Unity Insights

Review of the Mental Health Practitioner role in Kent & Medway

Summary report

January 2024

Working in collaboration with

Health Innovation
Kent Surrey Sussex

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NHS

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Executive summary

Context

The Mental Health Practitioner (MHP) role, a patient-facing primary care mental health specialist, has been implemented across primary care in the NHS through the Additional Roles Reimbursement Scheme (ARRS) and ICB funding since April 2021.

After two years of the funding being made available, Unity Insights were commissioned by Health Innovation Kent Surrey Sussex (HIKSS) to support with an evaluation and analysis into the impact of MHPs and their implementation into primary care.

Methods

The analysis approach was mixed methods, combining surveys and interviews with quantitative and health economic analysis.

Surveys and interviews were the primary data collection method for the analysis. Results were quantitatively analysed and themed.

Limited activity data was available due to poor coding and recording of MHP activity in routine datasets. Whitstable PCN was able to provide more detailed information and served as a key sample for the quantitative analysis.

A health economic analysis was performed, comparing MHP appointment times with GP appointment times, to demonstrate whether the MHP role is likely to produce a positive return on investment (ROI) overall. The analysis is not a complete estimate of the ROI, as a number of benefits and costs were unable to be modelled due to gaps in data.

Key results

Impact

Implementation of MHPs at scale in Kent & Medway was successful, with excellent feedback received from patients, GPs and MHPs themselves. KMPT, alongside PCNs, was able to successfully recruit at scale and ensure retention of a large majority of MHPs.

Patients saw MHPs as practitioners who respect, value, and genuinely care for them, while giving them the support they need to overcome their difficulties. GPs noted that MHPs, in general, had integrated well and were having positive impacts on their patients and on GP workloads. MHPs themselves were generally positive about the impact they have on their patients.

Nonetheless, samples of variation with opportunities for improvement were also observed, notably arriving from variations in management practices and working relationships between MHPs and PCNs.

The health economic analysis indicated that the MHP role is likely to be resource efficient and generate a positive ROI, but a full analysis could not be completed due to data gaps.

Workforce

Kent & Medway held a successful recruitment process and implemented a number of measures to ease MHPs into the role and support their ongoing success – as evidenced by the impact analysis.

Kent & Medway supported their MHP workforce through a dedicated central function in KMPT. Evidence indicated that activities carried out by this function were key to ensure a smooth and well-received recruitment process, minimise variation in MHP experiences, and support MHPs and PCNs to integrate and work together successfully.

The onboarding process was seen as an important factor in the successful implementation of MHPs. More experienced staff members moving into the MHP role from prior mental health roles found it easier to integrate, build trust and deliver in the role from an early stage.

Further work can be done to improve the links between MHPs and the wider system, notably secondary care.

Recommendations

Generalised recommendations were developed based on learnings from Kent & Medway, to be considered on a wider basis.

Maximising impact

- The MHP roles are effective, and likely to be resource efficient, and so activities to recruit and retain these roles should continue to receive investment of resources.
- Workforce satisfaction and management are key enablers for maximising impact, such that priority should be placed on attaining and maintaining high levels of both.
- Standard operating procedures, robust processes and means to gather and share learnings on a wider basis are key to minimise cases where greater barriers or worse outcomes are identified.

MHP workforce

- A centralised management function, operating on a system-wide basis, is a key enabler for much of the success observed in Kent & Medway. This function should be able to develop and implement guidance, support MHPs and PCNs to work together cohesively, and support with general recruitment and onboarding.
- MHPs should be integrated more into the wider system, particularly as part of wider system strategies, but also with links to secondary care and other providers.
- Support and guidance should be made available to support all MHPs and PCNs to implement best practice and avoid unwarranted variation.
- Clarity and opportunities for career progression should be further developed and communicated.

1. Introduction

The Additional Roles Reimbursement Scheme (ARRS) was created by NHS England to fund 26,000 additional roles and build bespoke multi-disciplinary teams within Primary Care Networks (PCNs) across England. The scheme was launched in One of the many new additional roles introduced by the scheme were Mental Health Practitioners (MHPs) who can address the biopsychosocial needs of patients with mental health problems.

Through collaboration with a multidisciplinary team, MHPs operate in PCNs and serve as a conduit between primary care and specialised mental health service providers. MHPs provide assessments and appointments for patients with more complex or severe needs in a primary care setting. This fosters a deeper integration between primary care and mental health services, leading to expedited access to specialised mental health support for patients. Consequently, this mitigates the requirement for unnecessary general practitioner (GP) consultations or referrals to secondary care, thereby augmenting the overall patient experience.

To maximise the success of the role, there are naturally concerns about workforce satisfaction and sustainability. When working as a singular MHP within a PCN, the likelihood of being overwhelmed and feeling unsupported in their role was increased, thereby increasing the chance of the practitioner experiencing burnout. Such a scenario could significantly diminish the MHPs job satisfaction, retention rates, and recruitment prospects. Furthermore, the role may be perceived as a "downward transition" from specialised services, which could negatively influence recruitment and retention. It is imperative that GP practices collaborate effectively to provide adequate support to the MHP. Failure to do so may have adverse repercussions on job satisfaction, retention rates, and the overall patient experience.

Kent and Medway NHS and Social Care Partnership Trust (KMPT) have been recruiting and implementing MHPs across four localities since the introduction of the role into the ARRS scheme in April 2021. As of September 2022, there were 31 MHPs across KMPT, with some PCNs recruiting a second MHP. To-date, however, little evidence has been made available to demonstrate the impact of the MHP role and to examine the sustainability of the role given wider NHS workforce pressures.

Unity Insights have been commissioned by Health Innovation KSS to support Kent & Medway ICB and KMPT to understand the impact of the ARRS MHPs and review factors affecting recruitment and retention of the workforce. This report uses mixed methods, including qualitative and quantitative techniques, to address both aims. From the insights gained, key recommendations have been developed that should collate learning from Kent & Medway and inform quality improvement activity, enabling the MHP role to be more effective and to reduce risks to workforce sustainability. These should also help future ARRS MHP implementation sites to progress at a faster rate and eventually achieve a more successful and fully integrated implementation of the role within their PCN.

2. Methodology

2.1. Approach

The analysis had two purposes:

1. To provide an assessment of the impact of the MHP role, considering primary care perspectives and health economic outlooks.
2. To conduct a review of the recruitment and retention of MHPs in Kent & Medway, to collate key learnings and improvement opportunities.

Aims 1 and 2 were delivered through a mixed-methods analysis, incorporating qualitative analysis of surveys and interviews, as well as quantitative analysis of available mental health indicators and the construction of a health economic model. The data and information for the analysis was primarily drawn from Kent & Medway, with an aim to produce generalised findings to support learning and improvement on the topics of MHP recruitment, integration, and practice in Kent & Medway and elsewhere in England.

2.2. Data collection and analysis

Qualitative data

Surveys

Patient feedback was supplied by Newton Place Surgery in the Mid Kent PCN in the form of a mental health practitioner patient satisfaction survey. 19 patients filled out this survey. Additionally, a series of twelve quotes from patients on their experience with the MHP from Whitstable PCN were supplied.

Staff feedback was supplied in an NHS survey with responses from GPs, Practice Managers and PCN Managers on their experience of the Additional Roles Reimbursement Scheme (ARRS) Mental Health Practitioners. This survey was completed by 30 staff members from within the Kent and Medway area between December 2022 to February 2023.

Additionally, a summary of feedback on the recruitment process was provided based on a survey of approximately 30 MHPs, all of whom were successful applicants, conducted by KMPT.

Interviews

Semi-structured interviews were conducted by Unity Insights with three MHPs from Kent and Medway as well as with management staff. These were conducted over Microsoft Teams in September 2023. The interviews focused on the topics of MHPs' perceptions of their role, their

levels of satisfaction, the recruiting process, and career planning. Follow-up questions were asked throughout each interview to further understand the factors that had led respondents to provide their initial responses or to form their opinion.

Participants gave consent for their interviews to be recorded and transcribed for analysis purposes.

Quantitative data

Activity data

The first data set analysed looked at the CMHT referrals from PCNs with and without MHPs within Kent and Medway ICB. The data was provided by KMPT. The data was recorded from April 2021 to January 2023 and provided to Unity insights in March 2023. This data allows investigation into a comparison between mental health referrals in PCNs with an MHP and how they differed from PCNs without one.

The second data set used was provided by Whitstable PCN which included details from each patient seen by an MHP, including presenting problem, appointment length, number of times seen to date, and patient outcome. This data set had information from 23rd November 2021 to 1st March 2023. This was analysed to look at the effect on GP time, repeated presenting problems, and outcomes.

The last data sets used were obtained online through NHS Digital, including the IAPT dataset and Mental Health Services dataset from Kent and Medway from August 2021 to January 2023. These datasets were analysed to look at trends over time and to see what proportion of GP referrals resulted in referrals being sent back to the GP from IAPT.

Health economic analysis

A rudimentary health economic analysis was conducted to consider the return on investment (ROI) of the MHP role. Given the gaps in available evidence for the effectiveness of the MHP role in the literature, the purpose of this analysis is not to provide a final estimate of the ROI but to indicate whether it is likely to be positive or negative.

The analysis was based on the time savings and costs associated with introducing MHPs into primary care, comparing the cost of MHP-related care against the reduction in burden of mental health related appointments on GPs. The estimated annual capacity of all MHPs in Kent was used to support the analysis.

Data on patient outcomes and wider impacts on the health and social care system was not available and not incorporated into the analysis, nor have any of the implementation costs associated with introducing MHPs into PCNs. The focus is on the trade-off in appointment cost for each type of practitioner.

Scenario modelling

Two scenarios were modelled, with the only difference between each being the length of time assumed per MHP appointment:

1. Scenario 1: MHP appointments take 55.9 minutes each.
2. Scenario 2: MHP appointments take 30 minutes each.

In both scenarios the number of MHPs in Kent & Medway is taken to be 26, as per data provided by KMPT. The annual capacity for an MHP (2,243 appointments per year) was derived from data on MHP appointment lengths provided by Whitstable PCN and is constant across both scenarios. Likewise, the average hourly cost of an MHP was taken to be £42.00. i.e., the hourly cost of a band 5 community-based scientific and professional staff member as per Jones et al. (2022). Finally, the cost of an average GP appointment of 9.22 minutes was taken directly from Jones et al. (2022).

Benefit stream 1: GP Time Saved

The calculation for the amount of GP time saved is displayed in Figure 1. It begins with the number of MHPs in Kent & Medway (26) multiplied by the number of appointments per MHP per year (2,243), to give an estimate of the total number of MHP appointments in Kent & Medway per year (58,318). This is then multiplied by the average cost of each GP appointment (£42.00). The assumption made was that each MHP appointment implies one GP appointment avoided.

If MHPs see each patient more than once, this assumption is only valid in so far as GPs would see the patient just as many times as an MHP would. This is an important limitation of this approach, as the number of appointments a patient may see a GP or MHP may differ based on their clinical needs, the outcome of each appointment, and the discretion of the practitioners in question.

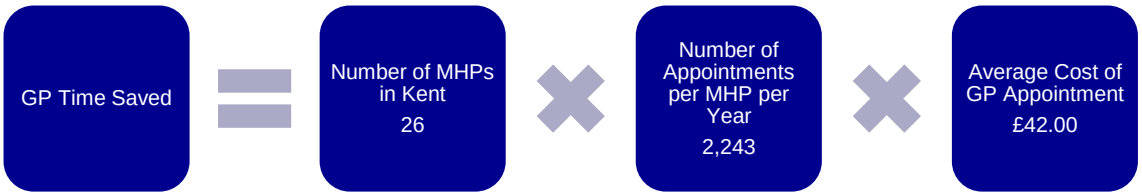

Figure 1: Calculations for GP Time Saved benefit stream.

Cost calculations

The only cost stream modelled for the purposes of this analysis was the MHP time cost required for MHPs to conduct appointments. No recruitment, set-up, training, or other costs were included as part of the model.

Cost stream 1: MHP Time Cost

The MHP time cost calculation was constructed in a very similar way to the GP time saved benefit stream. First, the number of MHP appointments in Kent & Medway each year was calculated by multiplying the number of MHPs in Kent & Medway (26) by the number of appointments per MHP per year (2,243).

Second, the average cost of an MHP appointment was calculated by multiplying the average MHP appointment length of 55.9 minutes (0.932 hours) by the average MHP employment cost per hour (£42.00). Finally, the total cost was therefore calculated by multiplying the estimate of the number of MHP appointments per year in Kent & Medway (58,318) by the average cost of an MHP appointment (£39.13). The full calculation for the MHP time cost stream is displayed in Figure 2.

Figure 2: Calculations for MHP Time Cost stream.

Importantly, in Scenario 2, the average MHP appointment length is assumed to be 30 minutes, or 0.5 hours, implying a significantly lower cost per MHP appointment (£21.00).

Assumptions

All the assumptions used in the health economic analysis are presented in Table 1 below, alongside their sources.

Table 1: Health economic analysis assumptions.

Variable	Value	Source
GP Cost per Appointment	**£42.00**	(Jones et al., 2022)
MHP Annual Capacity (appointments/year)	**2,243**	Whitstable MHP Data
MHP Appointment Length (minutes)	**55.9**	Whitstable MHP Data
MHP Appointment Length (minutes) S2	**30.0**	Assumed
MHP Cost per Appointment (55.9 min)	**£39.13**	Calculated
MHP Cost per Appointment (30 min)	**£21.00**	Calculated
MHP Cost per Hour	**£42.00**	(Jones et al., 2022)
Number of MHPs in Kent & Medway	**26**	PCN Referral Data

3. Results

3.1. Qualitative

Thematic analysis

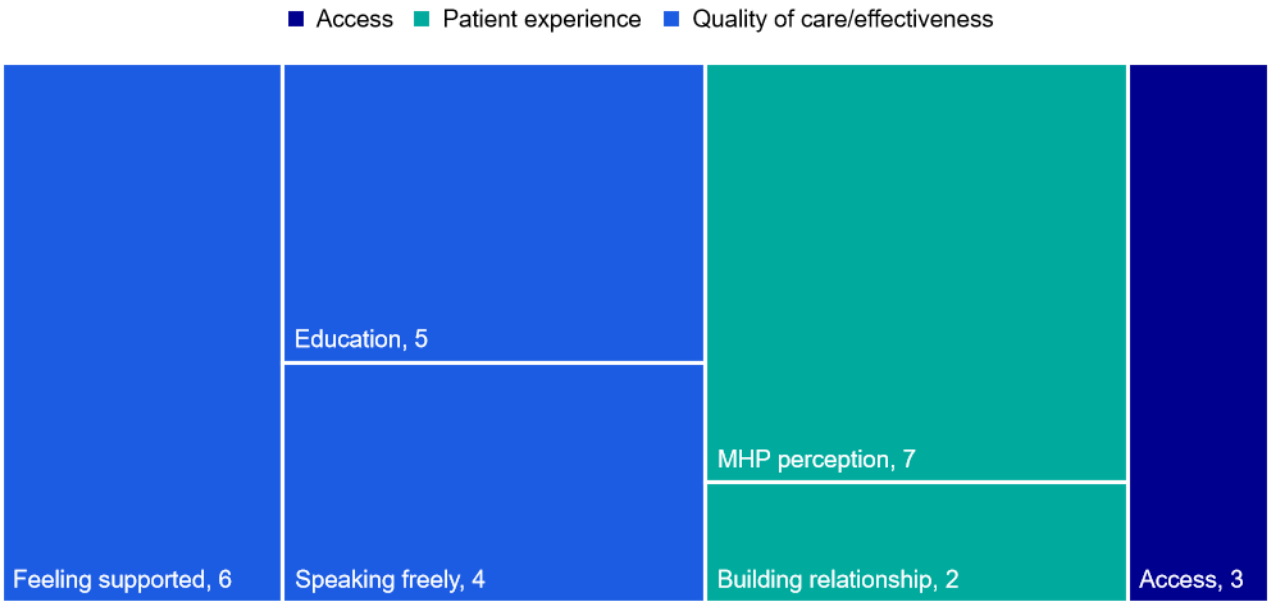

Figure 3. A tree map graph showing the overalls themes and their respective subthemes observed in the patient surveys.

Figure 3 shows the breakdown of themes observed in the patient feedback survey and Whitstable patient quotes by frequency, Quality of care/effectiveness was the most commonly observed them (15 occurrences), followed by patient experience (9 occurrences), and finally access to care (3 occurrences).

Access to care

Access to care is essential to achieve overall wellness by allowing patients to seek appropriate medical care when needed. If not provided, safety concerns can arise posing a risk to patients. One of those risks includes a patient's inability to access care at an appropriate time. Accessibility was a common theme that emerged in both patient and staff qualitative data.

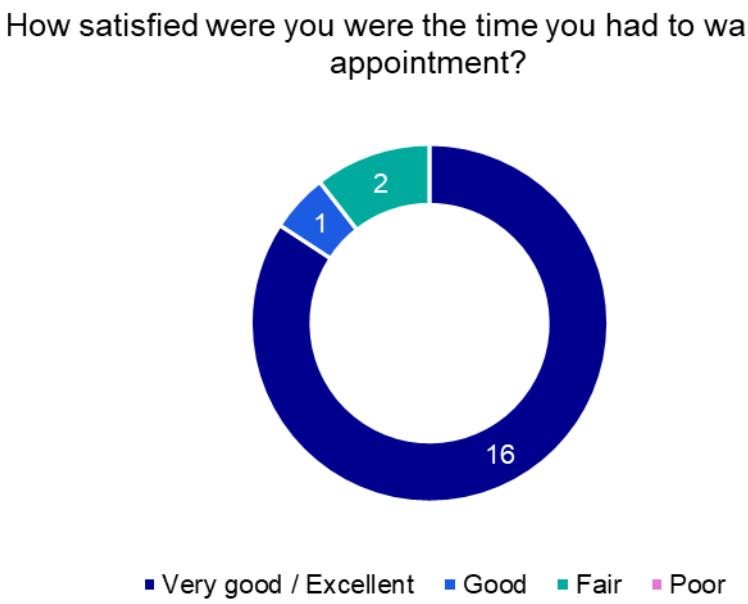

Figure 4. A doughnut chart to show the level of patient satisfaction with having to wait for an appointment.

Figure 4 highlights results from the patient survey, and shows that patients were satisfied with their waiting time for an MHP appointment with nearly 90% (n = 19) of respondents answering 'good' or 'very good / excellent'. No respondents had negative feedback for the time they had to wait for an appointment.

In addition to waiting times, several patients commented on the convenience of the service. One patient stated that they were *"impressed with the quickness"* of the service, whilst another expressed it was *"easy to make an appointment".* The ARRS MHP role was even seen favourably by some respondents when compared to appointments with GPs.

> *"I have been waiting a long time for some good advice about my condition and David in 15 minutes was able to help more than GPs over several years."*

Accessibility was also touched upon from a staff perspective in the Gather GP survey, as seen in Figure 5. As displayed, staff perspectives on accessibility aligned with those of patients, with over 80% of Gather GP survey respondents deeming access to an MHP as 'easy' or 'very easy'. No staff members thought MHPs were 'difficult' or 'very difficult' to access.

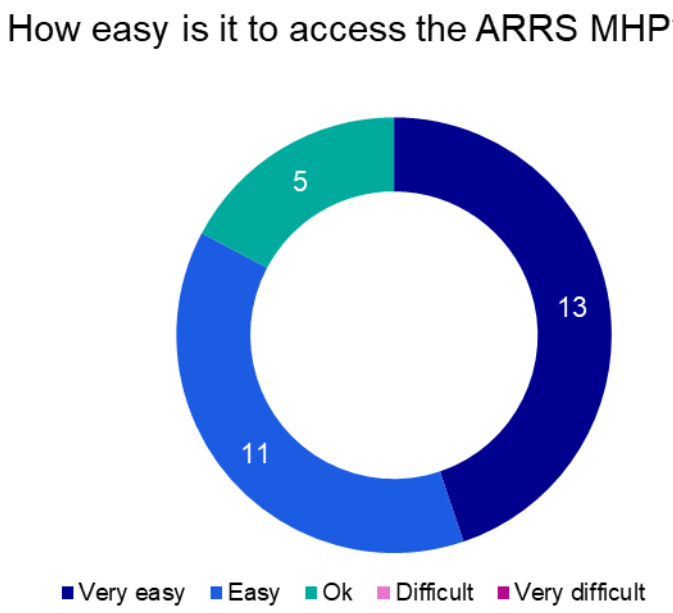

Figure 5. Staff perspectives on accessibility of MHPs.

Patient experience

MHP perception

Some patients commented on how they felt during their MHP appointment which related to their impression of the MHP and influenced by the practitioner's attitude, behaviour and the environment that they had created.

Survey respondents from Whitstable were unanimously positive feedback in relation to how patients felt during their appointment. All respondents felt they were treated with courtesy and respect, and all respondents felt able to freely ask questions and discuss their treatment during the appointment.

These results were reflected in patient quotes, with patients describing their MHP using positive terms such as *"kind", "non-judgemental", "thoughtful", "calming*" and *"helpful".*

"I feel you are genuine and sincere in your wish to assist me."

"I always like coming to talk to you because I find you so calming."

Building relationships with MHPs

Implementation of the ARRS role is expected to redirect mental health patients to MHPs rather than GPs. Given the workload pressures on GPs, it is expected that the introduction of MHPs will allow for mental health patients to have longer appointments than they would otherwise with a GP, therefore building a closer relationship with patients.

100% of patients (n = 19) who responded to the survey felt *"very good / excellent"* about the duration of their appointment with their MHP. One service user described the MHP as *"consistent"* whilst another patient stated they *"…had lots of time to chat".*

The increased time spent with patients was also corroborated from staff perspectives, who expressed that MHPs were able to spend longer with their patients:

"[They] spent a long time with [their] patients…"

"With the [MHP] they have had time to build a long-term relationship which has been very beneficial".

Quality of care

MHPs have a range of functions spanning the consultation, advice, triage, and liaison domains. More specifically, this includes providing support to patients through encouraging conversations around their goals and wishes, signposting to appropriate care channels, as well as providing direct emotional support.

Several patients expressed their MHP was successful at completing their intended roles, making effectiveness of MHPs being the most frequent theme emerging across patient feedback at a total of 15 times.

Speaking freely

Given the nature and sensitivity of mental ill health, it is important for patients to feel they are not being judged or stigmatised and are comfortable enough to be able to speak freely to their MHP during appointments about their thoughts and feelings. Leading to the establishment of a better therapeutic alliance with improved outcomes and experience.

In the patient survey, when asked whether they felt able to ask questions and discuss treatment freely, all respondents (n = 19) reported that they felt *"very good / excellent"* about this. Moreover, across free text responses, speaking freely emerged a total of six times across the patient feedback.

"You help me to speak out loud about things".

"You always help me to explore my thoughts and feelings. I enjoy talking to you".

"I felt very comfortable to open up and felt free to be honest without judgement."

Feeling supported

Numerous patients also highlighted in their comments that they felt supported by the MHP and that they had been helped in some cases to prevent a deterioration of symptoms:

"Without you I would have had a breakdown'".

'…thanks for sticking with me'.

'You are an anchor for me'.

'You help me to avoid falling off the path'.

'You help me in terms of taking the right steps.'

This was also reflected in staff feedback, describing one MHP as having *"always looked for new ways to help them [patients]".*

Education

In addition to feeling supported, patients commented on the ability of their MHP to educate them about their mental ill health – supporting patients in understanding and managing their mental health and improving their emotional wellbeing. Several patients referred to self-acceptance since speaking with their MHP.

"You help me make sense of things".

"…walked out feeling better with tips to think about to help me feel calm".

'I now realise through talking with you that I need to look after myself more, and that no one looks after me. I now realise I need to accept my own trauma'.

'You have helped me to further cope with what makes me ill and brings me down. I now feel I have new reserves of energy to overcome obstacles. You have been consistent with me. You have given me the energy to try to help myself'.

This was also commented on by staff, describing their MHPs ability to provide *"patients with support and guidance".*

Staff and System Impacts

Managing workload

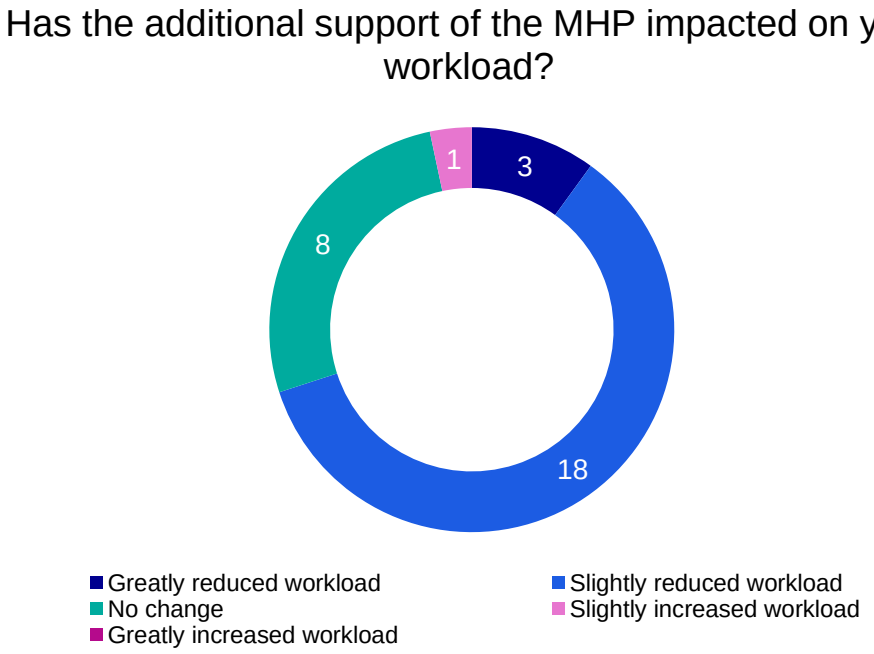

Figure 6. a doughnut chart to show staff perspective on the impact of MHPs on their workload.

Implementation of this ARRS role is expected to direct patients representing with poor mental health patients to MHPs and away from GPs, easing workloads and supporting the management workload capacity. Results from a staff perspective exploring the impact of MHPs on workload can be seen in Figure 6.

Of the 30 Gather GP survey respondents, 21 (70%) felt that their workload had reduced, with 18 (60%) responding that MHPs had 'slightly reduced' their workload whilst a further three (10%) felt their workload had 'greatly reduced'. Eight staff members however, experienced no change in their workload, while one staff member felt that their workload had slightly increased.

When asked if staff had any other comments about their experience of the ARRS MHP role, a couple of staff members touched specifically upon the MHP "*impacting on surgery workload"* and the expectation surrounding this in response to increasing demand:

> *"It is early days and our ARRS MHP has had some time off, so development is slower than expected. However, our referrals are increasing quickly and that will have very positive effects over the coming months including reducing GP workloads to a greater extent".*

Integration

To successfully meet the needs of patients and manage practice workloads, it is crucial for MHPs to integrate effectively into primary care teams.

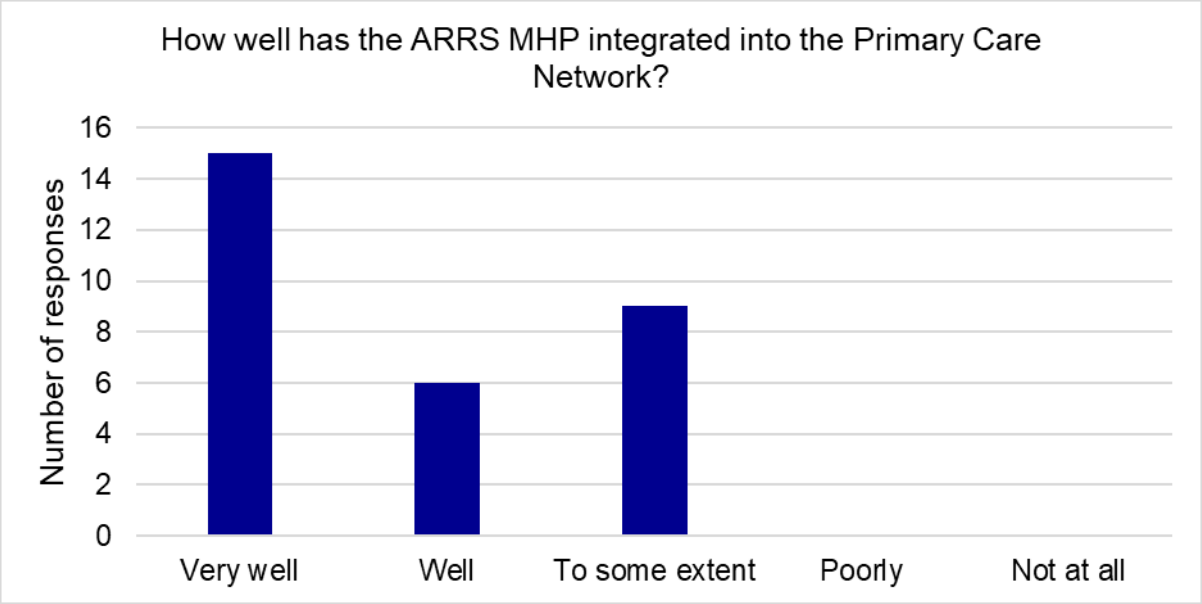

Figure 7. a bar chart to understand staff perspective on how well the MHP integrated into the PCN.

50% of staff believed that their MHP had integrated *'very well'* into the PCN. 20% felt their MHP had integrated *'well'* into the PCN, while the remaining 30% felt their MHP has integrated into the PCN *'to some extent'.* No staff members felt their MHPs' integration was *'poor'* or absent.

This contrasts with staff responses when asked if they had any other comments, where comments around integration emerged a total of six times but were mixed. Positive responses saw MHP being described as an "*asset", "great addition"* and *"fitting well into the team".* Contrasting to the four positive comment around integration, two staff members commented on their concerns surrounding poor team integration which *"might be an issue if the person is not able to work autonomously".* Remote working was also highlighted as a risk factor by one respondent:

> *"Too much working from home to integrate well into team".*

Operational and role management

On six occasions, staff commented on operational and management aspects of the MHP role. One third of these addressed issues with leave.

> *"Issues arise from requesting leave last minute and the PCN feeling like we can't refuse because employment sits with KMPT".*

"When she was on sick leave you had to always make contact to find out how is she when is she due back and can she send her sick note. It would never be asked once, and a reply was sent."

One staff member also referred to the lack of clarity around the roles and responsibilities of the MHP. Perhaps, as described by another staff member, this was due to employment sitting within KMPT meaning *"little input from the PCNs".*

"The role definition is not clear as to what they can and can't do."

It was flagged however, by one staff member that in terms of role management, *"regular reviews"* took place to address any new and / or ongoing issues.

Interview analysis

There was a variety of views from the MHP interviews that were conducted by Unity Insights. Several common themes emerged, including recruitment and onboarding, retention, job satisfaction, workforce, effect of patients, and integration. The results supporting each theme are detailed in the following sub-sections.

Recruitment

Feedback on the recruitment process indicated that it was thorough, organised, and straightforward. The interviewees were mostly positive about the process. One participant caveated their opinion as they felt the interview process was misrepresentative of the role because their "*skills were being questioned to make sure that [they] would be able to do that [preventative therapeutic] work*" but found that the role did not involve this. Furthermore, another MHP believed that the reason KMPT has been successful in their recruitment was not necessarily because of the standard of their recruitment process but more because "*other parts of mental health services are so unhappy and so broken*".

"It was a good interview process. Quite a rigorous interview with a panel of GP's, from across Kent and KMPT managers".

"I think KMPT has been very fortunate that it's been able to recruit so many people, but I'm a bit cynical. I don't think it's been because care KMPT have done such a wonderful job of creating these posts. I think it's been more the other parts of mental health services are so unhappy and so broken and so doing that

a lot of people are constantly changing jobs, trying to find something which is better."

"Really straightforward. Lots of time for me to ask my questions as well. So, I think in my mind I'd had a real preventative ethos built up, and that's what I thought I was going to be doing… offering more therapeutic intervention… I thought in interview, kind of my skills were being questioned to make sure that I would be able to do that work."

"I didn't realise that my ability to control my diary was going to be minimal."

Onboarding

Overall, the onboarding process was well received by the MHPs as shown by the common sub theme of feeling welcomed by the team. One MHP said how their team were *"very accommodating and very empowering",* another stated how they felt *"welcome*" and *"listened to"* but noted that every MHP has a *"different story about… how [they have] been welcomed".* This is mirrored by the last interviewee who stated they did not get the full two-week introduction to the role and "already had clinics booked for [them]" by the second week. Furthermore, this MHP did not mentioned that they felt welcomed during the onboarding process.

"They made me really, really welcome and are really interested in what I had to say. They were very accommodating and very empowering."

"It took a bit of time just to sort of get my name sort of known and making them all aware that I'm here. But once kind of everybody got to know me and I settled down into my role, then yeah, it was I'd say it was quite welcoming."

"I was made welcome, and I do feel very respected and very listened to. Every one of us has got a slightly different story about how we work and how we've been welcomed."

"You get a two-week induction but by the 2nd week I'd already had clinics booked for me."

Retention

Retention was commonly spoken about by the MHPs during the interviews, they gave potential ideas from on how to keep high retention rates. Some of these included focussing more on staff wellbeing, improving collaboration between GPs and MHPs. One interesting point to improve retention was *"the PCN being really open about what they want from the role",* this MHP felt like

the role was not what was expected from the interviews and job description. This may be causing people to apply and be hired for a role they did not expect or perhaps want, leading to poor retention of staff.

"From a retention point of view, needs to invest a little bit more in the kind of the wellbeing and the resilience of people doing my job. If I was a younger person earlier on in my career, I might be feeling like I was kind of working up a bit of a blind alley."

"Essentially, it could be a really good role, but if either of [these] issues become a problem, like the practitioner not doing enough or and or not feeling comfortable enough to do certain things, then that's going to cause retention issues. And vice versa if the GPs are not flexible enough with the practicing of them [MHPs]".

"I think being really open about what [the PCN] want[s] from the role… because I do feel that that differs from what they and MHP[s] may think the role should be."

"Being connected to the team, you know you aren't. Even on a normal 7- and 1/2-hour shift, if you see 16 people, even if they haven't got mental illness, they are still coming with emotional distress".

Job satisfaction

Job satisfaction varied across participants, they were asked to rate this on a sale of 1-5 (1 being very unsatisfied and 5 being very satisfied). The participant who rated their satisfaction a 5/5, stated that although *"it's been the right move for [them]"* they do find the *work "emotionally draining"* due to the isolation, minimum support, and emotionally intensive content of their sessions. Another participant rated their job satisfaction as a 4/5 as they have achieved *"work satisfaction now"* and are *"very happy compared to what it was before [at previous job role]",* the reason they did not score full points on this scale was *"nothing to do with the role"* but for personal reasons. The last participant rated their job satisfaction at 2/5, as "*there isn't flexibility"* and in their opinion they are not doing *"anything therapeutic*" or *"a meaningful intervention".*

"I think I think it's I think feel very satisfied. Nothings ever perfect. There are things that I'd like things to be better, but yeah, I'd struggle to rate it below a 5. I think it's been the right move for me."

"You're working on your own with the minimum of supervision and support. The work, I find, is very emotionally draining."

"I'd say probably a 4 and that's nothing to do with the role. I'd say it's more to do with…trying to figure out what to do more than anything else. I know I want to go down the leadership route. I'm very, very happy compared to what it was before."

"I feel like I've got work satisfaction now."

"Probably a 2. There isn't the flexibility. you don't do anything therapeutic. You don't do a meaningful intervention".

Patient care

The MHPs' opinions on their effects on their patients were also noted throughout the interviews. One participant noted how the MHP role helps reduce pressure on primary care as *"if they were being referred by the GP to secondary services, they might get bounced back and nobody really sort of gets any further than that. So, [the patient] end[s] up through this loop system [between primary and secondary care]"*, but as an MHP, the follow ups allow them to *"to fix any problems along the way".* Another positive noted was that MHP appointments allow those with poor mental health to have *"time and space to feel listened to and to feel validated"*. Although, one participant felt like they were not providing *"a meaningful intervention",* they said, *"the individual practices… have the control over [the clinics]"* and often give slots to those without diagnosed mental illness but instead people who have emotional distress and personal trouble. The MHP believed this was *"taking up slots that somebody in potential crisis or a relapse in mental health can't access*" but did believe it helped people to be *"able to reflect and… to be heard".*

"I do get some really, really positive feedback. But I also know how we let people down so often, and what most people struggling with the mental headload more than anything need is time and space to feel listened to and to feel validated."

"Before, if they were being referred by the GP to secondary services, they might get bounced back and nobody really sort of gets any further than that. So, you kind of end up through this loop system."

"I know this sounds awful, but you don't do anything therapeutic. You don't do a meaningful intervention. Very much being a compassionate ear."

"I think you know specifically for the client group that are not coming with clinical symptoms of mental illness. And I think having that space, being able to reflect, being able to be heard. And I think that, you know, they find that beneficial".

"I don't have control over my clinics… the individual practices have the control over that, and taking up slots that somebody in in potential crisis or a relapse in mental health can't access."

Role within the system

Issues with finding an appropriate place within the healthcare system, both between primary care organisations and between primary care and other parts of the wider system, were commonly observed topics in the MHP interviews. One participant felt that they were *"sublet by KMPT".* Other issues involved the wider infrastructure as one believed there had not been any groundwork about how MHPs *"fit within a wider KMPT strategy".* Additionally, challenges were raised around how the MHPs were working with their PCN, finding that in some cases *"there is no structure in place"* and that success was dependant on how *"willing [the staff] are to accept [the MHP]"* and *"how flexible"* the role is allowed to be by the PCN. Additionally, a key point made was that individual GP surgeries could be *"not cohesive*", and this was a struggle for the MHP as they would not work *"collaboratively*".

"I think the negatives are less about the PCN and more about the wider infrastructure. I don't think there's been any groundwork done really a deeper level about how these posts fit in with a wider KMPT strategy."

"I certainly don't enjoy any strategic strong links with the Secondary Mental health services that the Community mental health teams in this area, they don't really know exist."

"I have felt very much like I've been sublet by KMPT."

"We don't have any structure in place in my PCN."

"The GP surgeries that make up my PCN are not cohesive, and they don't work collaboratively. So, each GP practice has what they want and a very different way of working."

Management

Opinions on higher management varied throughout the interviews. One MHP stated that their practice manager was *"really supportive"* and seemingly gave them freedom to make the role their own by asking the MHP to think about what they *"would like [the role] to be for [them]"* and for the patient. Conversely, another MHP said that they had little support from their manager *"in comparison to the other services [their] manager has to offer supervision and support [to], it does feel that [MHPs] get a bit lost at times",* which highlights the variation between different MHP's experiences.

"My manager that recruited me to this role had said to me, 'what would you like it to be for you and what you'd like it to look like [for] the patient'."

"The practice manager and all of them have been really, really supportive, I've never had any issue with any of them. And the PCN lead and she's also very, very supportive."

"In comparison to the other services my manager has to offer supervision and support [to], it does feel that we get a bit lost at times."

Integration into the team

Two of the interviewees had positive experiences with their colleagues and managers, citing that "*they made me feel like one of the team*" and they have been *"very supportive".* However, one MHP felt that the role was *"hugely isolating"*, and they had to befriend *"a care coordinator just so that [they have] got somebody to have a chat with"*. One MHP stated how there is much variation between different PCNs and practices with accepting the MHP role, they said this might be dependent on the set up of the role as a role with *"strict boundaries"* makes *"it very difficult for them to do the work that they do"*, which could hinder the interpersonal relationships within the team.

"They made me feel like one of the team."

"I don't feel like an outsider. They're very good at facilitating me and they've been very responsive."

"I've befriended a care coordinator just so that I've got somebody to maybe have a chat with. It's hugely isolating."

"I'd say it does depend on the PCN. It does depend on the staff and how willing they are to sort of accept that staff member. Some of it is to do with how that role is set up, the more rigid the role is going to be, the more difficult is going to be for the practitioner because… they're working a lot on their own. If they've got very strict boundaries, it's going to make it very difficult for them to sort of do the work that they do."

Recruitment survey

A high-level summary of the results from a recruitment survey were provided. These summary results are provided in Table 2 below. The results demonstrate nearly unanimously positive

feedback for the process, with only a non-material decrease in satisfaction for the time to receive feedback after the interview.

Table 2: Summary of recruitment survey results

Survey question	% of respondents who were satisfied
It was easy to apply for the position	100%
Recruiter was friendly and professional	100%
I was always responded to in a timely manner	100%
I was happy with the time between the application and response	100%
I was happy with the time between the interview and feedback	97%
I would recommend the recruiter to a friend or colleague	100%
Overall, how satisfied are you with the recruitment process?	**100%**

3.2. Quantitative analysis

Whitstable PCN MHP activity data

MHP activity data was only available from Whitstable PCN, therefore, the figures and results from this PCN were assumed to be the average for all PCNs with MHP in Kent and Medway. However, it must be noted that there was no available baseline data to compare these results to, thus the impact of the MHP cannot be measured in a quantitative form. The data from Whitstable PCN shows a robust breakdown of the location of referral, how many times they were seen, the length of appointment and the presenting problem.

Table 3. Breakdown of appointments per month and the total time.

Month	Number of individual patients seen	Number of appointments	Actual total appt time (minutes)
Dec-21	23	41	2,080
Jan-22	31	77	4,090

Month	Number of individual patients seen	Number of appointments	Actual total appt time (minutes)
Feb-22	52	126	6,120
Mar-22	30	89	4,830
Apr-22	33	97	5,550
May-22	52	147	8,460
Jun-22	16	76	3,840
Jul-22	49	142	7,080
Aug-22	72	245	13,615
Sep-22	52	217	12,420
Oct-22	64	279	16,220
Nov-22	68	324	18,890
Dec-22	45	191	10,145
Jan-23	64	377	21,545
Feb-23	64	376	21,900
Total	**715**	**2,804**	**156,785**

Table 3 shows the number of patients, appointments and total time spent with patients by the Whitstable MHP from December 2021 to February 2023 (the original data covered from November 2021 - March 2023 but these months were likely truncated due to small numbers, meaning that these months were removed from this table). In this time, the practitioner saw 715 individual patients, conducted 2,804 appointments, and spent 156,785 minutes with patients. This data set also showed that the average appointment length was 56 minutes long, which is 46.78 minutes longer than the average GP appointment of 9.22 minutes (Jones et al., 2022). The average number of patients in a year was 572, the average number of appointments in a year was 2,243 and the average total patient contact time in a year for an MHP was 125,428 minutes.

Furthermore, the total GP appointments saved can be calculated using the number of individual patients seen by an MHP. In a year 2,804 MHP appointments were conducted; therefore, it can be assumed that 2,804 GP appointments were saved as a result of MHPs, further, an average GP appointment is 9.22 minutes (Jones et al., 2022), so this totals 25,853 minutes of GP time saved in a year. The average GP's cost per minute is £4.51 (Jones et al., 2022), which makes a total cost saving of £116,596.48 of GPs time in a year.

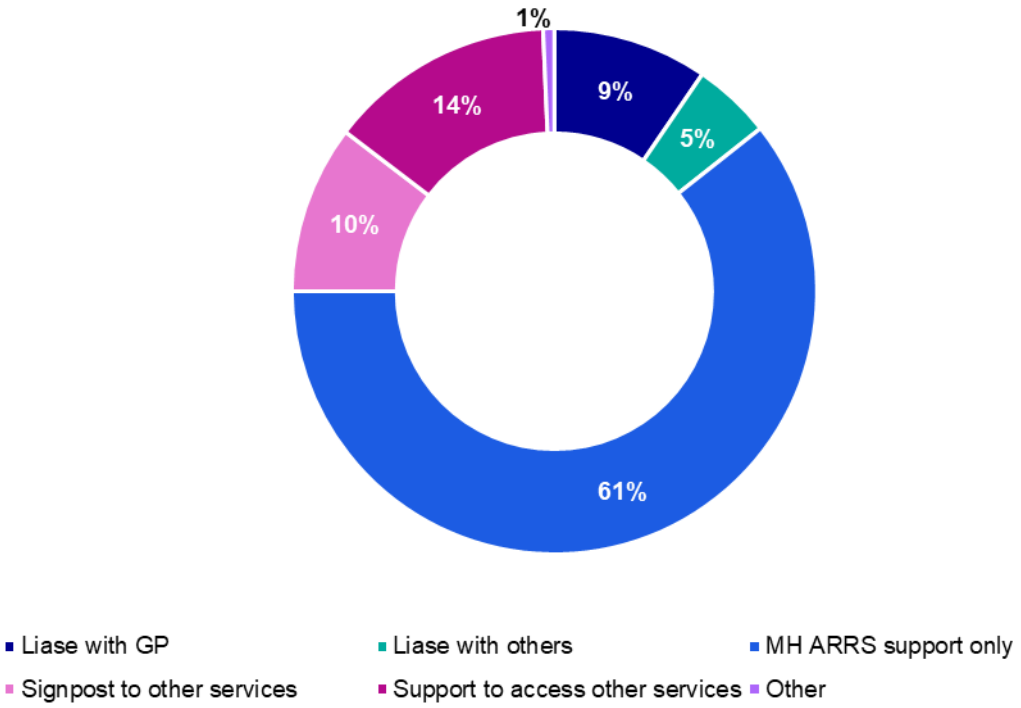

Figure 8. Breakdown of Whitstable MHP's patients onwards referrals.

From the original Whistable MHP data set, the MHP saw 724 patients in total, 61% (n = 439) stayed with just the MHP and their support, 14% (*n* = 101) were supported by the MHP in accessing other services, 10% (*n* = 75) were signposted to other services, 9% (*n* = 69) liaised with GPs and 5% (*n* = 35) liaised with other healthcare professionals (Figure 8).

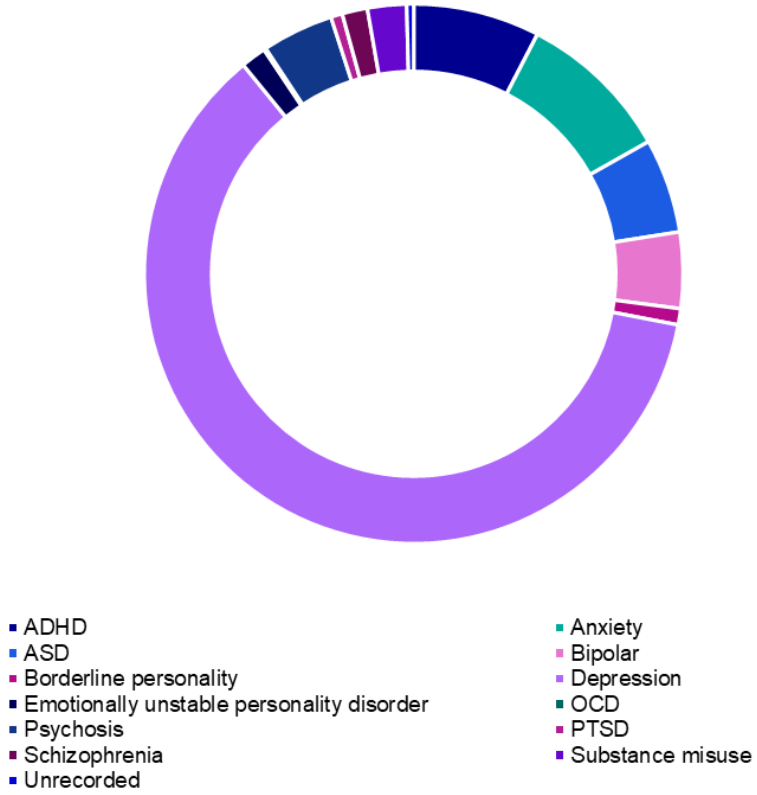

Figure 9, A donut chart showing the breakdown of primary presenting problems of the Whitstable MHP's patients over 14 months.

Figure 9 shows the breakdown of primary presenting problems of the Whitstable MHP's patients over the 14 months. The most common primary problem was depression (61%, *n* = 442), followed by anxiety (9%, *n* = 67), and ADHD (8%, *n* = 55). The least common primary problem was psychosis with only one patient presenting with this problem.

IAPT data

Table 4. referrals and outcome data from IAPT services for Kent and Medway

Referral source			Re-referral summaries post-assessment		
GP referrals	Other services referrals	Total referrals	Not suitable for IAPT – Referred back to referrer	Not suitable for IAPT – signposted to other services	Total re-referred elsewhere
7,410 (71.0%)	**3,030 (29.0%)**	**10,440**	**2,385**	**4,595**	**6,980**

IAPT service data showed that, over 18 months (August 2021 - January 2023), 7,410 GP referrals were received, and 3,030 other services referrals were received, totalling 10,440 (Table 4). In this same timeframe, 2,385 patients were considered not suitable for IAPT by the service and were referred back to their referral source, while 4,595 were also not suitable and signposted to other services. Overall, 66.9% of referrals were unsuitable of IAPT services.

This data set was limited as it did not include the actual outcomes from each patient or group, as 10,440 were referred in this time period but the 6,980 patients deemed not suitable may not directly correspond to the 10,440. Comparisons are, therefore, indicative with reasonable assumptions made due to the lack of data available.

Particularly with the interest of GP referrals in mind, 71% of the referrals were from GPs, so proportionally out of the 2,385 that were sent back to their referrer, it can be assumed that approximately 1,693 were sent back to their GP. This figure provides an estimation of how many patients were inappropriately referred to IAPT services in Kent & Medway and must now go back to receive treatment in primary care. All such patients could benefit from the introduction of MHPs in primary care.

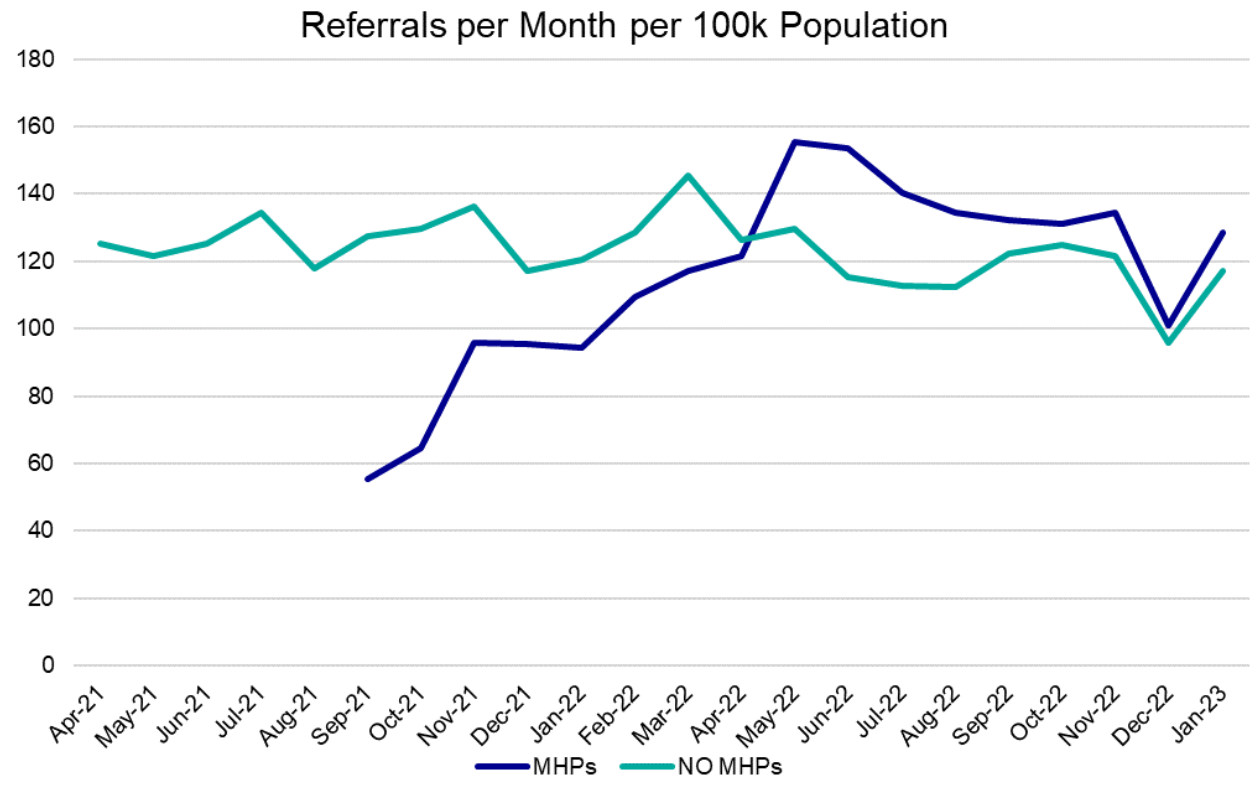

Figure 10. A graph showing the referrals to IAPT per month per 100k population for PCNs with and PCNs without MHPs.

A comparison of average IAPT referrals between PCNs with MHPs and PCNs without MHPs was performed (Figure 10). The average referrals per month per 100k population for PCNs with at least

one MHP was 116, and for those without an MHP it was 123. This is a difference of 7 more referrals per month on average for PCNs without an MHP. Moreover, 24 PCNs employed a single MHP whereas only two PCNs had two MHPs on staff.

Mental health demand analysis

A PCN-level analysis of demand for mental health services was conducted to identify any PCNs which may benefit from hiring more MHPs. A demand index was constructed based on PCN list size and multiple indicators related to mental health care at a PCN level.

Each variable was first standardised and then used to calculate an average, which was then normalised into an index ranging from 0-100. The steps in this process are outlined below in Figure 11: Index calculation steps flow chart. Each variable or indicator (listed below) is first standardised by dividing each value by the variable's standard deviation. This transforms the values from each PCN into a measure of the number of standard deviations away it lies from the given variable's mean. Figure 1

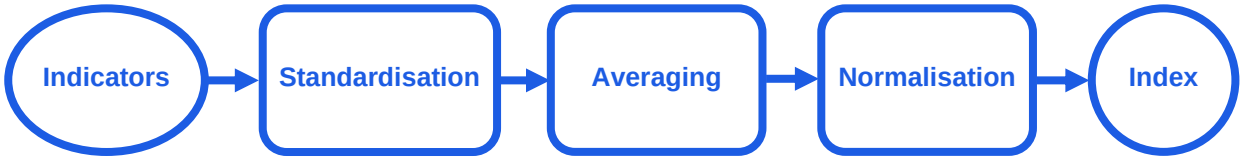

Figure 11: Index calculation steps flow chart.

The next step was simply to calculate the average (i.e., the mean) of all of the standardised variables to give one single measure of demand at each PCN. This was then normalised by dividing this measure by the range of the averages for all PCNs (i.e., the maximum minus the minimum). Finally, to aid readability, the index was multiplied by 100.

Below is a list of variables included in the calculation of this index, alongside their sources used:

- Total List Size (OpenPrescribing.net, 2023)
- Number of Antidepressants Prescribed (OpenPrescribing.net, 2023)
- Depression: QOF incidence (18+ yrs) - new diagnosis (NHS Digital, 2022)
- Depression: QOF prevalence (18+ yrs) (NHS Digital, 2022)
- Mental Health: QOF prevalence (all ages) (NHS Digital, 2022)
- Number of Anti-psychotics (OpenPrescribing.net, 2023)
- Number of Hypnotics and Anxiolytics (OpenPrescribing.net, 2023)
- Sub-ICB People in contact with services at the end of the reporting period (NHS Digital, 2023a)
- Sub-ICB People with an open hospital spell at the end of the reporting period (NHS Digital, 2023a)
- Sub-ICB IAPT Referrals (NHS Digital, 2023c)

- Sub-ICB IAPT Accessing Services (NHS Digital, 2023c)

In cases where only Sub-ICB level data was available, the data for that variable at a Sub-ICB level was simply used as a proxy for that variable at PCN level, i.e., all PCNs within a given Sub-ICB were given the same value.

Table 5 below shows the ten PCNs with the highest demand index scores in Kent & Medway, alongside the number of MHPs in Kent & Medway as per data provided for the project by KMPT.

Table 5: Top 10 demand indices and number of MHPs for PCNs in Kent & Medway.

PCN Name	MH Demand Index	Number of MHPs*
TUNBRIDGE WELLS PCN	**26.36**	**0**
MID KENT PCN	**21.81**	**2**
SEVENOAKS PCN	**18.00**	**0**
TONBRIDGE PCN	**17.56**	**0**
MARGATE PCN	**17.07**	**0**
SITTINGBOURNE PCN	**16.04**	**1**
RAMSGATE PCN	**14.94**	**1**
MEDWAY CENTRAL PCN	**13.73**	**1**
MALLING PCN	**12.88**	**0**
TOTAL HEALTH EXCELLENCE WEST PCN	**12.70**	**1**

*Data provided for Kent & Medway by KMPT

Table 6 below lists the ten PCNs with the highest demand index scores in the whole of England, alongside the number of MHP FTEs (NHS Digital, 2023b). It should be noted that data for the number of MHP FTEs at each PCN is missing from the NHS Digital Primary Care Workforce dataset used here for many PCNs, which indicated by blank cells.

Table 6: Top 10 demand indices and number of MHP full-time equivalents (FTEs) in all of England.

PCN Name	MH Demand Index	MHP FTEs*
NORWICH PCN	**100.00**	
BARNSLEY PCN	**96.72**	
SOUTH SEFTON PCN	**65.28**	**4.00**
BIRKENHEAD PCN	**64.88**	
SOUTHPORT & FORMBY PCN	**47.88**	**1.00**
NORTH SOUTHWARK PCN	**47.35**	
CENTRAL LIVERPOOL PCN	**45.17**	
SOUTH WORCS WORCESTER CITY GP PCN	**44.02**	**2.00**
HASTINGS & ST LEONARDS PCN	**43.64**	
ENFIELD UNITY PCN	**41.80**	

*The NHS Digital Primary Care Workforce dataset has substantial data quality issues with many MHPs not recorded in the data

3.3. Health economics

The results of the basic health economic estimates are displayed in Figure 12. For both 55.9- and 30-minute MHP appointments, the total value of the MHP time cost is less than the GP time saved. Of course, the difference is far greater for MHP appointments of 30 minutes in length.

In both scenarios the estimate of the total value of the GP time saved throughout Kent & Medway is equal to £640,889. In scenario 1, the estimated total cost of MHP appointments in Kent & Medway is £581,941, implying a net gain of £58,948. Alternatively, if MHPs adopt 30-minute appointment lengths, as in scenario 2, the estimated total cost of MHP appointments in Kent & Medway is £312,312, meaning a saving of £328,577.

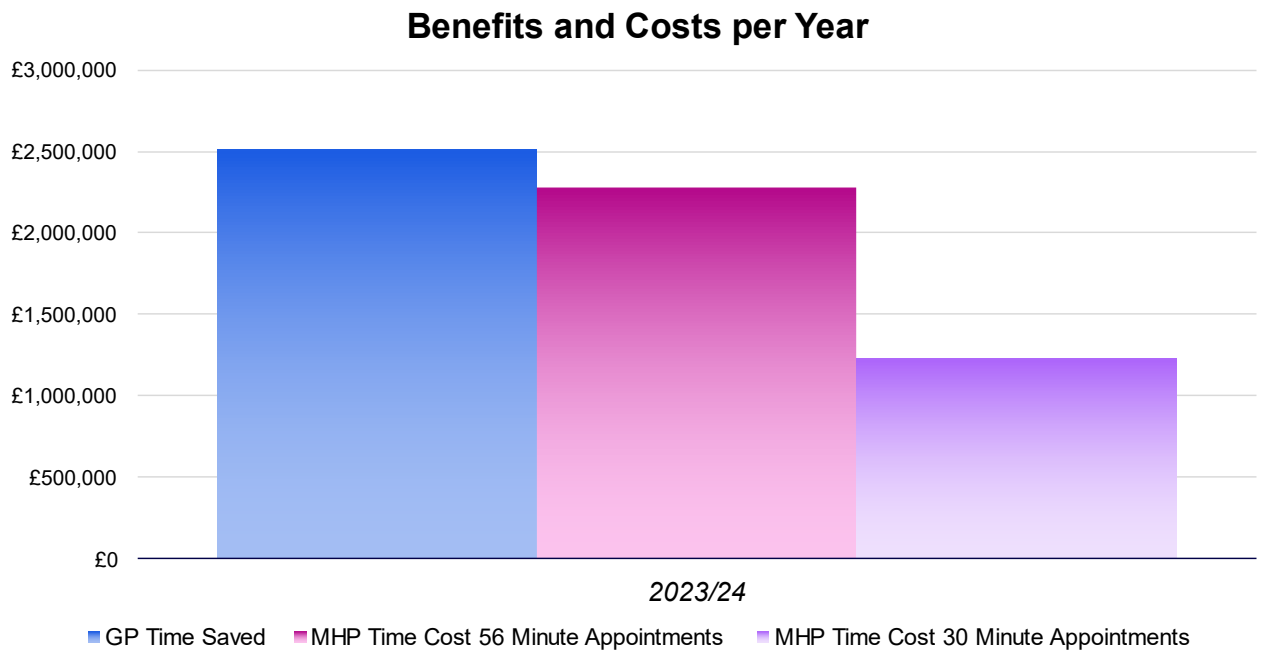

Figure 12: Health economics results for scenarios 1 and 2 (55.9, and 30, minute appointment lengths respectively).

4. Discussion

4.1. Impact

From the evidence available, it is clear that MHPs in Kent & Medway have a positive impact on their patients, their colleagues, and the wider system. This has been demonstrated using patient and GP feedback, and through data provided by KMPT on patient outcomes. Furthermore, the health economic analysis evidences the money saving aspect of implementing MHPs within KMPT.

Value for money

Based on the simple health economic analysis conducted above, MHPs are very likely to increase the efficiency of mental healthcare within primary care by diverting demand for mental health services away from GPs and towards MHPs. Not only are patients able to be seen by specialist mental health practitioners but GPs, in the context of workforce pressures and declining numbers of GPs relative to the population, are freed up to provide alternative or additional services. Even 56-minute MHP appointments cost less than an average GP appointment of 9.22 minutes, meaning this is a much more efficient use of staff resources. It follows that MHPs can deliver appointments that are much longer than a standard GP appointment cost-effectively.

This assessment is, however, a simplified analysis given the lack of data available. For example, MHPs may conduct multiple appointments with a patient that may have only seen the GP once, but that must also be traded-off against repeated, lengthier appointments that likely lead to improved patient outcomes, therefore reducing future demand for mental health services – from GPs or elsewhere in the healthcare system. Additionally, MHPs providing treatment through multiple appointments will reduce the burden on secondary care services and IAPT, while also potentially enabling a reduction in inappropriate referrals to other services such as IAPT through more effective patient assessments. Moreover, MHPs providing quicker access to mental health care could prevent deterioration and acute or emergency episodes of care.

Further study should be conducted to understand patient outcomes and waiting times in detail. This data should be readily available once more accurate tracking of MHP activity is available in routine primary care datasets. Current challenges with inappropriate recording and coding of MHP activity has prevented a more in-depth analysis from being included in this report.

Patient impact

Patient feedback on key topic areas such as access, experience and quality of care were very positive for MHPs in Kent & Medway. Patients responded well to the care provided and were generally very happy with the care that they had received and the impact that they felt that MHPs had had on them. Where MHPs themselves or GPs were asked to comment, they too saw similar benefits for patients. The specialised role enables patients to receive more tailored, bespoke care

that suits their needs. Based on the qualitative feedback from patients and staff, it can be concluded that MHPs in Kent & Medway have a materially positive impact on their patients.

Interviews with the MHP workforce, including management, indicated some enablers and barriers to achieving the positive patient impact demonstrated in this report. Flexibility was highlighted as a key factor by respondents in a positive sense, and this was corroborated when respondents were also able to highlight that a lack of flexibility was seen as a barrier to delivering more effective care and having a positive impact on patients. This could include factors such as allocating an inappropriate case-mix to the MHP (the MHP role is able to support more severe cases, but will not add as much value compared to alternative roles if allocated more mild cases), limiting the length of appointments that MHPs were able to offer, or inefficient management practices (for example, scheduling appointments at different surgeries on the same day). Some of these challenges relate to improvements to management processes, but others relate to PCNs and MHPs realising that they are not just a specialist GP but a different role entirely and learning to work better together. Based on interviews and survey results, these cases were rare in Kent & Medway but are nonetheless important to highlight for learning and improvement.

Patient outcomes could not be formally assessed as part of the analysis due to data quality issues. Once routine datasets can accurately isolate and track MHP activity, further analysis should be conducted to understand the impact of MHPs on patient outcomes.

Primary care workforce impact

From the analysis it is clear that the MHP have been a positive addition to the primary care workforce, with positive responses from GPs. This has been demonstrated by the qualitative staff feedback, which is positive about the introduction of the MHPs and their impact on patients. Importantly, workloads are reported to have reduced due to the introduction of the MHPs. In the context of substantial workforce pressures in primary care, this is a substantial benefit to PCNs.

As with the insights on patient impact, there are small areas for improvement. 9 (30%) respondents to the staff survey indicated no change or an increase in workload, which may indicate that some PCNs or staff groups are not receiving the full benefit of MHPs. This corresponds to 9 respondents indicating that the ARRS MHP had integrated into the Primary Care Network ‘to some extent’ rather than ‘well’ or ‘very well’. This could indicate that integration is key to success and maximising the benefits for the primary care workforce. Integration is further explored in the next section.

Uptake of the ARRS MHP offer

With a paucity of accurate and available data on MHP FTEs or headcounts outside of Kent & Medway, it is a challenge to compare regions and explore how the MHPs have been implemented. Nonetheless, variation is visible within Kent & Medway when compared against the potential levels of demand estimated for mental health services for each PCN (Table 5). Assessing the ‘correct’ number of MHPs for KMPT and each PCN to recruit is not simple, and will vary based on case-mix, but broadly could be expected to correlate with the demand for mental health services from the

local population. Reviewing the PCNs that are expected to receive the highest demand for mental health services in Kent & Medway, 5 (50%) did not have an MHP during the sample period.

There are, therefore, PCNs that are highly likely to be facing substantial mental health demand compared to their peers who were not utilising a funded specialist mental health primary care role as of March 2023. The reasons for this are not clear, but engagement with the PCNs who have not taken up an offer for an MHP would be valuable to understand any barriers or reservations that these organisations may have.

4.2. MHP workforce

The second part of this analysis focuses on the recruitment and retention of MHPs in Kent & Medway.

Recruitment

The interview analysis demonstrates that KMPTs recruitment process of the MHPs was well received by the staff, they stated that the interview process was *"rigorous"* and *"straightforward".* The survey feedback provided by KMPT, though based solely on successful applicants, also indicates that the process was well received with 100% of respondents satisfied with the overall process. Additionally, Kent & Medway were successfully able to scale up their MHP workforce at a steady and sustainable pace without being hampered by persistent vacancies.

A key enabler for the recruitment process in Kent & Medway has been standardisation, in turn driven by dedicated roles in KMPT for managing the ARRS MHP programme. A dedicated programme manager (or multiple staff members with dedicated time allocated) can enable consistent standards to be applied and learning to be gathered and then actioned at a system level. This has been the case for KMPT, with positive feedback from the recruitment survey specifically naming the ARRS MHP programme manager in post at the time. The value provided by a standardised process and a centralised, dedicated role is highlighted by the challenges that start to be observed when variation is seen across PCNs, as demonstrated in the results from the other sections of this report.

One MHP stated that although KMPT has been *"very fortunate that it's been able to recruit so many people"* they do not believe that it is necessarily because KMPT has done *"a wonderful job of creating these posts",* but also due to *"other parts of mental health services are so unhappy and so broken".* This is not a negative for the MHP recruitment process but rather an indication that the MHP recruitment process managed to get many factors right and up to standard while other mental health services, according to this individual, lag on implementing recruitment processes that leave applicants satisfied with the process. These differences in recruitment process between services may have been a deciding factor in some MHPs choosing the role over alternatives in other mental health services and, as such, there may be learnings for the mental health providers to gain from the process implemented for MHPs.

Onboarding

Onboarding is a key factor towards MHP job satisfaction and wellbeing, especially given the recency of the role's introduction and the importance of settling non-GP patient-facing roles into a PCN-level role in primary care, where they will be in the minority. The onboarding process should establish the MHP as part of that workforce within the PCN, it should provide the MHP and the PCN the necessary tools and information to work together effectively and enable a plan of work to be established. In Kent & Medway, there is much success in achieving these goals for MHPs, but some variation has been noted.

Overall onboarding was well received by MHPs, most were given a two-week induction period to settle in and get to know the team and the role. In this time, some of the MHPs interviewed said they felt very *"welcome"* by the staff, and they were *"very accommodating".* These MHPs also stated that the relationship with the teams in the PCNs is *"growing"* over time, which shows the ongoing integration into the team is going well. However, one MHP stated that they did not have an overly positive introduction to the role and to their colleagues, did not fully integrate into the team as time went on, they said they were left to befriend a *"coordinator just so [they] had someone to talk to".* While some of this variation may be due to particular MHPs and their expectations upon entering the role, it may also be another signal of the variation observed between PCNs in multiple areas of this report.

Another relevant factor is that an MHP interviewee, who was positive about the onboarding process and the relationship with their PCN, noted that they presented their work plan and vision for the role to the PCN team on the second week of starting in the role. For a role that has still only recently been introduced, this is exceptionally early to have a clear understanding of how the role should be delivered. On follow-up questions, it was established that the particular MHP was able to achieve this as they were highly experienced from other prior mental health roles that they had held. This experience perhaps highlights the risks and potential barriers to less experienced MHPs entering the role and the expectations that may be placed upon them in the initial weeks. It may also highlight that candidates with confidence entering into the role may have a better experience. It is, therefore, important to ensure consistency and maximise success that support is provided to every candidate to help them with the onboarding process, to manage expectations on the PCN-side who are also likely to be new to the role and what it entails, and also to introduce peer-support or centralised guidance to help MHPs to confidently put forward their work plans and ways of working early into the role.

One interviewee, however, noted that they felt misled by the questions asked about their skills and what the role would entail. This may have been because the role was still new at the time, so what the day-to-day practice would look like was unknown and subject to variability between PCNs. This issue, therefore, may be dependent on how the PCN manages the MHP role, as this MHP said they were mainly just there to listen to people without mental illness and not perform therapeutic interventions but data from Whitstable PCN showed that every patient had a primary presenting mental disorder (Figure 9).

Retention

Satisfaction

MHPs in Kent & Medway were broadly satisfied with the role and the impact that they were able to have on patients, although with some variation present as with other results. MHPs agreed that they have a positive effect on the patients that they see, which further validates the evidence from the patient feedback. One MHP, however, stated that they could do more to help them by giving patients who have diagnosed mental illness a *"meaningful intervention"* if they had control of the patients they see and had their skills utilised. They noted how their patients find the intervention *"beneficial"* but to maximise the impact of MHPs they need to have more *"control*" over their clinics. Another MHP stated how they *"know [they] let people down so often",* yet they realise how this role is beneficial to patients for them to not get lost in the system and end up in a *"loop system"* between primary and secondary care. Further, this MHP said they *"did not have control of [their] clinics, the PCN had control of that",* thus disallowing the MHP from tailoring their support as they saw fit.

Additionally, control and a lack of flexibility were key drivers of job satisfaction and MHPs' perception of their role. MHPs who had freedom to make the role their own were more positive about their job than the MHP who felt they "*were sublet by KMPT"* and that their flexibility was limited. In interviews, it was raised that there had been pressure on a small number of MHPs by their PCN teams to provide similar numbers of appointments for the same, much shorter, length of time as provided by GPs (10 minutes or less). The important issue appears to be a misalignment of expectations on topics such as flexibility and work plans between some PCNs and some MHPs. This could be cultural factors, perhaps some MHPs are entering the role with unwarranted expectations, or it could be that the specialist ARRS MHP role does require different approaches and management styles to GPs and other patient-facing primary care roles. The truth may somewhere in-between, but it highlights the importance of transparency at the recruitment stage on ways of working, aligning expectations in the onboarding process, and also some best practice standards or standard operating procedures (SOPs) on how MHPs should be managed, and their role should be conducted. Both PCNs and MHPs should each receive supporting materials and guidance to ensure that both sides can build a common understanding, bridge any gaps, and build trust in each other. The analysis indicates that trust, autonomy, and flexibility play a significant role in ensuring high job satisfaction, so these considerations are important in building and maintaining satisfaction in the MHP workforce.

An additional factor in satisfaction is integration. The role itself is fairly independent, and for some people this is *"isolating*" as they are *"working on [their] own with minimum supervision and support".* One MHP summarised the issue with this by saying it works for them but for a "*younger person earlier on in [their] career"* they might feel like they are *"working up a bit of a blind alley".* This is mirrored by the feedback from another MHP who said they felt left behind by their manager due to lack of support. Again, the natural advantage afforded to more experienced members of staff is evident and further support, perhaps including peer support, could be a key enabler to enable less experienced MHPs to integrate and maximise their satisfaction in the role. The job

itself is also *"emotionally draining"*, as stated by multiple MHPs, so adequate support is needed to protect staff wellbeing, perhaps including careful management of workloads.

Management structure

The MHP role in Kent & Medway is managed dually through the respective PCN and KMPT. Broadly, KMPT manage the individual (including aspects such as HR) while the PCN manages their workload and time. This structure has the potential to create serious challenges for MHPs in navigating this three-party working relationship but, in practice, there is little evidence that this has caused serious issues to-date. On the contrary, MHPs receive benefits from maintaining a working relationship with a specialist Trust with dedicated management resources as it can help open opportunities for peer support and advice from professionals experienced working with the mental health workforce, and also provide mediation while the PCN and the MHP adapt to each other, amongst other benefits.

There are, however, some areas for learning and improvement. This structure can have an effect on how staff members perceive their integration into either team, feeling not quite part of one organisation or the other. Nonetheless, the main alternative structure available, temporarily setting aside barriers around any contractual considerations and financial arrangements for sake of argument, would be a pure PCN-led approach. The PCN-led approach is not recommended, due to the loss of a dedicated mental health support structure, the risk of isolation in the role for MHPs, many of whom will be the sole MHP in a PCN, and the fact that the evidence indicates that many PCNs are still very much learning how to manage these ARRS MHP roles in practice which can be mitigated by peer support and consistent SOPs that can be introduced through a centralised function as provided by KMPT in Kent & Medway.

PCN maturity

A consistent result from the analysis was the variation in how MHPs were managed at the PCN level. There were examples of good practice with high satisfaction, but some other practitioners faced challenges with the PCNs that they were working with.

One aspect driving variation relates to how some PCNs are adapting to onboarding non-GP roles through the ARRS scheme more generally. The culture in primary care organisations has had to adapt in recent years to these new specialised roles and naturally forms a barrier to seamless integration for the MHP role as well. This factor should decrease as PCNs mature, mainly as the centralised management structure becomes more embedded, and as the primary care workforce becomes more accustomed to working alongside staff members in non-GP patient-facing roles.

The developing PCN management structure also had more practical implications, in terms of effective planning and balancing logistical challenges and political disputes with MHPs being pulled from practice to practice. Some MHPs have also reported that micromanaging could occur, as noted in the lack of flexibility afforded in a smaller number of cases. The result of this management style will hamper productivity and staff wellbeing. The best practice approach to management of the ARRS MHP role has not yet been established and should be an area of further research with

guidance to be developed and disseminated to MHPs, potential MHP applicants, and PCN management teams.

Centralised ARRS MHP leadership in KMPT

The analysis has highlighted potential and realised variation in the implementation of the MHP role. KMPT employed a dedicated ARRS MHP programme manager to support with the implementation of MHPs into Kent & Medway, a role that is still maintained but recently is being shared between programme managers with multiple responsibilities on a regional basis. There is strong qualitative evidence that the involvement of this centralised, dedicated role has had a positive impact on implementation (recruitment and retention) and reducing variation.

The programme manager was specifically named in positive feedback in relation to the recruitment process, and it is known that the programme manager was involved with onboarding MHPs, helping to standardise the process and also providing mediation in the case of disputes between the MHP and their PCN (either with onboarding or on an ongoing basis where issues arose). The impact of this centralised role is difficult to quantify, but clearly generates benefits and provides a natural route for the recommendations from this report to be implemented. The centralised management does not necessarily have to be enacted through a single individual, but a system-wide view of MHP implementation with the ability to ensure MHPs are able to network amongst themselves despite geography, and central consistent learning and guidance can be developed and shared, has clear benefits. Central management and/or coordination can also provide support in cases in need of escalation, for example where an MHP and a PCN are in dispute. These cases could be particularly valuable in ensuring retention, as there is a risk that disputes can escalate and lead to early departure from the role.

Career progression

Anecdotal interview evidence highlighted that, of the small number of MHPs that had left or were due to leave the role, several of these were leaving for the purpose of career progression. The recency of the MHP role means that its place in an individual staff member's career progression plan is not necessarily clear. The routes into becoming an MHP are still being established, but clear opportunities to recruit from secondary care are available. On the other hand, the opportunities for further progression once becoming an MHP are more varied and unknown.

MHPs wishing to further develop and progress in their career might find that, once they have progressed towards a band 6 role, the next step is more of a leadership position in the MHP space. The challenge for providers and ICBs is that there will only ever be few leadership opportunities in any one system. In interviews, MHPs were optimistic about their development prospects in Kent & Medway but were uncertain as to what that would be in specific terms as future plans for more advanced roles had not been clearly communicated. The KMPT strategy was deemed to be unclear, and clarity on workforce plans and, as a result, career progression opportunities was seen to be important.

Without natural progression opportunities within and beyond the MHP role, which is difficult to evidence given the recency of its implementation (2.5 years), the role risks limiting opportunities

which will affect recruitment in the future. Moreover, experienced and developing staff will be lost with time to other adjacent or more advanced roles in the wider system – most likely in secondary care.

Development and scope of the role

The MHP role is still new and best practice guidance detailing how the role should be conducted and integrated into primary care has not yet been established for all relevant parties. The role will naturally develop as it is implemented, different operating models are tested, and learning is gathered and shared.

The relatively recent introduction of the role is clearly a driver of variation. More experienced members of staff, such as those who have worked in similar mental health pathways in other areas of care, have an advantage in this circumstance. One MHP, with extensive prior relevant experience, who was interviewed highlighted that they were able to set out their plan for the role in their allocated PCN within the second week of starting. This MHP had positive feedback on their relationship with the PCN and their ability to deliver value in the role, but their ability to provide a clear plan within the second week is likely to have been a key enabler for these outcomes by adding credibility, building trust and having an effective plan in place at an early stage. For less experienced MHPs starting in the role, a strong onboarding process and support (perhaps in the form of peer support or guidance) to develop a plan for the role will be a key enabler to improve staff wellbeing and the effectiveness of the MHP.

5. Limitations

5.1. General model limitations

The health economic analysis conducted here was simplified due to a lack of suitable data on MHP patient outcomes, and no suitable comparator data to estimate an effect of MHP introduction. No benefits to clinical outcomes of MHP patients were modelled, nor were the benefits to those patients who were able to see their GPs sooner due to less demand on GPs for mental health services. The scope of the analysis was therefore narrowly restricted to the efficiency savings related to replacing GP time with MHP time, meaning the health economic results do not reflect the overall economic or social impact of introducing MHPs.

Similarly, no additional costs were modelled, meaning any recruitment, onboarding, training, or other costs required to actually employ an MHP were modelled. As such, the overall cost of hiring MHPs is likely to have been underestimated. It is not clear whether the wider clinical benefits of hiring MHPs outweigh these additional unmodelled costs; it is indeterminate if the overall impact of MHPs on the healthcare system is a net gain in monetary value terms. It is only clear that substituting GP time for MHP is beneficial as GPs are more expensive per time unit than MHPs.

A clear limitation of the above reasoning is that MHPs have longer appointments than GPs, and they are likely to see their patients more than once, reducing the overall efficiency saving brought about by their introduction. The former has been accounted for in the modelling by scaling the appointment cost according to the length of time of MHP appointments. The latter has not been accounted for in the modelling, although it is unclear to what extent this impacts the efficiency savings: there is no counterfactual to compare MHP data against – it is not known how many times a patient who is see by an MHP would have seen their GP under normal circumstances. These limitations of the health economic analysis conducted here mean the results should be interpreted with caution – it is not clear what the overall economic impact of MHPs is on the health care system.

5.2. Source data

Data access was a consistent issue, perhaps due to the recency of the role and the lag in centralised datasets updating to accurately record activity related to the role. At a local level, Whitstable PCN was able to provide valuable data for the project and is an exemplar in data recording in relation to the MHP role. It should not necessarily be expected that other PCNs can provide similar data, but it would benefit those that do in enacting quality improvement initiatives. The longer-term solution, however, is for routine healthcare datasets at national level to update and accurately capture information related to the MHP role.

Coding and recording issues of the MHP role in those national routine healthcare datasets rendered it impossible to enact a data collection on MHP activity and associated outcomes at scale. This information would be valuable for future projects, to accurately and objectively measure the practical impact of MHPs. This is a key area for future research. As a result, qualitative feedback was utilised as a proxy indicator for factors such as efficiency and patient impact.

5.3. Timeframe for the analysis

The analysis conducted within this report is based on information up to approximately two years after the first MHP was recruited in Kent & Medway. The results, therefore, predominately reflect the approach taken in those two years and not necessarily reflective of results from any more recent strategic changes made at the time of this report's publication.

Moreover, the short timeframe limits the assessment of the retention of MHPs in Kent & Medway because many of the MHPs have only been in-post for a year or less. Further ongoing monitoring will be required to maintain an accurate assessment.

6. Recommendations

The results from Kent & Medway highlight positive results on the implementation of the ARRS MHPs, with many cases of good practice and robust central processes. Nonetheless, this section highlights some areas of learning from cases of good practice in Kent & Medway and also some opportunities for improvement. As a result, many of the recommendations below are based on activities already undertaken by Kent & Medway and are intended for a more general audience.

Below is a summary of the key recommendations:

Maximising impact

- The MHP role, based on qualitative feedback but also a rudimentary health economic assessment of efficiency, provides significant benefits in an efficient manner. Recruitment and retention of the role is, therefore, important to maintain and dedicated resources should still be allocated to these activities.
- Several PCNs were identified with a likely high demand for mental health services relative to the rest of the region who had not yet recruited an MHP. Kent & Medway should now aim to support the recruitment of additional MHPs to provide to these PCNs.
- Workforce satisfaction and management are key drivers of impact. To maximise impact, it is important to ensure that the workforce is satisfied with an appropriate workload, case-mix and suitable management structures and processes in place.
- Further quantitative assessment of impact should be undertaken once coding and recording of routine datasets has updated to accurate capture MHP activity and track associated outcomes. Standard primary care metrics will be important to track, but onward-referrals and ‘bounce back’ (referral back to referral source) are important key performance indicators (KPIs).
- Resource pressures should not be the primary motivating factor to substantially reduce the appointment lengths of MHPs – this decision should be based more upon clinical appropriateness and with the input of the specific MHP.
- Additional support should be provided to MHPs to minimise variation, particularly between staff of varying levels of experience. This could include peer support, SOPs, or standard guidance provided to both MHPs and PCNs.
    - MHPs should not be managed in the same way as GPs within a PCN. The role is specialist and requires different approaches in some areas to maximise the benefits that the role can provide. More flexibility should be afforded for the MHP to utilise their specialist knowledge and plan their work to maximise the benefit, but this must also be balanced against ensuring accountability and maintaining PCN input. The development of centralised SOPs or guidance, or shared learning resources, may help MHPs and PCNs to work together to find a balance that works for both parties.

- A review should be conducted into the appropriate case-mix to be referred onto MHPs, to ensure clinical appropriateness but also to enable workforce optimisation.

MHP Workforce

- Centralised management through the Mental Health Trust is a key enabler across many of the domains that affect recruitment, retention and maximising impact. It is not yet evidenced whether this role should be enacted through a single individual or multiple, but a system-wide view is beneficial, and the centralised management function should be actively involved in recruitment and onboarding processes with dedicated time for this purpose.
    - The responsibilities of this central management function should include the development of SOPs, standardising processes where possible, gathering system-wide learning, developing and implementing guidance across the system, and providing an escalation route in cases of dispute.
- Further investigate and improve links between the ARRS MHP role and the wider system. MHPs, and other staff groups, were not aware of how the role fits within the wider KMPT strategy – particularly in the long term.
    - Additionally, the links between MHPs and secondary mental health services were reported to be underdeveloped. One exception was where the MHP had had previous experience in secondary care. SOPs and guidance identifying best practice could enable these links to be further strengthened in a standardised approach.
- Support and guidance should be provided to both MHPs and PCNs, to avoid a misalignment of expectations or understanding and to ensure that both sides are able to work together to maximise the chances of success.
    - Ensuring that guidance and information on the MHP role reaches GPs and other members of the primary care workforce will help to aid integration of the MHP and build trust amongst different staff groups.
- Career progression opportunities for MHPs should be identified and receive central commitment through an ICB and mental health trust joint workforce strategy. This will help to retain MHPs by providing clarity on their progression and future career opportunities. More experienced and better performing MHPs are likely to be retained for longer if they believe that the remaining in the role can help their future career prospects.
    - Offerings to fund or allow flexible hours to support external continuous professional development, through courses and formal qualifications (for example, postgraduate qualifications), should also be considered. PCNs are likely to be the most affected by these arrangements. As such, centralised SOPs for such scenarios should be developed and implemented to ensure that PCNs maintain MHP capacity and feel able to support the development of MHPs.

7. Conclusion

The results reflect a successful picture of the implementation of MHPs in Kent & Medway. Patients saw MHPs as practitioners who respect, value, and genuinely care for them, while giving them the support they need to overcome their difficulties. MHPs are able to spend significantly more time with them and are able to provide a specialised service. The wider primary care workforce, notably GPs, also benefit from time savings and positive patient feedback that lessens workload pressures. The MHP role is also likely to be resource efficient and generate a positive ROI, but patient outcomes could not be quantitatively assessed.

From the interview analysis, themes have emerged to support job satisfaction and retention, including feeling welcomed, part of the team, flexibility, and support from management. A centralised management structure in KMPT is seen as a key enabler to minimise variation and implement best practice and learnings from across a wider system.

Overall, the implementation of MHPs in Kent & Medway has been well received with positive impacts noted across all areas analysed. Recruitment, onboarding and management structures to ensure retention were also well received and successful. There are, however, a minority of exceptions that warrant further support and guidance. The report identifies and summarises generalisable recommendations to other systems, but also to benefit Kent & Medway with their exceptions. To conclude, it is clear that the MHPs are a valuable member of KMPT and valuable to their patients and the primary care workforce, so it is recommended that further work is performed to standardise their role and ensure continuous improvement as the role matures and develops further.

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