendle CMHT = 60 (25 1:1, 35 group).	HRR CMHT: 25 participants B&P CMHT: 15 participants 8 patients completed the qualitative box for the PEQ. 5 individuals from group interventions completed the qualitative box for the PEQ.	Quantitative -Pre and Post intervention psychometrics. Qualitative - Thematic Analysis	• The results showed a decrease in mental health scores (PHQ-9 & GAD-7) with improved mental health for the patients who had completed the full treatment. • Mean overall improvement from PHQ-9 = 7.00 • Pre SD = 4.75 • Post SD = 4.56 • Mean overall improvement from GAD-7 = 6.2. • Pre SD = 4.98 • Post SD = 4.14 • Two positive themes: 1) Helpful treatment and 2) Workforce qualities of TAPP • Two constructive theme: 1) Treatment approach not right, and 2) Environment

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of patients seen	Number of Participants Analysed	Analytic Strategy	Results
LSCFT	Pennine West and Pennine East Home Treatment Team (HTT)	Short term intervention including Distress tolerance and crisis coping plan psychoeducation, sensory toolkits to support distress, CBT and behavioural activation. Mood and anxiety management.	Patient experience questionnaire	72 23 of those completed crisis skills and coping workshops co-facilitated by the TAPP.	8	Quantitative- Means	• The average scores from the TAPP questionnaire showed that individuals found the session helpful with coping with the crisis/emotion, reduced levels of distress, felt listened too, felt understood, found the TAPP compassionate, and found the intervention helpful. • Average scores from the TAPP questionnaire. Likert scale scored on was rated 1-5. 1 being definitely disagree and 5 being definitely agree. • Q1) Have you found this session helpful in supporting you to understand your crisis? M= 4.88 • Q2) This session helped you to cope with your crisis and/or your emotions? M= 5 • Q3) Did you find that this session impacted on your levels of distress? M= 4.62 • Q4) Have you felt listened to today? M=5 • Q5) How well have you felt understood? M= 5 • Q6) Have you found the worker to be compassionate? M= 5 • Q7) Have you found this intervention to be helpful? M= 4.75
LSCFT	Blackburn with Darwen Community Mental Health Team (CMHT)	Trauma psychoeducation, Anxiety Management, Sleep Management, Stabilisation	PHQ-9 and GAD-7	One to one: 14 Group: 20	0 have completed both pre and post. Administered to 9 people so far.	Quantitative - Means and standard deviations	• PHQ-9 Pre-Mean = 20.61 (severe depression) • GAD-7 Pre-Mean = 17.83 (severe anxiety). • Post treatment data not available due to small caseload and disengagement before final session. This has been for a range of reasons including physical health problems, family circumstances and not turning up to appointments on multiple occasions.
LSCFT	Preston Community Mental Health Team (CMHT)	Sessions focused on anxiety management, depression, sleep hygiene, OCD, intrusive thoughts and grounding/stabilization	Patient Experience Questionnaire	Completed at least one session – 24 patients Successfully completed	6 consented	Qualitative - Thematic Analysis	• The Mean score when asked 'how helpful was the support from 1-5?' was 4.50 • Two positive themes: 1) Helpful treatment and 2) Workplace qualities of TAPP • One Constructive theme: 1) More sessions wanted

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of patients seen	Number of Participants Analysed	Analytic Strategy	Results
				intervention-16			
PCFT	Early intervention team (EIT)	One to one low intensity intervention Family intervention Carer support Staff training Peer supervision	Patient Experience Questionnaire, carer questionnaire and staff training questionnaire[1]		26	Qualitative - Thematic Analysis	• Four positive themes: 1) helpful 2) Knowledgeable, 3) Important psychological role (e.g., increases intervention access/availability), 4) Staff wellbeing • Two constructive themes: 1) Time, 2) Understanding of role
PCFT	Stockport Child and Adolescent Mental Health Services (CAMHS)	Low mood, anxiety, graded exposure, emotional regulation, IAPT initial assessment	Patient Experience Questionnaire	47	8 young people 8 parents	Qualitative - Thematic Analysis	• Four positive themes: 1) Treatment beneficial 2) better than expected, 3) Workforce qualities of TAPP 4) Family support • Two Constructive theme: 1) More sessions needed 2) Difficulties implementing strategies
PCFT	Stockport East Community Mental Health Team (CMHT)	DBT refreshers / motivational interviewing / psychoeducation / formulation / pre-therapy work	Verbal	7	3 patients 3 colleagues	Qualitative - Thematic Analysis	• Two positive themes: 1) Helpful treatment and 2) Help to team • One Constructive theme: 1) More time needed, 2) Treatment not helpful
PCFT	Child and Adolescent Mental Health Services (CAMHS)	Brief psychological intervention, cognitive assessment, group work and ASC/ADHD workups.	Child outcome rating scale (CORS) - measures wellbeing (personal, interpersonal, social)	44	11	Quantitative - Pre and Post intervention psychometrics	• The result shows that patient's overall wellbeing was lower (Mean =6.45, SD=0.85) at the beginning of treatment from a TAPP and improved after completing 4 or more sessions (Mean =7.75, SD=0.77). • The current result suggests that patients' overall wellbeing can be improved after seeing a TAPP. This suggests that the TAPP role is beneficial in improving patients' overall wellbeing after completing 4 or more sessions of trauma-informed interventions. This provides a rationale to use the TAPP role to offer brief intervention for those who are struggling from mild to moderate mental health problems, thereby potentially

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of patients seen	Number of Participants Analysed	Analytic Strategy	Results
							decreasing waiting list and providing early intervention before the patient is in crisis.
			Patient Experience Questionnaire	44	12	Qualitative - Thematic Analysis	• Two positive themes: 1) Helpful treatment and 2) Workforce qualities of TAPP • One Constructive theme: 1) More time needed, 2) Treatment approach not right
PCFT	Rochdale Community Mental Health Team (CMHT)	Anxiety management Low mood Behavioural activation Sleep difficulties	PHQ-9 and Gad-7	10	5	Quantitative - Means and standard deviation	• Overall reduction in anxiety and low mood across all patients • GAD-7 Pre-Mean = 15.40, SD= 4.39 • GAD-7 Post-Mean = 6.40, SD= 3.36 • PHQ-9 Pre-Mean = 18.60, SD= 2.60 • PHQ-9 Post-Mean = 8.80, SD = 1.30 • All patients engaged well and found sessions incredibly enlightening and helpful. All patients were better equipped with coping strategies to manage their anxiety and depression better which is evident in the reduction in scores from GAD-7 and PHQ-9.
			Patient Experience Questionnaire		4	Qualitative - Thematic Analysis	• Three positive themes: 1) Helpful treatment and 2) Supportive and encouraging, 3) Kind and patient TAPP • One Constructive theme: 1) Would have liked more sessions • The answers in the PEQ SF were all either 'very satisfied' or 'satisfied' for each session evaluated.
PCFT	Hope and Horizon inpatient units Fairfield General Hospital	Supporting Young people following a mental health crisis.	ROM's - YP core and REQUEST	15 one-to-ones 30 group setting	8	Quantitative - Pre and Post intervention psychometrics	• Request – The higher the score, the higher the chance there is of recovery, from admission to discharge, the means for the results had increased from 39.5 to 41.75 • YP CORE – A high score in the YP CORE indicates a high level of psychological distress. The means for the result had decreased from admission to discharge from 22.15 to 21. • Following intervention, the patients had a slight decrease in distress and an increase in chance of

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of patients seen	Number of Participants Analysed	Analytic Strategy	Results
							recovery indicating an overall positive impact on the emotional wellbeing of the young people.
PCFT	Bury Community Mental Health Team (CMHT)	Psychoeducation Anxiety management Coping skills Relapse prevention	PHQ-9 and Gad-7	3	1	Quantitative - Pre and Post intervention psychometrics	First session • GAD-7 = 21 • PHQ score of 19 Final session (5th Session) • GAD-7 = 11 • PHQ-9 = 11 The results show an overall reduction in scores on anxiety and low mood.
			Patient Experience Questionnaire		1	Qualitative - Thematic Analysis	• One positive theme: 1) Helpful treatment • One Constructive theme: 1) Would have liked more sessions • The patient rated the support as very helpful and would recommend TAPP support to others.

Notes: [1] The qualitative themes emerging from this analysis were based on combined feedback from patient experience questionnaires and feedback from carers and workplace staff who have received training by the TAPP. We also received an evaluation summary from a community team for Learning Disabilities (PCFT) who evaluated feedback from workplace staff who received training by the TAPP, but this does not appear in the Table above because no patient data were analysed. Analysis of this feedback from staff identified themes such as the value of the sessions and role and staffs' improved understanding, confidence and patient care.

3.3.1.1 Acceptability of the TAPP Role to Patients

The 9 qualitative analyses of patient feedback included data from LSCFT and PCFT (Table 5) with sample sizes ranging from 1 to 26, supporting the acceptability of TAPPs in secondary care. Common themes across the qualitative analysis are summarised below, showing that the approach was beneficial to some patients whilst others felt that a different approach was needed, and/or more time:

What's working well for patients?

- Personal and workplace qualities of the TAPP (e.g., kind, patient, encouraging)
- Helpful and beneficial treatment (improved confidence and understanding)

What changes would patients like?

- More sessions and time needed
- Challenges with the treatment approach

3.3.1.2 Impact of the TAPP role on Patient Outcomes

Table 5 includes 7 quantitative analyses, 4 from LSCFT and 3 from PCFT, with sample sizes ranging from 1 to 25. Most used Routine Outcome Measures of anxiety (GAD-7) and depression (PHQ-9), with results showing reductions in low mood and anxiety. It is noteworthy that TAPPs work with a smaller number of patients in secondary relative to primary care and so sample sizes are small and significance testing not possible.

3.3.2 Clinical Supervisor Feedback

Clinical Supervisors were asked about the impact they had noticed on patient care, as a result of the TAPPs' work. Two responded with one stating that ***"the future is optimistic – I feel the benefits far outweigh the costs, e.g., time constraints and close supervision".*** Comments from both supervisors are below.

Delivery of Psychological Interventions

- Trialling and evaluating an on online wellbeing group, which has helped with managing waiting lists.

Wider service benefits

- The impact has been primarily an additional resource to support training and co-facilitation.
- Support with managing patient waiting list through the introduction of telephone triage and appropriate allocation.

Increasing others' capacity

- TAPPs were flexible and worked across different teams, reducing pressures on the qualified psychologists.
- TAPPs have supported with assessment, consultation, co-facilitation and lower-level work. This allows space for senior practitioners to focus on other tasks.

The challenges of the role can be summarised as:

Embedding new roles

- The role is not suitable as a 'stand-alone' role without the support of fellow psychologists/trainees.
- The personal qualities of the TAPP/APP in terms of previous (NHS) experience is important.
- The difference between TAPPs and CAPs in secondary care ought to be considered; managing similar levels of complexity which is not reflected in banding differences.
- Deployment and utilisation of the role was not coordinated well. We weren't prepared for this additional role and had to consider their fit within a specialist service with complex cases.
- I'm not sure how the role fits in secondary care, given low psychology professionals within the teams, therefore limited space for supervision.

3.3.3 TAPP Feedback: Acceptability of Being a New Workforce

Ten TAPPs working in secondary care services responded to the survey. The feedback evidenced that TAPPs valued the role and the flexibility to provide interventions drawn from multiple modalities to provide person-centred care. TAPPs also reported that the role reduced waiting lists, complimented existing teams and was able to free up capacity of colleagues. It was also mentioned that the role was a great opportunity for TAPPs to develop as practitioners.

Some TAPPs reflected on the challenges of embedding this new role within secondary care, describing limited opportunities for clinical work due, in part, to the level of complexity and lack of understanding as to the scope of practice of the TAPP role. Some comments captured a lack of service readiness for the role and noted a lack of support, with one TAPP noting that a lack of accredited status limited their opportunities.

3.4 Living Well Salford - Community Mental Health Service

3.4.1 Patient Data

Table 6 and the supporting narrative below summarise the results based on patient data on data collected from TAPPs working in Living Well services. Delivered in partnership between GMMH, Mind in Salford, Six Degrees, Wellbeing Matters and 'START' mental health charity, Living Well Services are jointly funded by GMMH, NHS Salford Clinical Commissioning Group (CCG) and Salford Primary Care Networks.

3.4.1.1 Impact of the TAPP role on Patient Outcomes

Only quantitative analysis of patient outcome data was available from Living Well services. Table 6 shows 1 quantitative analysis based on the work of 2 TAPPs, showing some improvement in quality of life scores and treatment satisfaction and goal-based outcomes, yet these were not statistically significant.

Table 6: Summary of Patient Data Results from TAPPs Working within Living Well Services

Trust	Clinical Service and focus	Main reasons for patients accessing TAPP support	Materials and Procedure	Number of participants Supported	Number of Participants Analysed	Analytic Strategy	Results
GMMH	Salford Living Well	Difficulty managing physical condition Adjustment to diagnosis / Stress / Anxiety / Distress Low Mood / Depression High Healthcare usage Issues with clinical management, compliance to treatment and medication	ReQoL (Recovering Quality of life) scores DIALOG scores- Quality of Life and Treatment Satisfaction. Goal based outcomes	46	46	Quantitative - pre and post intervention psychometrics.	• ReQoL scores increases from session 1 to the final session but not enough for the results to be statistically significant. • For the DIALOG scores, most patients improved slightly on scores from the first session to the final session, however, not enough to be significant. • All bar one patient improved from the first to last session.

Section 4: Economic Evaluation and Modelling the Impact of TAPPs in Primary Care

4.1 Background

In 2021/22, Mental Health Practitioners were included in the 'Additional Roles Reimbursement Scheme' (ARRS) which supports the recruitment of staff into PCNs, paving the way for a new PCN based psychological workforce. The impact of deployment of APP practitioners with specific reference to the PCN setting has been explored in two pieces of work:

1. Economic analysis modelling by health economists Valerio Benedetto and Andrew Clegg. This adopted a healthcare system perspective to look at costs and outcomes of TAPPs' activities in comparison to routine mental healthcare provision (i.e. usual care). The report is included in Appendix 7
2. Workforce experts of the NHS Workforce Repository and Planning Tool (WRaPT) team modelled the impact of the APP role in Primary Care in terms of additional capacity to provide mental health care and the impact on General Practitioner (GP) capacity within the sector. The report is included in full in Appendix 8.

4.2 Economic Analysis (Cost Effectiveness)

The economic evaluation only measured direct staff costs related to TAPPs' activities and did not include other costs, such as medications. Patients' outcomes were measured in terms of generic and mental health-related quality of life. Cost and outcome data related to the comparator (i.e. usual care) were based upon secondary data extracted from two studies, which were selected following a systematic review of the relevant economic literature. Preliminary analysis indicated that individual patient work appeared cheaper than group work, however costs per patient for the group work naturally decrease as the group size increases. While the costs associated with individual TAPPs' work over the evaluation period appeared lower than usual care over 12 months, limitations on the comparability of cost items and uncertainty in the data need to be taken into account. Patients seen by TAPPs saw gains in generic and mental health-related quality of life over the evaluation period. In terms of generic health-related quality of life, the associated gains in *quality-adjusted life years (QALYs)* appeared similar to those that could have been observed in patients receiving usual care. However, a fuller economic analysis is needed to explore effectiveness in relation to outcomes other than QALYs, such as mental health. Ultimately, the economic evaluation was constrained by the comparability of cost items, size of the sample, and short timescale over which the clinical impact was explored. A fuller analysis based on adjustments for confounding factors and sensitivity analyses is required to substantiate and expand on the preliminary findings.

4.3 WRaPT Modelling

The findings from the WRaPT analysis looking at generating additional capacity within PCNs were impressive, suggesting that deploying one APP in each PCN in a large region would offer a substantial (50,000+) increase in brief intervention appointments, with additional group intervention capacity. One of the most important perspectives on this is that an APP in a PCN has

the potential to free up about 1,600+ GP appointments a year. This has great significance for addressing both GP capacity for those appointments where their clinical judgements are most critical, in saving money that can be directed to more pressing needs, and in taking some of the pressure off and supporting the wellbeing of incredibly over-worked GPs, possibly reducing the rate at which they leave the profession.

Section 5: Overall Conclusions and Recommendations

The overall aim of this evaluation was to evaluate: 1) TAPP progress and competence development during the 12-month training period alongside academic training experience (academic evaluation); 2) the acceptability and impact of TAPPs in clinical settings (clinical service evaluation), and 3) the cost effectiveness of introducing this new workforce into specific pathways (primary care economic evaluation). The findings are summarised below.

5.1 Lessons Learned from the Evaluation

5.1.1 Academic Evaluation

1. **Effectiveness of the PgDip APP in developing competencies and meeting the course aims:** 100% of TAPPs who completed the course within the 12-month training period achieved the required clinical competencies and passed the PgDip APP programme (this figure excludes those with extensions due to mitigating circumstances), allowing them to progress to a qualified Band 5 APP role.
2. **TAPPs' experience of the course.** Many TAPPs valued their role and see it as a valued career pathway that can provide direct clinical experience and support personal and professional development. Some TAPPs experienced challenges and highlighted the challenge of new roles being understood and embedded.
3. **TAPPs' learning acquisition and impact on clinical practice within the workplace.** As TAPPs who completed the training passed the course, the academic course and clinical role led to the acquisition of the intended knowledge, skills and confidence. TAPPs applied their learning and competencies to clinical practice within the workplace.

5.1.2 Clinical Service Evaluation

1. **Acceptability of the TAPP role to patients:** positive feedback was received from patients regarding the support they received from a TAPP, though some patients felt that modifications to the service were required, including 'more time/sessions', and this theme cut across both primary and secondary care.
2. **Impact of the TAPP work on patient outcomes**: across primary and secondary services there was evidence of improvements across mental health routine clinical outcome measures (ROMs), following intervention with a TAPP.
3. **Acceptability of the workforce to Clinical Supervisors:** supervisors identified a myriad of ways in which the TAPP role had a positive impact and service benefit that extended beyond the delivery of one-to-one or group psychological interventions. At a broader level, TAPPs were supporting colleagues by generating additional capacity within their service and were viewed as a new way of working to meet the ambitions of the NHS LTP and community transformation. Some supervisors however, highlighted challenges associated with TAPPs' integration and embedding into the service. Further work is needed to embed the role in some services and ensure service readiness.
4. **Acceptability of being a new workforce (the experience of TAPPs):** many TAPPs across a range of primary and secondary care services valued their role and could see the positive impact they were having in their service, such as on patient waiting times, freeing up capacity of other colleagues and adapting interventions based on patient need. The role was not

without its challenges however, with some TAPPs in both primary and secondary care describing difficulties in relation to service readiness and support for their role.

5.1.3 Economic Evaluation

1. The economic evaluation highlighted that, during the study period, individual participant work delivered by TAPPs is associated with lower total staff time costs than group work (i.e. individual versus group costs), though costs per patient for group work will naturally decrease as group size increases.
2. Despite the partial comparability, TAPP costs appear to be similar to the costs that could be incurred in usual care to deliver primary care services in the first 12 months, but these are preliminary findings and there were limitations to the analysis.
3. TAPPs' activities are associated with gains in patients' generic health-related and mental-health related quality of life. In particular, based on methodological assumptions, the quality-adjusted life years (QALYs) gained by patients seen by TAPPs appear to be at an equivalent level to the QALYs that could be gained by patients receiving usual care.

5.2 Summary of Key Findings across all Components of the Evaluation

1. The PgDip APP educational training programme continues to effectively develop Psychology graduates into competent psychological practitioners, thereby helping to meet the ambitions of the NHS LTP and community transformation to improve workforce supply and meet need.
2. In primary care, secondary care and living well services, support from a TAPP leads to positive patient outcomes (e.g., reduced depression and anxiety and/or improved resiliency and wellbeing), with many patient experience questionnaires also attesting to positive experiences and impact.
3. The positive impact of TAPPs extends beyond the delivery of one-to-one or group interventions to wider service benefits appropriate to the needs of the service and pathway in which they are working, with benefits such as additional capacity to manage referrals, supporting waitlist initiatives, completing service audits, and working with the community.
4. TAPPs generate capacity by providing a psychological presence in PCNs and enhance existing psychology teams/free up capacity in other primary and secondary care services.
5. With appropriate support and clear scope of practice for specific pathways, TAPPs effectively embed, add value and are a welcomed workforce.
6. The evaluation highlighted significant areas of strength (e.g., University teaching and learning, the clinical work exposure to enable skill development and broadening career opportunities).
7. Challenging aspects to address inherent in any new role include working with services to ensure service readiness for effective deployment, particularly in PCNs and services where there is complexity in need.
8. Preliminary cost-effectiveness analysis of TAPPs in primary care identified potentially similar costs and gains in patients' generic health-related quality of life (when measured in quality-adjusted life years or QALYs) compared with usual care, which could liberate resources from GP time. A fuller economic analysis is needed to confirm these findings and to expand the cost effectiveness analysis in relation to outcomes other than QALYs and in relation to comparative 'treatment as usual' data.

5.3 Strengths and Limitations of the Evaluation

Strengths and limitations of the evaluation echo those in the first evaluation report, highlighting the need for continued work in this area to follow existing best practice and to address ongoing challenges with a new role.

Key strengths include:

1. **This is a robust evaluation** that uses a range of quantitative and qualitative methods.
2. **Each level of Kirkpatrick's (1996) framework for evaluating training programmes has been utilised**. The framework provides a pragmatic structure and ensures a holistic and comprehensive evaluation, the results of which have direct implications for policy and practice and meet the needs of services.
3. **Data were triangulated across multiple sources** (e.g. patient routine outcome measures and feedback, feedback from clinical supervisors and feedback from TAPPs themselves) where appropriate and possible.
4. **Data have been captured from multiple service types** within Primary and Secondary care, and from Living Well services, allowing us to tease out any areas of strength or challenge.

Key limitations include:

1. Missing data was an issue for the academic evaluation, with only 26 (time 1) 25 (time 2) and 24 (time 3 (30%) of cohort 2 responding to the survey. Only 8 completed all three time points, 13 completed at least 2 time points and 25 completed the survey at one time point.
2. With regards to the clinical service evaluation, much data for TAPPs in some settings was qualitative. These data will need triangulating with data from other sources. In addition, the clinical service evaluation patient data were analysed by TAPPs, since the evaluation team did not have access to patients' raw data. Whilst the reliance on results summaries produced by multiple persons has the potential to enrich analysis, it also means that common themes across datasets could've been missed due to different interpretations of these data. In addition, some of the quantitative analyses used samples that were too small for significance testing, and therefore relied on descriptive analysis.
3. The economic evaluation had some limitations. First, the reliance on secondary data to estimate the costs and outcomes associated with usual care. These data were identified through a purposely developed systematic review. Searches were restricted to studies published from 2017 onwards, but only a few studies were deemed to be suitable for the scope of this analysis. Moreover, during the systematic review process it transpired that, even if studies were published from 2017 onwards, the years when the actual study took place (i.e. the study period) were older in the included studies. Setting the searches by years of study period may not be straightforward in most databases, but the temporal discrepancy between the study period and the publication year is recognised as a limitation.
   Second, the set of cost data examined across the comparators is not fully comparable: on the one hand, only the TAPPs and APPs time was considered while, on the other hand, the study by Duarte et al. (2017) took into account a wider set of primary care services cost data. More resource use information is needed to capture costs which go beyond the time invested by TAPPs in their work but may still be related to their activities (e.g., further consultations with other healthcare professionals in primary care).
   Third, based on the original 24-month estimate reported in Duarte et al. (2017), this evaluation estimated the QALYs change in patients receiving usual care over a 10-week period to allow comparability with the study period of this evaluation. This estimation

assumed that patients gained QALYs in a linear way (i.e. at a constant rate), but this may not necessarily be the case. Therefore, it remains difficult to estimate how many QALYs would have been gained by patients receiving usual care in the first 10 weeks, and any interpretation of the differences in QALY gains between the two comparators needs to be undertaken with caution.

Fourth, a comparison on the outcomes related to patients seen by TAPPs in GMMH with the outcomes related to patients receiving usual care was not possible, given the lack of mapping algorithms from ReQoL10 scores on to the EQ-5D-3L or –5L scores.

Lastly, we did not adjust our analysis for potential confounders nor perform a full sensitivity analysis to characterise the uncertainty surrounding our estimates, which should therefore be interpreted with caution.

5.4 Next Steps and Key Recommendations

The development of T/APPs has been an innovative and valued development in meeting the demand for psychological approaches in the North West. Given the workforce challenges, this new role has contributed to workforce transformation over the past two years and it is vital that the role continues to develop and the impact be evaluated. Based on the evaluation data, there have been numerous positive changes in preparation for Cohort 3, who commenced training in March 2023. The changes echo many of the themes from the first evaluation report based on Cohort 1. Thus, at the time of writing this report, some of the recommended 'next steps' have already been implemented in preparation for Cohort 3, as shown below.

5.4.1 Key Changes Already Implemented Prior to Cohort 3 (March 2023 – March 2024)

1. **Updated job description/competence framework** – The competence framework is embedded within the TAPP job description and was updated to include more specific descriptors of competence to further clarify the scope of practice, particularly in areas of assessment, formulation and intervention.
2. **Improved recruitment process to facilitate earlier engagement from services and improve TAPP and service experience**. Expressions of Interest for TAPP Cohort 3 commenced in summer 2022 until December 2022. During this time over 50 different services were met with via Teams to ensure the appropriate quality assurance for potential posts. The main purpose of the meetings was to ensure service readiness, understanding about the role, supervision capacity, funding arrangements and to provide an opportunity for services to have their questions answered. In addition, based on logistical issues which impacted on TAPP experience in Cohort 2, it was decided to implement a more localised approach to recruitment. The rationale was that more localised recruitment ensures that applicants are matched with their geographical locations and set up on the employer's electronic systems, prior to commencing work. To ensure a smooth and consistent recruitment, each service was provided with a recruitment pack. The recruitment pack to help standardise the process.
3. **Streamlined course documentation and handbooks** – Feedback from both TAPPs and clinical supervisors highlighted the need to streamline paperwork requirements, which has been actioned.
4. **Greater clarity around the TAPP scope of practice** – The project team have discussed the TAPP scope of practice at length and continue to do so, in keeping with the pilot nature of the role. Our revised "Clinical Training Handbook" now includes more detail and clarity regarding scope of practice. This includes expectations of what TAPPs can and can't do,

sample role descriptions across services, and further guidance regarding case load. This area continues to grow and develop, and opportunities and need are clarified.

5. **Updated course assessment strategy** – In tandem with the move to a Postgraduate Certificate (described below), the course assessment strategy has been updated. The format follows that of an Objective Structured Clinical Examination (OSCE).

Further development of the course and role includes the move from a 120 credit Postgraduate Diploma to a 60 credit Postgraduate Certificate which brings the role into alignment with other, similarly banded psychological practitioners. The course has been successfully re-validated in February 2023 and includes two modules: 1) Psychological Practitioner core competencies (40 credits) – this module aims to equip TAPPs with knowledge, skills and transferable competencies (e.g., in assessment, formulation and intervention); 2) Psychological Practitioners in Practice (20 credits) – this module primarily aims to equip TAPPs with knowledge and understanding of applying transferable competencies in a range of services and settings e.g. primary and secondary care settings.

This new 60 credit structure is being piloted with Cohort 3, allowing for further refinement of the curriculum and teaching and learning model, whilst further shaping the scope of practice of the T/APP . The new module structure is also the first phase of curriculum refinement, with future plans including the development of separate bespoke 20 credit modules for primary care, secondary care, and/or physical healthcare pathways (a response to our ongoing evaluation data). Alongside this 3rd pilot year is an ongoing consultation with the British Psychological Society (BPS) regarding accreditation standards for the course.

5.5 Recommendations

The specific recommendations emerging from this evaluation will require joint action from provider organisations, HEE, HEIs and NHS provider organisations. The recommendations from the evaluation report are set out below:

1. Given the success of the TAPP role, to move towards a sustainable commissioning framework to train APPs, working with HEE and NHSE.
2. To obtain BPS accreditation of the APP role and standardise University Quality Assurance processes and governance standards, supporting career development.
3. To support TAPPs in training (Cohort 3) and continue to embed the APP role in local services, starting with locally led approaches to recruitment and engagement with services early in the process.
4. To foster ongoing collaborative partnerships between the education provider and all services.
5. Ongoing evaluation of academic success and clinical and economic impact of TAPPs, and where possible, qualified APPs.
6. To complete the final evaluation of the three year 'test of concept' in May 2024.

5.6 Conclusion

Evaluation of Cohort 2 highlights significant successes, the value the role contributes, and challenges embedding this new role. This project has continued to demonstrate both excellent supply (over 500 applications for cohort 1, over 600 for cohort 2 and over 700 for cohort 3) and the benefits of recruiting career focussed psychology graduates to work in healthcare. This is a key area for development among psychological professions where there is currently no direct route from undergraduate degree completion to working in healthcare in a professional role.

The APP role is responsive to current rising demand and gaps in provision for mental health services; the TAPPs are improving population health outcomes. The role is helping to meet the strategic priorities of NHS LTP that relate to growth of the psychological workforce, new career pathways and new ways of working.

Since commencing in January 2021, the T/APP role has been shortlisted for multiple awards, some of which we have won (**those in bold)**: 1) **LSCFT outstanding contribution to education and research, 2021**; 2) Educate North mental health category, 2022; 3) **HSJ Patient Safety, Primary Care Initiative of the Year, 2022**; 4) HSJ Primary and Community Care Innovation of the Year, 2022; 5) **North-West Coast research and innovation: Ruth Young award for the first journal publication which is a clinical service evaluation of the role, March 2022**); 6) **Educate North Employer Engagement award, 2023;** 7) North-West Coast Research and Innovation: Innovation in Workforce Deployment, 2023; 8) North-West Coast Research and Innovation: Primary Care and Community Research Team of the Year, 2023. There is also reference to the role in the NHS 'Psychological Professions workforce plan for England' (December 2021).

The evaluation continues for Cohort 3 and this year represents the final year of the proof-of-concept project in developing a new role that can deliver psychological intervention work in a range of settings. The role has been well-received, and TAPPs/APPs are highly valued within the North West region, as key contributors to workforce supply, delivering improved outcome for patients. Consideration of future Cohorts is an essential priority for this year and clarification around future funding models is required. There has been interest in developing this role outside the North West of England as well as HEI interest in developing the courses more widely. Ensuring sustainability of the model will require investment from HEE/NHSE and a timeline for next steps needs to be determined.

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Appendices

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