PLANNING GUIDANCE FOR MENTAL HEALTH AND WELLBEING IN PRIMARY CARE SERVICES

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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;
    - make recommendations on 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
http://www.gov.scot/ISBN/9781802017212/documents/

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
http://www.gov.scot/ISBN/9781802017229

Annex D

Mental Health in Primary Care: Examples of Good Practice Used to Inform Short Life Working Group Report
http://www.gov.scot/ISBN/9781802017236

Annex E

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

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

Any enquiries regarding this publication should be sent to us at

The Scottish Government
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Edinburgh
EH1 3DG

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