





# The evaluation team



Health  
Innovation  
Wessex

## Evaluation team

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## Disclaimer

The final report presents findings from an evaluation of the mental health practitioner (MHP) role in Dorset conducted by Health Innovation Wessex (HIW). The findings of this evaluation are those of the authors and do not necessarily represent the views of NHS Dorset, primary care networks within Dorset, or individual practices. Analyses within this evaluation were completed before the announcement on 13 March 2025 that NHS England will be brought back into the Department of Health and Social Care. The evaluation description of the innovation, its deployment, and the evaluation findings were accurate at the time of publication. The government decision may, in the future, alter how the report's findings and recommendations are received in this new context. We raise this issue for the reader to note.

## Acknowledgements

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## Health Innovation Wessex Data retention statement

Our policy is to retain anonymised and pseudo-anonymised data for six years after the publication of the final report. We retain identifiable data in accordance with the Data Protection Act and General Data Protection Regulation and for a period of 12 months after the publication of the final report. Following these retention periods, the client will be given notice of imminent destruction and the opportunity to discuss any issues arising with the project manager concerned. Once a date has been confirmed the data will be destroyed and a certificate of destruction provided.



# Evaluation of the mental health practitioner role in Dorset

## Executive Summary





# Executive summary

## Introduction

This evaluation report examines the implementation, utilisation, and impact of mental health practitioners (MHPs) within primary care networks (PCNs) across Dorset, aligned with the NHS Long Term Plan's objectives to enhance integrated mental health care. Introduced through the Additional Roles Reimbursement Scheme (ARRS) in 2021, MHPs aim to bridge primary care and specialist mental health services, alleviating GP workloads and improving patient access to mental health support.

## Evaluation purpose and methods

The evaluation, conducted from June 2024 to March 2025, aimed to explore MHP activities, their financial value, and their perceived impact across stakeholders. Using a mixed-methods concurrent triangulation design, the study included:

- Analysis of MHP service utilisation data from six PCNs
- Review of 3,080 activity logs from 18 MHPs
- Semi-structured interviews with 19 MHPs, nine GPs, and six CMHT managers.

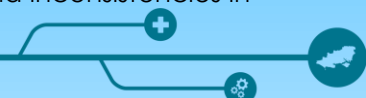




# Executive summary

## Key findings

- **Deployment and utilisation:** 27 MHPs are embedded in 15 of Dorset's 18 PCNs, with an estimated 23,850 appointments completed between December 2023 and December 2024, achieving an 88% utilisation rate.
- **Patient support:** MHPs address a wide range of mental health issues, but predominantly anxiety, depression, stress, and medication reviews. Based on an analysis of appointment activities, their role includes direct support, signposting, therapy, and crisis management.
- **Impact on healthcare services:**
  - **Primary care:** MHPs alleviated GP workloads, with an estimated 83% of MHP appointments preventing GP consultations, equating to around 19,080 avoided GP appointments annually.
  - **Community mental health teams (CMHTs):** 27% of MHP activities potentially avoided CMHT referrals, enhancing resource allocation for more complex cases.
- **Workforce wellbeing:** While MHPs improved GP and practice staff wellbeing, concerns about workload, isolation, and integration were noted among MHPs.
- **Financial implications:** The estimated cost savings from avoided GP appointments totalled approximately £448,380 annually. A more in-depth economic assessment is recommended to investigate the costs and benefits of MHPs.
- **Challenges and sustainability:** Key threats to sustainability include funding decisions within PCNs, MHP role isolation, variation in deployment, and alignment with practice priorities. Limited prescribing qualifications among MHPs and inconsistencies in appointment durations affect efficiency and service equity.





# Executive summary

## Main conclusion

The MHP role significantly benefits Dorset's primary care and mental health landscape, improving patient access, reducing GP burden, and contributing to financial efficiencies. Addressing sustainability challenges and operational improvements will be critical to maintaining and expanding these benefits.

## Key recommendations for commissioners

- Secure long-term funding by demonstrating cost-effectiveness on a broader scale.
- Increase workforce resilience through prescribing training, peer support, and optimising supervision opportunities for MHPs.
- Ensure service equity by standardising deployment of MHPs across PCNs.
- Integrate MHPs into primary care business models by aligning activities with GP incentives (e.g. QOF).
- Monitor MHP performance and outcomes through robust data collection and evaluation strategies.



# Evaluation of the mental health practitioner role in Dorset

Full report





# Background

- **About Health Innovation Wessex**

- Health innovation networks (formerly called Academic Health Science Networks or AHSNs) were established by NHS England in 2013 to transform the discovery, adoption and spread of innovation in health and care. We offer support and expertise across the health innovation pipeline, including the spread and adoption of technologies; enabling disruptive pathway redesign; building workforce capability; and evaluating implementation and impact to secure sustainable, transformative change.
- Health Innovation Wessex brings together the NHS, health and social care providers, universities, industry, community groups and voluntary organisations, and covers a regional population of almost three million. Working in partnership with our member organisations and industry, we support the NHS to generate economic benefits and improve health outcomes.

- **Origin of the evaluation**

- NHS Dorset Integrated Care Board (Operations Directorate, Adult Mental Health) asked Health Innovation Wessex for a real-world evaluation of their Mental Health Practitioner (MHP) service.

- **Reason for the evaluation**

- To explore the nature and extent of MHP activity across Dorset and provide an early indication of financial value.

- **Benefits of the evaluation to NHS Dorset ICB**

- To provide more detail than is currently available on the activities of MHPs, the perceived value and impact depending on different stakeholders' viewpoints, and an early indication of opportunity costs in the system.





## Background

- Mental health practitioners (MHP) support the NHS Long Term Plan ambition to develop new and integrated models of primary and community mental health care, to support adults with mental illnesses to live well in their communities.
- These roles were introduced to the Additional Roles Reimbursement Scheme (ARRS) April 2021<sup>1</sup>, enabling professionals with mental health expertise to be based in GP surgeries or neighbourhood settings, to support people with mental health needs and act as a 'bridge' between primary care and specialist mental health services. These roles sit alongside talking therapies for anxiety and depression, and a range of other roles within primary care that provide mental health support.
- The aim of the MHP role is to provide GPs and other primary care staff with timely support and advice, helping to relieve pressure on workloads and build stronger relationships with mental health services. MHPs may be the first mental health professionals people speak to at their GP surgery, and they can advise people on access to services in their area<sup>2</sup>.
- Twenty-seven MHPs are currently deployed within general practices across 15 of the 18 primary care networks (PCNs)<sup>3</sup> in Dorset. MHP roles were introduced into the first PCNs in January 2022 and since September 2024 all 27 have been in post supporting Dorset people.
- The MHPs are organised into two teams, and part funded by Dorset HealthCare University NHS Foundation Trust and individual PCNs. The MHPs work closely with general practice colleagues and community mental health teams.

<sup>1</sup><https://www.england.nhs.uk/mental-health/working-in-mental-health/mental-health-practitioners>

<sup>2</sup><https://www.healthwatch.co.uk/advice-and-information/2021-09-02/what-should-i-expect-after-being-referred-mental-health-support>

<sup>3</sup><https://dorset.communitypharmacy.org.uk/dorset-primary-care-networks-pcns/>





# Evaluation questions

## Evaluation questions:

1. What needs and situations do MHPs support?
2. What are the 'active ingredients' (key activities that make a difference) of the MHP role?
3. What is the perceived value and impact of MHP support to people with mental health symptoms?
4. What is the perceived value and impact of MHPs working with Community Mental Health Teams (CMHTs)?
5. What is the perceived value and impact of MHPs working with general practice?
6. What impact has the MHP role had on workforce wellbeing?
7. Are there opportunity costs, and for whom, associated with the use of MHPs in general practice?
8. Is the MHP service sustainable?
9. What aspects of the MHP role or their working environment could be improved?





# Evaluation methodology

The evaluation took place between June 2024 and March 2025 and used a mixed methods concurrent triangulation design to answer the evaluation questions.

## Methods and participation:

- 1. An analysis of mental health practitioner service-held utilisation data:** six of the fifteen Dorset PCNs with MHPs are collecting MHP utilisation data, which describes the number of planned appointments, actual appointments, and MHP utilisation rate. To estimate the MHP utilisation across the whole of Dorset, the existing data has been extrapolated and 23,850 estimated appointments were analysed between December 2023 to December 2024.
- 2. An analysis of mental health practitioner individual activity logs:** 18 MHPs across 13 PCNs recorded a total of 3,080 log entries between October 2024 and December 2024. These logs captured reasons for and outcomes of appointments, and MHP views on avoided GP and CMHT activity.
- 3. Semi-structured interviews with mental health practitioners:** 19 interviews were conducted with Dorset MHPs and thematically analysed.
- 4. Semi-structured interviews with general practitioners:** Nine interviews were conducted with Dorset GPs and thematically analysed.
- 5. Semi-structured interviews with managers at Community Mental Health Teams:** Six interviews were conducted with Dorset CMHT managers and thematically analysed.

Findings from all data sources were synthesised to develop detailed conclusions about the value and impact of the Mental Health Practitioner service across Dorset.

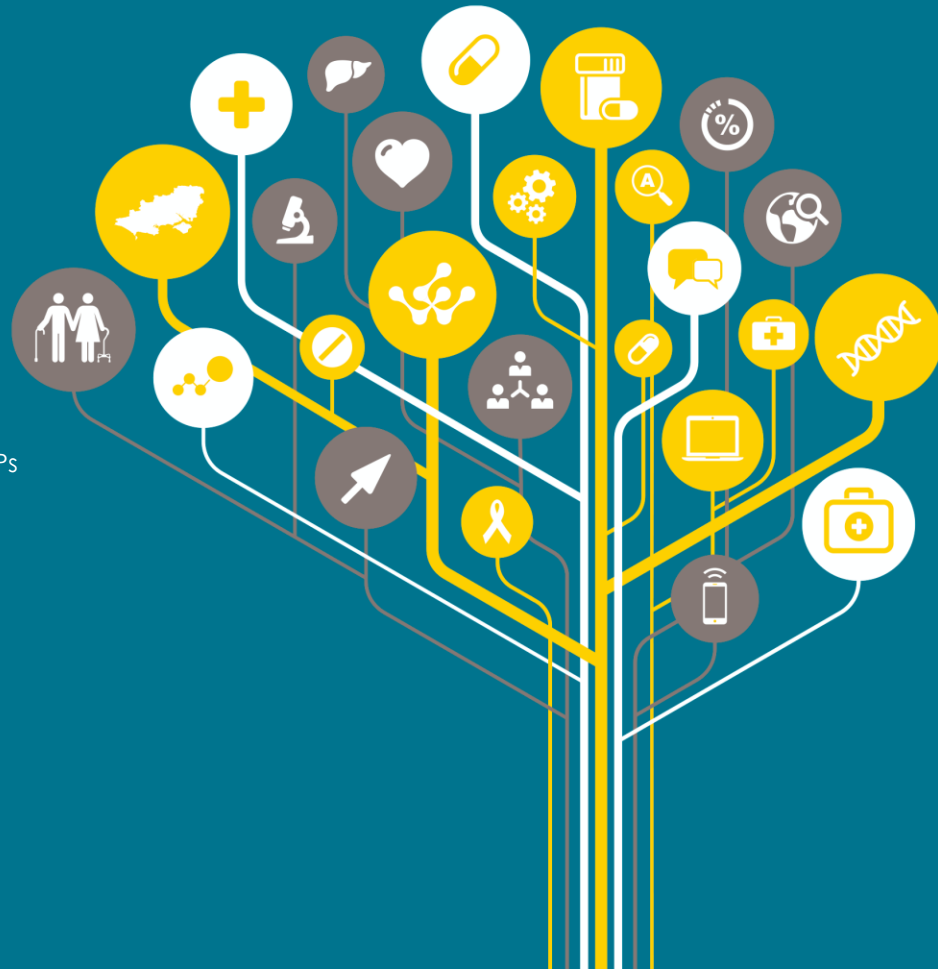




## Summary of results sections

The findings from all data sources were synthesised into several areas for this report.

1. MHP activity in Dorset
2. Potential financial benefits of employing MHPs
3. Impact of MHP role on general practice
4. Impact of MHP role on CMHT services
5. Impact of MHP role on patients
6. Key ingredients of the MHP role
7. Workforce and sustainability issues
8. Improvements to the MHP role





## MHP activity in Dorset



## Profile of MHPs working in Dorset

- Twenty-seven MHPs are currently deployed within general practices across 15 of the 18 primary care networks (PCN) in Dorset (see Appendix 1). MHP roles were introduced into the first PCNs in January 2022. Since September 2024, all 27 have been in post supporting people in Dorset.
- Each PCN have funding for up to two whole-time equivalents MHP roles and this can be organised to suit individual practice/PCN needs.
- Of the 15 PCNs with MHPs, eight (54%) PCNs employ two MHPs and five (33%) PCNs employ one MHP each. North Bournemouth PCN employs three MHPs and The Vale PCN employs two MHPs and a triage practitioner.
- All MHPs work across a range of general practices within their PCN and liaise with one or more CMHTs.
- The majority of MHPs have a mental health nursing background (81%; n=22), have previously worked for a CMHT (78%; n=21), are employed at a point equivalent to band 7 Agenda for Change (96%; n=26), are full-time employed (78%; n=21), attend their local CMHT MDT (100%; n=27), and attend their local practice MDT to manage patients (71%; n=19).
- Seven (26%) MHPs hold the independent prescribing qualification.
- As of December 2024, the average length of time MHPs have been in post is 14.0 months (with a standard deviation of 6.8 months, minimum 5.0 months, and maximum 27.0 months).





# MHP utilisation in Dorset

- At present, six of the fifteen Dorset PCNs with MHPs are collecting MHP utilisation data. This data was requested from the MHP service and described in the table below. One year of activity, from 24/12/2023 to 23/12/2024, describes the number of planned appointments, actual appointments, and MHP utilisation rate for six PCNs. To estimate the MHP utilisation across the whole of Dorset, the existing data has been extrapolated.

**Table 1: MHP utilisation in Dorset**

Dorset PCNs with MHP utilisation data	Planned appointments	Actual appointments	MHP utilisation rate %
1 Poole Central PCN (2 MHPs full time)	1575	1438	91.3
2 Blandford PCN (2 MHPs full time)	2437	1623	66.6
3 The Vale PCN (1 MHP full time, 2 MHPs 0.6FTE)	5487	5359	97.7
4 Shore Medical PCN (2 MHPs full time)	1618	1565	96.7
5 Poole North PCN (2 MHPs full time)	1535	1419	92.4
6 Sherborne PCN (2 MHPs full time, but data only available for 1 MHP)	2898	2827	97.6
Total - for 6 PCNs	15550	14231	91.5
Estimated activity at other Dorset PCNs	Estimated planned appointments	Estimated actual appointments	Estimated MHP utilisation rate %
7 Central Bournemouth PCN (2 MHPs full time)	1791	1511	84.4
8 South Coast Medical PCN (1 MHP full time)	895	755	84.4
9 Bournemouth East PCN (2 MHPs full time)	1791	1511	84.4
10 North Bournemouth PCN (1 MHP full time, 1 MHP 0.8FTE, 1 MHP 0.45FTE)	2015	1700	84.4
11 Poole Bay & Bournemouth PCN (1 MHP 0.6FTE)	537	453	84.4
12 Wimborne & Ferndown PCN (1 MHP full time)	895	755	84.4
13 Crane Valley PCN (1 MHP full time)	895	755	84.4
14 Mid Dorset PCN (1 MHP full time)	895	755	84.4
15 Weymouth & Portland PCN (2 MHPs full time)	1791	1511	84.4
<b>Estimated total MHP utilisation across Dorset</b>	<b>27058</b>	<b>23850</b>	<b>88.1</b>

- To estimate MHP utilisation across Dorset, the number of planned appointments and actual appointments from four PCNs was used to calculate an average per full time MHP. Poole Central, Blandford, Shore Medical and Poole North all employ two full time MHPs. To avoid the challenge of estimating activity based on part-time staff and to model the benefit of employing full time MHPs, the above four PCNs were used.
- Based on the four PCNs' known utilisation, an average of 895 planned appointments and 755 actual appointments was calculated for a full time MHP. These estimates have been used to estimate other Dorset PCN activity, accounting for how many MHPs they each employ.
- The estimated MHP utilisation rate was 88.1% across Dorset.





## MHP appointment activities in Dorset

All MHPs were invited to log their patient appointments to map their activities and outcomes of the appointments. MHPs were asked to log the following:

1. The length of each patient appointment
2. Key reasons for the appointment
3. Key outcomes of the appointment
4. Whether the appointment may have potentially avoided an appointment with a GP, referral to CMHT or contact with other relevant services

No personally identifiable details were recorded.

18 MHPs across 13 PCNs recorded a total of **3,080 log entries** between October 2024 and December 2024. The number of logs ranged from five to 337 entries per MHP. The distribution of appointment log per PCN is listed on the Table 2.

The logs were voluntarily recorded by the MHPs for three months period, therefore it is not intended to represent all activities from all MHPs throughout the year. Interpreting the information collected from the activity logs comes with methodological considerations and limitations (see Appendix 3).

**Table 2: Distribution of activity logs per PCN**

PCN	Number of entries
Blandford	573 (19%)
Shore Medical	504 (16%)
Poole North	394 (13%)
Bournemouth East	380 (12%)
North Bournemouth	366 (12%)
Poole Bay & Bournemouth	253 (8%)
The Vale	147 (5%)
Mid Dorset	138 (4%)
South Coast Medical	130 (4%)
Sherborne	97 (3%)
Bournemouth Central	74 (2%)
Wimborne & Ferndown	19 (1%)
Weymouth & Portland	5 (0%)
<b>Total</b>	<b>3080 (100%)</b>





# MHP appointment length

The length of patient appointments were recorded in 2,809 entries. The overall average length of appointment was 35 minutes. The original booking time for MHP appointments may vary across the PCNs as the appointment structures differ by MHPs. The comparison of original booking time and actual appointment length was not part of the evaluation objectives.

The range of appointment time recorded varied from 5 to 210 minutes. The distribution of appointment length are shown in the Figure 1 below:

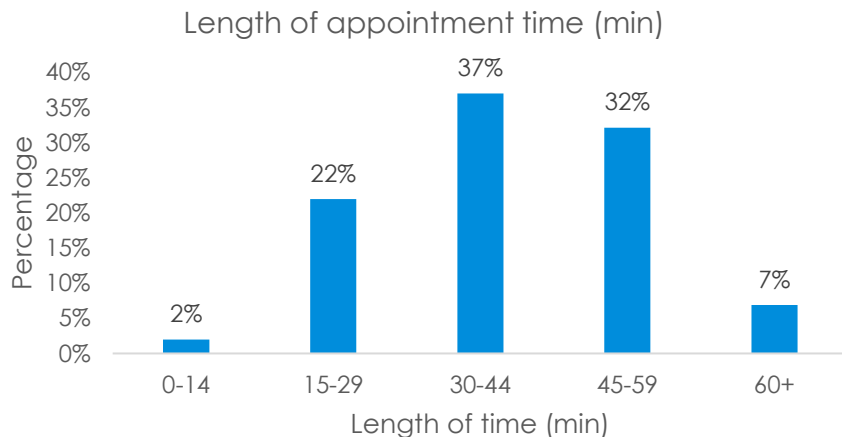


Figure 1: Distribution of average length of patient appointment time

The distribution of appointment length per PCN is listed in table 3.

**Table 3: Average MHP appointment time per PCN**

PCN	Average appointment time
Blandford	45
Mid Dorset	43
Shore Medical	42
The Vale	40
Wimborne & Ferndown	38
Bournemouth East	37
Poole North	35
South Coast Medical	27
Sherborne	27
Bournemouth Central	27
North Bournemouth	25
Poole Bay & Bournemouth	19
Weymouth & Portland	Not recorded
<b>Total average</b>	<b>35</b>





# MHP appointments – reasons and referral source

- Nearly 50% of patients visited MHPs for one reason and multi-reason appointments were less common. The analysis shows that the more reasons presented in an appointment, the longer the appointment lasted. Appointment lengths vary significantly, ranging from 5 to 210 minutes.
- The analysis of appointment reasons highlights a range of referral sources (when explicitly stated as referral). Of 115\* recorded referral sources, over 50% were from colleagues within a GP practice (e.g. GP, advanced nurse practitioner, wellbeing team, etc.), followed by CMHT (17%).
- It is important to caveat that not all MHPs recorded the reasons or details of the appointments. Therefore, the findings presented here are based on the available data.

Figure 2: Number of reasons for the appointment and time spent on each appointment

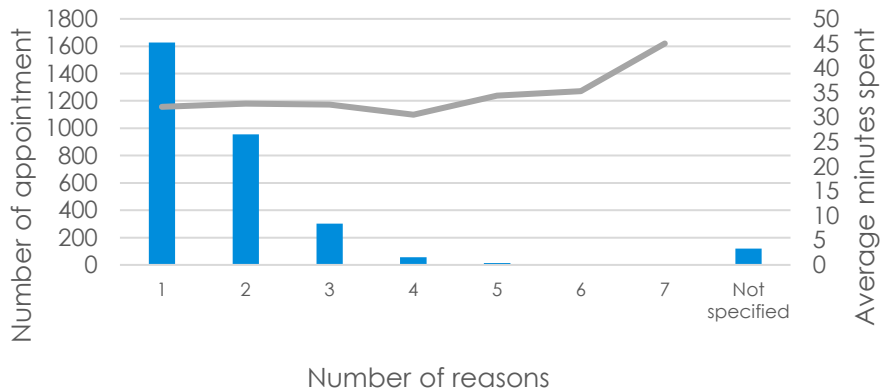


Table 4: Breakdown of referral source of MHP appointments

Referral source for MHP appointment	Frequency [n (100%)]
<b>Total</b>	<b>115 (100%)</b>
Colleagues within the GP practice	85 (74%)
CMHT	19 (17%)
Steps 2 Wellbeing service	3 (3%)
Other	7 (6%)

\*Other included carer, counsellor, practitioner (unspecified), social worker and South Western Ambulance Service Trust

\* The findings are drawn from the reasons reported in the activity logs. It was noted that reasons were not consistently documented by MHPs. As a result, some reasons and origins of appointments may have existed but were not reported.





# Top reasons for MHP appointments

- MHPs recorded the reason for each appointment between October and December 2024. Various ways of recording were seen in the dataset, ranging from MHPs documenting only the primary reason of the appointment to providing detailed descriptions of patients' conditions.
- From 3,080 log entries, a total of 42 categories of reasons were identified, with a total of 4,755 separate reasons collected and analysed.

## The key reasons for MHP appointments:

- **Anxiety (720, 15.1%)**
- **Low mood (545, 11.5%)**
- **Depression (422, 9.3%)**
- **Stress (313, 6.6%)**
- **Medication review (249, 5.2%).**
- The five main categories of reasons are consistently reflected across all PCNs.
- See Table 5 on the following slide for a detailed breakdown across PCNs.

By considering the findings on Table 5 on the next slide:

- While the proportions of each category (of reasons for MHP appointment) are similar across all PCNs, some variation across PCNs is apparent.
- In Bournemouth Central PCN, anxiety was still the first main reason for MHP appointments, but the second main reason was mental health review (9.7%), and third main reason was patients' seeking medication (7.2%).
- Bournemouth East PCN had the highest prevalence of appointments for ADHD-related MHP appointments (4.3%) across PCNs and at a higher level than Dorset overall (2.5%).
- Poole North PCN had the highest rate of patients not attending booked appointments (11.1%).





# Reasons for MHP appointment by PCN

Table 5: Reasons for MHP appointments

Reason of appointment	Total	Blandford	Bournemouth Central	Bournemouth East	Mid Dorset	North Bournemouth	Poole Bay & Bournemouth	Poole North	Sherborne	Shore Medical	South Coast Medical	The Vale	Weymouth & Portland	Wimborne & Ferndown
<b>Reason of appointment (Total count)</b>	<b>4755</b>	<b>783</b>	<b>195</b>	<b>696</b>	<b>285</b>	<b>580</b>	<b>293</b>	<b>588</b>	<b>184</b>	<b>665</b>	<b>214</b>	<b>262</b>	<b>3</b>	<b>7</b>
Anxiety (720)	720 (15.1%)	91 (11.6%)	27 (13.8%)	83 (11.9%)	55 (19.3%)	85 (14.7%)	59 (20.1%)	100 (17.0%)	39 (21.2%)	101 (15.2%)	27 (12.6%)	52 (19.8%)		1 (14.3%)
Low mood (545)	545 (11.5%)	117 (14.9%)	15 (7.7%)	55 (7.9%)	73 (25.6%)	27 (4.7%)	9 (3.1%)	85 (14.5%)	35 (19.0%)	63 (9.5%)	12 (5.6%)	53 (20.2%)		1 (14.3%)
Depression (442)	442 (9.3%)	131 (16.7%)	14 (7.2%)	44 (6.3%)	13 (4.6%)	41 (7.1%)	39 (13.3%)	73 (12.4%)		66 (9.9%)	18 (8.4%)	1 (4%)		2 (28.6%)
Stress (313)	313 (6.6%)	76 (9.7%)	11 (5.6%)	72 (10.3%)	18 (6.3%)	44 (7.6%)	27 (9.2%)	6 (1.0%)	11 (6.0%)	19 (2.9%)	10 (4.7%)	19 (7.3%)		
Medication review (249)	249 (5.2%)	36 (4.6%)	6 (3.1%)	1 (1%)		48 (8.3%)	77 (26.3%)	22 (3.7%)	9 (4.9%)	35 (5.3%)	14 (6.5%)	1 (4%)		
Providing support or advice or review patient's mental state (172)	172 (3.6%)	30 (3.8%)	19 (9.7%)	31 (4.5%)		24 (4.1%)	5 (1.7%)	29 (4.9%)	1 (5%)	23 (3.5%)	4 (1.9%)	3 (1.1%)	3 (100.0%)	
Other Complex mental condition, e.g. Functional neurological disorder (166)	166 (3.5%)	18 (2.3%)	12 (6.2%)	27 (3.9%)	10 (3.5%)	28 (4.8%)	9 (3.1%)	13 (2.2%)	15 (8.2%)	10 (1.5%)	17 (7.9%)	7 (2.7%)		
Suicidal ideation, thoughts or attempts (157)	157 (3.3%)	24 (3.1%)	0	21 (3.0%)	27 (9.5%)	12 (2.1%)	4 (1.4%)	38 (6.5%)	0	29 (4.4%)	2 (0.9%)	0		
Trauma (124)	124 (2.6%)	19 (2.4%)	13 (6.7%)	20 (2.9%)	6 (2.1%)	19 (3.3%)	4 (1.4%)	5 (0.9%)	6 (3.3%)	22 (3.3%)	7 (3.3%)	2 (0.8%)		1 (14.3%)
Attention deficit hyperactivity disorder (ADHD) (117)	117 (2.5%)	24 (3.1%)	2 (1.0%)	30 (4.3%)	2 (0.7%)	16 (2.8%)	6 (2.0%)	12 (2.0%)	1 (0.5%)	13 (2.0%)	8 (3.7%)	2 (0.8%)		1 (14.3%)
Requested by other service, e.g. GP (111)	111 (2.3%)	34 (4.3%)		15 (2.2%)	1 (0.4%)	8 (1.4%)	1 (0.3%)	4 (0.7%)		30 (4.5%)	6 (2.8%)	12 (4.6%)		
Did not attend (DNA) (101)	101 (2.1%)	18 (2.3%)	2 (1.0%)			9 (1.6%)		65 (11.1%)		7 (1.1%)				
Experiencing bereavement/grief, e.g. loss of a relative (100)	100 (2.1%)	10 (1.3%)	6 (3.1%)	18 (2.6%)		13 (2.2%)	9 (3.1%)	3 (0.5%)	9 (4.9%)	16 (2.4%)	4 (1.9%)	12 (4.6%)		
Patient seeking medicine (99)	99 (2.1%)	18 (2.3%)	14 (7.2%)	6 (0.9%)		9 (1.6%)	4 (1.4%)	3 (0.5%)	11 (6.0%)	8 (1.2%)	12 (5.6%)	14 (5.3%)		
Post traumatic stress disorder (PTSD) (98)	98 (2.1%)	11 (1.4%)	2 (1.0%)	14 (2.0%)	7 (2.5%)	11 (1.9%)	3 (1.0%)	13 (2.2%)		28 (4.2%)	6 (2.8%)	2 (0.8%)		1 (14.3%)
Administrative work, e.g. feedback GP, arrange a meeting (98)	98 (2.1%)	11 (1.4%)	1 (0.5%)	11 (1.6%)		9 (1.6%)	2 (0.7%)	5 (0.9%)	10 (5.4%)	40 (6.0%)	5 (2.3%)	4 (1.5%)		
Mood changing due to situational difficulties, e.g. Relationship breakdown (89)	89 (1.9%)	5 (0.6%)	7 (3.6%)	18 (2.6%)	4 (1.4%)	25 (4.3%)	1 (0.3%)	4 (0.7%)	8 (4.3%)	1 (0.2%)	9 (4.2%)	7 (2.7%)		
Bipolar personality disorder (85)	85 (1.8%)	9 (1.1%)		12 (1.7%)	19 (6.7%)	14 (2.4%)	1 (0.3%)	14 (2.4%)		13 (2.0%)	2 (0.9%)	1 (0.4%)		
Alcohol abuse or overconsumption (81)	81 (1.7%)	5 (0.6%)	2 (1.0%)	23 (3.3%)	4 (1.4%)	11 (1.9%)	6 (2.0%)	10 (1.7%)	2 (1.1%)	13 (2.0%)	3 (1.4%)	2 (0.8%)		
Problem with sleep, e.g. insomnia (81)	81 (1.7%)	8 (1.0%)	3 (1.5%)	11 (1.6%)	1 (0.4%)	22 (3.8%)	1 (0.3%)	6 (1.0%)	6 (3.3%)	7 (1.1%)	1 (0.5%)	15 (5.7%)		
Experiencing emotionally unstable and dysregulation (77)	77 (1.6%)	9 (1.1%)	5 (2.6%)	18 (2.6%)	9 (3.2%)	9 (1.6%)	1 (0.3%)	1 (0.2%)	4 (2.2%)	13 (2.0%)	1 (0.5%)	7 (2.7%)		
Problem with substance abuse, misuse and Overdoses (66)	66 (1.4%)	8 (1.0%)	6 (3.1%)	14 (2.0%)	2 (0.7%)	12 (2.1%)	4 (1.4%)	7 (1.2%)	3 (1.6%)	7 (1.1%)	2 (0.9%)	1 (0.4%)		
Mood changing due to domestic abuse, domestic violence (64)	64 (1.3%)	5 (0.6%)	2 (1.0%)	20 (2.9%)	1 (0.4%)	18 (3.1%)	1 (0.3%)	2 (0.3%)	1 (0.5%)	11 (1.7%)	2 (0.9%)	1 (0.4%)		
Patient is waiting for the other service (63)	63 (1.3%)	1 (0.1%)	1 (0.5%)	18 (2.6%)	1 (0.4%)	1 (0.2%)	1 (0.3%)	1 (0.2%)	2 (1.1%)	23 (3.5%)	7 (3.3%)	7 (2.7%)		
Panic attacks (57)	57 (1.2%)	1 (0.1%)		24 (3.4%)		13 (2.2%)	4 (1.4%)	7 (1.2%)		1 (0.2%)	3 (1.4%)	4 (1.5%)		
Urgent appointment: Mental Health in crisis (56)	56 (1.2%)	19 (2.4%)	6 (3.1%)	8 (1.1%)	3 (1.1%)	3 (0.5%)		16 (2.7%)	1 (0.5%)					
Mood changing due to physical health, e.g. cancer (55)	55 (1.2%)	2 (0.3%)	3 (1.5%)	25 (3.6%)	5 (1.8%)	5 (0.9%)	1 (0.3%)	5 (0.9%)	2 (1.1%)	2 (0.3%)	2 (0.9%)	2 (0.8%)		
Autism spectrum disorder (ASD) (54)	54 (1.1%)	2 (0.3%)	1 (0.5%)	18 (2.6%)	10 (3.5%)	4 (0.7%)	1 (0.3%)	6 (1.0%)		3 (0.5%)	5 (2.3%)	4 (1.5%)		
Obsessive Compulsive disorder (45)	45 (0.9%)	6 (0.8%)	2 (1.0%)	8 (1.1%)	3 (1.1%)		5 (1.7%)	13 (2.2%)	1 (0.5%)	4 (0.6%)	1 (0.5%)	2 (0.8%)		
Deliberate self-harm (43)	43 (0.9%)	16 (2.0%)	3 (1.5%)	3 (0.4%)	5 (1.8%)	8 (1.4%)		1 (0.2%)	2 (1.1%)	2 (0.3%)		3 (1.1%)		
Emotionally unstable personality disorder (EUPD) (34)	34 (0.7%)	5 (0.6%)		7 (1.0%)		3 (0.5%)	5 (1.7%)	7 (1.2%)		2 (0.3%)	4 (1.9%)	1 (0.4%)		
Patient requesting support on emotional wellbeing (31)	31 (0.7%)			2 (0.3%)	1 (0.4%)	2 (0.3%)		1 (0.2%)		3 (0.5%)	9 (4.2%)	13 (5.0%)		
Eating disorder (26)	26 (0.5%)	2 (0.3%)	6 (3.1%)	6 (0.9%)	1 (0.4%)		1 (0.3%)	3 (0.5%)	1 (0.5%)		5 (2.3%)	1 (0.4%)		
Giving containment calls/safety net/safeguarding (20)	20 (0.4%)		1 (0.5%)	1 (0.1%)						18 (2.7%)				
Mood changing due to chronic health concerns (20)	20 (0.4%)	1 (0.1%)	1 (0.5%)	1 (0.1%)		13 (2.2%)	1 (0.3%)		2 (1.1%)			1 (0.4%)		
Loneliness or dissocialised (19)	19 (0.4%)	2 (0.3%)		3 (0.4%)		10 (1.7%)			1 (0.5%)		2 (0.9%)	1 (0.4%)		
MHP providing guidance of using Flourish (19)	19 (0.4%)							3 (0.5%)		15 (2.3%)	1 (0.5%)			
Tiredness, burnout or fatigue (18)	18 (0.4%)	5 (0.6%)	1 (0.5%)	2 (0.3%)		1 (0.2%)				3 (0.5%)	4 (1.9%)	2 (0.8%)		
Intrusive thoughts (14)	14 (0.3%)	4 (0.5%)	1 (0.5%)	3 (0.4%)	2 (0.7%)	1 (0.2%)				3 (0.5%)				
Mood changing due to hormone, e.g. menopause or postnatal depression (9)	9 (0.2%)			3 (0.4%)	2 (0.7%)	1 (0.2%)	1 (0.3%)		1 (0.5%)			4 (1.5%)		
Schizophrenia (9)	9 (0.2%)										1 (0.5%)			
MHP providing guidance on DBT course (8)	8 (0.2%)									6 (0.9%)	2 (0.9%)			





# Overview of MHP appointment outcomes

- MHPs were asked to note the **outcome** of each appointment. Based on 3,080 activity log entries, a total of 5,518 individual outcomes were noted. The level of detail ranged from a simple list of actions to descriptive narrative of the care and support offered to a patient.

- In addition to the appointment outcomes, the entries also included details about the **activities within the appointment**. These included any details of treatment or care offered to help support the patient to plan the outcome of the appointments. The key categories of these activities are listed below:

1. Advice, support and psychoeducation
2. Medication review (by MHP)
3. Medication prescribed (by MHP)
4. Issuing a fit note
5. Completing / assisting with ADHD assessment request form
6. Safety plan / safeguarding process
7. Joint patient appointment with staff from another service.

- The details of the **appointment outcome** ranged from one single action to multiple actions.

The **key categories** of appointment outcomes were:

1. **Follow-up appointment arranged**
2. **Signposting to a service / support**
3. **Contact with other services (referral, liaising or letter)**
4. **No further input / discharged from MHP care**
5. **Continuing with the current service (other than MHP input)**
6. **Awaiting another service's input**
7. **Patient self-referring to a service.**

There were other entries which did not have a clear outcome, were missed appointments or not appropriate for MHP's input. These entries were categorised as:

- Unclear outcome
- Did not attend or declined input
- Inappropriate appointment (e.g. not mental health issue).





# MHP appointment outcomes by PCN

Table 6: List of outcome descriptions – Whole of Dorset and by PCN

Outcome descriptions / PCN [n (%)]	Total	Blandford	Bournemouth East	Shore Medical	North Bournemouth	Ile North	Poole Bay & Bournemouth	The Vale	South Coast Medical	Mid Dorset	Sherborne	Bournemouth Central	Wimborne & Ferndown	Weymouth & Portland
Follow-up appointment	1455 (26%)	210 (21%)	206 (22%)	265 (30%)	163 (20%)	272 (62%)	13 (4%)	81 (27%)	23 (10%)	97 (46%)	71 (39%)	44 (28%)	5 (9%)	5 (100%)
Signposting to a service / support	1393 (25%)	290 (29%)	388 (41%)	109 (13%)	243 (30%)	8 (2%)	108 (33%)	108 (36%)	39 (17%)	19 (9%)	36 (20%)	30 (19%)	15 (27%)	0 (0%)
Contacting a service (referral, liaison, or letter writing)	702 (13%)	138 (14%)	119 (13%)	154 (18%)	85 (10%)	20 (5%)	24 (7%)	47 (16%)	38 (16%)	30 (14%)	32 (17%)	14 (9%)	1 (2%)	0 (0%)
Advice & Support / psychoeducation	484 (9%)	42 (4%)	91 (10%)	42 (5%)	148 (18%)	1 (0%)	26 (8%)	14 (5%)	48 (21%)	3 (1%)	9 (5%)	43 (27%)	17 (30%)	0 (0%)
Medication review (by MHP)	331 (6%)	108 (11%)	3 (0%)	56 (6%)	48 (6%)	8 (2%)	62 (19%)	0 (0%)	20 (9%)	2 (1%)	4 (2%)	10 (6%)	10 (18%)	0 (0%)
No further input / discharge	284 (5%)	75 (8%)	23 (2%)	36 (4%)	7 (1%)	71 (16%)	7 (2%)	19 (6%)	4 (2%)	32 (15%)	6 (3%)	4 (3%)	0 (0%)	0 (0%)
Did not attend / declined input	207 (4%)	31 (3%)	4 (0%)	92 (11%)	10 (1%)	21 (5%)	47 (15%)	0 (0%)	1 (0%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Medication prescribed (by MHP)	153 (3%)	29 (3%)	5 (1%)	12 (1%)	56 (7%)	3 (1%)	20 (6%)	1 (0%)	16 (7%)	1 (0%)	1 (1%)	2 (1%)	7 (13%)	0 (0%)
Continuing with current service input	117 (2%)	20 (2%)	33 (4%)	20 (2%)	4 (0%)	17 (4%)	5 (2%)	5 (2%)	1 (0%)	8 (4%)	3 (2%)	1 (1%)	0 (0%)	0 (0%)
Issuing a fit note	95 (2%)	16 (2%)	4 (0%)	20 (2%)	23 (3%)	0 (0%)	0 (0%)	7 (2%)	14 (6%)	0 (0%)	3 (2%)	7 (4%)	1 (2%)	0 (0%)
Awaiting another service input	93 (2%)	7 (1%)	26 (3%)	20 (2%)	7 (1%)	2 (0%)	2 (1%)	12 (4%)	3 (1%)	13 (6%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
Other (unclear outcome, admin time)	55 (1%)	1 (0%)	0 (0%)	15 (2%)	2 (0%)	12 (3%)	6 (2%)	1 (0%)	18 (8%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Patient self-referring to a service	50 (1%)	1 (0%)	15 (2%)	11 (1%)	2 (0%)	0 (0%)	0 (0%)	4 (1%)	1 (0%)	1 (0%)	15 (8%)	0 (0%)	0 (0%)	0 (0%)
Safety planning / safeguarding	44 (1%)	15 (2%)	13 (1%)	8 (1%)	2 (0%)	1 (0%)	3 (1%)	0 (0%)	2 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
ADHD assessment request form	41 (1%)	4 (0%)	6 (1%)	6 (1%)	15 (2%)	2 (0%)	0 (0%)	0 (0%)	3 (1%)	0 (0%)	1 (1%)	4 (3%)	0 (0%)	0 (0%)
Inappropriate appointment	8 (0%)	0 (0%)	0 (0%)	1 (0%)	1 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	4 (2%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Joint appointment	6 (0%)	0 (0%)	0 (0%)	4 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
<b>Total</b>	<b>5518 (100%)</b>	<b>987 (100%)</b>	<b>936 (100%)</b>	<b>871 (100%)</b>	<b>816 (100%)</b>	<b>439 (100%)</b>	<b>324 (100%)</b>	<b>299 (100%)</b>	<b>231 (100%)</b>	<b>211 (100%)</b>	<b>183 (100%)</b>	<b>160 (100%)</b>	<b>56 (100%)</b>	<b>5 (100%)</b>

Table 6 is an overview of outcome descriptions recorded by PCN. The figures within the table indicate the number of entries and the percentage distribution per PCN. The colour gradient highlights the highest and lowest entries per PCN (e.g. dark green = highest number, no colour = least number).





# MHP appointment outcomes by PCN

Table 6 in the previous slide indicates:

- Overall, booking further follow-up appointments with MHPs seems to be the most common outcome across the PCNs, followed by signposting to other services.
- One exception is Poole Bay & Bournemouth PCN, which emphasise more signposting to other services instead of booking follow-up appointments.
- There are three PCNs (South Coast Medical, Bournemouth Central and Wimborne & Ferndown) with more emphasis on giving advice & support / psychoeducation to patients within the appointment.
- A sub-analysis of outcomes categories was conducted, e.g. the type of follow-up appointments and where patients were signposted to, and these are described in Appendix 2 (outcome categories 1, 2, 3, 5, 6 and 7).





## MHPs activity varies across PCNs

- The MHP profile findings in Appendix 1 indicate the number of MHPs per PCN varies which could affect equal coverage of mental health support when comparing areas. Also, one PCN has a 'triage practitioner role' (approximately band 4 Agenda for Change) supporting MHPs to manage appointments and undertake some appointments.
- The findings in Table 3 indicate the average appointment length varied by PCN.
- Theme 1 from the staff interviews (see Appendix) also highlighted **variation in the expectations** of the MHP role.

*"I made [practice staff] realise that I cannot be on a stopwatch and say, "Sorry you're suicidal, but your time's up." It just doesn't work with mental health so that had to be organised over a couple of months. I think we've got a nice happy medium now where I have my own slots in the day. I get two half-hours that I can do what is most effective. I can see one patient for two half-hours, or two patients, or I can squeeze in four phone calls." (MHP15)*

*"There isn't access to dialectical behaviour therapy in primary care...if you've got a patient with personality disorder and DBT is indicated but they're not high risk enough for CMHT...there isn't provision for DBT in primary care at the moment. I'm using a guided self-help DBT tool to support these patients, which is more than what they would have got before and part of my role that I really do love. But I know that not every MHP enjoys that aspect of work and there's no consistency in different PCNs...there are different expectations on the way we work." (MHP1)*

*"It may take 5 or 10 minutes to get to the point that the person's comfortable enough to even disclose what's really contributing to their stress, or for me to drill down to find out what the problems are. There might be a number of different barriers, so allowing the person to feel comfortable, managing expectations, and solving issues might take the best part of 5 or 10 minutes." (MHP14)*





## MHPs provide a 'broad offer' of support

Theme 2 from the staff interviews (see Appendix 4) describes MHP, GP, and CMHT manager views that MHPs were providing a 'broad range of support' for people with mental health symptoms.

### Major areas of MHP support:

1. Bridging the gap between primary and secondary care
2. 'Stabilising' people for onward care
3. First contact support
4. Follow up support
5. Signposting support
6. Providing therapy
7. Managing high risk patients with CMHT
8. Safety net support
9. Providing personalised mental health support.





## Summary of MHP activity in Dorset

1. Between December 2023 and December 2024, the overall utilisation of MHPs across Dorset was 88%. An estimated 23,850 MHP appointments were completed.
2. There is commonality in MHP professional backgrounds, most are nurses, have worked for CMHTs, employed at the same salary level, are full-time, and are embedded in their CMHT and GP MDT meetings.
3. People bring a very wide variety of reasons to MHP appointments. However, there are some common reasons across Dorset and across PCNs, namely anxiety, low mood, depression, stress, and medication review.
4. There is commonality in the outcomes of MHP appointments across PCNs. The key types of outcome are follow-up appointment arranged, signposting to a service / support, contact with other services (referral, liaising or letter), no further input / discharged from MHP care, continue with the current service (other than MHP input), awaiting another service's input, and patient self-referring to a service.
5. There is variation in the number of MHPs deployed across PCNs, in the length of appointment time, in some expectations of the role, on whether a triage practitioner role (approximately band 4 Agenda for Change) is supporting MHPs, and in some specific MHP activities, e.g. differences in medication review as a reason and outcome of the appointment across PCNs. The latter may be explained by only a quarter of Dorset MHPs holding the prescribing qualification.
6. Dorset MHPs are engaged a wide range of signposting and liaison activity. For example, toward CMHTs, GPs, Steps 2 Wellbeing, Dorset Recovery Education Centre, talking therapy, Access Wellbeing, We Are With You, LiveWell Dorset, counselling, housing services, social prescribers, and health coaches.
7. There was agreement by all interviewed stakeholders that MHPs provide a 'broad range of support' for people with mental health symptoms, including bridging the gap between primary and secondary care, 'stabilising' people, first contact support, follow up support, signposting support, providing therapy, managing high risk patients with CMHT, safety net support, and providing personalised mental health support.







## Potential financial benefits

Figure 4: Potential financial benefits

Several data sources in this evaluation were used to model the potential financial benefits of employing MHPs in Dorset.

• **The rate of avoided GP appointments:** based on an activity log of 3,080 MHP appointments recorded by 18 MHPs between October and December 2024, MHPs reported that **83%** of the 3,080 appointments represented avoided appointments for GPs.

• **Applying the rate to the Dorset-wide MHP utilisation analysis:** it was calculated 27 MHPs provided 23,850 appointments between December 2023 and December 2024. Assuming the same rate (83%) of avoided GP appointments, this would indicate **19,080** (83% of 23,850) MHP appointments were avoided GP appointments.

• **Calculating the cost per MHP appointment:** based on the salaries and full time equivalents (FTE) of the 27 MHPs in Dorset, the calculated average cost per MHP appointment is £18.50 [average MHP cost per hour £32 / average appointment length 35mins].

• **Cost of MHP appointments in Dorset:** 19,080 MHP appointments would cost £352,980 [total relevant appointments x cost per MHP appointment].

• **Cost of GP appointments in England:** Based on the unit costs of health and social care manual (Jones et al., 2022), the average cost of a nine-minute face-to-face GP appointment in England is £42. If Dorset MHPs were not in post and the 19,080 appointments were managed by GPs, the appointments would have cost £801,360.

• **Potential avoided costs across Dorset** [GP appointment cost minus MHP appointment cost for 19,080 appointments] amount to £448,380 in one calendar year.

Jones, K., Weatherly, H., Birch, S., et al. (2022) Unit Costs of Health and Social Care. <https://kar.kent.ac.uk/100519/>





## Themes related to practice finances

Theme 7 and 8 from the staff interviews (see Appendix) expand the discussion on finances.

Particularly amongst GPs, there was high positivity toward the MHP role but also indications that the decision to use MHPs in practices and generally how to spend ARRS/PCN funding was an ongoing issue.

*"All these different roles working in our surgeries have essentially allowed us to continue to meet our contractual demands...but if the funding was there in the first place to have enough GPs, I think we would just have more GPs." (GP1)*

Also, there were tensions between GPs and MHPs regarding appointment length and the use of Quality and Outcomes Framework indicators.

*"There was a little bit of kickback from the practice...asking me to squeeze in patients. I guess I've got the confidence to say I can't." (MHP19)*

*"With GPs, they have 10-15 minute appointments, so they had a big issue with my appointments being around 45-60 minutes...they were asking 'what on earth are you doing for 45 minutes?' But when you're seeing someone with a mental health problem you need the time to speak, write up, and refer on. It's been a bit of a battle for them to understand that. When I first started my appointments were 30 minutes but it wasn't sustainable. I know they can think if I saw more people, they'd get more money. For me, if you see someone and complete a piece of work, you might not need to see that person again. Whereas, if you have a shorter appointment time, you're more likely to bring that person back to complete the work and create more revenue. For the QoF, I would put mental health review or medication review or depression." (MHP16)*

*"There's lots of balancing with PCN and practices and having to get them to understand a different way of working. We're a bit protected because of being partly employed by Dorset HealthCare. If I were fully employed by a practice, it would be different and my appointments would be likely be longer." (MHP16)*







# Perception of avoided GP appointments

- Table 7 below summarises MHP views on whether they perceived their appointment avoided an appointment with a GP. The data within the table indicates the number of entries and the percentage distribution per PCN. The colour gradient highlights the highest and lowest entries per PCN (e.g. dark green = highest number, no colour = lowest number).
- Across Dorset, 83% of 3,080 appointments were considered avoided GP appointments.

Table 7: MHP's perception on whether their appointment with a patient avoided a GP appointment

Responses / PCN [n (%)]	Total	Blandford	Shore Medical	Poole North	Bournemouth East	North Bournemouth	Poole Bay & Bournemouth	The Vale	Mid Dorset	South Coast Medical	Sherborne	Bournemouth Central	Wimborne & Ferndown	Weymouth & Portland
Yes	2569 (83%)	492 (86%)	338 (67%)	316 (80%)	321 (84%)	342 (93%)	208 (82%)	131 (89%)	134 (97%)	115 (88%)	96 (99%)	52 (70%)	19 (100%)	5 (100%)
No	262 (9%)	49 (9%)	113 (22%)	2 (1%)	53 (14%)	13 (4%)	0 (0%)	6 (4%)	4 (3%)	10 (8%)	1 (1%)	11 (15%)	0 (0%)	0 (0%)
Unsure	16 (1%)	0 (0%)	4 (1%)	2 (1%)	1 (0%)	2 (1%)	0 (0%)	6 (4%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
N/A	152 (5%)	6 (1%)	47 (9%)	47 (12%)	2 (1%)	0 (0%)	43 (17%)	4 (3%)	0 (0%)	1 (1%)	0 (0%)	2 (3%)	0 (0%)	0 (0%)
(blank)	81 (3%)	26 (5%)	2 (0%)	27 (7%)	3 (1%)	9 (2%)	2 (1%)	0 (0%)	0 (0%)	3 (2%)	0 (0%)	9 (12%)	0 (0%)	0 (0%)
<b>Total</b>	<b>3080 (100%)</b>	<b>573 (100%)</b>	<b>504 (100%)</b>	<b>394 (100%)</b>	<b>380 (100%)</b>	<b>366 (100%)</b>	<b>253 (100%)</b>	<b>147 (100%)</b>	<b>138 (100%)</b>	<b>130 (100%)</b>	<b>97 (100%)</b>	<b>74 (100%)</b>	<b>19 (100%)</b>	<b>5 (100%)</b>

\*N/A = Not applicable. Majority of the response "N/A" were associated with entries with missed / inappropriate appointment or no further support indicated





# Impact of MHP role on general practice

Theme 4 from the staff interviews (see Appendix) describes MHPs', GPs', and CMHT managers' views that MHPs were having a substantial positive impact on general practice activities.

- Avoiding GP appointments
- Improving the practice offer to patients
- Reduced number of mental health related crises for GPs to manage
- Supporting ADHD assessments
- Helping to improve practice staff wellbeing
- People requesting 'direct to MHP' appointments.

*"Some GPs' regular attenders now see us instead, which has reduced the number of repeat visits to GPs." (MHP10)*

*"The reason we wanted MHPs was the idea was there's a certain amount of work that comes into the practice which can be time consuming for GPs and often gets attributed to a duty doctor...it's very much reducing demand on duty doctors." (GP1)*

*"Our MHP has extensive experience with a wide range of mental health services, so they're seeing quite a quite a breadth in terms of potential diagnosis. They are picking up on the expected and new presentations, schizophrenia and young people, with a bit of emotionally unstable personality disorder...it's increased our awareness in the practice and available options." (GP5)*

*"It's a bonus resource that's helped to increase our offer as a practice...we have the ability to get patients seen by the right person." (GP2)*

*"It definitely feels like we have less of crises coming our way." (GP1)*

*"There's a lot of ADHD work that seems to be shifted towards MHPs...I'm not convinced it's entirely appropriate but there's a lot of ADHD work and where should it go?" (GP2)*

*"I think there's so many things that are impacting GP job satisfaction at the moment...I would say there's a positive nudge forward from having good professionals in the team...but when I think about my work wellbeing, I immediately go to the swamp of overwhelm that I feel and that most of my colleagues are in...but I think there is a nudge." (GP4)*

*"I think the fact that patients want following up with MHPs specifically is testimony to the kind of service MHPs provide." (GP7)*







# Perception of avoided referrals to CMHT

- Table 8 summarises MHP views on whether they perceived their appointment avoided a referral to CMHT. The data within the table indicate the number of entries and the percentage distribution per PCN. The colour gradient highlights the highest and lowest entries per PCN (e.g. dark green = highest number, no colour = lowest number).
- Across Dorset, 27% of 3,080 appointments were considered avoided referrals to CMHT, which suggests some MHP activity is within the scope of CMHT activities but held by MHPs. However, the high percentage of No and N/A responses indicate MHPs are largely supporting people with mental health symptoms that do not meet the criteria for CMHT referral.

Table 8: MHP's perception on whether their appointment with a patient avoided a referral to CMHT

Responses / PCN [n (%)]	Total	Blandford	Shore Medical	Poole North	Bournemouth East	North Bournemouth	Poole Bay & Bournemouth	The Vale	Mid Dorset	South Coast Medical	Sherborne	Bournemouth Central	Wimborne & Ferndown	Weymouth & Portland
Yes	821 (27%)	50 (9%)	78 (15%)	61 (15%)	82 (22%)	84 (23%)	208 (82%)	5 (3%)	132 (96%)	10 (8%)	91 (94%)	11 (15%)	5 (26%)	4 (80%)
No	1138 (37%)	269 (47%)	227 (45%)	11 (3%)	273 (72%)	268 (73%)	0 (0%)	1 (1%)	6 (4%)	65 (50%)	4 (4%)	4 (5%)	10 (53%)	0 (0%)
N/A	956 (31%)	219 (38%)	171 (34%)	280 (71%)	10 (3%)	0 (0%)	44 (17%)	139 (95%)	0 (0%)	46 (35%)	0 (0%)	46 (62%)	0 (0%)	1 (20%)
N/A - known to CMHT	48 (2%)	9 (2%)	20 (4%)	2 (1%)	12 (3%)	2 (1%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)
Unsure	16 (1%)	0 (0%)	6 (1%)	1 (0%)	0 (0%)	3 (1%)	0 (0%)	1 (1%)	0 (0%)	4 (3%)	0 (0%)	1 (1%)	0 (0%)	0 (0%)
(blank)	101 (3%)	26 (5%)	2 (0%)	39 (10%)	3 (1%)	9 (2%)	1 (0%)	0 (0%)	0 (0%)	4 (3%)	2 (2%)	11 (15%)	4 (21%)	0 (0%)
<b>Total</b>	<b>3080 (100%)</b>	<b>573 (100%)</b>	<b>504 (100%)</b>	<b>394 (100%)</b>	<b>380 (100%)</b>	<b>366 (100%)</b>	<b>253 (100%)</b>	<b>147 (100%)</b>	<b>138 (100%)</b>	<b>130 (100%)</b>	<b>97 (100%)</b>	<b>74 (100%)</b>	<b>19 (100%)</b>	<b>5 (100%)</b>

\*N/A = Not applicable. Majority of the response "N/A" were associated with entries with referral or signposting to services other than CMHT or following-up appointment with an MHP. The N/A option may indicate that the appropriate support for these patients is out of scope of CMHT services.





## Impact on CMHTs

Theme 6 from the staff interviews (see Appendix) describes MHPs, GPs, and CMHT managers views that MHPs were having a positive impact on CMHTs in Dorset.

- Reducing referrals to CMHT overall
- Reducing unnecessary referral from practices to CMHT
- Avoided stabilisation work for CMHTs
- Helping to reduce CMHT staff stress levels.

*"Part of the setup that we have here is a coming together of a group of individuals from different organisations and backgrounds...so has it changed the way GPs do things? Yes, because what we're trying to do now is not blanket refer to CMHT...and considering what [MHP] might do when we're a bit stuck." (GP4)*

*"I go to the virtual MDT once a month in person and I hang around in the CMHT for a bit, link in with the duty worker and the relationship is good. I think understanding each other's pressures and what I can provide is important. If I refer to the CMHT, I will speak to them first, put on the consultation notes my specific reason for referring and I think that's been helpful. It's probably reduced the amount of GP referrals to the to the CMHT." (MHP16)*

*"A person with ADHD came off their medication and didn't trust CMHT. I liaised with the consultant at the CMHT and we agreed that [patient] wouldn't come into outpatients until he was ready and I would review him regularly. [Patient] comes into my clinic and it's lovely...it has taken a good year to get him stable enough for sustained outpatients support. The consultant is happy because he hasn't got an angry family in front of him. [Patient] has been discharged from CMHT and I'm allowed to attend a weekly meeting to discuss him if I need to." (MHP16)*

*"I suppose from us as a secondary care service, yes there's a saving on our time if we're not having to assess people that maybe aren't appropriate...so we're able to use our time more effectively elsewhere." (CMHT5)*

*"I see a breadth of mental health conditions...I can refer people on to other agencies such as Steps 2 Well-being, specialist trauma therapy, or escalate cases to CMHT." (MHP9)*

*"MHPs link extremely well with secondary services and the service Access Wellbeing which is part of the mental health redesign work in our area...it's overwhelmingly positive the role." (GP2)*







# Positive impact on people with mental health symptoms

Theme 5 from the staff interviews (see Appendix) describes MHPs, GPs, and CMHT managers views that MHPs were having a positive impact on people with mental health symptoms.

- Stabilisation ready for onward care
- Improved access to mental health support
- Avoiding people falling between the gaps between primary care, community support (Steps 2 Wellbeing), and CMHT.
- Supporting people beyond CMHT referral and right up to CMHT assessment
- Increased time for discussion.

*"Some people we have been able to get seen by CMHT. Others are waiting for ADHD appointments, which are months down the line, so we provide stabilisation in the meantime." (MHP10)*

*"I think without this role existing, there was a bit of a hole because a lot of these patients would have been declined from secondary care services and for whatever reason haven't been able to engage or didn't even know about services like Steps to Well-being." (MHP3)*

*"I work across four different GP practices, and I guess people don't have to be referred to me. They could just phone the GP surgery and if they're expressing difficulties with their mental health, they get booked straight in." (MHP9)*

*"I think a big part of this role is that, for a lot of patients, it might be their first experience with mental health services, and they just need to feel heard." (MHP3)*

*"One gentleman has schizophrenia and had stopped taking [medication] and was under CMHT for years but avoiding those services for fear he'd be put in hospital. He was isolated and not trusting of other people...he came to our practice and I did a couple of phone calls with him first to build up trust. He saw me on a two-weekly basis and we sorted out a care plan and wellbeing plan. We sat down together and formulated it, so he's got that for himself, so he knows this is what's going to happen if this happens...he's very secure in that plan so now I'm down to once monthly meetings. I know this is a middle ground...for patients that are with CMHT but not engaging and need the ongoing regular input to either teach them skills or facilitate them back into the community. It's about gaining trust with that person so they know they've got a service that they can dip in and out of when they need, and help them make the most of CMHT when they engage. I think it's a real win, that's the way I look at it." (MHP15)*







## Key ingredients of the MHP role

Theme 3 from the staff interviews (see Appendix) described several factors that MHPs, GPs, and CMHT managers felt were important to the MHP role.

1. Willing to work with any person with mental health symptoms
2. Previous CMHT role experience
3. Being 'robust' as an MHP
4. Flexible service (face to face and telephone contacts, and urgent same day slots)
5. Working with the expectations and I.T. systems of multiple practices
6. Being a prescriber
7. Being aware of local mental health services (e.g. Steps 2 Wellbeing)
8. Can provide brief psychosocial input (not DBT, CBT, grief counselling)
9. Has the confidence and skills to manage risk







## Sustainability of the MHP role

Theme 7 from the staff interviews (see Appendix) described several factors that MHPs, GPs, and CMHT managers indicated would affect the sustainability of the MHP role.

- Lone working
- Decisions by practices on how to spend their ARRS/PCN funding
- Aligning MHP activity with PCN and practice priorities
- Learning opportunities between MHPs
- Seeing the value of MHPs at practice and CMHT level.
- Ease of access to support electronic patient notes management

*"What I've heard from other MHPs based in surgeries is that they're quite isolated. They don't have rapport with GPs or CMHTs either. But for me, being based in CMHT, I've had a lot of valuable discussions." (MHP4)*

*"It's a blank canvas and what works in one area doesn't necessarily work in another area, so we've been through several iterations of how we can make this best work for both the mental health workers, practice staff, and for patients." (GP2)*

*"We're maxed out on our ARRS [Additional Roles Reimbursement Scheme] funding...so we couldn't have any more MHPs even if we wanted them." (GP2)*

*"Being linked in with CMHT means I have better access to discussions with specialists, but I don't see GPs much. Other MHPs in other surgeries have the opposite problem." (MHP4)*

*"For patients waiting for Steps 2 Wellbeing, we often hold them in primary care. If their risk escalates while waiting, they might no longer qualify for therapy, so it's a balancing act." (MHP9)*

*Managing MHP referrals: ... "I see about 10 patients a day. Of those, maybe four or five a week might be inappropriate referrals. But even if they are, I try to make the appointment meaningful regardless." (MHP3)*

*"At the beginning, honestly, I felt like putting my hair out. I had four SystmOne all set up differently for each of the surgeries and had to open two email accounts because I had the Dorset one and my NHS one...and I had three CMHTs to feed into." (MHP15)*





## Potential improvements to the MHP role



# Potential improvements to the MHP role

A range of areas for improvement were suggested in the staff interviews:

## MHP activity:

- More structured triage at the reception level to prevent inappropriate MHP bookings.
- Defined pathways for MHP and GP collaboration for major areas of MHP activity, e.g. people with anxiety, low mood.
- Consider extending the time allowed for MHP appointments to accommodate the needs of those who would benefit from more time to engage'
- Consider how MHP activity can support QoF indicators to optimise practice revenue.

## MHP capabilities:

- Optimise opportunities for regular supervision, peer meetings, or embedded support within CMHTs to reduce professional isolation.
- Increase number of MHP prescribers to avoid GP activity and streamline care for patients.

## Management of MHPs:

- Improve recruitment of MHPs by using available evidence on what MHPs can expect to work on.
- Clearer contractual arrangements between PCNs and practices, e.g. who is responsible for MHP annual leave requests / MHP notifying all stakeholders about leave.
- Request support from practices for MHPs to adapt to general practice working practices, pressures and challenges.
- Limited resilience in MHP operations (e.g. during sick leave) was reported. Consider operational processes to ensure patients are not left waiting for care if MHPs are on sick leave or annual leave. If patients have nowhere to seek support, this may result in avoidable GP appointments or CMHT referrals.

## MHP peer support:

- Limited collaboration with MHP colleagues was reported and a desire to share learning and address issues related to the role.







# Conclusions

## What needs and situations do MHPs support? (Evaluation question 1)

1. MHPs support a wide range of patient needs and situations in Dorset. Forty-two categories of reasons for MHP appointment were recorded. The most common reasons were anxiety, low mood, depression, stress, and medication review. This whole-of-Dorset profile was similar across PCNs.
2. Between December 2023 and December 2024, the estimated utilisation of MHPs across Dorset was 88%. An estimated 23,850 MHP appointments were completed (88% of estimated planned appointments). This would suggest MHPs are operationally efficient and meeting their own targets for planned appointments.
3. There is commonality in the outcomes of MHP appointments across PCNs. The key types of outcome are follow-up appointment arranged, signposting to a service / support, contact with other services (referral, liaison or letter), no further input / discharged from MHP care, continue with the current service (other than MHP input), awaiting another service's input, and patient self-referring to a service.
4. Dorset MHPs are engaged a wide range of signposting and liaison activity. For example, toward CMHTs, GPs, Steps 2 Wellbeing, Dorset Recovery Education Centre, talking therapy, Access Wellbeing, We Are With You, LiveWell Dorset, counselling, housing services, social prescribers, and health coaches.
5. There was agreement that MHPs provide a 'broad range of support' for people with mental health symptoms, including bridging the gap between primary and secondary care, 'stabilising' people, first contact support, follow up support, signposting support, providing therapy, managing high risk patients with CMHT, safety net support, and providing personalised mental health support.





# Conclusions

## Key ingredients of the MHP role (Evaluation Question 2)

6. A range of factors were reported as important to the MHP role. Several **personal qualities** were perceived as needed, including willingness to work with any person with mental health symptoms, and in the words of the interviewees - being 'robust' as an MHP. Several **experiential requirements** were perceived as needed, including previously holding a role within CMHT, being aware of local mental health services (e.g. Steps 2 Wellbeing), can provide brief psychosocial input (not DBT, CBT, grief counselling), has good risk management skills, and being a prescriber. In terms of **approach** to MHP activities, offering a flexible service (face to face and telephone contacts, and urgent same day slots) and managing the expectations and IT systems of multiple practices was considered important.

## Impact of the MHP role on people with mental health symptoms (Evaluation Question 3)

7. The MHP utilisation analysis indicated 23,850 mental health appointments were held between December 2023 and December 2024 with specialist mental health practitioners in Dorset for people with anxiety, low mood, depression, stress, and requiring medication review.
8. The average MHP appointment time was 35 minutes which is a significant amount of time to provide support. It provides time and space for complex discussions, which aim to build trust and stabilise people for onward support. Wide variation in MHP appointment length across PCNs was observed and this was in part due to decisions by collaborating practices which may result in inequality of access to MHP support.
9. MHPs play a large role in stabilising people for onward support. This can include assessing for immediate dangers, evaluating the risk of behaviour, and ensuring safety. This activity is vital for people to adopt more complex interventions and/or treatment plans.
10. Many examples were provided of MHPs supporting people whilst they were formally under CMHT care. There were many reasons for this situation to occur, e.g. patient refusal to engage with CMHT. Nonetheless, MHPs were often called upon to support patients when they contacted their practice and likely to have significantly contributed to the avoidance of patients falling between services.





# Conclusions

## Impact on CMHT services (Evaluation Question 4)

11. Across Dorset, 27% of 3,080 MHP appointments recorded in individual activity logs between October and December 2024 were considered avoided referrals to CMHT, which suggests some MHP activity is within the scope of CMHT activities but held by MHPs. However, the majority of MHP appointments largely support people with mental health symptoms that do not meet the criteria for CMHT referral.
12. Some MHPs reported they were co-supporting patients with CMHT, but this was not widespread across all PCNs. The purpose of co-support was patient stabilisation and re-engagement with CMHT. Arguably, this is avoided activity for CMHTs to either stabilise patients or provide interventions.
13. All GPs interviewed reported MHPs had strong links with CMHT and community services (e.g. Steps 2 Wellbeing), and this helped MHPs awareness of referral criteria and practices avoid inappropriate referrals to CMHT and community services. This issue was raised by CMHT managers who indicated reduced inappropriate referrals saved their time whilst many CMHTs are currently under pressure to provide services.





# Conclusions

## Impact on general practice (Evaluation question 5)

14. Several data sources indicate MHPs are releasing pressure on GPs' capacity to focus on other clinical presentations. In particular, GPs are seeing significantly fewer people presenting with anxiety, low mood, depression. From the assessment of 18 MHPs activity between October and December 2024, 83% of the 3,080 MHP appointments recorded were considered avoided GP appointments. An analysis of 27 MHPs across Dorset calculated 23,850 appointments were held between December 2023 and December 2024. Assuming the same rate (83%) of avoided GP appointments, this would indicate 19,080 (83% of 23,850) MHP appointments were avoided GP appointments.
15. The interviews highlighted that repeat GP visits are potentially being avoided as patients are aware of the MHP service and requesting support directly from MHPs.
16. Almost all the GPs interviewed agreed the MHP role had improved the practice offer to their communities. Namely, by providing specialist support and treatment, ensuring patients are seen by the right clinician, and by reducing the number of crises for GPs to manage.
17. The activity data and staff interviews indicate that ADHD discussions and pre-assessment/diagnosis support was increasing in general practice. MHPs were often asked to support this growing area of demand.





# Conclusions

## Impact on workforce wellbeing (Evaluation question 6)

18. MHPs reported a high workload (84% utilisation of MHPs across Dorset) and some isolation in their daily work activity. This situation can lead to low workplace wellbeing for some MHPs, especially those who are not fully integrated into MDTs linked to the practices or CMHTs. Those that were integrated felt more supported and reported higher workplace wellbeing.
19. GPs and MHPs interviewed reported a slight positive change in practice staff wellbeing because of MHP support. However, this was always discussed in the context of wider significant pressures on general practice and that staff were regularly overwhelmed by demand for support.

## Financial impact of the MHP role (Evaluation question 7)

20. Based on the MHP utilisation analysis, the potential avoided cost across Dorset was £448,380 in one calendar year. This is based on a comparison of a nine-minute GP appointment and 35-minute MHP appointment. Patients benefited from a longer consultation, targeted toward their mental health symptoms, at a lower salary rate, and GPs have avoided an estimated 19,080 appointments in Dorset in one calendar year.
21. Particularly amongst GPs, there was high positivity toward the MHP role but also indications that the decision to use MHPs in practices and generally how to spend ARRS/PCN funding was an ongoing issue.
22. There were tensions between GPs and MHPs regarding appointment length and the use of Quality and Outcomes Framework indicators for practice business needs. A range of appointment lengths was noted, from as low as 10mins and up to one hour, and this was often driven by practice-led requirements on appointment length. In the case of 45mins and one-hour long appointments, MHPs reported having to argue the case for these to manage patients.





# Conclusions

## Sustainability (Evaluation question 8)

23. There were several threats to the sustainability of the MHP role. Firstly, decisions by practices on how to use their ARRS/PCN funding was paramount. This decisive decision could heavily influence the future of the MHP role. There was positive sentiment from GPs and CMHT managers about the MHP role, but the issue of which ARRS-related roles were most suited to a practice was considered a 'live discussion'.
24. MHPs reported a high degree of lone working. This was described as difficult and required a robust and resilient approach to MHP activities. This is coupled with limited opportunities for MHPs to collaborate and connect to discuss professional interventions or challenges.
25. The alignment of MHP activity with PCN and practice priorities was also reported as a sustainability issue. Importantly, for some practices it was important MHPs contributed to income generating activity linked to the Quality and Outcomes Framework. However, this could also lead to tension on appointment length, as longer appointments – whilst beneficial for the type of patient activity MHPs were engaged in – may reduce the ability of MHPs to see more people and log activity against e.g. mental health review or medication review or depression indicators.
26. There is variation in how MHPs are being deployed, and this may lead to inefficiencies, inequality of access to care, and fragmented support. There was variation in the number of MHPs deployed across PCNs, the length of appointment time, some expectations of the role, whether a triage practitioner role (approximately band 4 Agenda for Change) supporting MHPs, and some specific MHP activities, e.g. differences in medication review as a reason and outcome of the appointment across PCNs. This may be explained by only a quarter of Dorset MHPs holding the prescribing qualification.





# Conclusions

## Improvements (Evaluation question 9)

27. A range of improvements were suggested by MHPs, GPs, and CMHT staff. These included improvements in managing MHP activity, optimising opportunities for supervision and peer support for MHPs, review MHP role structures, services and processes, maximise integration with MDTs to mitigate isolation, consider operational resilience to manage MHP absences, and increasing appointment length to take advantage of MHPs skillsets.
28. MHP capabilities can be improved through optimising opportunities for supervision and peer support to address issues related to the role.
29. There is limited resilience in MHP operations if MHPs are on leave. Operational processes should be considered to ensure patients are not left waiting for care. The latter may lead to avoidable GP appointments or inappropriate CMHT referrals.





## Overall conclusion

- The MHP role significantly benefits Dorset's primary care and mental health landscape, improving patient access, reducing GP burdens, and contributing to financial efficiencies. Addressing sustainability challenges and operational improvements will be critical to maintaining and expanding these benefits.





# Recommendations

## Recommendations for commissioners

- Secure long-term funding by demonstrating cost-effectiveness on a broader scale.
- Increase workforce resilience through prescribing training, peer support, and optimising supervision opportunities for MHPs.
- Ensure service equity by standardising deployment of MHPs across PCNs.
- Integrate MHPs into primary care business models by aligning activities with GP incentives (e.g. QOF).
- Monitor MHP performance and outcomes through robust data collection and evaluation strategies.

## Recommendations for MHPs

- Advocate for peer support and supervision to prevent burnout and professional isolation.
- Seek training in independent prescribing and other professional development opportunities to expand scope of practice.
- Review MHP role structures, services and processes to ensure service consistency across Dorset.
- Engage with GP and CMHT colleagues regularly to strengthen integration and role clarity.
- Monitor personal workload and boundaries to maintain wellbeing and career sustainability.





# Appendices



# Appendix 1: Profile of MHPs working in Dorset

Appendix table 1: MHP profile

MHP	PCN	Local CMHT	MHP professional background	Previously worked for a CMHT	Length of time as an MHP (months up to Dec 2024)	MHP is an independent prescriber	Agenda for Change band	FTE	Attends MDT with practice(s)	Attends MDT with local CMHT
1	Central Bournemouth PCN	Bournemouth West	Nurse	Yes	19	No	7	1	Yes	Yes
2	Central Bournemouth PCN	Bournemouth West	Nurse	Yes	10	No	7	1	Yes	Yes
3	South Coast Medical PCN	Bournemouth East	Nurse	Yes	19	No	7	1	Yes	Yes
4	Bournemouth East PCN	Bournemouth East / Christchurch	Nurse	Yes	9	No	7	1	Yes	Yes
5	Bournemouth East PCN	Bournemouth East / Christchurch	Psychological practitioner	No	19	No	7	1	Yes	Yes
6	North Bournemouth PCN	Bournemouth West	Nurse	Yes	11	Yes	7	0.45	No	Yes
7	North Bournemouth PCN	Bournemouth West	Nurse	Yes	9	Yes	7	0.8	No	Yes
8	North Bournemouth PCN	Bournemouth West	Nurse	Yes	12	Yes	7	1	No	Yes
9	Poole Bay & Bournemouth PCN	Bournemouth West	Nurse	Yes	25	Yes	7	0.6	No	Yes
10	Wimborne & Ferndown PCN	Wimborne and Ferndown	Nurse	Yes	8	Yes	7	1	No	Yes
11	Crane Valley PCN	Wimborne and Ferndown	OT	Yes	14	No	7	1	No	Yes
12	Poole North PCN	Poole	Nurse	Yes	11	No	7	1	Yes	Yes
13	Poole North PCN	Poole	Nurse	Yes	13	No	7	1	Yes	Yes
14	Shore Medical PCN	Poole	Nurse	Yes	24	No	7	1	Yes	Yes
15	Shore Medical PCN	Poole	Nurse	No	5	No	7	1	Yes	Yes
16	Poole Central PCN	Poole	Nurse	Yes	5	No	7	1	Yes	Yes
17	Poole Central PCN	Poole	Nurse	Yes	13	No	7	1	Yes	Yes
18	Mid Dorset PCN	Dorchester	Nurse	Yes	6	No	7	1	Yes	Yes
19	The Vale PCN	Shaftesbury	Triage practitioner	No	9	No	4	0.6	Yes	Yes
20	The Vale PCN	Shaftesbury	Nurse	Yes	12	Yes	7	1	Yes	Yes
21	The Vale PCN	Shaftesbury	OT	No	22	No	7	0.6	Yes	Yes
22	Sherborne PCN	Sherborne	Nurse	Yes	27	No	7	1	No	Yes
23	Sherborne PCN	Sherborne	OT	Yes	27	No	7	0.8	No	Yes
24	Blandford PCN	Blandford	Nurse	No	5	No	7	1	Yes	Yes
25	Blandford PCN	Blandford	Nurse	Yes	15	No	7	1	Yes	Yes
26	Weymouth & Portland PCN	Weymouth	Nurse	No	10	No	7	1	Yes	Yes
27	Weymouth & Portland PCN	Weymouth	Nurse	Yes	20	Yes	7	1	Yes	Yes





## Appendix 2: Appointment outcome category 1: Follow-up appointments

- The largest category of appointment outcome was the follow-up appointment (26% of all entries). There were seven different types of follow-up appointments booked, of which the majority (95% of all follow-up appointment as an outcome) was the with MHP themselves, including follow-up 'if needed' option. The breakdown of the joint appointment types are shown on Appendix table 2:

**Appendix table 2:** Breakdown of joint patient appointment with other service providers

Types of follow-up appointments booked	Frequency [n (%)]
<b>Total</b>	<b>1455 (100%)</b>
MHP	1274 (88%)
MHP if needed	97 (7%)
GP	77 (5%)
Other	7 (0%)

\*Other included GP if needed, advanced nurse practitioner, social prescriber and early intervention in psychosis service





## Appendix 2: Appointment outcome categories 2 & 7: Signposting and patient self-referring to service / support

- The second most common appointment outcome was signposting to a variety of services and patient self-referring to another service or source of support (n=1393, 25%). A small number of entries (n=50, 1%) also indicated that patients self-referred to a service or support as one of the appointment outcomes. The following tables include the breakdown of services which patients were signposted to and self-referred to onward support.

**Appendix table 3:** Breakdown of services the patients were signposted to by MHPs

Signposting to a service	Frequency [n (%)]
<b>Grand Total</b>	<b>1393 (100%)</b>
Steps 2 Wellbeing	233 (17%)
(unspecified)	233 (17%)
Dorset Recovery Education Centre	131 (9%)
Self-help	114 (8%)
Talking therapy	56 (4%)
Access Wellbeing	53 (4%)
Other	573 (41%)

**Appendix table 4:** Breakdown of services the patients self-referred to a service

Patient self-referring to a service	Frequency [n (%)]
<b>Grand Total</b>	<b>50 (100%)</b>
Steps 2 Wellbeing	40 (80%)
Dorset Recovery Education Centre	4 (8%)
Counselling (unspecified)	2 (4%)
We Are With You	2 (4%)
LiveWell Dorset	1 (2%)
Sleepstation	1 (2%)

\*Other included Able Futures, ACAS (Advisory, Conciliation and Arbitration Service), Andy's Man Club, AtALoss, autism, BEAT, Bournemouth Christchurch Poole council, Bournemouth Churches Housing Association, British Pregnancy Advisory Service, Care first, Child and Adolescent Mental Health Services, Childline, Citizens Advice Bureau, Community Adult Autism Service, community café, Connection, Cruse bereavement support, DadPad, Dorset Mind, Dorset pain management service, Early Help, Eating disorder service, EDAS, Family Fund, Flourish, Foodbank, General support (including addiction, ADHD, alcohol, anxiety, autism, baby groups, bereavement, cancer, carer, cognitive behavioural therapy, self-help, counselling, dialectical behaviour therapy, financial and debt services, domestic violence, eye movement desensitization and reprocessing therapy, employment, emotionally unstable personality disorder, exercise, homelessness, meditation, menopause, mindfulness, national stalking service, neurodiversity, obsessive-compulsive disorder, patient advice and liaison service, parenting course, power of attorney, safety service, sleep, social activities, stress, therapy, Headspace, Health coaching, Help & Care, Insight Timer, leisure and community parks, LiveWell Dorset, Macmillan Cancer support, Maximus, Men's Sheds, Mothers Matter, NHS low income scheme, Op COURAGE, Paragon, Parks in Mind, Prama care, REACH, Relate, Rendezvous, Sexual trauma and recovery services (STARS), Silence of Suicide (SOS), Silverline, Social prescriber, StepChange, Support, transition and recovery team (START), The Retreat, The Veterans Hub, We Are With You, Women's Aid





## Appendix 2: Appointment outcome category 3: Contacting a service (referral, liaison or letter writing)

- The third most common appointment outcome was to contact another service: consisting of making patient referrals, liaising with a service or clinicians, and writing a letter to services who offer support to patients. The following tables include the breakdown of each type of contact.

**Appendix table 5:** Breakdown of clinicians and services the MHPs liaised as part of patient appointment outcome

Liaising with a service	Frequency [n (%)]
<b>Total</b>	<b>188 (100%)</b>
GP	85 (45%)
CMHT	46 (24%)
MDT	12 (6%)
Steps 2 Wellbeing	7 (4%)
Eating disorder service	5 (3%)
Social prescriber	5 (3%)
Other	28 (15%)

\*Other included counsellor (unspecified), domestic violence support, Dorset pain management service, Early Intervention in Psychosis service, Frailty team, health visitor, housing services, Op COURAGE, Perinatal mental health team, pharmacy, Police, probation service, REACH, social services, therapy (unspecified), We Are With You

**Appendix table 6:** Breakdown of services the MHPs written letters to as part of patient appointment outcome

Letter sent to a service	Frequency [n (%)]
<b>Total</b>	<b>19 (100%)</b>
Housing services	6 (32%)
NHS Zero Tolerance case	2 (11%)
Personal Independence Payment service	2 (11%)
University support (unspecified)	2 (11%)
Workplace	1 (5%)
Other	4 (21%)

\*Other included CMHT, College support, Probation service, Steps 2 Wellbeing

**Appendix table 7:** Breakdown of services the MHPs referred patient for onward support

Referral to a service	Frequency [n (%)]
<b>Total</b>	<b>495 (100%)</b>
Steps 2 Wellbeing	147 (30%)
Social prescriber	90 (18%)
CMHT	73 (15%)
We Are With You	18 (4%)
Talking therapy	17 (3%)
Health coaching	12 (2%)
Other	138 (28%)

\*Other included Access Wellbeing, Alcoholics Anonymous, Child and Adolescent Mental Health Services, Diverse Abilities, Dorset Mind, Dorset pain management service, Dorset Recovery Education Centre, Early Help, Early Intervention in Psychosis Service, Eating disorder service, First Point Dorset, Flourish, Foodbank, Frailty team, Help & Care, Home treatment team, LiveWell Dorset, MDT (unspecified), multi-agency risk management, Op COURAGE, Perinatal mental health team, Psychiatric liaison service team, REACH, Relate, Sexual trauma and recovery services (STARS), Social services, Speech and language therapy, Support, transition and recovery team (START), The Freedom Programme, Underdogs Wellbeing, Unspecified (including autism support, carer support, counselling, therapy, attention deficit disorder, autism, addiction, bereavement, children's service, domestic violence support, exercise, gym, homelessness support, learning disability, neurodiversity, peer support, support groups, veteran support)





## Appendix 2: Appointment outcome categories 5 & 6: Awaiting another service input / Continuing with current service input

- One of the appointment outcomes for a small group of patients included waiting for another service to begin or agreement to continue with the ongoing input from other services. The following tables include the breakdown of services patients await input from.

**Appendix table 8:** Breakdown of services the patients are awaiting input to begin

Awaiting input from services	Frequency [n (%)]
<b>Total</b>	<b>93 (100%)</b>
Steps 2 Wellbeing	46 (49%)
CMHT	9 (10%)
Flourish	6 (6%)
Counselling (unspecified)	6 (6%)
Therapy (unspecified)	5 (5%)
Talking Therapy	5 (5%)
Other	16 (17%)

\*Other included Autism service, Bournemouth Churches Housing Association, Court hearing, Dialectical behaviour therapy, Eating disorder service, Health coaching, Learning disability service, Occupational health assessment, Peer support, Perinatal mental health team, Dorset Recovery Education Centre, Unspecified services, Social prescriber, sexual trauma and recovery service (STARS)

**Appendix table 9:** Breakdown of services the patients continue to engage with the input

Continuing with services	Frequency [n (%)]
<b>Total</b>	<b>117 (100%)</b>
Steps 2 Wellbeing	38 (32%)
CMHT	14 (12%)
Support (unspecified)	12 (10%)
Counselling (unspecified)	8 (7%)
Therapy (unspecified)	7 (6%)
We Are With You	5 (4%)
Other	33 (28%)

\*Other included Dorset Mind, Dorset Pain Management Service, Dorset Recovery Education Centre (REC), Early Intervention in Psychosis Service, Employee Assistance Programme, Flourish, Health coaching, Home treatment team, Learning disability team, Perinatal mental health team, REACH, RELAY (Regulating Emotion and Looking After Yourself) course, Social prescriber, The Freedom Programme.





## Appendix 2: Medication activity

- Records of medicines being prescribed to patients to help with their symptoms were noted in the MHP activity log data. There are seven MHPs who are qualified to independently prescribe medication within their scope of practice. Of those seven MHPs, four MHPs participated in the activity log.
- A total of 99 entries indicated medication request as a **reason for** an appointment with an MHP (for example, as first-time, repeat prescription, re-starting medication, changing a regimen, etc.). Nearly half of the entries (n=48, 49%) did not specify what type of medication was requested. The breakdown of medications requested by patients are listed in Appendix table 10.
- A total of 153 entries indicated medication being **prescribed** as part of the activities within the appointment. The most common medication type was antidepressants in various forms (n=81, 53%). The breakdown of the types of medication prescribed are listed in Appendix table 11.

**Appendix table 10:** Breakdown of medication requested by patients

Types of medication requested by patients	Frequency [n (%)]
<b>Total</b>	<b>99 (100%)</b>
(unspecified)	48 (49%)
Antidepressants (unspecified)	24 (24%)
Selective serotonin reuptake inhibitor (SSRI)	14 (14%)
Mirtazapine	4 (4%)
Zopiclone	3 (3%)
Propranolol	2 (2%)
Other	4 (4%)

\*Other included benzodiazepine, diazepam, risperidone

**Appendix table 11:** Breakdown of medication prescribed as part of the appointment outcome

Types of medication prescribed	Frequency [n (%)]
<b>Total</b>	<b>153 (100%)</b>
(unspecified)	58 (38%)
Selective serotonin reuptake inhibitor (SSRI)	46 (30%)
Antidepressants (unspecified)	17 (11%)
Mirtazapine	14 (9%)
Propranolol	12 (8%)
Serotonin and norepinephrine reuptake inhibitor (SNRI)	4 (3%)
Other	2 (1%)

\*Other included melatonin and zopiclone





## Appendix 3: Limitations with the MHP activity log data

- The MHP activity log data is the first of its kind to map out the activities carried out by MHPs across Dorset PCNs. The aim of the activity log was to explore the breadth of MHP activities and was not intended to assess the performance of individual MHPs.
- The activity log was a method to capture a snapshot view of MHP activity over a two-month period and is not intended to be used as a model to predict activities outside the data collection period.
- The data collection form was intentionally designed to collect free-text data to acknowledge the differences and variabilities in the role of MHPs across Dorset PCNs. If closed multiple choice questions were used, it may have restricted participating MHPs to truly reflect their activities.
- Due to the voluntary agreement from MHPs to take part in the activity log, the number of log entries and level of details (context, description of reasons and outcome of appointments, and relevance of information) were highly variable amongst the participating MHPs.
- A substantial qualitative interpretation of the data was required (e.g. the interpretation of 'shorthand' responses such as 'referred to S2W', 'ref S2W' or 'ref S2W, REC, WAWY').
- References made to other services were written differently between MHPs (e.g. S2W offers a variety of support including talking therapies, counselling, coaching, CBT, etc). One MHP may have recorded 'refer to S2W' and another MHP noting 'refer to talking therapy'. Both entries may have referenced the same services.
- It is assumed that not all actions / activities by MHPs were recorded in full on each entry. Therefore, the figures from the activity logs presented in this slide deck are a relatively accurate reflection of the MHP activities during the data collection period. It is advised the reader exercises caution when interpreting descriptive findings related to the activity logs.





## Appendix 4: Table of themes from staff interviews

	Theme	Sub-theme
1	<b>Variability of PCN deployment of MHPs</b>	Number of MHPs per PCN Appointment length Expectations of the role Triage practitioner role supporting MHPs
2	<b>A broad offer</b>	Bridging the gap between primary and secondary care 'Stabilising' people First contact support Follow up support Signposting support Providing therapy Managing high risk patients with CMHT 'Safety net' support Providing personalised mental health support
3	<b>Active ingredients of MHPs</b>	Willing to work with any person with mental health symptoms Previous CMHT role experience Being 'robust' as an MHP Flexible service (F2F and telephone contacts, and urgent same day slots) Working with the expectations and IT systems of multiple practices Being a prescriber Being aware of local mental health services (e.g. Steps 2 Wellbeing) Brief psychosocial input (not DBT, CBT, grief counselling) Has good risk management skills
4	<b>Substantial impact on general practice</b>	Avoiding GP appointments Improved offer of the practice Reduced number of crises for GPs to manage Supporting ADHD assessments Helping to improve practice staff wellbeing (from the "swamp of overwhelm") People requesting 'direct to MHP' appointments

	Theme	Sub-theme
5	<b>Positive impact on people with mental health symptoms</b>	Stabilisation ready for onward care Improved access to mental health support Avoiding people falling between the gaps between primary care, community support (Steps 2 Wellbeing), and CMHT. Supporting people beyond CMHT referral and right up to CMHT assessment Increased time for discussion
6	<b>Positive impact on CMHT</b>	Reducing referrals to CMHT overall Reducing unnecessary referral from practices to CMHT Avoided stabilisation work for CMHTs Helping to reduce CMHT staff stress levels
7	<b>Sustainability of the MHP role</b>	Decisions by practices on how to spend their ARRS/PCN funding Aligning MHP activity with PCN and practice priorities Learning opportunities between MHPs Seeing the value of MHPs at practice and CMHT level
8	<b>Challenges within the MHP role</b>	Lone working Limited collaboration with MHP colleagues to share learning To fully benefit, MHPs should be embedded within practice and CMHT MDT meetings Appointment length and QOF Recruitment challenges Adapting to primary care working practices and challenges Limited resilience in MHP operations (e.g. during sick leave)
9	<b>Improvements to the MHP role</b>	-





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