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.

Inverclyde CHCP welcomes the opportunity to respond to this consultation and inform the future of an integrated mental health strategy. The organisation also acknowledges its continuing role and remit to locally support Government in the development and implementation of a new strategy.

It is our view, the shift to integrate both mental health improvement and the care & treatment agendas into one policy while welcome is not reflected in the document's current format as it reads more as a discussion document opposed to a draft strategy. Moreover, in public mental health terms, the document could be viewed as retrograde step.

It is not evident in the document where there any overarching principles and appears not to be any fit into either a performance or service improvement framework. Nor are there explicit links made to other current strategies and work streams for the wider determinants of mental health and its improvement.

The document gives the impression of being weighted in favour of mental health services and therefore contained within a 'medicalised' context underpinning the document and with very little emphasis on the promotion of population mental well-being. In making this more explicit and recognising the supporting evidence base would ensure the positive move towards integration and mental health being a cross-cutting responsibility.

There is a lack of recognition for the continuum of mental health and therefore the document would benefit from a stronger emphasis of the variety of contributions from a range of partners involved in the delivery of services, where everyone has a part to play in improving population mental well-being. The overall approach to mental health needs to reflect a system wide responsibility, including communities, and agencies.

There is no mention in the document to the role of advocacy services and their contribution to enabling and participation of service users, carers and their families in both individuals care and service improvement. There is a need for national standards in respect of advocacy provision and governance arrangements to support this. Additionally consideration is

needed to adequately resource these fundamental legal requirements. From a structural perspective, the document is too complex and difficult to read and places insufficient emphasis on accessibility.

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.

In terms of some other general comments, there is general weakness in the document of a lack of suggested methodology for monitoring and evaluation. We appreciate there are tenuous links with the Health Scotland work on the mental health improvement outcomes framework and it would be helpful if the document clearly described the ways any impact would be measured with progress indicators determined.

Support of partnership approaches and recognition of the multi-agency approaches already in place would be welcome and there needs to be an understanding that Outcomes are delivered in the longer term and require funding to support their delivery.

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.

We believe the 14 outcomes do not demonstrate the cross-cutting nature of mental health and well-being and could be perceived as either statements of outputs rather than outcomes. Additionally, they lack coherence and cohesion, which compounds the sense that the document lacks a clear theoretical framework or vision. The key challenges do not have clarity about what achievement of the outcomes would be and this should be reflected after each outcome statement.

While targets might be helpful with the overall aim of service improvement, they do not provide adequate support in order for service users' needs to be met and in particular in accessing appropriate help. It would be helpful to have a message going out from the Scottish Government that EVERYONE has a part to play, not just frontline mental health services, but training on mental health (e.g. ASIST, safeTALK) should be available for everyone, including communities.

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

Comment

The outcome does not take into account the current economic climate, where very difficult decisions are being made, impacting on service delivery and therefore this could be better articulated in the document. There is benefit from building on existing economic evidence from NHS Health Scotland and elsewhere.

This outcome needs to be significantly broadened to include reference to improved public knowledge and understanding of mental health. This is compounded by the lack of priority throughout the strategy around preventative approaches. The shift towards individuals taking greater responsibility for their mental health and identifying their own needs will only be achieved through improved understanding of mental health.

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

Inverclyde CHCP's view is that there is a need to maintain a dedicated focus on suicide prevention activity in the years ahead, as an integral element of mental health improvement and service development work. It is well documented and reported to Scottish Government that the HEAT 5 target push has had an impact on the original evidence-based approaches of Choose Life and further community capacity building work is required. Continuing to provide investment in national support resources, such as training, 'knowing what works' through research is fundamental to maintain momentum and to enable change both in terms of health and behaviour.

It is necessary to undertake a review of the job disciplines associated with the HEAT 5 maintenance target and to embed training across all tiers or organisations and all disciplines, with specific links to equality and diversity, plus the cross-cutting themes of addictions and addressing health inequalities. Much of this could be achieved by championing the Choose Life programmes and getting wider partner organisations to attend training opportunities e.g. ASIST, MHFA, Safe Talk to promote understanding and tackle discrimination and making links between services and developing interfaces.

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

It would appear the 'medical' model is overshadowing the mental well-being aspects of this statement and does not acknowledge the many players and champions within communities nor does it reflect the growing evidence base on co-production, asset based approaches and building resilience, all of which contribute to achieving positive outcomes.

A national work programme focussed on anti-stigma for those experiencing dementia is also proposed, along with tackling staff attitudes towards those with mental illness, especially within the NHS, including mental health service, but additionally primary care, 'looked after and accommodated' children's units and addiction services are key health service target groups.

Further community group targeting of the stigma and discrimination associated with mental illness would be beneficial and linking this to wider physical health issues. This is coupled with the current financial climate where issues of discrimination by financial institutions relating to how they deal with customers who lack capacity and who wish to make financial transactions.

Enhancing the voice of those with lived experience of mental illness is a specific action identified, augmented with more education required, awareness raising of what mental health and well-being is about. A critical investment would be with young people and teachers using social education programmes and teacher training, which would also forge links with Curriculum for Excellence.

There should be the expectation of supporting changes in attitude in all settings that mental illness is the same as any other illness, which could be achieved by embedding this in training and up skilling.

Developing culture within organisations to free up non-health and care employees to access training to build understanding – it's not just about how you apply it to a work situation, it's about life in general - will strengthen communities.

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?

In addition to the points made in Question 4, there needs to be the continuation of championing both See Me and complementing this with those of the Choose Life programmes.

Regarding the work of 'See Me' and its partners, more of the same would be beneficial with a focus on early preventative work, particularly in schools and linking to the early year's agenda.

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

There are some concerns over a 'medical model' shaping the well-being agenda within this outcome, as it stands the outcome focuses on individuals and their relationship to mental health services and does not appreciate much to do with a community planning approach to mental health improvement, extending to other areas such as co-production, asset based approaches and building resilience to achieve better outcomes for people.

Having mentally healthy populations as a vision has already been clarified in 'Toward a Mentally Flourishing Scotland' (TAMFS) and we feel that the current draft strategy lacks this in its approach and added to the afore-mentioned confusion. Shared visions and actions are required to take forward the mental health improvement aspects of the new strategy and this is not reflected in the current proposed draft strategy.

It would appear there is little evidence on a public mental health approach to the draft strategy and it is disjointed in its leadership, particularly in the realms of mental health improvement. The document does not elicit a joined-up thinking approach with particular regard to the wider determinants of poor mental health such as poverty and deprivation, along with other cross-cutting issues such poor housing, employability, diet and exercise to improve physical health . Linkages with approaches to Addictions when Alcohol and Drugs are used to mask how people are feeling are required.

An action is required in working with media, social networks, sharing information using up to date technology.

It would be useful to utilise the economic case for good mental health, recognising the value of employees needing to have strong coping mechanisms especially when they are ill with stress/depression, developing a culture to support well-being. This would enable making the links with anti-stigma and promotion of positive mental health.

It is crucial to develop person centred/whole system approaches around the whole family with all life circumstances.

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

Comment

Bringing a focus on practical learning to develop 'how' people learn and how they go on to apply that to 'real' life, could help with developing coping mechanisms and having the required life skills to function. It's not just about a focus on CAMHS services, but about universal provision. CAMHS remit has a multi-agency approach, which is not reflected in the draft strategy.

People, from a young age need to know how to cope with life to be able to have good mental and physical health and stable life, on a whole population basis.

Corporate parenting processes within local authorities provide connectivity for young people who are Looked After and Accommodated but once the local authority role is over they can be left without support. Family style networks need to be established to mirror what happens within families naturally. This can be through community

provision, a thread running through their lives of being supported to make connections – all the way through their journey.

Preventative spend and action needs to be measured over the longer term to identify impact and there will be a significant impact of welfare reform on support for children e.g. Child Tax Credits, as well as very little funding for childcare means barriers to accessing services e.g. parents learning skills whilst child is cared for. This could be seen as a gender equality issue as the primary care givers tend to be women. If parents cannot access appropriate childcare to enable them to train and/or work then children may be living in poverty, which will have detrimental impacts on their mental well-being.

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

CAMHS needs further capacity support to ensure that young people can access services early enough and some of the early years work is wider than CAMHS – whole universal services have a role to play e.g. anti-bullying in schools, early years education, further development of primary mental health care to stop young people getting to crisis point – rolling this out across Scotland for all ages. Therefore, a tiered approach to young people's services needs to be developed as in the case of adult services.

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

Early intervention is crucial and requires resources with further development of Primary Mental Health in CAMHS also needing to be supported.

Linking with other services e.g. education services, including early years, along with building on multi-agency approaches to develop better signposting.

Parenting programmes are crucial and need to be delivered on a partnership basis – attachment 'window' small 0-3 years – use universal 24-30 month health checks to assess mental health as well as physical e.g. parental mental health and development disorders in a whole system approach.

Better partnership working regarding universal services e.g. working in schools regarding mental health and well-being issues and addictions.

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?

This outcome needs to be significantly broadened including reference to improved public's knowledge and understanding of mental health. This is compounded by the lack of priority throughout the strategy around

preventative approaches. Moreover, the shift towards individuals taking greater responsibility for their mental health and identifying their own needs will only be achieved through improved understanding of mental health. This means there is a need for adequate resources to ensure that training and awareness raising programmes are continued through a variety of means and delivered to the public as well as staff.

A fundamental action is to enable support for transitions in life:

- leaving school
- retiring
- redundancy
- having children
- family breakups / divorce
- death
- children leaving home

Some universal and clinical services can support people through the transitions and individuals need to be aware of how and who to get help from and maintain support networks. This would require an action of ensuring up to date information sources is available continually.

Better awareness raising for professionals of appropriately governed and supervised services. Further work is required with GPs to develop approaches to use of psychological interventions, including self-help resources in surgeries and appropriate referrals on CBT/Talking Therapies.

Appropriate level of services available e.g. online/anonymous as first step for young people are required with some national work on building life skills for young people through Curriculum For Excellence.

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

It is our view there is significant work required to raise awareness of gender issues in relation to the use of talking therapies, where men less likely to access these and some anti-stigma work is also required. It is important to recognise that not one size fits all and individuals need to have a variety of communication methods and types of support they can access. It would be advantageous to develop awareness and understanding of cognitive behaviour therapies e.g. Talking Therapies.

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?

Further work is needed to ensure that people can access services easily e.g. online or first contact staff are well briefed and having appropriate care

pathways to facilitate appropriate response to issues. This would be supported by the tiered approach to service delivery. These should be rolled out, developing each tier and the interface between tiers.

In addition, we recommend further development of primary care mental health and having the right capacity and level of service with clear ways of being able to share information. Some additional actions are required in the areas of ensuring there is adequate support in the right places at the right time linking across services, employing person centred approaches.

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?

There is a greater clarity required of the perspective on "non-value adding activities" as it is unclear what this means. There is a fundamental requirement to implement data gathering models, which are effective in co-producing services with service users and partners, particularly through commissioning and service re-design.

Our view is one where there is very little evidence within the current draft strategy, which is reflective and acknowledging of the understanding and expertise of those who have used services and thereafter may be involved in service evaluations. One of the factors to support this could be peer-led evaluations, which have a good evidence base. This would also be a direct method to support people, perhaps in their own recovery, in terms of empowerment and truly having their voice heard.

A whole systems approach in terms of care co-ordinating would assist in achieving this outcome. Some lessons could be learned from many of the existing approaches already developing in local areas, e.g. combining clinical and social care pathways.

Integrated training and up skilling on consistent system approaches, across the workforce, would support improvements and provide some of the way forward. While recognising resources are tight the draft strategy does very little in creating and promoting opportunities for service providers and users and wider stakeholders to come together in terms of service delivery planning and evaluation.

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

Comments

Clearer definition of what is an Integrated Care Pathway is required, in the context of multi-agency approaches to care and treatment of mental illness.

Integrated Care Pathways (ICP) are primarily NHS based and driven, however, wider acknowledgement of others involved in the patient journey of care is required, with greater importance placed on the patients experience. The outcomes anticipated from the pathways should be reviewed in relation to other factors that have an influence on them.

We believe this creates some issues with regard to training and highlights the role of the Care Inspectorate, which is a noticeable omission from the draft strategy.

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?

A helpful way forward would be the investment of localised funding and support for the involvement of service users at a strategic level. This should also take place at the core activities of assessment, care planning and review and peer-led evaluations, as per Question 12.

A greater emphasis should be placed on patient's satisfaction of the service(s) they receive and the overall outcome for the service user. These should be explicit and be made more obvious in national policies and practice guidance.

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

Opportunities for wider sharing of practice approaches that support and develop meaningful partnerships e.g. family conferencing approaches in dementia demonstrator work.

The work of the Scottish Recovery Network is seen as fundamental and the some potential for an increased strategic involvement with organisations such as the Royal College of General Practitioners and Royal College of Psychiatrists to influence training and ongoing professional development.
The Scottish Recovery Network needs to build upon its strength of giving access to international and national research professionals in the presentation of robustly evaluated and researched practices to support the recovery agenda.

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?

There is merit in evaluating outputs in the context of having a consistent approach in determining key qualitative outcomes. Consideration should be given to building upon existing approaches on a multi-disciplinary basis in practice, e.g. The Ten Essential Shared Capabilities.

Guidance on qualitative outcomes and consistent ways of recording are required for everyone who is involved in these tasks.

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

Further awareness raising of the benefits of the use of the SRI tool, complemented with encouraging discussions on the tool as part of practitioners support and supervision, would be an appropriate step forward.

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

Further awareness raising of the benefits of the use of the SRI tool, complemented with encouraging discussions on the tool as part of practitioners support and supervision augmented by further developing a tool to determine the impact on recovery when organisations are assessing new and improving on current policies and practices.

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?

This outcome makes the broad assumption the client will always give his/her concurrence, where in practice this is not always the case. This is mainly due to confidentiality and sharing of information issues. However staff need to be briefed on the importance of involving family and carers where appropriate and recognise their key role as partners in the delivery of care.

A measure to alleviate some of the above concerns might be through training staff in family behaviour therapy, where family members might be seen as co-workers who are involved in the client's care.

The encouragement of local areas to build in respite and short breaks for families and carers needs to be explicit. We should be thinking creatively about short breaks, e.g. community based activity could also be good, and link this with care plans.

Please also refer to Question 15.

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?

Encourage and raise awareness with local statutory organisations and third sector agencies engaging with families and carers already to have the skills and knowledge to work in partnership with all stakeholders to effect positive change in terms of assessments planning and achieving outcomes.

Staff need to be able to access information for families about conditions and promoting positive mental health through clear and accessible information.

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?

Further work of the Joint Improvement Team would support this. Examples of good practice need to be shared across areas through networking opportunities whether virtual or otherwise.

We are aware that there are a number of learned lessons through efficiently responding to the local authority duties and responsibilities in the 2003 Act. This has resulted in a number of joined-up strategies, including health care pathways, developing over the past few years and these should be built upon.

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?

Develop infrastructure and information online to make sure people can access information about services, in a variety of ways and there would be a benefit from some national guidance on evidence of needs. Also need the flexibility to determine local priorities based on levels of need e.g. reaching hidden groups with needs, young men at risk of suicide.

This is an area, which requires support from the centre in terms of investment in local resources e.g. guidance teachers in schools. There has to be building on EQIA processes and ensuring the equality agenda is at top of the list and mental health is included.

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

We understand this to be more about sharing best practice between health and other services to make sure we all develop services that are accessible to harder to reach groups. However, it is our view the response should be more about using Communities of Practice to share good practice, CPD, Equality and Diversity training, tackling discrimination work, getting information out in appropriate formats and languages, via email, web information etc.

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

There are gaps existing in services for young people particularly in relation to ADHD and the Autism spectrum disorders, along with issues around transitions from children to adult services, which need to be addressed.

Redesign work to introduce psychological therapies has begun and we need to build on this and it is suggest that a tiered system approach is brought into children's services as exists in adult services.

The recent change of responsibility of the Prison health care service to the Boards provides opportunity in respect of a hard to reach group and national support for these developments are required. There is also a need to strengthen approaches in through care for people within the criminal justice system, in respect of mental health, when there is an opportunity to intervene and provide support

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?

There is a clear need to raise awareness, information and empower services users and their carers around issues of personalisation and self-directed support particularly in view of implementation of the anticipated legislation. This will also require support to develop safe approaches in practice with staff.

Furthermore, resources are required for training staff to a level that is of a standard to enable the changing of culture / attitudes, e.g. to support the implementation of the standards for care in dementia.

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?

Training required to all staff in primary care and social care on mental health issues and the need for more dedicated resources to continue to provide mental health first aid and ASIST training. Consideration should also be given to wider training to develop psychologically minded practice.

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?

Promoting Excellence needs to be part of joint strategies and agreed shared priorities across the agencies, which could be supported by the requirements of joint reporting. Moreover, this could be more explicitly required within re-shaping care for older people.

With respect to wider mental health skills and knowledge, there is a need to break down barriers between different silos. Promoting good mental health is not solely the responsibility of Mental Health services, and needs to be shared across non mental health staff too. There may need to be different levels of training, but some mandatory training across at least the public sector, linked to CPD.

It should be incumbent on all staff to undertake mental health first aid and ASIST training including staff not involved in operational front line, in order to increase the level of their understanding about mental health in general and their own mental health, in particular.

Leadership is required to demonstrate commitment to right values and attitudes and support mechanisms. Organisational structures need to reflect this commitment and leadership.

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?

Evaluation of the impact of psychological interventions. Please see question 30 below.

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

In the development of appropriate standards and developing skills, resources need to be available in order to ensure staff comply in an evolving culture, which is changing and constantly responding to needs.

There is a need to link in with training institutions and by way of a good practice example at University of the West of Scotland in delivering on ASIST and Mental Health First Aid courses. A national push to include such training in all courses could help build wider community competence and awareness.

The impact of the change to national funding for the practice learning networks, in respect of mental health officer awards. This requires to be reviewed and action to secure the continuing training of mental health officers addressed with national support, if required.

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

There is a need to build psychologically minded approaches across all agencies. The roll out of a national evaluation toolkit, eg CORE would enable identification of the basic skills and training needed to be part of a portfolio of skills system wide to sustain capacity. This would also preserve the specialist resources to be provided to people identified as requiring them, within a tiered system.

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.

We believe a clear definition of benchmarking is imperative so that there can be direct like with like comparisons. It is necessary for any measuring and/or benchmarking to be based on SMART principles and clarity about what is being measured in identifying the benefits.
Benchmarking should include population information; deprivation indices and prevalence of mental ill health.
Development of national benchmarks for the clinical workforce.

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

This requires adequate time and resources, supported by mental health awareness training to be mandatory as is the current situation regarding child/adult protection. A useful clear understanding of outcome impact would be helpful.

There is a need for a clearer understanding of what needs to happen at Board and national level along with clearer understanding required of what an outcome is, and the tiered nature of it e.g. short, intermediate and long term outcomes – linked to the Health Scotland logic models- and that the impact of an outcome will be realised in the longer term.

We suggest 3 levels of training, linked to tiered model of service delivery:-:

- basic – mandatory to all
- More Complex – where relevant
- Specialist for practitioners specialising in mental health.

Expansion of the core national data set, and the integration of outcomes into core operational process is required, throughout assessment, care planning and review. IT infrastructure needs to support this integration to enable use, within and between agencies. This will support evaluation of the impact of service to the individual, and of changes made within services including reference to SPARRA, releasing time to care, HEAT target work. This requires national 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?

There would be benefits to making more robust links with Christie Report and Public Sector Reform. Encouraging changing behaviours and cultures require national intervention. This supports the empowerment of people, not just within mental health services, to enable them to contribute to wider mental health improvement, equality and diversity outcomes as outlined in Question 22.

Investments in outcomes focussing on change require to be for longer periods and for better understanding of cross cutting nature of outcomes rather than targets and measuring our contribution to outcomes.

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

It is fundamental to pull together the evidence base for preventative spend/spend to save and how it works and delivers benefits. There is a requirement for an analysis of causal factors of ill-health and what makes a difference to make it better.

Support to build capacity across all partner organisations to develop effective partnership working to deliver on outcomes, rather than targets and measuring contribution to outcomes.

There is the prerequisite for measurement of impact, which needs to continue over time – measurement should not just be on the shorter-term, with related shorter/intermediate term milestones for outcomes, in order for culture change to be achieved.

Lack of shared systems e.g.IT systems can be a barrier from a technical perspective and needs to be overcome.

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?

Please see question29.
Continuing to promote local and national training opportunities across the agencies, together with the work done by the Mental Welfare Commission would support this in part. This should include opportunities for shared reflective practice.

Provision of centrally available and updated learning materials, and

consolidation of this with a centralised site for practice guidance, and amendments to legislation would assist.