Healthcare Improvement Scotland

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Our Ref: JW/JB MHS Resp

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Dear Ms Christie

Mental Health Strategy for Scotland: 2011-15 A Consultation

Please find enclosed Healthcare Improvement Scotland's response to the Mental Health Strategy consultation exercise. The draft strategy document was widely distributed to key stakeholders within our organisation. The attached respondent information form contains the raw feedback that we received from stakeholders. I trust that this will be helpful as you formulate the final strategy document.

The joint letter of October 2011 to Chief Executives outlined the integrated approach to continuous quality improvement (CQI) in mental health being taken by Healthcare Improvement Scotland and Scottish Government. It highlighted the three main CQI initiatives currently being led by us, namely:

- development of the Mental Health Patient Safety Programme
- implementation of Integrated Care Pathways, and
- Releasing Time to Care – Mental Health.

These improvement programmes are set to continue for the foreseeable future and have relevance to a number of the outcomes outlined in the draft strategy. In addition to our detailed feedback, I would be grateful if these improvement initiatives are considered more broadly and integrated where relevant in the final strategy document.

Yours sincerely

Jan Warner

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Director of Patient Safety and Performance Assessment

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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

- It is a very comprehensive strategy and I think the overall approach for the strategy is the right approach. I think the strategy is particularly light in how, over the next 4 years, we will improve the outcomes for people with dementia in acute general hospitals. This strategy acknowledges the challenges which exist in providing services for older people who have dementia or a cognitive impairment however, whilst the patient safety programme is one action to improve outcomes for older people with dementia in acute hospitals, I believe that there should be a far wider range of actions to meet the significant needs of this growing patient group.
- The strategy has also got very little focus on primary care and in particular the role of the general practitioner. It is acknowledged that good mental health care and treatment which starts early provides the best outcomes for people. Accessing mental health care and treatment including psychological therapies must first of all be through the general practitioner and it is my view that there should be much more focus in the strategy on the role of general practitioner in ensuring early recognition and treatment of mental illness and disorder.
- It is difficult to comment on content when it reflects what has been done and is not shaped as an action plan for the future.
- The coverage of the work to date is appropriate apart from the absence of the separate commitments in the 'Towards a mentally flourishing Scotland' document.
- The peer support and person centredness agendas are not covered in actions that tie in with the wider government commitment to self-management, self-directed support and the role of the expert patient. These are all areas well covered in other parts of the health and social care sector and emphasised through the quality strategy.
- The recommendations from the McManus report and the government's response are not covered. Although it is understood that there is no legislative slot it is important to reiterate the messages and recommendations in the report.

- I found the Strategy to be somewhat fragmented and, to be frank, was left with the impression it was trying to be all things to all people. The reality is that the Government are proposing to have one Strategy rather than having separate strategies for the prevention/improvement agenda and one for service delivery and this obviously can cause some inherent conflict.
- My impression of the Strategy as it stands, is that it is more biased towards service delivery rather than to the prevention/improvement agenda. In addition, any assessment of the prevention/improvement agenda is complicated by the lack of apparent outcome measures to support this work, although this issue may, of course, be addressed as discussed regarding the Strategy as it progresses.
- I find the Strategy to be very aspirational and in many ways would not disagree with the aspirations outlined, but would have concern regarding how these would be prioritised and therefore financed in these difficult financial times.
- I was also unsure for whom the Mental Health Strategy was being written ie is it for whole populations, is it for specialist mental health services, is it for health board areas with or without their partners such as local authority etc etc? I therefore feel that it is essential there be some clarity as to whom the target audience the Strategy will be for and therefore who will actually "own" the Strategy and ensure it is taken forward.
- In summary therefore, I was concerned that the Strategy is too far reaching, not focussed enough, was somewhat aspirational and had no clear target audience.

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

- Dementia services and the work facilitated through the change fund in general, need a level of commitment to the inclusion and effective involvement of the voluntary sector and communities of interest. There is a need for independent advocacy in this field, including specialist carers advocacy. Support to empower people living with

dementia to work in the field as peer supporters either formally or informally, to talk about the quality of life issues that are already being worked on in some local areas and spread these messages eg the work on the DVD from Lanarkshire to be used at share and spread or learning events.

- Nationally more could be done to support that network of service users and carers to interact and share their learning.
- Also work in the acute sector interacts with the dementia work and we need to have a forum whereby all the lessons learned from psychiatrist services and the work in acute services can be shared.
- We should be acutely aware that the concentration on dementia standards doesn't isolate the older population who are being treated following a lifetime in adult services.

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

- The emphasis should be on work on patient reported outcomes.
- The work on patient experience done in acute and primary care is not ideally suited to mental health services. There is a need to use a combination of outcome measures but encourage that work through the combination of Healthcare Improvement Scotland's next ICP measure to be looked at, and the work of the JIT for social care.
- We have talking points and My View. These need to be routinely used, reported on and action plans developed following their usage. This can work in conjunction with the Scottish Recovery Indicator which is being taken forward with releasing time to care.
- A wider piece of work on outcomes more generally could be led nationally with the government improvement team and Healthcare Improvement Scotland. This could combine the outcome measure and their usage and look at reporting and action planning through the service outcomes via the SRI and the individual outcomes via for CAMHS Your Story, for adults My View, and for social care talking points.
- Gaps round about our work across Scotland a proper mental health needs assessment could be encouraged with the input of local advocacy or group advocacy organisations and reflected upon during visits from the divisional team. Again an action plan created and

some improvement support put into place to create the service or identify the data needed on the service to properly assess 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

- Wider training and a shared understanding of good practice within the acute sector and a visiting/scrutiny programme that is based on a peer evaluation model with practitioners from across the piece ie A and E and mental health for self harm.
- Suicide prevention an even wider spread of assist etc and a role for peer support here as well.
- Eradicate in-patient suicides by 2015:
  - Measuring the success of suicide prevention is a key challenge, especially given the complex mental health context.
  - What we can measure is the number of people who complete suicide in hospital. We can also argue that as a nation leading on patient safety, patients should not be taking their own lives in Scottish hospitals. There are clear areas that can be improved: risk assessing and removing access to suicide methods (including ward environmental factors on risk registers); staff awareness and training (especially for non-mental health staff); clinical record keeping and effective communication of information; multiagency working and communication; discharge planning and effective follow-up to prevent crisis re-admission; in partnership with patients, early referral, timely treatment and correct provision of service (person-centred care). If we are able to measure and begin to see tangible improvements in the reduction of the number of inpatient suicides, this would have a positive impact on staff and provide assurance to the public that patients are safe in our hospitals.
  - We are working to improve the critical incident review processes that NHS boards follow to investigate the circumstances surrounding a patient who has taken their own life. However, the outcome of these reviews already provides a valuable learning resource for improving services which should be taken forward to reduce and eradicate suicide in our hospitals.

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

- More work in line with the wider empowerment of the individual as opposed to the work with the mental health population in isolation.
- The messages that people have taken from mental health about self management about peer support about self directed support all for these if framed in the right way can reduce stigma by empowering the service user and by doing it in that way break down barriers.
- The public mental health messages are much better carried through at a local level with communities empowered to understand their own constituents and learn from them.

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

See q 4

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

Comments

See q 4

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

- A problem for the areas where the current cut off age is 16 is that in order to bring it into line with the 18 age limit all new resources will be taken up in order to accomplish that. The starting point will not be the same.
- Nationally priorities for action could be developed while acknowledging gaps. An emphasis on a shared understanding of an implementation framework for ICPs, supported by local staff and Healthcare improvement Scotland and also a dedicated piece of work on transitions for CAMHS to adult but also for adult to old age.

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

Comments

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

- Support for advocacy types of organisations and encourage planning to fill gaps in provision for different groups eg young people, older people, carers, prisoners, BME communities etc.
- Have an overview of the provision of advocacy and the reports generated and some way of completing an improvement programme supported by partners like the SIAA and VOX, but identifying a resource to drive improvements.
- Create a similar support mechanism round self directed support to tie in that area with opportunities within mental health for its usage.

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

Comments

- Streamline links with primary care.
- Create pathways that work and emphasise through the patient safety programme in mental health the needs for primary and secondary care to make access points into services known.
- Use the patient safety approach from primary care and use the local public partners or identified experts by experience /peer support to share lessons learned with the patient population.

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
See above

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

- Help to identify priorities with all partners and then support and create an improvement plan which satisfies the partners that outcomes for service users will improve. The plan to include the data points to be measured, and the place of anecdotal evidence.
- The divisional team could then measure progress.

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

Comments

- Specific links to the Healthcare Improvement Scotland national coordinators and a dedicated resource that must be able to deliver both adult and CAMHS implementation.
- Public involvement support both nationally and locally as service users and carers have to be able to prioritise into which parts of the pathway it is most important to work on and which variances have to have some remedial actions taken to address them.
- Nationally agreed priorities and support for a link between this work and the work on the elements of the healthcare scrutiny model where reporting will be robust and while less burdensome will be able to work on areas where risks are identified.

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

- See all comments to date as gaining and using service user views and a role in either advocacy for or support of others is an integral part of all the other solutions.

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

Comments

- A re-invigorated commitment to the principles of shared leadership as was initiated through the Scottish Leadership Foundation and is now being introduced in other health areas where the duty of user focus has meant that the inclusion of service users in governance is now one aspect.
- In mental health it seems that user focus may not be addressed in this way as currently lessons learned have been passed to others and there is a danger of not ensuring their continuation in mental health as we look more to data sources as an alternative for the collection of views and opinions.
- The participation standard would have been looking for evidence of direct involvement at this level which will now be collected against the healthcare quality standard which incorporates the participation standard, and used to pursue gaps in supports to service users and their families to enhance partnership working.

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

- Use a range of outcomes measures, Your Story CAMHS, My View Adult, Talking Points Social Care already available in combination with the SRI. Use to complete an action plan which can feed into the improvement work of the organisation.
- Mental health is much further advanced in this work and should lead the way in this work while other health services are using a much more basic approach to get their base line.

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

Comments

See above

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

Comments

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

- See earlier comments about more specific advocacy for carers as opposed to generic support.

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

- Carers' views are still a hostage to fortune in terms of the weight given by the clinical team.
- A properly appointed named person and a bit of thought about someone being appointed to that role and an understanding of it should improve the situation for those subject to compulsion for others. Carers input can now be measured in the SRI and that should be encouraged where appropriate.

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

- In terms of learning from each other the implementation advisors and others could link together and as, in all areas where services are being redesigned, there has been good involvement which could inform others.
- We could also learn from the work of independent scrutiny panels.

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

- Wider work on the involvement of communities.
- Tie into the equalities lead network.
- Work with the VOX diversity facilitator and Comic Relief on support for the active inclusion of people from marginalised communities in influencing strategy.

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

Comments

See above

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

Comments

- Transitional care.

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

See all comments to date

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

- Advocacy provision (including in prisons) and its oversight. Legislation and its usage, Adults with Incapacity and its linkages with MHCTSA.

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

- Promoting Excellence is a good starting point. However, social work departments often outsource social care and increasingly promote direct payments to service users/carers, particularly in rural/semi-rural areas. Local councils will need to consider changes to procurement criteria to ensure that agency staff are at least as well trained as their own staff and have access to;
  - the resources that have been developed for NHS and social services staff, and
  - ongoing training and development.
- How is it envisaged that this training will be available to agency and privately employed staff? Could some of the monies paid directly to service users/carers be used to purchase 'training time' for regular employees? There may need to be incentives (or sticks) for agencies to ensure that the staff delivering care are appropriately trained. Additional training may help to reduce agency staff turnover.
- Individual universities and organisations involve service users in different ways for different disciplines.
- A national task might be to make that involvement mandatory.

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

- Surveys are not particularly helpful or innovative enough for a mental health setting.

- At the least the survey should be designed by the partners including service users and their carers.
- Research should be promoted to be led by the service user led research network in order to ensure this methodology.

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

Comments

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

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

- Data points to be chosen by negotiation.

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

Comments

See above

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

See above

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

Comments
See above

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
• When the mental health care and treatment Scotland act came into being multi disciplinary groups, including their local service users and carers, created appropriate local protocols and undertook joint training. • Individual disciplines have carried out refresher training. • The protocols need to be reviewed by a local legislative focus group and overseen nationally to ensure consistency.