CONSULTATION QUESTIONS

Overall Approach

This consultation reflects a continuation and development of the Scottish Government's current approach for mental health. There is a general consensus that the broad direction is right but **we want to consult on:**

- The overall structure of the Strategy, which has been organised under 14 broad outcomes and whether these are the right outcomes;
- Whether there are any gaps in the key challenges identified;
- In addition to existing work, what further actions should be prioritised to help us to meet these challenges.

Comments
Broadly these are the right outcomes. For those familiar with Delivering Mental health the outcomes make more sense as a stand alone document it might be confusing for people with little or no prior knowledge.
Questions are pertinent and encourage engagement.

Gaps in key challenges :

- Employment : While fully recognising the Health Works Strategy will aim to address employment issues including mental health problems / illness, as individuals with mental health problems are disproportionately likley to be unemployed and consequently disadvantaged and excluded from society the Mental Health Strategy should include reference to this as a priority for action. The best predictor of wellness and recovery is stable employment. There is a robust evidence base to support job retention, and the Individual Placement and Support model. ICPs should ensure the employment question is asked, training programmes should become standard for staff to ensure they sign post onto services or take direct action to address employability issues. A key group of staff who can support this priority are AHPs.

- More explicit reference and recognition of Health & Social Care, Partnership Organisations, Advocacy, Third Sector Organisations, link to single outcome agreements, integration agenda and Health Works Strategy needs to be made.
- Document is very NHS health orientated and secondary prevention / tertiary care orientated. Recognition of Public Health role in primary prevention should be referenced.

- Data on capacity, activity, outputs and outcomes-very process driven, of course have to start somewhere,however recommend expansion within the strategy to include service user outcomes.

- Psychological Therapies matrix is excellent, however value of all tiers not recognised especially high volume, low intensity and AHPs. Only 2/3 rds people benefit from talking therapies, non talking therapies provided by AHPs including approach to addressing physical health, meaningful occupation, diet, communication, and life roles is crucial

to addressing patient needs and should be valued within the Strategy, including support to develop evidence base. Interventions and approaches without an evidence base must not be automatically excluded, it may not exist purely due to lack of research in the area rather than lack of effectiveness.

- Address the need for specific services and models of care to minority groups of service users eg Brain Injury , Huntington's Chorea, Adults with ADHD/Developmental Disorders.

- We agree that mental health is a continuum and the core principles apply across the spectrum however people with severe, serious and chronic conditions often need additional, flexible and appropriate support to access information, services and activities, this group are sometimes stigmatised even within a "mental health service" context for example they may be excluded from accessing evidence based psychological therapies, as a result of the complexity or duration of their condition or circumstances. More emphasis within the strategy could be placed on this.
- A multidisciplinary approach is not right or necessary for everyone but it can be difficult for people with less severe mental health needs to access the same range of professional expertise available within an MDT. Better information about the range of professional help available and the development of direct self referral routes would be more empowering for individuals and potentially more cost effective for the health service..

Further actions should be prioritised:

- Support Boards locally to implement NHS Health Scotland's Mental Health Improvement Outcomes Framework and The Health Works Strategy. Driver diagrams and logic models offer methodologies for local redesign not to be constrained by resources.

- Roll out standardised approach utilised in CAMHS, New to CAMHS, Competency Framework, and Passport. Work with NES to introduce across age ranges. Good practice, evidence and published standards should be achieved no matter where the care is delivered. Published standards should be the norm.

- Support rapid implementation of Condition Specific ICPs. Generic ICP mainly focused on currently in Board areas.

- Maximise use of telehealth/telemedicine/e-health to redesign services – AHPs have a significant contribution to make to this agenda espially around supported self management and recovery, not simply CBT approaches

Improvement Challenge Type 1

We know where we are trying to get to and what needs to happen to get us there, but there are significant challenges attached to implementing the changes. An example of this is the implementation of the Dementia Strategy. There is a consensus that services for people with dementia are often not good enough and we already know about a range of actions that will improve outcomes. However some of these changes involve redesigning the way services are provided across organisational boundaries and there are significant challenges attached to doing this.

Question 1: In these situations, we are keen to understand whether there is any additional action that could be taken at a national level to support local areas to implement the required changes.

Comments

- Promote an intergration agenda supported in particular by change fund developments in mental health, evaluate the impact providing evidence on what works with a strong steer to implement locally, followed up in implementation visits to Boards.
- Showcase exemplar practice and ensure dissemination
- Progress accreditation and roll out of generic and condition specific ICPs
- Build up data to support redesign through benchmarking, commissioning research, workforce planning methodologies, setting targets to shift the balance of care, reintroducing mental health collaborative support. Analysis of data key to understanding of good practice.
- Data sharing around priorities needs to be strengthened bwteen all public services, voluntarary and private sector organisations. In order to shift the balance of care and strengthen preventative partnership work, examples of agreed priorities could be around a broad heading of « community safety. »
- Strong partnerships between mental health and criminal justice at a national level would be helpful.
- Build on mental health promotion and mental illness prevention : The economic case to inform practice.
- Support AHP Fit Note, and in collaboration with NHS 24 redesign access to AHPs. Direct access and early interventionshould be promoted. Reduce the traditional gate keeping by CMHT /GP to AHP services.

- Work with e-health to reduce barriers to sharing information across organisations and agencies

- There needs to be more emphasis on changing hearts and minds, values based practice and meaningful user & carer involvement. Promoting the use of outcome measures that have a qualitative component would support this.

Improvement Challenge Type 2

We know we need to improve service provision or that there is a gap in existing provision, but we do not yet know what changes would deliver better outcomes. Supporting services to improve care for people with developmental disorders or trauma are two areas where further work is needed to identify exactly what needs to happen to deliver improved outcomes.

Question 2: In these situations, we are keen to get your views on what needs to happen next to develop a better understanding of what changes would deliver better outcomes.

Comments

- Support and evaluate pilots, once model developed provide a strong steer from the centre to boards to move to this practice within agreed and negotiated timeframes.

- Improve resilience of individuals to sustain recovery and promote social inclusion by ensuring all staff are trained in secondary prevention. Every health professional should ask a range of questions related to : self harm, substance misuse, smoking cessation, weight mangement, employability and then sign post / directly offer intervention as part of treatment approach. Evidence from Public health and primary prevention programmes indicates if we tackle substance misuse, poverty, obesity and smoking we could improve health including mental health.

- Capture patient experience and utilise this evidence as a valued contribution to evidence.

- Direct and timely access to a range of specialist AHP assessments and interventions would enhance opportunities for supported self management , the effective use of personalisation budgets and a reduction of dependency on health and social care service providers. Many of these individuals are not aware of the potential benefits of consulting an AHP or are not afforded the opportunity.

- Increase emphasis on cross agency partnership working, collaboration and sharing good practice, genuine partnerships with clear objectives gain collaborative advantage and better outcomes

Outcome 1: People and communities act to protect and promote their mental health and reduce the likelihood that they will become unwell.

Question 3: Are there other actions we should be taking nationally to reduce self harm and suicide rates?

Comments

- Seen as key for all AHP's to be aware of training in all services, not just mental health e.g. Community dieticians
- Would suggest 20% reduction only attainable if training rolled out to all new staff, all front line staff in physical health education etc.
- Maintain national publicity, education about link to self harm and suicide. Primary and secondary prevention, including multi-media programmes in schools, good parenting classes, and drug and alcohol awareness programmes.
- Use social networks as part of publicity campaign.

Question 4: What further action can we take to continue to reduce the stigma of mental illness and ill health and to reduce discrimination?

Comments

- Training – Awareness/MH 1ST Aid for health staff and third sector staff
- Investment in service – user involvement
- Undergraduate AHP student placements integrated into mental health
- Academic content of some AHP Undergraduate courses do not include mental health
- Targeting different populations such as school age children – education & mental health awareness training
- NHS to tackle it's own issues with staff who are off sick due to stress at work
- Encourage exemplar employer in mental health status be adopted by all Boards
- Continue work with employers, and links to Health Works Strategy to promote healthy workplaces and job retention. Encourage large employers to include awareness of mental illness within their employee induction process.

Question 5: How do we build on the progress that *see me* has made in addressing stigma to address the challenges in engaging services to address discrimination?

Comments

- Re launch of a similar campaign as profile has dropped – was a worthwhile campaign. Progress by linking to self help literature & websites e.g NHS Inform/Breathing Space.
- More emphasis has to be made in school and workplace schemes to educate students, employees and employers of the damaging effects of discrimination, and the value to society and productivity of challenging and addressing the problem.

Question 6: What other actions should we be taking to support promotion of mental wellbeing for individuals and within communities?

Comments

- Develop strategies for building social capital and working with communities
- Social prescribing
- Access to WRAP online, develop accessible "Lifestyle management " education across all groups, not just those in deprived communities, unemployed. Work with faith communities, private business, health clubs, slimming groups etc. Use more, positive, marketing strategies. There is limited access to support for those currently in work but struggling, with young families or with full time caring responsibility, make use of technology to reach more people to demedicalise mental health problems and empower people.
- Health care professionals should support self-management in mental health. This requires that they have the underpinning knowledge about health behaviours change and approaches such as providing appropriate information, maintaining social connections, maximising employment and or educational opportunities and making connections between physical, emotional, spiritual, social and economic wellbeing.

Outcome 2: Action is focused on early years and childhood to respond quickly and to improve both short and long term outcomes.

Question 7: What additional actions must we take to meet these challenges and improve access to CAMHS?

Comments

- Increase capacity of specialist CAMHSs in order that HEAT target "Time To Treatment Target" can be met at multidisciplinary level.
- Dedicated ring fenced funding for AHP's and the recognition of

impact and outcomes, particularly in the areas of work, rest and play. Promoting age appropriate, valued life roles and social inclusion.
- Improve links between education services, child services , GPS and CAMHS.
- Provide education for parents and teachers within appropriate settings and stages.

Question 8: What additional national support do NHS Boards need to support implementation of the HEAT target on access to specialist CAMHS?

Comments

- Dedicated funding to Tier 3 CAMHS (out patients) for multidisciplinary team. This should include dedicated funding for AHP STAFF. Large areas in Scotland have very limited access to AHP's – in particular Art Therapy, Occupational Therapy, Dietetics, SPLT
- Develop standards for MDT members of CAMH service which includes AHPs.
- Recognise hidden contribution of AHPs if not part of CAMHS team accessed from other children's services therefore not acknowledged with bench marking tool. This use of resource has impact on wider children's services.

Outcome 3: People have an understanding of their own mental health and if they are not well take appropriate action themselves or by seeking help.

Question 9: What further action do we need to take to enable people to take actions themselves to maintain and improve their mental health?

Comments

- NHS itself improving performance on numbers of staff off with sickness absence due to stress at work
- Utilise e-health, telehealth, and telemedicine to promote healthy lifestyles and self management, the benefits of work, exercise and diet.
- Expand approach beyond psychological therapies to include social prescribing, bibliotherapy, art and culture
- Increase opportunities and support to local communities to develop creative solutions, not always mental health services but putting value on positive mental health outcomes.
- Develop stronger partnerships across multiple agencies, job centres, welfare rights, debt management agencies, develop promotional literature in partnership with financial institutions, parent councils, primary care staff, expand available information via NHS 24,
- Better information and signposting, if people don't recognise that they have a mental health problem, they won't seek help for it but they may seek practical assistance for relationship problems, housing problems, financial problems - one stop shop (could be virtual, telephone or web based)

- Self management groups, open door clinics, drop in points
- Investment in early education with key messages about wellbeing, assertion, self efficacy and esteem.
- Develop a one stop, user friendly national website which sign post to other relevant web resources.
- Use social networking and age appropriate media resources to advertise key messages about mental health and well being.
- Strengthen key messages about exercise, activity and the positive impact on mental health.

Question 10: What approaches do we need to encourage people to seek help when they need to?

Comments

- Improve availability and access to managing stress education session for NHS staff
- Easy access (Libraries, schools) to self help materials written & computer
- Public information campaigns e.g. supermarkets, Daytime TV, Social Networking sites
- Incorporate wellness and crises intervention plans into general health care pathways so that people recognise when to seek help.
- Raise public expectations through education, better access to information, not always linked to mental health services. Much better use and promotion of personal recovery / crisis plans for those with more complex, recurrent mental health issues. Better recording of user feedback and sharing outcomes. Promote hope.
- Acknowledge and identify depression in older adults, consider developing a carers advice line - link with NHS 24

Outcome 4: First contact services work well for people seeking help, whether in crisis or otherwise, and people move on to assessment and treatment services quickly.

Question 11: What changes are needed to the way in which we design services so we can identify mental illness and disorder as early as possible and ensure quick access to treatment?

Comments

- Further develop enhanced 'Special interest in MH' professionals in Primary Care.
- Change pathway in NHS 24 which will enable carers to seek help for those they care for such as in advanced statements.
- Improve education on mental health when training those entering healthcare, fire service, police, teaching, spiritual leadership positions
- Support the personal resilience of carers and family members by increasing their knowledge and awareness of their own health and

well being needs
- Matched/stepped care models welcome
- Nursing members of general practice – ensure MH awareness training & education
- Drop In MH Clinics in GP surgeries
- If target of 50% MHS frontline staff training should be increased to 90%
- Access to job retention and employability services
- Needs to be quick ways back into mental health services if individuals have been discharged.
- Establish single point of access delivered through the medium of telehealth care and developing enhanced web-based information and advice resources.

Outcome 5: Appropriate, evidence-based care and treatment for mental illness is available when required and treatments are delivered safely and efficiently.

Question 12: What support do NHS Boards and key partners need to apply service improvement approaches to reduce the amount of time spent on non-value adding activities?

Comments
- LEAN methodology , Releasing Time To Care seen as good systems
- Support – Time for training for AHP staff to use above
- Support for AHP Leadership skills/education and Action Learning Sets
- AHP personnel strategy at NHSL Lead – Collaborative with perhaps Knowledge Transfer partnerships
- Health Economics – access to and training
- Realising Potential, support to develop and strengthen evidence base, particularly impact and outcome data
- 6 Steps methodology to workforce planning and redesign promoted, approach contains excellent tools to redesign and modernise the workforce including identifying and reducing unnecessary variation in practice
- Acute Health Care Directives such as HAI are insensitive to the MH environment and can negatively impact on quality and opportunity for normalising experience and activities for in-patients on the road to recovery.
- Raise awareness of the range of options available and promote self referral and direct access to non medical support services, AHPs, commissioned services, social support, peer support. Increased partnership working, empowering carers through better education and access to information

Question 13: What support do NHS Boards and key partners need to put Integrated Care Pathways into practice?

Comments

- More efficient IT system to support audit of ICP and expand variance analysis measures
- Knowledge Transfer Partnership
- Link to single outcome agreements and commissioning of services from the Third Sector.
- Unified data collection system across Scotland.

Outcome 6: Care and treatment is focused on the whole person and their capability for growth, self-management and recovery.

Question 14: How do we continue to develop service user involvement in service design and delivery and in the care provided?

Comments

- Ensuring, particularly for those diagnosed with dementia, that life history information and preferences are documented at a stage when the person can participate in this process – not as an after-thought
- Increase peer and staff support for service users who contribute to service design, attend meetings and groups.
- Ensure service user involvement should be routine as far as possible in the design and delivery of services.
- Feedback from service users after any treatment intervention in a format appropriate to their needs – using electronic, written, verbal, mailbox options.
- Hold service user feedback/open days, face to face and consider holding these somewhere that the service user can feel empowered and not intimidated.
- Encourage service user groups to form and respond to local policies.
- Have a ring fenced small budget to pay competitive hourly rates to service users and carers for contributions to service redesign, with these fees protected with no detriment to benefits, otherwise there is a continuance of inequality
- Talking Points established in culture knowledge outcome
- Patients Council
- Advocacy Service
- Peer Educators school age/carers
- Strengthen service user strategy – good example is Youth Parliament.
- Peer support Workers, both formal and informal support
- Better monitoring of user and carer experience/feedback.

Question 15: What tools are needed to support service users, families, carers and staff to achieve mutually beneficial partnerships?

Comments

- Agreed outcome measures used across NHS Scotland to capture service user and carer feedback as well as the impact services have on their lives.
- To reflect the cultural diversity of our nation and to empower all, then there should be a concerted effort to develop tools that are generically accessible and not reliant solely on language skills
- Develop national protocols for the use of social networking sites for promoting pro active messaging and exchanges on MH matters
- Developing use of Talking Points and/or other outcome measures that measure service user satisfaction Develop training on use of and access to these measures.
- Have Information/feedback tools in different formats – electronic, written, verbal, DVD.
- Electronic Information points for all Boards with all the available services, accessible and up to date that is accessible to all.
- Further training to improve staff confidence in sharing information with family's carers without breaking confidentiality.
- Ensure user/carer involvement is not tokenistic give appropriate, relevant information so involvement can be realistic.

Question 16: How do we further embed and demonstrate the outcomes of person-centred and values-based approaches to providing care in mental health settings?

Comments

- Ensure that people are properly involved in goal setting and treatment planning, not just as a token gesture, but as an active participant in their own care. Ensure that accessible written information is provided to support discussions with healthcare professionals with clear choices/action plans/points of contact.
- Explain further what this means to the person on the street and be clear the methods that can be used to help people express what really matters to him/her without solely being reliant on verbal communication methods.
- Ensure the learning delivery centres cover the whole of Scotland
- Provide services where the service user needs them.
- Easier access to services – self referral.
- Joint reporting of outcomes with voluntary sectors/local authorities partners
- Enhance mechanisms by which the clinical evidence of smaller professions can be heard and influence practice change
- Focus on outcomes/clinical indicators
- Utilise Patient Stories/narratives
- Invest in Knowledge Transfer partnership
- Passport for all staff, containing mandatory competences inc attitudes and behaviours required, 10 essential shared capabilities,

mental health act training, recovery training etc.
- Support and information for mental health professionals to enable them to engage in a discussion about work and offer appropriate signposting or referral is required. Recording data around this intervention is essential to identify what sources of support a, signposting and referral are most helpful and require further development.

Question 17: How do we encourage implementation of the new Scottish Recovery Indicator (SRI)?

Comments
- HEAT Target required to ensure it is implemented
- Evaluate the SRI 2 tool to ensure it has been simplified and is compatible with NHS IT Systems

Question 18: How can the Scottish Recovery Network develop its effectiveness to support embedding recovery approaches across different professional groups?

Comments
Comments
- SRI should second persons to Boards to lead from within to establish baselines and monitor progress otherwise the system continues to have ownership and falls short of true change.
- The launch of the SRI 2 should help this process.
- The SRI network should liaise with the professional bodies to agree an implementation plan of recovery based practice and then monitor progress
- Greater visibility of the SR Meeting in services would help
- Role for developing an AHP representative
- Measure effectiveness , complete audit action plans
- Continuing professional development for all staff groups, mandatory training, embedded in student education, involve users and carers in delivering local training,
- Get senior staff, clinical leads and consultants on board.

Outcome 7: The role of family and carers as part of a system of care is understood and supported by professional staff.

Question 19: How do we support families and carers to participate meaningfully in care and treatment?

Comments
- This can be difficult in an in-patient setting, i.e. not always able to link easily with family due to limited visiting time or possible distance from setting. Liaising with family and carers can be invaluable in adding to the case history, information about day to day problems and

concerns and also to share information with, to enable clients to be supported appropriately on discharge allowing to reach their full potential.

- Resolve some of the complexity around confidentiality for the professionals.
- Provide more psycho-education sessions run in partnership with carers... through information 'informed' choices can be made
- Provide information and choice on a range of treatments, interventions and self management approaches in a variety of settings
- Support development of AHP self-management groups for various conditions
- Strengthen links with the Voluntary sector
- Gain feedback using different formats.
- Signposting to support groups
- Appointments for Carers/Families
- Training re: boundaries of confidentiality including working with the client to promote the benefits for them of inclusion of supports
- Family meetings with MAT Team
- Ensure they can access an assessment of their needs and as an-outcome appropriate services as required.
- Consideration of the needs of carers. Treat as equals, develop mutual trust, give respect and share of information, provide flexible methods of communication and consider timing of meetings.

Question 20: What support do staff need to help them provide information for families and carers to enable families and carers to be involved in their relative's care?

Comments

- The issue of patient confidentiality may in some circumstances deter staff from routinely suggesting that families and carers are involved in patient care and if raised permission may not be given by the patient. The importance of family and carer involvement should be emphasised to all staff. Clarity on sharing confidential information, and boundaries to supporting carers when patient is not providing informed consent.
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- Provide more access to family therapy by developing and implementing enhanced practice modules across the care pathways.
- Provide more IT with internet connection options for staff on the go, in remote and rural locations , thereby making health information accessible and contextual to the needs of each family/carer/individual
- More listening time to be released.
- Pool and agree national forms/tools that the staff can give to a service user's family and carers
- Look at ways to use secure e-mail for communication with families/carers would be useful as not always possible to communicate face to face or on the telephone.
- . Training in policy and practice

- Better access to quality information in a range of formats, leaflets, online, co-ordinated centrally and updated and informed by best practice.
- More flexible working, ability to see people outside office hours,

Outcome 8: The balance of community and inpatient services is appropriate to meet the needs of the population safely, efficiently and with good outcomes.

Question 21: How can we capitalise on the knowledge and experience developed in those areas that have redesigned services to build up a national picture of what works to deliver better outcomes?

Comments

- Encourage all Boards to establish Early Psychosis Intervention Services to include the employment pathway.
- Ensure the accuracy of the Benchmarking data. Factor in a formula for remote and rural variation.
- For Personality Disorder roll out the evidence of planned admissions at Board levels to reduce in crises behaviours.
- We need to share what we do. Often individuals and teams underestimate the importance of sharing their pieces of work and lessons learnt – both positive and negative. The focus can be too much on evidence based practice rather than practice based evidence.
- Continue to encourage and support AHPs working in Mental Health to attend relevant National Special Interest groups to meet and share experience and outcomes with colleagues, e.g. Scottish SLT Mental Health SIG.
- Investment to support service leaders to visit areas of good practice
- Community of Practice
- Publications including sign guidance
- Through government implementation visits, sign posting
- Quality Strategy and Quality Improvement Teams
- Encourage use and development of managed knowledge networks, virtual special interest groups, more targeted newsletters
- National benchmarking for AHPs to consider where we are best placed.

Outcome 9: The reach of mental health services is improved to give better access to minority and high risk groups and those who might not otherwise access services.

Question 22: How do we ensure that information is used to monitor who is using services and to improve the accessibility of services?

Comments

- Improving access to services; Need to move away from appointment letters to text and e mail, and invite opt in by return.

- Need to have a security lock on email correspondence just like internet shopping protecting people's privacy. Then more emails for attachment of pre-assessment and entry level data from service users and carers to be completed before first clinical visits could happen.
- ISD recording is not sufficiently robust to capture all activity data and that should be a priority.
- By incorporating this information into existing mandatory information that is collected by teams.
- Equality across Scotland for the development of electronic infrastructure and systems at clinical level to support data gathering
- Annual Report on such demographics highlighting high risk groups in relation to incidence of mental illness
- Include within IT system, ICPs, balanced score card, Benchmarking.

Question 23: How do we disseminate learning about what is important to make services accessible?

Comments

- Annual report
- Subsequent training NHS STAFF/Undergraduate courses
- Global communications to the Staff groups by Boards into mail box , under specific headings with links attached to hot topics Being mindful not to overload or we could habituate to non response mode.
- Shared Learning in appropriate format for audience

Question 24: In addition to services for older people, developmental disorders and trauma, are there other significant gaps in service provision?

Comments

- Adults on the Autistic Spectrum with social communication difficulties
- Young offenders with Language disorders and social communication difficulties.
- Adults on the ASD spectrum with co morbid mental illness with no intellectual impairment (not solely adults with ADHD).
- Need diagnostic service
- Early intervention to include vocational rehabilitation.
- Speech and Language services to Adults with Mental Illness and Brain Injury
- Access to assessment and treatment interventions
- Increase in Exercise and Fitness services for forensic and in patient

services for health and wellbeing and to support the employability pathway
- More prevention services in primary/acute physical settings.
- Meeting the needs of families where one of the family members e.g. parent is involved in active military service
- Eating Disorders Psychological Therapies for the obese (BMI 40 plus)
- Physical Disorders / Long Term Conditions
- Early intervention to prevent physical deterioration
- LBGT access to services
- Vocational rehabilitation for mental health service users and inparticular forensic and drug and alcohol services

Outcome 10: Mental health services work well with other services such as learning disability and substance misuse and are integrated in other settings such as prisons, care homes and general medical settings.

Question 25: In addition to the work already in place to support the National Dementia Demonstrator sites and Learning Disability CAMHS, what else do you think we should be doing nationally to support NHS Boards and their key partners to work together to deliver person centred care?

Comments
- Strengthened focus between health and the prison services on the routes to re-ablement, making positive health choices, and preparation for the employability pathway, using the skills and expertise of Allied Health Professionals.
- Mental Health Liaison Teams & network
- Collaborative, Interagency Service redesign
- Prioritise top 10 diagnostic illness in mental health and ensure matched/stepped care in place
- Pathways which go across organisational boundaries
- New models of Integration of vocational and health services to form Centres of Excellence based on international evidence base.
- Data sharing partnerships
- Secondment of staff

Question 26: In addition to the proposed work in acute hospitals around people with dementia and the work identified above with female prisoners, are there any other actions that you think should be national priorities over the next 4 years to meet the challenge of providing an integrated approach to mental health service delivery?

Comments

- Obesity
- Substance Abuse
- Inactivity
- Smoking cessation
- Physical health of people with serious mental illness.
- Closer working with primary care
- Provide incentives to improve partnership working and seek evidence of meaningful outcomes and benefits to all partners.
- Autistic spectrum disorder

Outcome 11: The health and social care workforce has the skills and knowledge to undertake its duties effectively and displays appropriate attitudes and behaviours in their work with service users and carers.

Question 27: How do we support implementation of *Promoting Excellence* across all health and social care settings?

Comments

- The care of the older person in the community requires regulation and scrutiny particularly in the context of the allocation of appropriate levels of time to care, and the contractual arrangements and pay structures, to ensure that genuine vocation and desire to support is not quashed by low pay and significant unsociable hours.
- In Job Descriptions with mandatory training for each level

Question 28: In addition to developing a survey to support NHS Boards' workforce planning around the psychological therapies HEAT target – are there any other surveys that would be helpful at a national level?

Comments

- Survey of scale obesity problem within mental health in Out Patient clinics
- Equally malnutrition & addiction clinics
- Positive destinations of these users of MH service e.g. employment, truancy, community involvement, education
- Employment awareness among mental health staff
- Psychological Interventions supporting psychological therapies Survey on training needs for psychological literacy in various professional groupings
- What is the current provision of dedicated SLT resource in settings providing Mental Health Care?

- Survey around AHP and the Health and Works Agenda: namely what workforce planning and changes are Boards undertaking to support the Agenda.

Question 29: What are the other priorities for workforce development and planning over the next 4 years? What is needed to support this?

Comments

- Appropriate accommodation & infrastructures
- Support worker training in MH
- Training strategy for AHP's working in mental health in Scotland
- Ensure other non-mental health areas having more knowledge on mental health.
- Ensure that personnel working in mental health have robust support and supervision
- Enhance protected time for staff to engage with the Healthy Working Lives agenda, to reduce staff sickness and absence.
- Workforce plans that are realistic and sustainable to meet future demographic changes and meet the needs of an ageing population
- Focus on supporting community services to support people and carers at home.
- Require Boards to present robust plans to support the training requirements of carer support workers.
- Up skill the health workforce to communicate effectively with those living with autistic spectrum disorder.
- Development of electronic workforce planning tools
- Better understanding and awareness of minority professional groups such as AHPs and pharmacy.

Question 30: How do we ensure that we have sustainable training capacity to deliver better access to psychological therapies?

- Courses developed to appropriate level e.g. CBT Techniques. Not every patient will require a highly specialist intervention, only the most complex.
- Workforce planning essential to identify requirement and succession planning
- Allow cascaders time for cascade training.
- Run courses from a central point- NES.
- Build psychological literacy into healthcare pre-reg university courses.
- Have mental health mandatory training for all staff – e.g. SAMH.
- Fund the delivery of more frequent CBT and other low intensity level courses at certificate level rather than diploma.
- Lower the entry bar for cascade trainers for specific courses e.g. CBT diploma bar for Behavioural Activation is too high.
- Train practitioners in cardiac and pulmonary and stroke rehabilitation to deliver more low intensity psychological interventions.
- Commitment to continue protected time and capacity to provide and undertake training and ongoing evaluation of this.
- Continue to develop online training resources and distance learning opportunities.

Outcome 12: We know how well the mental health system is functioning on the basis of national and local data on capacity, activity, outputs and outcomes.

Question 31: In addition to the current work to further develop national benchmarking resources, is there anything else we should be doing to enable us to meet this challenge.

Comments

- Improved data collection
- Improved technology
- Assuring confidence in current data
- AHP minimum data set

Question 32: What would support services locally in their work to embed clinical outcomes reporting as a routine aspect of care delivery?

Comments

- Agreed standard reporting of performance data
- Outcome measures on database
- More robust , flexible IT infrastructure and administrative support

Outcome 13: The process of improvement is supported across all health and social care settings in the knowledge that change is complex and challenging and requires leadership, expertise and investment.

Question 33: Is there any other action that should be prioritised for attention in the next 4 years that would support services to meet this challenge?

Comments

- Increased understanding of Health Economics
- Ring fenced budgets for leadership training.

Question 34: What specifically needs to happen nationally and locally to ensure we effectively integrate the range of improvement work in mental health?

Comments

- Mental health Collaborative refresh
- Investment in AHP leadership training
- Develop a diagram which shows how the various national programmes integrate with each other, therefore help staff understand the connections and prevent duplication

Outcome 14: The legal framework promotes and supports a rights based model in respect of the treatment, care and protection of individuals with mental illness, learning disability and personality disorders.

Question 35: How do we ensure that staff are supported so that care and treatment is delivered in line with legislative requirements?

Comments

- Accredited training delivered
- Caseload supervision
- Robust professional supervision & development plans
- Educational framework for staff