**FAQs**

**MENTAL HEALTH PRACTITIONERS**

**Why do Mental Health Practitioners have to be employed by the secondary care provider of community mental health services**?

The introduction of these roles is part of a wider transformation and expansion of community-based mental health services set out in the NHS Long Term Plan. Having the practitioner employed by the CMHT but fully embedded within the PCN via a service agreement maximises the opportunity to integrate two different organisations and working cultures, in an area where seamless transfers of patient care are particularly critical.

The practitioner will be embedded as part of the PCN MDT working alongside the other roles and they will also part of the community mental health MDT with ready access to a wide range of support and expertise across both MDTs. It is envisaged that the focus of a practitioner’s work will generally be people whose needs cannot be met by IAPT services but who may not need ongoing care from secondary care community mental health services. The practitioner can facilitate onward access to other secondary care-based services or third sector services integrated within the mental health pathway. Local agreement will be needed on the scope of the role based on the parameters set out nationally.

A further benefit of this model is that it reduces the “employer” burden on the PCN and gives the PCN the benefit of a full time embedded mental health practitioner whilst only having to fund 50% of their costs (up to the maximum level of reimbursement). The practitioner will be supported by the provider’s robust clinical governance mechanisms to support safe, effective and high-quality practice. The model facilitates a joint approach to recruitment and closer integration between primary care and secondary mental health providers.

**The PCN has already employed a mental health practitioner, what can we do?**

To be eligible for reimbursement under the ARRS scheme, the mental health practitioner must be employed by the secondary care of provider of community mental health services for adults and older adults. We suggest that PCNs have a discussion with their local provider, supported by their CCG if necessary, to explore whether there are any potential options for mental health providers to take on the employment of staff already appointed by PCNs, in order to unlock access to ARRS funding and deliver the benefits of the joint model.

**The PCN already has a contract with a local provider who isn’t the secondary care provider of community mental health services?**

To be eligible for reimbursement through the ARRS the mental health practitioner must be employed by the secondary care community mental health provider. We suggest that PCNs have a discussion with their local secondary care community mental provider, supported by their CCG if necessary, to explore whether there are any potential options around employment by them for staff who have been recruited via another provider.

**Does it have to be the local secondary care community mental health provider or can it be a neighbouring one or other provider like MIND?**

The mental health practitioners need to be employed by the secondary care provider of community mental health services that covers the PCN geography so that they can provide the necessary links and facilitate access to specialist mental health services where this is clinically appropriate. A local Mind, or similar organisation, would therefore not be an appropriate employing organisation for practitioner roles under the ARRS scheme and would render a PCN ineligible to receive reimbursement under the ARRS.

**Can the PCN employ our own mental health practitioners under the ARRS scheme in addition to those employed by the community mental health provider?**

No. To be eligible for reimbursement under the ARRS the staff must be employed by the secondary care provider of community mental health services.

**How will PCNs fund these costs?**

The ARRS funding covers 50% of the salary, NI and pension costs, up to a maximum reimbursable amount for each of the indicative bands (5 – 8a), in line with the rules of the Scheme

**Will Mental Health Providers receive more money to fund their contribution to these posts?**

Mental Health providers are responsible for all remaining costs associated with these roles, once the PCN contribution via ARRS funding is factored in. They have a contractual obligation to provide PCNs with a mental health practitioner.

Mental health providers have received funding in MHIS CCG baseline allocations and SDF allocations, as set out in the LTP MH [implementation plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf). Where CCG baseline allocations and SDF allocations for community mental health are already committed for 21/22, MH providers’ share of these costs can be funded via Spending Review (SR) settlement for Mental Health, which includes £58m for accelerating community mental health transformation (for further detail please see [MH Recovery funding letter](https://future.nhs.uk/MHLTPat/view?objectId=97795685) and [21/22 MH Delivery Plan](https://future.nhs.uk/MHLTPat/view?objectId=97321349)). In future years, these roles should be funded by increases in CCG baseline funding.

Please note that the £58m SR settlement covers the costs for roles supporting adults and older adults only. While PCNs and MH providers may also agree MH practitioners to support CYP under the ARRS scheme, this is not an entitlement for PCNs and the funding should be agreed locally.

**What is the Mental Health Investment Standard (MHIS), and how will funding these roles affect MHIS?**

The Mental Health Investment Standard (MHIS) requires CCGs to increase investment in Mental Health services in line with their overall increase in allocation. Therefore CCG investment in mental health should rise at an equal or faster rate than their overall published programme funding. Each year CCGs must validate that they have met the MHIS via an independent audit process.

In 21/22, these roles can be funded via CCG baseline funding, SDF allocations, or the Spending Review settlement for MH. If these roles are paid for via CCG baseline funding, then they will be included in MHIS calculations. Spend of SDF allocations or Spending Review settlement to pay for these roles will not count towards meeting the MHIS.

**What is the Community Mental Health transformation, and will funding these roles take away from the transformation programme?**

The Long-Term Plan commits to delivering new models of integrated primary and community MH care for people with ‘severe mental illness’ (defined below), covering every PCN in every ICS by March 2024. The transformation is underway in every STP/ ICS from April 2021. The goal of the transformation is to improve experience and outcomes for people with severe mental illness, give them greater choice and control over their care, and support them to live well in their communities. The integration of care pathways across community MH and primary care are central to the transformation, and PCNs and MH providers should work together to ensure that the MH practitioner roles enable and accelerate this transformation.

**What do you mean by Severe Mental Illness (SMI) and is there flexibility on the focus of the roles?**

It is envisaged that the focus of a practitioner’s work will generally be people whose needs cannot be met by IAPT services. Of note, ‘SMI’ includes a much broader cohort in the context of Community Mental Health transformation than what is included in the GP QOF SMI register. It is defined in the LTP MH [Implementation Plan](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/07/nhs-mental-health-implementation-plan-2019-20-2023-24.pdf) as ‘a range of needs and diagnoses, including psychosis, bipolar disorder, ‘personality disorder’, eating disorders, severe depression, and mental health rehabilitation needs – some of which may be co-existing with other conditions such as frailty, cognitive impairment, neurodevelopmental conditions or substance use.

PCNs and providers will need to agree the focus in the context of transformation happening across the local ICS and delivery of the [Community Mental Health Framework](https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/). We would remind local partners that one of the key benefits of the role is its ability to draw on the wider PCN and MH MDT to help address people’s needs.

**Is there any flexibility on these roles for Early Implementer sites for community transformation?**

A number of sites around the country have received national funding since 2018/19 to become ‘early implementers’ of the NHS Long Term Plan commitment to create new and integrated models of primary and community mental health services. In those circumstances, where a new integrated service model has already been put in place and is proving effective, a PCN may not need to use its ARRS funding to take up the mental health practitioner entitlement through the ARRS. Where a PCN does wish to take up the ARRS entitlement, local partners should work together to ensure alignment with these models so that adoption of the scheme builds on and complements the new models and does not destabilise progress made to date. This is specified in the full-length document of the [NHS Standard Contract](https://www.england.nhs.uk/publication/nhs-standard-contract-particulars-full-length/).

**What band practitioner are we able to employ?**

This practitioner can be reimbursed through the ARRS from a band 5 to band 8a level. As the GP Contract and NHS Standard Contract set out, the practitioner can be any clinical registered role including a Community Psychiatric Nurse, Clinical Psychologist, or Mental Health Occupational Therapist. This is not an exhaustive or definitive list and local partners may wish to explore other types of roles that fulfil the same criteria. In addition, certain non-registered psychological professions roles (including those on voluntary and accredited registers) may be included when under the direct supervision of a registered psychological professional. Non-registered psychological professionals (including those on voluntary and accredited registers) should be included only when they have specific competences in evidence-based psychologically informed interventions or NICE-recommended psychological therapies for severe mental health problems. Examples of non-registered psychological professionals that could be considered include CBT therapists with specific competence in working with severe mental health problems, and graduate psychological practitioners with a postgraduate training in evidence based brief psychological interventions for people with severe mental health problems. This scheme is not for the reimbursement of IAPT practitioners since these continue to be funded through existing routes.

The PCN and the community mental health provider should work together to find a practitioner most suited to the PCN’s population mental health needs, taking into consideration local mental health workforce availability and pressures.

**What can the roles do?**

The exact scope of the role and job description should be agreed between the PCN and MH provider. Broadly, the roles can:

* work with patients to support shared decision-making about self-management; facilitate onward access to treatment services; and provide brief evidence-based psychological interventions, where qualified to do so, for patients ineligible for IAPT and where the intervention can be safely offered outside of a multi-disciplinary mental health team
* work closely with other PCN-based roles to address wider patient needs, e.g. PCN clinical pharmacists for medication reviews, and social prescribing link workers for access to community-based support
* operate without the need for formal referral from GPs, including accepting some direct bookings where appropriate, subject to agreement on volumes and booking mechanism between PCN and provider
* provide a consultation, advice, triage and liaison function, supported by the local community mental health provider through robust clinical governance structures to maintain quality and safety, including supervision where appropriate

**Who will be the employer and line manager for the mental health practitioners?**

The community mental health provider will be the employer and provide line management but the mental health practitioner will be fully embedded in the PCN and part of the PCN MDT. The PCN will agree their job description and scope of duties with the community mental health provider. NHSEI have developed [guidance on employment models](https://future.nhs.uk/P_C_N/view?objectID=92029765), including a template service level agreement, which PCNs may find helpful.

**Who will have HR responsibility?**

The community mental health provider will indemnify the mental health practitioners and will be responsible for all HR management in line with usual employer responsibilities. We suggest that the PCN agrees with the provider how staff will be supported whilst working in primary care and how any feedback for appraisal, including compliments or any concerns about performance, will be shared and addressed. NHSEI has produced support on [employment models here](https://future.nhs.uk/P_C_N/view?objectID=92029765) which may be of help.

**Can the mental health practitioner see Children and Young People?**

The post is intended to support adults and older people but PCNs can secure a children and young people’s mental health practitioner under the same model, with the agreement of the mental health provider. There is no contractual obligation on secondary care providers to supply this role in the same way that there is for the adult and older adult role. However, PCNs and secondary care providers of children and young people’s community mental health services can pursue this arrangement if both parties believe it is desirable and practicable. Mental Health Providers cannot use the Spending Review settlement for 2020/21 to fund roles supporting CYP in the same way they can for adult and older adult ones, therefore funding for these roles should be locally determined.

**Can we employ our own CYP practitioner under the ARRS scheme?**

To be eligible for reimbursement under the ARRS, the CYP practitioner must be employed by the local secondary care provider of community mental health services for children and young people.

**How will we recruit to these posts when there is already a shortage of staff?**

We believe that PCNs and the local mental health provider working collaboratively will provide an opportunity to create innovative posts where care will be provided closer to people’s homes and communities. It provides a unique and exciting opportunity to work in primary care as part of the wider PCN team and will be attractive to staff as part of the wider development of new and integrated models of primary and community mental health services set out in the Long Term Plan.

We will be using the workforce planning returns that PCNs submit to develop a supply and demand model across the ARRS roles and working with Health Education England to ensure a pipeline of staff are available for primary care going forwards.

We also anticipate that earlier intervention may reduce escalation of needs, and will allow secondary care community mental health services to dedicate more resources to improving access and quality for people with more severe and complex needs. This is ultimately the direction of travel of the Long Term Plan and [the Community Mental Health Framework](https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/).

**Do these staff have to be additional to current mental health staff – the same as the ARRS staff in primary care? Will mental health providers just use them to fill their current vacancies or use them for services under pressure such as ADHD?**

The MH provider must provide a role which is additional to:

* any role already provided by them to work as a member of a general practice or PCN core team; and
* any co-located IAPT practitioner.

The post holder will be fully embedded in the PCN and working to a job description developed by the PCN and the mental health provider.

PCNs that are already within community mental health transformation ‘early implementer’ sites that choose to take up this arrangement, should work with partners to ensure that adoption of ARRS builds on and complements the new models and progress made to date.

**Are we limited to 1.00 WTE mental health practitioner per PCN and can larger PCNs recruit more staff?**

The proposed staffing levels are intended to reflect PCN size and increase each year, subject to positive review. In 21/22 they are 1 WTE per PCN size of 99,999 and 2 WTE for PCNs >100k population. This entitlement will increase to 2 / 4 WTE in 2022/23 and 3 / 6 WTE by 2023/24, subject to a positive review of implementation. This allows time for the scheme to bed in and to build up the workforce supply and an assessment of the impact of the scheme on the wider transformation of primary and community mental health care.

**Why don’t you just pay the community mental health provider directly, rather than PCNs claiming via the ARRS and having to pay the Trust?**

It is important the PCN retains control of its full ARRS budget and decides the roles that it needs to recruit in the light of its own population health needs. The PCN can agree payment terms with the mental health provider and payment processes to the provider may be able to be automated to reduce the administrative burden.

**Is there a timing mechanism in place for this or will that be down to PCNs / local CCGs / ICSs to determine?**

PCNs become contractually entitled to take up these roles from 1 April. However, PCNs, CCGs and mental health providers are able to agree a later start date taking into account practical considerations and the wider Covid context.

**Do mental health providers need to start with PCNs that previously indicated that they wanted to appoint to PCN MH roles in prior submissions? Recognising that all may review that in light of this new guidance**

This is likely to be a sensible approach, although providers are reminded that all PCNs may choose to take up their entitlement and so they should plan to engage with all PCNs.

**Other areas that have been raised are about who is the employer? This ARRS role is different model to previous ones. I.e. so, would PCN and MH provider together be the co-employer? Can PCN "choose" their MH worker from the MH provider? If it doesn't work and PCN withdraw funding, who holds the risk?**

The secondary care provider of community mental health services will be the employer of the mental health practitioner role. PCNs and providers will need to agree on the role and job description and PCNs should be involved in the recruitment or selection of their mental health practitioner. There should be a service agreement between PCNs and the mental health provider that captures how the role will operate. NHSEI have developed a template service level agreement which may be helpful and can be accessed here within guidance on [innovative employment models](https://future.nhs.uk/P_C_N/view?objectID=92029765).

**Isn't there a high level of potential for unwarranted variation if this is a choice for primary care?**

PCNs have a through and detailed understanding of the needs of their population and this is likely to vary across the footprint of an ICS or provider Trust so different PCNs are likely to require different roles to meet their particular population needs. As with the other ARRS roles PCNs are able to choose which roles they recruit to and whether to take up their entitlement to adult / older adult MH practitioners or not.

To address the potential for unwarranted variation, providers can hold discussions with multiple PCNs to reach a shared view of the requirement. CCGs and ICSs may also want to facilitate discussion to ensure a consistent approach to similar needs in the context of their community mental health transformation plans.

**What if a PCN chooses not to have an MHP?**

This is entirely up to each individual PCN. PCNs will be aware that regardless of whether or not they take up their entitlement to these practitioner roles, all ICSs will be implementing plans to transform community mental health services and will be delivering new models of integrated primary and community mental health care for adults and older adults with severe mental health problems in every PCN by March 2024.

**I'm worried about B5s acting as lone practitioners. I think that could be risky for them and the patients.**

It is essential that PCNs and providers work together to ensure that the practitioner is well supported by the PCN MDT and community mental health MDT with appropriate clinical supervision arrangements in place. NHSEI [clinical supervision information](https://future.nhs.uk/P_C_N/view?objectID=92374533) can be accessed here.

**What’s the link between SPLWs, health and wellbeing practitioners, and others in the PCN workforce?**

Please see section 8.5 from page 28 onwards in the link provided: <https://www.england.nhs.uk/wp-content/uploads/2020/03/network-contract-des-guidance-2020-21.pdf>

**How have the links been made with IAPT on this?**

Local partners will need to ensure that there are comprehensive primary and community care services that dove tail together to meet the different needs of patients and eliminate the gaps between services. This role should not duplicate aspects of the offer from IAPT but will help build capacity within local systems to respond to mental health needs that cannot be served by IAPT.

**It has been suggested that providers don't need to employ new people but can use those in current roles, so that whilst these will be 'additional' from a PCN perspective they will not have to be additional necessarily to the provider? This appears to contradict my reading at least of standard contract consultation which states all roles must be additional posts and CCGs will need to fund these?**

The roles need to be ‘additional’ to those mental health practitioner roles, employed by secondary mental health providers, working as part of the PCN core MDT or in general practice as at 31 January 2021.

**Is the match funding the part that can then be reimbursed through the ARRS?**

Yes.

**How much thinking has been gone into this being a similar offer for CYP? CAMHS operates very differently**

The CYP role is entirely optional for both PCNs and providers of secondary care community mental health services for CYP. The nature of the role is more flexible and can be agreed between local partners, if they both agree that they wish to pursue such an arrangement.

**GP space is at a premium. Would the requirement be physical co-location?**

The key is that the practitioner should be embedded as part of the PCN core MDT. This does not necessarily equate to physical co-location.