Mental Health Practitioner webinar 24 March 2021

Questions and answers

Webinar Link

Speakers

- **Robert Kettell**, Deputy Director, Primary Care Networks, NHS England and NHS Improvement
- **Dr Omotayo Kufeji**, Clinical Director, The Bridge PCN MK & Board Member, PCN Network
- **Gemma Bow**, Lead for Local Primary Care Mental Health Services, Central and North West London NHS Foundation Trust
- **Lesley Halford**, Service Director, Mental Health, Milton Keynes, Central and North West London NHS Foundation Trust

Where the provider trust has a different IT system from primary care, which should be used?

Any system can be used but having joint IT systems is definitely a plus. If this is not possible, then the key is to be able to share information quickly with each other. So if on different systems, try sharing information quickly if there has been a change in the treatment plan e.g send an initial notification of the change to the GP asap before a formal letter is typed and posted.
PCN

Could you please expand on the pathway from GP to MHP to CMHT. Are MHPs providing interventions or is it like a triage system?

The GP does a referral into the primary care plus service using an online form which is embedded in the GP system. This is triaged by the single point of access and then assigned to the Primary Care Plus worker, who is based in the practice, if appropriate, or to another mental health service if that is more suitable for the patient. relevant team within the mental health trust. The MHPs that are based in primary care do offer interventions and treatments, as well as triage.
PCN

We have heard from early implementers that retention has been problematic for Band 6 staff recruited to these sort of posts and the paperwork burden is significant as need to be trained in e.g. IAPT paperwork and secondary care paperwork. Any quick and smart solutions?

We have not experienced this difficulty – in the four years we have been functioning we have had four staff leave. Two for promotion, one retired and one for a career break. The paperwork burden may seem high, but progress is being made with data-sharing. Also, we always review and consider alternative ways of working.The shared IT system is probably the best solution to this as it removes the need for repetition of documentation.
Mental Health Trust

Can you expand on shared IT systems, is this sharing access to systems across primary care and the MH Trust and vice versa? and have you found a good solution around shared appointment books across practices?

In our system, all GP practices as well as the Mental Health Trust are all on System one. They are separate units but they ‘share’ information to each other so that the notes can be seen by either organisation. We currently don’t have shared appointment books but the MHPs based in practice run their clinics within the practice and can then input directly onto the IT system at the practice. System one has been excellent from this point of view, as it allows all parties to see the records that are documented. All Local Health and Care Records (LHCR) are moving towards working like this, but it will depend on the maturity of the LHCR.
PCN

Some areas are working to 40+ PCNs – any advice on working to embedding across a large geography?

This is a very large geography. Is it possible to manage them in groups/cohorts? Perhaps 10-20 PCNs together? The key thing in our patch was the Mental Health Trust explained to all the PCNs what banding they recommended and why they were recommending it and also how it would fit into the overall mental health structure. This helped PCNs understand the rationale. This may not work everywhere but dialogue is key. It is also important to understand that a one-size-fits-all approach does not always work with PCNs as they are so diverse. As a MH trust, you may need to be flexible enough to manage some MH practitioners at different bands across the different PCNs.
PCN

The importance of corridor conversations was raised. Is daily support/de-brief with the GP built into contract for when MH practitioners are working in a surgery?

The MH practitioners in practice are autonomous practitioners, so there is no daily debrief or supervision with the GPs. However, because they work within the practices, we have found that we can discuss cases over a cup of coffee in the staff room and chat about treatments offered or further treatment plans etc. The MHPs also attend the practice clinical meetings on a monthly basis.
PCN

Providers are being asked to manage these staff – we have 14 PCNs who all want something different which makes this unmanageable – what solutions have been thought of in respect of this?

The PCNs will decide how best the MHPs can serve their population and work within their teams and this could be different in each PCN as each may have different demographic needs. But from a MH trust point of view, the Trust is responsible for the HR, employment contracts, appraisals etc. Surely this is the same for all the MHPs regardless of how the PCNs are using them? The PCNs should be responsible for day-to-day clinical supervision, deciding their workplan etc. So they are employed by the MH Trust but the day to day work is decided by the PCNs.
PCN

Our local mental health trust has been in special measures for a number of years. Poor reputation and difficulty recruiting staff as a result. GP federation is keen to be involved and hold employment contracts. Is there any room for flexibility?

Is there a joint approach that can be implemented here with the Fed and the MH trust working together? A win-win! The trust would still have to fund the 50% of the staff but they could subcontract all the management functions to the Federation. If this is not possible, then I would suggest approach the CCG or NHS regional team to see if they would be able to broker an alternative arrangement but not sure if this is possible.
PCN

What support is available to improve relationships between CMHTs and PCNs? There are real concerns that some CMHTs are unclear how best to support PCNs which would cause a delay in the MHPs being employed.

Communication is key. As a MH Trust, approach your PCN lead and offer to chat with clinical directors at their next meeting. Ask what they think they need for the MHP role and offer to work with some of them to develop the role. As a PCN CD, approach your MH Trust lead and ask what their thoughts are regarding the role and offer to work with them to develop the role further. CCG MH leads or neutral parties such as GP federation leads or LMC leads can help with facilitating these discussions if the relationship has not been good in the past.

PCN

Social workers were not in the list of roles in the guidance. Is the ARRS scheme able to cover a MH social worker?

Yes, any role that is suitable can be employed into this role. The list of roles in the guidance were examples and not an exhaustive list.

PCN