BNSSG Training Hub

Toolkit for Embedding Mental Health Practitioners (MHPs) in Primary Care

Content compiled by

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This toolkit is intended to support GP practices who wish to employ a **Mental Health Practitioner** (**MHP**) either independently or through the **Additional Roles Reimbursement Scheme** (**ARRS**), as a 'jointly funded ARRS Role'. It has been developed in collaboration with MHPs already embedded in general practice and **Avon** & **Wiltshire Mental Health Partnership** (**AWP**). It is not a mandatory tool, but it provides recommendations to support the embedding process, as well as considerations for clinics and supervision arrangements.

Please note: some points within this document are highlighted as being in relation to the **jointly funded ARRS role** and have therefore been established and / or recommended by AWP.

For **further details** on the **Mental Health Practitioner** ARRS roles, for a copy of the standard operating procedure (SOP), or to discuss alternative ways of working, **please contact**:

- **Laura Starr** for Bristol | **laura.starr2@nhs.net**
- **Jayne Stride** for North Somerset & South Gloucestershire | **jayne.stride@nhs.net**

Differences between

Jointly Funded ARRS MHPs & **Independently Employed** MHPs (**IEMHPs**):

Jointly Funded ARRS MHPs…

- Are employed collaboratively between PCN(s) and AWP
- Can be RMNs / Social Workers / OTs

- No formal referral needed from GPs
- Only exclusion criteria – under 18s and dementia
- Initial appointment (support conversation) with up to 3 follow-up appointments offered as required
- Provide brief interventions if appropriate
- Advice and liaison function with support and links throughout AWP
- Supporting the wider MDT within the PCN
- Understanding of integration work, and links with CMHF developments
- Integral part of IPCT / IMHTs
- Ability to “warm transfer” directly to community teams (Recovery/Crisis/Early Intervention) without need for repeated assessments
- Access to RIO
- Supervision provided by AWP to ensure practitioners are supported
- Team structures in place to link in with peers; reducing isolation and increased support / overall sustainability of these roles

Independently Employed MHPs (**IEMHPs**)…

- Employed directly through practice
- Tend to be RMNs or Non-Medical Nurse Prescribers
- Exclusion criteria dependent on practitioners' knowledge and skills and practice individual need - to be agreed between MHP and the practice
- Patients can access through usual pathways for accessing appointments
- Triage and assessment of patients, with follow up according to individual patient need
- Prescribing and reviewing medication if appropriately qualified and indicated
- Liaison and referrals to other services as required
- Supporting the wider MDT
- Support with QoF – SMI, depression

Considerations for MHPs:
(**N.B.**: this may require further discussion with AWP if employing through ARRS)

- It is recommended that MHP's have significant post-qualifying experience working within mental health prior to working in primary care. A review of available job descriptions recommends between 2-5 years' experience due to the level of autonomy associate with this role.

- When employing collaboratively with AWP, on-boarding is done in partnership, to ensure expectations about the roles are agreed from the outset. This work is vital, as we acknowledge the differences between primary and secondary care. This process also recognises the importance of integration and partnership, whilst utilising mental health practitioners effectively – in an outcome focused way.

- Practitioners in this role see a high turnover/number of patients daily so please consider how to make this role sustainable in the long term for full-time MHP's. Feedback from MHP's on this include making a day for an area of special interest/therapy work (if appropriately qualified), QoF, having set clinics for particular presentations e.g. ADHD / ASD queries.

- Consider length of appointments to aid sustainability & retention – please see below for further recommendations.

- Try to avoid having MHP's working across too many surgeries – This can impact on integration with colleagues/wider team and ability to follow up patients. This can lead to difficulties with sustainability and retention.

Induction Recommendations

General:

- **For jointly funded MHPs:**

  There is a clear induction process in place between PCN(s) and AWP – 1-week induction with AWP (introduction to secondary care teams, RIO / system training, locality & team induction,

stat / man training), then 2-week induction with the PCN (allocation of GP Mentor, EMIS training, induction & orientation to PCN, stat / man training, laptop collection and IT set up).

- **For both jointly funded MHPs and IEMHPs:**
  Orientation to practice – access codes, layout of surgery, where to find things (e.g., stationary, etc.)

- Access to all relevant IT systems and suitably trained up – Remedy, EMIS, Docman, Accurx, etc.
- Awareness of protocols and policies within the practice, including risk management and safeguarding.

- **For practitioners who are not prescribers:**
  Having a clear process in case of patients who want to access medication.

- Having a clear plan for the role, including available appointment types and who can book in. It would be helpful to disseminate this information to the team ahead of the MHP starting and to arrange for the MHP to meet with wider team to discuss this. *It may be helpful to hold meetings to review this and alter according to practice / MHP need.*

  (**For jointly funded MHPs**, this would be clarified prior to start date, alongside AWP, and reviewed on a regular basis recognising the need to tweak things collaboratively.)

- Complete stat / man training.
- QoF training – SMI, depression.
- Link in with local services in the area that are available to refer to (e.g., CMHT, IAPT, VSCE services).
- Having clear expectations between employee / employer / ARRS management.

Supervision & Support:

- **For jointly funded MHPs:**
  AWP provide full management & clinical supervision and hold a monthly team meeting.

AWP also offer 2x weekly lunchtime check-ins with other jointly funded MHPs. The PCN are recommended to identify a GP Mentor also for daily support.

- **For jointly funded MHPs:**
  AWP & PCNs will hold regular reviews of the role to support communication and integration, and tweak role set-up as required.

- **For IEMHPs:**
  Clinical supervision through a GP (a mental health lead is ideal) / Senior RMN / Nurse Manager – frequency to be agreed between supervisor and MHP. Management supervision to be arranged with Line Manager.

- **For both jointly funded MHPs and IEMHPs:**
  - Peer Support Network identified and allowed time to attend.
  - Identify Link Psychiatrist within local CMHT.
  - Identify leads within surgery (e.g., Safeguarding, Mental Health)
  - Awareness of meetings within surgery (e.g., significant events, link meetings with psychiatrist(s)).
  - Clear plan of how and who to access support from on the day if difficulties / urgent matters arise in clinic.

Clinics:

- **For jointly funded MHPs -** recommended for initial appointments to be 30 - 40 minutes, then 20 - 30 minutes for follow-up appointments.

- **For IEMHPs -** to be agreed between MHP and practice. Recommendation of minimum 30 minutes for urgent / initial assessment / routine appointments. Recommended that meds / non-meds review(s) be minimum 10 - 15mins, accordingly.

- **For both jointly funded MHPs and IEMHPs:**
  Set clinics up with a variety of appointment types – face-to-face / video call / telephone and urgent / routine / follow-up for medication / non-medication.
  - Longer appointment times are advised if practices would like MHPs to provide more structured interventions within appointments.
  - Consider separate clinics for ADHD /SMI / urgent - should be set up in collaboration with individual practitioners.
  - Daily admin time – for referrals, letters, fit notes, repeat prescription requests.
  - Discussions with colleagues (internal / external), reviewing notes, docman.
  - Breaks built into clinics.
  - Encourage “open door policy” between patients.
  - Allow time for new practitioners to embed into new way of working (e.g., appointments blocked off to allow time to adjust to shorter appointments).
  - See **pages 6 & 7** for example clinic templates.

Induction Recommendations:

- 2 weeks' shadowing, general working of surgery, training with systems, as well as shadowing other practitioners within surgery (unless otherwise agreed with AWP in the case of **jointly funded** MHPs).
    - If possible, arrange for worker to spend a day shadowing a mental health practitioner already in post.
    - Allow time to meet with local MH teams to forge relationships and links, including knowing how to access A&G link consultant.
    - Following induction – start own clinics with blocked slots to allow time to embed to a different way of working.
    - See example morning clinic templates below for **IEMHPs** and **jointly funded** MHPs respectively.

Example clinics for Mental Health Practitioners (MHPs)

Example clinic for **IEMHPs** to support **embedding process:**

Prescribers			MHPs	
09.00AM	ROUTINE		09.00AM	ROUTINE
09.30AM	BLOCKED		09.30AM	BLOCKED
10.00AM	SAME DAY APP		10.00AM	SAME DAY APP
10.30AM	BLOCKED		10.30AM	BLOCKED
11.00AM	break		11.00AM	break
11.10AM	MH MEDS REVIEW		11.10AM	MH REVIEW NO MEDS
11.20AM	BLOCKED		11.25AM	BLOCKED
11.30AM	7D SSRI REVIEW		11.40AM	MH REVIEW NO MEDS
11.40AM	BLOCKED		12.00PM	admin
11.50AM	7D SSRI REVIEW		01.00PM	lunch
12.00PM	admin			
01.00PM	lunch			

Example clinic for **IEMHPs** once **embedded:**

Prescribers			MHPs	
09.00AM	ROUTINE		09.00AM	ROUTINE
09.30AM	ROUTINE		09.30AM	ROUTINE
10.00AM	SAME DAY APP		10.00AM	SAME DAY APP
10.30AM	SAME DAY APP		10.30AM	SAME DAY APP
11.00AM	break		11.00AM	break
11.10AM	MH MED/7D		11.10AM	MH REVIEW NO MEDS

11.20AM	MH MED/7D		11.25AM	MH REVIEW NO MEDS
11.30AM	MH MED/7D		11.40AM	MH REVIEW NO MEDS
11.40AM	MH MED/7D		12.00PM	admin
11.50AM	MH MED/7D		01.00PM	lunch
12.00PM	admin			
01.00PM	lunch			

KEY	
SAME DAY APP	For urgent same day mental health presentations (e.g., worsening mental health / increasing risk).
ROUTINE	For non-urgent presentations (e.g., general follow-up / ongoing assessment / complex patients, or for GPs to book into if they feel further assessment is required).
MH MED / 7D SSRI	Mental health meds review **or** 7d SSRI review for under 30's - dependent on surgery need.
MH REVIEW NO MEDS	For mental health reviews of patients known to them – only to be booked by MHP.
N.B.: these are example options of appointment types, not an exhaustive list. As previously mentioned, if you want practitioners to provide psychological intervention or other interventions, please amend accordingly.	

Example clinic for **jointly funded** MHPs**:**

09.00AM	Admin
09.10AM	Mental Health Initial Appointment
09.40AM	Admin
09.50AM	Mental Health Initial Appointment
10.20AM	Admin
10.30AM	Mental Health Initial Appointment
11.00AM	Admin
11.10AM	Mental Health Initial Appointment
11.40AM	Admin
11.50AM	MH Nurse Use Only