



1 July 2022

RCGP Response to Department of Health and Social Care consultation on the Mental health and wellbeing plan: call for evidence

Chapter 1 - how can we all promote positive mental wellbeing?

1. How can we help people to improve their own wellbeing?

A strong primary care service is essential for promoting positive wellbeing for patients at all ages.

GP surgeries are at the centre of a community. They are places that people of all ages and walks of life enter on a daily basis, without stigma. Many GP surgeries and their teams are innovative and deliver a range of wellbeing activities for their community on top of healthcare services, based upon local needs and local demographics. By investing in primary care services, including the infrastructure of the premises and in the workforce, it will allow this innovation to continue and to grow. Examples of these activities include well-being “walks for health” that meet at the surgery door, breast feeding clinics for mums, gardening clubs, various support groups, educational talks and even food banks. There are growing examples of these activities, all in the centre of the community at the GP surgery or health centre. Another way to support people to improve their own wellbeing is by further utilising and supporting already active patient participation groups within GP surgeries, ensuring they are appropriately funded and empowered to devise/cocreate community wellbeing activities for their neighbours, and supported by a primary care team who are fully aware of their local population needs.

2. Do you have any suggestions for how we can improve the population’s wellbeing?

3. How can we support different sectors within local areas to work together, and with people within their local communities, to improve population wellbeing?

Chapter 2 - how can we all prevent the onset of mental ill-health?

4. What is the most important thing we need to address in order to reduce the numbers of people who experience mental ill-health?

Prevention is not always possible, as some people have a genetic predisposition to a psychiatric disease, or mental ill health suddenly arises due to unforeseen events e.g. PTSD. For this cohort, early recognition and early intervention becomes most important. Assuming it is possible to “prevent” more mental ill health may add to the stigma if it is not carefully handled, and this narrative must be balanced to ensure those who develop ill health do not feel that they have “failed” to prevent their mental health deteriorating through no fault of their own.

All primary care professionals should have an understanding of mental ill health through education including allied health care professionals who may not currently have mental health within their curriculum during qualification.

High-quality mental health training (e.g. mental first aid training) for all public-facing professionals that come into contact with people (across health, education, social care etc) is essential to reduce the stigma of mental ill health and to ensure early signs are spotted.

All public-facing professionals should be taught to recognise risk factors for mental ill health in order to provide early support and intervention if needed. This will require workforce up skilling and will be dependent upon local cultural and community needs and sensitivities.

5. Do you have any ideas for how employers can support and protect the mental health of their employees?

More than 4/5 GPs have experienced work-related anxiety, stress or depression (BMA, Rebuild general practice 2021). A soaring workload and workforce crisis has increased the risk to primary care professionals with suicide and depression increased in the medical profession compared to the general population.

In order to allow GPs and their teams to manage the emotional demands of delivering compassionate care, it is vital that they are well supported. With severe workforce shortages in general practice, protected time for reflection and considering the emotional impact of their work is not assured. The Government needs to take greater action to expand the workforce, as outlined elsewhere by the RCGP (Fit for the Future: a new plan for GPs and their patients, 2022). There also needs to be greater recognition of the emotional impact and, in some instances, the post-traumatic stress that primary care teams experience, including the experiences during the pandemic. There also needs to be improved supervision support to manage expanding multi-disciplinary teams in

general practice, which can help to support the wellbeing of all employees at the practice.

The very qualities that make for a caring effective GP such as empathy and concern, are often the qualities that can lead to emotional distress and later potential mental health problems through excessive emotional toll. The NHS Practitioner Health service was welcomed by the RCGP and is available for all doctors and dentists in the UK. However, we think this service should be extended to all healthcare professionals and support the wider general practice team.

More broadly, GPs and their teams do not uniformly have access to occupational health services, due to the way that primary care services are commissioned. The RCGP believes that GPs and their teams should not be disadvantaged healthcare teams, who do have occupational health support through their community or secondary care trusts. While some investment was previously announced for occupational health services for staff in general practice, this does not appear to have been implemented. A consistently funded occupational health offer is needed across the country to support general practice staff to stay well at work. This should be centrally funded and accessible to all. The RCGP also recommends that resources are invested to enable GPs and practice staff to have protected time to reflect upon more complex/ difficult cases with peers or through formal supervision sessions, and to ensure universal access to occupational health for everyone who works within the NHS, irrespective of where they are based.

6. What is the most important thing we need to address in order to prevent suicide?

Suicide prevention is everyone's responsibility. Improving education, social media safeguarding, community support and reduction in stigma will all help.

Dealing with undifferentiated patient presentations is the bedrock of primary care. Not knowing what symptom or disease a person will consult with requires all GPs and the extended primary care multidisciplinary team to be skilled in all aspects of health, including mental health. By ensuring every member of the primary care team understands how to recognise acute mental ill health and suicidal thoughts and then refer on for more in-depth review/ full assessment will help ensure opportunities are not missed. Importantly, as primary care expands the range of professionals working within it, it is essential that all allied health care professional groups have strong mental health knowledge, including recognition of suicidal thoughts, as part of their core training curriculum. This should include ensuring health professionals have exposure to treating people with mental ill health, whilst being supervised prior to qualification.

Redesign of community mental health services is essential to provide adequate support for those with suicidal thoughts. Currently, too many people are being diverted to A&E as the only "place of safety" due to lack of community mental health services or services that are overwhelmed. Moving funding into the community and ensuring 24-hour access

to experienced CRISIS teams would be a first step towards the dignified support people and their families/carers need, closer to their home.

Current evidence based resources aiming to improve suicide prevention include the [NICE, quality standards](#) published in 2019. This lists 5 key statements as the most important changes that the health and care sector should consider to prevent suicide and aims to ensure improvement in quality of life for people bereaved or affected by suicide, reduce rates of self-harm, reduce rates of hospital attendances/admissions for self-harm and a reduce suicide rates. It is unclear whether the health and care system has invested in implementation of these recommendations, and if it has, what the outcomes are.

Chapter 3 - how can we all intervene earlier when people need support with their mental health?

7. Where would you prefer to get early support for your mental health if you were struggling? Please tick all that apply.

- from family and friends
- from the NHS
- from your local authority
- from an education setting
- from a social care provider
- in your community
- from the voluntary and community sector
- from your workplace
- from digital-based support or advice
- from the private sector, for example by paying for counselling
- don't mind – as long as the support is high-quality
- other – please specify

8. What more can the NHS do to help people struggling with their mental health to access support early?

The aetiology of mental ill health is wide and varied. Once recognised, early intervention is key, but it is important that early intervention is focussed on more than a medical “NHS” model. The support people require at an early stage is usually multifactorial. Early intervention to resolve issues such as financial, work, family, relationship and bereavement issues may be enough to prevent deterioration to mental ill health, but navigating this support is often difficult. This must be simplified to ensure people are able to access all the support that they need in a simple streamlined way, with advocates who can help them if needed.

For people presenting to primary care, the RCGP recommends ensuring direct access for practice teams and their patients across the country to ‘one stop’ systems, which include all allied support services that people may need when in difficulty. By providing easy

access to all services such as housing, debt management, benefit/welfare support, legal advice, respite for young children, food banks and social services support, with advocacy for those who need it, will hopefully reduce the need for repeat GP appointments for help navigating these support services resulting in reduced workload for primary care. RCGP continues to call for further investment in social prescribers / community link workers, as well as investment in clinical 'leads' across networks of practices to lead the work required to build community links between services and with general practice.

RCGP believes there needs to be a review of the commissioning pathways for mental health alongside other health services to ensure they are joined up between primary, community, and secondary care, as well as with public health and social care.

If a medical intervention is required, a holistic view of the person and their needs is essential. Ideally support will be offered in line with national guidance, including early access to counselling/ therapy/ IAPT. Importantly, at the current time, post pandemic, services are so overstretched, that waiting times for intervention are increasing, meaning that some people are left with no option but to take medication to support them whilst waiting for definitive psychological treatment or psychiatric intervention. If we want to reduce the burden of antidepressant and antipsychotic prescribing as per [national guidance](#), then investment in psychological support, community psychiatric services and whole pathway approaches to mental health are urgently required.

Health inequalities and barriers to digital access must be carefully considered as new technology is rolled out.

9. Do you have any suggestions for how the rest of society can better identify and respond to signs of mental ill-health?

- yes
- no

If yes, please share your ideas.

10. How can we ensure that people with wider health problems get appropriate mental health support at an early stage if they are struggling?

All health and social care workers must be able to identify mental ill health, irrespective of their speciality, especially when associated with wider health problems. In primary care, we understand the interaction between physical and mental health well, providing holistic care and screening patients with chronic disease for mental ill health. We use the biopsychosocial model of care ensuring the effect of physical and mental health, that are interlinked are considered. Some other health and social care colleagues, especially those who specialise in one disease area or body system, may be less aware of the need (or able) to assess mental health when chronic physical health is present. All training for

health professionals should have a strong generalist element, including at undergraduate level.

Chapter 4 - how can we improve the quality and effectiveness of treatment for mental health conditions?

11. What needs to happen to ensure the best care and treatment is more widely available within the NHS?

It is essential to recognise that mental ill health is not usually isolated and does not often exist on its own. Therefore, whole pathway approaches to mental and physical ill health are essential. Whilst individual disease experts are an essential part of the NHS, generalist skills, with people who can holistically assess a person (including GPs), using the biopsychosocial model of care, ensures all of a person's needs are considered equally and the right diagnosis and treatment plan is made for that individual using shared care decision making.

Innovation is not limited to digital technology in mental health. Whilst this is important, there are other innovative approaches to improve care, including pathway redesign. Using joint commissioning through primary, community, public health and secondary care, we can ensure investment is front loaded onto the clinical pathway aiming to prevent deterioration and reliance on acute or in patient services.

By learning from the RCGP work on "Long covid" we can see that integrating physical and mental health into a single pathway can improve patient care. The STIMULATE ICP trial will read out in 2023. This NIHR funded research programme as well as looking at current "long covid" care, aims to learn from the pathway design for post covid clinics (where physical and mental health are treated equally) and compare this to current NHS care of other long-term conditions, which are treated in silos. This includes mental health care. A redesigned integrated care pathway for all long-term conditions will then be recommended for ICSs to consider as a way of truly integrating primary, community and secondary care for mental health.

Overarching considerations to improve care include:

- Facilitating increased appointment lengths within primary care to allow full and holistic assessments to be made for all patients. 10 minutes is not enough to undertake a mental health assessment. See RCGP's [Fit for the Future](#) campaign, which describes a range of actions required from Government to enable this.
- Increase investment in primary care to ensure continuity of care is possible for those with complex mental health conditions. Continuity of care and relationship-based care is of utmost importance for all conditions, but especially in mental health care, with each consultation building on the last. The current government approach prioritises access over continuity, which means that patients with complex needs often do not get the continuity that they need to improve health outcomes. See RCGP's recent publication on [relationship-based care](#), which sets

out a range of recommendations to support relationship-based care in general practice.

12. What is the NHS currently doing well and should continue to support people with their mental health?

13. What should be our priorities for future research, innovation and data improvements over the coming decade to drive better treatment outcomes?

14. What should inpatient mental health care look like in 10 years' time, and what need to change in order to realise that vision?

Chapter 5 - how can we all support people living with mental health conditions to live well?

15. What do we (as a society) need to do or change in order to improve the lives of people living with mental health conditions?

16. What things have the biggest influence on your mental health and influence your quality of life?

- housing
- provision of social care
- employment and job security
- money and debt management
- social and family relationships
- physical health
- connection to your community
- other – please specify

17. What more can we do to improve the physical health of people living with mental health conditions?

People with severe mental illness experience some of the starkest health inequalities, dying on average between 10 and 25 years earlier than the rest of the population. The RCGP recommends that the physical health care of people with SMI should be approached and managed in the same way as any other long-term condition.

In our recently published [Long term condition recovery](#) recommendations for primary care, we highlight that people living with serious mental illness are 4.9 times more likely to die than those without. We recommend that where possible, people should be

prioritised for an annual review who have serious mental illness or a learning disability and have not had a health check in the last 12 months, or have an additional long term health condition.

18. How can we support sectors to work together to improve the quality of life of people living with mental health conditions?

19. What can we change at a system level to ensure that individuals with co-occurring mental health and drug and alcohol issues encounter 'no wrong door' in their access to all relevant treatment and support?

It is essential that services are supported to work together to ensure that people are not excluded from care. A person with an alcohol problem and depression may be unable to access either psychological support services (because they are alcohol dependent) or the alcohol support services, (because they have a mental health issue). This leaves patients without care, held in primary care with little support and at risk of deterioration. A review of commissioning of patient pathways must be undertaken to truly integrate primary, community, voluntary and secondary care services, ensuring no person is left without care because services are not able to accept them based on individual organisation criteria and rules, rather than a systemwide approach to care.

Chapter 6 - how can we all improve support for people in crisis?

20. What can we do to improve the immediate help available to people in crisis?

Access to treatment in a timely way will prevent crisis occurring in some instances. Current waiting times for IAPT/ therapy/ support can be from several weeks to many months in some instances. During this time, mental health will often deteriorate creating in some instances crises that could have been avoided.

Ensuring 24-hour access to fully staffed mental health CRISIS support teams in the community is key to improving care for those in extreme distress. Primary care is available 24 hours a day via out of hours service providers, and so if it is felt that escalation to urgent specialist mental health support is required, it would be ideal for primary care to be able to refer, any time of day or night, to a community CRISIS team who can visit the person in the comfort of their own home. This would then prevent referral to A&E which is often seen as the only "safe place" for people to access care once they have seen their primary care provider.

21. How can we improve the support offer for people after they experience a mental health crisis?

22. What would enable local services to work together better to improve support for people during and after an experience of mental health crisis?

Next steps and implementation

23. What do you think are the most important issues that a new, 10-year national mental health plan needs to address?

- wellbeing and health promotion
- prevention
- early intervention and service access
- treatment quality and safety
- quality of life for those living with mental health conditions
- crisis care and support
- stigma
- other – please specify

Please explain your choice

Workforce issues within primary care, community mental health services and secondary care mental health services are the single most important issue facing mental health over the next 10 years. Without the expert staff to investigate, diagnose, treat and provide care, none of the aims of the mental health plan will be realised. This must be the priority.

If we are able to provide continuity of care and relationship-based care in GP services, (by building the generalist workforce and extending appointment times), aiming to detect early signs of mental ill health, and then have timely access to psychological support services to prevent deterioration, in addition to 24 hour access to community CRISIS team care for those who urgently need it, then significant improvements in mental health care will be realised. Innovative approaches to mental health and long-term condition care through integrated care pathways will be published as part of the STIMULATE ICP trail in 2023.

24. What 'values' or 'principles' should underpin the plan as a whole?

25. How can we support local systems to develop and implement effective mental health plans for their local populations?

The provision of mental health support within primary care does not meet currently the needs of the system, which has increased at an unprecedented rate during the pandemic, and this means that demand outstrips supply. There are significant gaps in care especially for children adolescents and older people with gaps in care and long waiting times seen.

GPs will continue to be central to mental health care in the community as leaders of the primary care multidisciplinary team and therefore need the resources to support people in need. The RCGP is calling for increased investment in the primary care workforce, as part of its 2022 [fit for the future campaign](#), as well as aiming to restore funding back to 11% of the total NHS spend. We are calling for a new recruitment and retention campaign to allow us to reach and go beyond the target of 6000 more GPs. In addition, by better supporting continuity of care and relationship-based care, including increasing appointment lengths where needed, we believe that care for those with mental ill health will significantly improve.

The RCGP welcomes the recent additional flexibility within the ARRS programme for recruitment of mental health therapists to support general practice. However, there needs to be further flexibility so that local systems can recruit the staff their local population needs, in the areas that it needs, rather than appointing numbers of practitioners based on centralised NHSE/I directives. This current approach is restricting practices and primary care networks from recruiting the staff they need to support patients.

A 2022 RCGP tracking survey shows that 44% of GPs now have access to mental health practitioners within the community, compared to 31% in 2021, with a third saying access is good. This is an improvement, but further improved access to mental health staff in primary care is required. To achieve this there needs to be improved workforce planning for general practice, to ensure a pipeline of appropriately trained professionals and mental health staff are a key to improving access further. This will require further investment in training and recruitment.

26. How can we improve data collection and sharing to help plan, implement and monitor improvements to mental health and wellbeing?

Interoperability of systems between primary, community and secondary care does not currently allow full sharing of records in an easy and seamless way which will ultimately impact on patient care. Some progress has been made to digitise health records, but the focus on digitalisation has prioritised 'quick wins' (such as uploading PDF versions of patient records/ letters) that do not improve the accessibility or quality of data for clinicians across health and social care.

Interoperability needs to be more than just access to data. To truly realise the aim of integrated care, records should be accessible by all those involved in the patient's care, allowing each practitioner access to add to patient notes in a timely way. As we move towards increasingly multidisciplinary ways of working, true interoperability will be required to ensure continuity of care across different health and care systems.

Priority should be given to developing effective system-wide technologies that enable interoperability to occur, and a less hurried approach to digitisation should be encouraged if it feeds into these wider strategic systems. In doing this, inspiration should be taken from existing interoperability technologies and strategies which currently exist outside of the NHS rather than seeking to develop new unwieldy and unproven systems.

Properly categorising patient data and ensuring it is usable by clinicians and other health and care staff will be essential to avoid lost information and put patient care first.

It is critical that as digital transformation allows for greater data sharing, appropriate safeguards are in place to guard against any inappropriate uses of patient data. Data captured for care is information about and belonging to patients, and most importantly, any sharing of data must be transparent and maintain public trust in how general practice and the NHS more widely uses or shares their information. Patients must have the opportunity to make informed choices about the use of their data.

Progress in making data available for clinical research will be improved by ensuring the safeguards outlined above are always in place. We are pleased that there has been a government commitment that data collected as part of GDPR will only be made available via a Trusted Research Environment (TREs). As per the recommendations of the Goldacre Review, the RCGP believes that patient data should always be held in and only accessed within TREs.