AGENDA ITEM NO: 10

Report To:	**Inverclyde Integration Joint Board**	**Date:**	**27 June 2022**
Report By:	**Allen Stevenson Interim Chief Officer Inverclyde HSCP**	**Report No:**	**IJB/27/2022/AM**
Contact Officer:	**Anne Malarkey Head of Mental Health, Alcohol and Drug Recovery and Homelessness Services**	**Contact No:**	**01475 715284**
Subject:	**MENTAL HEALTH & WELLBEING SERVICE**		

1.0 PURPOSE

1.1 The purpose of this paper is to provide details of planning for the development and implementation of the Inverclyde Mental Health and Wellbeing Service (MHWS).

2.0 SUMMARY

2.1 Scottish Government require all HSCPs to develop and fully implement a mental health and wellbeing primary care service by April 2026. Service plans are to align with recommendations from the attached report by a national short life working group on Mental Health in Primary Care. A national oversight group has been established by the Scottish Government which is leading on this work and will review the plans submitted by each HSCP.

2.2 A MHWS steering group was established in Inverclyde in February 2022 with representation from key stakeholders. There have been five meetings of the group between February and May 2022, the group will continue to meet on a monthly basis. Two service user focus groups held in March and April have enabled service user contribution to the planning process.

2.3 Indicative budget for implementing the service is:

2022/23 - £156,876.54
2023/24 - £313,263.86
2024/25 - £631,746.06

2.4 The steering group has developed a proposal based on developing and implementing the Inverclyde MHWS in alignment with the existing Primary Care Mental Health Team. This will involve an expansion of the team and an increase in multi-disciplinary roles. Pathways into the service will be developed to ensure it is easily accessible and processes will be established that ensure individuals receive a timely, trauma informed, strengths based and recovery oriented response.

2.5 As well as providing assessment and treatment the service will use prevention/early intervention strategies that improve mental health and wellbeing and support self-management. It will work proactively with people who require support with the aim of avoiding a deterioration in mental health that would lead to a requirement for treatment from clinical mental health service.

3.0 RECOMMENDATIONS

3.1 It is recommended that the Integration Joint Board notes the content of this report and approves the proposals to develop and implement the Inverclyde Mental Health and Wellbeing Service as detailed in the report.

3.2 It is recommend that the Interim Chief Officer is authorised to issue the Direction attached to this report to NHS Greater Glasgow and Clyde.

Allen Stevenson
Interim Chief Officer
Inverclyde HSCP

4.0 BACKGROUND

4.1 Mental Health has been identified as a key issue across communities and for Primary and Community care services. Primary and Community care services are the services that provide healthcare in a local area. These services are often the first point of contact for individuals who are seeking advice or help with a health concern. There are a wide range of mental health concerns that individuals seek support for, commonly these include stress and distress, emotional and relational difficulties, feelings of anxiety and low mood. Often there are socio economic pressures that contribute to these difficulties and frequently they are underpinned by experiences of adversity or trauma. Experiences of the Covid 19 pandemic have exacerbated mental health concerns for many people and in some cases have led to an increase in social isolation.

4.2 GPs are often the first point of contact for people seeking help for a mental health issue. Some estimates suggest that approximately one third of GP consultations have a mental health component. GPs are able to refer to specialist mental health services if further assessment or treatment is required but often manage mental health concerns themselves if thresholds for specialist treatment are not met. Feedback from GPs indicates that they often feel that they are not best placed to provide the mental health support that people need. The range and complexity of mental health issues that GPs are required to respond to do not all fit with existing pathways of care and would often benefit from a holistic, person centred, multi-disciplinary approach. Individuals who are experiencing mental health difficulties related to social, environmental or circumstantial stressors often require a response that incorporates linking them with appropriate non-clinical supports in the community.

4.3 There has been widespread recognition that the Primary and Community Care part of the mental health service system requires development in order to better meet the needs of individuals seeking support for their mental health and provide a more positive experience of care. Over the last five years a number of different initiatives aimed at addressing the needs of individuals presenting to primary care have been supported across Scotland. Learning from these has been shared and further information can be found in the attached Evidence Paper.

4.4 HSCPs were notified in early 2022 about the requirement for the development of the MHWS and were issued planning guidance at that time. A MHWS steering group was established in Inverclyde in February 2022 with representation from key stakeholders. There were five meetings of the group between February and May 2022, the group will continue to meet on a monthly basis. The steering group will oversee the development and implementation of the service.

4.5 Inverclyde context: There is a well-established Primary Care Mental Health Team that works closely with GP practices across the area. This team offers assessment and psychological therapy based interventions. Each GP practice in Inverclyde also has a Community Links Worker (CLW). The CLWs are practitioners who work within GP practices providing non-clinical support with personal, social, emotional and financial issues. Inverclyde also has a Distress Brief Intervention Programme, currently delivered by SAMH, which offers short term intensive support to individuals experiencing distress. There are also numerous third sector organisations and community groups that offer support with mental health and wellbeing, many of these have benefited from grants awarded through the Inverclyde Communities Mental Health and Wellbeing Fund.

5.0 PROPOSAL

5.1 The Inverclyde Mental Health and Well-being Service (MHWS) will be implemented within the structure of Community Mental Health Services in alignment with the current Primary Care Mental Health Team (PCMHT). The PCMHT has links with GP practices, is accessible by self-referral and provides low intensity psychological therapy. In addition to what is already offered by PCMHT the MHWS will bring an expansion in the scope of the current triage function so that wider mental health and wellbeing needs are considered. The MHWS will be multi-disciplinary and will introduce specialist workers with a focus on children and young people and also the older adult population.

5.2 The overall aim of the MHWS will be to provide a trauma informed, strengths based and recovery oriented service that takes in to account the circumstances (including determinants of health), goals, and preferences of services users. Taking in to account the social and psychological factors influencing mental health and wellbeing in a primary care setting could help reduce the pathologising of normal human responses to difficult circumstances. The MHWS will offer support and specialist advice without the need for diagnosis first. The use of a trauma informed, recovery-oriented and strengths-based framework will support individuals to understand their mental health problems within the context of a psychological, social and situational narrative. Such an understanding will lead to empowerment and give control to the person seeking help while supporting them to set goals and respond effectively to difficult emotions.

5.3 The service will be delivered by a multidisciplinary team made up of a range of mental health professionals and support workers. Strong and productive links with a wide range of stakeholders will underpin the service, these will include, but are not limited to, general practice teams, Community Links Workers, third sector organisations, community groups, secondary mental health services, alcohol and drug recovery services and health improvement colleagues.

5.4 The MHWS will offer a front line, first point of contact service for anyone seeking mental health and wellbeing support. Triage and assessment within the service will involve a compassionate, person centred, holistic assessment of needs and a strengths based approach to identifying goals. If the MHWS is unable to provide the care or treatment an individual requires it will support individuals to engage with an alternative service. The service will be easily accessible and will be delivered in local areas in a way that actively seeks to combat stigma and overcome barriers to access

5.5 In addition to the low intensity psychological therapy that is currently delivered by the PCMHT, Occupational Therapy interventions will be introduced. Group programmes will be developed and delivered, these may include peer support groups.

5.6 The inclusion of a post that is specific to children and young people will mean that the mental health and wellbeing needs of our younger population can be addressed. It is anticipated that including this post within the team will increase the awareness and understanding of all team members about the mental health and wellbeing of children and young people. This worker will provide advice and support to young people and their families and will have well established connections with child and adolescent services. One of the key functions of the role will be to ensure people are aware of supports and services and how to access them. A similar role is proposed for the older adult population.

5.7 Service development and expansion will be informed by demand, it is hoped that once the MHWS is operational across all GP practices there will be scope to include a more proactive approach to supporting mental health and wellbeing in year three. Such an approach would target specific populations such as those affected by inequalities, experiencing multi morbidity or long term health conditions. If demand and capacity allow the service will expand to include an innovative approach to upstream working that will target people at risk of developing poor mental health and wellbeing before they identify themselves as having a problem

5.8 The focus during the first year of implementation will be on establishing robust and efficient processes that deliver a timely and effective response to mental health and wellbeing needs. The service will be rolled out incrementally. A communication plan is under development as part of the planning process and development and engagements events will be carried out with GPs/GP practice teams and wider community members

6.0 IMPLICATIONS

Finance

6.1

Financial Implications:

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
		2022/23	£156,876.54		See indicative allocation letter from Scottish Government

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (If Applicable)	Other Comments
		2023/24 2024/25	£313,263.86 £631,746.06		

Legal

6.2 There are no specific legal implications arising from this report.

Human Resources

6.3 This proposal include the introduction of 13 additional post as detailed below. The plan will be reviewed on a six monthly basis and depending on demands on the service the number and type of posts in the second and third year may be amended.

2022/2023
1 x Band 4 Administrative assistant
1 x Band 6 Occupational Therapist
1 x Band 5 Occupational Therapist
1 x Band 5 Child and young person support worker
1 x Band 6 Primary Care Mental Health Clinician

2023/2024
1 x Band 7 CBT Therapist

2024/2025
3 x Band 4 Group activity/Health improvement coordinator
1 x Band 5 Older adult support worker
1 x Band 5 Inequalities outreach worker
2 x Band 6 Primary Care Mental Health Clinician

Equalities

6.4 Has an Equality Impact Assessment been carried out?

	YES (see attached appendix)
X	NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

6.4.1 How does this report address our Equality Outcomes?

Equalities Outcome	Implications
People, including individuals from the above protected characteristic groups, can access HSCP services.	The Mental Health and Wellbeing Service will be available to people of all ages without any care group or condition boundaries. Equalities data will be collected so that access to and uptake of the service is monitored and variation responded to if required
Discrimination faced by people covered by the protected characteristics across HSCP services is reduced if not eliminated.	None
People with protected characteristics feel safe within their communities.	None
People with protected characteristics feel included in the planning and developing of services.	None
HSCP staff understand the needs of people with different protected characteristic and promote diversity in the work that they do.	None
Opportunities to support Learning Disability service users experiencing gender based violence are maximised.	None
Positive attitudes towards the resettled refugee community in Inverclyde are promoted.	None

CLINICAL OR CARE GOVERNANCE IMPLICATIONS

6.5 The new service will sit within already established service structures meaning that any clinical or care governance implications will be managed within the processes of these structures structures.

NATIONAL WELLBEING OUTCOMES

6.6 How does this report support delivery of the National Wellbeing Outcomes?

National Wellbeing Outcome	Implications
People are able to look after and improve their own health and wellbeing and live in good health for longer.	The overarching aim of the Mental Health and Wellbeing Service is to support people to improve and maintain good mental health and wellbeing. The service will use evidence based interventions and will link closely with third sector partners and community groups that support health and wellbeing.
People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	The MHWS will support improvements in mental health and wellbeing that will enable independent living. It will be proactive in reaching out to individuals with long term

	conditions and seek to engage them in activities that will improve their wellbeing.
People who use health and social care services have positive experiences of those services, and have their dignity respected.	Service user experience will be routinely collected, monitored, and responded to.
Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	Quality of life is directly impacted by poor mental health, this service will seek to improve quality of life by enhancing mental health and wellbeing and supporting people to develop skills which will enable them to maintain a good quality of life.
Health and social care services contribute to reducing health inequalities.	Often those most affected by inequalities experience poor mental health and wellbeing – a cyclical pattern is evident where one issue exacerbates the other. By improving mental health and wellbeing, health inequalities can be both directly and indirectly reduced.
People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.	The MHWS will link closely with carer support services to ensure that the specific mental health and wellbeing needs of carers are addressed
People using health and social care services are safe from harm.	The service will provide safe and effective care and support. It will be underpinned by trauma informed approaches which ensure people feel safe.
People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	Staff wellbeing will be promoted and a positive workplace culture will be established. Learning and development opportunities will be supported and encouraged.
Resources are used effectively in the provision of health and social care services.	By linking with established services and building on what is already available the new MHWS will avoid duplication and increase efficiency

7.0 DIRECTIONS

7.1

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	
	2. Inverclyde Council	
	3. NHS Greater Glasgow & Clyde (GG&C)	X
	4. Inverclyde Council and NHS GG&C	

8.0 CONSULTATIONS

8.1 Two service user focus groups were conducted in April and May enabling service user contribution to the early planning stages of the service.

8.2 Further engagement and development sessions will be carried out during 2022 with events proposed for GPs/ practice teams and also members of the wider community.

9.0 LIST OF BACKGROUND PAPERS

9.1 Mental Health in Primary Care Short Life Working Group Report

9.2 Primary Care Mental Health Models in Scotland

9.3 MHWPCS Planning guidance

9.4 Letter to stakeholders – indicative funding allocations

EINVERCLYDE INTEGRATION JOINT BOARD
DIRECTION ISSUED UNDER S26-28 OF THE PUBLIC BODIES (JOINT WORKING) (SCOTLAND) ACT 2014

1	Reference number	IJB/27/2022/AM
2	Report Title	Mental Health and Wellbeing Service
3	Date direction issued by IJB	27th June 2022
4	Date from which direction takes effect	27th June 2022
5	Direction to:	NHS Greater Glasgow and Clyde only
6	Does this direction supersede, revise or revoke a previous direction – if yes, include the reference number(s)	No
7	Functions covered by direction	Primary Care Services Mental Health Services- Young People, Adult and Older Adult
8	Full text of direction	NHS Greater Glasgow and Clyde is directed to develop and implement the Inverclyde Mental Health and Well-being Service (MHWS) all as detailed in the report, including the appointment of the proposed 13 additional posts as set out in paragraph 6.3.
9	Budget allocated by IJB to carry out direction	Indicative allocation from Scottish Government 2022/23 - £156,876.54 2023/24 - £313,263.86 2024/25 - £631,746.06
10	Outcomes	As detailed in paragraph 6 of the report. The overall aim of the MHWS will be to provide a trauma informed, strengths based and recovery oriented service that takes in to account the circumstances (including determinants of health), goals, and preferences of services users. Taking in to account the social and psychological factors influencing mental health and wellbeing in a

Appendix 1

		primary care setting could help reduce the pathologising of normal human responses to difficult circumstances. The MHWS will offer support and specialist advice without the need for diagnosis first. The use of a trauma informed, recovery-oriented and strengths-based framework will support individuals to understand their mental health problems within the context of a psychological, social and situational narrative. Such an understanding will lead to empowerment and give control to the person seeking help while supporting them to set goals and respond effectively to difficult emotions.
11	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Inverclyde Integration Joint Board and the Inverclyde Health and Social Care Partnership. This Direction will be monitored and progress reported bi-annually.
12	Date direction will be reviewed	June 2023 and updates will be brought back to the IJB on a regular basis.

Appendix 2

REPORT OF THE SHORT LIFE WORKING GROUP FOR MENTAL HEALTH IN PRIMARY CARE

Scottish Government
Riaghaltas na h-Alba
gov.scot

27th January 2020

Introduction

1. The Scottish Government Mobilisation and Recovery Group (MRG) was established to support our 'Remobilise, Recover, Redesign Framework for Scotland'. Its aim is to ensure key expert, stakeholder and system-wide input into decisions on resuming and supporting healthcare service provision, in the context of the COVID-19 pandemic. The MRG sub group on Primary and Community Care highlighted the provision of mental health support as a key issue for primary and community services, supporting the parity of esteem between mental and physical health, as we emerge from the Covid-19 pandemic.

2. In response to this, the Short Life Working Group (SLWG) for Mental Health in Primary Care was commissioned and Terms of Reference can be found in Annex A. Its purpose was to consider "what good might look like" in terms of provision of mental health support within Primary and Community care settings.

3. Membership of the SLWG drew on a variety of geographical areas and specialisms and can be found in Annex A. At the outset of the group, a statement of intent (Annex B) was agreed between the Scottish Government, Royal College of General Practitioners and Royal College of Psychiatrists in Scotland, with input from the Royal College of Nursing. This described the ambition of the group – to agree principles and consider clinical models to deliver improved mental health capacity in Primary and Community care.

4. The Group agreed the following principles which should underpin service delivery for mental health in Primary and Community Care:

   - All parts of the system should enable support and care that is person centred, looking to access the most appropriate information, intervention and support in partnership with the individual through shared decision making. Trauma Informed Practice will be the norm. Wherever a person is in touch with the system they will be listened to and helped to reach the most appropriate place for them - there is no wrong door.

   - Primary Care mental health services should have no age or condition/care group boundaries, and meet the needs of all equalities groups.

   - Local systems will positively seek to address health inequalities, proactively engaging those that are less likely to access support.

   - Digital approaches to self and supported management of distress and mental health conditions will be an integral part of the service with the caveat that those who are digitally excluded need to be engaged positively in different ways.

   - Where support can be accessed to help an individual within the Primary Care setting in their own local area this should be the default. If referral to specialist services is required, then this should be straightforward and timely.

- People presenting in the Out of Hours period should have access to the full range of options available in hours, accepting some options may not be available immediately.

- The Primary Care Mental Health Services (PCMHSs) linked to a group of practices or a locality to serve a population needs to be developed and resourced to provide appropriate levels of mental health assessment, treatment and support within that Primary Care setting.

- Staffing levels within PCMHSs will be subject to, and compliant with, safe staffing legislation.

- Evidence based psychological therapies need to be offered, with appropriate supervision and stepping up seamlessly to secondary care mental health services where appropriate.

- The use of screening and clinical measures pre and post intervention is encouraged, as this can indicate efficacy of intervention as well as assist with triage to ensure people are seen in the right service as quickly as possible.

5. The group collated examples of Mental Health models that are in place across various board areas in Scotland, which demonstrate good practice – the evidence paper alongside this report. This gave the group an understanding of current mental health service provision in Primary Care settings, highlighted potential gaps and helped to inform recommendations setting out how services can be improved.

6. The group met four times between September and December 2020 and this report reflects its discussions.

7. In the context of this report “Primary and Community care” is defined as all services that provide healthcare in a local area. These are services that are usually the first points of access for people in the community who are seeking advice or help with a health concern. “Primary and Community care” is linked closely to the wider services and assets within the community such as social care and support, education, community groups, leisure opportunities, workplaces etc. All of which may have roles to play in supporting the wellbeing of the local population.

8. “Mental Health in Primary Care” or “Primary Care Mental Health” (PCMH) in this report refers to a community based response to the following issues:

- stress and distress, including the outcome of socioeconomic pressures and the consequences of complex trauma and adversity;
- emotional and relational difficulties;
- anxiety and depression;
- wellbeing; and
- mental illness.

9. Presentation with such issues is often multifactorial and frequently requires a biopsychosocial formulation and can include the following three factors:

    - A stressor (commonly relational, financial, or social difficulties) which the patient cannot manage within their usual resources.
    - A background history of exposure to adversity and trauma, often in childhood.
    - Limited availability of immediate, confiding social support.

10. Responding to these issues require a multifactorial approach, with the person at the centre. Early intervention especially with first line depression and anxiety can prevent difficulties escalating.

11. There is a considerable evidence base for psychological therapy in relation to presenting issues in mental health.

Discussion

Mental Health in Primary Care

12. General Practice are long-standing anchor institutions of their communities providing ongoing care for the mental and physical health across the whole lifespan. Practices provide universal, comprehensive and accessible care to all individuals offering continuity of care, particularly important for those who are socioeconomically disadvantaged, and oversee care from a range of service providers.

13. GPs are increasingly working as part of Multidisciplinary Teams (MDT) within their practice, based in the community or alongside specialist colleagues. The vast majority of patients are cared for in Primary and Community Care close to their homes, especially when supported by an MDT. To reduce stigma and encourage the creation of mental health communities, there has to be acceptance that the responsibility for Mental Health is for everyone and not only for specialist services.

14. GPs are usually the first port of call for people seeking professional help for mental health issues and the vast majority of mental health consultations occur in Primary Care, covering a diverse range of needs. Approximately 1/3 of GP consultations (c8million / year) have a mental health component. GPs may diagnose, treat and monitor the individual themselves or they may refer the individual to specialist services for further investigation, and / or treatment. People can present with mental health issues to other members of the General Practice team, however, this data is less formally captured.

15. The management of people who present with mental health problems in the Out of Hours (OOHs) period varies across health boards and their associated partnerships. A study has shown that people who present with mental health concerns have on average five contacts before they reach the most appropriate person in the OOHs period compared to physical health concerns which have on average two contacts. As OOHs is an urgent care service, the majority of these presentations will be in crisis. This means that timely and easy access to

secondary care services for all age groups is essential. It is imperative therefore that when considering people who present with mental health concerns in Primary Care, a 24/7 view is taken of service delivery.

Current Challenges in Service Provision

16. The range and complexity of mental health presentations in Primary Care do not all fit existing pathways of care. While GPs can refer to specialist services, those services may reject that referral on the basis that the condition does not meet the criteria for specialist care, or where people require mental health and substance misuse support, resulting in a referral back to the GP. This means GPs become the primary clinical support for individuals with complex needs that they are not always trained to deal with. Having only general practice involvement in this range of complex needs is unsatisfactory for the person and can have a high impact on GP workload, therefore looking to a multidisciplinary response will ensure the best outcomes for people. It is also important to have strong connections with secondary care mental health services in order to be able to "step up" treatment if needed, as seamlessly as possible.

17. Another concern for GPs is management of less complex mental health issues, often associated with other social stressors. This may require little clinical input and while that is important, it will not address the underlying issues. Links to alternative supports in the community, including social services, community groups and those services delivered by third sector organisations is vital for this group.

18. Patients with severe and enduring symptoms of mental illness need referral to specialist services for diagnosis, treatment and for advice about managing risk including those whose presentation is complex or for whom there is diagnostic uncertainty. They may also require ongoing access to support in Primary Care.

19. GPs are often satisfied with the response such patients receive once they have an established place in secondary care services. But any delay in assessment and care planning may lead to a significant reliance on unscheduled presentations, including to crisis and out of hours' services. Improved access to prompt scheduled care therefore has the potential not only to improve the patient experience, but also to reduce the overall resource burden on the system.

20. Specialist services also have an important role to play in providing peer-to-peer decision support for the care of people with complex illnesses in the community. This works best in areas that are able to invest in relationships between clinicians across the health and social care interfaces and where access is available to the electronic patient records such as Clinical Dialogue.

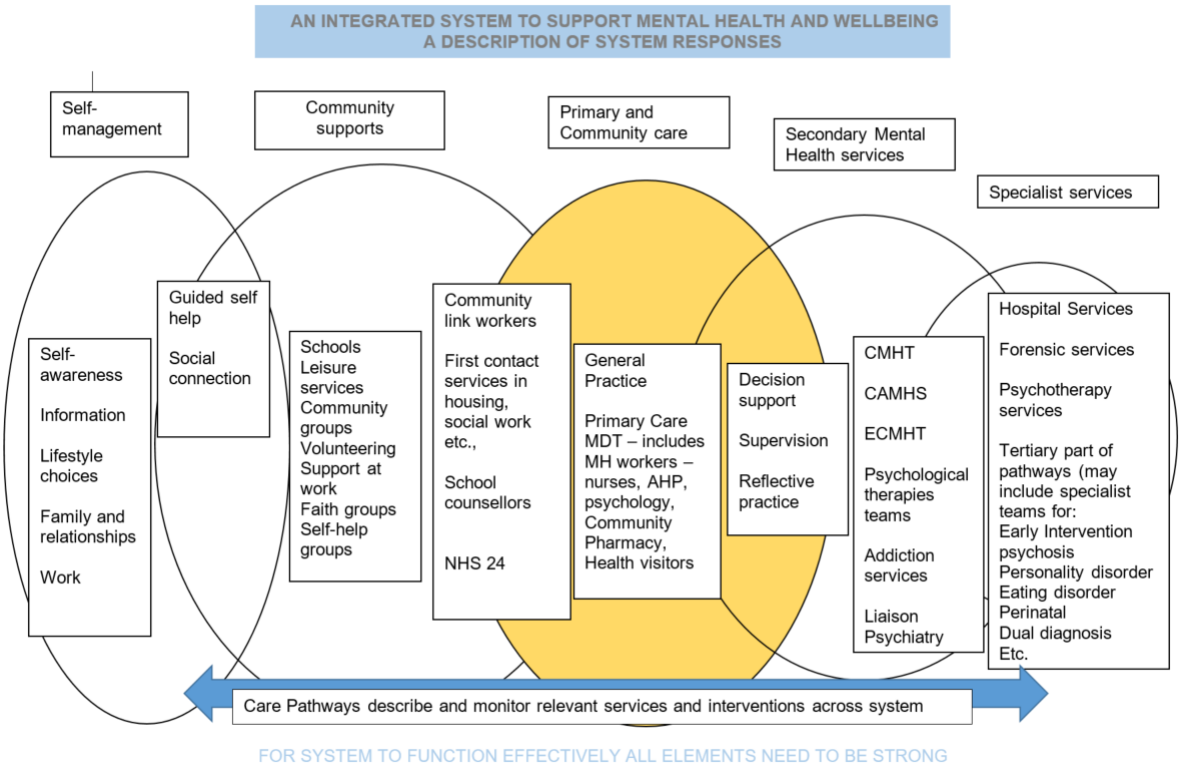
21. There are significant challenges with obtaining access to mental health specialist service provision for children and adolescents. Contributing factors to this include long waiting times and high levels of rejected referrals. Primary Care mental health teams that are able to offer crisis intervention and support to young people early in their journey, significantly limit potential future damage for young people and their families.

Where Primary and Community care fits into an integrated mental health care system

22. Primary and Community Care Teams have a pivotal role within an integrated mental health system and are key in developing and sustaining a system that supports the population with improved mental health and wellbeing. The services provided by such teams is necessary, but not sufficient: they depend on a wider system of care to function optimally. The Scottish Government Mental Health Transition and Recovery[1] plan sets out the range of areas where improvements are required to deliver an improved mental health and wellbeing service to the wider population.

23. An integrated system requires strength across all components, including public health messaging for the whole population, provision of information to assist self-management, third sector provision of community services and Primary and Community care as well as highly specialised aspects of care and treatment.

24. The role of Primary and Community care is central to this system, as illustrated in the diagram below:



[1] https://www.gov.scot/publications/mental-health-scotlands-transition-recovery/

25. Primary Care provides support and care to the majority of those that seek help but also provides the link into secondary and more specialist services where required.

26. There is widespread recognition that the Primary Care part of the Mental Health system requires attention and development. A range of local initiatives have been supported through recent Primary Care Improvement Funding and/or funding via Action 15 of the Mental Health Strategy for Scotland[2]. Many of these initiatives to date are described in the evidence paper that accompanies this report. Further evidence can be found in '*Exploring Distress & Psychological Trauma'* research commissioned by NHS Greater Glasgow and Clyde[3] and '*Mental health and Primary Care networks - Understanding the opportunities'* a report published jointly by the King's Fund and the Centre for Mental Health[4]. These reports highlight both the concerns and the opportunities that exist to improve this aspect of the system.

27. Whist the distress/crisis response element within mental health is very important, it is part of the wider multi-disciplinary system and at the moment services are being developed in silos, without the overview of how different aspects of care and treatment will connect with each other. For the Primary Care team, it is really important that they can understand the system to navigate appropriately on behalf of their patients, with whatever form of mental health problems/symptoms they are experiencing.

28. This report and its recommendations focus on early clinical intervention by MDTs, supporting 'key priority 5' in the Memorandum of Understanding (MoU) between Scottish Government, British Medical Association, Integration Authorities and NHS Boards.[5] This priority requires that additional professional roles will provide services for groups of patients with specific needs that can be delivered by other professionals as first point of contact in the practice and/or community setting. These additional roles should include community clinical mental health professionals (e.g. nurses, occupational therapists, psychological therapists and enhanced practitioners) based in general practice. The MoU envisages that "by 2021 specialist professionals will work within the local MDT to see patients at the first point of contact, as well as assessing, diagnosing and delivering treatment, as agreed with GPs and within an agreed model or system of care. In line with the recommendations in this report, it provides for service configuration to vary dependent upon local geography, demographics and demand." Current system configuration/demands present significant challenges to implementation. This report seeks to describe the kind of system changes which would be required to make this possible.

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[2] Mental Health Strategy for Scotland

[3] Exploring Distress & Psychological Trauma - NHS GG&C Report

[4] Mental health and Primary Care networks - Understanding the opportunities

[5] Memorandum of Understanding between SG, BMA, Integration Authorities and NHS Boards

29. Below are examples of existing models demonstrating how mental health support services are integrated in Primary Care settings:

30. In Lanarkshire, Occupational Therapists (OTs) are working in Primary Care settings offering open access appointments to patients requiring prevention and early intervention solutions. This enables patients to self-manage their condition and build resilience. OTs are skilled in assessing components of everyday occupations and roles that matter to people, identifying the impact of development, physical and mental health conditions on these occupations and devising intervention plans to enable people to overcome such impacts and engage fully in their day to day lives. OTs use scientific bases, and a holistic perspective to promote a person's ability to fulfill their daily routines and roles.

31. Mental Health Liaison Nurses are also used in Lanarkshire, providing triage, assessment and short term intervention to people experiencing mild to moderate mental health problems of a short term nature.

32. In Lothian, Dumfries & Galloway and Lanarkshire, Mental Health Nurses have been recruited to meet the needs of patients with mild to moderate mental health difficulties. Their interventions consist largely of clinical advice/triage, crisis management, case management of those with complex mental health needs, general psychological support, brief intervention, treatment for addiction, independent prescribing and signposting to local services. In Lanarkshire, they have built on this to develop a stepped/matched Mental Health & Wellbeing Service model, using Action 15 funding. It has continued to expand, with the service being rolled out to 40 GP practices.

33. In Ayrshire and Arran, they are increasing mental health provision within Primary Care Teams/Clusters by embedding Community Link Workers and Mental Health Practitioners within Primary Care Teams to assist with sign-posting, access, and provision of time limited interventions. They have seen great value in having Mental Health and Psychological Therapy aligned with Primary Care.

34. In Grampian and Lanarkshire, the Accessible Depressions & Anxiety Psychological Therapies model increases access to psychological therapies and interventions in Primary Care adult mental health and develops the specialist mental health workforce in secondary care. This is achieved through expanding the competencies of the existing workforce to deliver the most effective treatments, developing Primary Care Teams with multiple disciplines and providing guidance and support on the model of service delivery. This enables cost-effective stepped care, patient choice, quality assurance and increases capacity.

35. In Fife, a comprehensive matched care model offers a wide and flexible range of early intervention, self-help, groups and one to one psychological therapy including integrating web based, remote and face to face interventions.

36. In Scottish Borders, a recent development is a partnership between GPs/Primary Care and Mental Health utilising funding from PCIP and Action 15.

This is a collaborative Primary Care service that is currently operating completely remotely, offering a wide range of interventions.

37. The most important common factor is that each of these approaches are moving towards a reframing of the 'task' for Mental Health and support workers in Primary Care settings. The traditional model prioritises triage and diagnosis, with a view to identifying people who will be accepted for care by specialist Mental Health services on the basis of 'mental illness'.

38. A more useful model in Primary Care settings is a prompt and compassionate response to all forms of distress, which is provided at a local level using community assets and peer networks wherever possible. Specialist Mental Health input must be available whenever indicated, but should not be the default response for all presentations.

39. Other common factors in the success of these services are:

- Where available, regular reflective practice (or other wellbeing support) to deliver a sustainable, timely and compassionate mental health service.
- Taking a person centred approach to meet the needs of the person in a timely way.
- Integration with digital/remote Primary Care mental health and wellbeing resources, increasing access to resources such as NHS inform, interactive self-care guides, NHS 24's 24/7 mental health hub, Breathing Space crisis line and computerised CBT.
- Alignment with Primary Care and the use of the wider multi-agency team.
- Close linkage with Social Work and addiction services in the locality.
- Raising GP Awareness about the role and availability of the wider multi-agency team.
- Providing continuity of care.
- Highlighting the importance of providing training, standardised operational procedures and opportunities for feedback.
- Increased GP cluster working.
- Integration of psychological therapy pathways, reflective practice, training and supervision.
- Utilising a stepped/matched care model of evidence based treatment. Fidelity to an evidence based model has been shown to consistently improve outcomes.
- Access is available to the electronic patient records.

40. These factors have resulted in people accessing the correct support quickly, leading to better outcomes for them. This in turn leads to a reduction in GP, GP Practice and clinical attendance rates.

Proposals, Recommendations and Principles

Proposed Model

41. Within an area served by a group of GP practices (this could be a locality, part of a locality or a cluster area) there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing problems. The multi-agency team may include Occupational Therapists, Mental Health Nurses, Psychologists, Enhanced Practitioners, Link Workers as well as others such as those providing financial advice, exercise coaches, family support and peer networks.

42. That team would provide assessment and support to the individual to access appropriate levels of advice, community engagement treatment or care – some of which would be delivered within the Primary Care setting, depending on the skills and capacity of the team.

43. The team would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

44. Although the team would be aligned to a group of GP practices, there should be named members of that team that work closely with each individual practice to provide continuity and allow the development of effective clinical or multidisciplinary team relationships.

45. Practice systems should allow patients to be directed to an appointment with the appropriate members of the MDT based on self-directed care, including self-referral. This option should be publicised and communicated to the practice population.

46. The team would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed and work in partnership with the Primary Care team where appropriate (e.g. shared care around medication).

47. The team should have members that are trained in mental health and may be drawn from mental health nursing, clinical psychology or Allied Health Professional (AHP) disciplines. The team should also have members or close links with other staff with relevant expertise and experience e.g. Community Link Workers, Addiction Services, Health Visitors, Health Improvement staff and financial inclusion teams.

48. The SLWG recognises that the use of terminology can be a source of confusion about what we are trying to achieve. The terms Primary Care multidisciplinary team or locality multidisciplinary team have different connotations for different professional and geographic groups. Rather than seek to ‘name this model’, the SLWG has sought to describe the function which local areas can name as appropriate.

49. A critical part of this approach will be a local communications strategy to inform local populations about how they can access services. Tools may range from social media channels, website updates and local newsletters, posters, flyers.

Proposed benefits

50. The Group suggest that this approach would realise a number of improvements that would benefit both individuals and practitioners. An enhanced range of service provision, embedded within a range of wider community assets would mean individuals can be better, and more quickly, connected to the support that meets their needs in the right settings. This will also support more efficient and targeted use of resources across a local area. Better communication across service providers will improve early intervention, continuity of care and better support self-management. The Group also considers that such a model would potentially reduce referrals to specialist services while also improving support for those who do and ensuring it is delivered promptly.

Proposed next steps

51. To further develop this approach, initial work should be undertaken to establish the baseline by identifying the level of support currently available in teams across Scotland, however, they are currently named and described. Posts in the Primary Care setting funded through Action 15 or the Primary Care Improvement Fund should be considered, and any opportunities to further expand capacity through those funds should be supported and encouraged.

52. A needs analysis should be conducted to scope the need for expansion of such a team/service. The expansions should be funded through a proposed Primary Care Mental Health (PCMH) development fund that will be jointly managed through the mental health and Primary Care planning processes within Health and Social Care Partnerships (HSCPs).

53. The development of an asset-based community development should be a collaborative one, led by HSCPs as part of Integration Joint Boards (IJBs) strategic commissioning plans. Local communities and 'experts by experience' should be fully engaged in this. As a minimum, local GP sub-committees, HSCPs, locality management, mental health service leads, psychology leads, interfaces with schools and third sector interface structures should be part of this collaborative approach.

Recommendations

54. To support the implementation of 'the model' described in this paper, the SLWG recommends the following:

- **Recognise the central role of Primary Care** within the Mental Health system and of MH & WB within Primary Care. This should be a priority for development within the MH Services Renewal Plan and also the revision of the GP Contract MoU (through further definition of MH as an "additional role"

for expansion and development). In developing PCMH capacity to deliver a 24/7 service, the principles that we have set out above should be followed.

- **Review existing additional role developments** in PCMH, such as those funded under Action 15 of the Scottish Government's Mental Health Strategy or through Primary Care Improvement Plans (PCIP). This work should be led by a newly established **Development Group**. There should be a partnership between the MoU/PCIP process and the MH planning process at local level with objective of maximising PCMH capacity along the lines of the model described in this paper.

- The same Development Group also undertake a "**gap analysis**" to scope workforce and resource requirements associated with providing a 24/7 service with a view to implementing a **funded PCMH development programme** in 22/23 and thereafter. This should include a plan for monitoring impact of this approach going forward.

- The Development Group would also promote implementation of robust systems to deliver **peer-to-peer decision support between community and specialist services and within Primary Care mental health services** to ensure patients are receiving the best care, from the most appropriate staff, irrespective of where they present in the service.

Annex A

Mental Health in Primary Care Short Life Working Group

Terms of Reference and Membership

1. **Background**

Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

Approximately 1/3 of GP consultations have a mental health component and this constitutes a significant workload within practice settings. While some people need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved

2. **Purpose**

These guidelines are intended to provide clarity and direction to the activities of the SLWG. They can be revised and amended as necessary once the work is underway.

The overall purpose of the SLWG is to improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

The expectation is that the final document will be issued within four meetings.

3. **Working Group**

Remit

The SLWG will provide a vision of how mental health care could be delivered better in Primary Care and in localities.

The SLWG will review the models currently in place, identify commonalities/success factors and produce a report with actions, suggesting

how these models could be implemented by health and care systems across Scotland.

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4. Method

- **Meeting 1**
  Discuss consensus statement and invite comments by next meeting.
  Discuss evidence paper and strengths/gaps in evidence.

- **Between meeting 1&2**
  Shape consensus statement into a vision.
  Collate additional evidence submitted around models.
  Skeleton report of output.
  Brief Ministers and other relevant stakeholders.

- **Meeting 2**
  Discuss and if possible agree vision.
  Discussion of evidence and describe an agreed model or models.

- **Between 2 & 3**
  Adjust vision.
  First draft of a report with vision, what works and initial estimates of workforce/resource requirements.

- **Meeting 3**
  Discussion of first draft report.
  Discussion about implementation and how that might be managed.

- **Between 3&4**
  Redraft of report to reflect group inputs.
  Draft implementation plan.

- **Meeting 4**
  Final report signs off.
  Discuss implementation plan and agree any next steps.
  Sign off the work of the group and hand over to those tasked with implementation.

5. Timescale

The SLWG will meet monthly or as necessary and agreed by the membership. The first meeting of the group will be Thursday 24th September 2020.

6. Communications

The Scottish Government will co-ordinate communications. There will be a formal minute recorded of each meeting which will be circulated to the members of the group. In this regard, progress updates on the activities of the Working Group will be translated into lines for communication and cleared by Scottish Government and issued to stakeholders for further dissemination.

Public Mental Health and Primary Care
Scottish Government
10 September 2020

Annex B

Mental Health in Primary Care Short Life Working Group

Statement of Intent

1. Background

   Approximately 1 in 4 people experience a mental health problem at some point in their lifetime and at any one time approximately 1 in 6 people have a mental health problem. Early evidence suggests mental health problems will increase following the Covid pandemic with a disproportionate effect on younger people, women and that a widening of already existing inequalities is likely.

   The vast majority of mental health and wellbeing issues can be managed appropriately in the community with self-management, community assets, third sector, primary, community care and specialist mental health services all having a part to play. This can only happen if there is capacity across all parts of the system to support management of problems in a timely way

   Approximately 1/3 of GP consultations (c8million/year) have a mental health component and this constitutes a significant workload within practice settings. While some need to access secondary care mental health services, many do not and the limited capacity of specialist services can lead to limits on access through waiting times and rejected referrals.

   The Short Life Working Group (SLWG) will set out to describe what an improved range of options in the Primary and Community care settings might look like and how these could be achieved.

2. Aim

   To improve outcomes for people with mental health problems and distress within the Primary and Community Care setting.

   By

   Providing a vision of how mental health care could be delivered better in Primary Care and in localities, suggesting models that could be implemented by health and care systems across Scotland.

   Possible elements of that vision:

   That enhanced services within Primary and Community care sit within a wider system that emphasises the value of self-management, access to community assets and linkage to specialist services where required

   That by enhancing access to mental health expertise and resources within the Primary Care setting we will:

- Improve the experience of support and care for those currently already managed in Primary Care through more rapid access to support, within a team that they know and trust, using a shared Primary Care clinical record.
- Reduce the referral burden to specialist services, allowing quicker access to specialist help for those that need it.
- Improve the outcomes for patients through earlier intervention and support.
- Raise awareness and confidence within the wider Primary Care team to support people with their emotional needs.
- Build interfaces with local specialist mental health services (for example, to offer clinical decision support, to plan discharges).
- Build interfaces with local schools, and work collaboratively to support the mental health needs of young people with a common approach and language.
- Support and enable 'reflective practice' for all clinicians managing mental health issues, to sustain compassionate practice and reduce professional burnout.
- Ensure that there is capacity to deliver CBT and other initial talking therapies to support patients with mental health conditions such as anxiety, depression and adverse trauma experience and that this can be accessed directly (face to face or digitally) from Primary and Community care or through self-referral.

This will be achieved by embedding mental health professionals, support workers and others with appropriate skills into Primary Care multidisciplinary teams within clusters or localities. Their role will be to directly assess and support people presenting with mental health problems and distress but also to support the wider Primary Care team in managing mental health problems.

Assessment, advice, support or intervention needs to be tailored as appropriate to the person and a range of skills, expertise and knowledge should be available within the team (or easily accessed by the team) to maximise the options available for individuals and facilitate person-centred care.

Mental health workers in the Primary Care team need to be able to directly access advice, support or make referrals to specialist community mental health teams (CMHTs), psychological therapies (virtual and face to face, individual and group), and Distress Brief Interventions (DBI).

Mental health workers within the Primary Care team would work closely with community link workers (CLWs), peer support workers and third sector and voluntary groups to maximise the assets of their local community.

Depending on the mental health resource and expertise available in the team, there would be the potential for training opportunities for practice based staff, community pharmacists and for all others within the cluster or locality (for example case-based discussion, PLT sessions).

Mental Health workers would support GP practices in the management of acute and ongoing mental health and addiction issues and engage with other community resources to achieve this.

The SLWG is tasked with using the expertise of those on the group to agree the vision and illustrate how this could be implemented by citing examples of good practice, and sharing the available evidence base. The group will also make recommendations about workforce that would be required to support implementation of these models and how that might be deployed.

Drafted with input and comments from Carey Lunan and Miles Mack, RCGP, Linda Findlay, RCPsychiS and Alastair Cook, PMO Mental Health

22/09/20

Appendix 3

Primary Care Mental Health Models in Scotland

December 2021

Scottish Government
Riaghaltas na h-Alba
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Introduction

The purpose of this paper is to outline some of the Mental Health models that are in place across various board areas in Scotland, which demonstrate good practice, and seeks to draw out some of the commonalties and success factors from them. This is not an exhaustive list and the intention is for this to be a live document which can grow to include other examples that Members would like to add. This will give us an understanding of current mental health service provision in primary care settings, where there are potential gaps and help inform recommendations on how services can be improved.

From the models of good practice sourced so far we have gleaned a number of **success factors** and potential impacts that are common across all models cited.

These are:

- Regular reflective practice (or other wellbeing support) is an essential part of being able to deliver a sustainable, compassionate mental health service;
- integration needed with digital/remote primary care mental health and wellbeing resources, such as the health, wellbeing, and mental illness content on NHS inform, interactive self-care guides, NHS 24's 24/7 mental health hub, the Breathing Space crisis line, computerised CBT, telephone CBT, telephone interpersonal counselling, and the various specific digital therapies available through SIlvercloud, Sleepio. These can improve access and reduce clinician time;
- many models are GP Practice based and all use the wider multidisciplinary teams (MDTs);
- some of the models have identified the need to raise GP Awareness about the role and availability of the wider MDTs;
- a skilled assessment at the point of presentation is crucial to the quality of the overall patient experience;
- continuity and a joined up service needed;
- reduction in GP and GP Practice attendance rates;
- some highlight the benefits of no referral system or discharge. MDTs are able to directly access advise and support;
- request for assistance model used in Allied Health Professionals (AHP) Children and Young People services and has shown to promote shared responsibility and decision making;
- all of the models highlight the importance of providing GP teams and wider primary care multidisciplinary teams with training, standardised operational procedures and opportunities for feedback;
- the models highlight the benefits of cluster working; and
- the models bring training opportunities for practice based staff.

As part of the next iteration of this report these factors will be further expanded to provide more detail.

The following sets out a brief summary of the models so far sourced in primary care:

Patient Assessment & Liaison Mental Health Service (PALMS) – Tayside

PALMS was launched in February 2019 in Dundee. The purpose of the project was to enable access to a within-GP practice Mental Health Specialist (MHS) with the outcome being that assessments carried out by MHSs should allow patients access to the most appropriate mental health support through referral/more tailored signposting, whilst also helping to reduce GP workload.

Funding of the project allowed embedding of two Band 8a 0.5 WTE clinical/counselling psychologists into two Dundee-based GP practices. Each of the clinicians held regular 5 sessions a week within the respective practices.

The inclusion criteria was patients 16-64 years old and the pilot was designed to encourage self-referral. As part of this posters and leaflets were added to waiting rooms and adverts added to the practice website. Reception staff, GPs and other clinical staff were provided with flowcharts to guide them on identifying suitable patients for the PALMS service.

Each appointment lasted 30-60 minutes, depending on severity of presentation, and took place in one of the medical centre consultation rooms. Through assessment the MHS considered whether accessing MH/support services would be appropriate and by what method this would be best achieved. Direction of referral/signposting was based on factors such as nature of difficulties, severity, and level of impairment. The MHS role also extends to providing information on mental health coping strategies and self-help material, signposting to local community support services and, if appropriate, making referrals to specialist NHS services for further treatment.

Evaluation:

- GP feedback was highly positive and indicated that consultancy with MHS was valued;
- for reception staff involved in triaging telephone calls and making PALMS assessment appointments, the perception was that this did not cause their roles to become more challenging;
- the PALMS pilot appeared to provide support towards increased MDT;
- significant reduction in re-presentations for mental health consultations four months after PALMS assessment indicating workload for GPs may have decreased in this regard;
- non-referral routes were the most common post-assessment outcomes for patients, followed by referrals to other NHS/non-NHS services; and
- Primary care psychology (NHS) was the largest recipient of referrals that were made. This would fit with severity of presentation, the majority of which were within mild-moderate category.

Data indicated the requirement for 1 session per 2,000 patient population. It also highlighted the need to move towards cluster based working with the view of each practice not having physical space to accommodate the PALMS service. The pilot indicated the best way of moving forward is having a Band 8A responsible for each of the clusters with a number of Band 7 Clinical Associates in Applied Psychology/ Psychotherapists and Band 6 Mental Health Nurses in post.

Occupational Therapy (OT) in Primary Care - Lanarkshire

OT clinicians are skilled in assessing the components of everyday occupations and roles that matter to people, identifying the impact of developmental, physical and mental health conditions on these occupations and devising intervention plans to enable people to overcome areas of dysfunction and engage fully in their day-to-day lives. Funding from the Scottish Government supported the recruitment of two 0.6 whole time equivalent (WTE) Band 7 OT Advanced Practitioner posts to an 18 month secondment opportunity which commenced in October 2017.

The OT service accepted referrals from all of the GP practice team for registered patients aged 16 and over who identified issues arising from mental or physical ill health which related to their occupational performance and/or environment. All those referred were contacted by telephone within two working days and triaged in order to establish patient need, confirm appropriateness of referral to OT or need for alternative intervention/service, and offered an initial assessment appointment.

Depending on need, patients engaged in a brief intervention (1-3 contacts) or an episode of care (4+ contacts). All contacts were recorded in GP Vision. Written and verbal feedback was also provided to GP teams and health and social care providers. The OT service was located within the GP practice. Telephone triage within two working days and initial assessment within two weeks enabled patient need to be met ‘at the right time’ and ‘in the right place’.

Educating GP clinical teams at the start of the test combined with a consistent OT presence, feedback from patients and OT use of Vision electronic records increased GP team knowledge about what OT is able to offer. As a result GPs made fewer inappropriate referrals. This highlights the importance of providing GP teams and wider primary care multidisciplinary teams with training, standardised operational procedures and opportunities for feedback.

Educating reception staff is key to enable them to confidently triage patients to OT as a first point of contact. To date limited protected learning time to train reception staff and the challenge of developing a simple algorithm for reception staff to follow in order to triage relevant patients to OT has prevented this.

Evaluation:

- The test concluded that OT service provision in primary care requires a range of qualified and support staff to meet patient need including Band 7 Advanced Practitioners, band 5 and 6 clinicians, band 4 support staff and administrative support;
- the OT service has increased primary care capacity to manage patients, reduce onward referrals to secondary care services and reduce uptake of social care and sickness benefits, whilst improving health outcomes;
- measurable benefits were recorded for patients in terms of improvement in their occupational performance and quality of life;
- GPs reported a notable reduction in attendance rate;
- GPs valued having direct access to OT through co-location in the GP practice;

- inclusive criteria enabled patients with multiple co-morbidities, whose mental or physical health resulted in reduced occupational performance, to have access to a streamlined service; and
- the test highlighted that GPs lack of awareness about the role and availability of OT services and this had a negative impact on patients' access to OT.

Craigmillar Medical Group – Mental Health Model - Lothian

As GPs working in an area of high deprivation, the prevalence of mental health issues is very high, across all ages. The practice estimates that mental health issues were discussed in around one third to one half of all our GP consultations. Previously all mental health workload was managed by the GPs – or referred on to local voluntary/third sector organisations or specialist services, with varying levels of engagement.

Craigmillar Medical Group have recruited a team of three primary care mental health nurses, (one lead nurse – band 7; two nurses in training and development posts – band 5). The team see a large number of young people, from the age of 12, referred internally from the GPs. They are contacted quickly by telephone and offered an appointment after school. Common issues discussed are social anxiety, gender identity, self-harm and peer pressure issues (drugs, alcohol etc.).

Their interventions consist largely of crisis management, general psychological support and signposting to local services. A very small percentage of patients are referred on to Child and Adolescent Mental Health Services (CAMHS).

Evaluation:

- Around 400 referrals in 6 months. High DNA rate for appointments – team responded by initiating phone triage / consultation both as initial assessment then follow up. About to have a drop-in session by invite – where all of the team will see patients who attend;
- they are based within the GP practice so access is less intimidating;
- 30 minute appointments;
- the practice uses a triage system to meet needs, including having a care plan with a named clinician (GP, PN or MHN) for those in the top tier of need. Trauma informed discussions take place to discuss care needs with patients in a proactive way and there are 4-weekly meetings to discuss cases;
- reception staff are now called Care Co-ordinators and they all look after a cohort of patients so they develop relationships and know them well;
- the whole team has undergone team building and profiling so they know and respect each other's 'type', particularly helpful when having difficult conversations as it makes it less personal;
- they offer a primary care model of mental health provision; no formal internal referral system, rapid access to appointments, shorter and more frequent appointments, no "discharge" from the service;
- they are often already known as healthcare professionals to patients' families (often parents) therefore less stigma, more trust;

- they focus on de-medicalising social issues (estimated 99% of referrals are for mental distress and not mental illness); and
- quality assurance is maintained through regular case discussion, joint consulting and good access to specialist decision support.

ADAPT – Accessible Depressions & Anxiety Psychological Therapies (Grampian & Lanarkshire)

ADAPT was developed by NHS Education for Scotland (NES) and aims to double access to psychological therapies and interventions in primary care adult mental health and to develop the specialist mental health workforce in secondary care. This is achieved through:

- Expanding the competencies of the existing workforce to deliver the most effective treatments;
- increasing the workforce in primary care and providing training, supervision and consultation for the new primary care mental wellbeing workforce associated with Action 15 and the developing Primary Care Multidisciplinary Teams;- and
- providing guidance and support on the model of service delivery that enables cost-effective stepped care, patient choice, quality assurance and increases capacity.

The model draws upon the Increasing Access to Psychological Therapy (IAPT) services in England which demonstrate clinical recovery from anxiety and depression in 50% of people treated and see over 1 million people per year. Adjusting this model for the Scottish context to take into account the workforce commitments in the Primary Care Services Policy and the Mental Health Strategy a 'scalable' ADAPT team would comprise of; Clinical Lead 5%, Psychological Therapists 55%, Psychological Practitioners 25%, Link Workers 10%, and admin support 5%. It is suggested that the minimum ADAPT team size is 10 WTE.

- Clinical Lead provides leadership, governance of service, clinical supervision and psychological therapy.
- Psychological Therapists (e.g. specialist nurses, clinical psychologists, clinical associates and AHPs) provide assessment and therapies such as Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Mindfulness-based Cognitive Therapy (MBCT).
- Enhanced Psychological Practitioners (e.g. AHPs, nurses, psychology graduates, other caring professionals) conduct structured assessments and provide brief psychological interventions; such as Guided CBT, Behavioural Activation (BA), Motivational Interviewing (MI) and groups interventions.
- Link Workers & Welfare Advisors provide signposting to community services, psychological informed care and support groups.
- Admin staff provide a first-line contact and ensure the efficient administration of the team's caseload, support the patient pathway, and facilitate data recording and reporting.

Staff are trained in the competencies to deliver evidence based psychological therapies and interventions. Staff in the multidisciplinary primary care team whose role is not primarily to provide psychological treatment, can be upskilled in the competencies required to provide interdisciplinary care.

Staff could have access to NES training programmes including; psychological therapies, specific enhanced psychological interventions and the Enhanced Practitioner Programme.

NES has considerable experience in providing comprehensive education and training programmes in evidence based psychological therapies and interventions to support the provision of match stepped care in mental health services. These link with the NES training programmes for other practitioners working in Primary Care. The NES work-based national training programmes aims to build multidisciplinary capacity within all the NHS boards and partnership organisations across NHS Scotland, to provide psychological therapies and interventions within adult mental health services. This means implementation of expansion in services will involve close working with key national networks e.g. Heads of Psychology Services Scotland (HOPS). NES can provide education and training to support the ADAPT service model including the Clinical Doctorate, MSc in Primary Care, Diploma in CBT, and short training programmes. The Enhanced Practitioner Programme is a new training programme and would represent significant expansion at this level.

Evaluation:

- The pilot provided accessible, effective, person centred, integrated care in primary care settings in Lanarkshire and Grampian;
- training in adapting Cognitive Behavioural Therapy for common LTCs resulted in significantly higher knowledge, confidence and evaluated positively by staff, patients and service managers; and
- clinical outcomes included highly statistically significant improvements in depression, anxiety, quality of life and progress towards healthy lifestyle goals.

<u>Primary Care Mental Health (PCMH) Service - NHS Dumfries & Galloway</u>

The PCMH Service was initially piloted in 4 GP practices in Dumfries and Galloway for 12 months from mid 2017. Following a successful evaluation of the pilot collaborative work began with the GP cluster leads to develop and begin rollout of the service in early 2019.

The model now see’s 13 experienced Mental Health Nurses based in general practice across the region. Sessions have been allocated at GP practice level based on GP population size. People can access the service via the individual triage system within each practice and appointments are booked via the electronic GP system. There is no requirement for people to see the GP or Advanced Practitioner (AP) prior to seeing the Primary Care Mental Health Nurse (PCMHN), thus assisting in reducing GP workload and streamlining pathways.

The service offers mental health triage, assessment, brief interventions, assisted self-management and appropriate signposting for those with mild to moderate mental health issues. The approach aligns itself to the Scottish Governments 2017- 2027 Mental Health Strategy as the focus is on ease of access, early intervention and self management, as well as early identification of more serious mental health issues.

The service uses a multi-disciplinary/multi-agency approach facilitating timely onward referral to other agencies and the wider mental health services where appropriate, ensuring people are seen by the right person at the right time. Active participation with family and Carers is encouraged, recognising the contribution Carers make to an individuals' recovery.

Each PCMHN is aligned to the locality CMHT, operational responsibilities; clinical supervision and training are jointly supported by GPs and CMHTs. This arrangement ensures the PCMHNs receive adequate support, are skilled and confident to carry out their work and quality is developed which supports performance. It maintains the connection with secondary mental health and has improved links and consistency between Primary Care and secondary Mental Health Services.

Covid-19 has moved work towards reduced face to face contacts with more consultations taking place via telephone or NHS Near Me. Remote working has afforded the ability to provide cover across practices and localities to respond to staff absence. So far, feedback from people offered telephone or NHS Near Me appointments has been that this provides the support required and they feel comfortable with this.

Evaluation

Local research study carried out with the GPs identified the PCMH service reduced GP workload and provided capacity for them to focus on the more complex patients, leading to a reduction in GP stress levels. The study highlighted that early assessment and intervention by a skilled specialist provided more effective non-pharmacological management of people with mental health difficulties, thereby reducing prescribing.

PCMHNs were viewed as a resource to educate, support and advise the primary care team, co-location was felt to support delivery of a collaborative approach to person centred care; enabling sharing of knowledge/understanding and building relationships. Joint working between PCMHNs and pharmacists on antidepressant reviews has been welcomed.

Patient/carer feedback (qualitative surveys) has been extremely positive across the region. Core 10 and GIS were used to score patient outcomes on perceptions of their mental health, connections to family, community and social groups. 50% of patients achieved their personal outcomes, 22% were signposted to other appropriate services/agencies, 10% disengaged (18% had an unidentified outcome).

Referrals to secondary services, e.g. CMHT, Psychology, have been dealt with effectively and efficiently, ensuring people see the right person at the right time.

Compassionate Distress Response Service – NHS Greater Glasgow & Clyde

The Compassionate Distress Response Service was commissioned late 2019/early 2020 from Glasgow Association for Mental Health (GAMH) which started providing an out-of-hours (5pm – 2am, 7 days) service by telephone during Covid-19 lockdown from late May 2020. The service is for people aged 18+ resident in Glasgow City who are emotionally distressed and require support but do not require medical or specialist psychiatric assessment.

Distressed people are referred to the service from statutory services, including first responders, GP Out of Hours, Out of Hours CPNs, NHS24, A&E and Mental Health Assessment Units, Urgent Care Resource Hub, etc., provided they have capacity to engage and consent to do so. The service gives 'listening' support to each individual via telephone (this will also be face to face and outreach when appropriate post-Covid), provides support to develop a plan of action to alleviate their distress and onward referral to appropriate support services for each person accessing the service. People who are referred to the service should receive a call within an hour of referral for immediate support and receive a follow up phone call the following day. The case is kept open for a month, or more in some circumstances.

Initial feedback from this research supported the need for in-hours provision for general practice referrals and this service commenced in September 2020.

The Jigsaw Project - NHS Greater Glasgow & Clyde

The Jigsaw Project was established in the Drumchapel GP Cluster, funded as part of the NHS GG&C Primary Care Mental Health Transformation Fund bid to the Scottish Government.

The project aimed to consider, better understand and help find solutions for people who experience longer term mental health difficulties who were not well-served by existing arrangements. The project also helped to raise awareness of other community supports which help improve mental health and a directory of these was produced for each locality to assist GPs to direct patients to these.

The voice of people with lived experience ran throughout the project, alongside those of GPs and their teams (regarding managing their own mental wellbeing as well as that of their patients). A Jigsaw tool kit was developed to engage with the community to identify problems and solutions, and these 'jigsaw lids' helped illuminate wider perspectives on the issues. The project also provided seed funding to local groups to develop solutions to poor mental health.

Mental health services were seen to rely too heavily on GP practices to support those whose needs were not being met, which impacted on their stress levels and mental wellbeing. The study found some evidence of GPs negatively affected by their workload around mental health and the challenges of negotiating the system and, although preserving non-clinical space within the diary was one of the successful approaches to avoiding burn out, most felt they were operating at the full extent of their resilience. Mutual support has improved across the cluster and active

support such as Mindfulness Based Stress Reduction training and yoga practice have supported this within primary care.

Evaluation:

The project highlighted the different ways of working amongst the public and Third Sectors but also the importance of continuing the dialogue and looking at solutions to improve communications, understanding and service delivery to better meet the needs of local people.

Initial data suggests that a significant proportion of those referred to mental health services are not accepted for treatment by the CMHT, but are directed to the PCMHT, Third Sector providers or back to the GP. This may be due to inappropriate referrals, lack of capacity or other issues but this perhaps suggests that better communications between GPs and mental health services (around what is and is not an appropriate referral) and a single point of entry to mental health support – of all kinds – would assist in ensuring patients receive the support they need.

The Govan SHIP Project - NHS Greater Glasgow & Clyde

The Govan SHIP Project was established in 2015 to provide additional resources within primary care to enable a more effective response to the challenges faced by health and social care professionals in deprived areas. The project was prompted by work of the Deep End Group and funded by the Scottish Government Primary Care Transformation Fund.

The project focussed on person-centred care delivered by MDTs, creating capacity for GPs to support more complex patients and understanding demand for health and care services at GP practice level. One part of the project focussed on mental health as more deprived areas have a higher incidence of mental health issues and there was a professional perception that mental health support services were not being accessed by those most affected and in need of support. The work involved consultation with a variety of key players: GPs, CLPs, wider primary care team, social work, PCMHTs, CMHTs, Lifelink, SAMH, GAMH, the Health and Social Care Alliance amongst others. Work was done to develop a better understanding of the type of mental health concerns presenting to primary care. Fresh data was gathered by reviewing GP consultations which had substantive mental health components and an audit of outcomes of referrals to mental health support services.

It was found that 20% of patients attended with a mental health issue, primarily (74%) with depression, anxiety, low mood or stress - a significant proportion (72%) were on medication (mainly antidepressants) to assist with this but were not linked into additional support services, although most had been referred/engaged previously. Overall, less than 20% of patients referred to PCMHTs and CMHTs received treatment, raising questions around processes. The study found that the way in which mental health concerns were responded to by different practitioners was inconsistent, there was not a shared understanding around the definition of mental health needs, and current support services were challenging for both

referrers and patients. This suggested a need for clearer pathways, guidance and consistent practice.

Evaluation:

- Further analysis of referral outcomes to mental health teams needed;
- consultation with patients about their experiences of help for mental health issues needed;
- the need to develop a protocol for the routine mental health screening of all primary care patients with long term conditions (who often develop mental health issues);
- continued mental health input to the development of the CLP role;
- GP input to mental health service planning;
- better links needed with NHS 24, Scottish Ambulance Service and Police Scotland to coordinate local and national efforts;
- online referral guidance needed for GPs; and
- create a visible leadership team to be accountable at a strategic level for mental health, to support joined up, collaborative partnership working.

<u>The National Digital Wellbeing Hub – NHS Tayside</u>

- Enables staff, carers, volunteers and their families to access relevant support when they need it.
- Provides a range of self-care and wellbeing resources designed to aid resilience as the whole workforce responds to the impact of coronavirus (COVID-19).

The National Wellbeing Hub offers a range of resources and self-help materials to help individuals at work and at home. The National Wellbeing Hub also provides direct links that will enable individuals to access e-health programmes. There are computerised programmes and all NHS staff have free access. They provide a structured online programme based on Cognitive Behavioural Therapy, that focuses on supporting wellbeing, including managing mental health, building and maintaining resilience, managing stress and sleep.

The Scottish Government has also launched a new mental health helpline for health and social care workers. This helpline will offer support 24 hours a day, seven days a week.

Trained practitioners at NHS 24 will offer callers a compassionate and empathic listening service based on the principles of psychological first aid, as well as advice, signposting and onward referral to local services if required.

NHS Tayside Psychological Therapies Service are offering NHS Tayside staff the opportunity for brief 1-1 interventions (up to 4 sessions)with a psychologist. These are low intensity, informal but structured support sessions helping staff to:

- understand what they are experiencing, thinking or feeling;
- work out what can help, including practical exercises;
- get the best out of self-help materials; and

- identify other options for support.

These sessions are available to anyone who may be experiencing common psychological or emotional reactions to difficulties at work or home (including stress, anxiety, worry, low mood and sleep difficulties).

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

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Appendix 4

PLANNING GUIDANCE FOR MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

Scottish Government
Riaghaltas na h-Alba
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December 2021

Introduction

1. This guidance should be used to support the formation and implementation of the Mental Health and Wellbeing in Primary Care (MHWPC) Service model as proposed in the Mental Health in Primary Care Short-Life Working Group Report. It is intended to guide the establishment of local planning groups, the development of their plans and implementation of the service.

2. This guidance should be used in conjunction with:
   - The MHWPC service Local Planning Template at Annex A;
   - resources to support implementation currently under development, to be published: March/April 2022 [Annex B];
   - Mental Health in Primary Care Short-Life Working Group report at Annex C;
   - examples of good practice used to inform the Mental Health in Primary Care Short-Life Working Group report at Annex D; and
   - Outcomes and Measures currently under development, to be published: March/April 2022 [Annex E].

Mental Health and Wellbeing in Primary Care Services

Improving Mental Health and Wellbeing in Primary Care Services

3. MHWPC Services should be established within an area served by a group of GP practices (this could be a locality, part of a locality or a cluster area). This guidance does not define how the MHWPC Service should be constituted; however, there should be a multi-agency team providing assessment, advice, support and some levels of treatment for people who have mental health, distress or wellbeing needs. The MHWPC Service could include Occupational Therapists, Mental Health Nurses, Psychologists, Enhanced Practitioners, Peer Support Workers as well as linking to others such as those providing financial advice, exercise coaches, family support networks. Every MHWPC Service should ensure that it provides access to a link worker to support wellbeing.

Defining the Link Worker function*:*

- Every GP Practice must have access to a Community Link Worker who, through their role, will support mental wellbeing. This may be a Community Link Worker who is supporting more than one GP Practice; and
- other members of the MHWPC Service should be encouraged to contribute to the link worker function by referring/signposting to wider community services, as appropriate.

4. The MHWPC Service would provide assessment and support to the individual to access appropriate levels of advice, community engagement, treatment or care – some of which would be delivered within the Primary Care setting, depending on the skills and capacity of the team.

5. The MHWPC Service would work closely with and / or be part of the wider community team in that area, engaging with the wider assets of the community, health and social work staff and with other agencies as appropriate.

6. Although the MHWPC Service would be aligned to a group of GP practices, there should be named members that work closely with each individual practice to provide continuity and allow the development of effective clinical or multidisciplinary team relationships.

7. Practice systems should allow patients to be directed to an appointment with the appropriate members of the MHWPC Service based on self-directed care, including self-referral. This option should be publicised and communicated to the practice population.

8. The MHWPC Service would provide timely support and treatment for people in that setting with the GP providing clinical leadership and expert general medical advice where needed. Where more specialist input is required the resources of Community Mental Health Team or other appropriate secondary care Mental Health service would be accessed in partnership with the wider Practice Primary Care team, where appropriate (e.g. shared care around medication).

9. The MHWPC Service should have members that are trained in mental health and may be drawn from mental health nursing, clinical psychology or AHP disciplines. It should also provide access to link worker support to the GP practices it serves. The team should also have members or close links with other staff with relevant expertise and experience e.g. addiction services, health visitors, health improvement staff and financial inclusion teams.

10. It is not expected that the MHWPC Service will only be involved in the most complex of cases, rather they will be a resource that facilitates improved communication, effective triage and provides the right level of support quickly. This would include early intervention and prevention, to a range of people, including access to community assets such as support groups, social activities and exercise.

11. Services had to quickly adapt in light of the Covid-19 pandemic and many of the changes have resulted in significant benefit for both patient experience and service capacity and quality. The MHWPC Service should continue to realise these benefits, for example, through collaboration with multiple partners, improved communication and the use of digital technology to deliver services.

<u>Embedded, Aligned or Hybrid Model</u>

12. There are three options available for implementing an MHWPC Service to serve a practice or group of practices; aligning, embedding or hybrid model.

13. **Aligning** the MHWPC Service to a cluster or group of GP Practices would mean teams are employed or contracted by the relevant Health Board. Service Level Agreements could be considered with professional groups to deliver some of the services which would preserve line management and clinical governance of these groups.

14. We recognise there can be large variances in practice list sizes, therefore by aligning services to a cluster; resource can be spread and distributed where needed. Given workforce limitations, this would make best use of existing resource, while striving to expand mental health capacity.

15. Aligned services may be seen as “distant” and potentially difficult to contact, therefore it is imperative that work is carried out to communicate and promote the MHWPC service and to develop close working relationships with practice staff.

16. **Embedding** the MHWPC Service within General Practice settings may mean they are employed or contracted by the Practice and are dedicated to that Practice for patient care. This model has been traditionally used where there is specific and significant ongoing need in a particular areas that requires dedicated full-time resource.

17. In some areas, particularly with levels of high deprivation, it has been found patients will not attend services out with their GP practice premises, particularly when related to mental health. The GP Practice is a place that patients know and trust, if implementing an aligned model, consideration should be given to having staff employed by the Health Board but basing them within a practice for a number of day/sessions per week. It will also be important to consider resource allocation for health centres with more than one GP Practice in the same building.

18. Using a **hybrid model** to implement the MHWPC Service will include elements of both the embedding and alignment models. This could allow flexibility based on population need, rurality and resource. For example, a MHWPC Service aligned with a GP cluster with psychology, OT and various other workers aligned, could complement a mental health worker embedded in a GP Practice.

19. The model that is implemented will depend on the needs of each local area, including but not limited to; geographic area, population size, additional demographic factors and local need. It is expected that the model used will also be driven by existing structures of service provision and will enable ease of access for patients, as well as ease of “stepping up” to other services in primary and secondary care and mental health/psychology services. It should be noted that in line with other policies and the GP Contract Memorandum of Understanding, additional workers are increasingly being employed by Heath Boards.

<u>Access</u>

20. Individuals should be able to access their MHWPC Service without the need for a referral from a GP or other medical professional. Individuals will normally access their MHWPC service through their General Practice appointment system. All members of the Primary Care team should be able to arrange appointments with the MHWPC Service for patients when deemed appropriate.

21. MHWPC Services will provide mental health support, treatment and assessment across all demographics rather than targeted groups, for example, there will be no lower or upper age limit to the service.

Digital and Self-Help

22. MHWPC Services should make use of appropriate digital approaches to self-help and supported management to complement the provision of the service and make it more accessible.

23. Digital approaches to self and supported management of distress and mental health conditions should be an integral part of the service. Those who are digitally excluded, for any reason, should be engaged positively in alternative ways.

24. There are a number of online and digital resources available nationally to support the MHWPC Service, these are detailed in the resources to support implementation.

Urgent Care

25. People who require urgent mental health care should find pathways easy to access, quick and responsive at the earliest possible point. Individuals may not contact their GP to access mental health support or they may request support during the out of hours period. They should be guided to the right intervention, support or treatment quickly. It should therefore be possible for the MHWPC Service to provide assessment, treatment and support in such circumstances. The MHWPC Service should work with the Out of Hours GP/Primary Care Service and Flow Navigation function (established in each Board to provide access to a Mental Health Competent Decision Maker) to facilitate the ability to make appointments with the team, where appropriate for that individual.

Communities Mental Health and Wellbeing Fund

26. The Fund[1] provides significant investment into community support for adults and builds upon the children and young people's community wellbeing supports currently being rolled out across Scotland. The Fund will be delivered through a locally focused and co-ordinated approach via local partnership groups (building upon existing partnerships), working together to ensure that support to community based organisations is directed appropriately and in a coherent way. Funding will be distributed through a grant to the 32 local Third Sector Interfaces across Scotland in line with current NHSScotland Resource Allocation Committee Formula (NRAC). Working in collaboration with Integration Authorities and other existing local partnerships.

27. The MHWPC Service Local Planning Groups should engage with the Communities Mental Health and Wellbeing local partnership groups to ensure interfaces with further support options can be maximised.

[1] https://www.gov.scot/news/gbp-15-million-to-help-improve-mental-wellbeing/

Timescales, System Change and Workforce

28. It is accepted that it may not be possible to implement the entire MHWPC Service in the immediate term. We recognise the workforce constraints and current pressures in the system. This is why we expect full MHWPC Services to be developed incrementally by spring 2026, this could include phasing different elements of the service. However, we know that mental health support is already provided in primary care settings across Scotland and should continue to be in place through the implementation of service improvement. Dedicated funding has been in place to support mental health in primary care through Action 15 of the Mental Health Strategy and Primary Care Improvement Funding. The development of MHWPC Services will build on this work.

29. Fully staffing MHWPC Services relies on workforce supply. The Scottish Government recognise the current constraints that a finite workforce has on planning for service transformation and that the pandemic will likely have a significant impact on the development of workforce. The Scottish Government will continue to engage with Integration Authorities as workforce policy develops.

30. It is also recognised that that in order for MHWPC Services to be successful, significant system and culture change will be required at a local level to develop the required interfaces with specialist and other services as well as peer to peer support. This is also likely to take time and should be factored into local plans.

Responsibilities

31. Funding will be distributed to Integration Authorities who will convene local planning groups.

Local Planning Groups

Remit

32. These groups will be responsible for developing and implementing MHWPC Services in line with this guidance. This will include:

- Developing and agreeing plans outlining evidence on what is already in place and what is required to incrementally develop MHWPC Services. Plans should be completed using the template at Annex A;
- Equality Impact Assessing local plans;
- identifying funding requirements;
- supporting the ongoing development and implementation of MHWPC Services, including overcoming delivery challenges;
- reporting, monitoring and evaluation to ensure that the service is meeting local needs and plans are being delivered as agreed;
- liaison with the National Oversight Group (see below); and
- local engagement and communication, including securing lived experience to inform local planning.

Membership

33. Local planning groups should be convened with representation from the following groups as a minimum:

- GP sub-committees
- Health and Social Care Partnerships
- Mental Health Service Leads
- Heads of Psychology
- Nursing
- Relevant links to Action 15 and PCIP
- Third Sector
- Experts by Experience
- Primary Care Out of Hours Services
- GPs
- Community Planning Partnerships
- Allied Health Professionals
- Local Authority representation

34. This list is not exhaustive. Initial planning should consider, on the basis of local need, whether other professionals or organisations should be included in the planning process. This could include, for example, School Liaison, Health Visitors, Addiction Services and Third Sector Interfaces. It is for local areas to determine how these local planning groups function, for example, it may not be necessary for all representatives to meet face to face.

National Oversight Group

35. The National Oversight Group will review and scrutinise local area plans submitted by local planning groups and take forward national level activity, as required.

Remit

36. The role of the Group will be to:
    - ensure local plans are aligned with this guidance, the model and principles outlined in the Mental Health in Primary Care Short-Life Working Group report;
    - MHWPCSs provide additionality;
    - liaise with local planning groups;
    - ensure consistency of decision making;
    - approve the release of funding;
    - review local reporting on progress;
    - manage national level risks; and
    - take forward actions at a national level, for example, where delivery challenges arise that require change at a national level.

Membership

37. The following will be included in membership
    - SG – Mental Health/Primary Care
    - Principal Medical Officer
    - GP/BMA
    - Health and Social Care Partnership
    - RCPsychiS
    - RCGP
    - RCN
    - AHPFS
    - HOPS
    - Out of Hours
    - Equalities

Funding

Distribution

38. The level of funding available will be calculated using the NHS Scotland Resource Allocation Committee (NRAC) formula. Consideration will be given to establishing a minimum floor to ensure Boards have access to sufficient funding, to allow a MHWPC Service to be implemented.

39. Funding will be distributed through Integration Authorities (IAs) to implement the plans developed by local planning groups. To inform the development of plans, IAs will be informed of their maximum NRAC allocation in advance of local planning commencing.

40. Once complete, IAs will submit their plan, or joint plan, to the National Oversight Group. On approval of the plan by the group, IAs will be able to draw down funding to allow them to proceed with implementation of their plans. This allocation of funding will be based on the gaps/needs outlined in the plans submitted.

41. A small proportion of the overall funding available may be retained to support national actions, as required.

Set up and ongoing support costs

42. The initial work of establishing local planning groups and developing robust plans will require resourcing. A small proportion of funding will therefore be allocated to resource the development of long-term local plans. This will cover admin or project costs and facilitate the creation and ongoing running of the local planning group.

Additionality

43. Funding will only be allocated to support the implementation of MHWPC Services. The funding should provide additionality, it must not be used to replace existing investment in mental health primary care activity.

44. It should complement, not replace, the progress made through Action 15 and the Primary Care Improvement Fund. How additionality will be achieved should be demonstrated in all aspects of implementation, including planning, monitoring and evaluation.

Funding scope

In scope:

45. **Staffing** –The majority of funding should be used to staff the MHWPC Service.

46. **Out of Hours** – It is expected that people presenting in the Out of Hours period should have access to the full range of options available in hours, while accepting some options may not be available immediately. Any provision of an out of hours service should be detailed in local plans.

47. **Training** – There may be training and CPD requirements associated with the MHWPC Service, this includes training for General Practice staff. Training requirements should be detailed in local plans.

48. **Administration** – It is accepted that there will be administration and support costs associated with the creation of the MHWPC Service. Where possible, this should be provided using existing resource. However, as highlighted funding will be made available to support the coordination and creation of the local planning groups. Any further support necessary for the ongoing implementation of the MHWPC Service should be detailed in local plans.

49. **Equipment** – Any equipment needed (laptops/desks/chairs etc.) should be sourced from existing supplies in HSCPs. Where this is not possible, a small amount of funding may be made available.

50. **Transport** – Staff providing the MHWPC Service may be required to travel between GP practices. It is expected that local arrangements for reimbursement of travel costs will be followed. It is acceptable for these to be included in local plans as part of staff associated costs.

51. **Communications**– It is expected that local areas will plan their own communication to raise awareness and promote understanding of the MHWPC Service. Where this activity is expected to incur costs, this should be detailed in local plans.

52. **Service Accessibility** – The concept of accessibility does not just apply to disabled people - all users will have different needs at different times and in different circumstances. Accessibility should be considered in the planning stages

to ensure the MHWPC Service can meet the needs of people using the service. As a result, there may be costs incurred due to need for interpreters, BSL or Braille translation, easy read formats or resources for physical accessibility requirements. The practice or group of practices the MHWPC Service is supporting will already be accessible, the service therefore will align with existing requirements. Any additional anticipated costs, such as BSL translation and/or interpretation or large print formats should be detailed in local plans.

Out of Scope

53. **Community and secondary services** – While it is expected that there will be an interface with secondary or community care services, this is not within scope of this funding. Referrals to additional primary care services are also not within scope of funding. While these services are out of scope, they will continue to be funded through existing channels. It will be vital for MHWPC Services to interface with community and secondary services.

54. **Accommodation** – Building on the work already achieved to establish Multi-Disciplinary Teams under the Memorandum of Understanding, MHWPC Services should be accommodated within existing infrastructure. If this presents a barrier to implementation this should be reported to the National Oversight Group.

Process

55. The formation and implementation of the MHWPC Service teams will occur in stages. The key stages will be as follows:

December 2021	• Guidance, template and implementation plan issued to IAs • Local planning groups convened. • Discussion and planning of local models commences. • Additional evidence gathering in local areas to identify need.
March 2022 (though plans may be submitted earlier when ready for review)	• Local plans outlining activity to 2026 and robust implementation plans for 2022/23 submitted to the National Oversight Group. • National Oversight Group review of local plans submitted and liaise with local planning groups. • If necessary, any amendments to the local model will be made by the local planning groups. • If necessary, final submission of the local plans will be to the National Oversight Group.
Spring 2022	• Funding agreed and allocated.
Spring 2022	• National implementation of MHWPCS commences.
October 2022	• 6 monthly reporting on progress required.

(each year thereafter)	
March 2022 (and each year thereafter)	• Detailed plans for following 12 month period submitted as well as any changes to initial plans outlining activity to 2026.

Reporting

56. Regular reporting will be required to demonstrate how funding is being utilised. Reporting will be undertaken using the reporting template at Annex A. This template should be completed in full when submitting local plans in March each year.

57. For returns in March, current workforce figures should reflect staff in post on 28 February, and returns in September should reflect the staff in post at 31 August.

58. The tabs for future workforce should reflect staff forecast to 28 February when returned in September each year, and staff forecast at 31 August when returned in March each year. The future workforce to 2026 tab should be updated for every return.

59. IAs will be responsible for reporting and publishing local plans or a summary of those plans when they are submitted each year.

Annex A
Mental Health and Wellbeing in Primary Care: Local Planning Template

[Insert excel spreadsheet link from APS publication page to be added here]

Annex B

Mental Health and Wellbeing in Primary Care: Resources to support implementation currently under development, to be published: March/April 2022.

Annex C

Mental Health in Primary Care: Short Life Working Group Report January 2021

[Insert link from APS publication page to be added here]

Annex D

Mental Health in Primary Care: Examples of Good Practice Used to Inform Short Life Working Group Report

[Insert link from APS publication page to be added here]

Annex E

Mental Health and Wellbeing in Primary Care: Outcomes and Measures currently under development, to be published: March/April 2022

Appendix 5

Minister for Mental Wellbeing and Social Care
Kevin Stewart MSP

Scottish Government
Riaghaltas na h-Alba
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Integrated Joint Board Chief Officers
Integrated Joint Board Chief Finance Officers
NHS Board Directors of Finance
NHS Chief Executives

By e-mail

Our ref: **Mental Health and Wellbeing in Primary Care Services**

17 February 2022

Dear Colleagues,

MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

In December 2021, I committed to writing to you to confirm the future projected national levels of funding, which will inform the development of Mental Health and Wellbeing in Primary Care Services (MHWPCS).

As I announced in the Scottish Parliament on 12 January 2022, we expect this to be a significant investment reaching £40 million per year by 2024-25, subject to the approval of future Scottish budgets by the Scottish Parliament. Funding for 2025-26 onwards will be modelled on the basis of the plans that are submitted in March but we anticipate that an increase will be required to fund 1,000 additional roles in the final year of implementation.

The expected total national levels of investment are set out below:

2022-23 indicative (£)	2023-24 indicative (£)	2024-25 indicative (£)	2025-26 Indicative (£)
£10 million	£20 million	£40 million	TBC

You will find the indicative maximum allocation for your Board area for 2022-25 at Annex A. These amounts will be in addition to the £1.5 million already allocated in December 2021 to support the initial planning process.

The National Oversight Group for MHWPCSs will make recommendations on the release of annual funding allocations, starting from the 2022/23 financial year, based on receipt of local plans. Local plans should also include detail of how the MHWPCs will interface with other national and local services. The funding will be issued to Integration Authorities (IAs) to support the establishment of multi-disciplinary MHWPCS teams, within GP clusters or localities.

In line with the Local Planning Guidance, a small proportion of the overall funding will be retained for national level activity. The level of funding available for Boards/IAs has been calculated using the 2021-22 NHS Scotland Resource Allocation Committee (NRAC) formula. As you will be aware the formula is updated annually so allocations will be subject to a degree of minimal change. A minimum floor has been established for Island Boards and Highland, in line with the Local Planning Guidance, to ensure that all Boards have access to sufficient funding, to allow a MHWPC Service to be implemented.

Please could I ask, that on receipt of this letter, you nominate a Lead Planning Contact for your area and submit their name and email address; along with an expected submission date for your 2022-23 and long term plan to the Mental Health in Primary Care Team at MHWPCServices@gov.scot. Please do not hesitate to contact the Team if you have any questions or queries.

Thank you again, for your commitment to developing MHWPCS to ensuring they meet the needs of their local communities.

Kevin Stewart
Minister for Mental Wellbeing & Social Care

Annex A

Indicative funding allocations share by Health Board and Integration Authority

2022-23

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 709,530.74	East Ayrshire HSCP	£ 229,896.79
		North Ayrshire HSCP	£ 261,159.42
		South Ayrshire HSCP	£ 218,474.52
Borders	£ 204,537.20	Scottish Borders HSCP	£ 204,537.20
Dumfries & Galloway	£ 287,827.74	Dumfries and Galloway HSCP	£ 287,827.74
Fife	£ 655,388.47	Fife HSCP	£ 655,388.47
Forth Valley	£ 523,851.35	Clackmannanshire and Stirling HSCP	£ 246,804.52
		Falkirk HSCP	£ 277,046.83
Grampian	£ 936,798.00	Aberdeen City HSCP	£ 366,761.68
		Aberdeenshire HSCP	£ 405,085.77
		Moray HSCP	£ 164,950.55
Greater Glasgow & Clyde	£ 2,136,844.34	East Dunbartonshire HSCP	£ 178,370.73
		East Renfrewshire HSCP	£ 153,089.26
		Glasgow City HSCP	£ 1,147,733.95
		Inverclyde HSCP	£ 156,876.54
		Renfrewshire HSCP	£ 326,786.85
		West Dunbartonshire HSCP	£ 173,987.00
Highland	£ 704,172.13	Argyll and Bute HSCP	£ 203,157.81
		Highland HSCP	£ 501,014.32
Lanarkshire	£ 1,179,900.70	North Lanarkshire HSCP	£ 610,193.12
		South Lanarkshire HSCP	£ 569,707.58
Lothian	£ 1,440,245.46	East Lothian HSCP	£ 178,824.72
		Edinburgh HSCP	£ 804,915.13
		Midlothian HSCP	£ 154,914.04
		West Lothian HSCP	£ 301,591.56
Orkney	£ 118,226.56	Orkney Islands HSCP	£ 118,226.56
Shetland	£ 116,987.81	Shetland Islands HSCP	£ 116,987.81
Tayside	£ 751,379.63	Angus HSCP	£ 207,838.55
		Dundee City HSCP	£ 278,759.05
		Perth and Kinross HSCP	£ 264,782.03
Western Isles	£ 134,309.87	Western Isles HSCP	£ 134,309.87
Total	£9,900,000.00		£9,899,999.97

2023-24

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 1,416,848.80	East Ayrshire HSCP	£ 459,076.65
		North Ayrshire HSCP	£ 521,504.42
		South Ayrshire HSCP	£ 436,267.73
Borders	£ 408,436.56	Scottish Borders HSCP	£ 408,436.56
Dumfries & Galloway	£ 574,757.90	Dumfries and Galloway HSCP	£ 574,757.90
Fife	£ 1,308,733.12	Fife HSCP	£ 1,308,733.12
Forth Valley	£ 1,046,069.06	Clackmannanshire and Stirling HSCP	£ 492,839.38
		Falkirk HSCP	£ 553,229.68
Grampian	£ 1,870,674.59	Aberdeen City HSCP	£ 732,379.61
		Aberdeenshire HSCP	£ 808,908.27
		Moray HSCP	£ 329,386.71
Greater Glasgow & Clyde	£ 4,267,024.91	East Dunbartonshire HSCP	£ 356,185.21
		East Renfrewshire HSCP	£ 305,701.11
		Glasgow City HSCP	£ 2,291,888.69
		Inverclyde HSCP	£ 313,263.86
		Renfrewshire HSCP	£ 652,554.62
		West Dunbartonshire HSCP	£ 347,431.43
Highland	£ 1,406,366.59	Argyll and Bute HSCP	£ 405,745.05
		Highland HSCP	£ 1,000,621.55
Lanarkshire	£ 2,356,121.88	North Lanarkshire HSCP	£ 1,218,483.35
		South Lanarkshire HSCP	£ 1,137,638.53
Lothian	£ 2,875,999.50	East Lothian HSCP	£ 357,091.78
		Edinburgh HSCP	£ 1,607,320.14
		Midlothian HSCP	£ 309,344.98
		West Lothian HSCP	£ 602,242.60
Orkney	£ 236,302.72	Orkney Islands HSCP	£ 236,302.72
Shetland	£ 233,829.10	Shetland Islands HSCP	£ 233,829.10
Tayside	£ 1,500,416.08	Angus HSCP	£ 415,028.95
		Dundee City HSCP	£ 556,648.78
		Perth and Kinross HSCP	£ 528,738.34
Western Isles	£ 268,419.18	Western Isles HSCP	£ 268,419.18
Total	£19,770,000.00		£19,770,000.00

2024-25

NHS Board Name	NHS Board Area Indicative Allocation	IA Name	IA NRAC Share of Total Indicative Board Area Allocation
Ayrshire & Arran	£ 2,857,299.46	East Ayrshire HSCP	£ 925,800.60
		North Ayrshire HSCP	£ 1,051,696.06
		South Ayrshire HSCP	£ 879,802.80
Borders	£ 823,676.85	Scottish Borders HSCP	£ 823,676.85
Dumfries & Galloway	£ 1,159,090.10	Dumfries and Galloway HSCP	£ 1,159,090.10
Fife	£ 2,639,267.10	Fife HSCP	£ 2,639,267.10
Forth Valley	£ 2,109,563.54	Clackmannanshire and Stirling HSCP	£ 993,888.48
		Falkirk HSCP	£ 1,115,675.06
Grampian	£ 3,772,510.86	Aberdeen City HSCP	£ 1,476,959.20
		Aberdeenshire HSCP	£ 1,631,291.33
		Moray HSCP	£ 664,260.34
Greater Glasgow & Clyde	£ 8,605,129.89	East Dunbartonshire HSCP	£ 718,303.74
		East Renfrewshire HSCP	£ 616,494.60
		Glasgow City HSCP	£ 4,621,955.64
		Inverclyde HSCP	£ 631,746.06
		Renfrewshire HSCP	£ 1,315,979.49
		West Dunbartonshire HSCP	£ 700,650.36
Highland	£ 2,833,828.31	Argyll and Bute HSCP	£ 817,576.16
		Highland HSCP	£ 2,016,252.15
Lanarkshire	£ 4,751,492.03	North Lanarkshire HSCP	£ 2,457,264.19
		South Lanarkshire HSCP	£ 2,294,227.83
Lothian	£ 5,799,907.37	East Lothian HSCP	£ 720,131.99
		Edinburgh HSCP	£ 3,241,415.00
		Midlothian HSCP	£ 623,843.02
		West Lothian HSCP	£ 1,214,517.36
Orkney	£ 474,209.65	Orkney Islands HSCP	£ 474,209.65
Shetland	£ 469,221.20	Shetland Islands HSCP	£ 469,221.20
Tayside	£ 3,025,826.07	Angus HSCP	£ 836,971.46
		Dundee City HSCP	£ 1,122,570.22
		Perth and Kinross HSCP	£ 1,066,284.40
Western Isles	£ 538,977.57	Western Isles HSCP	£ 538,977.57
Total	£39,860,000.00		£39,860,000.01