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.

Generally we would like more explicit recognition of the importance of promotion of mental well-being, prevention of mental ill-health and early intervention, and commitment to building on the significant amount of work that has taken place in this area to date.

We would like to see some recognition of the difficult economic climate we are in & the impact of poverty, deprivation, isolation, potential loss of jobs etc on mental health. We are in a time of rapid change, with some of the 'props' that we have taken for granted e.g. jobs for life within the public sector disappearing, and need to make sure that we are joining up mental health policy with other cross-cutting agendas (such as Early Years and Tackling Poverty) to recognise this and minimise the damage, at a political and practical level.

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.

1.1 We would appreciate further development of the Mental Health Improvement Indicators to help us understand more about the picture of mental health improvement in smaller areas such as Shetland. At present, it isn't possible to drill down as far as Shetland in order to measure impact of the work that we do.

1.2 We would also want to be clear that any policy recommendations on redesign and working across organisational boundaries fit in with and do not duplicate or detract from the current locally driven health and social care integration agenda being pursued as government policy i.e. we would not want a

separate integration agenda to be pursued in implementation of the Mental Health Strategy aside from current work on health and social care integration for older people.

1.3 One important factor to recognise is that strategies effective in larger areas may sometimes be less workable in smaller communities and it is requested that indicators recognise 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.

2.1 A better understanding of the impact of trauma and development disorders on individuals would be useful. The matrix highlights some evidenced based interventions which might assist people overcome these challenges.

2.2 Once complete a national programme of training could be undertaken to ensure commonality of approach and wider access to services.

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?

3.1 Continue to support 'Choose Life' training at a national level. Liaison at a national level with organisations such as National Farmers Union, Crofters' Commission (groups with traditionally higher suicide rates) to promote collaboration at a local level – e.g. to increase uptake of suicide prevention training.

3.2 Work with national organisations such as COSLA to ensure that any radical restructuring e.g. of local government, recognises the impact of this on mental health & resilience of both individuals and communities & takes steps to minimise this.

3.3 Promote and ensure the link between the maternity framework and early years in terms of the importance of mental health management in the same way that Realising Potential has been recognised in Allied Health Professions services

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

4.1 Continue to promote the voices of people who have lived with mental ill health and real life experience of recovery.

4.2 Promote the assistance given by bodies who specialise in this such as the Scottish Recovery Network, Ron Coleman (Working to Recovery) etc.

4.3 Specifically target hard to reach groups i.e. young men.

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?

5.1 Continue to champion See Me and Choose Life.

5.2 Support national and and local organisations themselves support people into employment and other mainstream activities.

5.3 Educate/aid employers in providing a suitably supportive environment.

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

6.1 Skills development and focus on effective mental health interventions delivered through primary care to ensure that community based mental health services are able to respond and deal with issues effectively before crisis. This allows the service to effectively work preventatively rather than fire fight.

6.2 This should include ensuring clear referral criteria and pathways, emphasis on outcomes and moving people on, training for GPs & other 'first contact' staff in understanding variety of supports other than primary care services.

6.3 A greater use of third sector partners in the provision and delivery of associated support services.

6.4 Broaden the range of public services promoting mental wellbeing e.g. leaflets in police stations, train stations, airports etc.

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

There are significant challenges facing services in remote and rural areas, particularly with island Boards, with small scale generic and specialist services that rely on links to other services both locally and in larger and more specialised services. Some of the challenge of responding more quickly and with improved outcomes needs better defined pathways across organisational boundaries and collaborations such as obligate networks to promote more integrated approaches to service responses.

There are also examples of staff shortages nationally that have an additional impact in remote and rural areas with challenges in recruitment and retention - in areas such as access to local psychotherapy.

The Shetland CAMHS team has in previous years taken advantage of the centrally funded and provided systemic and family therapy training – provided specifically for remote and rural practitioners. Either completion of the master's degree, or attendance at the centrally funded child psychotherapy training is not possible for CAMH clinicians because of access to appropriate work placement experiences locally.

One of the current outstanding issues is the need to develop IT for CPD for remote and rural practitioners.

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

7.1	It is suggested that national initiatives regarding work force capacity and service delivery take account of current work in this area. This research recognises the importance of achieving the correct balance between direct clinical and non direct-clinical duties. This work could be similar to that undertaken for CPN's utilising the Wiseman workload measure.
7.2	Get GIRFEC working properly; with CAMHS teams well embedded in GIRFEC processes locally.
7.3	Ensure that no waiting lists occur between the various public sectors making up Scotland's 'children's workforce'.
7.4	Encouraging multi-disciplinary professional forums (for example the 'twilight' meetings we have established in Shetland), to promote mutual understanding and greater knowledge within the wider children's workforce, thus limiting 'silo working'.
7.5	Encourage more of a learning culture to tackle interagency communication and collaboration e.g. local short-life multi-agency working group wherever/whenever access/communication seems to be at a very low level between the agencies; e.g. work together with colleagues who are providing examples of good practice for example recent OT early intervention project with newborn babies.
7.6	NHS specialist CAMHS to promote learning for colleagues in health, for example 'New to CAMHS' teaching package offered on a regular basis for Health Visitors etc.
7.7	Acknowledging the role of AHPs (specifically OTs) in CAMHS and realigning resources to achieve their specialist input.
7.8	Work together with colleagues to provide straightforward pathways, for example for LD CAMHS.

7.9 Links to training for professionals to support parenting programmes and understand when problems/issues can be supported through good positive parenting support rather than being addressed as a mental health issue.

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

8.1 Additional support would be appreciated in developing specialist networks for remote and rural CAMH services (in particular taking into account geographical challenges of access).

8.2 Explore, by a commissioned study, in purposely selected areas, the factors that most commonly contribute to waiting lists between the various agencies within public sector, or extend waiting times targets to multi-agency pathways.

8.3 Better recognise the service-factors particular to CAMHS remote & rural working, including the future IT and CPD needs in these areas; also put funds behind the welcome aspiration (held by CAMHS advisor to government) that an island representative should, and can effectively, regularly contribute to the CAMHS advisory group being assembled for the SG.

8.4 Establish initiatives that bring CAMHS and Primary Care and Child Health closer together; in remote & rural areas these are vital NHS partners for local capacity.

8.5 Give more emphasis to short-life working groups to review/ problem-solve/propose in areas of manifest difficulty (e.g. the relative inaccessibility to beds for adolescents in the Glasgow unit because of its low bed-turnover).

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?

9.1 Further use the local charities and voluntary sector partners whose sole purpose is to raise awareness about mental health e.g. Mind Your Head. Shetland Link Up, Alzheimer Scotland (Aberdeen and Shetland).

9.2 Preventative spend approaches and social capital approaches would be helpful.

9.3 Promotion of non-clinical approaches such as social prescribing, self-help around depression and anxiety; support for GPs to recognise, respect and promote services within local communities and anti-stigma messages around engaging with services.

9.4 Wider dissemination of guided self-help interventions. That is easily accessible and in an understandable form.

9.5 Investment in mental health literacy for the general population including further development of the opportunities within Curriculum for Excellence.

9.6 Promotion of WRAPs (Wellness, Recovery Action Plans) for users of mental health services

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

10.1 The strategy needs to articulate that people need to have the foundations in place to address mental health and well-being issues, but this is entwined so closely to other factors – having secure housing, social supports, income etc. So development of mental health awareness within housing, social inclusion partnerships, employability and anti-social behaviour teams is important.

10.2 Strong links with addictions services are vital; as are recognition of the links with traditional health promotion services e.g. smoking cessation, weight management.

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?

11.1 Shetland currently has a process that works and gets results. What would help locally is being enabled to implement With You For You (WYFY - Shetland's Single Shared Assessment process) with our partners without further national directives/targets which at times can add another layer of bureaucracy.

11.2 It was recognised during the recent revision of the Shetland Psychiatric Emergency Plan that a national directory of such plans could provide a useful database. A national database incorporating a library of such resources could support the swifter sharing of information and enable access to and promote the cascading of solutions to local issues from across Scotland.

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

KEY CHALLENGES

Using information to improve the safety, effectiveness and efficiency of services.

Increasing the capacity of our workforce to deliver effective care within the current financial constraints

It will require continued effort to ensure that the capacity of the local workforce is increased in the face of continuing financial constraints and that practitioner minds remain open to new ideas. For these reasons the continued contact and influence of colleagues on the mainland through mechanisms such as Obligate Networks is regarded as essential, though the impact of limited resources on access to learning opportunities should mean that greater emphasis is placed on scrutinising effectiveness and value for money.

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?

12.1 Firstly in recognising the importance of the support that non-clinical admin support colleagues provide to clinicians it might be necessary in order to protect and preserve clinical duties to ensure that appropriate levels of administrative support are firstly, recognised and secondly made available, this would then ensure that clinical time is maximised rather than being 'lost' to admin tasks.

12.2 Any support that promotes and enables effective supervision would be particularly welcomed. The Matrix recognises the importance of clinical supervision as a cornerstone in the delivery of evidenced based psychological therapies, however few commentators appear to have factored in the additional costs that come with providing appropriate 'psychological therapist' supervision, in addition the amounts charged for 'supervision' vary greatly and the production of 'an approved National supervisor approved contact list' with agreed national 'hourly rates as indicators' could assist in bringing uniformity to charging and enhance provision.

12.3 The guidance issued by the ISD psychological therapies HEAT target group has been welcomed and is regarded as very helpful. It would be appreciated if future developments could be supported in the same way.

12.4 NHS Shetland and Shetland Islands Council are making some progress merging elements of their IT systems. There is a view held by some that one single joint IT system with appropriate access for all partners would have a significant impact on the service user/patient experience and could potentially significantly reduce the amount of time clinical staff spend accessing external records and liaising with others. Any support in this key area would be appreciated.

12.5 As the integrated service delivery across /between agencies and sectors picks up pace a nationally led skills audit and possibly a nationally developed skills bank could increase the capacity of the national workforce to deliver effective care within the current financial constraints across services. Recruitment and retention of appropriately qualified staff can be challenging for remote and rural service providers. The costs of advertising etc could be reduced if the National staff bank allowed for practitioners to express an interest in a secondment to remote and rural locations and vice versa for remote and rural staff wishing to up-skill in a city or busier town location.

12.6. Greater dissemination of evidence base practices across agencies and a

greater focus on implementation of what works in mental health settings. Additionally the dissemination of core ICP's *built around person centred planning* and incorporating evidenced based practices.

12.7 Although National benchmarking is a useful starting point and assists the comparison of services at a National level, it would be more useful if it could be refined in order to take into account local issues. For instance comparing the 3 Island Boards might make more sense than comparing any of them with either Edinburgh or Glasgow.

12.8 Increased provision and wider availability of 'spend to save' initiatives e.g. Change Fund with a particular focus on prevention.

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

13.1 As highlighted in 12.4, comprehensive IT issues complicate the delivery of ICPs into practice. The lack of a 'fit for purpose' comprehensive patient records system that is able to monitor all aspects of treatment and effectiveness in the field of mental health is hindering progress. Where possible existing systems are being manipulated to fit, however the increasing costs of licensing access to software packages e.g. CORE is an added cost pressure. National negotiation and direct support with this key theme would be appreciated at a local level.

13.2 To date the promotion of ICPs and associated activity would appear to have been developed in a primarily NHS landscape. The wider dissemination of what an ICP is and how it needs to function across both the Social Care field and voluntary sector could be hugely beneficial. The over 'medicalisation' of many aspects of the pathways has created the danger that they are regarded primarily as an NHS Tool, for those areas who have adopted a more integrated approach (Shetland being a key example) a national message that requested consideration be given to promoting both Health and Social Care pathways would be welcomed. Financial encouragement via targeted incentives could be offered to achieve in this area sooner.

13.3 The support that has been offered to NHS Shetland and local partners by the QIS team has proved invaluable in supporting progress against the challenges of ICP development. It is therefore recognised by smaller Boards that such help and assistance is important and that it be recognised centrally. The continuation of productive teams such as QIS and NES with direct and hands on support is requested.

13.4 Key objectives in relation to mental health services and sharing information across health, social care and other partners would be desirable. In particular, links with the national e-health strategy and national systems for client records and managing the information flows.

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

KEY CHALLENGES

Ensuring service users are at the centre of care and treatment

Ensuring that people can access information to manage their own mental health

Embedding recovery approaches within services

In line with other Boards ensuring that every aspect of service improvement, modernisation and re-configuration is service user approved remains a big challenge.

Though on a case by case basis the philosophical base directing all intervention and support is that of 'person centred', the practicalities in a remote and rural location can be extremely challenging.

Limitations to direct access to specialist services, public transport, IT etc all require innovative 'solution focussed' thinking.

The historical stigma of mental health and associated issues within a remote and rural island location remains and although it is being challenged, it remains a significant factor.

Anonymity can be elusive leading to issues linked to confidentiality etc....

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

14.1 The emphasis of partnership working across all aspects of service delivery within the field of mental health needs to continue. Ensuring that service users/patients are truly at the centre of assessments, support planning and systematic reviews is crucial. For those requiring the most intensive support the more widespread use of Care Programming (utilising CPA) could help achieve this. The emphasis on recovery and independence ought to be integrated in to all existing policies and procedures. Clarity from a national perspective regarding the use of CPA would be helpful.

14.2 In the same way that the focus on 'child protection' has shifted to become 'everyone's business' then mental health (and associated issues i.e. capacity and support and protection) would benefit from being approached in the same way. It ought to become the responsibility of **all** staff dealing with mental health issues to have a minimum working knowledge. Examples of how to achieve this include the Glasgow mental health e-health resource. The production and promotion of similar initiatives for remote and rural locations where access to resources can be limited and expensive would have advantages.

14.3 Although supportive and valuable Partnership arrangements exist

countrywide it is recognised that some issues might benefit from greater service forum discussion, currently there appears no national initiative to support either the funding or co-ordination of service user input. Examples of this type of activity include Patient and Liaison support workers (PALS services) where dedicated independent workers liaise with local service user's and communities and voluntary sector partners to co-ordinate responses service design proposals and service provision. It is important to state that this type of service is not an advocacy service, rather it complements Advocacy.

14.4 Crisis Intervention and emergency support is a key area and it is requested that it remains a key focus at national, regional and local levels. What works is a key driver in the support of patients/service users who use emergency care or receive short-term crisis input. Greater central dissemination of 'what works' in this area would be advantageous, in particular, promotion of Advanced Statements (nationally and locally) could be advantageous.

14.5 It is universally recognised that patient/ service user involvement in the design and planning of mental health services is a good thing. However although there are many examples of good service user involvement there are also areas where involvement can be at risk of being tokenistic or where a small number of activists can have a disproportionate voice for change. In order to offset this issue the following is suggested:

- Increase effective peer support opportunities.
- Payment for "customer feedback". By securing the services of non statutory agencies to produce professional feedback regarding mental health issues. The provider of feedback could then link into all national and local organisations with expertise i.e. Scottish Recovery Network, Alzheimer Scotland thereby providing a direct source of what can work to engage service users on a range of different topics.
- Greater involvement of people living with mental health issues and their families /friends and carers in research projects, both as participants and advisors.
- Ensure that service user and carer involvement is a priority in all forthcoming initiatives. This would include both from a service design perspective and an Individual perspective. Inclusion of service user/patient perspectives on staff training initiatives and pre-recorded training aids would be an advantage.

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

15.1 Specific training resources that enable everyone involved in the delivery and receiving of mental health support services to understand the complexities involved in establishing and maintaining 'mutually beneficial partnerships'.

15.2 As part of a primary care, family and mental health practitioner toolkit particular guidance to be circulated assisting resolution when family and service user/patient opinion regarding the 'best way' forward clash, in particular incorporating advice on the key areas of information sharing and

confidentiality. In building up a toolkit for family work the greater promotion and dissemination of evidenced based family therapies and family based interventions.

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?

16.1 The work being undertaken by various voluntary bodies at a national level is recognised in supporting current 'person-centred initiatives therefore the continued resourcing of these organisations is regarded as crucial. This resourcing includes the Scottish Recovery Network, Alzheimer Scotland etc. it might therefore remain an important feature that those undertaking funding and commissioning at all levels recognise a need to ensure local 'recovery networks' are supported and that commissioning arrangements include a clause that requests 'national and local activity is linked' in order to make best use of the national supports.

16.2 If person centredness is to be further embedded in mental health settings, it might also seem sensible to undertake the following:

- Ensure staff from all agencies and professional backgrounds train together and have a collective understanding of the term, its principles and associated concepts.
- Audit case files to ensure evidence exists re person centredness.
- Develop and utilise a range of outcomes measures. In particular, to demonstrate that outcomes are measured against the person's view of recovery.
- Ensure a collective understanding of the term that is interchangeable and relevant between settings (both community and inpatient).

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

17.1 Build the SRI as a core expectation of any commissioned service (see 16.1).

17.2 Demonstrate the value of the Indicator and offer incentives to see its use increased. As with many very good initiatives there remains a need to ensure that local services and local practitioners have the capacity to absorb the change in order to ensure a successful outcome. One of the most effective methods of ensuring that significant initiatives are implemented is to make them a national target (e.g. HEAT)

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

18.1 The SRN is a widely respected organisation and it would be useful if it could export its knowledge and influence to remote and rural locations more

effectively. Where there is not a significant presence the SRN is less well known to local communities, therefore targeting those areas of the country where the organisation is less known would bring advantages to those areas.

18.2 Other suggestions regarding SRN effectiveness could include enabling targeted access to training for different professional groups, for NHS staff E-KSF is used and for social workers SSSC registration criteria. Many other staff could be influenced at pre-registration training.

18.3 Equal focus on all age groups. An important factor will be that professionals and service users of all ages will require a clear understanding of a recovery model and how it translates to them in order to ensure that expectations are appropriate, this is particularly important for patients with long-term or degenerative conditions or those requiring earlier interventions.

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

The supporting role of carers and families in remote and rural locations should not be under-estimated. Access to resources can be challenging and the distance to the mainland can bring its own unique complications in arranging support visits and liaison for after care support etc.

Sustained direct support offered to remote and rural services from a regional or central position would be appreciated.

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

19.1 Not looking at the person as a single entity, but looking at them and their needs that arise from having a mental illness in their own unique context.

19.2 This is supported locally by our With You For You/Understanding You (Single Shared Assessment) assessments.

19.3 By educating those involved with the individual into understanding the mental health manifestation, impacts, coping strategies and treatment options.

19.4 By listening to carers and valuing their opinions.

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?

20.1 Staff need to be supported to ensure that they are updated and briefed on relevant research, changes in legislation and also to be able to use all policy, procedures and legislation as a collective framework.

20.2 Staff also need to have training in specific areas of communication for example but not exclusively, autism. A person with autism may well have a

mental illness or may be a family member or carer of someone with a mental illness, so it is essential that services develop communication in terms of providing information in an accessible format to support them either to remain within their family or for them to provide support.

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

KEY CHALLENGES

Getting the right balance between community and inpatient care

Many of the problems in getting this right in areas such as Shetland are due to the remote and rural features of the local area and the small scale of services on island, and therefore any national solutions need to be tailored to local needs.

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?

21.1 One of the more useful resources to have been circulated recently has been the QIS Best Practice Statement- March 2009 entitled 'Admissions to adult mental health inpatient services', the production of this style and type of useful literature and in addition access to the team that produced it has proved useful in delivering better outcomes. In addition opportunities for professional dialogue is core in order to share best practice and good practice models, for more remote and rural locations this is being achieved via the Obligate Network. Opportunities for professional dialogue, and mutual support should not be under-estimated to enable the effective cascading of knowledge. Peer review is another useful tool in creating opportunities for better outcomes and more facilitation of such events in ways that are remotely accessible ought to be considered.

21.2 Service redesign in mental health for remote and rural locations can prove to be a complex issue, what might work in one location with particular resources may not work in another. If guidance is issued, can it recognise the 'one size does not fit all principle' with particular reference to remote and rural locations.

21.3 One of the methods being used locally to identify areas for service re-design is the systematic review of MWC Inquires and the production of a local action plan. Such national networks are invaluable in ensuring drivers for change are circulated and it is regarded as advantageous that they continue.

21.4 In addition to national networks and the MWC some service design issues also become evident following contact with other scrutiny bodies, in order to ensure that these do not just remain local a regional or national mechanism for sharing 'lessons learned' might prove advantageous to everyone.

21.5 The use of key productive, efficiency and quality improvement metrics and continued support for service improvement could be beneficial as explicit and

embedded objectives in the new strategy.

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?

22.1 Active monitoring of service uptake by minority groups with reference to local populations, and challenges to service around inclusion are important. The use of tools such as equality impact assessments and the dissemination of best practice examples would be welcomed, with a focus on the context of remote and rural areas with their additional challenges around confidentiality, lack of anonymity and stigma.

22.2 Links to national anti-stigma campaigns such as see-me and other strategies such as the national Sexual Health Strategy and work with young people e.g. Looked After Children would be helpful.

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

Disseminating good practice examples; using and encouraging direct user experience of barriers and successful services. It is also important to look at dissemination and learning in ways that are remotely accessible – the use of technologies including web-based resources.

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

- Crisis intervention and home treatment
- Early interventions
- Assertive outreach
- Dual diagnosis

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?

25.1 Raise awareness and provide wider dissemination of knowledge across all services regarding learning disability and substance misuse issues.

25.2 Ensure service user consultation is utilised.

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

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.

A local skills audit is planned during 2012 and its outcomes will assist work force planning over the coming years. One of the most challenging aspects of managing services in remote and rural locations is the recruitment and retention of suitably qualified staff.

Another key issue in relation to 'skilling' a remote and rural workforce is access to training opportunities. We have recently negotiated distance access to the South of Scotland Diploma Level CBT qualification with support from NES. This type of initiative is proving extremely valuable and distance learning via video-conference has potential as a useful 'option for the future'.

Shetland is also contributing to the joint international service response to the challenges of dementia service design (in particular for remote and rural settings). Currently a Canadian and Shetland/NHS Grampian initiative exists that is proving beneficial to both services in developing tele-psychiatry health care. It is anticipated that aspects of psychological therapy work will be delivered to remote and rural communities by way of video conferencing and the Living Life telephone pilot has been a successful precursor to this.

Shetland has joined the Northern Periphery collaborative (comprising Stirling University, the Western Isles, Sweden, Norway, Northern Ireland and Faroe with the possibility of Greenland) bidding for European funding in order to develop a care delivery template (purpose to maintain independent living) for service user's with dementia living in remote and rural locations.

KEY CHALLENGES

Developing the skills and knowledge of all individuals who are involved in delivering care to people with dementia.

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

27.1 There needs to be a joint strategy developed between all agencies involved in providing care to people with dementia and their families. Work is taking place locally to integrate services provided by NHS Shetland, Shetland Islands Council and Alzheimer Scotland. Greater dissemination by a National

task force might help in the promotion of this.

27.2 Though there has been joint training provided to NHS Shetland, SIC and Crossreach staff by the Stirling Dementia Services Development Centre it is recognised that this needs to continue to ensure all staff have an opportunity to have standardised training provided at a level appropriate to their role. One of the ways in which Government might assist is by providing greater support and incentives for such training. The E-KSF and associated appraisal processes for all staff groups could be a useful vehicle in achieving this goal.

27.3 It is essential that the spirit, actions and practices outlined within the recommendations in Promoting Excellence become mandatory for all staff that will come into contact with people with dementia. Often the best of intentions become lost in jargon and 'professional language', therefore could the messages from the centre be delivered in plain English and be as 'jargon free' as possible.

27.4 It is recognised that the initiatives listed above that are targeting the promotion of supported independent living are essential to the promotion of 'promoting excellence' across community based services and for the benefit of service users avoiding early admission to institutional settings. Therefore it is requested that support for community provision is continued and the emphasis on joint working be maintained.

27.5 Sufficient trained, competent staff to deliver evidence-based psychological therapies.

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?

On the assumption that the national survey will be asking questions related to the current qualifications/experience that our staff have in respect of clinical practice, supervision and training, we don't think there are any other obvious PT surveys that need national level support.

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

29.1 There remain challenges in ensuring that small psychological therapy staff groups are suitably qualified and have sufficient capacity and flexibility to deliver an appropriate specialist range of MATRIX recommended High Intensity, Low Volume (HILV) interventions in remote and rural settings. In recognising this it would be help for National guidance and support on the development of care pathways that incorporate the provision of "at a distance" clinical services that can be delivered in remote and rural settings and are sometimes affected by the challenges of geography and patient choice.

29.2 Developing increased knowledge and understanding of mental health issues among frontline NHS/third sector/Social Care staff will increase the number of staff equipped to deliver Low Intensity, High Volume interventions as part of

an integrated health and social care response to mental health and wellbeing needs. Generic "Training for Trainers" is being provided across Scotland and it is recognised that this training is particularly important for Mental Health staff to maximise their contribution to capacity building in remote and rural areas. Continued recognition of this programme is requested.

29.3 As the Psychological Therapy HEAT target gathers momentum, providing access to specialist treatment areas will be extremely important. It is requested that specialist conditions including personality disorder, trauma and self-harm continue to receive attention because the specialist psychological therapy services required to support these conditions are not readily accessible in remote and rural settings.

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

30.1 This question can be answered by ensuring the development of HILV clinicians so that they can function as practitioner/trainers with a workload/case mix that is appropriate for delivery AND training. This will have the added advantage of ensuring that a) training is informed by current practice and b) that practice is refreshed by the clinician having regular exposure to the current evidence base for interventions. The challenge will be to have appropriately designed stepped/matched care pathways to balance demand and capacity at each tier of the service. Access to clinical supervision is also essential; to ensure that the training people receive is used and maintained appropriately.

30.2 It is advised that the 'training the trainers' model that is being used by NES across Scotland is continued, it is proving to be a quick and efficient model that can disseminate training nationally, however greater dialogue is requested to ensure it continues to meet the needs of remote and rural locations.

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

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

Comments

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.

KEY CHALLENGES

Supporting services to deliver improved outcomes for the same or less resource.

The challenge for remoter and rural locations remains accessing national initiatives such as JIT, the Mental Health Collaborative, TAMFS, various QIS initiatives including ICPs and the NES national training programme (particularly when they are not available by vc), covering staff attending events (the impact of delivery to services should not be underestimated when practitioners leave the Island to up skill) and most importantly the cost of travel and accommodation.

Change is recognised as complex and challenging and the modernisation of mental health services is utilising various tools and programmes in order to achieve it. The continued investment in specific management qualifications e.g. MBA and SVQ5 and OU management courses has proved invaluable in supporting the local development of managers. The learning achieved from all these academic courses is being utilised in the delivery of services and the planning of future activities.

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?

33.1 The sharing of efficiency information linked to key service areas could prove useful, in a similar way to the Collaborative initiative of 2009-2011.

33.2 Greater support for integration initiatives that add value to the delivery of mental health services at a local level, for example continuing the improvement agenda with a 'mental health change fund'.

33.3 It might also prove beneficial to increase direct funding and provide service guidance for the provision of the core mental health service areas of crisis intervention, assertive out-reach and early intervention. Often the needs of people accessing the above services are extremely complex.

33.4 Ensuring national improvement programmes work towards common aims and there is effective co-ordination on the issues held in common so as to reduce duplication and contradictory messages.

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

34.1 National support for this would be highly desirable, to both ensure that the focus on continuous service improvement does not lose direction, and also in order to assist Boards and Local Authorities access training and resources for staff who lead on this work. There are many ways in which this could be achieved suggestions include:

- A national task group

- Following the identification and acknowledgment of key integration and improvement issues the use of existing bodies such as JIT, QIS, and NES who currently link with Boards to support progression on them.
- Introducing integration and improvement as an agenda item into the twice yearly Board Mental Health Reviews.

34.2 The continued building and integration of shared electronic recording of care and support procedures, the Shetland 'With You For You' initiative being a positive example, with national and regional support. In the longer term a national patient/service user data base and case recording procedure would be extremely advantageous.

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.

KEY CHALLENGES

Ensuring that legislation continues to develop in response to changing societal needs, for example, the care and treatment of people with dementia.
Integrated legislative framework to support and protect people

The treatment, care and protection of individuals with mental illnesses, learning disabilities and personality disorders brings with it unique challenges in remote and rural settings like Shetland. Ensuring that the complete legislative framework is applied to everyone requiring interventions that are legally driven is challenging because of the restricted number of specialist posts leading to at times a restricted availability of specialist services. It needs creative and innovative thinking across a spectrum of service delivery to ensure that services are provided within an appropriate legislative framework. Regular contact with the Mental Welfare Commission and attendance at ADSW meetings and legal briefings are useful proving useful vehicles for sharing and learning in this key area.

Access to learning opportunities for staff remains a high priority, though costs can be a barrier to these. The use of Video Conference equipment is one method utilised to keep financial costs to a minimum

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

35.1 The provision of all forms of learning materials e.g. e-modules, manuals, work books etc. is regarded as important, during times of economic pressure associated course/learning fees, travel and accommodation costs and at times back fill are prohibitive to accessing learning. The promotion of affordable video conferencing facilities at mainland events and use of web-based media could assist greatly in this key area.

35.2 The introduction of organisational mandatory training programmes in mental health, possibly using corporate induction programmes might assist ensuing

that mental health matters have a higher profile.

35.3 Where training is delivered ensuring that cross referencing is always made to other associated and linked legislation might assist to bring greater clarity to this complex arena? The production of one key reference guide for the three significant pieces of legislative framework (namely Mental Health Act, Adults with Incapacity and Adults requiring support and protection) could assist promote increased staff awareness of the breadth of legislation in this field. The Mental Welfare Commission/MIND/CAB might support this work?